

# **Examining the Issue of Equitable Compensation for Ontario's Midwives**

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**REPORT OF PAUL DURBER**

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## A. Introduction

1. I am an independent consultant in pay equity and job evaluation providing advice to clients in Ontario and other Canadian locations. (My expertise in the areas job evaluation, pay equity and compensation has been acknowledged in proceedings of the Ontario Pay Equity Hearings Tribunal and the Canadian Human Rights Tribunal. Details are set out in Section “D” below). Attached at Annex 1 is a copy of my Curriculum Vitae.
2. I have been retained by the Association of Ontario Midwives [AOM] to carry out a pay equity analysis of the registered profession of midwifery from the start of midwifery regulation in January 1994 to the present. In particular, I have been asked to consider this matter in relation to the work and compensation for male comparator family physicians at Community Health Centres [CHCs], as well as nurse practitioners at CHCs. These comparators were chosen as they were the main comparator professions chosen by the Ministry of Health and Long-term Care to set the compensation of Ontario midwives as of 1994. (This was recommended by a Working Group which reported in July of 1993 – see below at “Morton Report”). I understand my overarching duty to provide opinion evidence that is fair, objective and non-partisan on matters that are within my areas of expertise.
3. The purpose of this analysis is to examine whether midwives, as an almost completely female profession, have been paid equitably and free of sex bias since 1 January 1994. “Equitable” in this context is not only based on the estimated value of the profession but also on an understanding of “sex” given the very high sex-predominance of midwifery.
4. In order to carry out this analysis, I have been guided by human rights principles, including the *Canadian Human Rights Act*, which includes a provision for equal pay for work of equal value, section 5 of the *Ontario Human Rights Code*. I have also been guided by pay equity principles established in Ontario (e.g., the *Pay Equity Act*) and the *Equal Remuneration for Work of Equal Value Convention* of the International Labour Organisation (1952, ratified by Canada in 1972). I have taken equity in work and pay through estimating the value of skills, efforts, responsibilities and working conditions [“SERW”]. These criteria form the internationally and domestically recognised criteria for valuing work for equity purposes. Such an analysis was also used in a modified way for the Ministry’s setting of the compensation level for the midwife as of 1994. In order to estimate the value of the work of the three professions noted (especially midwives and CHC family physicians), using a gender-neutral comparison system [“GNCS”]. In this case, I have used the “Equitable Job Evaluation Factor Plan” <sup>1</sup> [See Annex 3] It was developed especially to assess public sector work.

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<sup>1</sup> A publicly available GNCS developed by the Pay and Employment Equity Unit of the New Zealand Department of Labour

5. In order to carry out this pay equity analysis, I have taken a contextual perspective on the question of equitable treatment, that is having regard to the sex of the professions, the description of the competencies and work demands more generally, both initially and as they have evolved to the present; to the matter of the setting of the compensation of midwives by the MOHLTC, within the setting common to the three professions; to the common policies and values governing the professions, that is primary health care reform, and the relative value of the work and compensation.
6. The 19993 Morton Report, after indicating the need to consider the four criteria of skill, effort, responsibility and working conditions, highlighted “education, breadth of knowledge and responsibility in decision-making”. It did, however, acknowledge that a fuller analysis was not conducted. (See page two of the report, which is discussed in more detail below.) This is perhaps because the profession had not yet started in a regulated framework.
7. This report, accepted by the Ministry, led to the initial positioning of the salary maximum for midwives at 65%<sup>2</sup> of that for the CHC family physician, or 90% of the salary minimum.
8. My own Report [shown here with a “capital R”] starts with a current analysis of the professions, that is, approximately 2009-13. In order to analysis the period back to the time of regulation, I took as a first period of review the period of 1994 to 1996. Consequently, the estimate of value is derived by working back from a detailed evaluation of the current work of the midwife and CHC family physician. The reasoning for this process is set out in more detail below. In brief, it is that the Morton Report does not provide sufficient information for a comprehensive evaluation of the work for 1993; that in the intervening 20 years, much documentation has been produced to enable such an evaluation, and that the highlights of changes in the demands of midwifery work can be tracked in the those intervening years. Moreover, in my opinion, it is good practice to audit work every three to four years to maintain equitable compensation. This Report does so for three-year intervals from 1996 to 2012 and a one-year period to 2013 representing the current situation.
9. My analysis proceeds through a number of steps to answer the question of equitable compensation. These follow the logic of pay equity principles and practice. Steps taken in analysis include ascertaining:
  - Whether the professions involved are sex-predominant as part of understanding whether the compensation of midwives is free from sex discrimination; and predominant either because of the proportions of women or men, stereotyping or

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2 Note that this percentage was calculated against direct salary, and did not include compensation allowances, e.g., related to being on call. If that were included, the percentage would drop to 63%. See Mackenzie Report.

historical incumbency, taking into account the traditional characteristics of work done by women;

- What are the values promulgated by the MOHLTC, the common decision-making authority, that should inform decisions for compensating midwives and the CHC family physician professions;
  - Why the comparison of midwife and CHC family physician is appropriate;
  - What is the appropriate means of valuing the work, including appropriateness in relation to
    - The characteristics of work in the professions, recalling that women's work needs to be made visible;
    - The values of the funder, i.e., MOHLTC;
    - The requirement to measure work without sex bias;
  - What is the nature of the work, currently and at various points in time since 1994 (see below at paragraph 13(d));
  - What is the estimated value of that work, using a chosen means of evaluation – the GNCS noted above, and
  - What the resulting values, compared with salary, say about gender equity and proportionate compensation for the midwife.
10. In the analysis of value, it should be added, a “conservative approach” has been taken. If there is a choice between two levels of values to be assigned to the physician I may take the higher, depending on the circumstances. The approach is also conservative in taking a graduated approach to valuing the full range of midwife work such that the SERWC values are recognised over time. Values of the midwife's job grow over time, from an estimated 81% of the CHC family physician's job value to 91% currently of that value. [See Annex 7] The end of each review period is also taken as the date for the evaluation and therefore any required adjustment, e.g., for the 1994 to 1996 period, January 1997 would be the effective date.
11. The evolution of the work has consequently been considered, from the initial 1993 entry-level competencies set out for midwives by the Morton Report and the brief work descriptions of the CHC nurse practitioner and family physician and “authorised acts” for the three professions. Account is taken of subsequent changes in conditions and demands as well as the regulatory framework within which the professions operate. This evolution takes a number of points in time, marked either by signal changes in work such as a widening in scope of practice. These points in time in several instances also reflect key reports about the compensation of the profession that have come to the attention of the MOHLTC.
12. Note that the tracking of the midwife's work through the period since 1994 uses the constant reference point of the CHC family physician.<sup>3</sup> That work is taken to be at its current

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3 See Annex 7 for details.

value for the whole period. This is important since the work also serves as the male-predominant comparator. (By contrast, the female-predominant CHC nurse practitioner is not the comparator for this examination of possible sex-linked inequities. The value of that job is therefore not tracked over the twenty-year period, but is assessed for current value.)<sup>4</sup> I would reiterate that the primary focus of my examination is the effects of sex domination for equitable compensation of the midwife.

## B. Summary of Findings

13. The following are the main observations and findings of this Report:

- a) My conclusion from having analysed and assessed the work using the detailed Equitable Job Evaluation Factor Plan is 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 physician), and third is the CHC nurse practitioner (at 79%). The following is the summary table of the detail found in the Annex 6 rating data:

	EVALUATION RATING IN POINTS		
	<i>Midwife</i>	<i>CHC nurse practitioner</i>	<i>CHC family physician</i>
<b>TOTAL POINTS:</b>	<b>664</b>	<b>575</b>	<b>726</b>
<i>% of physician</i>	<b>91%</b>	<b>79%</b>	<b>100%</b>

- b) While the ratio set by the MOHLTC at regulation in 1994 between midwife and CHC family physician salary maximum was 65% [see footnote two also], the *current compensation ratio* of physician to midwife is *just* 53% (not 91% as my evaluation would have it). In my view, the compensation of the midwife is and has been indicative of unequal treatment, given this disparity between the salary maxima – that is, instead of the receiving 91% of the CHC family physician’s salary maximum, they receive just 53%.—a wage gap of some 38% on a proportional basis.
- c) It is my view that 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 using

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4 The value of the CHC nurse practitioner work, however, also suggests that they are not equitably compensated in relation to the CHC family physician and further review should be pursued on that matter.



the Morton analysis which included a market analysis and not a full pay equity analysis. 81%. The gap did not appear in 2013, but has persisted during the period studied. I have taken three-year periods following regulation, that is, beginning with January 1997, and I have found increasing value, which means the following gaps:

- Period of Review – *January 1, 1994 to December 31, 1996*: the ratio moves from 65% [direct salary: see footnote 2 re allowances] of the salary maximum rate of CHC family physician to **81%** as of January 1, 1997;
  - Period of Review – *January 1, 1997 to December 31, 1999*: increase in compensation from 81% of the maximum rate of CHC family physician to **85%** as of January 1, 2000;
  - Period of Review – *January 1, 2000 to December 31, 2002*: no increase –**still 85%**;
  - Period of Review – *January 1, 2003 to December 31, 2005*: increase in compensation from 85% of the maximum rate of CHC family physician to **86%** as of January 1, 2006.
  - Period of Review – *January 1, 2006 to December 31, 2008*: increase in compensation from 86% of the maximum rate of CHC family physician to **90%** as of January 1, 2009;
  - Period of Review – *January 1, 2009 to December 31, 2012*: increase in compensation from 89% of the maximum rate of CHC family physician to **91%** as of January 1, 2013.
- d) I would add in this regard that “equal pay for work of equal value” does not (in my view) restrict itself to the *precisely equal*, but includes also “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 as discussed below.
- e) Moreover, while I discuss primarily “direct wages”, i.e., salary, it is important to recall that equity applies also to “indirect wages” or benefits.<sup>5</sup> This means that any gap in wages (e.g., the 38% noted above) should also be applied to midwives’ benefits. While I have not treated this aspect of compensation in any detail in this Report, further analysis is also required to compare the benefits of midwives against those provided to the CHC family physician. If they are of less value, then that would represent a further wage inequality during the period being studied.
- f) I should add that another aspect of compensation that could not be adequately treated following this assessment of value methodology is hours of work. According to 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

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5 Pay equity principles call for equality in “total compensation”, including direct and indirect elements of pay.

basic course of care now requires about 10% more time than in 1993.<sup>6</sup> My conclusions with respect to the value of work assumes approximately the same hours as in 1993. This change should also be integrated into the funding formula and any adjustments due to wage gaps.

- g) Finally in relation to conclusions about the wage gaps, I have made reference to the calculations in the Mackenzie Report of the monetary amounts produced by taking these various percentage gaps and applying them to the CHC family physician salary over the time periods taken here.
- h) The 1993 Report to the Ministry, which established the framework for determining the compensation of midwives is helpful particularly in two respects –
  - in selecting two publicly funded primary health care jobs as comparators, one of which in my view was male-predominant whereas the midwife job is almost exclusively female, thereby enabling an analysis for equitable treatment based on sex; and
  - in making reference to the SERWC criteria set out in the *Pay Equity Act*. They were considered in reviewing the positioning of the pay maximum of the midwife.
- i) There are clear indications that the extremely female-predominant work of both the midwife and the nurse practitioner<sup>7</sup> 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 such challenges as their work was 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.)
- j) In contrast, male-predominant work has traditionally often been over-described and possibly over-valued. In particular the physicians have been situated at the apex of health care professions, and have often been favoured in terms of compensation. To ensure equity and gender neutrality, the compensation of both the family physician at CHCs and the midwife needed to be considered together.

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6 "Findings of the 2007 Ontario Midwives Workload Study", Association of Ontario Midwives, 2007

7 Note that there are a number of nurse practitioner roles, including that within the CHC – our focus here. Others include nurse-practitioner –led practices, hospital and other institutional work that have some unique features and demands of work not considered here.

- k) Because it is generally agreed that women mostly do different work from men, that is, they are found predominantly in different occupations, it has been possible to identify features of women's work [see Annex 2]. 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.
- l) In this case there are a number of features of these 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.<sup>8</sup>
- m) The literature is extensive about systemic discrimination that has resulted in women generally being paid less than men for work of equal value. While there has been specialised 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. The following observations may be made in this regard:
- A number of cases before the Ontario Pay Equity Hearings Tribunal have established that health jobs occupied largely by women have been systemically disadvantaged by compensation practices. There is a need for a gender-neutral approach to establishing the *value* dimension of the requirement for equal pay for work of equal value. Systems for valuing work are frequently biased against women's work in not recognising or appropriately valuing features of women's work. (As noted above these features are set out in Annex 2.)
  - Care should be taken with valuing women's work, including the documentation of the work content, the approach to valuing (the "GNCS"), comparisons with male job values and their compensation.
  - Avoiding stereotyping and biases against women's work, ensuring as comprehensive a set of information about work as possible, and ensuring the appropriateness of the GNCS to women's work are concerns here. (All goals must, of course, also ensure gender neutrality in measuring men's work.)

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8 While the literature does not generally provide an authoritative list of the features of male-predominant work, in my experience they include supervision and management skills and responsibilities, credentialed education (including apprenticeship), intellectual effort, responsibility for contacts within hierarchical lines, physical effort, especially in relation to "heavy" work; certain working conditions such as exposure to the elements while working outdoors, disagreeable features of classically male work such as mechanics, and the physical risks associated with those working conditions.

- In my opinion, the GNCS chosen here to estimate the value of work (the Equitable Job Evaluation Factor Plan) enables a gender-neutral assessment of the work to be reviewed in this case.
- n) Despite the stereotyping and sex predominance, both of the female-predominant occupations expanded in their scope of practice, with the midwives gaining the ability to apply for 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 nurses” until 1998. The Morton Report references their predecessor as “senior primary care nurse/nurse practitioner”.)
- o) With regard to the primary health care policy regime applying to all three primary health care professions, it is clearly determined both by legislation and the Ministry of Health and Long-term Care. In my 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. [Annex 4 provides the analysis leading to this conclusion.]
- p) Having analysed policy and contractual documents<sup>9</sup>, I conclude 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. In my opinion, the GNCS used is also appropriate to the policy framework of the MOHLTC as well as to the standards in the professions.
- q) 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 male. Therefore the issue of equitable treatment in light of sex can proceed. It is notable, for example, that the physicians (including family physicians employed within CHCs) through their representative, the Ontario Medical Association, have a compensation agreement covering the profession with the MOHLTC. [Census figures are discussed by Richard Shillington in his Expert Report.]<sup>10</sup> In addition, the family physician generally was 70% male predominant in and about 1993.<sup>11</sup> While more female physicians

9 “Master Contract – Ministry, Transfer Payment Agency and Midwifery Practices”

10 “Expert Report”, Richard Shillington: “Prepared Proceedings before the Pay Equity Hearings Tribunal, Re: Service Employees International Union Local 1 and Ontario Nurses’ Association V. Participating Nursing Homes, April 2013

11 See [http://www.cihi.ca/cihi-ext-portal/internet/en/document/spending+and+health+workforce/workforce/physicians/release\\_26no\\_v09\\_fig5](http://www.cihi.ca/cihi-ext-portal/internet/en/document/spending+and+health+workforce/workforce/physicians/release_26no_v09_fig5)

have entered the profession since 1993 thereby decreasing its male predominance, it stills remains male predominant for pay equity purposes as more fully discussed below.

- r) The initial job documentation (1993) for the three professions relied on by the Ministry omitted a number of features of work needed to understand the work and value it equitably according to pay equity principles (including applying the SERW criteria). There is, however, sufficient evidence about the work from a myriad of other sources, including professional standards, MOHLTC guidance and policy, professional and academic literature and job descriptions. As a result, I would observe that a full analysis of the work is quite feasible. Since 1996 there has been sufficient information to understand the work (discussed below).
- s) There is also widespread documentation on the nature of the work of the jobs in question, as expressed in regulation, professional standards and statements. Joint statements and policy directions supplement the common policy directions for primary health care set out by the MOHLTC. I have also relied on research and other reports. This documentation provides sufficient job content base upon which an equity analysis can be performed.
- t) Given the stereotyping and traditional compensation disadvantages experienced by women in the workplace, it is particularly important to follow good pay equity (and compensation) practice. It requires periodic review of compensation relationships. Updating the picture of value is also in order given the development of the newly regulated midwife work and the midwifery program generally. I have noted above the results obtained by tracking this development – both in terms of increasing value and consequent pay gaps.
- u) Finally, my 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 1993 to an increasingly greater degree as the program and the work have developed and contributed to primary health care.

### **C. Methodology**

- 14. A brief note has been made above of the methodology followed for this Report. This section sets out in more detail how my analysis has been conducted as well as the sources of evidence considered, through the following matters:
  - What framework should be used to understand whether there is discrimination in compensation based on sex;
  - Whether to characterise the occupations involved as sex-predominant and how to correlate the work with women and men;

- How to document the work itself through the three professions;
- What time period to select and the basis for the selection;
- How to apply the framework for understanding discrimination, in this case whether there is equal pay for work of equal value, that is by understanding the value of the work of occupations;
- How to select a method for assessing that value, and in particular by applying generally accepted criteria for selection (appropriateness to the values of the decision-maker on compensation and to the work involved);
- How to draw conclusions about equality, in this instance whether proportionality is reasonable as between the estimated value of the midwife's work and that of the CHC family physician.

#### THE FRAMEWORK

15. The framework is noted in paragraph 13(m) above, that is human rights and pay equity. A link between the two is perhaps the Supreme Court of Canada ruling in respect of the *Syndicat des employés de production du Québec et de l'Acadie v Canada (Canadian Human Rights Commission)*, 1989, brought under the *Canadian Human Rights Act* [CHRA].<sup>12</sup> One may note that decision recognised the discrimination in wages experienced by women and a means of understanding their work through the optic of skills, efforts, responsibilities and working conditions as set out in section 11 of CHRA. The decision was issued at about the same time as the *Pay Equity Act* was being implemented; it contained the SERWC criteria.
16. Key principles of this framework include (a) noting that pay equity is about discrimination in compensation practices; (b) applying one of several criteria to enable identification of occupations as sex predominant; (c) ensuring that the work of women (and men) is assessed using a gender-neutral comparison system or GNCS; (d) making comparisons of compensation of the work according to relative value and using a GNCS; (e) enabling the use of proportionality in that comparison, and (f) providing for the comparison of the values and compensation for work to ensure equality.

**SEX PREDOMINANCE** (for detailed discussion, see Section "L" below):

17. Criteria for sex predominance include:
  - A numerical element, that is, the percentage of the sexes in the occupation.<sup>13</sup>

<sup>12</sup> SEPQA [1989] 2 S.C.R. 879 at <http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/527/index.do>

<sup>13</sup> The technical term in the Pay Equity Act is "job class". For the purposes of this report, a broader concept of "occupation" is used since the former is associated more specifically with individual employers, whereas the "jobs" cited by Morton are more generic.

- Examination of sex stereotyping of the work, and
- “Historical incumbency” – whether traditionally the work was occupied mostly by men or by women.

These have been used to understand where and whether sex has affected compensation.

18. An important element of the context for **midwifery** work is that of “sex”, one of the matters of concern in pay equity and equitable treatment more generally. The profession was, and remains, either totally female or nearly so. (The first male has entered midwifery recently according to the AOM.) It is also notable that the “consumers” of midwifery service are women, although there is also reference to families and friends. Accordingly, midwifery is one of the most female predominant occupations in Ontario. There is no doubt about the association of their work with women.
19. The **nurse practitioner** was and remains more than 90% sex predominant – a pattern generally found in the nursing profession as a whole, both historically and currently.<sup>14</sup>
20. Another important criterion for predominance is the “stereotypical” association between an occupation and sex. Historically, the field of medicine has been male-predominant. The **family physician**, as part of that field, can also be taken to be male-predominant, using the notion of “stereotyping” of fields of work as noted in section 1(5) of the *Pay Equity Act*. [See also footnote 10 above.]

#### DOCUMENTING THE WORK:

21. There are two levels of considerations here: one that is more general and over-riding, the other more technical means to realise the more general goals. They are that the work to be assessed and compared must be comprehensively “made visible” as the Pay Equity Hearings Tribunal would put it. [Haldimand-Norfolk No. 6, 1991] Documenting work cannot overlook features and demands of work. That is to say that the methods need to be gender neutral. The technical means of assuring comprehensiveness and gender neutrality include reviewing job descriptions, questionnaires, other surveys, interviews other relevant job information and having review committees examine the work.
22. Some combination of these methods has been used in this Report. The initial material in the Morton Report included job descriptions and other job content, interviews, consultation, and input from professional associations and committees. That documentation remains useful points of reference. My information also included both job descriptions and notes from interviews to update the 1993 information. To supplement these sources, I have consulted most professional standards from the three professions, legislation applicable,

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14 See “Expert Report”, Richard Shillington as footnoted above

professional journals and academic research as well as a wide range of reports from independent consultants and from the professions. Some of these reports also took the form of submissions to the Health Professions Regulatory Advisory Council to the MOHLTC.

23. I did not consider that questionnaires or surveys, or a greater use of interviews, were necessary given the very large literature as noted in paragraph 22. First, the work involved appears to be both highly regulated (both by legislation and professional bodies) and homogeneous. While there may be variation in the CHC family physician, for example in terms of whether attending births is a significant part of the work<sup>15</sup>, I have credited all family physicians with the highest demand found in the job descriptions or literature. [See also Annex 5-A for notes on further features of the work of the CHC family physician, as well as Annex 6 for details of ratings of the work.]

#### SOURCES OF MY EVIDENCE

24. These are shown in the bibliography attached at Annex 8, which I have organised by theme. Key sources include the following :
- a. *Third-party reports* as follows:
    - The Morton Report referenced above (1993)
    - Reports of 2003 and 2004 from Hay Consultants including “Association of Ontario Midwives Compensation Review,”; “Final Report submitted to the Nurse Practitioners’ Association of Ontario,” and “Toward a Primary Care Recruitment and Retention Strategy for Ontario: Compensation Structure for Ontario’s Interprofessional Primary Care Organizations,”<sup>16</sup>
    - Reports from Courtyard Consultants – “Compensation Review of Midwifery,” Courtyard Group, September 2010; “Compensation Review Of Midwifery.”<sup>17</sup>;
  - b. *Professional standards and statements* applying to each of the professions including both colleges and associations, as well as joint statements and guides with other associations such as the Ontario Hospital Association and the Society of Obstetricians and Gynaecologists of Canada;
  - c. *Information about primary health care*, notably: “A Strategic Review of the Community Health Centre Program,” Dr. Chandrakant P. Shah , and Dr. Brent W. Moloughney; the “Declaration of Alma-Ata”, World Health Organisation, September 1978 and the “Ottawa

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15 See interview notes with CHC medical director and the two job descriptions for the physician: they differ on this point.

16 Provided by the NPAO to the author

17 Provided by the AOM to the author



Charter of 1986" (also noted in the bibliography); Ontario's Action Plan for Health Care – 2012;

- d. *Reports on demographics and other characteristics of the three professions*, including "Expert Report", Richard Shillington as footnoted above; "2010 Workforce Profile of Nurse Practitioners in Canada," Canadian Nurses Association, November 2012; *Reconceiving Midwifery*, eds., Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd;, and *Push! The Struggle for Midwifery in Ontario*, Ivy Lynn Bourgeault;
- e. *Expert analysis of gender and work* including *Critical to Care: Women and Ancillary Work in Health Care*, Dr. Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon; "'I See and am Silent": A Short History of Nursing in Ontario," by Judi Cobourn from *Women at Work: Ontario, 1850-1930*; and "Social Construction of Skill: Gender, Power and Comparable Worth," Ronnie Steinberg;
- f. *Interview notes* with professionals and one midwifery consumer (by the author of this Report: September 2013) – Bobbi Soderstrom, A CHC medical director, Katrina Kilroy, Theresa Agnew, Sheila McIntyre, Vicki van Wagner
- g. In addition, I have relied on *my own experience* in pay equity and job evaluation, as set out in the next section of this Report, including expert testimony, analysis of work and its value, examination of policy issues such as the identification of the "establishment and employer" for purposes of Section 11 of the *Canadian Human Rights Act*, development and assessment of job evaluation plans particularly for gender neutrality and comprehensiveness.

#### **TIME PERIODS AT WHICH TO ESTIMATE THE VALUE OF MIDWIFERY WORK:**

- 25. As I have noted, this study began with the present picture of the work. It is the most complete for all three professions, and is most accessible through public sources as well as through a range of academic research and professional literature. Annex 5 (A, B and C) provides excerpts from this literature under a number of features of work.
- 26. I have noted the need for periodic review of the work, its value and compensation. In my opinion good compensation and pay equity practice requires the review of pay and value of work periodically. When I was at the Canadian Human Rights Commission I recommended every three or four years as a reasonable period of time between updates. Reasons include changes to the work or organisation, changes in the basis for comparisons for pay and value of work, the need to keep pay and job information reasonably current and to avoid situations of "catch-up" after a long period of not re-examining the work. If this periodic review is not conducted, in my experience pay equity will recur and not be remedied, given the dynamics of on-going systemic gender discrimination.

27. The base period of 1994-95 covers the three years following regulation at 1 January 1994. As noted above, changes in work are tracked during that period and intervening ones to the present (see Annex 7).

#### **UNDERSTANDING AND ANALYSIS OF THE WORK:**

28. In light of the significance of the Morton Report of 1993 in the Ministry's setting of midwives' salaries, my point of departure for analysis is Appendix "C" to the Morton Report. Its framework contains a number of headings that are reproduced in Part A of each of the parts of Annex 5 (one for each profession). Because that framework is outdated by changes in work of both midwives and nurse practitioners and is insufficient for family physicians, it is necessary to supplement those first headings, at Part B. The matters omitted are, for example, administrative and data responsibilities, hospital privilege issues, supervision and management of a practice; research and practice improvement, as well as continuing study; and inter professional collaboration and negotiation. All are grounded in documentary or interview information.

#### **CHOOSING THE APPROACH TO VALUING THE WORK – THE GNCS:**

29. Proper pay equity practice requires that the method chosen for valuing women's work ensure that overlooked and undervalued features of women's work be made visible, for example through the criteria for evaluation. This is enlarged upon below. Other criteria for a gender-neutral job evaluation plan are as follows:
- It should also be comprehensive, certainly of skill, effort, responsibility and working conditions as part of a full consideration of the features of work, in this instance of primary health care work.
  - The plan should positively value these features of work. An example (also noted below) is the relatively recent recognition that stress experienced by the individual is a "compensable factor", that is that it should be a component of the evaluation system, possibly under emotional or psychological effort.
  - The job evaluation plan should be capable of a broad and liberal interpretation, that is, it should not set out inflexible formulas with which an evaluator cannot find equivalents that might be needed to link to the work being valued. An example of this problem in traditional job evaluation schemes is "years of experience required". By themselves such years cannot be equated to something more qualitative such as knowledge of the organisation (as noted below, a frequently overlooked aspect of women's work).
  - The GNCS should avoid stereotypes and invite the evaluator to examine the components of the work, setting aside from traditional images of it.

- Finally, the GNCS should be capable of being administered component (or factor) by component, with each being reasonably independent of the others, and not confounded with them. While factors are inter-related, double-counting should be avoided as it too can introduce bias.
30. I have noted toward the end of this Report (at SECTION “O”) detailed considerations in the choice of the GNCS, and indicated that I believe that it meets the criteria for good pay equity practice.

#### **EQUALITY AND PROPORTIONALITY – LINKING VALUE AND COMPENSATION:**

31. In my experience, the application of pay equity practice has involved a flexible interpretation of what “equality” means in the dictum that for work of equal value there should be equal pay. Exact equality may not be necessary, for example, to find that a woman’s job is disadvantaged in comparison with that of a man for approximately the same (or equal) value. Moreover, women’s work can be disadvantaged by not being compensated proportionately with male work on the basis of value. That is, the two – value and pay – should be proportionately related.
32. Proportional valuing is a necessary tool for establishing such an equitable compensation on the basis of sex. If, for example, a woman’s job is worth 80% of a man’s, but she receives 50% or 60% of the pay, the pay for the points of value is unequal. Therefore, I propose here the use of proportionality as part of the methodology for matching value of work and its pay.

#### **D. The Consultant – Expertise and Experience**

33. **OVERVIEW:** I am currently an independent pay equity expert and compensation consultant based in Ottawa, Canada. My practice focuses on job evaluation, primarily in the context of gender-based pay equity. Over the 14 years in which I have had an independent practice, I have had a variety of clients: unions, employers and joint parties; government and private sector; located in Ottawa-Gatineau, Montreal, Toronto and Iqaluit primarily. Prior to my independent consulting work, I served for over nine years in a leadership role on pay equity, and was Director of the Canadian Human Rights Commission’s Pay Equity group. In that capacity, I oversaw investigations primarily under sections 10 and 11 of the *Canadian Human Rights Act* [CHRA] (relating to systemic discrimination and to equal pay for work of equal value), as well as policy development and inter-agency relations in the field of wage equality.
34. Attached at Annex 1 is a copy of my Curriculum Vitae. The details of my expertise and experience which support the opinions and evidence provided in this Report are summarized below.

35. **EXPERTISE RECOGNIZED BY COURTS AND TRIBUNALS:** As the CHRA Director of Pay Equity, I testified frequently before the Canadian Human Rights Tribunal during which I was qualified as an expert witness in the fields of job evaluation, classification in the federal public service and pay equity more generally. I testified extensively before that Tribunal on the federal public service, both as the Tribunal's witness and to provide testimony on behalf of the Commission. The former came at the invitation of the Tribunal (and with agreement of the parties) to give them an overview of the occupational structure of the public service, its classification system and how work was compensated. The later testimony on the merits set out the views of the Commission on a wide range of matters, in which I provided both factual and opinion evidence with respect to provisions of the *Canadian Human Rights Act* and regulations; women's work and how it was valued or "under-valued" in effect, the results of the Commission investigation of the parties' equal pay study, and compensation matters. My evidence is referenced in the Tribunal's decision. (T1698-98, Canada (Attorney General) v. Public Service Alliance of Canada (T.D.) Trial Division, Evans J.)
36. I also testified at length in both the Canada Post and Air Canada Tribunals (both of which went to the Supreme Court of Canada). The policies of the Commission were a focus of the first Tribunal, where I was also qualified as an expert witness. It covered the question of whether the work done by women (largely clerical work) was equal to that of Postal Workers.
37. In the Air Canada case, I also testified for ten days on behalf of the Commission with respect to the Commission's investigation and the meaning of the term "establishment", whether it should be given the very restrictive meaning that the respondents maintained (that was, following the boundaries of bargaining units), or a broader meaning to enable pay equity. Given that I was the investigator, I had to examine that question for the Commission and in explaining the investigation to the Tribunal, to provide what amounted to opinion evidence. The testimony was referenced in the eventual Supreme Court decision.
38. **ADVICE TO EXPERT BODIES RE: PAY EQUITY LEGISLATION AND ENFORCEMENT:** I was asked to appear before legislative committees at the federal level and in New Brunswick on legislation touching wage equality. The first involved the provisions of the Public Service Equitable Compensation Act, which was included in the 2009 Expenditure Restraint Act. The second involved an appearance via video link to the committee in Fredericton that was reviewing a private member's bill that would have implemented "proactive" pay equity legislation in that province.
39. One of the Director's major roles was to seek reports from outside experts to provide the Commission with independent advice on matters that were unclear in the federal legislation (including regulations). One of those experts was Dr. Pat Armstrong, whose work on health care I have consulted for this Report. The matters on which I sought advice from experts

included how to value benefits such as pensions, how best to carry out statistically valid equal pay comparisons, and how to estimate the reliability of the major study of the value of work in the federal public service, including the question of bias in the study.

40. As the CHRC Director of Pay Equity, I became familiar with the legislation governing wage equality in other jurisdictions, especially Canadian. I initiated gatherings of agency heads from those jurisdictions to develop greater mutual understanding of the field as well as of the specific practices in each province. I also had the occasion to meet with employers and employer associations to explain the legislation, to note the differences between federal and various provincial equal pay frameworks and to contrast the meaning of a “pay equity wage gap” and the more general “wage gap” on which there are statistical reports and interpretations in the literature.
41. PAY EQUITY CONSULTING: My work has included advising on the implementation and maintenance of pay equity in organisations, designing job evaluation plans and implementing them with parties, adjudicating classification grievances, facilitating job value reviews (including health jobs such as nursing), developing job descriptions, studying equal pay complaints (under both federal and Québec legislation) and providing advice in cases being litigated. I have also given advice on equitable compensation (including the use of external comparisons).
42. As an example, I have dealt with an encompassing study of primarily office and technical jobs (along with their technical, male-predominant positions) at the Commission de transport de l’Outaouais. The study was part of a joint initiative by the employer and the union representing the female-predominant employees. In-depth study of the work was required, to document the demands made and custom-design criteria for valuing the work and designing a questionnaire. I also advised on an equitable pay structure.
43. A later major study, undertaken at the behest of an employee association, required an examination of the value of work of nearly 200 public service jobs. The report, which has been distributed to the employer and Adjudicator, was presented at the Public Service Industrial Relations Board in the spring of 2013.
44. In addition to the above work as a consultant, I collaborated with a U.S.-based expert appointed by the Ontario Pay Equity Hearings Tribunal to work with the parties in implementing the provisions of the Ontario Pay Equity Act at the Toronto Public Library. The study involved examining a wide range of work within the Library as well as in unionized jobs in the City.
45. My previous experience at the House of Commons, where I was Chief of Compensation, and in the federal Public service, over some 23 years is outlined in my Curriculum Vitae. While at the House of Commons, I brought the under-compensation of women cleaning staff to the

attention of the Board of Internal Economy. I also initiated and directed a study resulting in an equal pay regime for administrative staff of the House.

46. While at the federal Treasury Board Secretariat (the “employer” for the public service), I designed a job evaluation plan and later planned a service-wide compliance audit. Both assignments involved extensive examination of work (for example of computer technicians in the instance of the plan, and several dozen jobs in Atlantic Canada and Ottawa for the audit). Results from that report eventually went to the Public Accounts Committee of the House of Commons.
47. During the course of my work, I have reviewed the characteristics of work frequently found in female-predominant occupations. As a result, I have expanded on the brief list adopted by the Ontario Pay Equity Hearings Tribunal (in Haldimand-Norfolk). These lists have served as the basis for my critiques of existing job evaluation plans and questionnaires, as well as for training of parties. Attached as Annex 2 is the expanded list I have created.
48. Over the years I have dealt with a range of individual employees, as well as their representatives – both legal counsel and unions. In the course of many conversations I became aware of how difficult it was for the individuals in particular to bring equal pay and systemic complaints to the Commission, and how vulnerable many felt to retaliation from their employers – even though such action was contrary to law. I am also aware of the psychological effects on employees of undervaluing of their work, from both tribunal evidence and conversations.
49. On behalf of the Canadian Public Personnel Management Association (now International Personnel Management Association, Canada, of which I am a life member), I organised the first (and perhaps only) Northern conference on pay equity, held in Yellowknife and supported by the Territorial government.
50. **HEALTH CARE AND SOCIAL SERVICES SECTOR EXPERIENCE:** In terms of the health care and social services sector, I have had significant experience in relation to the pay and work primarily of health care sector jobs including nursing work, as well as some experience with community services. Most recently, I have offered analysis and testimony in a case involving a wide range of health workers in four hospitals and whether aspects of the job evaluation plan used was appropriate to the values of the employer and the demands of work. The matter settled with the parties using as a base for further work a factor I recommended for valuing the impacts of work.
51. In addition, I have also examined for the Pay Equity Hearings Tribunal the issue of maintaining pay equity for health care jobs in long-term care homes. That case is ongoing.

52. With respect to the health professions in the federal jurisdiction, I reviewed the findings of the federal equal pay study with respect to nurses, physiotherapists and dietitians.
53. I also directed the Canadian Human Rights Commission's work in preparing for an earlier Tribunal on the Health Services complaints involving nurses' aides in a Veterans hospital and Community Health Representatives in First Nations communities across Canada. One of my investigators carried out extensive interviews with the Representatives, giving the Commission an insight into their work and their working conditions. I also formed an opinion about the vulnerability of the women who performed such work – vulnerability in terms of their working alone with many clients, and their belief that they were relatively powerless vis-à-vis their employer. The case also involved an examination of the gender neutrality of the job evaluation plan respecting jobs across the whole occupation, which included food workers and others in federal hospitals and Veterans homes (which were in the public service at the time the plan was instituted).
54. A further case, which was eventually settled by the union and the federal employer, revolved around clinical social workers, many of whom worked in health-related jobs. At issue was whether these jobs, embedded in a larger occupation, could be treated separately under the federal legislation for purposes of equal pay comparisons. The Commission staff was required to examine professional characteristics of work as one of the criteria for deliberating.
55. I examined a number of jobs within the hospital sector in Montréal as part of an investigation for the Commission des droits de la personne du Québec. The examination and documentation was aimed largely at technical jobs occupied mostly by women.
56. I advised two small not-for-profit organisations on the compensation of their Executive Directors. One was a community health centre and the other a mental health provider. This work involved examining the work and making outside comparisons, with a view to enabling boards to directors to situate compensation equitably in relation to an outside pay universe in Ottawa.
57. I examined nursing jobs in the new Territory of Nunavut, as part of a joint re-examination of their value. The work included hospital nurses, directors of nursing stations across the Territory, and practical nurses as well as midwives. My role was to guide a joint grievance committee through interviews with incumbents and supervisors with a view to understanding work demands equitably and re-establishing a reasonable value for the work.
58. I was also asked by legal counsel to an employee organisation representing nursing staff in the federal government to review the work the female job class, Medical Examiners, and the male-dominated doctor job class over a period of time. This work related to issues arising in pay equity proceedings (Ruth Walden et al., CHRC, Social Development Canada et al, 2009

CHRT 16 and further proceedings on the issue of wage discrimination). There were job documents and testimony before a Tribunal to examine, as well as the submissions of parties on the subject of the proportionate value of the work. The issue to be determined was how to approximately quantify the size of the wage gap, an earlier Tribunal having already established that the compensation was not equitable, even though the jobs were not equal in value. As a result, a somewhat novel approach was taken to applying section 11 of the CHRA. That is, the objective of equal treatment could be said to go beyond simple equal value to proportionate compensation for proportionate value. The case was settled this past year (2012) along the lines that I (and the employer's expert) recommended.

59. **TEACHING AND TRAINING:** I have frequently provided training on pay equity and job evaluation. For example, I gave a course on such matters, as well as the federal legal framework, to employees of the Canada Department of Labour who were to be involved in that Department's audit program of small- and medium-sized employers.

#### **E. Contextual Considerations – Commonality of “Primary Health Care” to all three professions**

60. The three professions being studied are integral to the reform of the Ontario health care system through funding and emphasis on primary health care. They are all patient-centred and are the first line of care for clients. Many of the goals of this reform have been set out in MOHLTC documents, including an Action Plan for Reform.<sup>18</sup> A number of the features of work of the three professions flow from the reforms, such as professional autonomy (as part of their scope of practice), educational requirements and inter professional collaboration. The formation of group practices, such as in midwifery and the Community Health Centres are also examples of the reform. The centrally determined funding by the MOHLTC is a further example of the working of primary health care reform. Funding agreements are extraordinarily detailed and point to a myriad of aspects of work that are to be funded and controlled, including compensation.
61. The complexity of the context is evident in the wide range of MOHLTC policies, the myriad of statutes, regulations and policies affecting all three professions, their professional standards and the process of authorising educational requirements, the influence of public policy more broadly (such as the Alma Ata Declaration and the Ottawa Charter – both informing the framework for primary health care), and the wide variety of client needs and conditions.<sup>19</sup>

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18 “Ontario’s Action Plan For Health Care: Better patient care through better value from our health care dollars,” [http://www.health.gov.on.ca/en/ms/ecfa/healthy\\_change/docs/rep\\_healthychange.pdf](http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)

19 I have listed the main documents consulted in a bibliography, shown at Annex 8. The list is not meant to be exhaustive, certainly not (for example) of the many professional standards and reflections on roles and work that exist. The Society of Obstetricians and Gynaecologists alone,



62. The MOHLTC used the CHC family physician as the key comparator for setting midwifery compensation. This is particularly appropriate in the two senses that both professions are part of primary health care and both are publicly funded. In my opinion, it is not necessary to go beyond the comparison that was central to Morton, at least in terms of comparing the work of other occupations or jobs. (Other professions were introduced by Morton, but those were points of possible market comparisons, which are generally outside the scope of a pay equity analysis, given the possible sex biases in market rates.<sup>20</sup>)

#### **F. Context: Historical indicators of stereotyping of midwifery and nursing work**

64. INTRODUCTION: As noted above, sex stereotyping can work in two ways to disadvantage women's – particularly midwives' – wages. That is, not only can the traditional status and stereotype ascribed to the work produce lower wages than an objective value would produce, but the relative favouring of the work of physicians, seen as superior because of stereotyping, can reinforce the negative image and valuing of midwifery work.
65. Several academic sources point to negative images of midwifery and nursing that contribute to the stereotype that has been and continues to be in place. Stereotyping and prejudice are recognised in the *Pay Equity Act* and decisions made under the Act as being gender-specific. Stereotyping is one of the criteria for identifying which job classes under that legislation are gendered. For the purposes of this Report, I have widened the technical term of "job class" to profession or occupation. As noted above, stereotypes usually operate as filters in making work invisible and adversely impacted, and in arriving at an objective view of the value of work. In my experience, the result is usually compensation that is lower than it should be relative to that of male dominant occupations.
66. Bourgeault makes a connection between the image of midwives in Canada in the late 19<sup>th</sup> century and the rise of medicalized birthing:

"Physicians [around the 1870s], in contrast [to attempts to legalize midwifery], were promoted as superior birth attendants trained in 'scientific technological childbirth practices.... Canadian women's confidence in giving birth and in attending birth was slowly being eroded, a trend beginning with the upper class and moving to the middle class...."<sup>21</sup>

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for example, lists several dozen. And the statutes themselves are not part of the list. Some 22 were touched in establishing the statutory framework for midwifery.

20 Note that the pay equity framework also includes "reasonable factors" that can "exempt" certain salary situations from the equality equation. They include "temporary market shortages". There is no indication of any such exemptions in the setting of the compensation of family physicians.

21 Bourgeault, page 45

67. In relation to the image of the midwife, Leslie Biggs notes the popular myth of the neighbourhood midwife, which she says does not properly represent reality<sup>22</sup> – but which is nonetheless (in my opinion) useful to recall as part of the notions surrounding midwifery. These are not inconsistent with Ehrenreich (see below) and Bourgeault. Like many such myths, they miss many of the skills and challenges that the work has entailed. It is the role of objective documentation of the work to be conscious of stereotypes and to focus on the real requirements of the work.
68. Bourgeault also refers to gender issues in an article on primary health caring:
- “The meaning, context and provision of care work are issues that have in the past decade become much more salient in the literature of female healthcare providers [...]and in the broader sociology of women’s work [...].One of the central concepts in this literature is the caring dilemma first described by Susan Reverby (1987) in her historical examination of nursing work. She describes this dilemma as the imposition of a duty to care in a society that devalues the care being provided. At the heart of this dilemma is a tension between altruism and professional autonomy and by extension between the interests of the care provider and her client.”<sup>23</sup>
69. A recent U.S. study from Barbara Ehrenreich makes a note of stereotypes that have historically affected midwives, as follows:
- “Witch hunts did not eliminate the lower-class woman healer, but they branded her forever as superstitious and possibly malevolent. So thoroughly was she discredited among the emerging middle classes that in the seventeenth and eighteenth centuries it was possible for male practitioners to make serious inroads into the last preserve of female healing—midwifery.”<sup>24</sup>
70. With regard to nursing, Ehrenreich speaks to the roots of the profession in domestic work and its association with traditional women’s roles:
- “...While some women were professionalizing women’s domestic roles, others were ‘domesticizing’ professional roles, like nursing, teaching, and, later, social work. For the woman who chose to express her feminine drives outside of the home, these occupations were presented as simple extensions of women’s ‘natural’ domestic role. Conversely the woman who remained at home was encouraged to see herself as a kind of nurse, teacher,

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22 In *Reconceiving Midwifery*, eds., Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd; McGill University Press, 2004, pages 21 and 22

23 “THE CARING DILEMMA IN MIDWIFERY”, Ivy Lynn Bourgeault, Jacquelyne Luce & Margaret MacDonald, in *Community, Work and Family*, Vol. 9, No. 4, November 2006, pp. 389-406, at page 390

24 *Witches, Midwives & Nurses: A History of Women Healers*, by Barbara Ehrenreich and Deirdre English, Feminist Press, 2010, page 57

and counselor practicing within the limits of the family. And so the middle-class feminists of the late 1880s dissolved away some of the harsher contradictions of sexism.” [Page 94]

71. Judi Cobourn in an article outlining the history of nursing and women’s health professions in Canada notes other characteristics of sex stereotyping in the late 19<sup>th</sup> century, and hence of historical disadvantage to these professions as follows:

“Although the medical advances led to a decrease in mortality rates, the new institutions were hierarchic, undemocratic and removed from the community to such an extent that many extremely valuable aspects of the old community health care system were lost. The institutionalization of health care had serious implications for women’s role in medicine. Once independent practitioners, they were denied training and were thus relegated to a subservient position within the medical profession.”<sup>25</sup> [Page 135]

“In fact, popular ideology as to the proper place for women sanctioned employers’ exploitation of women’s work outside the home. The low wages paid to women were accepted since the work was only supplementary to the primary duties of a woman to her family. The public sector, as an employer of women, made particularly profitable use of the feminine mystique. It was hardly necessary to justify low wages for nurses when their work was considered a public service and similar to unpaid work in the home. Like housework—nursing the ill, teaching small children and tending the poor were “esteemed” as familial labours of love.” [Page 155]

The link is also made here between the image and status of these professions and their low compensation, one that is pertinent to the matter before the Tribunal. Women in Canada still earn lower wages than men, including in the health professions. Not only do the Census figures from 1991 to 2006 show this consistent pattern, but they are a further reason for testing the equity of wages since 1993 for midwives in view of their female predominance.<sup>26</sup>

#### **SIGNIFICANCE OF SEX as a consideration in equitable treatment:**

72. Dr. Pat Armstrong: Dr. Armstrong sets out the significance of these considerations for equal treatment as follows:

“Pay equity legislation is based on evidence relating compensation discrimination to three factors:

1. The majority of women are segregated from men into different work and different workplaces

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25 “I See and am Silent’: A Short History of Nursing in Ontario,” by Judi Cobourn from *Women at Work: Ontario, 1850-1930*, Janice Acton et al. editors, Canadian Women’s Educational Press, 1974

26 See Richard Shillington, “Expert Report” as cited above.

2. In general, women's segregated work is paid less than men's work and the higher the concentration of women, the lower the pay

3. Lower pay reflects the systemic undervaluation of women's work relative to that of men

"These three factors combine to create pervasive and often invisible discrimination. This systemic discrimination is, for the most part, evident without regard to the particular skills and characteristics of the women involved or to the specific employer. The evidence of systemic discrimination has led, at the provincial, national and international level, to legislation that allows the different jobs performed by women and men to be compared in order to ensure that differences in compensation do not reflect and perpetuate this systemic discrimination."<sup>27</sup>

73. During my research, including interviews, I have observed that there is a belief among both midwives and nurse practitioners that discrimination on grounds of sex is still operating. Some of that belief is based on others' views about their occupations. Given the fact that these professions are so overwhelmingly female-dominated, there is reason to think that the views continue stereotypical attitudes (discussed under section "K" below) about women's work as being less trustworthy of exercising autonomy or being competent. There are statements by medical colleges about working with midwives and nurse practitioners.<sup>28</sup> I would presume that the statements must have been needed and that collaboration was not what it should have been. To underscore the presumption, it is significant the MOHLTC also made policy statements to the same effect.<sup>29</sup> The AOM also documented these needs in respect of midwives in particular. All of this is further reason to test the value and compensation of midwives in particular (as they are before the Tribunal) for sex neutrality. Other background for the views about the stereotyping of midwives and nurses is examined in section "K" below.

74. More detail about the disadvantages midwives perceive they suffer as individuals and an occupation are contained in statements by members of the AOM. They report comments from physicians that they must "clean up your [the midwives'] mess [that is to say the

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27 Pat Armstrong, EQUAL PAY FOR WORK OF EQUAL VALUE, June 2008, prepared for the Public Service Alliance of Canada

28 For example: 58. "A Joint Statement of Professional Relations between Physicians and Registered Midwives In Ontario", Ontario Medical Association and the Association of Ontario Midwives, March 2011 at <https://www.oma.org/Resources/Documents/MidwiferyJointStatement.pdf>;

"Joint Policy Statement on Normal Childbirth," SOGC, December 2008 at <http://sogc.org/clinical-practice-guidelines/>

29 For example, "Interprofessional Care: A Blueprint for Ontario," HealthForceOntario, July 2007, at [www.healthforceontario.ca/IPCProject](http://www.healthforceontario.ca/IPCProject)

difficult birth cases]” or “[midwives] don’t bring women [clients] to hospital when necessary [and are creating] harm and endangering [health]”.<sup>30</sup>

### **G. Context: the obverse stereotyping relating to the physician**

75. The literature quoted above also comments on the gradual ascendancy of the entirely male medical profession during the 19<sup>th</sup> century<sup>31</sup>, and the subordination of female-predominant occupations such as midwifery and nursing. That ascendancy translates itself into the stereotype of the physician as the dominant profession, and that in turn has its expressions in human resources decisions such as compensation. [See Bourgeault, in *Push!*] Historically, the physician is compensated at a much superior rate to the other two professions. Moreover, in professional terms the physician has been accorded a more authoritative role, for example in hospitals.
76. Since the 1980s, there has been an evolution in the relationships of the three professions toward equality and mutual respect, for example, through joint statements and Ministry policy. Nonetheless, it is important to evaluate the work of physicians, for example, the CHC family physician, taking care not to retain some of the “halo” of the historical image of authority, autonomy and competency in clinical and other matters. “Haloing” is a recognized form of evaluation bias. In my own evaluation, I have given a certain degree of credit for authoritativeness to the CHC family physician, but have linked it to the wider scope of practice relating to the range of illnesses, diseases and conditions that are presented.

### **H. Context: The Key Characteristic of “sex”, its definition and presence and significance as a consideration for equity**

75. WHAT IS MEANT BY “SEX”? In terms of equity, sex is one of the proscribed grounds of discrimination, that is, differentiating treatment for reasons related to a person’s or group’s sex. In pay equity, it is recognised that not all differences in wages are due to sex. Many are understandable, such as hours of work, or time in an occupation. Others are subject to less agreement, such as what work men and women “choose” to take up. In the end, however, even with quite long lists of reasons for differences in wages between women and men, an “unexplained” part of the wage gap is found – that is in large-scale or macro-economic terms. That part is generally attributed to sex. [See also Armstrong, cited above.] This smaller gap is generally termed “the pay equity wage gap”.

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30 Statements of midwives to the AOM, 2013

31 The literature is clear that women were prohibited from becoming physicians well into the 19th century, and from admission to medical schools. Emily Stowe, the first female physician licensed (in 1871) to practice in Canada was refused entry to the University of Toronto medical school in 1865, for example, and went to the United States for her medical education. She later founded the Ontario Medical College for Women in 1883. See <http://www.collectionscanada.gc.ca/physicians/030002-1000-e.html>

76. The fact that much of the labour market is marked by distinct patterns of sex predominance is the main systemic reason for differences in pay. Most occupations (using the standard definitions of the National Occupational Classification of Statistics Canada) are in fact sex predominant <sup>32</sup>— a smaller number being female than male. While there are more sex neutral occupations where there is more of a balance between the sexes. Using a numerical definition only for predominance, it is a continuing fact that the Health Sector (also and more recently called the Health and Community Services Sector) is itself heavily female. The exception has historically been the physician group.<sup>33</sup>
77. It should be pointed, however, that the specifics of any pay equity gap depend on detailed study of work and wages within a particular ambit. (This “ambit” will be discussed below. Classically, “employer” or “establishment” form the boundaries for the study of the pay equity gap, but here, where there is a profession, which is categorised as an independent contractor, one needs a more flexible approach. In this Report, the ambit of comparison is the midwifery profession and other community-based primary care professions for which the Ministry funds compensation.

**I. Context – Indicators for denoting occupations as sex predominant – midwives, nurse practitioners and family physicians**

78. While this Report has asserted that both of these professions in Ontario are sex predominant, reference should be made to criteria for making the assertion. The relevant sections of the *Pay Equity Act* are as follows:

[Definitions:] “female job class” means [...] (a) a job class in which 60 per cent or more of the members are female....

“male job class” means [...] (a) a job class in which 70 per cent or more of the members are male....

(5) In deciding or agreeing whether a job class is a female job class or a male job class, regard shall be had to the historical incumbency of the job class, gender stereotypes of fields of work and such other criteria as may be prescribed by the regulations. R.S.O. 1990, c. P.7, s. 1 (5).

79. On the basis of at least two criteria – historical incumbency, gender stereotypes and percentage of incumbents (i.e., 60%), both midwives (at nearly 100%) and nurse

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32 Statistics Canada employs a numeric cut-off for sex predominance, i.e., 70%. More will be said below about how to actually define the terms.

33 See Richard Shillington, “Expert Report prepared for Pay Equity Hearings Tribunal – Long-term Care Homes and the SEIU”, April 2013. More detail will be examined below.

practitioners (at 95%) are female. I should add that, while the former are a profession unto themselves, the nurse practitioners can be seen as part of the larger nursing group as they are regulated by the College of Nurses of Ontario. Because the nurse practitioners in this case are located in CHCs, they have distinct job characteristics, as well as legislation that established and revised their scope of practice.<sup>34</sup>

80. This raises another matter, whether the two occupations can be seen as distinctive, at least in terms of equitable treatment. Under the *Pay Equity Act*, there are criteria for determining this issue, with the following definition:

[S. 1(1)] “job class” means those positions in an establishment that have similar duties and responsibilities and require similar qualifications, are filled by similar recruiting procedures and have the same compensation schedule, salary grade or range of salary rates....”

For midwives, in my opinion, the four criteria are met (similar duties, etc.). The question remaining is that of “establishment”, which this Report treats below. For nurse practitioners, the logic is similar, with the job class being distributed across CHCs.

81. As for CHC FAMILY PHYSICIANS, the matter is somewhat more complex. As Dr. Shillington points out, physicians as a whole in Ontario have historically been male predominant on the basis of the percentage of males in the occupation and in particular the percentage of women in 1991 was 27% (for the combined National Occupational Classification sub-group of specialist physicians, general practitioners and family physicians). The percentage of men moved up subsequently to 71% in 1995, 66% in 2000, and 64% in 2005. Nonetheless, at the time of the Morton Report when the MOHLTC set midwifery compensation, the physician profession overall was male predominant under the criterion of percentage. The CHC family physician is a specialist group within the profession, with broadly similar duties, qualifications and wages as reported by Morton. A key consideration is that since 2005, the compensation for the group has been clearly covered by the agreement between the Ontario Medical Association and the Ministry of Health and Long-term Care.
82. There appears to be no breakdown as of 2003 of the sex of CHC family physicians. However, given the association of the profession as a whole (of which family physicians are an integral part), it is reasonable to consider them from the point of view of their compensation setting as male predominant. The duties are also closely associated with the treatment of illness and disease and the medicalization of health, including the broad use of both technology

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34 That is, the Nursing Act of 1991 and the Expanded Nursing Services for Patients Act, 1998. The latter is referred to in a number of MOHLTC documents, the most explanatory of which is “Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario”, January 2005 at [http://www.health.gov.on.ca/en/common/ministry/publications/reports/nurseprac03/nurseprac03\\_mn.aspx](http://www.health.gov.on.ca/en/common/ministry/publications/reports/nurseprac03/nurseprac03_mn.aspx)

and referrals to other specialists. These characteristics, as noted above in the discussion about midwifery and nursing in contrast with physicians' work, have been historically associated with males.

83. **CONCLUSION:** if one of the measures of equitable treatment is comparison between the work of women and men, then in my opinion it is appropriate to choose the CHC family physician as a comparator for the midwife (and indirectly for the nurse practitioner).

**J. Context: Steps in integrating midwifery into the Ontario Health System, and features of work**

**AROUND THE TIME OF REGULATION OF THE MIDWIFERY PROFESSION:**

84. Authoritative sources have commented on the "state" of the profession between 1983 and 1993, that is, in preparation for the regulation of midwives. [See Bourgeault, *Push!* and *Reconceiving Midwifery*] What follows serves as the basis for my evaluation of the work of midwives, at least as of 1993, which is just before their regulation. As will be apparent during this section of the Report, a number of key facets of the work were not made visible at that time (at least officially), but may be inferred. Others either developed or became clearer with time. The role of government in both the initial determination of what might be called "compensable factors" of the work is highlighted here as well. A note is made in section F that, despite contracting the mechanism for paying salaries to midwives to "transfer agencies", the overall terms of reference remained subject to central determination by the Ministry of Health and Long-term Care.

**ISSUES AROUND THE WORK OF MIDWIVES:**

85. A key issue in integrating midwifery into the public health system in Ontario<sup>35</sup> was whether the midwife should be seen as a self-regulating and autonomous profession. Ivy Lynn Bourgeault [see *Push!* page 93] comments that "Medical and nursing organizations expressed acceptance of the principle of midwifery as a legitimate health practice, but felt that it should either be a part of nursing or otherwise under medical control." Another key issue was the nature of training and education. Bourgeault also notes a characteristic of the midwife's work, continuity of care which was "not found in the present [health] system, and ... infant mortality rates are lower in countries that allow midwives to practice..." [Quote from Dave Cooke, MPP, at Bourgeault, page 103]

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35 In her research work, *Push! The Struggle for Midwifery in Ontario*, Ivy Lynn Bourgeault reports that this work was embodied in the Midwifery Task Force of Ontario, beginning about 1984. In parallel, an earlier Ministry of Health initiative (at arms-length from government) was examining issues of regulating health professionals more generally – including midwives. (This was the Health Professionals Legislation Review.) [See Bourgeault, pages 75 and 82, following.]



## OTHER CRITERIA FOR INTEGRATING MIDWIVES INTO THE HEALTH SYSTEM AND WORK REQUIREMENTS

86. Another aspect of this historical context was the involvement of the Ministry of Health. Bourgeault noted that the Minister of Health of the time (1986) appointed another Task Force chaired by Mary Eberts to recommend how to integrate midwifery into the health system. She comments that several objectives informed the decision – equity, accessibility to midwifery services and the cost-effectiveness of those services. [*Push!* Page 118]<sup>36</sup> Some of the same focuses of attention that are found in the Morton report were incorporated into the Task Force's terms of reference: (a) Education of midwives<sup>37</sup>; (b) Requirements for entry into practice, and (c) Scope of practice.
87. In 1988, the Ministry of Health appointed a Midwifery Coordinator to “direct the implementation” of midwifery (quote from the Minister of Health, Bourgeault page 135). She helped to draft the Midwifery Act with the health Professionals Legislative Review. [Bourgeault, page 136] The Ministry, subsequent to the passage of the *Midwifery Act* in 1991, appointed members of the independent body that was the precursor to the College of Midwives of Ontario, to develop policies and standards of practice. It was funded by the Ministry. [Bourgeault, pages 143-44]

## EVOLUTION OF THE WORK UP TO 1993:

88. Some of the other characteristics of midwifery work had become more pronounced prior to 1994, notably the philosophy and practice that women should have a choice in the location of births, that is, at home rather than in hospitals. Bourgeault reports that family physicians had been prohibited by their College from attending home births (1983 and 1984). As a result, “midwives’ scope of practice at home births expanded to that of primary caregivers.” [Page 151] Clearly, this would have been well known to members of the Work Group whose thoughts went into the Morton Report.
89. In addition, the conferring of hospital admitting privileges was recommended by the Eberts Task Force to report prior to regulation. [Bourgeault, page 162, referring to the Task Force on the Implementation of Midwifery in Ontario] The difficulties of integrating midwives into hospital practice were also understood:

“These amendments [to the *Public Hospitals Act* in the 1991 legislative package of changes required for regulation of midwifery, would leave the ultimate decision-making as to whether or not they [the hospitals] would like to appoint midwives in the hands of the

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36 The group was the Task Force on the Implementation of Midwifery in Ontario.

37 It is my understanding that the key clinical and philosophical aspects of education were determined by 1993, including the need for a baccalaureate, even though the programs themselves were not launched until after regulation.

hospitals. The Task Force felt that making such by-law changes compulsory would create a counterproductive, hostile environment between midwives and hospital administrators.” [Bourgeault, page 162-63]

90. The challenges of integration into hospital practice were the subject of comment by midwives that I interviewed, and developed subsequent to the regulation of midwifery (given that the *Midwifery Act* was not promulgated until December 31<sup>st</sup> 1993).<sup>38</sup> Recognising the energies and demands of such integration in terms of the value of the midwife’s work is thus left to a date later than September 1993, when the formula for compensation was established in the Midwifery Funding Framework, which adopted the Morton Report recommendations.
91. The Ministry of Health determined that the *Public Hospitals Act* regulations would enable hospital admitting privileges, but leave the operational decisions in individual cases in the hands of existing Medical Advisory Committees within the hospitals themselves. [Page 179]

#### GROUP PRACTICE ISSUE:

92. The Morton Report left a question mark in the column pertaining to the supervisory work of the midwife, while completing the information for the CHC family physician and nurse practitioner. Bourgeault reports that by the mid-1980s, many midwives were working in pairs for backup and other reasons. [Page 152] Moreover there were some group practices such as the Toronto Midwives Collective (founded in the mid-1980s: Bourgeault, page 82). It “set up office space.” Nonetheless, it is apparent from Bourgeault’s research that the funding of practices was not decided prior to regulation, so possibly understandable that Morton left a question mark. Jane Kilthei, a leading midwife involved in negotiations about funding with the Ministry of Health’s Community Health Branch, reported to Bourgeault her comment to the Branch that “...part of what’s good about the way midwifery evolves with practice groups is that there’s a unit there that provides care co-operatively together that also is in place to do peer review, to make sure that there’s ongoing quality improvement....” [Page 200]

#### OTHER KEY FEATURES OF WORK:

93. The Morton Report includes a lengthy set of “core competencies” at the entry level for the midwife. As noted earlier, they are entry-level competencies (and not a job description). It was based on then-current practice as well as research into standards in countries where

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38 Bourgeault provides and extended commentary on these challenges – see pages 170-184. A concluding observation that she makes is that despite extensive review, the Public Hospitals Act was not amended in respect of mechanisms surrounding hospital privileges for midwives: “The review dissipated in response to many concerns, including intense medical opposition to changes in hospital governance.” [Page 177]

midwifery was better established. They were produced by the Interim Council of the College of Midwives [ICRM] and were intended not as a job description but as a “foundation for midwifery education programs”. [Morton Report, page 10] A brief internationally accepted definition of the work was also included. The features of work are evident in the definition, though they are not expanded upon, that is:

- i. Supervision, care and advice to women during pregnancy, labour and the post-partum period
- ii. Taking preventive measures, including detection of abnormal conditions, procurement of medical assistance and taking emergency measures
- iii. Counselling and education in a number of areas relating to maternal and family care
- iv. Practice in a number of locations including hospitals, clinics and homes [Morton, page 10]

94. The literature and other research material for my Report have expanded on a number of these areas, either for midwifery since its inception as a regulated profession or later. These would include communications skills, physical skills and responsibilities for both outcomes and services. The knowledge apparent at the outset appears to have been supplemented later as this Report sets below. (For example, midwives estimate that a significant increase in the range of their skills came with the expansion of their scope of practice to include assistance at Caesarean sections undergone by the women in their care.)

95. It may be useful to note that the 1993 entry-level competencies themselves are divided into a number of subjects:

- a. General ones, which relate first to maternal care, then to education and counselling skills, followed by abilities that include communication, empathy and assessing clients’ needs and tailoring counselling accordingly
- b. Ability in interprofessional collaboration
- c. Antepartum care, including assessments and testing of a clinical nature
- d. Intra-partum care – also clinical and obstetrical
- e. Post-partum care, covering assessment, testing and counselling as well as support (also apparent in the other maternity and newborn stages of care)
- f. Gynaecological principles and assessment
- g. The professional and legal framework for midwifery

96. Given that the entry-level competencies did not include certain practices such as management and handling information and data or staff, it is understandable that the Morton Report did not either. (University courses offer more training on those subjects.)

## K. Context: Emergence of the Nurse Practitioner Profession

97. THE NURSE PRACTITIONER: The Morton Report includes some analysis of the Nurse Practitioner, then known as the “Primary Care Nurse”. This position was located in the CHCs that were then well-established. The analysis is based on a “job description”. Morton first sets out some of the general context, such as that the primary care nurse is governed by the College of Nurses of Ontario. The actual “responsibilities and activities” are divided two main sections – clinical and community, the former being client-oriented and consisting of assessment, diagnosis, determining and implementing a plan of nursing care, advocacy and research. Community-related responsibilities include working with community groups, promoting health and advocacy – particularly in relation to the “environmental and socioeconomic determinants of health” and health policy. “Administration” falls under “clinical” for some reason. Qualifications are also included.
98. The equivalent of “core competencies” is given in both the “qualifications” section of the job description and in another part of the Morton Report, the “Authorized Acts” at Appendix A. That Appendix also contains points pertaining to the CHC family physician.
99. The Registered Nurses Association of Ontario notes that “Beginning in 1994, many of these NPs [nurse practitioners] were instrumental in creating new initiatives with the Ministry of Health and Long Term Care as part of government’s primary health care reform strategy. This resulted in the re-establishment of nurse practitioner university education programs in 1995<sup>39</sup> and the Expanded Nursing Services for Patients Act which was passed in 1998. 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. ” There were approximately 250 nurse practitioners at the time of regulation in 1998.<sup>40</sup>
100. It would appear from a 2003 report written by IBM Corporation in 2003 for the MOHLTC<sup>41</sup> that the role of nurse practitioner was not well integrated into the health system, and that role clarification was hindered in part by the relationship with family physicians. In particular it appears to have been unclear what autonomy the nurse practitioner had in relation to clients, at least up to the point of the research. The issue is not reflected in the Morton

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39 It is also useful to point out another parallel between the midwife and the nurse practitioner, that is, that a tailored educational program followed regulation: “The Council of Ontario University Programs in Nursing (COUPN) established the Ontario Primary Health Care Nurse Practitioner (PHC NP) Programme in 1995. A consortium of nine Ontario universities offers the program....” [Ontario Primary Health Care Nurse Practitioner Program, at <http://np-education.ca/>]

40 RPAO, “Nurse Practitioner History in Ontario”, page 1

41 Report on nurse practitioners (no title page), IBM Corporation, 2003 (278 pages) at [http://health.gov.on.ca/en/common/ministry/publications/reports/nurseprac03/np\\_report.pdf](http://health.gov.on.ca/en/common/ministry/publications/reports/nurseprac03/np_report.pdf)

Report (any more than the issue of midwives' integration into hospitals, through the Medical Advisory Committees, was in 1993). Nurse practitioners faced parallel challenges to some of those outlined above for the midwife: difficulties in gaining admitting privileges in hospitals, maintaining autonomy when consulting with a physician or having laboratory tests performed. As to the role in the CHC, the IBM report gives feedback from physicians surveyed, that "MDs in CHCs value NPs' role in prevention/wellness care/health promotion the most...." [Page 21]

101. About 1998, the College of Nurses of Ontario published the "Practice Standard: Nurse Practitioner" (updated 2011). The version now available was used in establishing the current value of the work. It reflects a scope of practice that is much larger than that of the primary care nurse in 1993. We have not traced the evolution of the work since this Report primarily tracks the relativity of the midwife and the family physician.
102. As with the midwife, the nurse practitioner was over 90% female in 1993 and remains female-predominant currently. The way in which sex enters into this Report is discussed at greater length below, in connection not only with the percentage of dominance but also (as with the midwife) with stereotyping and overlooked characteristics of work. These dimensions of the profession help to give shape to how the work should be documented and valued.

#### **L. Context: The CHC Family Physician and CHCs**

103. COMMUNITY HEALTH CENTRES predate the regulation of the two professions discussed above. They were in the forefront of primary health care reform, and became vehicles for some of the initiatives that included the transformation of the primary care nurse into the nurse practitioner, and the introduction of the regulated midwife. An early expression of the goals of primary health care was the Canada's agreement to the Alma Ata Declaration of 1979 and the Ottawa Charter for Health Promotion of 1986.<sup>42</sup> Both included the principles of the social determinants of health. The "prerequisites for health" are embodied in the Charter are associated with MOHLTC policy and the CHCs.
104. The relationship of these principles to the mandates of CHCs may be seen in the Ottawa Charter's statement about health promotion:

"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for

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42 Milestones in Health Promotion Statements from Global Conferences, WHO at [http://www.who.int/healthpromotion/Milestones\\_Health\\_Promotion\\_05022010.pdf](http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf)

everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.” [Ottawa Charter]

105. As noted in the IBM paper cited above, health promotion in the CHC context is pre-eminently associated with the work of the nurse practitioner, particularly in later iterations of the job description. However, the orientation is also part of the community relations part of both the 1993 descriptions for family physician and primary care nurse. It is apparent that the full expression of the primary care reform occurred somewhat later.
106. Family medicine is a recognized as a specialty within the medical field. There is, for example, internship for family medicine, following graduation from a four-year university program. Examples of related university education is illustrated in the following:
  - a. “Since 1977 the Department of Family Medicine at Western University has offered a program leading to the degree of Master of Clinical Science in Family Medicine (M.Cl.Sc.).” [At <http://www.schulich.uwo.ca/familymedicine/graduate-program>]
  - b. “Residency training is training which leads to specialty (or subspecialty) certification by the Royal College of Physicians and Surgeons of Canada (RCPSC) or to certification as a family physician by the College of Family Physicians of Canada (CFPC).” [University of Toronto at <http://www.pgme.utoronto.ca/content/residency-training>] This is a two-year program.
  - c. “The community residency program at the Department of Family Medicine offers selected residents the opportunity to spend their two years of family medicine training in a community medical practice, either in the urban community of Ottawa or in the nearby rural communities.” [University of Ottawa, Department of Family Medicine at [http://www.familymedicine.uottawa.ca/eng/pg\\_Teaching-Program-Community.html](http://www.familymedicine.uottawa.ca/eng/pg_Teaching-Program-Community.html)]
107. From the above, it is apparent that of the three professions, the family physician was the most clearly and completely established at the time of midwifery regulation. An implication for my own Report is that the family physician work serves as a continuing point of reference.
108. The CHC family physician job description attached to the Morton Report contains a number of areas of work under the overall statement “The family physician provides the full range of primary health care services including obstetrical care to clients of the centre [CHC].” Duties are client-oriented, clinical-related (that is, systems, education, clinical policy and staff), centre-related (including organisation, human resources and information and data issues as examples) and community related (as with the nurse practitioner, including education and outreach).

109. Sensitivity to the social and environmental factors of health is implied. A CHC medical director interviewed for this Report indicated that understanding of these factors is increasingly important, especially given the mandate of the CHCs. She indicated, however, that family doctors' education does not include sufficient content about the social and environmental determinants of health; rather on-the-job training is required in this matter. [Interview with Dr. Nitti]

## **M. FEATURES OF WORK OF THE THREE PROFESSIONS & EQUITABLE COMPENSATION ANALYSIS**

### **BACKGROUND**

110. The foundation for equitable analysis is an understanding of the work itself. The features of the work have been shaped both by primary health care reform and by the input of the professions themselves, as well as by the demands of clients for particular services, for example, midwifery.
111. The professions of midwifery and nurse practitioner were emerging in 1993<sup>43</sup>, and were both subject to challenges in the process of becoming integrated into Ontario's health system. These continue apparently to the present. Despite their being newly regulated shortly after the Morton Report was given to the MOHLTC, the work of these professions – and of the family physician – was not new. For the first two, it was, however, being codified. And most important, the educational and experience requirements (already established for the physician) were about to be shaped by policy from both the MOHLTC and the respective professional colleges (the CMO and the CNO). As a result, in my opinion, it would have been difficult for the Work Group to have given full credit to this work. Indeed, it will be my observation that key aspects of the work, particularly of the midwife (whose compensation is at issue in this analysis), were clarified only subsequently and so needed to be the subject of further review here.

### **GENERAL COMMENTS ON FEATURES OF WORK:**

112. A number of features of work are evident in this discussion of context, notably professional clinical knowledge and responsibilities, patient-centred orientation, the value of primary health care both to the funder and to each of the three professions. The complexity of the relationships with clients is also apparent. These features of work, and others that develop within the midwife profession, facilitate comparisons of the value of the work, and through them understanding the equity of the compensation. One should emphasize here that value is not taken as being intrinsic to the work, but is the product of comparisons through a

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43 As noted earlier, the outlines of the work in 1993 was based on what had already been developed within both professions.

systematic estimating of the value of characteristics and demands of work. I have used this widely accepted pay equity approach to fairness of wages.

113. Obstetrics touches all three professions, but pre-eminently the midwife. While she is not an obstetrician or gynaecologist in terms of training, she is part of that professional spectrum of work. She is the only one of three professions to specialise in maternity care. More will be said later in terms of reasons for this observation. The work in all three professions goes beyond clinical diagnosis and the treatment of disease, illness or conditions, for example in giving expression to the social determinants of health, the respect for clients' informed choice, preventive measures at the root of practice, continuity of care and an emphasis on wellness. Any estimate of value of the work needs to take these aspects of context and the professions into account. Where this Report may differentiate its estimate of value from others (e.g., as implied in Morton, or later in Hay), it will be partially because of them.

#### **RECOGNISING THE DISTINCTIVENESS OF WOMEN'S WORK:**

114. As noted above, the fact that women often perform different work from men is a pattern underlying such structural differences in the occupations and their compensation. Such differences have been recognised in decisions at tribunal and court levels over the past 20 and more years (perhaps beginning with the Supreme Court of Canada in the *Syndicat des employés de production du Québec et de l'Acadie v Canada (Canadian Human Rights Commission)*, 1989.<sup>44</sup>) Important analytical consequences from the pattern, notably that there are identifiable characteristics of work performed largely by women, that they have been frequently overlooked and undervalued (either in consequence of being overlooked or because they have been accorded less esteem). A landmark case in this regard is the Pay Equity Hearings Tribunal in Haldimand-Norfolk, where the Tribunal provided a synthesis listing such features of women's work. These are shown (and cited) at Annex 2 As a result of my experience with work, I have enlarged that list (also in that Annex).

#### **MIDWIVES' WORK IS WOMEN'S WORK:**

115. As has been noted, midwifery work is performed by women for women, and is clearly to be seen as classically women's work. As Bourgeault and others have commented, much of the role of midwife is rooted in the home and is associated with uncompensated work that has not traditionally been professionalised. [See above cites for *Push!* and other works as set out in Annex 8, Bibliography.]
116. More particularly, for the midwives and nurse practitioners, features of women's work are discernible, and are also present in the work of the family physician, i.e., while such features

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44 SEPQA [1989] 2 S.C.R. 879 at <http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/527/index.do>



may be present in some men's work (especially in health care – itself predominantly female), they are mostly under-compensated, for example:

- a. *Communications skills* – in my opinion strongly associated with work that women do – are marked, and especially so for the midwife. She needs to use many skills to understand and empathise. Many health jobs require such skills, given the patient-centred care that is now underscored by the Ontario legislation (for example through the *Excellent Care for All Act* of 2012) and by government policy (the “Action Plan” published by the MOHLTC<sup>45</sup>). The skills have been associated with women's work more generally because of the dominance of women in such occupations as teaching, retail sales, clerical and secretarial work with clients, librarian and social work and many other professions. They have tended to be overlooked and undervalued in traditional job evaluation plans that are more focused on position and authority within an organisational hierarchy.
- b. *Interprofessional consultation* – a subset of communications skills is specifically required in the health sector. There are many standards requiring such consultation, between midwives and physicians, for example. They grow out of specialisation and areas of competency. There is a tendency in traditional job evaluation, however, to downplay the exercise of skills where consultation is mandatory. Given the authoritative role traditionally played by medical specialists, a result can be that other professions (female-dominated) may not be enabled to work to their full scopes of practice. Work within hospitals has been one example of challenges facing both midwives and nurse practitioners.
- c. *Physical skills* – it may seem odd, given the physical nature of stereotypically male dominated occupations that physical skills are important to female dominated occupations. We need to recall secretarial, clerical and information workers who must have fine motor dexterity – a physical skill. Such skills are found in all three of the professions before the Tribunal, but especially so in the work of the midwife. She is physically involved with the client to a high degree, through feel and manipulation, especially during birth (“intrapartum”).
- d. *Coordination of detail* – features of work such as serving a number of clients and organising their clinical and life details are examples of such work. All three professions (as with health sector jobs generally) display such features. That they are associated with women's work more generally is evident in occupations like the travel agent, the teacher (dealing with many students at once), conference organiser, interior designer, retail sales person and many other occupations dealing with clients.
- e. *Client-centred features of work* – patient-centred work is characteristic of the health sector as well as of women's work generally. When considering the importance and

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45 “Ontario's Action Plan For Health Care: Better patient care through better value from our health care dollars,”  
[http://www.health.gov.on.ca/en/ms/ecfa/healthy\\_change/docs/rep\\_healthychange.pdf](http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)

complexity of such work, the client-orientation needs to be borne in mind. In stereotypically male dominated work, on the other hand, impacts for the organisation (such as its costs and public image) may be the exclusive focus in documenting and valuing work. The value of equipment used in a job is another example that fits well with male-predominant work, but is less so with women's work generally. In the health sector, the contrast may be drawn between a technologist using very expensive scanning equipment and a nurse dealing with patients and their individual health. In the case before the Tribunal, the client-orientation is clear for all three professions. Considering all of their circumstances, in addition to symptoms that they may be presenting, is necessary – for both gender neutrality and for giving due credit to the work itself.

- f. *Understanding client needs*—these skills flow from the client-oriented duties, and involve assessment and sensitivity to the client and her or his situation and condition. All three professions display the need for such knowledge and skills. Women's work has been classically service-oriented (think clerical and "support" work generally, and the "ancillary worker" in the health sector). Because of the subordinate position of those giving such service, it has been tempting to downplay the importance (i.e., value) of these skills in contrast to the exercise of authority. Given the autonomy of the three professions in the case before Tribunal, the skills need to be made visible. (This is one of the requirements of pay equity – discussed below.)
- g. *Use of experience in addition to educational credentials* – this is perhaps more controversial as it applies to women's work. A reason why this characteristic is associated with women's work is the recentness of credentialling of many women's occupations, and the fact that women have joined the workforce in much greater numbers since the Second World War. Apprenticeship credentials, for example, have been more formally established for male dominated occupations than for classically female dominated ones such as secretary (even medical secretary) or documentalist jobs. Experience may also be informal, such as in volunteer work, yet may not be considered as valuable. This is not to say that education is unimportant in valuing, only that qualitative experience needs to be borne in mind as well. With emerging occupations such as midwives and nurse practitioner, consideration of experience in practice needs to be borne in mind. With the family physician, I have already reported how the job requires practice within the CHC to integrate consideration of the social determinants of health into how clients are viewed and assessed.
- h. *Organisational knowledge* – again, as with physical skills, it may not be obvious that such knowledge is to be associated with women's work. We should think about the roles that many women's occupations play: the more service is offered to clients, the more such work requires inter-professional and inter-unit coordination and knowledge. The reception is a stereotypically female-dominated job embodying such skills. Without them, the job could not be performed. Organisational knowledge in the setting of the three professionals includes understanding others' scope of practice in relation to client needs, community organisations that deal with socio-economic issues, organisation of

the practice or the CHC, hospital organisation, various standards and codes in place in various settings (professional for example). In traditional approaches to valuing work, such matters are often seen as constraints on the decisions to be made by the professional, and therefore to be detracting from value. They are not usually positively valued, in which eventually the work is undervalued.

- i. *Emotional effort or stresses* – it may appear to be counterintuitive to suggest that, in a health care setting particular, that such features of work would be overlooked or undervalued. Until recently, however, some compensation consultants held the view that stress could not be valued at all, that employees who were well-suited to their work and could perform it well would not be stressed. In health care work, it is clear from researchers such as Dr. Pat Armstrong that stress is a major consideration in their jobs.<sup>46</sup> Because the sense of stress is sometimes seen as an expression of human vulnerability or weakness, it may be devalued or not even admitted except in an interview situation. Public documents, such as presentations to the MOHLTC or legislators, do contain some references to these emotional demands. Along with conditions of work, this set of characteristics of work is frequently not documented – the descriptions that are part of the Morton Report, and more recent ones collected for this Report, are examples. Fortunately the literature on the professions sheds light on this aspect of professional work.

## **N. The organisation of work: three professions**

### **OVERVIEW:**

117. As described more fully in Annex 5, the elements of the work of each of the professions may be understood as follows:

#### ***The midwife:***

- As a professional, each midwife is registered with the College of Midwives of Ontario [CMO], which sets standards and provides guidance to the profession.
- Qualifications are set in conjunction with the MOHLTC and education at the baccalaureate level in universities. Standards for integrating midwives trained outside the province are also set by the CMO.
- The scope of practice is set by legislation and regulation so that midwives may perform their roles with autonomy in a variety of settings. A philosophy framework was established prior to regulation in 1993-94.

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46 Critical to Care: Women and Ancillary Work in Health Care, Dr. Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon, The National Coordinating Group on Health Care Reform and Women, February 2006 at [www.cewh-cesf.ca/healthreform](http://www.cewh-cesf.ca/healthreform)

- Interprofessional relationships (often termed “collaboration” in policy documents from the CMO, AOM and MOHLTC) are performed within a framework of guidance, but according to the judgement of the midwife.
- She generally works within a group practice with an average size of six professionals, and has practised with a professional colleague since before regulation. Professional practice is facilitated within each practice by peer discussion, case review and formal annual quality review established by regulation.<sup>47</sup>
- Her integration into hospital practice has been facilitated by legislation since regulation, subject to the discretion of Medical Advisory Committees established within each hospital. The Ontario Hospital Association and the CMO, Ontario Hospital Association and the AOM have developed a 2010 Manual for that integration<sup>48</sup>. Yet there are still challenges in hospital-based midwifery work.
- The midwife is accountable for continuing education and for annual peer review for quality assurance, practice and methods updating, and case management and documentation, as provided under legislation (see footnote 36).
- In addition, the nature of the work focuses on women as clients, including (as set out in the Philosophy) decision-making by the client and continuity of care by the midwife. Informed decisions by the client bear on planning the various stages of childbirth (before, during and after). These are reflected in core competencies and training, including emergency training.<sup>49</sup>
- Clients may come from a variety of economic and social classes and live under a variety of conditions. The midwife develops both an empathy and an understanding of these and helps the woman to manage her own health more generally.
- The midwife must assess the condition of the client initially and on an ongoing basis. Perceiving abnormal conditions and issues relating to natural childbirth is required.
- The midwife shares in the management and administration of her practice and is responsible for the Preceptorship of midwives-in-training each year and for the mentoring of registered midwives.
- She may also contribute from her own salary to the running of the practice, as for example in designating a midwife as the coordinator of relations with hospitals and matter involving hospital admission privileges.

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47 Midwifery Act, 1991 : ONTARIO REGULATION 335/12 GENERAL at [http://www.cmo.on.ca/documents/QualityAssuranceRegulation\\_November2012.pdf](http://www.cmo.on.ca/documents/QualityAssuranceRegulation_November2012.pdf)

48 “Resource Manual for Sustaining Quality Midwifery Services in Hospitals,” College of Midwives of Ontario, Ontario Hospital Association and the Association of Ontario Midwives, September 2010, also at [http://www.oha.com/KnowledgeCentre/Library/Documents/2206\\_midwiferyToolkit\\_inside\\_sept28.pdf](http://www.oha.com/KnowledgeCentre/Library/Documents/2206_midwiferyToolkit_inside_sept28.pdf)

49 See The Midwifery Emergency Skills Workshop Manual, Association of Ontario Midwives – Fifth Edition, 2013, developed by seven Registered Midwives and staff of the AOM, an update of the first one developed in 1995

- She shares in overseeing the human and other resources of the practice. These may include clinical facilities for birthing. She also purchases and maintains her own obstetrical equipment.
- The midwife is a member of her own professional association but is also an associate member (midwifery) of the Society of Obstetricians and Gynaecologists of Canada.

***The CHC nurse practitioner:***

- She is also an autonomous professional with a scope of practice in primary health care that is established by legislation (as noted above). In addition to her membership in her own professional association she may belong to the SOGC as an Associate Member – nursing, where her duties bear on maternity care.
- In the job set out in Morton and currently, the nurse practitioner in a CHC is analysed. She has her own clients, and works closely with a multi-professional group of practitioners, including the family physician.
- She develops a continuing relationship with clients, enabling them to manage their own health and developing nursing plans with them. Plans include taking preventive measures to improve wellness or promote healing. She must also assess their general condition, including family, social and economic condition. She has a particular mandate for helping them to manage chronic conditions like diabetes. She is responsible for interprofessional collaboration and consultation. Given the CHC setting, she has a particular concern with the social determinants of health and often deals with multi-cultural clients who may well be disadvantaged. She may have hospital admitting privileges, a possibility added by Regulation 965 of the *Public Hospitals Act* in 2012.<sup>50</sup>
- The work of the nurse practitioner is generally informed by standards and practice guidelines set out for her specialty by the College of Nurses of Ontario, which also registers her as a registered nurse (extended practice). A number of universities provide approved courses of study leading to a Master's degree after two years. The framework for the educational program has come under the policy framework of the MOHLTC. In addition, the nurse practitioner has a strong role in health promotion and education with community groups through work within the CHC as well as outreach, often with professional colleagues and partners from outside organisations.
- The nurse practitioner is also responsible for interprofessional collaboration and consultation.
- As with the midwife, the nurse practitioner is accountable for continuing education and for quality assurance review. It is organised somewhat differently from that pertaining to midwives, given the CHC setting and management. There is generally a clinical or medical

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50Found

at:  
<http://www.oha.com/CurrentIssues/keyinitiatives/PhysicianandProfessionalIssues/Physicians/Resources/Documents/Final%20-%20NP%20Guide.pdf>

director within the CHC who along with the family physician may participate in quality reviews with the nurse practitioner. (See job descriptions appended to this Report.)

- She may contribute to the administration of the Centre and its public programs, and has an advocacy role given her understanding of health-related social and economic conditions within the wider community. She may also mentor nurse practitioner students.

***The family physician within the CHC:***

- This position usually reports to a medical director, and has his or her own clinical practice comprised of several hundred clients. The focus of the work is assessing the general health of each client and developing both diagnoses and treatment plans with the client. The physician generally has less time to spend with each client presenting at the Centre than the nurse practitioner.
- The CHC family physician deals with the full range of health circumstances, and may refer clients to other professionals within the Centre or to specialists outside the Centre.
- The family physician maintains professional standards, including those covering interprofessional collaboration and consultation.
- The clients present the same variety of circumstances as encountered by the nurse practitioner. This includes the full range of life circumstances from birth to death, including illness, health conditions and wellness. The physician must be aware of the social determinants of health, but may refer clients for more attention to the nurse practitioner or other professionals. Both chronic conditions and wellness promotion are typical issues that he may diagnose but then refer to the nurse practitioner.
- The physician is certified as a specialist by the College of Family Physicians of Canada (CFPC) which approves his education and continuing knowledge. A range of standards is set by the College, as for the two professional occupations described above. Clinical and practice guidelines are set out by the CFPC, as informed by policy circulars and information from the MOHLTC, for example on immunisation and pandemic management. He is accountable for ensuring the quality assurance and review of his clinical practice in concert with a medical or clinical director.
- The physician also has responsibilities for contributing as a professional to the clinical and administrative management of the CHC. He may mentor and supervise medical students in family medicine, and develop plans of applied study for them. He may provide support to the nurse practitioner in her own quality assurance planning and reporting. He is involved in the staffing of positions within the CHC.

*Note that further details about the work of all three professions are contained in both Annexes 4 and 5.*

## **O. Valuing work—Criteria for Choosing a Valuing Approach**

118. This Report has noted a number of key issues for establishing the value of work, particularly its role in testing and understanding how equitably the three professional occupations here are treated. Reference has been made to the framework for equity that has been set out in the *Pay Equity Act*. Guidance is also found in the publications of the Pay Equity Commission of Ontario and the Canadian Human Rights Commission, and covers such matters as gender neutrality and the choice and application of a plan for valuing work. In a signal case, the Pay Equity Hearings Tribunal (in *ONA v. Haldimand-Norfolk*, no. 6, 1992) set out the following criteria for ensuring gender-neutral valuing of work:

The valuing plan needs to be assessed in relation to the following considerations:

- a. The range of work performed in the establishment [is captured];
- b. Whether the system made work, particularly women's work, visible in the workplace;
- c. Whether the information collected accurately captured the skill, effort and responsibility normally required in the performance of the work and the conditions under which it is normally performed for both the female job classes in the plan and the male job classes to be used for comparison; and
- d. Whether the job information was being collected accurately and consistently for each job class to be compared. [Page 106]

#### **COMPLETENESS OF THE JOB INFORMATION:**

119. One of the challenges in any evaluation of work is understanding its characteristics and demands. In this instance, the work of the three professionals, which must be comprehensively understood (as implied by criterion (a) above), is complex, technical and varying by clients and patients. Moreover, it is not only the actual person herself or himself who comes to the professional as an individual but is also their social and economic circumstance. There is also a substantial body of information available about that work – from the initial information considered by the Ministry as set out for the midwife job in Morton, to job descriptions past and present to interviews and the literature. Overarching all is legislation and regulation as well as MOHLTC policy and the standards of at least four professional colleges, including those of the obstetricians and gynaecologists. There are reports and surveys of what has been expected and achieved through these three professions as part of primary health care reform.
120. In the literature, structured questionnaires are one instrument for collecting work information. Interviews are preferred, given the possibilities of clarification that face-to-face encounters afford. Job descriptions are useful in providing an authoritative framework, but frequently are not sufficiently detailed about all of the skills, efforts, responsibilities and working conditions to be documented.

121. It is my opinion that the collection and analysis of job content information as described in this Report and its annexes is the most appropriate in the circumstances to capture the full variety of the three professions' skills, efforts, responsibilities and working conditions. I am also satisfied that its very detail and volume are sufficient for describing key features of work to be valued.
122. A question that needs to be addressed here is whether the information collected from these many sources are sufficient and appropriate to represent the features of work and demands that it makes for each of the three professions. That is especially important for the two jobs directly compared for purposes of testing the equity of the compensation – the midwife and the CHC family physician. Often, a sample is gathered where there are numbers of jobs as there are here. A sample may help to shed light on the extent of variation within a set of jobs that are occupationally linked as those reviewed here. That has not been the route chosen for this enquiry into the work, nor was it the one used by the Ministry in 1993. I am satisfied that there is a degree of standardization defining the framework within which professionals operate within midwifery practices and CHCs. These standards have been built through a process that in effect accomplishes what a survey would ordinarily do: To bring together the best knowledge from within each profession, at levels of associations, colleges and the MOHLTC. The real variation within the work emanates from the circumstances and differences between each of the clients. That is foreseen in the philosophy of patient-centred primary health care and permeates not only the framework noted but also the approaches of each professional to working with clients.

#### **MAKING WOMEN'S WORK VISIBLE AND GENDER NEUTRALITY:**

123. Earlier in this Report, a number of features of work have been outlined. When one says that they need to be "made visible", it means that they first need to be documented, and I am satisfied that they have been in the circumstances of this analysis. It also means that whatever the scheme for establishing their value in a systematic fashion has to give those features due consideration. It is also essential that both documenting and valuing are gender neutral, that is, avoiding stereotyping, not overlooking the features of work, and withholding judgement about the overall value of the work until an analysis of various required skills, efforts, responsibilities and working conditions has been tested, weighed criterion by criterion and compared as objectively as possible with clearly defined measures, job by job.

#### **CHOOSING THE JOB EVALUATION PLAN:**

124. In choosing a GNCS, I considered the following:



- **AVAILABILITY:** The job evaluation plan must first of all be available and affordable. This is a challenge that can prove insurmountable – as I found during the years that I was directing investigations at the Canadian Human Rights Commission. Proprietary plans dominate the market. Many clients cannot afford them, or the customisation that may be required. (That would hold true with the small organisation in this case – the AOM). The alternative is a custom-tailored plan appropriate to both the values of the organisation and the work itself. This alternative is very time-consuming. Moreover, it is not clear that in view of the varying parties in the case that it would have been do-able in a reasonable period of time, let alone within the timeframe for preparing evidence in the action before the Tribunal. Fortunately, in this case (and others with which I have been involved over the past two years) there is a publicly available plan that can be interpreted flexibly to apply to the work of the three professions.
- The plan chosen is described below – the “Equitable Job Evaluation Factor Plan”. I believe that it is not only available at the cost only of applying it to the work but that it does make the features of work visible.
- **COMPREHENSIVENESS:** The plan needs to encompass the four SERWC criteria and be suitable for measuring the work. Testing the sub-criteria (“factors”) in the GNCS for valuing work through the plan is required. I am satisfied that the work for the three professions as summarised above and detailed in Annex 5 (as well as noted in Annex 6 rating notes) can be measured fairly and objectively by the plan that has been chosen. I am also satisfied that the various classical aspects of women’s work noted in Section “E” above will also be measured fairly. In that Section, I took note of several features frequently not measured in traditional plans – physical skills, emotional efforts and person-centred services. This plan captures all three (and others referenced).
- **GENDER NEUTRALITY:** The Equitable Job Evaluation Factor Plan was developed by the New Zealand government with the assistance of international experts on gender neutrality, to ensure its validity and conformity with pay equity principles.<sup>51</sup> The Plan was also tested very extensively.
- **APPROPRIATENESS OF THE PLAN TO THE VALUES OF THE ORGANISATION:** The values of the MOHLTC with respect to primary health care are described in many publications. They set out the expectations of primary health care reform in its various forms, including both midwifery practices and CHCs. Outcomes from these vehicles for reform are also set out or are prescribed in legislation and regulation
- In my opinion, the values of the organisation are also those of the three professions that are central to primary health care reform, inform its direction and content and apply it. As a result, one needs to pay attention to whether the professional standards that inform the work can also be reflected in how the work is valued through the job evaluation plan. A number of these, along with MOHLTC policies have been referenced in the preceding sections of this Report.

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51 I know from personal communications that two experts – Dr. Nan Weiner of Toronto, and Dr. Lois Haignere of Albany New York provided advice during the development of the plan.

- In Annex 4, I have set out an analysis the Equitable Job Evaluation Factor Plan does in fact accord well with the values of primary care reform.
- **WEIGHTING:** I have also considered whether the of the Plan's weighting of the various factors is also appropriate to the values and the work. In traditional job evaluation plans which were not gender neutral such weighting often involved calibrating the plan to the existing wages within a workplace. Given that wages may have imported undervaluing of women's work from the employment market, this may not be a gender neutral means of determining the plan's appropriateness. In the case of the Equitable Job Evaluation Factor Plan, I am satisfied that in aggregate it does justice to both the values of primary care and the work itself. The following distribution of points is not unreasonable:

Criterion	Points allocated (of 956)	Weighting (as %)
<i>SKILLS</i>	436	46%
<i>RESPONSIBILITIES</i>	420	44%
<i>EFFORTS</i>	75	8%
<i>WORKING CONDITIONS</i>	25	3%
Note that the total percentage is larger than 100% because of rounding.		

- The literature suggests that the weighting of factors varies according to the business of the organisation. Here that is governing and more specifically the provision of health care services. Generally, both skills and responsibilities are heavily weighted – between 35 and 45 for skills and 30 to 40 for the responsibilities. About a third of the remaining weights (from 15 to 25%) are split, in a ratio of about three to one for the other two sets of factors. In this instance, the work is heavily **skills oriented**. One also needs to take account of the fact that the literature generally misses “physical skills”, which in this plan are weighted at about 7%. Consequently, in my opinion this is a reasonable weighting to skills for the work and values. **Responsibilities** may appear also to be somewhat high. However, in my opinion this weighting is appropriate given the autonomy of the professions and their accountability for results and services.
- **TESTING:** A further examination of the job evaluation plan is required in practice, as the work to be assessed and compared becomes clearer in terms of what is significant in establishing value. Moreover, that value (as noted earlier in this Report) is not intrinsic but relative. There are no absolute or pre-set values. Instead, they must be established by exercising reasonable judgement as to whether one set of knowledge skills, for example, that pertain to one job are more or less complex or demanding or difficult to obtain and exercise than those in another job.
- As Annex 6 will show, I am satisfied that in practice a reasonable relative value can be established through the various factors, and their numerous levels in recognition of the work itself.

- **REVIEWING (“SORETHUMBING”) TOTAL RELATIVE VALUES:** Job evaluation consists not only of a careful collection, analysis and consideration of as many features and demands of the work as possible, but also a judgement of the relative value of jobs. Each factor is applied in turn for the three jobs. A review of why each job is slotted in a level hierarchy needs to be done at the end of each factor examination. While each factor measures a distinct aspect of work, there are threads between factors – the work after all is integrated in its performance.
- A further review of how jobs have been slotted in any one factor may need to be compared with results for related factors. An example in the Equitable Job Evaluation Factor Plan is how “knowledge skills” are scored as opposed to how “problem solving skills” are scored. A total score is produced.
- The following section describes how these steps were taken in this analysis.

## **P. Evaluating the work: general approach**

### **DESCRIPTION OF THE EQUITABLE JOB EVALUATION FACTOR PLAN:**

125. This Plan consists of twelve factors as set out in the chart on the following page, organised by each of the four criteria (skill, effort, responsibility and working conditions) and measure (“make visible”) the features of work summarised in the third column of the chart beside each of the factors:

CRITERION	FACTOR	FEATURES MEASURED
SKILLS	KNOWLEDGE SKILLS (11 LEVELS; 3 USED)	<ul style="list-style-type: none"> <li>• nature, depth and breadth of the knowledge required</li> <li>• level of thinking associated with that level of knowledge</li> <li>• alternative experience equivalent to the knowledge indicated</li> </ul>
	PROBLEM SOLVING SKILLS (8 LEVELS; 3 USED, INCLUDING DURING THE “EVOLUTION” PERIOD)	<ul style="list-style-type: none"> <li>• creative, analytical, organisational and planning skills required</li> <li>• degree to which the jobholder is free to find solutions</li> <li>• support available in solving the problem</li> </ul>
	INTERPERSONAL SKILLS (6 LEVELS; 1 USED)	<ul style="list-style-type: none"> <li>• nature and intent of the interpersonal skills required</li> <li>• any requirements for communication out of the ordinary</li> <li>• requirement for functioning in a multi-cultural situation</li> </ul>
	PHYSICAL SKILLS (5 LEVELS; 2 USED)	<ul style="list-style-type: none"> <li>• nature of physical skill required</li> <li>• training or experience required to acquire the skill</li> </ul>

		<ul style="list-style-type: none"> <li>• requirement for speed and/or precision</li> <li>• need for adaptation/variation in use of skill</li> </ul>
RESPONSIBILITIES	PEOPLE LEADERSHIP (7 LEVELS; 3 USED)	<ul style="list-style-type: none"> <li>• nature of line leadership</li> <li>• nature of non-line influence<sup>52</sup></li> </ul>
	RESPONSIBILITY FOR RESOURCES (6 LEVELS; 1 USED)	<ul style="list-style-type: none"> <li>• nature and extent of the resources involved</li> <li>• jobholder's authority or control over those resources</li> <li>• jobholder's responsibility for financial resources</li> </ul>

52 Note that an optional feature of work that could be measured is "numbers of direct reporting staff involved". That is not appropriate to this work, and has not been included.

CRITERION	FACTOR	FEATURES MEASURED
RESPONSIBILITIES (continued)	RESPONSIBILITY FOR OUTCOMES (8 LEVELS; 2 USED)	<ul style="list-style-type: none"> <li>• nature of the position's responsibility for outcomes</li> <li>• share of the organisation controlled or influenced<sup>53</sup></li> </ul>
	RESPONSIBILITY FOR SERVICES TO PEOPLE (7 LEVELS; 2 USED)	<ul style="list-style-type: none"> <li>• nature of the service provided directly to people</li> <li>• need for assessment or adjustment of the service</li> <li>• impact of the service</li> </ul>
EFFORTS	EMOTIONAL EFFORT (4 LEVELS; 2 USED)	<ul style="list-style-type: none"> <li>• intensity of the emotional demand</li> <li>• frequency and duration of exposure to the demand</li> </ul>
	SENSORY EFFORT (4 LEVELS; 2 USED)	
	PHYSICAL EFFORT (4 LEVELS; 1 USED)	
WORKING CONDITIONS	WORKING CONDITIONS (4 LEVELS; 2 USED)	<ul style="list-style-type: none"> <li>• nature and extent of conditions and hazards</li> <li>• intensity and frequency of exposure to these factors</li> </ul>

#### THE JOB INFORMATION AND JOB EVALUATION:

126. Emphasis was put initially on documenting the most recent set of job information, taking into account all of the sources discussed in this Report (job descriptions, core competencies, interviews, the literature, standards and policy statements were the main ones). I also developed a process to track at reasonable intervals what changes there appeared to have been in the work of the midwife and the CHC family physician. (It should be recalled that the latter's work is taken as a constant, that is at the full range described currently.) This process was necessary for the following reasons:

- Indications of evolution or development over time, beginning with the first three-year period after regulation, and including additions to scope of practice for midwife – the family doctor's scope appears to be essentially constant. (A few alterations will be noted under the section on tracking evaluations over time.)
- Another reason is that aspects of the midwife's practice changed at several times because of experience, recognition of partnership and practice responsibilities or because there were periodic reports coming to the attention of the MOHLTC suggestive of the need for review of compensation.

53 This feature has been interpreted in non-hierarchical terms, that is, in view of collaborative nature of the midwifery partnerships and the collegial style of CHCs.

- Finally, as noted at the outset of this Report, good compensation practice and required pay equity practice mean that the content and value of work (and potentially compensation) should be reviewed periodically.

#### **VALUING THE THREE PROFESSIONS:**

127. As noted earlier in this Report, the steps in valuing work begin by taking stock of information about the work. In many instances, this was quite clear, particularly on matters like education and specific clinical responsibilities. In others, the literature and standards were helpful in setting out some dimensions like interpersonal skills. Others, like physical skills were implied, particularly in relation to obstetrics, where, as noted, there was a decision to be made as to whether all CHC family physicians were directly involved in catching babies during birth. (The benefit of the doubt was given that they were.) This process was repeated for each of the factors in turn for each of the jobs.

#### **Q. Rating the Professions**

128. Annex 6 sets out in detail my rating notes on each of the professions for the 12 factors involved. I should reiterate that the rating process proceeded one factor at a time. A reason for this approach is that the hierarchy of levels within a factor becomes clearer as one examines and re-examines, in light of the work of each job, the signposts for each level. A view of the range of possibilities is therefore formed. If, on the other hand, one rates each job for *all* factors, one forms an idea about the overall job, which is not helpful to taking each feature of work and giving it a value. This latter approach also promotes gender neutrality as the focus is on the work and not the overall value of the job.
129. As noted earlier at several points, in the evaluation process (especially the midwife and the family physician), I made an effort to be “conservative” in the sense of recognising that the midwife job was in the process of evolving – a consideration more relevant for the past than currently, though some aspects of work are still emerging (such as management of practices, which I have not credited to the midwife). The practice is also conservative in giving the benefit of the doubt to the family physician, for example in birthing and in continuing to be recognised as the authoritative source of medical advice within the CHC and in relation to the midwife should there be consultation.
130. In any event, each of the three jobs is seen as autonomous and working within their scopes of practice, though there may well be constraints. Noted are the constraints facing midwives in being integrated into hospitals, a challenge now facing nurse practitioners, as well as the constraint of time for clients faced by the CHC family physician.

#### **R. CONCLUSION: THE RESULTS**

The Chart on the following page shows the results after all the steps as outlined above have been taken and the job facts and understanding applied to the various levels in each of the factors of the Equitable Job Evaluation Factor Plan.

<i>Factor</i>	<i>Midwife</i>	<i>[LEVEL]</i>	<i>Nurse Practitioner</i>	<i>[LEVEL]</i>	<i>CHC Physician</i>	<i>[LEVEL]</i>
Knowledge	100	7	100	6	142	10
Problem Solv Skills	70	5	56	4	84	6
Interpers. Skills	84	5	84	5	84	5
Physical Skills	70	5	56	4	70	5
Leadership Resp	45	3	30	2	60	4
Resource Resp	45	3	45	3	45	3
Outcomes Resp	60	4	60	4	75	5
People Service Resp	90	6	75	5	90	6
Emotional Demands	25	4	19	3	19	3
Sensory Demands	25	4	19	3	19	3
Physical Demands	25	4	19	3	19	3
Working Conditions	25	3B	13	2A	19	2B
<b>TOTAL POINTS</b>	<b>664</b>		<b>576</b>		<b>726</b>	
<b>%</b>	<b>91%</b>		<b>79%</b>		<b>100%</b>	

131. Overall, the highest value attributed to the family physician stems from his scope of practice, which is the widest of the three jobs, the added specialized knowledge to support that scope and the additional skills and responsibilities attached to the greater variety of client circumstances that are associated with the scope. The midwife is valued more highly than the physician only on emotional effort, where it is considered that the continuity of service and the closeness she has as a professional to an intimate and all-consuming event (giving birth) on a frequent basis needed to be borne in mind. I noted also that fewer family physicians appear to attend births than previously. While one could say that the outcome of the midwife's work in this regard is at least that of the physician, on the whole, the wider range of service from the physician made the higher value attributed to that job seem

reasonable. The changes in the family physician work are not, in my opinion, significant to warrant any downward shift in past evaluations. (It is the current description that is a little more demanding.)

132. On the other hand, the resulting closeness of the midwife's value to that of the family physician deserves some comment: The midwife bears a great deal of responsibility as the specialised medical professional in charge of birthing – particularly in the one-fifth of times when the birth takes place at home. The emergency training and procedures clearly envisage difficult and unpredictable circumstances that the midwife and her assistance need to deal with. The fact of significant training and experience in the theories and practicalities of birthing (as well as maternity care more generally) sustains the rating in my view. Ensuring the health of mother and newborn is a significant objective that also needs to be kept in mind in establishing the value.
133. I also note the following:
  - a. The demand for midwifery services has outstripped the supply;
  - b. Midwifery outcomes appear to be more positive than those of more medicalised approaches; and
  - c. The Society of Obstetricians and Gynaecologists of Canada has a joint statement on the desirability of natural childbirth also indicate the value of the role of midwife.

I make these points out of an awareness that the history and some of current challenges of validating midwifery and integrating the program into primary health care suggest that the value has been in some doubt until less than a generation ago.

## **S. Ratings over time**

134. There have been a number of changes over time for the two jobs that are most relevant to the issue of equitable compensation for the midwife – that job and the family physician. The latter displays only a few changes, if one compares the job descriptions of the Morton Report and the most recent one for the same position (South-east Ottawa CHC). The Table of results of over time are shown on the next page. Note that the final two time periods are 2008 to 2012 (the end of the fifth period), and 2013, representing the current portrait.



135. The changes in the midwife's work is somewhat more complex and are summarized as follows (full detail at Annex 7), with changes over previous period marked in BOLD :

<b>SUMMARY TABLE</b>		<b>MIDWIFE RATINGS</b>				
<b>Factor</b>	<b>1994</b>	<b>1999</b>	<b>2002</b>	<b>2005</b>	<b>2008</b>	<b>2013</b>
1, Knowledge	86	86	86	86	<b>100</b>	100
2, Problem Solv Skills	42	<b>56</b>	56	56	56	<b>70</b>
3, Interpers. Skills	84	84	84	84	84	84
4, Physical Skills	70	70	70	70	70	70
5, Leadership Resp	30	<b>45</b>	45	45	45	45
6, Resource Resp	45	45	45	45	45	45
7, Org'nal Outcomes Resp	45	45	45	45	<b>60</b>	60
8, People Service Resp	90	90	90	90	90	90
9, Emotional Demands	25	25	25	25	25	25
10, Sensory Demands	19	19	19	<b>25</b>	25	25
11, Physical Demands	25	25	25	25	25	25
12, Working Conditions	25	25	25	25	25	25
<b>TOTAL POINTS</b>	<b>586</b>	<b>615</b>	<b>615</b>	<b>621</b>	<b>650</b>	<b>664</b>
<b>% of Family Physician (726)</b>	<b>81%</b>	<b>85%</b>	<b>85%</b>	<b>86%</b>	<b>90%</b>	<b>91%</b>

## T. Compensation issues

### FRAMEWORK FOR CONSIDERING EQUITABLE COMPENSATION:

136. In pay equity terms, equitable treatment would follow these steps:

- The value of the work of the female occupation would be assessed relative to the male comparator profession, with a total or an equivalent measure to enable comparison. The question would be asked whether the jobs (in this case midwife and physician) are equal in value. In some cases, the question is varied when compensation is also considered – that is the third of these steps.
- If the jobs are of equal value then the question is whether for the equal value are the jobs receiving equivalent pay. If they are not, then there is not equitable treatment.
- The other circumstance, which pertains in the case before the Tribunal, is whether the pay is proportionately equivalent to the relative value of the two jobs. This was the reasoning in a recent case under the *Canadian Human Rights Act*. While the nursing job in *Walden v Social Development Department* was not equal, it was clear to the Tribunal that the difference in pay was far from warranted by the difference in value. As a result, a *proportionate* approach to the question of equitable treatment was taken. That is, the percentage relationship in value was used in deciding the percentage relationship in pay. In the end result, the compensation to the nurse was increased to just under 85% from about 65% [as noted above, see also footnote 2 re direct salary and allowances].

137. In this case, it is my opinion that a proportional approach is fair and reasonable. As a result, one would ask the question “is the compensation of the midwife proportionately equivalent to the value relationship between the two jobs?” It is clearly not, given that the current pay of the midwife is approximately \$104,000 at the maximum, and that of the CHC family physician is just under \$200,000. This is a difference not of some 10% as suggested by the relative value of the midwife job, but nearly 50% less. Even with some margin for error in value, it is clear that the compensation of the midwife is not fair and equitable. It is my opinion that sex bias is operating in the unequal compensation being received by midwives.

138. It should be said that there are explanations for the difference, but that they are not justified under pay equity principles:

- There could be market conditions that have produced high wages for the family physician. Indeed, a large increase that took place in 2005 is part of the explanation. However, so far as I can determine there are no justifications such as a temporary market shortage for this job.

Instead, there appears to have been an equalizing with other physician work through negotiations between the Ontario Medical Association and the MOHLTC.

- The inverse could have pertained to midwifery work: there might have been a very large surplus, meaning that there was no difficulty in retaining or attracting people to the profession. It appears instead that there are retention problems in the profession because of pay not being commensurate with the range and value of the work. Such was not the case as demand for midwifery services has outstripped the ability of midwives to provide the level of service.
139. In other words, market conditions which for non-pay equity purposes might be brought forward for justifying the difference, are not acceptable in excusing inequitable treatment. Such criteria are (as noted elsewhere in this Report) are outside the usual ambit of pay equity comparisons. The exception is that an employer (or in this case, the funder and decision-maker) may justify a comparator rate on the basis of temporary market shortages. I am not aware of such shortages with respect to family physicians. There is information on both midwives – where there have been increasingly larger classes of graduate from universities to meet increasing demand for services – and for nurse practitioners, where a report shows that there are shortages in CHCs due to uncompetitive salary rates.<sup>54</sup>
140. The difference was not so great initially at the time of regulation. However, Morton tied the maximum rate for the midwife to the *minimum* of the wage range of the family physician. There is no apparent logic for this choice evident in the Morton Report, and it does not square with government policy as expressed in pay equity legislation, where the salary maximum, as noted in the above example from the federal jurisdiction. (All pay equity legislation of which I am aware has the same requirement.) It appears from my investigation of the process surrounding the Morton Report that the ultimate choice of the \$77,000 salary maximum for midwives was influenced by factors in addition to the rough pay equity analysis.
- Had Morton fixed the compensation at about 96% of the maximum, instead of in relation to the minimum, it would have been \$114 thousand.
  - Moreover, it appears that no pay equity analysis was conducted by the Ministry after 1993, and there was no investigation of the equity implications of increasing family physician wages from \$118 thousand (at the maximum) to nearly \$200 thousand (an increase of 69% over 20 years) If it had been reviewed, it would have been apparent that the increase of just 35% over the same period to midwives was in itself a pay equity issue..

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<sup>54</sup> 20. “Toward a Primary Care Recruitment and Retention Strategy for Ontario: Compensation Structure for Ontario's Interprofessional Primary Care Organizations,” Association of Family Health Teams of Ontario, the Association of Ontario Health Centres and the Nurse Practitioners' Association of Ontario, June 2013 (with report highlights from 2012 compensation study by the Hay Group)

While it may have been permissible to do only a rough pay equity analysis in 1993, it was necessary to a thorough one after the midwives had settled into their roles after regulation. That was not done, nor was it done thereafter. Consequently, the pay equity gap has been greatly exacerbated during that 20 years – the result of little if any underlying equity analysis or point of reference, and no analysis of relative wage increases. Even though the Hay Reports and the Courtyard Reports were not proper pay equity analyses consistent with pay equity principles as set out in this Report, they did provide important comparative information about the three professions and their relative work. They did, it is important to say, note that pay equity remained a concern.

## **U. Summary Conclusions**

141. This analysis has applied pay equity principles and practices to discern whether the compensation of midwives is equitable. That has required an examination of whether sex is linked with both the work and the compensation of this profession. It is clear first, that midwives' work is women's work provided to women, and second that the profession is almost entirely female. In addition, pay equity requires a comparison with work of the profession of CHC family physician. That has been found to be male predominant, with work that historically and in 1993 was associated with men. The analysis has led me to conclude that:
  - a) As a female predominant profession, midwives' work has not been subjected to a pay equity analysis, despite concerns expressed that it be so. Consequently, the work has not been comprehensively valued. Much of the work has been invisible – an issue that public policy (and the *Pay Equity Act*) in Ontario was designed to resolve.
  - b) A framework has been available from the outset of regulation of the profession for making the comparisons necessary to ensure equity, that is, the comparison with the CHC family physician. The framework encompasses a common decision maker in the Ministry of Health and Long-Term Care. These comparisons have not been made.
  - c) As a result, even the initial pegging of the salary maximum for the midwife (at 63% of the salary maximum of the CHC family physician) has not held. Instead, it has regressed to 53%, as indicated above, with effects on pay set out in the Mackenzie Report.
  - d) A value analysis, using a comprehensive pay equity plan that is gender neutral, shows that the value of the midwife's work has increased since 1994, as the work has become more demanding and the services provided have become more complex and been integrated into the Ontario Health System, both at the primary health care level and in hospitals.
  - e) The value of the midwife's work has, therefore, become closer to that of the CHC family physician, while the relative pay has gone in the opposite direction.
142. Consequently, I conclude that pay equity principles have not been well served in the compensation treatment of midwives, as indicated by a comparison with the CHC family physician. Indeed, I would conclude that the women in the midwifery profession have become more disadvantaged over time, despite being asked to do more in line with the

values and goals of the primary health care system of the Ontario Ministry of Health and Long-term care. Pay equity wage gaps are evident throughout the nearly twenty years since the profession was regulated at the beginning of 1994.

143. I am confident that,

- Given the extent of the pay equity gap, and the results of value comparisons, there exists significant wage discrimination adversely affecting midwives in their compensation, that is, it is not free from sex bias.
- This disadvantage is strongly associated with sex given the sex predominance of the two professions involved in comparisons, the nature of women's work (as expressed in midwifery) and the gender neutral approach taken to valuing their work and that of the CHC family physician.
- Such discrimination and disadvantage run counter to public policy and human rights and pay equity principles.
- Redressing the undervaluing and under-compensation of midwives should be based on the proportionate relationship in value and compensation between the midwife and CHC family physician during the period from the end of 1996 to the present.
- The proportions as set out here range from 81% in January of 1997 to 91% beginning on January 1<sup>st</sup> 2013.

Paul Durber, November 24, 2013

## **ANNEX 1 TO REPORT OF PAUL DURBER**

# Curriculum Vitae: Paul Durber

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## Curriculum vitae for Paul Durber

**Currently:** Senior Consultant, Opus Mundi Canada, Ottawa, Canada  
(from mid-1998 to the present)

- Facilitating joint union-association-employer job equity study with Laurentian University in Sudbury that aims to establish equitable values for about 350 staff and supervisory positions at the University.
- On retainer to legal counsel for advice on various files –
  - o one involving the value of nursing and medical advisor jobs and pay equity issues generally;
  - o a second requiring an affidavit as an expert on pay equity in relation to legislation passed at the federal level which purports to install a new régime for pay equity; and
  - o a third that involves a pay equity complaint between a job family and a variety of pay comparators in the federal public service.
  - o In addition, am on retainer as expert witness in a case under the Pay Equity Act of Ontario (maintenance of pay equity after proxy comparisons are effected.)
  - o I am advising in a further case in which the value of certain other health care jobs and compensation is to be reviewed for equitable treatment.
- Has provided independent advice to a variety of organizations, including employers (e.g., Museums of Nature, Civilization and Science and Technology, Privacy Commissioner, City of Iqaluit), legal counsel (in relation to litigation involving pay equity and job evaluation questions) and unions (including the Canadian Association of University Teachers, Public Service Alliance of Canada, the Office and Professional Employees Union, and the Canadian Association of Professional Employees), on job evaluation tools and comparable worth, from the perspective of equal pay for work of equal value (e.g., gender neutrality). Has also advised some not-for-profit agencies involved in the health sector.

- Developed job evaluation and classification plans for several employers (Rights and Democracy, City of Iqaluit, Caveau des Jeans, Société de Transport de l'Outaouais); designed job questionnaires (Caveau des Jeans, STO , etc.); completed a contract with the Société de Transport de l'Outaouais for these purposes as part of a joint management-union pay equity exercise (completed in 2009). Plans were developed in either English or French.
- Acted as mediator in a pay equity dispute in Montréal; heard grievances on two occasions for the City of Iqaluit and provided the employer and union representatives with two reports with recommended resolutions; facilitated job evaluation and classification exercise for 16 jobs for the City; recommended job questionnaire; facilitated joint grievances processes for the Nunavut Government (nursing jobs, corrections officers, a second series of administrative jobs and another set of professional positions).
- Worked as third-party chair of joint union-management committees at the House of Commons and the Senate of Canada (2006-7) examining the merits of a number of classification grievances against the application of the job evaluation plan of the House.
- Acted on five occasions as neutral facilitator of joint union-management committee (Nunavut Employees Association and Government of Nunavut) which produced decisions on a number of classification appeals relating to a variety of jobs, including professionals, administrators, trades and support.
- Arbitrated a series of grievances for the Public Service Alliance of Canada and Qulliq Corporation of Nunavut in 2011 where the parties agreed on each of the revised ratings using the Corporation's job evaluation plan.
- Contracted to arbitrate a number of classification grievances at the National Gallery of Canada (2008 -2010). These parties agreed that decisions rendered would be binding.
- Has reported to the Canadian Human Rights Commission on several complaints of alleged wage discrimination and has advised the Commission on pay equity issues arising in complaint investigation and litigation
- Acted as consultant on retainer to the Québec Human Rights and Children's Rights Commission (1998 to 2003) on wage equity in the health, education and manufacturing sectors; researched the nature of work, job evaluation tools being employed and the equity of their design and application, and the comparability of job worth; has investigated a series of complaints involving questions of equity in job evaluation, wage gaps and equity within salary practices.



- Produced two policy papers for the federal Pay Equity Task Force on pay equity issues (2004), including the use of job evaluation; subsequently produced a paper on a similar question for the Québec Pay Equity Commission and conducted a seminar on the question of occupational grouping for the Commission. Also provided a paper on bargaining power as a possible issue in pay equity for the Task Force.
- Gave testimony to a legislative assembly committee in New Brunswick on a private member's bill to put in place a proactive régime of pay equity similar to that applying to Ontario and Québec.
- Examined a number of executive, administrative and personnel jobs at the Privacy Commission; interviewed incumbents and supervisors; assessed adequacy of job information; recommended adjustments and evaluations.
- Has developed a series of senior-level work descriptions for a directorate within the Chief Information Officer Branch (Treasury Board Secretariat), in the Executive, Computer Systems and Economics occupations.
- Provided advice (in 1998-99) to a public sector union (CUPE) and library employer in Toronto (as sub-contractor) on the value of work in a range of professional, white collar, and blue-collar jobs as part of a pay equity study (part of team appointed by the Ontario Pay Equity Hearings Tribunal).
- Has delivered both courses and workshops on aspects of pay equity, job evaluation and classification, including assessment of features of work (Université de Moncton, Bishop's University, Human Resources Development Canada, Pay Equity Task Force, Commission d'Équité salariale de Québec, joint union-management exercises noted above).
- Has acted as committee member in valuing senior-level jobs at the Superintendent of Financial Institutions and the House of Commons; made detailed market comparisons between jobs at the Library of Parliament and the Public Service; examined evaluations in the civil service of the North West Territories.
- Has been qualified as an expert witness on pay equity and the job evaluation and classification system in the public service at several Human Rights Tribunals in the federal jurisdiction (Public Service Alliance of Canada et al. v. Treasury Board; Public Service Alliance of Canada et al v. Canada Post and a short-lived tribunal involving supervisors at women's prisons. (See also below.)

## **Earlier Work History<sup>55</sup>**

### **Director, Pay Equity**

Canadian Human Rights Commission  
(from May 1989 to September 1998)

Was responsible to:

- improve the effectiveness of the program and manage the pay equity group of the Commission;
- investigate and conciliate complaints of pay inequities and systemic wage discrimination; the most wide-ranging complaints included the equal pay complaints in the federal public service;
- act as the client for Commission counsel in Human Tribunals examining major pay equity disputes (e.g., Canada Post, Bell Canada, Air Canada and Canadian Airlines), and in a number of instances provide expert testimony.

*Note that I was qualified as an expert witness in the federal public service and Canada Post cases, and gave such testimony without being so qualified in the Air Canada tribunal case. (For details, see page 8.)*

Among other duties:

- develop greater understanding of the theory and practice of pay equity among those involved in industrial relations;
- examine the use of job evaluation and classification plans in connection with investigations and advice to employers and complainants;
- propose changes in federal pay equity practices and legal provisions to reach the goal of wage equality between men and women, for example how to consider

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<sup>55</sup> Note that I retired from the federal public service in October 1998 after 32 years of service, and then responded to requests for consulting advice.

compensation benefits in pay equity, deal with temporary market shortages and performance pay;

- direct research into factors accounting for wage disparity, including the nature of women's and men's work, the phenomenon of occupational segregation, factors underlying gaps in compensation including benefits and salary practices, and the structure of occupations;
- update policies for comprehensive implementation of pay equity within federally regulated organizations, including a comprehensive Guide to Pay Equity and Job Evaluation, and a guide to gender neutral job evaluation practices, including the relationship between parties to collective bargaining and pay equity negotiation;
- mediate disputes between parties and encourage settlements, including both the Personnel Group and the Social Worker complaints in the federal Public Service;
- promote pay equity with employer, union and other audiences and expand the educative program of the Commission on pay equity, a duty which included giving workshops and presentations both within the public sector and outside;
- develop a national network of provincial, federal and local agencies with responsibility for equal pay for work of equal value and organize exchanges and workshops.

## **Previous Experience**

**Chief of Compensation, House of Commons**—August 1985 to May 1989. Responsible to:

- prepare management for collective bargaining, in respect of salary comparison research and positioning on wage and job evaluation policy;
- complete a study to amalgamate classifications while improving salary relationships and move toward equal pay;

- plan and implement new job evaluation and classification standards;
- develop internal controls, data systems and analytical capacity, and direct compensation research and surveying;
- promote management support for policies and practices in this area of personnel management;
- review internal compensation for pay equity purposes.

**Chief of Classification and Organization, Consumer and Corporate Affairs --**  
February 1983 to August 1985. Responsible to:

- identify key management needs and problems in respect of the organization and valuing of work;
- develop joint personnel-manager teams to resolve needs through projects, and develop consensus on study implementation;
- develop consultant abilities in unit staff;
- justify unit resources through work plans and detailed work analysis;
- contribute as member of personnel specialist team to the human resources direction of the Department.

**Senior Program Analyst, Personnel Policy Branch, Treasury Board Secretariat --1980**  
to February, 1983 -- staff position. Responsible to:

- develop a classification audit strategy and plan for the Chief;
- contribute to establishing audit methodology through research and policy development;

- audit work requirements in a variety of occupations across Canada; describe work requirements in detail and assess job values;
- establish whether positions are described and valued according to standards.

**Senior Project Officer, Personnel Policy Branch, Treasury Board Secretariat --1978 to 1980 -- staff position. Responsible to:**

- revise workforce adjustment policy;
- revise decentralization policy (personnel aspects);
- represent Treasury Board on two National Joint Council committees;
- study the occupational grouping of the federal public service and recommend feasible amalgamations;
- study alternate forms of a bilingual bonus and communicate with unions and management on the issue.

**Project Officer, Personnel Policy Branch, Treasury Board Secretariat --1976 to 1977 -- staff position. Challenges, to:**

- plan and coordinate intergovernmental conferences (including first conference of heads of treasury boards on total compensation; duties included drafting final communiqué);
- write policy proposals for revising personnel legislation.

**Research leader, Compensation Policy Review Project ("Starnes Study") -- 1975 to 1977 -- organize research on the future shape of compensation for the federal public service.**

**Prior to 1975 (1971-75),** I was a Standards Officer (job classification) in the federal Treasury Board Secretariat; wrote classification standards in consultation with

departments of the public service and with unions, advised negotiators on the implementation of classifications standards and new salary scales; prepared submissions for Treasury Board on implications of the introduction of new standards.

### **Other Experience:**

Testified as expert witness before a number of federal tribunals, including but not limited to the following:

- the equal value complaint of the Public Service Alliance of Canada v. Treasury Board (Hospital Services Group) in 1989 [Canadian Human Rights Tribunal];
- wage disparities in the federal public service (PIPSC and PSAC v Treasury Board of Canada) in 1993, including serving as witness for the Tribunal on the structure and working of the classification structure in the Public Service, its history in the preparation for collective bargaining and policies and practices connected with the structure and bargaining units [CHRT]; and
- the complaint of the Public Service Alliance of Canada (on behalf of clerical employees) v Canada Post in 1993 [CHRT].

### **Volunteer Experience:**

Worked to build the public personnel management association both locally (on Executive of the local chapter of the Canadian Public Personnel Management Association for nine years in the 1980s and 1990s) and nationally (was director of communication and published and edited *Personnel in Perspective*).

Coordinated a number of workshop series and conferences, including the first pay equity conference in Yellowknife, and a national Employment Equity Conference in Ottawa that was designed for private sector senior executives. Developed several networks to encourage education and awareness among job evaluation and other human resources practitioners. Serves on the organising committee for the 2010 national conference in Ottawa (responsible for communications).

Organised the Citizens Panel on Policing and the Community (March to May 2002), chaired by the late Marion Dewar, and co-founded the Ottawa Witness Group, which grew out of the Panel's recommendations and which continues to

monitor policing of demonstrations and comment on policing policy, budgets and legislation.

Contributed to the congregation of First United Church in Ottawa in various ways, including its personnel management (currently as member of the congregation's ministry and personnel committee and healing pathways ministry), its lay coordination (as Chair of Council for four years) and its social justice outreach efforts.

Serves on the Board of Directors of local non-governmental organizations (e.g., Centre 507, which serves vulnerable poor in Ottawa with a variety of employment, social, housing referral and other programs); has served on the coordinating committee for People for a Better Ottawa (bringing together civic organizations in municipal issues).

Serves on the Board of Directors of the Iranian Queer Railroad for Refugees (and was a member of the founding Board), which helps people who have escaped persecution in their homeland because of their sexual orientation to find safe refuge and gain refugee status. The organization also provides counseling and some material support to those who have no means.

**Other:**

Has been a foster parent to a formerly poor family in the highlands of Crete since 1968, helping them with basics (education, decent housing and education and more recently with the business projects of the children) and encouraging the younger members of the family to undertake higher education. I and my partner still provide some material support to various members of the family.

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## **ANNEX 2 – FEATURES OF WOMEN'S WORK**

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This Annex contains an extract from a decision of the ONTARIO PAY EQUITY HEARINGS TRIBUNAL [Haldimand-Norfolk no. 6, referenced in the Report] dealing with the appropriateness of a job evaluation plan in a pay equity context. They cited research findings about characteristics of women's work and used them as one test of whether the job evaluation plan could be applied in a gender-neutral fashion to nurses' work. The Tribunal noted that such characteristics were "frequently overlooked" and undervalued – a problem that pay equity legislation was designed to remedy. I have also a Supplementary List based on my own experience and observations.



## **Features of Women's Work<sup>56</sup>**

### **SKILL:**

- operating and maintaining several different types of office, manufacturing, treatment/diagnosis or monitoring equipment;
- manual dexterity required for giving injections, typing, or graphic arts;
- writing correspondence for others, and proofreading and editing others' work;
- establishing and maintaining manual and automated filing systems, or records management and disposal;
- training and orienting new staff;
- deciding the content and format of reports and presentations to clients

### **EFFORT:**

- adjusting to rapid change in the office or plant technology;
- concentrating for prolonged periods at computer terminals, lab benches;
- performing complex sequences of hand-eye co-ordination;
- providing service to several people or departments, working under many simultaneous deadlines;
- developing work schedules;
- frequent lifting (office or medical supplies, retail goods injured or sick people)

### **RESPONSIBILITY:**

- caring for, and providing emotional support to children, institutionalized people;
- protecting confidentiality;
- acting on behalf of absent supervisors;
- representing the organization through communications with clients and the public
- supervising staff;
- shouldering consequences of error to the organization;
- preventing possible damage to equipment;
- coordinating schedules for many people

### **WORKING CONDITIONS:**

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<sup>56</sup> Extracted from Ontario Pay Equity Hearings Tribunal decisions—see **Haldimand-Norfolk (No. 6), (1991) 2 P.E.R. 105.**

- stress from noise in open spaces, crowded conditions; and production noise;
- exposure to disease and stress from caring for ill people;
- dealing with upset, injured, irate or irrational people;
- cleaning offices, stores, machinery, or hospital wards;
- frequent bending or lifting of office or medical supplies, retail goods
- stress from answering complaints;
- long periods of travel and/or isolation

### **Supplementary list of features of women's work<sup>57</sup>**

#### **1. Intervening in others' communications**

- Editing correspondence for other people, rereading and correcting others' writing
- Understanding other languages and interpreting communications from one language to another, particularly the sense of the message and its original style
- Understanding the nuances of meaning in verbal and non-verbal communications

#### **2. Preparing and formatting information**

- Selecting the content and material presentation of reports and briefs to clients
- Organising clients' work
- Representing the organisation with clients and the public through communications
- Understanding client needs and those of audiences with regard to information
- Ensuring the quality and accuracy of documents and files, on paper or in electronic form
- Responding clearly and concisely to requests for information

#### **3. Being responsible for the protection and confidentiality of personal information**

- Protecting confidentiality
- Producing and providing information bearing on income, health and well-being of individuals, for example their pay, dietary regime, psychological state and medical examinations
- Evaluating individuals in the light of information provided for purposes of human resources, for medical care and social assistance

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<sup>57</sup> Results from analysis by P. Durber of occupations traditionally viewed as predominantly female, as described in the *National Occupational Classification*. These occupations include those noted in the 1995 Census as being 70% or more female – largely from service, health, educational and administrative fields.

4. Specialized skills relating to communications
  - Interviewing, for example, candidates, patients or clients to subscribe them to programs such as social assistance
  - Counselling clients in order to help them to acquire the skills needed to resolve their personal or social problems
  - Promoting programs bearing on health or social well-being and their objectives
  - Implementing the programs themselves
  - Explaining ideas or describing products to internal clients, and informing external clients about products for sale and about their prices
  - Teaching know how and demonstrating techniques
  - Promoting the image of an organisation, for example by meeting visitors and clients
  
5. Evaluating and foreseeing needs of other individuals in terms of services, products and programs
  - Evaluating the needs of patients or clients for health care, for example their dietary needs, therapy, medical care and diagnosis
  - Understanding the needs of an organisation in relation to administrative services
  - Understanding the tastes and needs of internal and external clients in respect of the preparation of foods and beverages and related services
  - Understanding needs for personal services such as tailoring
  
6. Deal with stresses stemming from working conditions related to interpersonal interactions
  - Provide services to several people or departments and having to meet many deadlines simultaneously
  - Coordinating the work schedules of many other individuals, and from one work unit to another
  - Being exposed to illnesses and stresses related to giving health services to the ill
  - Dealing with the stress related to managing complaints
  - Having to deal with others who are conflictual, injured, irritated or displaying irrational behaviour
  - Witnessing personal and social problems of clients and groups
  - Experiencing the stresses involved with resolving personal or social problems of others, which may continue despite personal or program efforts

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**ANNEX 3 – EQUITABLE JOB EVALUATION  
FACTOR PLAN – WORKING TOWARDS  
GENDER EQUALITY, NEW ZEALAND PAY  
EQUITY UNIT**

This document tracks a number of values expressed in Ministry of Health and Long-term Care policy documents, standards relating to the work of the three professions involved, and where these are reflected in the Equitable Job Evaluation Factor Plan for pay equity evaluation

Department of Labour  
TE TARI MAHI



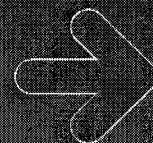
■ ■ PAY AND EMPLOYMENT EQUITY UNIT

# EQUITABLE JOB EVALUATION FACTOR PLAN

Working towards Gender Equity

2007

FOR INFORMATION ONLY



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## ■ INTRODUCTION TO THE EQUITABLE JOB EVALUATION PROCESS



Job evaluation is a process that can be used in the development and operation of an effective remuneration system. It can provide a clear and fair measure of the relative values of jobs within an organisation, a job discipline, or other specified group of jobs. Job evaluation also provides a means of establishing external relativities with jobs of similar value in other organisations.

Like most effective job evaluation processes, Equitable Job Evaluation uses a number of *Factors, Levels* and *Points* to analyse job sizes. This is called the points/factor comparison method of job evaluation.

This manual contains the *Factor Level Definitions and Factor Guidelines* of the Equitable Job Evaluation Process. Detailed guidance for using the job evaluation process is contained in the *User's Guide*. It is important to remember that job evaluation is a *process, not a formula*, and this manual is *only a tool* to assist in that process. The manual provides a structured methodology that enables the evaluator to arrive at an appropriate job size through a logical and consistent process.

The guidelines in this manual are just that: *guidelines, not absolute rules*. They are provided to clarify the scoring levels available in establishing relativities among jobs in terms of the factors described, and their application must be interpreted in the context of the broader culture of the organisation or job grouping.

The Equitable Job Evaluation Process has been developed with a particular focus on ensuring gender neutrality in the sizing of jobs.



## THE EQUITABLE JOB EVALUATION FACTOR FAMILIES, FACTORS AND FACTOR METRICS

The Equitable Job Evaluation Process uses the following **factor families** and **factors** in the job evaluation process.

SKILLS FACTOR FAMILY		The Skills Factor Family reflects the knowledge and problem-solving skills required of jobholders, as well as the role of interpersonal and physical skills associated with the job.
METRICS		
<b>Factor 1</b> Knowledge Skills	<ul style="list-style-type: none"> <li>• nature, depth and breadth of the knowledge required</li> <li>• level of thinking associated with that level of knowledge</li> <li>• alternative experience equivalent to the knowledge indicated</li> </ul>	
<b>Factor 2</b> Problem-solving Skills	<ul style="list-style-type: none"> <li>• creative, analytical, organisational and planning skills required</li> <li>• degree to which the jobholder is free to find solutions</li> <li>• support available in solving the problem</li> </ul>	
<b>Factor 3</b> Interpersonal Skills	<ul style="list-style-type: none"> <li>• nature and intent of the interpersonal skills required</li> <li>• any requirements for communication out of the ordinary</li> <li>• requirement for functioning in a multi-cultural situation</li> </ul>	
<b>Factor 4</b> Physical Skills	<ul style="list-style-type: none"> <li>• nature of physical skill required</li> <li>• training or experience required to acquire the skill</li> <li>• requirement for speed and/or precision</li> <li>• need for adaptation/variation in use of skill</li> </ul>	

## RESPONSIBILITY FACTOR FAMILY

The Responsibility Factor Family reflects the leadership responsibilities of jobs, as well as responsibility for resources, service outcomes and delivery of services to people.

### METRICS

#### **Factor 5** People Leadership

- nature of line leadership
- nature of non-line influence
- numbers of direct reporting staff involved

#### **Factor 6** Resources

- nature and extent of the resources involved
- jobholder's authority or control over those resources
- jobholder's responsibility for financial resources

#### **Factor 7** Organisational Outcomes

- nature of the position's responsibility for outcomes
- share of the organisation controlled or influenced

#### **Factor 8** Services to People

- nature of the service provided directly to people
- need for assessment or adjustment of the service
- impact of the service

## DEMANDS FACTOR FAMILY

The Demands Factor Family reflects the work context and interactions of the job, as well as the different stresses and the working environment that jobholders typically encounter.

### METRICS

#### **Factor 9** Emotional Demands

- intensity of the emotional demand
- frequency and duration of exposure to the demand

#### **Factor 10** Sensory Demands

- intensity of the sensory demand
- frequency and duration of exposure to the demand

#### **Factor 11** Physical Demands

- nature and intensity of effort demanded
- frequency and duration of the demand

#### **Factor 12** Working Conditions

- nature and extent of conditions and hazards
- intensity and frequency of exposure to these factors

## ■ FACTOR 1: KNOWLEDGE SKILLS



### THE FACTOR

This factor assesses the combination of knowledge and experience required to competently perform the job. It covers technical, specialist, procedural, product, organisational and conceptual knowledge, including numeracy, literacy, languages, theories, techniques, policies, procedures and practices.

The factor assesses the depth and breadth of the total knowledge required for the job, whether acquired through formal education, self-study, life experience, on-the-job training, work experience or some combination of these.

### FACTOR GUIDELINES

The factor is about the requirements to perform the job competently – not the level of knowledge and/or experience the current or any potential jobholder may possess. The incumbent may have high levels of either, but if they are not actually required to do the job, they should not be considered in the evaluation. The factor is assessed on the highest level of knowledge normally required on the job. Generally speaking, it does not consider how often that level of knowledge is used. However, knowledge that may be required only in rare or unique circumstances should not generally be used to determine the appropriate level.

Specific, relevant qualifications and training are not required for assignment to a particular level. However, they may provide a useful indicator of the type and level of knowledge needed to perform the job duties properly. Jobholders need not necessarily hold such qualifications – they may have acquired an equivalent level of knowledge through some combination of relevant formal or informal experience. Evaluators should take care not to under-score the knowledge requirement simply because there is no qualification equivalent.

This factor includes knowledge of language skills, including Braille and sign language, learned either formally or informally, that are required for the job. The manner of application of those skills is also addressed in Factor 3, Interpersonal Skills.

### FACTOR METRICS

The factor considers the

- a) nature, depth and breadth of the knowledge required
- b) level of thinking associated with that level of knowledge
- c) alternative experience equivalent to the knowledge indicated.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	<p>The job requires understanding of simple work procedures requiring a depth of knowledge that can be gained on the job in a limited, mainly manual, role, such as the driving of vehicles, delivery of mail, storage of materials, operation of basic tools and equipment or equivalent tasks.</p> <p>Foundation literacy, oral and mental skills are required. Knowledge is typically gained through some combination of training/induction and experience.</p>
2	<p>The job requires understanding of a number of regular work procedures of defined breadth that would require specific knowledge, job training or period of induction. The job requires literacy, numeracy and knowledge of the appropriate procedures for a range of tasks typically, but not always, gained through formal secondary education or on-the-job training or the equivalent level of experience.</p>
3	<p>The job requires skills and knowledge in an administrative, trade, craft or manual specialisation where tasks involve achievement of results initiated at a higher level. This may include ability to understand and apply administrative and operational work procedures or the ability to use complex machinery or equipment.</p> <p>Work is typically based on experience in relevant areas of work or training to a recognised standard of expertise beyond standard secondary school, supplemented by a further induction/familiarisation period.</p>
4	<p>The job requires specialised skills and knowledge of a trade, craft, technical, processing, clinical, commercial, administrative or operational nature at a skilled level, requiring a defined base of knowledge such as knowledge of work processes or technology and how to achieve end results.</p> <p>Experience would typically involve application of coordination, planning and problem-solving skills under general supervision. An equivalent depth or breadth of acquired knowledge typically involves formal training at a level equivalent to a trade certificate or one-year polytechnic certificate/diploma.</p>

LEVEL	FACTOR LEVEL DESCRIPTOR
5	<p>The job requires considerable skills and/or knowledge required to undertake technical, clinical, commercial, administrative or other specialist activities in the workplace, with limited supervision. The scope of tasks is reasonably complex, requiring experience in coordination, evaluation, analysis or technical investigation and solution of substantial issues and application of principles in a broad environment. This could include in-depth knowledge of use and capabilities of technical equipment, policies, practices and/or products.</p> <p>An equivalent depth or breadth of acquired knowledge is typically at the level of an advanced trade certificate or a two-year polytechnic diploma.</p>
6	<p>The job requires advanced levels of knowledge required for the completion of complex activities in technical, clinical, administrative, operational or comparable fields where external assistance may not be immediately available. Experience would normally include planning, developing and recommending appropriate courses of action to achieve successful results.</p> <p>Work is of substantial complexity, requiring a depth or breadth of theoretical knowledge plus practical and procedural knowledge in a specialist area, typically represented at the national certificate level or a three-year polytechnic diploma.</p>
7	<p>The job requires more advanced knowledge at a recognised professional level, sufficient for complex analytical constructive thinking in a conceptual problem-solving situation where many complex issues are involved. Experience would likely be in the achievement of significant organisational or professional outputs and/or objectives in a functional, operational, technical, clinical, scientific, administrative or other broad environment.</p> <p>Specialised knowledge is typically based on a foundation of theoretical learning or expertise, backed by formal recognition equating to a university Bachelor's degree or equivalent in a specific field, although an equivalent depth or breadth of knowledge gained less formally can be equally acceptable.</p>

LEVEL	FACTOR LEVEL DESCRIPTION
8	<p>The job requires the ability to contribute constructive and creative thinking in a broad range of social, technical, clinical, business, governance and/or professional environments. It requires academic, practical and procedural knowledge of a specialist area, plus detailed knowledge of the associated policies, practices and procedures.</p> <p>The work typically involves demonstrable evidence of expertise based on recognised qualifications or a combination of formal academic knowledge and less formal but advanced learning acquired through a variety of other sources. This is broadly the equivalent to a Bachelor's degree with substantial further study in an area of specialisation, or the equivalent depth or breadth of experience.</p>
9	<p>The job requires experience in planning and determining courses of action that achieve desired outcomes in a varied and complex environment. Experience would include initiating strategies and policies based on effective research and enquiry in a professional, technical, scientific or human relations environment.</p> <p>The job requires advanced knowledge at a senior level of formal qualifications or equivalent expertise derived from knowledge acquired in unique non-quantifiable areas, such as research, planning, management and/or operations and similar endeavours. This would typically be demonstrated by advanced practical and procedural knowledge across a specialist area equivalent to a Master's degree.</p>
10	<p>The job requires advanced theoretical and practical knowledge typically calling for higher levels of specialist knowledge within the relevant field or broad knowledge from different fields. A background of advanced scientific, technological or management expertise, combined with extensive professional, practical and theoretical ability, can be demonstrated and applied effectively.</p> <p>Knowledge requirements at this level would be for conceptual and intellectual thinking typically found at the broad equivalent of a doctoral degree or other advanced specialist training, research or study.</p>
11	<p>The job requires a breadth of expertise and experience gained from working at the highest levels in a leading role, in a combination of advanced disciplines that could include management, academic, technical, scientific, administrative, clinical or political functions in a unique commercial, service, academic or government arena. The job will require increasing levels of unique expertise/experience as a cultural, business, professional or government opinion leader.</p>

## ■ FACTOR 2: PROBLEM-SOLVING SKILLS



### THE FACTOR

This factor assesses the skills of creativity, innovation, analytical reasoning and judgment required to solve problems typically encountered or that may occur in the coordinating, organising and planning required to achieve the job's or the organisation's objectives. The factor considers the complexity of problems, issues or activities undertaken in usual circumstances.

### FACTOR GUIDELINES

The factor considers the context, variety and relative difficulty of the material or information upon which decisions are based, as well as the clarity of the problem and the accessibility of the information required to make the needed decisions. The factor assesses the highest level of problem-solving normally expected of the jobholder. It does not consider the exceptional problem or challenge that may arise in rare or unique circumstances and that it would not generally be considered the responsibility of this role to address.

### FACTOR METRICS

The factor considers the

- a) creative or analytical skills required
- b) degree to which the jobholder is free to find solutions
- c) support available in solving the problem.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	<p>The job requires skills to deal with problems of a generally minor nature that are clearly defined, needing little analysis and minimal effort in choosing between limited, clear options. The work is closely supervised and largely planned for the jobholder, although there is the opportunity to organise day-to-day tasks.</p> <p>Most information needed is straightforward and readily available, and decision-making methods and procedures are clearly established and defined.</p>
2	<p>The job requires some judgmental skills to deal with problems or situations of a familiar nature and limited difficulty, which may involve choosing solutions from defined alternatives. Some judgment may be required to interpret information, situations or instructions, but the jobholder is expected to solve recurring problems primarily through reliance on previous experience. Little close supervision is necessary, but resources are generally available for reference or advice.</p> <p>Information needed is readily available; decision-making generally involves solid information and established procedures, with only some clarification.</p>
3	<p>The job requires analytical and judgmental skills to solve varied problems of a recurring nature or to develop solutions, interventions or plans with a more immediate, localised impact. The skills include interpreting information or situations and choosing between options or existing procedures for undertaking work requirements. The jobholder generally has ready access to resources for advice and guidance on policies and non-recurring problems.</p> <p>Some information is readily available, but investigation and reference to other sources may be needed to inform solutions or the course of action.</p>
4	<p>The job requires analytical, diagnostic, creative and developmental skills. This level requires the judgmental skills to analyse unfamiliar problems, information or situations, work with multiple variables, evaluate a range of options and make decisions on new situations or processes. The jobholder is subject to occasional direction by a supervisor/manager or technical specialist who is readily accessible for guidance on more complex problems and policy interpretation.</p> <p>Information necessary to make decisions is not easily identified and investigation/research and possibly some interpretation is necessary to gather the data and ideas needed.</p>



**5** The job requires creative ability essential for solving problems of considerable complexity, along with the development of new approaches, solutions and/or recommendations for further action. Judgment is required in planning, researching a range of actions and evaluating alternative solutions and strategies over the longer term. Responsibilities and objectives are assigned with considerable latitude, with work reviewed according to achievement of objectives and pre-defined goals. The jobholder is expected to set quality standards for work.

Information necessary to make decisions is available through research, but requires considerable clarification, interpretation and adaptation to the needs and nature of the particular problem.

**6** The job requires multiple, advanced skills for the solution of problems of advanced complexity. The role involves interpreting overall policies and strategies within broad parameters and undertaking significant conceptual and imaginative approaches to solutions in areas of major development. The jobholder has wide discretion for setting objectives and assessing organisational or professional performance.

Information necessary for decisions requires extensive research or development. Considerable analysis is needed to clarify the possible problems.

**7** The job requires highly creative skills for development of solutions to highly complex problems. Solutions may require the application of sophisticated research or enquiry techniques and analysis. The jobholder generally sets strategic goals and longer-term objectives, as well as assessing the levels of outcomes to complex problem-solving processes.

Decision-making areas are multi-faceted, vague and difficult to identify. Information must often be generated from source material, using specialised knowledge of the function/service and/or technical discipline.

**8** The job requires development of innovative solutions to 'one-of-a-kind' problems. Issues dealt with will have major significance for future services, policies or practices. The solutions will involve the development of action or plans that have broad implications for the organisation, with support only distantly available.

Decision-making involves conceptual skills, abstract intellectual thought and the creation of hypotheses or theories. Information is unavailable or incomplete and options are difficult to identify and apply.

## ■ FACTOR 3: INTERPERSONAL SKILLS



### THE FACTOR

This factor assesses the level of communication and interpersonal skills required for competent performance of the role. It measures communication, including the need to communicate through means other than verbal exchange. The factor assesses the nature of personal contacts required with other people, including clients, customers, suppliers, government agencies, the media or peers in other organisations or professional associations, as well as relationships with other employees.

The purpose of the communication and interpersonal skills and the complexity or contentiousness of the material being communicated are both considered. The subject matter may be complex, sensitive, confidential or unwelcome. The factor also takes into account the nature, diversity, cultural background, size and receptiveness of the intended audience.

### FACTOR GUIDELINES

The factor measures the highest level of interpersonal skills required of the job. Frequency of use of the indicated skills is not generally considered in this factor. However, contacts that may occur only in rare or unique circumstances should not generally be used to determine the appropriate level.

The purpose of the interaction may include training, promotion, informing, advising, motivating, empathising, persuading, presenting, counselling, reassuring, negotiating, gaining cooperation, meeting the needs of others or caring for others. It considers human relations skills such as empathy, sensitivity, understanding of human and organisational behaviour and motivational techniques.

The score on this factor generally will increase with the greater sensitivity or complexity of the interpersonal situation and the criticality of the interaction for individuals, groups of people or the organisation as a whole.

### FACTOR METRICS

The factor considers

- a) the nature and intent of the interpersonal skills required
- b) any requirements for communication out of the ordinary
- c) the requirements for functioning in a multi-cultural situation.

## INCREMENT MULTI-CULTURAL SKILLS INCREMENT

**0** Many jobs in New Zealand are presumed to require some familiarity or ability to function on an informal basis in cultural situations outside that of the jobholder's own culture.

**14 Points** The job requires a broad application of language skills, customary concepts and traditions of another culture, along with the ability to function effectively on a solid working level in that culture on an extended basis.

### LEVEL FACTOR LEVEL DESCRIPTOR

- |          |  |
|----------|--|
| <b>1</b> | The job requires exchanging straightforward information, usually orally, with work colleagues, but could include other people. It involves politeness to avoid friction in relationships while working with others.  |
| <b>2</b> | The job requires effective exchange or transfer of information, as well as courtesy and cooperation, when dealing with external clients or people in the workplace on a day-to-day basis. It involves skills to explain, present or discuss ideas or data pertinent to an assignment. The job requires satisfactory people-responsiveness skills based on careful listening and some tact or diplomacy.  |
| <b>3</b> | The job requires instructing or guiding others in activities or considering complaints and suggestions from others. It involves effective people-responsiveness skills to elicit and understand people's personal or service needs. Contact is transactional in nature, requiring tact in coping with enquiries or challenges.   |
| <b>4</b> | The job requires use of strong interpersonal skills that contribute to the effectiveness of the organisation or service when negotiating, interviewing, motivating, persuading or information-gathering, with either other employees or external clients/customers. The jobholder may teach, motivate, influence, advise or give counsel to others through an interactional relationship based on professional background, expert knowledge and experience. The job requires very good people-responsiveness skills, involving discretion and diplomacy in dealing with others in situations of some stress or concern and/or in emotionally charged situations. |

LEVEL	FACTOR LEVEL DESCRIPTOR
5	<p>The job requires influencing others to accept a point of view or convincing people to take a different course of action willingly. The jobholder may negotiate with or influence others to promote significant ideas or resolve major issues or demonstrate leadership with a high level of communication, where the outcome depends on diplomacy and professional counselling skills or building of empathetic relationships in situations of considerable stress. Contacts require exceptional human relations skills to deal with difficult, specialised or emotionally charged situations.</p>
6	<p>The job requires diverse and complex negotiation, counselling, influence and/or leadership skills of a very high level, involving intensive personal effort and profound participation in discussions and interactions that are critical to outcomes for people, groups of people or the organisation/ service as a whole. This level of skill may be required when representing the interests of the organisation or profession as a whole on matters of critical importance where the impact internally/externally is significant. Contacts are of such importance that their effective handling becomes a major consideration.</p>

## **FACTOR 4: PHYSICAL SKILLS**



### **THE FACTOR**

This factor assesses physical or fine motor skills required on the job.

Physical skills encompass manual dexterity, hand/eye coordination, coordination of limbs, manipulation and sensory skills. It takes into account requirements for speed, precision and accuracy in tasks requiring accurate coordination and fine motor movements.

Frequency of use of the indicated skills is not considered in this factor. However, skills that may be required only in rare or unique circumstances should not generally be used to determine the appropriate level. If the demand for the skill is sustained over a period of time, that additional requirement will be accounted for in Factor 11, Physical Demands. Physical skills are about dexterity, coordination and fine motor movement skills, rather than the effort or energy expended.

### **FACTOR GUIDELINES**

The factor measures the highest level of physical skills required in the job. The skills involve the use of large or small muscle groups and associated hand/eye coordination. The skills are acquired through practice or formal training.

Rating on this factor will increase with the level and sophistication of the training and experience required, the detail of the activity, the need for precision, exactness and speed and the degree to which the skill set is used in existing work situations or adapted to new ones.

There are many jobs where some level of physical skill is required but is not central to the role. Examples of this include word processing or driving in professional roles. Skill requirements of this nature will be captured at level 2 of this factor.

### **FACTOR METRICS**

The factor considers the

- a) nature of the skill required
- b) training or experience required to acquire the skill
- c) requirement for speed and/or precision
- d) need for adaptation/variation in use of skills.

LEVEL	FACTOR/LEVEL DESCRIPTION
1	The job does not require training or experience in particular physical skills. There may be requirements for physical activity, but these are what might be considered typical of everyday life.
2	<p>The job requires acquired physical motor skills normally obtained through practice or practical training. The skills usually involve the manipulation or manoeuvring of objects, equipment or machinery where the same skill set is used throughout the job. Care, but not precision, is required.</p> <p>This skill level also covers jobs where there is some demand for physical dexterity beyond the requirements of everyday life.</p>
3	The job requires physical skills where training or specific experience is the key to proficiency. There is a need for precision in meeting the particular physical specifications of the job. Dexterity and hand/eye coordination, in addition to larger muscle movements and possibly speed of action, is typically required. It is also likely to require some variation in the application of the skill set while performing the job.
4	The job requires more complex physical skills that are acquired through a formal training programme. The skills generally involve detailed hand and/or finger dexterity and hand/eye coordination. There is always a need for precision and generally for speed – although in some jobs a higher level of precision may mean less speed is expected. The requirement can be for either one very detailed physical activity or adaptation across activities.
5	The job requires physical skills for which formal training is highly specialised and typically lengthy and complex. The job involves detailed and very precise hand/eye coordination and dexterous movement. The skills are applied in a variety of complex ways, require adaptation to different job situations and are likely to be updated over time.

## ■ FACTOR 5: RESPONSIBILITY FOR PEOPLE LEADERSHIP



### THE FACTOR

This factor assesses the leadership requirements of the position. This includes responsibility for direct line leadership, as well as functional control of staff, advisers, trainees, volunteers, consultants, contractors or other individuals whom the role can influence or for whom it has responsibility. Leadership may be in the form of direct management or supervision, functional guidance, professional leadership, coordination, technical influence or direction and/or specialty advice or any of many other forms of direct influence over the work patterns of others.

### FACTOR GUIDELINES

At levels 1 and 2, the emphasis is on either close or intermittent supervision and monitoring of the work processes, without full-time responsibility for personnel actions.

Level 3 supervision is generally periodic, as in shifts, projects, or work teams that form over time.

Level 4 supervision refers to situations where there is a direct, clearly understood reporting relationship between the leader and staff. Leaders are typically responsible for assigning the work, reviewing progress, and checking the results. They may also be responsible for performance reviews, discipline, coaching and recommending promotion or demotion, but generally do not hold the final authority.

Level 5 management usually includes ultimate responsibility for the personnel functions listed below. Supervisors at level 4 are unlikely to have full responsibility or final accountability for these personnel actions. Note that levels 4 and 5 make a distinction between supervising/managing a single person and multiple staff.

Influence is causing or achieving action or work by others where direct control is absent, that is, causing others to act in a desired way without having direct control over them. These "others" can be either within or outside the organisation. This ranges from achieving immediate tasks to establishing broader habits of work or professionalism across the organisation or associated group. Other forms of leadership or influence include:

- project responsibility involving coordination with others, internal and/or external to the organisation
- consultative and advisory roles that have an impact on people and organisational operations
- technical or professional direction provided by a knowledgeable expert in a field or discipline to others for whom they have no formal responsibility.

#### PERSONNEL ACTIONS TO CONSIDER IN THIS FACTOR

Supervisory Level (4) Recommends and Management Level (5 or 6) Makes Final Decision or Gives Formal Approval

Evaluating employee performance	Promoting employees	Reviewing work performance
Providing on-the-job counselling	Making salary adjustments	Assigning work activities
Taking disciplinary actions	Discharging employees	Scheduling work hours
Employing new staff	Acting on complaints and grievances	Providing on-the-job training
Negotiating contracts	Coaching/counselling on the job	Planning/scheduling training

#### EXCLUSIONS

The factor does not address influence that may have an effect some time in the future, such as that of teachers, lecturers, journalists, politicians, or other popularly influential people, on students/clients/customers.

#### FACTOR METRICS

The factor considers the

- a) nature of line leadership
- b) nature of non-line influence
- c) numbers of direct reporting staff involved.



LEVEL	FACTOR LEVEL DESCRIPTOR
<b>1</b>	The jobholder is responsible only for their own work. They are not normally required to lead, supervise, coordinate or otherwise direct other employees. The job has very limited or no accountability or responsibility for other staff.
<b>Influence</b>	The jobholder may be required to show others how to perform tasks or duties (that is, orientation) or provide guidance or on-the-job training to new employees.
<b>2</b>	The jobholder has occasional supervisory responsibility for immediate, on-site work allocation to other employees, such as supervising trainees, students, volunteers or other temporary staff. This may include occasional direction of contractors or consultants.
<b>Influence</b>	The jobholder is responsible for providing advice of an authoritative nature, such as in relation to compliance with quality or safety requirements, audit controls, by-laws, regulations, statutes, and so on, either within or outside the organisation.
<b>3</b>	The jobholder is responsible for the provision of non-permanent coordination or direction of a number of people with similar work responsibilities, such as a shift or duty roster. The job involves some direct accountability/responsibility for other people for specified periods of time, such as project leadership or periodic coordination/direction of small groups or individual staff focused on work assignments and achievement of job outputs. This may also include full-time supervision of a single staff member.
<b>Influence</b>	The jobholder applies mentoring or coaching skills in the regular provision of direction, guidance and/or training to people, without supervisory responsibility. They may coordinate contractors, consultants or other non-employees, either within the organisation or externally, on a regular basis. This may include regular influencing through dissemination of expertise or professional advice to non-reporting staff.

LEVEL	FACTOR LEVEL DESCRIPTOR
4	The jobholder has full-time, direct accountability/responsibility for supervision of more than one staff member in work assignments or coordination/direction of groups on an ongoing basis. This is generally full-time supervision, responsible for allocation, direction and monitoring of work while exercising team leadership and coaching skills. The jobholder is likely to make recommendations on most personnel actions (see Factor Guidelines), but will generally not have final approval/disapproval authority.
<b>Influence</b>	The jobholder provides professional mentoring and maintenance of standards through direct influence on designated staff within a discipline, without line management responsibility. They are accountable for directly influencing professional outputs and levels of performance within the organisation, or of associated people outside the organisation.
5	The jobholder has full-time, direct authority and accountability for the range of personnel management functions within the organisational context (see Factor Guidelines) for more than one staff member. People at the next level down are managed rather than merely supervised. The jobholder is required to demonstrate ongoing people-management skills in which direction, counselling, coaching and leadership of staff, often through supervisors, is required to ensure effective operation.
<b>Influence</b>	The jobholder has a high level of influence over people, including peers, through professional, traditional, social or other accepted measures of recognition. The position plays a key role in setting professional standards both within and outside the organisation.
6	The jobholder has direct accountability/responsibility for higher-level management of other staff. Accountability typically involves leadership, performance management and direction of a significant number of other staff, covering several different organisational units or areas of activity through subordinates/managers or different senior staff, ranging from key specialists and professional staff to leaders of functions. This typically includes the management of a number of positions at level 5, that is, managing other managers with little direct responsibility for, or involvement with, staff at level 4 and below.
7	The jobholder has overall accountability for the full personnel resources of the organisation or of a major division or unit within a large organisation where accountability for personnel management is devolved to that division or unit. This typically involves the management of a number of positions at levels 5 and 6.

**INCREMENT FOR NUMBERS OF PERSONNEL DIRECTLY CONTROLLED  
THROUGH LINE SUPERVISION OR MANAGEMENT**

This scale does not apply where the responsibility level indicated above is achieved through influence.

Number of Direct Reports	1 – 5	6 – 10	11 and over
Level/Point Increment	A – 0	B – 15	C – 30

## **FACTOR 6: RESPONSIBILITY FOR RESOURCES**



### **THE FACTOR**

This factor assesses the responsibility the jobholder has for control, management, acquisition, disposal, security or use of various resources. The range of resources extends from the most basic tools, equipment and information required for individual task completion to the broad spectrum of diverse material, intellectual and financial resources that make up the organisation. These resources are used by employees at all levels to achieve outputs and goals, but the degree of responsibility for them varies among those employees.

The factor measures the responsibility for three distinct kinds of resources – physical, information and financial. Some jobs will involve responsibility for more than one of these. In such cases, the score for the job will be the highest score for any of the resources responsibilities. For example, if a job would score at level 3 for financial resources and level 4 for equipment, the score for the job will be level 4.

### **FACTOR GUIDELINES**

#### **Physical and Information Resources**

Resources include such elements as manual or computerised information, data and records, materials, processes, technology, office and other equipment, tools and instruments, vehicles, plant, machinery, land, construction work, buildings and fittings and fixtures, goods, produce, stocks and supplies, natural and other such resources.

The nature of the accountability/responsibility includes handling, cleaning, maintenance and repair, security and confidentiality, deployment, purchasing, replacement, development, issuing, preserving, protecting, storing, collation, controlling access and quality control of physical or natural resources.

#### **Financial Resources**

The factor also assesses the direct accountability for budgeting, handling, spending, allocating, authorising, saving or otherwise disposing of the financial assets of the organisation. This includes cash, vouchers, debits and credits, credit card payments, invoices, budgets and revenue. The responsibility can be for correctness and accuracy, safekeeping, confidentiality and security, deployment and degree of direct control, cost control and budgetary processes.

Responsibility/accountability means the authority to make final decisions to effect the activities described.

## FACTOR METRICS

The factor considers the

- a) nature and extent of the resources involved
- b) jobholder's authority or control over those resources
- c) jobholder's responsibility for financial resources.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	<p>The job involves responsibility for the use of or access to resources provided. This job involves limited responsibility for personally generated information and/or physical resources, including low-value equipment or materials. There is limited or no responsibility for financial resources, possibly extending to the occasional handling or allocation of small amounts of cash, processing cheques, invoices or equivalent.</p>
2	<p>The job involves responsibility for ensuring that specific assignments/tasks are resourced appropriately. This involves some direct accountability/ responsibility for limited physical or information resources, along the following lines:</p> <ul style="list-style-type: none"><li>• use of expensive equipment or facilities</li><li>• controlling limited amounts of stock or supplies</li><li>• provision and maintenance of materials and resources for limited tasks</li><li>• responsibility for processing or maintenance of significant amounts of confidential information or data</li><li>• responsibility for day-to-day security/maintenance of buildings, materials, equipment or other resources</li></ul> <p><b>Financial Resources</b></p> <ul style="list-style-type: none"><li>• handling or processing limited amounts of cash, cheques, invoices or equivalent</li><li>• accounting for considerable sums of money</li><li>• accountability for expenditures from an agreed budget or equivalent income.</li></ul>

LEVEL	FACTOR LEVEL DESCRIPTOR
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3 The job involves responsibility for the allocation and utilisation of resources within a work unit to meet service requirements. This involves significant direct accountability/responsibility for physical resources, along the following lines:

- regular use of very expensive equipment or facilities
- controlling a large range of stock, equipment or supplies
- provision and maintenance of materials and resources within a work unit
- processing of substantial manual or computerised information of a sensitive personal nature where confidentiality is paramount
- security, protection, maintenance and repair of a range of equipment, buildings, materials or other physical resources

**Financial Resources**

- accounting for large sums of money in various forms
- accountability for significant expenditures from an agreed budget or equivalent income.

Responsibility may include involvement in setting and monitoring of the relevant budget and its expenditure.

LEVEL	FACTOR LEVEL DESCRIPTOR
4	<p data-bbox="505 415 1352 548">The job ensures resource requirements for a major function/ department to meet operational objectives. This involves high, direct accountability/responsibility for physical resources, along the following lines:</p> <ul data-bbox="505 573 1352 947" style="list-style-type: none"> <li>• ensuring resource requirements for a major function/department are organised to meet performance/operational objectives</li> <li>• maintaining information systems to meet specifications, or operation of an information system at a higher level, as a major job responsibility</li> <li>• adaptation, development or design of a wide range of equipment, land or buildings</li> <li>• security and protection of high-value physical or natural resources</li> <li>• discretionary ordering of a wide range of equipment and supplies</li> </ul> <p data-bbox="505 972 751 999"><b>Financial Resources</b></p> <ul data-bbox="505 1024 1271 1136" style="list-style-type: none"> <li>• accounting for very large sums of money in various forms</li> <li>• accountability for large expenditures from an agreed budget or equivalent income.</li> </ul> <p data-bbox="505 1161 1317 1224">Responsibility may include setting/monitoring of the budget and its expenditure.</p>

LEVEL	FACTOR LEVEL DESCRIPTOR
5	<p>The job ensures organisational structure and service execution among multiple major functions/departments aligned with organisational goals. This involves a major direct accountability/responsibility for physical resources, along the following lines:</p> <ul style="list-style-type: none"> <li>• ensuring organisational structure and service execution among multiple major functions/departments are aligned with business/organisational goals</li> <li>• operation/maintenance of large-scale information systems</li> <li>• security, protection or confidentiality of a wide and very high-value range of physical resources</li> <li>• ordering of a wide and high-value range of equipment and supplies</li> <li>• adaptation, development or design of a wide range of high-value equipment, land, buildings or other physical resources</li> </ul> <p><b>Financial Resources</b></p> <ul style="list-style-type: none"> <li>• major direct accountability/responsibility for major financial resources. The responsibility includes contributing to the setting and monitoring of the relevant budget(s) and physical assets of several services.</li> </ul>
6	<p>The job determines wide-scale, long-term resourcing requirements needed to satisfy organisational or professional goals. This involves the highest level of direct responsibility for substantial physical resources, along the following lines:</p> <ul style="list-style-type: none"> <li>• determining wide-scale, long-term resourcing requirements needed to satisfy business/organisational/professional goals</li> <li>• managing/developing information systems across the organisation or profession</li> <li>• broad accountability for the physical resources of the organisation or profession</li> </ul> <p><b>Financial Resources</b></p> <ul style="list-style-type: none"> <li>• very major direct responsibility for the financial resources of the organisation or profession, including accountability for very large expenditures from an agreed budget or equivalent income and direct involvement in setting and monitoring the relevant budget(s), long-term financial planning and altering the budget or expenditures to meet service or other requirements.</li> </ul>



## **FACTOR 7: RESPONSIBILITY FOR ORGANISATIONAL OUTCOMES**



### **THE FACTOR**

This factor assesses the nature of the job's impact on the achievement of the organisation's mission and outcomes, that is, its services to the organisation's clients. While focused on external outcomes in most cases, the factor may also assess the job's impact on internal clients where there is a clear service relationship.

At the same time, the factor reflects how much of the service outcomes the jobholder is responsible for. The size of the organisation will have an impact on how some jobs are scored. Generally, the multiple roles referred to in the lower levels are more typical of larger organisations.

### **FACTOR GUIDELINES**

The application of this factor depends on clearly defining the nature of the service outcomes. For many organisations and professions, particularly the health, education and welfare sectors, this will include responsibility for people and services to people. At higher levels, the factor also reflects the span of influence the position holds within or across the organisation or profession, that is, the breadth or extent of responsibility for delivery of service outcomes to clients.

Assigning a job to a level in this factor does not necessarily imply any particular leadership or people- management role that will be reflected in the Leadership Factor. This factor is about responsibility for and impact on service outcomes, not leadership.

### **FACTOR METRICS**

The factor considers the

- a) nature of the position's responsibility for outcomes
- b) share of the organisation controlled or influenced.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	The jobholder carries out familiar assignments under detailed instructions and close supervision. The job may be one of several essentially similar jobs that do the same or similar clearly defined activities within a work unit, following policies determined by others, with little or no responsibility for service development or delivery.
2	The jobholder is accountable for delivering individual service outcomes in their own work area, while sharing or contributing to team outcomes. The job entails work assignments following clear instructions under intermittent or regular supervision. Routine tasks are governed by established work routines and the influence is restricted to the immediate task, with some contribution to organisational or professional outcomes. There is often more than one jobholder performing duties of this nature.
3	The jobholder performs tasks or activities where key result areas are localised but may have some impact on service outcomes. The job may be accountable for provision of the service outcomes of a team or may share or contribute to larger unit outcomes, but still under direction from a higher level. The specific role is often interchangeable with other employees working in the same/similar disciplines, with their own areas of work responsibility, performing comparable tasks in other parts of the organisation.
4	The jobholder is responsible for or in control of a "patch" or identifiable area of activity, for example a function, operation, output or physically defined area. The job coordinates defined assignments or projects in that specified work area or function with an impact on the service outcomes. This is often the lowest level with "ownership" or independent responsibility for outcomes. It is generally specialised in function, with skills not readily applicable to other positions.
5	The jobholder controls or is responsible for an element of the organisation that is responsible for service outcomes in one or (frequently) more functional areas or operational units comparable to the following examples: provision of specialised services to clients, information processing, clinical services, technical services, maintenance, distribution, finance, research, legal and/or administration or other special services or projects critical to the outcomes.

LEVEL	FACTOR LEVEL DESCRIPTION
6	The jobholder directs or controls a major element of the organisation that has a significant impact on the service outcomes of the organisation, for example a major business or operational unit. The job is responsible for operation of a large division, business unit or structure within a higher-level organisation, including policy and service development. This may be for divisional, regional, area, or other units or other structures with large unit or cross-organisational outcomes with a major influence on organisational end results.
7	The jobholder directs or controls a single-purpose organisation, or a division of a larger organisation, usually controlling its own resources and providing major service outcomes in a private, public, quasi-public or not-for-profit sector. This is the most frequent category for the most senior leader responsible for strategic, policy and service development of a whole, stand-alone organisation. It may also include a major functional advisor with influence across a large organisation or whole profession.
8	The jobholder directs or controls a multi-divisional organisation providing service outcomes across a range of sectors in a private, public, quasi-public or not-for-profit sector. This category is suitable for the most senior leader of a large, complex organisation with multiple service outputs operating independently of each other.

## ■ FACTOR 8: RESPONSIBILITY FOR SERVICES TO PEOPLE



### THE FACTOR

The factor assesses the responsibility the jobholder has for the direct provision of services to individuals or groups of people/clients/customers/patients, etc. While the main focus of the factor is on external service provision, services to internal clients are also acknowledged at the lower levels. It measures the *nature* of the service provided and the degree to which the service impacts on the person's needs and well-being.

The factor excludes consideration of any "services" that may be provided by a manager or supervisor or other leadership role to any reporting staff.

### FACTOR GUIDELINES

The factor measures service delivery to people both inside and external to the organisation. The service relationship may involve the provision of information, advice, assistance, instruction, support or some other form of direct service intervention that impacts on the individual or group or meets their needs. The complexity of the service relationship is increased by the need to make the initial assessment of the nature of the service required and any need to re-assess needs or progress over time.

At the higher levels of the factor, service delivery or development will be a substantial or total component of the role.

### FACTOR METRICS

The factor considers the

- a) nature of the service provided directly to people
- b) need for assessment or adjustment of the service
- c) impact of the service.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	The job provides little or no service to other people either inside or outside the organisation or associated group.
2	The job provides information or assistance to people to help them access or provide appropriate services to others.
3	The job actively gains understanding of people's particular situations or needs in order to provide advice, instruction, care or assistance to individuals or groups of people either within or outside the organisation or associated group. Jobs at this level also include those that develop systems or services to assist others manage or perform their work.
4	The job provides direct support for external client needs of a more complex or sensitive nature. The service and service relationship directly impact on people's ability to manage, improve, be independent and/or participate. This level also includes jobs involved in the development, design or improvement of such services.
5	The job provides services that impact on people's well-being or development. The services will need assessment and adjustment over time and require sensitivity to progress or change. The job will either directly provide the services or develop, support and resource the service for delivery.
6	The job provides ongoing services to people that will involve regular assessment of complex and changing needs throughout the duration of the service. The service support or service intervention is central to the well-being or development of individuals or groups.
7	The job directly assesses complex, changing and potentially competing needs in order to provide, create, develop, modify or resource services of crucial importance to people's well-being or development.

## ■ FACTOR 9: EMOTIONAL DEMANDS



### THE FACTOR

This factor assesses the emotional demands arising from contact or work with people or situations that are intrinsically stressful, upsetting or traumatic.

### FACTOR GUIDELINES

Emotional demands arise from working in a variety of situations in which pain, distress, anxiety, anguish, and other emotional conditions are a necessary part of the job context.

This can occur when working with people with communication difficulties or who are angry, difficult, upset, unwell or somehow difficult to work with or who require some form of care, protection, attention, instruction or assistance.

It can also come from the emotional demands of work with people who may be terminally ill, very frail, at risk of abuse, homeless or seriously disadvantaged in some other way.

Consider also the ability to seek relief by breaking off from the task or performing less demanding tasks. The ability to break off from the distressing situation when desired indicates a lesser stress level.

Emotional demands are those demands that are a necessary and inherent part of the job. In some cases, different combinations of intensity and frequency may apply to the job, for example high intensity infrequently and low intensity frequently. In such cases, choose the combination that scores higher.

### EXCLUSIONS

This factor does not consider the existence of deadlines associated with completion of the task or activity or stress from overwork or the challenges of any particular tasks or activities, as the job is presumed to be designed correctly for competent performance and employees are presumed to be capable of completing the assigned work.

This factor does not consider stress arising from work with difficult or demanding colleagues, managers or other staff at any level.

## FACTOR METRICS

The factor considers the

- a) intensity of the emotional demand
- b) frequency and duration of exposure to the demand.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	The job involves minimal emotional demand. There is limited contact with or work for people who, through their circumstances or behaviour, could place emotional demands on the jobholder.
2	The job involves working in situations of stress or distress on an occasional basis.
3	The job involves working in situations of high distress, personal need or crisis on an occasional basis.  Alternatively, it involves working in situations of stress or distress on a frequent basis.
4	The job involves working in situations of trauma or extreme levels of distress on an occasional basis.  Alternatively, it involves working in situations of high distress, personal need or crisis on a frequent basis.

## FREQUENCY SCALE

• Occasional	Demand occurs occasionally, generally less than a third of the time.
• Frequent	Demand occurs frequently, generally more than a third of the time.

## **FACTOR 10: SENSORY DEMANDS**



### **THE FACTOR**

This factor assesses the demands for sensory attention, that is, concentration, alertness or focused attention required by the job.

### **FACTOR GUIDELINES**

Sensory demands arise from the requirement to focus on an activity or process with an intensity where an interruption could have a negative impact. This could include activities such as listening, comprehending, watching, driving or thinking *when applied in combination with one or more of the five senses* (sight, taste, smell, touch and hearing) to a degree that results in mental/sensory fatigue.

Some degree of attention is required in all jobs, but this factor considers only those jobs that require higher levels of concentration.

Consider the intensity and severity of the concentration required by the job, as well as the continuity and frequency of that effort. Consider also the ability to seek relief by breaking off from the task or performing less demanding tasks. The ability to break off from the work as desired indicates a lesser demand for that attention.

In some cases, different combinations of intensity and frequency may apply to the job, for example, high intensity infrequently and low intensity frequently. In such cases, choose the combination that scores higher.

### **EXCLUSIONS**

This factor does not consider “thinking” concentration or purely mental effort, such as reading or problem-solving, which is accounted for elsewhere. Nor does this factor consider any demand for “paying attention” or otherwise relating to other people that may be considered an interpersonal skill. It requires effort through the other senses that may be linked to mental concentration, to score in this factor.

### **FACTOR METRICS**

The factor considers the

- a) intensity of the sensory demand
- b) frequency and duration of exposure to the demand.



LEVEL	FACTOR LEVEL DESCRIPTOR
1	The job presents sensory demands requiring the jobholder to focus or concentrate on specific activities. The jobholder is free to focus attention as desired.
2	The job requires extra attention, demanding the jobholder to focus on the activity at hand, though maintenance of that focus is not exceptionally difficult. The jobholder needs to be particularly alert or attentive to a task for periods of one to two hours at a time, but interruptions can be easily handled.
3	<p>The job requires occasional focused sensory and mental concentration, demanding distinct effort to maintain that focus where a distraction can mean a disruption in the work process. The requirement for concentration is made more difficult by possible interruptions, deadlines or conflicting demands beyond the control of the jobholder.</p> <p>Alternatively, the job may involve frequent demands at level 2 above.</p>
4	<p>The job requires occasional intense concentration demanding in-depth mental attention, combined with proactive engagement with the subject. Interruptions to the concentration will result in serious disruption to the work process.</p> <p>Alternatively, the job may involve frequent demands at level 3 above.</p>

## FREQUENCY SCALE

• Occasional	Demand occurs occasionally, generally less than a third of the time.
• Frequent	Demand occurs frequently, generally more than a third of the time.

## **FACTOR 11: PHYSICAL DEMANDS**

### **THE FACTOR**

This factor assesses the physical demands of the job.

### **FACTOR GUIDELINES**

Physical demands cover strength and stamina required for strenuous or repeated use of muscles (including fine muscle movements). The factor takes into account all forms of bodily effort, for example, those required for standing or walking, lifting and carrying, pulling and pushing and other similar forms of exertion.

It also takes account of any circumstances that may affect the degree of effort required, such as working in a confined space or in an awkward position, for example, bending, crouching, stretching or holding a position for an extended period of time.

Consider the length of time the effort is required and the frequency of the task occurring during the normal workday or shift.

Standing or being on foot all day in a single place will score at level 2. The ability to move freely and break the routine does not create the same demand.

Consider the intensity and severity of the physical effort, rather than the strength or energy needed to perform the task as required by the job, as well as the continuity and frequency of that effort. Consider also the ability to seek relief or perform less demanding tasks. The ability to break off from the work requirements or situation requiring attention as desired indicates a lesser demand for that attention.

In some cases, different combinations of intensity and frequency may apply to the job, for example, high intensity infrequently and low intensity frequently. In such cases, choose the combination that scores higher.

### **FACTOR METRICS**

The factor considers the

- a) nature and intensity of effort demanded
- b) frequency and duration of the demand.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	The job requires light effort, involving little physical effort beyond normal day-to-day movements.
2	The job requires moderate effort, involving physical effort such as lifting, carrying, pushing or pulling items of light to moderate weight. It may require periodic repetitive fine muscle movements or working in an awkward or constrained position.
3	The job requires considerable physical effort, involving either the lifting, carrying or manoeuvring of heavy items (including people), or sustained repetitive fine muscle movements or work performed in a constrained or awkward position.  Alternatively, the job may involve frequent demands at level 2 above.
4	The job requires intense physical effort, involving either the occasional lifting or manoeuvring of very heavy items or prolonged, extremely fine muscle movements or work performed in a highly constrained or awkward position.  Alternatively, the job may involve frequent demands at level 3 above.

## FREQUENCY SCALE

• Occasional	Demand occurs occasionally, generally less than a third of the time.
• Frequent	Demand occurs frequently, generally more than a third of the time.

## FACTOR 12: WORKING CONDITIONS



### THE FACTOR

This factor assesses exposure to recognised disagreeable, unpleasant or uncomfortable conditions or physical hazards arising from the work environment. Essentially, the factor measures those physical aspects of the work that the jobholder cannot control, yet are integral to the job being done.

The factor covers things like dust, dirt, extremes of temperature, humidity, human or animal waste, grease or oil and the risk of illness or injury arising from exposure to diseases, toxic substances, machinery or work locations. The emphasis is on the degree of unpleasantness, discomfort or hazard caused. It also covers recognised risk of injury from other people, such as clients or patients.

### FACTOR GUIDELINES

The factor addresses only those conditions or hazards that are inherent in the nature of the work. The factor is about *exposure* to these conditions and hazards, not the actual incidence of such events. This does not include extreme situations where the risk of a specific situation or accident occurring is unlikely.

All applicable health and safety regulations are assumed to be met and jobholders are presumed to follow safe working practices, including wearing of appropriate protective gear. However, a requirement to wear certain kinds of protective gear may in itself create a degree of discomfort that may be considered in this factor or in Factor 11, Physical Demands.

### EXCLUSIONS

This factor does not cover irregular work hours or shift work, per se, although it may be used to address conditions encountered in such work that may differ from the standard workday.

Driving, other than that involving specialised equipment, is covered in Factor 10, Sensory Demands.

### FACTOR METRICS

The factor considers the

- a) nature and extent of conditions and hazards
- b) intensity and frequency of exposure to these factors.

LEVEL	FACTOR LEVEL DESCRIPTOR
1	The job involves minimal or no exposure to disagreeable, unpleasant or hazardous environmental conditions or injury by people. It involves "normal" working conditions, as experienced by most employees.
2	<p><b>Conditions</b> – The job involves minor conditions such as dust, dirt, chemicals, fumes, heat or cold, noise, humidity, vibration, inclement weather, poor lighting, extreme isolation, or human/animal waste/bodily fluids, which can be unpleasant and a discomfort possibly detracting from work, but are unlikely to pose any actual danger to personal health or well-being.</p> <p><b>Potential hazards</b> – These could be:</p> <ul style="list-style-type: none"> <li>• injuries causing slight discomfort for a short period of time, with little inconvenience</li> <li>• minor health and accident hazards, such as mild sprains, abrasions, minor cuts, burns, bruises, etc., resulting from procedures, equipment or machinery</li> <li>• exposure to mild infectious diseases.</li> </ul>
3	<p><b>Conditions</b> – The job involves extreme conditions, such as those listed above, that may result in actual or potential danger to personal health or well-being.</p> <p><b>Potential hazards</b> – These could be health and accident hazards of a serious nature, for example severe cuts, burns or injuries requiring medical attention and involving lost time, from working with risky procedures, hazardous materials or equipment, or exposure to serious infectious disease.</p>

## FREQUENCY SCALE

• Occasional	Demand occurs occasionally, generally less than a third of the time.
• Frequent	Demand occurs frequently, generally more than a third of the time.

## SCORING MATRIX

Level/Frequency	A - Occasional	B - Frequent
1	7	7
2	13	19
3	19	25

## ■ FACTOR SCORING TABLES



**SCORING TABLE – FACTORS 1-3**

Factor 1		Factor 2		Factor 3	
Level	Points	Level	Points	Level	Points
11	156	8	112	6	98
10	142	7	98	5	84
9	128	6	84	4	70
8	114	5	70	3	56
7	100	4	56	2	42
6	86	3	42	1	28
5	72	2	28		
4	58	1	14	Incr	14
3	44				
2	30				
1	16				

**SCORING TABLE – FACTORS 4-6**

Factor 4		Factor 5		Factor 6	
Level	Points	Level	Points	Level	Points
5	70	7	105	6	90
4	56	6	90	5	75
3	42	5	75	4	60
2	28	4	60	3	45
1	14	3	45	2	30
		2	30	1	15
		1	15		
		Incr B	15		
		Incr C	30		

# SCORING TABLE – FACTORS 7-9

Factor 7		Factor 8		Factor 9	
Level	Points	Level	Points	Level	Points
8	120	7	105	4	25
7	105	6	90	3	19
6	90	5	75	2	13
5	75	4	60	1	7
4	60	3	45		
3	45	2	30		
2	30	1	15		
1	15				

# SCORING TABLE – FACTORS 10-12

Factor 10		Factor 11		Factor 12	
Level	Points	Level	Points	Level	Points
4	25	4	25	3B	25
3	19	3	19	2B / 3A	19
2	13	2	13	2A	13
1	7	1	7	1A / 1B	7

## EQUITABLE JOB EVALUATION UNIT SIZING



Consistent with other job evaluation systems, in the Equitable Job Evaluation System (EJE), the unit size scores are based on an examination of total organisational operational budget and FTE staff number according to the following table. To assign a unit size, identify the unit sizes that align with the total employee numbers and the total operational budget of the organisation. If the resulting sizes are different, use the larger of the two. If they are different by more than one size, then use the size between the two indicated.

Unit Size	Employees	Operational Budget*	Note
5	2001 plus	300 million plus	
4	1001 – 2000	100 – 300 million	
3	301 – 1000	50 – 100 million	
2	101 – 300	20 – 50 million	
1	< 100	1 – 20 million	

\*Operational budget is the cost of operation of the organisation, not 'flow-through' funds that are merely passed on as part of that organisation's outputs.

### SPECIAL CASES

While the above table will provide the appropriate unit size for the majority of organisations, there are likely to be a few Public Service organisations with specific influence on the overall New Zealand economic/social/political environment and some adjustment may be necessary to identify the appropriate size. Such organisations will be assigned a unit size on a case-by-case basis.

During the beta release phase of the Equitable Job Evaluation System, the Pay and Employment Equity Unit will audit and maintain a central registry of all unit sizes in order to ensure consistency in the application of this scale. The Pay and Employment Equity Unit will confirm the final unit size for all organisations and will make any determinations of exceptions to the table.



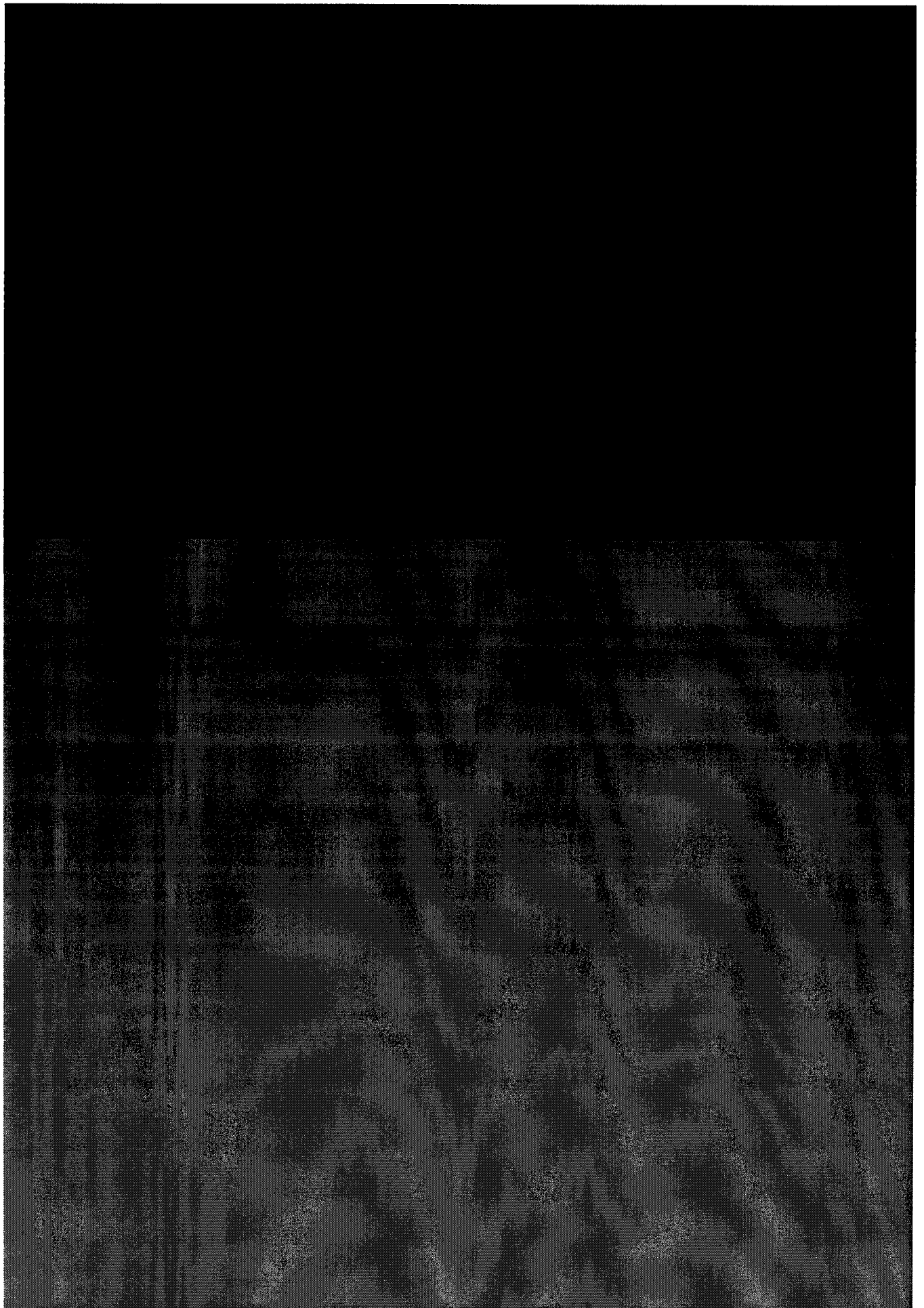
## EFFECT OF UNIT SIZE ON SCORING

The sizing adjustment is built into Factors 6 and 7. All scores over level 4 in each factor are multiplied as follows for the 5 unit sizes.

- Unit Size 1 – factor scores x 1.0
- Unit Size 2 – factor scores x 1.2
- Unit Size 3 – factor scores x 1.4
- Unit Size 4 – factor scores x 1.6
- Unit Size 5 – factor scores x 1.8

The maximum points for the two factors for the 5 unit sizes are as follows:

Factor/Unit Size	Size 1	Size 2	Size 3	Size 4	Size 5
6	90	108	126	144	162
7	120	144	168	192	216
<b>Total possible Points</b>	<b>1000</b>	<b>1042</b>	<b>1084</b>	<b>1126</b>	<b>1168</b>



**DURBER REPORT: Examining The Issue Of Equitable Compensation For Ontario  
Midwives**

**ANNEX 4 – APPROPRIATENESS OF  
EQUITABLE JOB EVALUATION FACTOR  
PLAN – WORKING TOWARDS GENDER  
EQUALITY RE: PRIMARY HEALTH CARE  
VALUES**

**Analysis of work and policies and 12  
evaluation factors**

## Reviewing the Appropriateness of the Equitable Job Evaluation Factor Plan to certain Primary Health Care Occupations and the values of the Ministry of Health and Long-term Care

The following table links various standards pertaining to three jobs that were the key points of reference in 1993 when compensation for midwives was considered (i.e., the midwife, nurse practitioner (then called primary care nurse) and family physician – the latter two in Community Health Centres). The table also includes a column for the various values, missions and strategies that have been set out over the years by the Ministry of Health and Long-term Care [MOHLTC].

A. ASPECT OF PRIMARY HEALTH CARE & Professional Standard Pertaining <sup>58</sup>	B. MOHLTC STRATEGIES RE “A”, or OTHER POLICY INSTRUMENTS	C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN
<p>1. Scope of practice of midwife – “assessment and monitoring of women during pregnancy, labour and post-partum period and of their newborn babies...” [CMO, policies, standards &amp; guidelines]</p> <p>Midwife Philosophy – “The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on preventive care and the appropriate use of technology.”</p> <p>NP practice is grounded in the values, knowledge and theories of professional nursing practice. It emphasizes health promotion and the prevention of illness, injury and complications for clients. NPs work with diverse client populations in a variety of contexts and practice settings across the health-illness continuum. They are a resource to clients, other nurses and health care professionals, and they provide leadership in advocating for clients. [CNO]</p>		<ul style="list-style-type: none"> <li>The <i>Responsibility for Organisational Outcomes</i> factor “assesses the nature of the job’s impact on the achievement of the organisation’s mission and outcomes, that is, its services to the organisation’s clients. While focused on external outcomes in most cases, the factor may also assess the job’s impact on internal clients where there is a clear service relationship.” For “organisation” can also be read either MOHLTC or the health system of which the three occupations are a part.</li> <li>The <i>Responsibility for Services to People</i> factor “assesses the responsibility the jobholder has for the direct provision of services to individuals or groups of ....</li> </ul>

<sup>58</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC] of which there is an Ontario chapter.

A. ASPECT OF PRIMARY HEALTH CARE & Professional Standard Pertaining <sup>59</sup>	B. MOHLTC STRATEGIES RE “A”, or OTHER POLICY INSTRUMENTS	C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN
<p>“Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients’ experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients’ lives.</p> <p>“Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people’s changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients’ needs.” [CFPC, principles]</p>	<ol style="list-style-type: none"> <li>1. The health care system is focused on the quality of care and the best use of resources.</li> <li>2. The main goal of the health care system is to get better and better at what it does. [MOHLTC, at <a href="http://health.gov.on.ca/en/public/programs/ecfa/default.aspx/">http://health.gov.on.ca/en/public/programs/ecfa/default.aspx/</a>]</li> </ol>	<p>people/ clients/customers/patients, etc.</p> <p>While the main focus of the factor is on external service provision, services to internal clients are also acknowledged at the lower levels. It measures the nature of the service provided and the degree to which the service impacts on the person’s needs and well-being.”</p> <p>That is, the N.Z. plan reflects the value of patient-centred service and its outcomes measured in many aspects.</p>
<p>2. Collaboration: “Midwives, who have always worked from a philosophical base that recognises and utilizes the benefits of collaboration, are well poised to be active contributors to effective inter-professional care. Midwives are required, through the College’s “Indications for Mandatory Discussion, Consultations, and Transfer of Care” standard document, to engage in consultation with other health providers and plan care appropriately.” [CMO, Response to the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collabo-</p>	<p>“We can do better. We need a patient-centred system that has better integrated health providers — such as family health care, community care, hospitals and long-term care — that moves patients more seamlessly from one care setting to another.” [MOHLTC, Action Plan]</p> <p>“Interprofessional Care is the provision of comprehensive health services to patients by multiple health care professionals who work collaboratively to deliver the best quality of care in every health care setting. It encompasses partnership, collaboration and a multi-disciplinary approach to enhancing care outcomes and is the cornerstone of the HealthForceOntario strategy.” [HealthForceOntario,</p>	<p>For notes on communications skills, see page 3 below.</p> <p>As for working in professional teams and the responsibilities for doing so, the factor <i>Responsibility for People Leadership</i> makes reference to influence with others. It does not specifically include “partnership”, but can be interpreted in a broad and liberal way to do so.</p> <p>The difficulties of working a team</p>

<sup>59</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC] of which there is an Ontario chapter.

ration among Health Colleges and Professionals, at <a href="http://www.cmo.on.ca/downloads/HPRAC-InterprofessionalCare.pdf">http://www.cmo.on.ca/downloads/HPRAC-InterprofessionalCare.pdf</a>	Interprofessional Care, found at <a href="http://www.healthforceontario.ca/en/Home/PolicyMakers%20and%20Researchers/Interprofessional%20Care">http://www.healthforceontario.ca/en/Home/PolicyMakers and Researchers/Interprofessional Care</a>	can also be measured through the <i>Problem Solving Skills</i> factor.
A. ASPECT OF PRIMARY HEALTH CARE & Professional Standard Pertaining <sup>60</sup>	B. MOHLTC STRATEGIES RE “A”, or OTHER POLICY INSTRUMENTS	C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN
<p>2. (Continued) “Collaboration is the cornerstone of inter-professional and intraprofessional care. Collaborative practice involves communication, partnership and active participation among health care professionals and clients in a coordinated approach to shared decision-making. It is a process that enables the knowledge and skills of various providers to influence client care synergistically and positively.” [CNO, Nurse Practitioner, page 12]</p> <p>“Physicians, nurses, and other members of the Patient’s Medical Home team should each be encouraged and supported to develop and sustain ongoing professional relationships with patients; each caregiver should be presented to each patient as a member of his or her personal medical home team.” [CFPC, A Vision for Canada: Family Medicine Practice, page 11 – one of many points re collaboration, found at <a href="http://toolkit.cfpc.ca/en/files/PMH_A_Vision_for_Canada%5B1%5D.pdf">http://toolkit.cfpc.ca/en/files/PMH A Vision for Canada%5B1%5D.pdf</a>]</p>	<p>“Primary health care:</p> <p>“...7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.” [Alma Ata Declaration]</p> <p>“A collaborative, team-based approach to care can be an enabler for improving patient care and meeting the demands that the system is facing. This process, called interprofessional care, is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. Interprofessional care can be systemically implemented to assist in health care system renewal and improved sustainability.” [HealthForceOntario, “Interprofessional Care: A Blueprint for Action in Ontario, July 2007, page 7, found in the web at <a href="http://www.healthforceontario.ca/UserFiles/file/PolicyMakersResearchers/ipc-blueprint-july-2007-en.pdf">http://www.healthforceontario.ca/UserFiles/file/PolicyMakersResearchers/ipc-blueprint-july-2007-en.pdf</a>]</p>	<p>Values such as “collaboration” imply that the job evaluation plan, to be appropriate, needs to make visible (1) communications skills – here through the factor of <i>Interpersonal Skills</i>; and to take a flexible approach to how people work together, e.g., in relation to supervision not to over-emphasize organisational authority and hierarchy. In this plan, the factor <i>Responsibility for People Leadership</i> takes such an approach.</p> <p>Note that there are also standards for collaboration set out by the CWO.</p>
3. Re teamwork and outcomes:	Interprofessional Mentorship, Preceptorship, Leadership	In the plan, the factor

<sup>60</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC] of which there is an Ontario chapter.

<p>"There is high-quality evidence supporting positive outcomes for patients/clients, providers and the system in specialized areas such as inter-professional collaboration in mental health care, and chronic disease prevention and management.</p> <p><i>Continued on the next page</i></p>	<p>and Coaching Fund (IMPLCF) 2006/07</p> <p>"The Interprofessional Mentorship, Preceptorship, Leadership and Coaching Fund (IMPLCF) was designed to support collaborative team-based health service delivery and to prepare health professionals to work in the health care system, enhance</p> <p><i>Continued on the next page</i></p>	<p><i>Responsibility for People</i></p> <p>Leadership recognises guidance to students and mentoring generally as valuable.</p> <p>The <i>Responsibility for Outcomes</i> factor also recognises the contributions of specialists, professionals and team members to results. <i>(More comments:)</i></p>
<p>A. ASPECT OF PRIMARY HEALTH CARE &amp; Professional Standard Pertaining<sup>61</sup></p>	<p>B. MOHLTC STRATEGIES RE "A", or OTHER POLICY INSTRUMENTS</p>	<p>C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN</p>
<p>"There are findings in the literature, and in some jurisdictions, which support positive outcomes for patients/clients, providers and the system when interprofessional collaboration (for example, physicians/nurses, physicians/pharmacists, physicians/dietitians in partnerships) is fostered and supported on the basis of servicing geographic populations or population health models. These outcomes include enhanced patient/client self-care, knowledge and outcomes; enhanced provider satisfaction, knowledge, skills and practice behaviors; and system enhancements such as the provision of a broader range of services, better access, shorter wait times and more effective resource utilization."<sup>62</sup></p>	<p>"...their career satisfaction, increase their leadership capacity, and facilitate career transitions within the health sector. The funded projects were intended to build sustainable collaborative health delivery models that would lead to system change at the micro and macro levels of health care delivery."<sup>63</sup></p>	<p>This factor does not limit the value of a job to its "place in a hierarchy", nor to the exercise of formal authority within a team. It is therefore amenable to the recognition of the professional as being responsible within their scope of practice.</p>

<sup>61</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC] of which there is an Ontario chapter.

<sup>62</sup> Canadian Health Services Foundation, "Interprofessional Collaboration and Quality Primary Healthcare," December 2007, found at [http://www.cfhi-fcass.ca/Migrated/PDF/SynthesisReport\\_E\\_rev4\\_FINAL.pdf](http://www.cfhi-fcass.ca/Migrated/PDF/SynthesisReport_E_rev4_FINAL.pdf)

<sup>63</sup> HealthForceOntario, bulletin on Interprofessional Care, at [http://www.healthforceontario.ca/en/Home/Policymakers\\_and\\_Researchers/Interprofessional\\_Care/Interprofessional](http://www.healthforceontario.ca/en/Home/Policymakers_and_Researchers/Interprofessional_Care/Interprofessional)

<p>4. There are standards from the three colleges on competencies and training required.</p> <p>Example of statement (for midwives): "The College of Midwives strongly recommends that the concepts of continuity of care, choice of birth place and community input be inherent parts of the theoretical education of midwives.</p> <p>Clinical education takes place within the model of practice, with student midwives following the ..."</p> <p><i>Continued on next page</i></p>	<p>Both the midwives and nurse practitioners are required to pursue continuing education, for example:</p> <p>"6.(1) A member shall participate in continuing education and professional development activities for the purpose of maintaining and enhancing the member's knowledge, skill and judgment. O. Reg. 335/12, s. 6 (1)." [Midwifery Act 1991, ONTARIO REGULATION 335/12 at <a href="http://www.cmo.on.ca/documents/QualityAssuranceRegulation_November2012.pdf">http://www.cmo.on.ca/documents/QualityAssuranceRegulation_November2012.pdf</a>]</p>	<p>The responsibility for maintaining both knowledge and competency is recognised in the plan through a <i>skills</i> factor, i.e., <i>Knowledge Skills</i>. It is comprehensive and includes not just essential academic and clinical education but it "assesses the depth and breadth of the total knowledge required for the job, whether acquired through formal education, self-study, life experience, on-the-job training, work experience or some combination of these."</p>
<p>A. ASPECT OF PRIMARY HEALTH CARE &amp; Professional Standard Pertaining<sup>64</sup></p>	<p>B. MOHLTC STRATEGIES RE "A", or OTHER POLICY INSTRUMENTS</p>	<p>C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN</p>
<p>"...woman's care throughout the pregnancy, birth and the post-partum periods. During their education, students must attend birth in all settings.</p> <p>"The RHPA (Regulated Health Professionals Act) provides for the development of a continuing education program that promotes competence in all areas of skill for all settings." [COM, Model of Practice, 1994]</p>	<p>See above</p>	
<p>5. Re problem solving and use of judgement:</p> <p>Midwife: "This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help." [COM,</p>	<p>"What is needed is an action plan to create a system that delivers care in a better way — a smarter way." [MOFTC, Ontario's Action Plan..., page 6]</p> <p>"In consultation with doctors, nurses, and other health care providers, we will expand our focus on quality improvement to family health care, and ensure that all family health care providers are equipped to integrate the</p>	<p>"Transformation" the health system implies and is based on solving problems.</p> <p>Quality assurance and adoption of research also suggest analysis and creativity.</p>

<sup>64</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC], of which there is an Ontario chapter.



<p>The Midwife Model of Practice, page 1]</p> <p>Nurse practitioners “must base treatment decisions on the best available evidence from appropriate, objective sources, clinical judgment and client needs and, whenever feasible, client choice.” [CNO, Nurse Practitioner, page 11]</p> <p>Family physicians: “To ensure relevance for the populations being cared for in primary care/family practice settings, clinical practice guidelines and performance indicators must be applicable to patients with comorbidities and complex medical presentations.” [CFPC, Vision for Canada..., p. 15]</p>	<p>latest evidence-based care into their practice.” [MOFTC, Ontario’s Action Plan..., p. 9]</p>	<p>These features of work are measured through the <i>Problem Solving Skills</i> factor of the plan. The factor “assesses the skills of creativity, innovation, analytical reasoning and judgment required to solve problems typically encountered or that may occur in the coordinating, organising and planning required to achieve the job’s or the organisation’s objectives. The factor considers the complexity of problems, issues or activities undertaken in usual circumstances.”</p>
<p>A. ASPECT OF PRIMARY HEALTH CARE &amp; Professional Standard Pertaining<sup>65</sup></p>	<p>B. MOHLTC STRATEGIES RE “A”, or OTHER POLICY INSTRUMENTS</p>	<p>C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN</p>
<p>6. Re emotional connection with the client:</p> <p>“The midwife coordinating the woman’s care and the second midwife must make the time commitment necessary to develop a relationship of trust with the woman during pregnancy, to be able to provide safe, individualized care, fully support the woman during labour and birth and to provide comprehensive care to mother and newborn throughout the postpartum period.”[COM, Model of Practice]</p> <p>Nurse practitioner: “<b>Therapeutic professional relationship.</b> This relationship is established and maintained by the nurse and is the foundation for providing nursing services. The relationship is</p>	<p>“Preamble</p> <p>“The people of Ontario and their Government:</p> <p>“[...] Share a vision for a Province where excellent health care services are available to all Ontarians, where professions work together, and where patients are confident that their health care system is providing them with excellent health care....” [Bill C-46: <a href="http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&amp;Intranet=&amp;BillID=2326">http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&amp;Intranet=&amp;BillID=2326</a>]</p> <p>“Recognition of the role of culture, income and other</p>	<p>With regard to the preamble to the <i>Excellent Care for All Act</i>, it suggests the other part of the trust and empathy noted in the professional statements in column A, as part of public policy.</p> <p>Most job evaluation plans lack a factor that clearly deals with stress and the psychological demands of the work.</p> <p>The Equitable Job Evaluation Factor Plan assesses them through the <i>Emotional Effort</i> factor, which “assesses the emotional demands</p>

<sup>65</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC], of which there is an Ontario chapter.

<p>based on trust, respect, empathy, intimacy and the appropriate use of the nurse's inherent power." [CNO, Nurse Practitioner, page 7]</p> <p>Family physicians: "The goal of self-managed care should be to build confidence in patients and their personal care givers to help them deal more effectively with their illnesses and improve their health outcomes." [CFPC, Vision for Canada..., page 23]</p> <p><b>"Goal: A Patient's Medical Home will be patient centred.</b></p> <p>"Care and caregivers in a Patient's Medical Home must be person-focused and provide services that are responsive to patients' feelings, preferences, and expectations." [CFPC, Vision for Canada...]</p>	<p>determinants of health in shaping individuals' health and access to health care is critical. The practice teams will need to ensure that their services are equally accessible to everyone, and that they are sensitive to the cultural needs and the degree of comprehension of each of their clients." [MOHLTC, Preventing and Managing Chronic Disease: Ontario's Framework, May 2007: <a href="http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf">http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf</a>] – page 22</p>	<p>arising from contact or work with people or situations that are intrinsically stressful, upsetting or traumatic."</p> <p>More specifically, the factor notes circumstances "when working with people with communication difficulties or who are angry, difficult, upset, unwell or somehow difficult to work with or who require some form of care, protection, attention, instruction or assistance."</p> <p>In addition, the establishment of trusting relationships based on empathy is part of the factor <i>Interpersonal Skills</i>.</p> <p>With regard to the social determinants of health (noted in the Chronic Disease Framework), those may be measure in the <i>Problem Solving Skills</i> factor.</p>
<p><b>A. ASPECT OF PRIMARY HEALTH CARE &amp; Professional Standard Pertaining<sup>66</sup></b></p>	<p><b>B. MOHLTC STRATEGIES RE "A", or OTHER POLICY INSTRUMENTS</b></p>	<p><b>C. RELATED PROVISION OF EQUITABLE JOB EVALUATION FACTOR PLAN</b></p>
<p>7. Re physical skills: The various standards and core competencies reference such physical procedures as are required during labour and birth (in the instance of the midwife and possibly the family physician); observing and testing (all of the occupations), and</p>	<p>The core competencies of the midwife and nurse practitioner are set out in legislation. The funding schedule for the physician includes a number of operational procedures that involve physical skills.</p>	<p>Many (if not most) job evaluation plans do not include a factor to measure this area of skills. The N.Z. plan contains the factor <i>Physical Skills</i>, which includes the following provision: "Rating on this</p>

<sup>66</sup> These are taken from the College of Ontario Midwives [COM], the College of Nurses of Ontario [CNO] and the College of Family Physicians Canada [CFPC], of which there is an Ontario chapter.

care in physically touching and manipulating the patient. [There is no need to enter quotations here.]		factor will increase with the level and sophistication of the training and experience required, the detail of the activity, the need for precision, exact-ness and speed and the degree to which the skill set is used in existing work situations or adapted to new ones.”
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**DURBER REPORT: EXAMINING THE ISSUE OF EQUITABLE COMPENSATION FOR  
ONTARIO MIDWIVES**

**ANNEX 5-A – FEATURES OF WORK  
Community Health Centre [CHC]  
Family Physician**

This is the first of three sets of detailed analysis of the work of three professions, based on characteristics set out in the Morton Report of 1993 and supplementing them from currently available information

TABLE ON WORK CHARACTERISTICS OF THE CHC FAMILY PHYSICIAN<sup>67</sup>: A. AS SET OUT IN APPENDIX "C" OF MORTON REPORT (1993)

Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Assessment: as with nursing, may include environmental	<p>"The CCFP designation may also be granted without examination by the CFPC to physicians who have successfully graduated from accredited postgraduate family medicine training programs in approved jurisdictions which have equivalent accreditation standards for family medicine training."<sup>68</sup></p> <p>A two-year program in family medicine is offered at the University of Ottawa<sup>69</sup>. (The Family Medical Centre describes itself as follows: "Varied patient population providing primary care for the elderly, children, pregnant mothers, teenagers as well as the general population</p> <p>Specialty clinics include minor surgery, dermatology, and smoking cessation clinic. Residents are exposed to a variety of clinical problems involving pediatrics, obstetrics, gynecology, internal medicine, geriatrics, palliative care, psychotherapy and more."<sup>70</sup></p> <p>One job descriptions shows "Family Practice Certification, Licensed by the College of Physicians and Surgeons of Ontario and certified by the College of Family Practice of Canada. Minimum five (5) years of experience in primary care (excluding internship and residency) including community health and/or family practice preferred."<sup>71</sup></p> <p>Another job description indicates that either General Practice or Family Practice is available, with the latter preferred.<sup>72</sup></p>	<p>The basic requirement is an MD plus graduate training in the family medicine specialty for two years. Goals are "learning through exposure, practice and assessment in all domains of clinical care, through exposure to teachers, mentors, and role models of comprehensive care, and through practice and assessment of all seven CanMEDS-FM Roles (Family Medicine Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, Professional)"<sup>73</sup></p> <p>We may presume for purposes of evaluation that the post-graduate</p>

<sup>67</sup> Note that the title in Morton is "Primary Care Nurse". In these notes, "NP" is used for Nurse Practitioner. In some publications and legislation, the title also used is Registered Nurse (Extended Class).

<sup>68</sup> College of Family Physicians of Canada, at <http://www.cpsnl.ca/default.asp?com=Pages&id=133&m=351>

<sup>69</sup> Curriculum at [http://www.familymedicine.uottawa.ca/eng/pg\\_Curriculum-Urban.htm](http://www.familymedicine.uottawa.ca/eng/pg_Curriculum-Urban.htm)

<sup>70</sup> See [http://www.familymedicine.uottawa.ca/eng/pg\\_Teaching-Program-Academic-Civic.html](http://www.familymedicine.uottawa.ca/eng/pg_Teaching-Program-Academic-Civic.html)

<sup>71</sup> Southeast Community Health Centre, "Family Physician"

<sup>72</sup> Access Alliance Multicultural Community Health Centre description

<sup>73</sup> See [http://www.familymedicine.uottawa.ca/eng/pg\\_Postgraduate-Education\\_Home.html](http://www.familymedicine.uottawa.ca/eng/pg_Postgraduate-Education_Home.html)

		education is preferred. Morton notes certification in family medicine. <sup>74</sup>
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<sup>74</sup> See Morton Report, 1993 elsewhere cited

Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Assessments – complete, environmental included, with risk assessment	<p>The nature of assessments is partially dependent on the population covered. An article on Primary Care Providers (PCPs) notes that “Poor patients generate a higher workload for PCPs in CHCs; however, this is principally because they are sicker than higher-income patients are. Further information is required about the spectrum of services used by poor patients in CHCs.</p> <p>“Poverty is an important determinant of health. The poor have higher incidence, prevalence, and severity of chronic diseases, acute illnesses, and injuries<sup>1</sup>; use more medications and physician and hospital services; and require more clinician time in the primary care setting, not only owing to their complex health needs but also because of relationship and communication challenges.”<sup>75</sup></p> <p>The medical director at Access Multicultural CHC notes the need for the family doctor to assess from the points of the view of the social determinants of health. [Interview with a CHC medical director]<sup>76</sup></p> <p>A further research article bears out this scope: “Community orientation (CO) is an important dimension of primary care. Researchers and policy makers believe that CO allows practitioners to recognize and address social and environmental determinants of health through knowledge of the community and actions and partnerships at the community level.”<sup>77</sup></p>	<p>This would suggest a broad range of assessments conducted by both physicians and NPs that would also be illustrated by the range of examinations and tests.</p> <p>This is borne out by the views of the director of medicine noted.</p> <p>The second research article (at footnote 11) indicates that CHCs are much more responsive to “community orientation”.</p>
Determinants of health	<p>Determinants of health: ;Income and social status ; Education and literacy; Social support networks; Employment/working conditions; Social environments; Physical environments; Personal health practices and coping skills; Healthy child development Biology and genetic endowment; Health services; Gender; Culture. Source: Health Canada</p> <p>Cited in “Preventing and Managing Chronic Disease: Ontario’s Framework”, Ministry of Health and Long-Term Care, May 2007, found at <a href="http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf">http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf</a></p>	

<sup>75</sup> See “Patient poverty and workload in primary care”, cited from *Canadian Family Physician*, April 2013 found at <http://www.cfp.ca/content/59/4/384.full>

<sup>76</sup> Telephone interview, 24 September 2013

<sup>77</sup> See “Community orientation in primary care practices”, cited from *Canadian Family Physician*, July 2010 found at <http://www.cfp.ca/content/56/7/676.full>





Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Diagnosis – not restricted	<p>A research article concluded that “CHCs [Community Health Centres] provided more comprehensive care than the other models. [...] CHCs showed superior comprehensiveness even after controlling for patient and provider confounders. We found no consistent differences in comprehensiveness between the other three models [for offering primary health care, including independent practice].</p> <p>A cursive review of the publication <i>Canadian Family Physician</i> shows a range of issues for diagnosis (either by the family physician or the NP. <i>Continued on next page</i></p>	<p>This contrasts with both the midwife and the NP, i.e., those are “within their scope of practice”</p> <p>The research indicates both a wide range of health and health-related issues at CHCs.</p>
Diagnosis – not restricted	<p>These issues include mental health (depression for example), varieties of cancer and the risks of delay in diagnosis, hypocalcemia, gene mutation and breast cancer, jaundice, hypothyroidism, Parkinson disease.<sup>78</sup></p>	<p>The issues presented will depend on the population covered; see factor of poverty noted above.</p>
Screening – general screening test	<p>The literature indicates that there are no limitations on the screening tests that can be used, as well as those ordered, up to radiation-powered tests like MRI.<sup>79</sup></p> <p>A research article notes (for example)<sup>80</sup> that “Ninety-two percent of women in the study sample were either appropriately screened for cervical cancer or had been approached for screening.” In this instance, the population is “refugee women at a community health centre (CHC) in Toronto”. The study (at Access Multicultural CHC) indicates that “Nurse practitioners or physicians did all Pap tests”.</p> <p>A review of articles in <i>Canadian Family Physician</i> shows tests for blood pressure, newborn screening, screening neonatals for chromosomal disorders, use of mammography, genetic screening, and screening for</p>	<p>Screening may relate to the social determinants of health.</p> <p>Note that the physician in the CHC may refer such screening to other primary health care providers such as the NP.</p>

<sup>78</sup> See <http://www.cfp.ca/search?fulltext=Diagnosis&submit=yes&x=0&y=0>

<sup>79</sup> See *Healing Arts Radiation Protection Act* and Regulations, enabling “A legally qualified medical practitioner” to operate an X-ray machine. At [http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90h02\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h02_e.htm)

<sup>80</sup> “Cervical cancer screening among vulnerable women”, cited from *Canadian Family Physician*, September 2012, found at <http://www.cfp.ca/content/58/9/e521.full>

	cancer survivors – as examples of the screening done by primary health care providers including physicians. <sup>81</sup> <i>Continued on the next page</i>	
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Screening (continued)	Other examples are found in the international journal <i>Family Practice</i> and include screening for chlamydia, osteoporotic fractures in older women, PTSD screening, cognitive screening related to dementia and screening for eating disorders. <sup>82</sup>	
Counselling – related to all areas of health care	This is part of overall client-oriented responsibilities: “Provide ongoing comprehensive primary medical care of all ages including assessments, diagnoses, counseling, screening, referral, education, treatment and follow-up.” [Job description, Access CHC]  An example is provided in the <i>following box....</i>	Note that physicians and NPs may share counselling.
Counselling (continued)	“The 5 As (ask, assess, advise, agree, and assist), developed for smoking cessation, can be adapted for obesity counseling. Ask permission to discuss weight; be nonjudgmental and explore the patient's readiness for change. Assess body mass index, waist circumference, and obesity stage; explore drivers and complications of excess weight. Advise the patient about the health risks of obesity, the benefits of modest weight loss, the need for a long-term strategy, and treatment options. Agree on realistic weight-loss expectations, targets, behavioural changes, and specific details of the treatment plan. Assist in identifying and addressing barriers; provide resources, assist in finding and consulting with appropriate providers, and arrange regular follow-up.” <sup>83</sup>  Examples in <i>Canadian Family Physician</i> include obesity counselling, genetic counselling, exercise counselling, counselling on inappropriate medications [done by NPs and pharmacists but could also be done by physicians], preconception counselling with reference to risks, air quality effects counselling and healthy fish consumption (with risk of mercury in view). <sup>84</sup>	
Counselling, continued	“Taking into account risk factors (environmental, social, psychological and medical) provide education in a manner which can be understood by the client and when applicable, their families.” [Partial job description,	Note that many of the “educational” duties of primary health care

<sup>81</sup> Found at <http://www.cfp.ca/search?fulltext=Screening&submit=yes&x=0&y=0>

<sup>82</sup> Found at <http://fampra.oxfordjournals.org/search?fulltext=Screening&submit=yes&x=0&y=0>

<sup>83</sup> Cited from *Canadian Family Physician*, January 2013 found at <http://www.cfp.ca/content/59/1/27.abstract>

<sup>84</sup> <http://www.cfp.ca/search?fulltext=Counselling&submit=yes&x=0&y=0>

	<p>Dr. Nitti]</p> <p>The Morton job description notes that a duty is “encourages clients and their families to take responsibility for their own health by involving them in risk factor and health problem identification, goal setting and the choice of interventions for disease treatment and prevention, and health promotion.” [Morton Report, page 23]</p>	<p>providers are shared, but are essentially counselling in nature.</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Education – formal and community resources	<p>An example of a community resource that may be called upon by the physician (or the NP) is the Alzheimer’s Society: “Early diagnosis of dementia has been shown to be of benefit to patients and caregivers. Referral to the Alzheimer Society can help with non-pharmacologic management of dementia at the time of diagnosis and at any time during the course of the illness. Services include education about dementia, caregiver support, coordination of community services, and a variety of written resources for patients and caregivers.”<sup>85</sup></p> <p>“Participates in primary health care program and service delivery within the broader community context in partnership with other institutions and agencies as may be required from time to time.” [Access CHC job Description]</p>	<p>Note that the Morton description does not note community resources, except in relation to “outreach”.</p>
Referral – may refer clients to specialists	<p>A national survey reported in 2010 showed over two dozen other health professionals. Of these, the most frequently referred to were physiotherapists (nearly 60% of all referrals by family and general practitioners), dietitians (almost one-quarter), psychologists (about the same percentage), social workers (just over one-sixth) and occupational therapists (about one-tenth).<sup>86</sup> Referrals are also made to a wide variety of technologists and other health workers, including nurses. (A very few go to midwives.)</p>	<p>The variety is much higher than suggested in Morton, and indicates the complexity of the “health team”, whether within or (mostly) outside the organisational team.</p>

<sup>85</sup> “Resources for people with dementia – The Alzheimer Society and beyond” Cited from *Canadian Family Physician*, December 2011 vol. 57 no. 12 1387-139 found at <http://www.cfp.ca/content/57/12/1387.full>

<sup>86</sup> Source: 2010 National Physician Survey. The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

Treatment – treats a wide variety of conditions	While the range of treatments is appropriately described as “wide”, there are changes in the physician’s share of treatment within the CHC. A research study comments that “The critical role of physician leadership in supporting change to collaborative care has similarly been documented elsewhere and was confirmed by our findings. This study also highlights the essential role of the FHT [Family Health Team] manager, whose expertise appears to be critical in supporting and sustaining an inter-professional FHT.	While the treatments offered by the family physician are widest of the three primary care providers in this enquiry, the physician’s share is affected by the collaboration noted in the research. Physicians are able to spend more time with patients.
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Treatment (continued)	This finding should not be surprising, as it is not feasible to expect physicians or other health professionals to perform this vital organizational role in addition to their clinical responsibilities.” “...The focus [of the CHC family physician] is often on illness for the MD. She may order investigations.” [Interview with a CHC medical director]	
Follow-up – case management	The matter of <i>chronic care</i> appears to be a key consideration in the case management within a CHC. A research study noted that “In 2009, more than 40% of Canadian adults reported that they had at least 1 of 7 common chronic conditions—arthritis, cancer, emphysema or chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders, not including depression. <i>Continued, next page</i>	
Follow-up – case management (continued)	“Caring for people with chronic conditions involves supporting some patients with a single condition, other patients who have comorbidities (issues related to an initial condition, such as diabetes leading to renal failure), and other patients who are dealing with multi-morbidity (multiple conditions, some related to one another, some complicating one another, and some that are unrelated but coexisting). A common example of multi-morbidity is a person with diabetes, hypertension, and asthma who develops arthritis or dementia.” <sup>87</sup> “...The Canadian Academy of Health Sciences identified the following	

<sup>87</sup> “Achieving care goals for people with chronic health conditions”, *Canadian Family Physician*, January 2013 vol. 59 no. 1 11-13 found at <http://www.cfp.ca/content/59/1/11.full?sid=571de38c-0dee-4235-b521-7a3a86ba4621>

	<p>overarching recommendation to transform care for Canadians living with chronic health conditions<sup>3</sup>: Enable all people with chronic conditions to have access to a system of care with assigned clinicians or teams of clinicians who are responsible for providing their primary care and for coordinating care with acute, specialty, and community services throughout their lifespans.” [Same source]</p>	
Follow-up – case management (continued)	<p>“In accordance with the philosophy of primary health care, encourages clients and their families to take responsibility for their own health by involving them in risk factor and health problem identification, goal setting and the choice of intervention for disease treatment and prevention, and health promotion.” [Job Description, S-E Ottawa CHC]</p> <p>“Initiates and manages the medical care of clients and/ or monitors the ongoing therapy of clients with chronic stable illness, where necessary and appropriate in consultation, collaboration with other members of the team, by providing interventions, including the prescribing of drugs, and by providing referrals to other appropriate specialist consultants.” [Job Description, Access CHC]</p>	<p>Note that this flows from the immediately above research finding on the need for health care teams, with other professionals following up on diagnoses, e.g., through education and self-care.</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Record-keeping – keeps records of all clients	<p>“Ensures appropriate, comprehensive treatment and continuity of care by maintaining complete and accurate client records.” [Job Description, Access CHC]</p> <p>“Keeps complete, accurate, and timely records of client visits, using the charting format established by the Centre, which will provide information to assist other practitioners in continuing the client’s care.” [Job Description, S.E. Ottawa CHC]</p> <p>It appears that CHCs collect data to contribute to a CHCs-wide data system – Community Care Information Management, which notes as follows:</p> <p>“By equipping health care providers with tools that can facilitate the collection and use of client information, the Assessment Projects are working towards creating an assessment system that is improving the quality of care Ontario clients are receiving. Through the integrated assessment record, health service providers servicing the same client access previous assessment information to support collaborative care planning and service delivery.”<sup>88</sup></p> <p>The role of the physician appears to be to contribute records for data collection: “Ensures that encounter forms, day sheets and/or other statistics have been recorded and participates in review of summary statistics.” [Job Description, S.E. Ottawa CHC]</p>	

<sup>88</sup> Community Care Information Management, at <https://www.ccim.on.ca/default.aspx>

Confidentiality	As a regulated health care practitioner, the physician has obligations under the <i>Personal Health Information Protection Act</i> (2004) Confidentiality is noted in the job description for the S.E. Ottawa Job Description.	There are many issues such as with adolescents, workers, family members and suicide involvement. <sup>89</sup>
Supervision – students and educating staff	For example: “Creates and annual plan for accommodating, supervising and evaluating a specified number of medical students. Assists medical students by collaborating on the development of learning plan and implement the learning plan through individual student instruction and interdisciplinary client care. Participates in the supervision and education of students in health care professions other than medicine as may be required, and promotes interdisciplinary approach to client care during the period of supervision.” [Job Description, Access CHC]  “Participates in the recruitment and retention of Centre staff, including training, supervision and evaluation of the same.” [Same source]	

TABLE ON WORK CHARACTERISTICS OF THE FAMILY DOCTOR – CHC: B. NOT INCLUDED IN APPENDIX “C” OF MORTON

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Managing resources	Resources can include systems, e.g., of triage: “Participates in ensuring that centre-wide triage system is efficient and effective through monitoring the Clinical triage system and recommending and implementing appropriate changes.” [Job Description, Access CHC]	Implicit is that actions are also governed by the awareness. Awareness of financial resources is noted in the Job Description for the S.E. Ottawa CHC.
Hospital privileges – skills or responsibilities	While there may be issues in relation to the percentage of family physicians with privileges in hospitals, and participating in hospital duties, there is no indication in materials reviewed that there are particular skills required because of challenges in	

<sup>89</sup> See *Canadian Family Physician* index at <http://www.cfp.ca/search?fulltext=Confidentiality&submit=yes&x=0&y=0>

	gaining or keeping the privileges – rather it is a matter of individual doctor preferences. <sup>90</sup>	
Research and practice improvement, as well as continuing study	<p>“Initiates or participates in the implementation of new methods of client assessment and therapeutic techniques. Initiates or participates in the development of clinical policies, procedures and protocols, including medical directives. Initiates or participates in the development of clinical policies, procedures and protocols. Participates in clinical research with colleagues internal and external to the Centre.” [Access CHC Job Description]</p> <p>“Initiates, participates in, or leads program development, delivery and evaluation, and does committee work within the context of the Centre’s core program areas in collaboration of other clinical and health promotion staff.</p> <p>“Participates in program development, delivery and evaluation, and may also do committee work within the broader community context in partnership with other institutions and agencies as may be required from time to time.” [Same source]</p> <p>“Creates an annual learning and development plan for her/ himself which may include attendance at conferences, presentation of papers, maintenance of membership in appropriate bodies/ organizations in addition to those that are mandatory.” [Access]</p>	
Other communications skills – inter-professional negotiation & consultation	<p>“Participates in collaborative practice with RN (EC’s).” [Access CHC Job Description]</p> <p>“Initiates and maintains functional relationships with relevant Community professionals, agencies and services.” [S.E. Ottawa CHC Job Description]</p> <p>“The formal designation of an FHT [Family Health Team] and the hiring of additional health professionals meant that FHT members had a responsibility to explicitly reflect upon and address how to work as a team.”<sup>91</sup></p>	
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Patient-centered care communication	<p>“There are also case conferences for particularly complex situations and staff will discuss how to deal with them.” [Interview with A CHC medical director]</p> <p>“...Encourages clients and their families to take responsibility for their own health....” [S.E. Ottawa Job Description]</p> <p>“Provide care to selected client group at secondary care level such as palliative care, addiction medicine, needs of special groups, etc.” [Access CHC Job Description]</p> <p>Skills include “demonstrated superior communication skills, both written and oral....” [Access CHC Job</p>	Implies understanding varying clients’ needs and how to communicate.

<sup>90</sup> “Hospital care by family physicians. Exodus or opportunity?”, cited from *Canadian Family Physician*, May 2001 vol. 47 no. 5 925-927, found at <http://www.cfp.ca/content/47/5/925.full.pdf+html?sid=081527e0-4fba-4439-8cde-c48cdd02b01d>

<sup>91</sup> “Inter-professional collaboration in family health teams”, cited from *Canadian Family Physician*, October 2010 found at <http://www.cfp.ca/content/56/10/e368.full?sid=10e8ca2c-f09b-4efc-ae6d-7b6c5808df63>

	<p>Description]</p> <p>See also Counselling above (e.g., the article on obesity and how to communicate for counselling purposes).</p>	
Problem solving and scope for analysis and consideration in practice	<p>“Creativity: people don’t present the way the textbooks say: they will be more nuanced, so one must act as a detective, digging deeper. There is the art of managing with the patient, to have them understand and participate in their care. This takes creativity, especially in view of the social determinants of health. How is someone able to manage their illness when they live in poverty? One must deal with the person as one finds him or her.” [Interview with a CHC medical director]</p>	
Policy development & advice	<p>“Participates in the development and the evaluation of Centre policies, protocols and procedures to improve client care and/or to promote co-operative and efficient staff functioning.” [S.E. Ottawa CHC Physician Job Description] “Acts as a medical resource to staff at SEOCHC.” <i>Note</i> that this implies an authoritative level of advice.</p> <p>“This position works within an interdisciplinary team for clinical practice as well as program planning, implementation and evaluation.” [Job Description for Family Physician, Multicultural Access CHC]</p> <p>“Initiates or participates in the development of clinical policies, procedures and protocols, including medical directives. Initiates or participates in the development of clinical policies, procedures and protocols.” [Same source]</p> <p>“Ensures that all manuals, policies and procedures relative to clinical practice are current and complete through full review on not less than an annual basis and discussion with the appropriate staff.” [Same source]</p>	
Emotional effort, stress, risk, etc.	<p>“There is a high demand for emotional effort, from the stories of vulnerable people, and they may be tragic. One may be able to help people to move forward but not be able to resolve the underlying tragedy or trauma. An example she saw recently was a woman who had been tortured by her mother-in-law and husband, and had been raped, still bearing the scars (she was from Afghanistan, and had left three children there). The story was very moving.” [Interview with a CHC medical director]</p>	
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Working conditions	<p>“Working conditions: They will depend on the CHC; it will depend on the leadership, with a good team dynamic. Regardless of the population, the team will work on the issues to be dealt with. But there can be difficulties with teams working together. The doctor does not run the show!” [Interview with a CHC medical director]</p> <p>Note that there are the same risks faced by any health worker in terms of exposure to risks to the health from encountering clients with episodic and communicable illness, infestations, etc. There are some meetings out in the community and some encounters with clients, but there do not appear to be house visits as with the NP and more so with the Midwife.</p>	



**DURBER REPORT: EXAMINING THE ISSUE OF EQUITABLE COMPENSATION FOR  
ONTARIO MIDWIVES**

**ANNEX 5-B – FEATURES OF WORK**  
**Midwife**

This is the second of three sets of detailed analysis of the work of three professions, based on characteristics set out in the Morton Report of 1993 and supplementing them from currently available information

TABLE ON WORK CHARACTERISTICS OF THE MIDWIFE: A. AS SET OUT IN APPENDIX “C” OF MORTON REPORT (1993)

Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
<ul style="list-style-type: none"> <li>Assessment: re pregnancy; environmental factors included; risk assessment</li> </ul>	<ul style="list-style-type: none"> <li>* Also “assessment of general well-being, safety, psychological and emotional situation, including housing and social issues” (Katrina Kilroy)<sup>92</sup></li> <li>* “Midwives [MWs] are primary care providers, and make the decisions on care management – they are responsible for considering all of the factors: needs, conditions, outcomes likely.” (Kilroy)</li> <li>* “There is also an education component – what the needs and what the midwife can do to help the woman to make an informed decision. The MW can facilitate, but can make a recommendation (if the MW thinks a particular route better).” (Meeting with Bobbi Soderstrom)<sup>93</sup></li> <li>* “There is care planning, based on continuing assessment, issues like place of birth (40 to 50 topics to be discussed over the course of care).” (Soderstrom)</li> <li>* “There may be assessments weekly or monthly, more frequent during labour and birth, and present afterward (visits and number will vary according to the needs of the mother and baby).” (Soderstrom)</li> <li>* “This care [by the MW] includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and important task in counselling and education, not only for women and their families but also within the community. The work involves antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care.” [Push! <i>The Struggle for Midwifery in Ontario</i>, page 153]<sup>94</sup></li> </ul>	<p>Note that prior to 1993, (Bourgeault), “There was then the Task Force on the Implementation of Midwifery in Ontario (1986), formed by the government.</p> <p>“Specific acts proposed to be within the midwives’ scope of practice included antepartum care (i.e., conducting a general physical assessment, completing prenatal examinations, and ordering and interpreting, screening and diagnostic procedures); intrapartum care (i.e., monitoring and managing of normal labour and delivery); and postpartum care (i.e., physical examination of mother and newborn and contraceptive counselling and prescription). [Push, page 158]</p> <p><i>Comment:</i> Given the work of the Task Force, one may presume that the knowledge about the functions of the MW was also considered in</p>

<sup>92</sup> Interviewer’s notes; meeting of 20 September 2013<sup>93</sup> Interviewer’s notes, meeting of 16 September 2013<sup>94</sup> By Ivy Lynn Bourgeault, McGill-Queen’s University Press, 2006

		examining what “assessment” meant in Morton.  <i>Note often poor clients – e.g., non-insured [fn.: Annex 5A, page 1 for CHC family physician applies to the midwife.]</i>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Assessment (continued)	* Midwifery Scope Of Practice: “The practice of midwifery is 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.” [ <i>Midwifery Act</i> , 1991]	Note that discussions with MWs showed link with the social determinants of health, that is, a wide perspective on the conditions in which a woman is to give birth. Assessment is taken to include such considerations. <sup>95</sup>
Diagnosis – related to pregnancy	* “Diagnosis: this began with assessment, but was actually diagnosis, until the Health Professions Act recognised that diagnosis was happening. There is a general “explosion” in testing and screening and interpretation – affecting all three professions. The volume of work in this regard is much higher. There is more access to technologies.” (Vicki van Wagner) <sup>96</sup>  * The AOM periodical newsletter highlights a resource for clients	Note that diagnosis relates to diseases more generally, though “relating to pregnancy” could cover many conditions. Other newsletters set out how to diagnose other conditions in newborns and infants as well.

<sup>95</sup> See World Health Organisation – [http://www.who.int/social\\_determinants/sdh\\_definition/en/index.html](http://www.who.int/social_determinants/sdh_definition/en/index.html); also the “Ottawa Charter for Health Promotion” (November 1986), including the following statement reflected in much of the “Philosophy of Midwifery” [See College of Midwifery of Ontario]: “Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.”

<sup>96</sup> Interview’s notes from meeting of 19 September 2013

	about one infection common among women that can impact the baby's health at birth and that clients may acquire and how to recognise and deal with it – Group B Streptococcus [GBS], with excerpts. The AOM has produced a Clinical Practice Guideline for midwives; the client resource provides information on what the infection is, screening and treatment, choices for labour and birth as well as a plan of care. The factors at play include how to convey to clients how to recognise whether they have the infection, chances the baby may have GBS, and choices to reduce the chances a baby will become sick during the first week of its life.. <sup>97</sup>	Note also that the midwife is able to provide fuller information to clients in line with the full outline on the website.
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Diagnosis (continued)	<p>“PPH [Post-partum Hemorrhage] is an acute emergency. Midwives must quickly assess the likely cause of hemorrhage so that appropriate action can be taken to control the bleeding, while simultaneously initiating resuscitative measures.” [P. 22]<sup>98</sup> There are various reasons for postpartum bleeding, which need to be diagnosed and promptly treated. The stability of the client must be observed and assessed.</p> <p>Seven other common emergency situations of varying complexity and urgency are described in the “Emergency Skills Workshop” document – Intrapartum and antepartum hemorrhage, abnormal fetal heart rate, malpresentation and cord prolapse, shoulder dystocia, emergency breech birth, emergency twin birth and anaphylaxis. References are provided to guide the RM in the correct assessments and control steps and understanding of the emergent nature of the situations. The Society of Obstetricians and Gynaecologists is cited in many instances.</p>	<p>It should be added that the scope of the midwife has been expanded. An example is the pharmacopeia. As noted by the AOM in a communication to the author, recent changes to the pharmacopeia enable the midwife to diagnose, prescribe and assess. The CMO produced an online learning module that all midwives were required to complete. It covered aspects of new medications that midwives can now prescribe. [See <i>Midwifery Act, 1991, ONTARIO REGULATION 884/93 DESIGNATED DRUGS.</i>]</p>

<sup>97</sup> “Midwifery care resources” [Spring 2011] also at [www.aom.on.ca](http://www.aom.on.ca), page 8

<sup>98</sup> The Midwives Emergency Skills Workshop, Association of Ontario Midwives, Fifth Edition, 2013, developed by seven Registered Midwives and staff of the AOM, an update of the first one developed in 1995

Determinants of health	Note that as with the CHC family physician, the MW must be conscious of determinants given diversity of clients & their socio-economic and cultural situations.
Screening – general screening test, interpretation	<p>* E.g. from AOM newsletter: “[In response to a question about what a practice has done in regard to pandemic preparation...] “We reviewed the risks of transmission and the criteria for risk assessment, for example how and when to screen and what to do in response to elevated risks. We ensured our practice has adequate supplies of barrier protection like goggles, face masks and gowns, and made sure we had enough hand washing stations and alcohol-based pumps. We changed the answering machine message to indicate to clients the need for risk screening and put up signs around the office to the same effect. Our practice has also talked about what we would do if midwives are compromised by illness, and how to manage limitations in staffing due to potential hospital restrictions if an outbreak takes place.”</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources
Screening & testing (continued)	<p>* “Since 1994, midwives have had to acquire the competencies to order medications and lab work.” [Soderstrom”] There is also screening of hearing of newborns, which some midwives perform (in hospitals, nurses may perform the tests or they may be performed in community health agencies). Genetic screening has become much more commonplace and a wider range of genetic tests has been introduced. Midwives also routinely screen for abuse (childhood sexual abuse and domestic violence).</p> <p>Numerous H1N1 notices from the Ministry requested increased screening for respiratory illnesses in the clinic setting.</p>
Counselling— extensive, related to pregnancy, labour, infant care, nutrition	<p>From the Ottawa Charter for Health Promotion: “Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to</p>
	Comments
	<p>Note that newborn and infant screenings have also been added (e.g., hearing)</p> <p>There are also tests in relation to emergency situations. These are noted briefly in the “core competencies”.</p> <p>Other testing and screening during and after labour are also set out in the competencies.</p>
	<p>The complexity of factors and considerations in counselling are implied in the core competencies, that is, “the emotional status of the woman and her social context”,</p>

	<p>make choices conducive to health.</p> <p>“Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.”</p> <p>* “Midwife Wins Race Relations Award” [Fall, 2010]: This article bears on the intertwining of health and cultural considerations that can be presented to a midwife. [...] The award is the Urban Alliance 2010 Race Relations Award “in recognition of her work with new immigrants, women with no OHIP coverage and women without documented status in Ontario. The article comments on the midwife’s awareness of the “social determinants of health and health inequities that exist.” It also notes that she is the Chair of the Diversity Work Group of the AOM., which has produced a statement on diversity and “a tip sheet for other midwives working with undocumented and uninsured clients....”</p>	<p>responding to “educational needs”, explaining “care alternatives”, “physical, emotional and social change of pregnancy”, “nutritional requirements”, “common discomforts”, physical health and well-being, comfort and support during labour, newborn status and any abnormalities, breastfeeding, etc.</p> <p>Counselling for informed choice decisions is expected by the regulator [see CMO’s 2005 <i>Informed Choice Standard</i>].</p>
<p>Characteristics Noted in Morton (1993)</p>	<p>Characteristics noted in other sources</p>	<p>Comments</p>
<p>Counselling (continued)</p>	<p>An example of one quite focused counselling is provided in an article in the journal “Midwifery”<sup>99</sup>:</p> <p>Preferably, prenatal counselling for congenital anomaly tests should be consistent with the three-function model of prenatal counselling i.e. maintaining a client-midwife relation, providing health education as well as decision-making support, and tailored to clients’ individual preferences. Since not all midwives subscribe to these functions,</p>	

<sup>99</sup> From *Midwifery* in <http://www.sciencedirect.com/science/article/pii/S026661381300274X>; article title: MIDWIVES’ VIEWS ON APPROPRIATE PRENATAL COUNSELLING FOR CONGENITAL ANOMALY TESTS; DO THEY MATCH CLIENTS’ PREFERENCES? By Linda Martin, Eileen Hutton, Evelien Spelten, Janneke T. Gitsels-van der Wal, Sandra van Dulmen.

	reflection on their views is important. Furthermore, midwives need to bridge their views on appropriate prenatal counselling and client preferences. To do so, midwives may benefit from the Shared Decision Making approach.” [Summary]	
Education—same as the core competencies	<p>“In the five academic terms of midwifery clinical learning, each student is assigned to a midwifery practice group and a designated midwife preceptor, i.e., supervisor/teacher/mentor. [...] The student must be available for all antenatal and postnatal visits and is on-call with the preceptor for labours. The student provides care to women under the watchful eyes and guiding hands of the preceptor.<sup>100</sup></p> <p>“[...] A faculty retreat was held in late 1996 and a plan emerged to reorganize the program from three calendar years to four academic years. [...] A second major change that was supported by the external review was to increase the biological science content and broaden the options in social science and health science offerings.” [Page 199]</p> <p>“Two courses have been added [in re pharmacology, biology and microbiology].” [P. 200]</p>	Note that the core competencies do not focus on the training courses that produce the competencies, nor the practical experience that does so, e.g., the “clinical experience” as a student.
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Education (continued)	<p>“A second external review was conducted in 2001. The panel concurred with the conclusion of the first reviewers. They also provided recommendations to assist with organizational issues, increase support to students and preceptors, and increase recruitment of applicants from different communities.” [P. 200]</p> <p>“[...] In the final analysis, it is how midwives <i>practise</i> that matters most. The conclusion that emerges is that in order to gain competence in the full spectrum of care, from the woman-centred</p>	

<sup>100</sup> “Midwifery Education in Ontario: Its Origins, Operation and Impact on the Profession”, Karyn Kaufman and Bobbi Soderstrom. (Chapter 9 of *Reconceiving Midwifery*, eds., Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd; McGill University Press, 2004

	holistic approach to techno-medical interventions, it can be argued that midwives need to be educated in a full spectrum of settings, from home to birth centre to hospital. They must be able to integrate the life-worlds of the women they attend with the work world of midwifery in such a way that the client's needs are fully met. Systems that provide training environments where midwives can function fluidly in both home and hospital, like those so far developed in Canada, can be seen as more beneficial to more women than hospital-dominated systems, which in effect splits home and hospital, allocating hospital care to university-trained nurse-midwives and home care to direct-entry midwives are apprentice- or vocationally trained.” <sup>101</sup>	
Formal education (an example) (See also Annex for Regulation under the <i>Midwifery Act</i> of 1991)	<p>Ryerson's program notes the following:</p> <ul style="list-style-type: none"> <li>• The Midwifery Program's course can be completed in 4-6 years.</li> <li>• All academic courses must be completed before beginning clinical courses.</li> <li>• Clinical segments of the program cannot be completed on a part-time basis.</li> </ul> <p>Clinical placements/practicums can involve being on call 24 hours a day, and students must organize their work and life schedules to accommodate the demands of clinical work. Clinical segments of the program include Normal Childbearing, Midwifery: Complications and Consultation, Midwifery: Maternal and Newborn Pathology, and Clerkship as well as two terms of Interprofessional Placements. (28 courses in the undergraduate program)</p>	<p><i>Canadian Midwifery Registration Examination (CMRE)</i></p> <p>The Cdn Midwifery Registration Exam (CMRE) is a national written examination designed to assess applicants for midwifery registration to ensure that they meet entry-level competency standards set out in the Cdn Competencies for Midwives. Its goal is to ensure that midwives [...] are competent and safe practitioners providing a consistent standard of care ....</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Education (comparison with	Implicit comparison in the following: “2. “Shorter midwifery education program ideal for nurses” [Fall 2010] <sup>102</sup>	

<sup>101</sup> Chapter 10, “Models of Midwifery Education”, at page 184 of *Reconceiving Midwifery*.

<sup>102</sup> Ontario Midwifery



nurses)	<p>Note that for individuals entering midwifery who have a background in health care, the “Post-Baccalaureate Program for Health Professionals” provides for a two-year course of study (instead of the usual four years for others). This is intended to be a stream for nurses. A reason why the course is shorter for nurses is that “many of the courses they take in nursing school overlap with courses midwifery students take: anatomy, physiology, biology, chemistry and a social/cultural course....” [Page 4]</p>	
<p>Referral – high risk cases; midwives may refer client to other [professional] resources</p>	<p>“Pilot project first step to ensuring midwives maintain primary care” [Spring 2011].<sup>11</sup></p> <p>“With approximately 80% of midwifery clients giving birth in the hospital, more than 10,000 women annually would benefit from having midwives perform their role to the utmost of their training and remain as primary care giver as defined by their scope of practice.”</p> <p>The project is for one year at the Southlake Regional Health Centre in Newmarket.</p> <p>“With the project’s rollout, the Midwives of York region will no longer have to transfer care of clients who wish to have an epidural and will work closely with nurses, who will maintain epidural monitoring.</p> <p>“The project sees midwives maintain primary care of patients for all aspects of labour and delivery (i.e., midwives remain with clients who have epidural throughout labour), while nurses will assist anaesthetists with the epidural insertion and from there will manage the epidural as per hospital protocol.”</p> <p style="text-align: right;"><i>Continued on the next page</i></p>	<p>This report indicates that rules for referral are not so simple as to mandatory as set out in Morton, for example the AOM notes that the Ontario Medical Association fee schedule enable specialists to bill for services to clients referred to them by midwives.</p> <p>Since some hospitals require consultations and transfers of care beyond what is required by the College of Midwives, “referrals” are more complex than what was outlined in Morton.</p>

Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Referral (continued)	<p>“Allowing midwives to maintain primary care may help reduce the cascade of interventions often seen in cases of induction, augmentation and epidural and ultimately low c-section rates – helping hospitals to achieve improvement targets [established pursuant to the Excellent Care for All Act].” [page 10]</p>	
Hospital privileges (not heading in Morton)	<p>“About 142,000 babies are born in Ontario every year and as many as 25,000 are delivered by midwives. Midwives are integrated into most hospitals in Ontario and are providing care across many parts of the province, including urban and rural areas. According to a 2011 survey by the provincial Ministry of Health, midwives provide care in 85% of hospitals providing labour and delivery services (up from 82% in 2007).</p> <p>“Despite the successful proliferation of midwifery and the increasing demand from women and families (40% of whom are still unable to access care because of a shortage of midwives), challenges persist, some of which are seen within hospitals.</p> <p>“Challenges include issues of access. According to the ...survey, midwives had been denied privileges at 13 hospitals, many in rural and remote communities. Of the hospitals where midwives do provide care, 19 (23%) limit privilege and nine (11%) limit the number of births a midwifery practice can attend. About 24% of midwifery practice groups are prevented from increasing the number of women they care for because of hospital privileges being denied or capped.</p> <p>“Challenges also include optimizing the role of midwives in hospital settings. Despite the fact that the Midwifery Act sets out in law that a midwife may provide autonomous care, some midwives are not able to maintain primary care for their clients in hospital. This may lead to unnecessary transfers of care from a midwife to a physician. This most typically occurs when a woman requires augmentation or induction or when she requires an epidural – all situations that midwives are qualified</p>	<p>This excerpt indicates the extent to which midwives are integrated into hospital care, at least in terms of the breadth of the integration, though not the depth, which interviewees indicated leave a number of steps to accomplish.</p> <p>Note that having hospital privileges is the sequitur to referral, but also goes with the decision of women opting to have their babies in hospitals with the services of the midwife.</p> <p>Note that Katrina Kilroy estimated that over three quarters of applicants for midwifery services at her practice (Midwife Collective in Toronto) could not be accommodated because of the CAP on the number of births that the practice were allowed at Mount Sinai Hospital.</p>

	to manage.” [Page 3] <sup>103</sup>	
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Treatment – treatments related to pregnancy, labour, delivery, infant	<p>Note that the list in the Core Competencies of 1991 has been extended in the 2009 version of the <i>Midwifery Act</i>: Administering a substance by injection or inhalation as provided for in subsection 4.1 (2). In addition, two further “act” is listed in the current version of the Act that is not on the Core Competencies list: “Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour and the post-partum period” and “Intubation beyond the larynx of a newborn.” Moreover, putting the “finger beyond the labia major” is supplemented by “or anal verge”.</p> <p>Note again the expanding pharmacopeia [see CMO 2010 CMO Standard “Guideline to Prescribing and Administering Amended Ontario Regulation 884/93 Designated Drugs”]</p>	<p><i>Note comment on treatment by the College of Ontario Midwives:</i></p> <p>“Midwifery is a unique profession. It differs on a fundamental level from the traditional medical paradigm of Ontario’s health care system. Midwifery care isn’t the treatment of illness; rather it is the protection and promotion of health and wellness, and the prevention of unnecessary medical interventions in childbearing.”<sup>104</sup></p>
Follow-up – long-term	<p>“Typically, each client cared for by a midwife receives 14 prenatal appointments (including one home visit). During the intrapartum period the midwife manages the labour and the delivery of the baby. Postnatal care extends over a period of a six week period post-delivery. Typically, women receive three home and three clinic visits during this period. Midwives are on-call and available to their clients on a 24 by 7 basis.” [Courtyard Report]<sup>105</sup></p> <p>“There is care planning, based on continuing assessment, issues like place of birth (40 to 50 topics to be discussed over the course of</p>	<p>These aspects of the work are based on the principle of “continuity of care”, which is one of the mainstays of MW philosophy. One of the interviewees (Katrina Kilroy) noted that each appointment or visit lasted about 45 minutes.</p> <p>Transfer to a physician would interrupt this care. (Transfer may be</p>

<sup>103</sup> *Ontario Midwife*: “Midwives in hospital: meeting community demand and maintaining primary care” [Winter 2012]

<sup>104</sup> Statement of College to the Health Professionals Regulatory Advisory Council, May 2008, page 4

<sup>105</sup> Compensation Review of Midwives, Prepared on behalf of the Ministry of Health and Long-term Care, Association of Ontario Midwives: Courtyard Group, September 2010; page 5

	<p>care). There is being on call for a number of days in a month if one is in a team of two; primary care responsibilities are accommodated. This is for 24 hours a day.</p> <p>"The MW is available for phone advice during pregnancy and early labour and after birth. Being present during labour." (<i>Continued on next page</i>)</p>	<p>necessary for medical reasons, though if only for hospital protocol, may not be. Transfer can cause risks for the health of woman and baby and may disrupt communication, causing further risk, underscoring importance of good "hand-off" between care givers.)</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Follow-up (continued)	<p>"There may be assessments weekly or monthly, more frequent during labour and birth, and present afterward (visits and number will vary according to the needs of the mother and baby).</p> <p>There are also interactions with the mother's circle (they are not the clients). [Notes from Soderstrom]</p>	
Record-keeping (all clients)	<p>Midwives have always maintained client records. More recently, the Quality Assurance Regulations of 2012<sup>106</sup> have provide for "Information re care of patients":</p> <p>5. (1) At the request of the Committee, a member shall provide information relating to the member's care of patients to the College in the form and manner specified by the Committee and within the time period specified in the Committee's request or, where no time period is specified, within 30 days after the member receives the request. <i>O. Reg. 335/12, s. 5 (1).</i></p>	<p>This is not noted in the Core Competencies, but is noted in the Comparison table of Morton</p> <p>The Ontario College of Midwives has published two standards for record keeping ("Standard on Record Content" (1994) and "Record Keeping Standard" of 2013).</p> <p>By law, records must be kept, e.g., See PHIPA requirements.</p> <p>Also, see BORN<sup>107</sup> requirements.</p> <p>Midwives must provide record</p>

<sup>106</sup> See [http://www.cmo.on.ca/documents/QualityAssuranceRegulation\\_November2012.pdf](http://www.cmo.on.ca/documents/QualityAssuranceRegulation_November2012.pdf)

<sup>107</sup> Birth Outcomes Registry and Network, at <http://www.bornontario.ca/>

		keeping in BORN database or else they do not receive compensation.
Confidentiality required	See above	

TABLE ON WORK CHARACTERISTICS OF THE MIDWIFE: **B. NOT INCLUDED IN APPENDIX "C" OF MORTON**<sup>108</sup>

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
<p>Supervision &amp; leadership:</p> <ul style="list-style-type: none"> <li>• Includes mentorship</li> <li>• Peer reviews</li> <li>• Guidance as a peer of the practice, or managing the practice</li> </ul>	<p>MWs are required to act as preceptors for students in the Midwife Education Program (clinical placements). "During the final six terms of the program students participate in clinical placements; four terms are spent within a midwifery clinical practice and two terms are spent in inter-professional placements. During the practical components of the program, students are required to attend a minimum of 60 births, acting as primary caregiver for at 40 births in home and hospital settings." [Courtyard Report, page 8]</p> <p>"The preceptor role was not in the original competencies." [Soderstrom]</p> <p>Regulation 7 of the Quality Assurance Regulations provide for peer review, i.e., that each MW is likely to participate in one every year: "A member shall participate in at least six peer case reviews in every 12-month period commencing on a date to be specified by the Committee. O. Reg. 335/12, 7 (2)." [See footnote 15 above]</p> <p>There are currently <b>84 practices</b> (including five with one midwife) in Ontario, varying in size from one to 17 midwives (support staff are not noted).<sup>109</sup></p> <p>"There is also administrative work. The centres are partnerships. The business is more complex than anyone anticipated. This is major issue. About half of the time in weekly meetings is around the business of the centre. There are staff and resources, enhancing the working of the practices." [Soderstrom]</p>	<p>"Mentoring" is recognized as a compensable factor in the formula for compensating each midwife, that is, acting as preceptor one student. [Courtyard Report, page 14] According to one interviewer, this amount does not reflect the actual draw on the MW's time to provide mentoring.<sup>110</sup></p> <p>This is a form of leadership, in which the nature and quality of the work of another MW is reviewed from a professional point of view.</p> <p>Note also that the MW is responsible for organising documents for peer review of her own cases.</p> <p>There are human resources matters for which many practices are responsible. Assuming that average or larger practices (that is, with = or &gt; than SIX midwives, i.e., <b>51 practices</b> of the 86) require support, each of the MWs must take some responsibility</p>

<sup>108</sup> See also "Hospital Privileges" above.<sup>109</sup> See AOM document on Number of Registered Midwives, September 2013<sup>110</sup> Katrina Kilroy: "There has also been no change in the moneys available for the honorarium for preceptors. It comes to \$500 a month for about 200 hours. The result is that it is difficult to attract people to do this aspect of the work. There are no clinical educators to support the MW in this."

	Note that managing the application of standards is part of this work.	for the staff of the practice.
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Managing resources	<p>"Essential equipment is noted on the College website. Midwives also obtain other equipment that they feel they need. This may go beyond what is strictly required." [Soderstrom]</p> <p>"An additional \$500 per course of care was allocated for operational costs." [Courtyard, page 12]</p> <p>One interviewee commented on practice complexity, including coordinating hospital privileges, information technology needs, and the administrative workload with a practice (none of which are explicitly funded). [Katrina Kilroy]</p> <p>"There should be an average profile, which has to include heading the practice (cooperatively or delegated), and taking into account the practice issues and other work like committees. The infrastructure needs to be developed, including support and management." [Vicki van Wagner]</p> <p>Responsibility for coordination with hospitals in re privileges and integration of MW needs also to be noted: "...the head midwife is not paid by the hospital, so the Cooperative has taken its own money to do so." [Katrina Kilroy] That is, this is also a resource matter.</p> <p>"There is a lot of equipment in the home birth: oxygen, resuscitation equipment (baby and mother), sterile materials, drugs – like a level-one hospital – doppler for the heartbeat (for example)." [Interview with Sheila McIntyre]</p>	<p>It should be noted that the compensation formula for practices does not specifically include overhead or resource costs (except for equipment for new entrants and lease-hold improvement). "Caseload variables" for work outside the courses of care also do not include human resources or coordination costs. [Courtyard Report, page 14]</p> <p>Note that the Hay Report could not assess "operational needs" for practices because of lack of information.</p> <p>Given co-management ("partnering") in the practice, each of the MWs is responsible for the stewardship of resources. Hay commented on this (in that neither of the comparators has "fiscal responsibilities" .) [Page 6]</p>
Applying for, gaining and maintaining hospital privileges	<p>"With approximately 80% of midwifery clients giving birth in the hospital, more than 10,000 women annually would benefit from having midwives perform their role to the utmost of their training and remain as primary care giver as defined by their scope of practice." The project is for one year at the Southlake Regional Health Centre in Newmarket.</p>	<p>The Morton Report refers only to "collaboration" with other professionals, particularly in relation to consultation and referral of clients.</p>

	<p>“With the project’s rollout, the Midwives of York region will no longer have to transfer care of clients who wish to have an epidural and will work closely with nurses, who will maintain epidural monitoring.</p> <p><i>Continued on the next page</i></p>	
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Hospital privileges – skills or responsibilities	<p>“The project sees midwives maintain primary care of patients for all aspects of labour and delivery (i.e., midwives remain with clients who have epidural throughout labour), while nurses will assist anaesthetists with the epidural insertion and from there will manage the epidural as per hospital protocol.</p> <p>“Allowing midwives to maintain primary care may help reduce the cascade of interventions often seen in cases of induction, augmentation and epidural and ultimately low c-section rates – helping hospitals to achieve improvement targets [established pursuant to the Excellent Care for All Act].” [page 10]<sup>111</sup></p> <p>“Challenges [relating to having privileges in hospitals] include issues of access. According to the ...survey, midwives had been denied privileges at 13 hospitals, many in rural and remote communities. Of the hospitals where midwives do provide care, 19 (23%) limit privilege and nine (11%) limit the number of births a midwifery practice can attend. About 24% of midwifery practice groups are prevented from increasing the number of women they care for because of hospital privileges being denied or capped.</p> <p>“Challenges also include optimizing the role of midwives in hospital settings. Despite the fact that the <i>Midwifery Act</i> sets out in law that a midwife may provide autonomous care, some midwives are not able</p>	<p>These are also skills and represent an updating of Morton competencies. There are also indications for “outcomes”.</p> <p>There may also be some points for the issue of bias when it comes to the predominantly female profession and its acceptance, but note that midwives have privileges at 85% of Ontario hospitals.</p> <p>But note Hutton observation:</p> <p>“Midwives are well integrated into the Ontario health care system; they have admission and discharge privileges at their local hospital(s), and access to other health care providers for consultation or transfer of care as required.”<sup>113</sup> [Fn. text on next page]</p> <p>Cf: “As a newly regulated member of Ontario’s health professions community, midwifery must address a</p>

<sup>111</sup> Ontario Midwife: “Pilot project first step to ensuring midwives maintain primary care” [Spring 2011]

<sup>113</sup> “Outcomes Associated with Planned Home and Planned Hospital Births in Low-Risk Women Attended by Midwives in Ontario, Canada, 2003–2006: A Retrospective Cohort Study”, Eileen K. Hutton, PhD, Angela H. Reitsma, BSc, BHSc(Midwifery), and Karyn Kaufman, DrPH, in *Birth*, 36:3 September 2009, p. 180



	to maintain primary care for their clients in hospital. This may lead to unnecessary transfers of care from a midwife to a physician. This most typically occurs when a woman requires augmentation or induction or when she requires an epidural – all situations that midwives are qualified to manage.” [Page 3] <sup>112</sup> <i>Continued on the next page</i>	challenging, ideologically impure rhetorical exigence: to “maintain the model and philosophy of practice which emerged through a grassroots ‘demand’ for an alternative to the medical system of obstetrical care,” while simultaneously cooperating with and securing insider status within the system that it has traditionally resisted ” <sup>114</sup> ....
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Privileges in hospitals, skills required, and challenges	<p>“Midwives in hospitals are attached to departments of obstetrics, where they have no representation on medical advisory boards, and few hospitals have done so in the absence of legislative change (Public Hospitals Act). There is a role that the midwife has to play in integrating her work into that of the hospital. Some of this is administrative work as well. There is, however, development of relationships, expertise about the system, to advocate on behalf of the client, so for example maintaining the full scope of practice within the hospital setting. This is where the restrictions happen – especially maintaining primary care for a client who is to be inducted (overdue, but with no complications). Another example is where there is to be an epidural – the decisions and monitoring during the birth. These are not new, but the roles were quite restrictive. These were never envisaged at the rate that they have become.” [Soderstrom]</p> <p>“There are integration meetings for the midwife when midwifery is introduced for the first time to a hospital, and how to deal with them. The hospital appoints a head midwife. Interaction with the hospital is</p>	There are responsibilities (e.g., in re consultation and administration) that are noted here, and they are also the subject of some standards, in terms of inter-professional relationships. (See below.)

<sup>112</sup> Ontario Midwife: “Midwives in hospital: meeting community demand and maintaining primary care” [Winter 2012]

<sup>114</sup> *Interdisciplinary.net*: “Making Sense of Ideological Conflicts in Midwifery Healthcare,” Philippa Spoel and Susan James, Laurentian University, page 5

	required to advocate on behalf of the midwifery staff and know their needs. (In the case of privilege in a hospital.) This role is billed separately apart from client workload. This is substituted, and recorded. This is compensated separately.” [Soderstrom]	
Experience with hospital practice	“Since midwives started practicing in hospitals 15 years ago, the practice has evolved, interprofessional relationships have formed, and hospital organizational structures and management have adapted to these changes. This evolution provides a wealth of information and insight that is useful for consideration regarding midwifery integration into hospitals.” Ontario Hospital Association’s 2011 manual “Sustaining Quality Midwifery Services in Hospitals”	<i>Continued on the next page...</i>
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Experience with hospital practice (continued)	By the time midwives approach a hospital to apply for privileges, they have already undertaken a rigorous needs assessment process, including engaging community stakeholders, the TPA, and the MOHLTC, to establish the suitability of midwifery services to that area. Ontario Hospital Association’s 2011 manual “Sustaining Quality Midwifery Services in Hospitals”, p.35	
Research and practice improvement, as well as continuing study	“Meetings; committee meetings at the hospital (departments, once a month); educational rounds where the maternity committee discusses the latest research, or doing an educational program: takes time.” [Soderstrom]	This topic is noted in the Core Competencies noted by Morton: “Apply research findings to midwifery” (item no. 11 under “General”, page 11).
Other communications skills – inter-professional negotiation & consultation	“In particular, the challenge of the Indications document to midwifery’s alternative, women-centred philosophy suggests possibilities for re-thinking how midwifery and medical ideologies interact in this new context. For example, rather than seeing the Indications document simply as the imposition of authoritative biomedical discourse/ideology onto the new, alternative profession of midwifery, we can also see this text as, at least to some extent, a fluid, flexible site of negotiation and cooperation across professional boundaries.” [Spoel and James, page 5]	
Inter-professional communication	“When physicians, nurses and midwives are asked to identify barriers to inter-professional care and select key issues they would like to address, poor communication in birth units is often the most pressing issue identified, followed	

(Continued on next page)	by a need for care providers to work to full scope. “Better education about providers’ roles and responsibilities, improved transfer of care and clarity on liability issues also top the list. Some hospitals create solutions including: <ul style="list-style-type: none"><li>• Developing a working group to create transfer of care protocols;</li><li>• Developing a debriefing process to discuss cases;</li><li>• Establishing regular educational rounds, and developing guidelines to improve communication.”</li></ul> Some hospitals participate in the patient safety program known as Managing Obstetrical Risk Efficiently (MOREOB), “a program jointly developed by the Society of Obstetricians and Gynaecologists of Canada and the Healthcare Insurance Reciprocal of Canada.” One such hospital is the Trillium Health Centre in Mississauga. It works through team-building exercises, for example. <sup>115</sup>	
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Interprofessional communication & integration into Hospital practice (continued)	<p>The importance of this communication has been underscored by the publication of the Ontario Hospital Association (noted above):</p> <p>“Interprofessional relationships are critical to ensure midwives are well integrated into the labour and delivery teams and that consultation and transfers of care of clients can occur when needed. The midwifery model of care is collaborative and involves ongoing dialogue and relationships with other members of the maternal-newborn team.</p> <p>“Maternity care provision in a hospital will directly involve midwives, nurses, obstetricians, anaesthetists, family physicians, paediatricians and others. It is essential that the various maternity care providers work collaboratively to deliver the best quality of care in every health care setting. The roles of key professions involved in a midwife-attended hospital birth are outlined below.” Ontario Hospital Association, “Sustaining Quality Midwifery Services in Hospitals”, page 55.</p>	<p>Note that several interviewees noted that the funding of research into midwifery is limited, particularly around the use of midwife-practice-</p>
Continuing education and research (Continued on next	<p>“I think we probably should have spoken further regarding the increased expectations of advanced continued learning that have arisen for all health care practitioners since 1994 as clearly the advances in research and knowledge have increased. Plus I think it is true that with the increased use of technology there is also a faster</p>	

<sup>115</sup> From Ontario Midwife, “Interprofessional communication key to midwifery integration” [Winter 2013],

page)	<p>pace expectation for practitioners to be keeping up. That is you are not just relying on the journals that you receive in the mail or that you search out in your medical library but on all the wealth of resources you are expected to keep up with via the internet.” [communication from Soderstrom]</p> <p>6. (1) A member shall participate in continuing education and professional development activities for the purpose of maintaining and enhancing the member’s knowledge, skill and judgment. O. Reg. 335/12, s. 6 (1).</p>	<p>generated data.</p> <p>Note below on the use of the BORN<sup>116</sup> data.</p>
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Continuing education and research (continued)	<p>(2) Continuing education and professional development activities shall, among other things, address the following topics:</p> <ol style="list-style-type: none"> <li>1. Standards of practice.</li> <li>2. Changes in practice environment.</li> <li>3. Advances in technology.</li> <li>4. Changes made to entry to practice competencies. [Quality Assurance Regulations to Midwifery Act – see above footnote]</li> </ol>	
Data responsibilities	<p>“The BORN system: gathering data is a story: Government has funded continuing education for nurses on techniques (breast-feeding, etc.). The Eastern Ontario group recognised the need to gather data. This became the NIDAY database, and then envisioned by another midwife</p>	<p>This is above the responsibility for record-keeping noted above (and in the Quality Assurance Regulation), specifically the BORN [Better</p>

<sup>116</sup> “BORN is Ontario’s pregnancy, birth and childhood registry and network. Established in 2009 to collect, share and rigorously protect critical data about each child born in the province, BORN Ontario manages an advanced database that provides reliable, secure and comprehensive information on maternal and child health.” *Perinatal Indicators for Ontario*, BORN, Ottawa, 2012, page 4 – at <http://www.bornontario.ca/assets/documents/specialreports/Perinatal%20Health%20Indicators%20for%20Ontario%202012.pdf>

Note that home births are not included in this Report. Births in hospital at which midwives were present are included. [Page 7 of text] The information in the Report is not broken out by type of primary care provider (midwife, family doctor, etc.). There are such figures in the Courtyard Report and in Hutton et al. cited above on outcomes.

	(Wendy Katherine) for a provincial database. The data is not only about birth but the health of the women and the babies. Genetic screening data are also included. The local midwifery groups were included, and fed their data to this registry (also one called Midwifery Outcome Register, which was transferred to BORN). The ministry required the midwives to contribute data to the system (this is a change to the requirements of midwives). Midwives had to learn how to input the data.” [Notes, Soderstrom]	Outcomes and Registry Network <sup>117</sup> Ontario] information system.
Problem solving and scope for analysis and consideration in practice (continued)	Re PLANNING within a practice – example published: ““ ...The AOM recently developed and distributed a checklist to assist practices in developing their own pandemic plan.  <i>Continued on next page</i>	
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments

<sup>117</sup> BORN Information System:

“The BORN Information System (BIS) enables the collection of, and access to, data on every birth and young child in Ontario. Sourced from hospitals, labs, midwifery practice groups and clinical programs, the data are collected through a variety of mechanisms including HL7, batch upload, and manual entry. Information is reported via standard reports and analytical tools within the BIS.” See <http://www.bornontario.ca/born-information-system/>

<p>Problem solving and scope for analysis and consideration in practice (continued from previous page)</p>	<p>“Each practice will have different needs according to their own community and practice situation. The checklist can help guide a planning discussion around several topics including:</p> <ul style="list-style-type: none"> <li>• General knowledge for caring with clients with respiratory symptoms</li> <li>• Caring for women who are ill</li> <li>• Role clarity</li> <li>• Key services</li> <li>• Supplies</li> <li>• Services and human Resources</li> <li>• Security</li> <li>• Data systems, client appointments</li> <li>• Planning for unexpected costs.” [Page 5]</li> </ul> <p>[In response to a question about what a practice has done in regard to pandemic preparation, an MW reported...] “We reviewed the risks of transmission and the criteria for risk assessment, for example how and when to screen and what to do in response to elevated risks. We ensured our practice has adequate supplies of barrier protection like goggles, face masks and gowns, and made sure we had enough hand washing stations and alcohol-based pumps. We changed the answering machine message to indicate to clients the need for risk screening and put up signs around the office to the same effect. Our practice has also talked about what we would do if midwives are compromised by illness, and how to manage limitations in staffing due to potential hospital restrictions if an outbreak takes place.</p> <p><i>Continued on the next page...</i></p>	<p>This is an example of planning and problem solving analysis, combining professional with administrative considerations. The former would have been implicit in the Core Competencies, but not the latter. This problem solving was required to meet the requirements of the Ministry as well as the goals of the practice.</p>
<p>Characteristics for Evaluation</p>	<p>Description of characteristics &amp; notes from sources</p>	<p>Comments</p>

<p>Problem solving...continued from previous page</p>	<p>“Because we are a larger practice, we assigned roles and responsibilities to a smaller subcommittee. Any practice can decide what’s most important for them and work until they have a full plan.”</p> <p>Problem solving: Clinically, the way that midwifery is structured is around a holistic treatment, so problems are more complex. The average appointment is 45 minutes long, with assessment of general well-being, safety, psychological and emotional situation, including housing and social issues.</p> <p>Discussion of decision-making is important “to give women agency”, to give them counselling and enable the woman to make strategic decisions. Resources available to the woman to solve problems may be important. Poverty is one example, where the woman does not have the money to get on the bus. Most women do have complexities in their lives. There are complex issues involved in planning natural childbirth, and can avoid the interventions. How to explain the absolute depths of strength, and facing being parents. The woman makes the decision. [Vicki van Wagner]</p> <p>“Midwives in practice groups meet regularly (once a week usually) to discuss client care and what are the standards of their practice and how to operationalize through protocols. An example is that of 265 Carling (an Ottawa MW practice), where they describe a plan of care for each client reaching 36 weeks. Additionally there can be discussions of someone with more complicated situations.” [Soderstrom]</p>	<p>It is notable that (as with both the Nurse Practitioner and the Family Doctor) the social determinants of health are descriptive of the factors borne in mind during analysis of situations affecting patients.</p>
<p>Emotional effort, stress, risk, etc.</p>	<p>Note in data that the “emotional work” is very high, in terms of vaginal births because one is with the woman in pain – one tries to avoid pain relievers. This is much more personal. Medical-legal risk has to be faced, and the uncertainties are stressful. There are uncertainties in the birth process. Moreover, the home birth is extra demanding. The responsibility is more stressful. Vicki thinks that this aspect of home birth was not factored in to the evaluation of the work initially. [Vicki van Wagner]</p>	<p>The Hay Report notes: “we calculated the on call requirement to represent an average of approximately 4,400 on call hours per year” Comment: This is a very extensive requirement for on call duty, particularly where the average public service year amounts to approximately 2,000 hours. (Hay, p.</p>

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Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Emotional Stress and risk (continued)	<p>(Continued from previous page) "There are enormous disruptions to family life by the absences of the midwife from home as a result of the on-call nature of the work." Kilroy]</p> <p>"The work situation for midwives in Ontario, such as the extended periods of being awake (&gt;24 hours), extended periods of being on-call, the highly stressful environment, the long hours worked each week... (continued)</p> <p>(may be &gt;80 hours/wk) as well as the fact that our profession is young (both in experience level of practitioners and integration) makes it very similar to the working conditions for medical residents"<sup>118</sup></p> <p>Katrina has done consulting with hospitals and finds that the hospitals still often have biases against their competence – an experience that those in nursing have gone through. There are stresses in establishing the profession in this way, and being devalued at the same time. Outcome reports are greatly at variance with the way they are being treated. [Kilroy]</p> <p>"We note, in particular, that Midwives experience a high degree of stress resulting from lengthy periods of being on-call, 24 hours/day, seven days/week (including weekends and holidays." [Hay, page 4]</p> <p>Emergency situations need also to be referenced. These are not predictable, but usually involve labour. There may, however, be risky situations in homes that have not been described but are likely.</p>	<p>It is, nonetheless, an important consideration in evaluating the work, Note that the Reports (Morton, Hay, Courtyard) make no reference to stresses other than the one noted opposite from Hay.</p> <p>All of the jobs in this comparison involve significant emotional stresses because of the situations and personal nature of the clients' presenting.</p>
Working	It should be noted that the working locations are three (other than	Home visits are also found in the

<sup>118</sup> "CMO Discussion Paper: Conditions for Safe Practice", College of Midwives of Ontario, November 2006, at <http://www.cmo.on.ca/downloads/CMOConditionsforSafePracticeDiscussionPaperMemComm.pdf>



conditions	travel to homes): <ul style="list-style-type: none"> <li>Office (that is, the practice location)</li> </ul> <p><i>Continued on the next page...</i></p>	Nurse Practitioner job description. I would expect, however, that the frequency is actually lower than that of the midwife,
Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Working conditions (Continued from previous page)	<ul style="list-style-type: none"> <li>Home (for meetings and for birthing in 25% of cases where the midwife is attending a birth)</li> <li>Hospital – both in-patient situation and operating room</li> </ul> <p>In addition, there may be circumstances in which the MW is accompanying the client to a hospital because of an emergency situation.</p>	<p>...given the number of visits on the part of the midwife to the client (3 per client times 40 clients as primary midwife and up to 40 clients as second midwife) during a year.</p> <p>Home visits can present risks and adverse working conditions (as set out in the CHC nurse practitioner features of work – See Annex 5-C).</p>
Sensory Effort	<p>“They are attuned to the sounds, like the voice of the mother, because of their experience with the signs of the various stages of labour. They can radiate calmness.</p> <p>“There are symptoms that the midwife recognises, e.g., the changes in the patterns of the labour contractions – they are excellent observers. They have intuitions about whether the mother is thriving and well after the birth. They pursue the observations with questions and examining possible reasons for the situations.” [Sheila McIntyre]</p>	

*ANNEX: Midwifery Act, 1991*

Loi de 1991 sur les sages-femmes  
ONTARIO REGULATION 168/11  
REGISTRATION

Issuance — general class

8. (1) Subject to subsections (2) to (5) and to subsection 15 (4), the following are non-exemptible registration requirements for a certificate of registration of the general class:
  1. The applicant must have at least one of the following,
    - i. A baccalaureate degree in health sciences (midwifery) from a university in Ontario.
    - ii. A degree, diploma or certificate from a program listed in Schedule 1.
    - iii. Qualifications that are equivalent to the degree referred to in subparagraph i, as determined by the Council or by a body or bodies designated by the Council.
  2. The applicant must,
    - i. have current clinical experience consisting of active practice for at least two years out of the four years immediately before the date of the application, and
    - ii. have attended at least 60 births, of which at least,
      - A. 40 were attended as primary midwife,
      - B. 30 were attended as part of the care provided to a woman in accordance with the principles of continuity of care,
      - C. 10 were attended in hospital, of which at least five were attended as primary midwife, and
      - D. 10 were attended in a residence or remote clinic or remote birth centre, of which at least five were attended as primary midwife.
3. The applicant must have successfully completed the qualifying the examination that was set or approved by the Registration Committee at the time the applicant took the examination. O. Reg. 168/11, s. 8 (1).

**DURBER REPORT: EXAMINING THE ISSUE OF EQUITABLE COMPENSATION FOR  
ONTARIO MIDWIVES**

**ANNEX 5-C – FEATURES OF WORK  
Nurse Practitioner**

TABLE ON WORK CHARACTERISTICS OF THE NURSE-PRACTITIONER<sup>119</sup>: A. AS SET OUT IN APPENDIX "C" OF MORTON REPORT (1993)

Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Assessment: nursing, may include environmental	<p>The NP deals often with how to help people to deal with their issues: the NP becomes like a partner in their life issues, to give tools, connect them to resources, and give support, dispel myths. They practise at being where the person is. Doing motivational interviewing is designed to bring out whether people want to change and why, to articulate that for themselves. [Interview with Theresa Agnew, September 20, 2013]<sup>120</sup></p> <p>The NP tends to take a holistic approach rather than the "reductionist" one, which targets evidence and specific treatments of particular conditions. The latter does not deal with the social determinants of health (see the Ottawa Charter: WHO Alma Ata) as the holistic approach does.</p> <p>Many have drug problems, as well as housing, drug addiction, food security problems, rehabilitation from incarceration. Many are HIV positive. They deal with single mothers, children with autism, on the run from CAS. The NP advocates to help them with their parent roles. [...] She deals with clients presenting many medical problems – cleanliness-related such as rashes. They have many other issues relating to poor nutrition, for example. Some have asthma. [From audio recorded by Emer Kelly-Rombough, an NP at Carlington Community Health Centre in Ottawa]<sup>121</sup></p> <p>The NP "spends sufficient time with the client to determine the presence of existing and potential health problems, with a major focus on lifestyle, psychological, socio-cultural, and environmental risk factors that may influence the client's health status. The [NP] deals with these personally or by referral to</p>	<p>Note the reference here to the social determinants of health in the interview notes and in the audio clip. This is suggestive of the breadth of assessments being conducted by the NP at the CHC.</p> <p>Born out as well in the job advertised in RNAO newsletter: "Knowledge of/experience with health issues facing seniors, rural residents, youth and families with young children. Specific expertise in any of the following areas would be considered an asset: geriatrics, dementia, mental health, chronic disease management, maternal and infant/child health."<sup>123</sup> The autonomy of the assessment role is</p>

<sup>119</sup> Note that the title in Morton is "Primary Care Nurse". In these notes, "NP" is used for Nurse Practitioner. In some publications and legislation, the title also used is Registered Nurse (Extended Class).

<sup>120</sup> Notes from interview by P. Durber – quotes indicate author's wording

<sup>121</sup> Author's notes, taken from "Ontario Primary Health Care Nurse Practitioner Program at <http://np-education.ca/>

	or in consultation with other service providers and programs in the community <sup>122</sup>	indicated by the comment "The Linwood site is a nurse practitioner office, in which the RNEC functions independently, with physician consult available by phone and videoconferencing."
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Assessments (continued)	"Many services provided by primary care NPs are valued by MDs who work with NPs such as health promotion and wellness care, monitoring of chronic illness, and supporting post-episodic continuity of care. [...] Almost all physicians with experience in working with NPs indicated that care of episodic illness is a valuable contribution. ... And 70% of physicians interested in working with NPs indicated that this service is valuable." [Study of Nurse Practitioners] <sup>124</sup>	Illustrates some of the scope of assessments
Diagnosis – within scope of competence	"S/he [the NP] diagnoses and manages common health problems and diseases both independently and in collaboration with the client and the physician. [...] "Provides ongoing, comprehensive primary health care to clients of all ages within the scope of the R.N. (E.C.) including assessments, diagnosis...." [Job description]  [The CHC PN in the audio clip] She sees about 20 clients a day, providing therapeutic services for episodic illnesses and other issues. [Debbie Tirrul, source: see footnote 5]	The Scope of Practice is set out in legislation. See Annex.  Note that the range of illness goes beyond the "common", e.g., HIV, tuberculosis, etc., depending on the population in the CHC area.
Screening – (none shown by Morton)	She operates a walk-in clinic at a local high school, and provides STD testing.... [Debbie Tirrul, CHC PN audio clip]  [Emer Kelly-Rombough] she is working in the walk-in	See also 1994 scope of practice, including diagnosis & identification of disease (e.g., from

<sup>123</sup> From Registered Nurses Association of Ontario website (at <http://rnao.ca/resources/toolkits/np-toolkit/introduction>) for job of Primary Health Care Nurse Practitioner, Woolwich Community Health Centre, 26 Sept 2013

<sup>122</sup> From "Nurse Practitioner Job Description", South-east Ottawa Community Health Centre", May 2008

<sup>124</sup> IBM, 2003, study done for the Ministry of Health and Long-term Care, page 15

	<p>clinic and people are presenting issues such as rashes, or want anonymous tests for HIV....</p> <p>“Determines the need for, orders and interprets screening and diagnosis laboratory tests and chest and limb X-rays and diagnostic ultrasounds “ [Job Description]</p> <p>NPs can order electrocardiograms in non-acute cases. [Nurse Practitioner Revised Report, August 2005 as per footnote #6, page 43 of web version; p. 33 of text]</p> <p>Can also perform venipuncture to take blood for tests. [Bill 179 – See Annex]</p>	<p>patient’s history, comprehensive health examination, tests).[See fn. #6, page 33 of text.]</p> <p>NPs may <i>treat</i> patients (whereas RNs may <i>assess</i>) Can also use mammography. [Fn. 6, p. 34] Nurses can order any laboratory tests, incl. diagnostic imaging, not CT or MRI. [Agnew]</p>
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Counselling – on general health care	<p>“Supports clients and their families to take responsibility for their health by involving them in risk factor and health promotion identification, goal setting, and the choice of interventions for disease treatment and prevention, and health promotion.” [Job Description]</p> <p>“Initiates and manages the care of clients and/or monitors the ongoing therapy of clients with chronic stable illnesses by providing pharmacological, complementary and counselling interventions [...] Counsels individuals and families on health-related and lifestyle issues “ [Job Description]</p> <p>The PNs do crisis counselling. [Tirrul audio clip]</p> <p>“Much nursing is concerned with health promotion, which in turn is about providing support and helping people to change behaviours that are detrimental to their health, such as smoking or drinking too much alcohol. Sidell ... goes on to provide examples, saying that, ‘Community nurses may need to counsel someone who is having to deal with incontinence. Health visitors counsel on immunization of infants.’ [...] Another example is <sup>125</sup>nurses engaged in family planning who use counselling skills to enable the client to make an informed decision about their sexual and</p>	<p>It is also clear, depending on the population involved, that there may be barriers to communication – cultural and economic, for example, that require skill to deal with. Note the promotional aspect of counselling, which will vary by population and patterns of issues (e.g., mental health).</p>

<sup>125</sup> from “Counselling Skills for Nurses, Midwives and Health Visitors”, Dawn Freshwater, McGraw-Hill, Berkshire, UK and Philadelphia, USA, 2003

	reproductive health. [Page 8]	
Education – formal and community resources	<p>The NP courses can usually be completed within 1 year of full-time study.<sup>126</sup></p> <p>This is additional to an RN course of study, i.e., “registered nurse – extended course” include Pathophysiology, Advanced Health Assessment and Diagnosis and Therapeutics in Primary Health Care.</p> <p>“After the Baccalaureate, they practise for five years, and then often work to obtain the MSc (Nursing) with a specialisation in primary nursing care.”</p>	The program was being developed (as it was for midwives) at the time of the legislation of 1991 and the Morton Report.
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Continued Education	<p>“The educational program has also expanded as a result of an increasingly wide scope of practice. In 1994, there was a very short list of medications. (See the Compendium of Pharmaceuticals.) Continuing study is required of both the current and emerging drugs, and their interactions.” [Theresa Agnew] See Also <i>Nursing Act Regulations</i>, 275, which requires a “learning plan” coming from self- and peer-assessment.<sup>127</sup></p>	
Education – formal and community resources	<p>“Primary Health Care Nurse Practitioners (PHC NPs) are registered nurses, who are specialists in primary health care, who provide accessible, comprehensive and effective care to clients of all ages. They are experienced nurses with additional nursing education which enables them to provide individuals, families, groups and communities with health services in health promotion, disease and injury prevention, cure, rehabilitation and support.” [See fn. No. 8]</p>	Knowledge of community resources appears to be gained through workshops on the job. They may also be part of courses.
Referral (none in 1993)	<p>“NPs can now refer clients to hospitals and care and apply to the Medical Advisory Committee for privileges at hospitals. Transfer of care can also be accomplished. This is a recent development as a result of changes to the <i>Public Hospitals Act</i>. It is a role that has yet to be realised – [at least Theresa does not have numbers of NPs with privileges].” [Theresa Agnew]</p> <p>“Referral is a form of consultation. It is an explicit request from one health care professional to another</p>	This power is correlated with continuity of care: “an NP-Paediatrics may continue to provide health care services to a client who is now a young adult with a life-limiting chronic

<sup>126</sup> Source: Nurse Practitioners, Education Program, at [www.npeducation.ca](http://www.npeducation.ca)

<sup>127</sup> See article 25, at [http://www.e-laws.gov.on.ca/html/reg/english/elaws\\_regs\\_940275\\_e.htm#BK45](http://www.e-laws.gov.on.ca/html/reg/english/elaws_regs_940275_e.htm#BK45)

	to provide specific health services to address client needs (for example, further investigation, treatment, intervention or a procedure). Referral can result in a time-limited (episodic) intervention provided by the other health care professional, or concurrent management during which both the NP and the other health care professional provide services within their respective areas of expertise.” <sup>128</sup>	disease if that NP has the competencies and expertise, because it would promote continuity of care and meet the client’s needs.”  [See fn. No. 9, at page 4]
Treatment – implements plan of nursing care	“Spends sufficient time with the client to determine the presence of existing and potential health problems, with a major focus on lifestyle, psychological, socio-cultural, and environmental risk factors that may influence the client’s health status. The [NP] deals with these personally or by referral to or in consultation with other service providers and programs in the community.” [Job Description] (Continued....)	Whereas the Morton report notes “minor episodic illness” [Morton, p. 15], the NP also deals with <i>chronic</i> conditions such as asthma and diabetes.
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Treatment (Continued)	“If additional or different information is determined after receiving the report, the NP notifies the client and adjusts the treatment plan as appropriate.” [See fn. No. 9, at page 5]	
Follow-up – monitors condition	<p>“Had 600 clients enrolled with her as RNP (Registered Nurse Practitioner, herein shown as “NP”) in the community health clinic (east Toronto). She saw people from “cradle to grave”, for all of their health needs, managing chronic diseases for example.” [Theresa Agnew]</p> <p>Follow-up is implied in the scope of practice: “<i>The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function (Nursing Act, 1991).</i>” [See fn. No. 9, page 4]</p> <p>A history of NPs in Ontario notes the following skills, implying continuity of care, that NPs:</p>	The job description also uses the term “ongoing” (which appears in the “History” – at fn. 10 – but not under the primary care PN in that description): “Provides ongoing, comprehensive primary health care to clients of all ages....” [Page 1] “Continuing client care” is also referenced. [Page 2],

<sup>128</sup> College of Nurses of Ontario, “Nurse Practitioner Practice Standard” 2011, page 13  
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	<ul style="list-style-type: none"> <li>• Manage women during and after pregnancy;</li> <li>• Manage individuals with stable chronic diseases, such as diabetes, hypertension and a variety of respiratory conditions.<sup>129</sup></li> </ul>	and under “Therapeutic” the following is noted: “Initiates and manages the care of clients and/or monitors the ongoing therapy of clients with chronic stable illnesses by providing pharmacological, complementary and counselling interventions.” [Page 2]
Record-keeping – as required by the CHC [See also job description – paragraph 3 opposite] <sup>130</sup>	<p>The NP has the duty of “retaining records of medication dispensed, administered, sold and compounded for a minimum of 10 years.” [See fn. No. 9, page 16]</p> <p>The NP also has a duty of “Documenting all aspects of their practice”. [Fn. No. 9, page 16]</p> <p>“With regard to clinical data, most NPs use an electronic health record. They input data into systems, and have done so for 30 years.” [Theresa Agnew]</p> <p>“Keeps complete, accurate and timely records of client visits, using the charting format established by the Centre, which will provide information [...] in continuing client care.”</p>	It is not clear that Morton contemplated electronic data and record keeping. Research for this enquiry has not uncovered the degree of support available to the NP, but given the CHC context, there is support available (systems, for example).
Characteristics Noted in Morton (1993)	Characteristics noted in other sources	Comments
Confidentiality	The <i>Personal Health Information Protection Act</i> applies [See 2004 legislation: <a href="http://www.cno.org/Global/docs/prac/41069_privacy.pdf">http://www.cno.org/Global/docs/prac/41069_privacy.pdf</a> ] for health professionals	
Supervision – may supervise students	<p>“Supervises and trains nursing and nurse practitioner students on placement at the centre and participates in the training of other health professions students.</p> <p>“...Participates in the organization, coordination and presentation of clinical case conferences, in cooperation with health services staff and other</p>	There are also responsibilities as a member of the CHC team that may involve working with colleagues and providing guidance to others such as support

<sup>129</sup> Source: Nurse Practitioners Association of Ontario, page 2, at <http://npao.org/nurse-practitioners/history/>

<sup>130</sup> Note more responsibility for record-keeping in an *independent NP practice*: See CMO practice guideline at [http://www.cno.org/Global/docs/prac/41011\\_fslndepPrac.pdf](http://www.cno.org/Global/docs/prac/41011_fslndepPrac.pdf)

	<p>staff of the Centre.</p> <p>"Participates in the hiring, orientation and evaluation of primary care staff." [Job description]</p> <p>There is also a College Practice Standard for "supporting learners".<sup>131</sup> Guidance, coaching, evaluating and supervising are required.</p>	<p>staff. These duties are not noted in the job description.</p>
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TABLE ON WORK CHARACTERISTICS OF THE NURSE PRACTITIONER: B. **NOT INCLUDED IN APPENDIX "C" OF MORTON**

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Managing resources	<p>"Maintains an awareness of the financial position of the Centre as it influences the provision of primary care and health education." [Job Description]</p> <p>Responsible for the use of equipment and space within the CHC. (Not in the materials, but implicit in the work)</p> <p>"She [Theresa Agnew] could order same pharmaceuticals as a physician except for narcotics (and that is changing in the next year it is expected)." [Interview notes]</p> <p><i>Continued on next page</i></p>	<p>The use of diagnostic testing resources and pharmaceuticals is part of managing resources.</p>

<sup>131</sup> Guidelines for Nurses in the Preceptor Role: In practice settings, nurses act in formal support roles, such as preceptors, to ensure client safety and facilitate a learning environment that encourages professional growth, career development and high-quality client care. For the purpose of this document, the term preceptor is defined as a proficient or expert practitioner (Benner, 2001) who enters into a one-to-one relationship with a learner for a set period of time to provide on-site supervision along with clinical teaching and instruction (Nehls, Rather & Guyette, 1997; Usher et al., 1999). See [http://www.cno.org/Global/docs/prac/44034\\_SupportLearners.pdf](http://www.cno.org/Global/docs/prac/44034_SupportLearners.pdf)

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Managing resources (continued)	<p>Note also that NPs can dispense, sell or compound prescriptions under specified circumstances, largely relating to the circumstances of the client (e.g., financial means and access to a pharmacy). They must document all aspects of the transactions.<sup>132</sup></p> <p>When setting, reducing and casting fractures and reducing dislocated joints, NPs are accountable for:</p> <ul style="list-style-type: none"> <li>■ ensuring they have the necessary resources available to perform the procedure appropriately and safely, and to manage potential outcomes associated with the procedure [same source, page 10 and elsewhere]</li> </ul>	The Practice standard makes a number of references to the responsibility for ensuring adequate resources before carrying out procedures.
Applying for, gaining and maintaining hospital privileges	<p>See “Referral” above (from notes of interview with Theresa Agnew)</p> <p>Note reference to referral or transfer of clients to others for issue beyond scope (though to hospital is not specified) in the job description . (The term “referral” is used, but in the context of team practice, not specifically in relation to hospital care.)</p>	There do not appear to be standards for transfer of clients to doctors (though that is inferred by scope of practice and some interview material).
Hospital privileges – skills or responsibilities	<p>No documentation. Note Annex, under the RHPA, NPs have the power to admit clients to hospital (Reg. 965 of the <i>Public Hospitals Act</i>).</p> <p>“NPs manage and provide care for both inpatient and outpatient populations, collaborating and consulting with physician colleagues and the inter-professional team as needed to address patient care needs. Treatment and discharge planning is one of several components within a comprehensive plan of care that is developed by NPs in consultation with the inter-professional team in the hospital setting. Currently, collaboration focuses on treatment and discharge with admission to follow July 1, 2012.”<sup>133</sup></p> <p>“NPs assess patients' and their readiness for discharge throughout the hospital stay and work with inter-professional care teams to ensure discharge arrangements align with a safe transfer of accountability to the primary (or other) care provider.” [See fn. 15]</p>	There are more details in the OHA manual “Enabling Nurse Practitioners to Admit and Discharge: A Guide for Hospitals” <sup>134</sup>

<sup>132</sup> Taken from *Practice Standard* – see footnote 9

<sup>133</sup> Registered Nurses Association of Ontario, “Nurse Practitioner In-patient Practice Elements” at <http://rnao.ca/resources/toolkits/np-utilization-toolkit>

<sup>134</sup> <http://www.oha.com/KnowledgeCentre/Library/Pages/Guides.aspx#sthash.4ZoCY1LX.dpuf>

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Research and practice improvement, as well as continuing study	<p>"In re research: that can mean taking evidence about the outcomes of the practice and steps that have been taken to improve them and formulating improved practices and then pass the lessons on to other professionals and to management. With regard to the research role, NPs are expected to be aware of research findings and integrate them into the practice, to use "best practice" guidelines, to participate in research." [Theresa Agnew notes]</p> <p>"Stays current and aware of opportunities to implement new methods of client assessment and treatment." [Job Description]</p>	
Other communications skills – inter-professional negotiation & consultation	<p>"Collaboration involves NPs [...] participating in interprofessional conflict as required." [See fn. No. 9, page 12]</p> <p>"The inter-professional aspect of the work is important. In the CHC the NP makes connections with dietitians, therapists, social workers, physicians and a range of other members of the health care team." [Theresa Agnew]</p> <p>"She [Shelley Walkerley] works to accepted standards. Her first collaborative relationships were with doctors, nurses, pharmacists as well as clients. She has had to negotiate the terms of the relationships, within and outside the centre (for example from her previous work as a nurse specialising in tuberculosis). [Audio tapes]</p>	"Key elements of effective collaboration are partnership, communication, common goals, shared decision making, mutual trust, mutual respect, autonomy and a feeling of shared responsibility." <sup>135</sup>
Patient-centered care communication	In the therapeutic relationship, the College of Nursing of Ontario indicates that the nurse has the duty of "negotiating with the client both the nurse's and the client's roles, as well as the roles of family and significant others, in achieving the goals identified in the care plan...." <sup>136</sup>	
Problem solving and scope for analysis and consideration in practice	"With regard to problem analysis, one needs to take inspiration from the social determinants of health and their complexity. One also needs to have expertise in the health issues affecting the population that one is dealing with. The expertise includes the clinical expertise in health along with knowledge of how to care for people from a psycho-social perspective (e.g., guilt or shame or trauma in the refugee communities). The NP has to work with these issues. <i>(Continued on the next page)</i>	

<sup>135</sup> See footnote 9 above (Nurse Practitioner Practice Standard), page 12

<sup>136</sup> CMO, Practice Standard, "Therapeutic Nurse-Client Relationship", Revised 2006, page 6 at [http://www.cno.org/Global/docs/prac/41033\\_Therapeutic.pdf](http://www.cno.org/Global/docs/prac/41033_Therapeutic.pdf)

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Problem solving (continued)	<p>For example at Theresa's CHC the East Asian women are afraid to report domestic abuse. The NP started a cooking and sewing group, as a safe place where some connections between the individuals and with the NP can be made. This is a creative problem solving approach." [Theresa Agnew]</p> <p>"Implements strategies to promote health and prevent disease with individuals, families and groups." [Job Description]</p> <p>"Synthesizes information from individual clients to identify broader implications for health within the family and the community." [Job Description]</p> <p>"Participates in the development and the evaluation of policies, protocols, and procedures to improve client care and/or to promote cooperative and efficient staff functioning." [Job Description]</p> <p>"Participates in the development, planning and evaluation of treatment, education, counselling and health promotion programs." [Job Description]</p> <p>"She [Joanna Binch] partners with a mental health nurse, going to people with housing issues (rooming houses for example). She encounters people with problems like rashes and infestations and chronic mental issues. She connects them with resources in the city."</p> <p>"They [a CHC health team visiting clients] deal with single mothers, children with autism, on the run from CAS. The NP advocates to help them with their parent roles. [...] Every two weeks there is a round-table discussion with a psychiatrist. They brainstorm about difficult issues such as children and others with PTSD." [Emer Kelly-Rombough audio tape]</p> <p>In a therapeutic relationship, "reviewing the best possible medication history to obtain a complete understanding of the medication the client is using (the medication history may be conducted by the NP or another qualified health care professional, for example, a pharmacist or another nurse) [and] deciding that the medication is warranted." [CMO, Nurse Practitioner, see footnote no. 9]</p>	
Emotional effort, stress, risk, etc.	<p>Dealing with stories: "She [Debbie Tirrul] describes the population, which includes those with special needs, e.g., "street-involved", having substance-abuse problems, many Asian extraction. There are cultural interpreters. There are people without housing, in housing assistance situations. They provide services also to those going to the food bank." [Audio tape]</p> <p>Another example is "going to people with housing issues (rooming houses for example). She encounters people with problems like rashes and infestations and chronic mental issues. She connects them with resources in the city." [Joanna Binch, Audio Tape]</p> <p>"Some of the clients are displaced persons from abroad. They may have many other issues such as PTSD and trauma. Others are women who have suffered from genital mutilation. [...] At the housing development (privately owned) had had problems with violence.</p>	Continued on the next page....

Characteristics for Evaluation	Description of characteristics & notes from sources	Comments
Emotional effort (continued)	Many have drug problems, as well as housing, drug addiction, food security problems, rehabilitation from incarceration. Many are HIV positive. They deal with single mothers, children with autism, on the run from CAS. [Emer Kelly-Rombough Audio Tape]	
Working conditions	In addition to working in the CHC, the NP pays home visits, deals with populations that may consist of street people, are exposed to people with many health issues – health-related or social, cultural and economic. As a result there is exposure to communicable diseases, the risks inherent in dealing with people who may be unstable, infestation and other disagreeable conditions. Similarly, when working with clients in their homes and in hospitable, they also face the risk of communicable disease. Extra hours may also be required, which can produce disruption in social and family life.	

ANNEX: CHANGES TO NURSE PRACTITIONERS' SCOPE OF PRACTICE (Bill 179, 2009)<sup>137</sup> and Hospital Privileges Practice Details

## What changes to nursing practice have been proclaimed?

To date, the changes to nursing practice that have been proclaimed relate specifically to Nurse Practitioner (NP) practice. The table below summarizes the new authorizations approved for NPs, the effective date of the change to practice, and the legislation that was amended to support the change.

<b>New authorizations for NPs</b>	<b>Effective Date of Change</b>	<b>Amended Statute or Regulation</b>
Admit persons to hospitals.	July 1, 2012	Regulation 965 under the <i>Public Hospitals Act</i>
Provide client care orders to be implemented by RNs and RPNs for procedures related to diagnosing and treating clients (e.g., venipuncture to obtain blood samples).	October 1, 2011	<i>Nursing Act, 1991</i>
Broadly prescribe drugs appropriate for client care (i.e., NPs no longer have to prescribe from a list of drugs).	October 1, 2011	<i>Nursing Act, 1991</i> and Regulation 275/94
Dispense, compound, and sell drugs in keeping with the regulation.	October 1, 2011	<i>Nursing Act, 1991</i> and Regulation 275/94
Set or cast a fracture of a bone or dislocation of a joint.	October 1, 2011	<i>Nursing Act, 1991</i>
Order any laboratory test appropriate for client care (i.e., NPs no longer have to order from a list of laboratory tests).	July 1, 2011	Regulation 682 under the <i>Laboratory and Specimen Collection Centre Licensing Act</i>
Order diagnostics and treatments for hospital in-patients and discharge patients from hospital. (This does not change the diagnostic test list, which is still in effect for all NPs in all practice settings.)	July 1, 2011	Regulation 965 under the <i>Public Hospitals Act</i>
Order services for which patients are	July 1, 2011	Regulation 552

<sup>137</sup> College of Nurses of Ontario, FAQ on Bill 179 – <http://www.cno.org/what-is-cno/regulation-and-legislation/legislation-governing-nursing/faq-bill-179/>

insured. (These amendments support the previously noted changes related to ordering laboratory tests and treating hospital patients).		under the <i>Health Insurance Act</i>
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PRACTICE DETAILS IN RE HOSPITAL CARE WITH NURSE PRACTITIONERS (as of 2012)<sup>138</sup>

NP accountabilities for treatment and discharge vary in different settings. Depending on both the complexity of coordinating the discharge or transition as well as access to members of the inter-professional teams (that may or may not include discharge planners), treatment and discharge may include:

- Comprehensive care planning, treatment and assessment of readiness for discharge,
- Plan to transfer care to the *right provider, at the right time, to the right place*,
- Development and communication of the discharge plan with patients, families and the inter-professional team,
- Communication of transfer of accountability to another care setting / care provider or coordination of care services in the community,
- Writing the discharge order and completing the prescriptions and appropriate chart documentation (e.g., health record summary), and
- Medication reconciliation.

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<sup>138</sup>For source document, see footnote 15 above

**DURBER REPORT: Examining the Issue of Equitable Compensation for  
Ontario's Midwives**

## **ANNEX 6 – EVALUATION RATINGS BY FACTOR OF MIDWIFE, CHC PHYSICIAN AND CHC NURSE PRACTITIONER**

Summary of ratings	Page one
<b>LIST OF FACTORS</b>	<b>Page number</b>
Knowledge Skills	2
Problem Solving Skills	4
Interpersonal Skills	6
Physical Skills	9
Leadership Responsibilities	11
Responsibility of Resources	13
Responsibility for Outcomes	14
Responsibility for People Services	16
Emotional Demands	17
Sensory Demands	18
Physical Demands	19
Working Conditions	20

## SUMMARY TABLE OF RATINGS

<i>Factor</i>	<i>Midwife</i>	<i>[LEVEL]</i>	<i>Nurse Practitioner</i>	<i>[LEVEL]</i>	<i>CHC Physician</i>	<i>[LEVEL]</i>
Knowledge	100	7	100	6	142	10
Problem Solv Skills	70	5	56	4	84	6
Interpers. Skills	84	5	84	5	84	5
Physical Skills	70	5	56	4	70	5
Leadership Resp	45	3	30	2	60	4
Resource Resp	45	3	45	3	45	3
Outcomes Resp	60	4	60	4	75	5
Service Resp	75	5	75	5	90	6
Emotional Demands	25	4	19	3	19	3
Sensory Demands	25	4	19	3	19	3
Physical Demands	19	3	19	3	19	3
Working Conditions	25	3B	13	2A	19	2B
<b>TOTAL POINTS</b>	<b>643</b>		<b>576</b>		<b>726</b>	
<b>%</b>	<b>89%</b>		<b>79%</b>		<b>100%</b>	

## Rating three Primary Health Care Jobs – Midwives' Report

### FACTOR: KNOWLEDGE SKILLS

<i>Job</i>	<i>L e v e l</i>	<i>P o i n t s</i>	<i>Explanation</i>
1. Midwife [MW]	7	100	<p><i>Breadth of knowledge:</i> Theory includes anatomy, midwifery practices, infection and infection control, maternity and birth control, abnormalities during maternity, socio-cultural and economic issues, assessment methods and testing, pharmacology, nutrition, physiology, application of technology, legal framework within which the midwife works, business practice, risk assessment and insurance, inter-professional relationships and roles, institutional organisation and practices, ethics, informed choice decision-making, conflict resolution and motivation and communication</p> <p><i>Depth of knowledge:</i> Extensive experience is required in the phases of maternity and its evolution – normal and abnormal for mother and newborn, screening and examining the mother's and baby's body, labour and delivery as well as emergency procedures; counselling and facilitating informed choice decisions by the client especially in the antenatal period; planning for home or hospital (or out-of-hospital) delivery; methods for assessing the state of both mother and fetus; alternatives for dealing with intra-partum complications and emergency skills; counselling and monitoring at various stages including post-partum</p> <p><i>Level of thinking:</i> The work is complex in terms of the factors at play in pregnancy, including the social determinants of health, the complexities of individual pregnancy and state of health, the interplay between fetus and mother and the need to monitor for changes that might alter plans for birth and involve early recognition of emergency situations. The autonomy of the midwife means that at critical points she may have her own and her practice partner's knowledge and experience to deal with the unpredictable. Consultation with physicians and specialists is available for particular complexities, and referral is a possibility.</p> <p><i>Education:</i> A bachelor's level (Bachelor of Science in Midwifery) is the minimum, with one year of CMO required mentorship following registration with an experienced midwife, with a number of years of experience in midwifery or nursing, particularly to plan and to deal confidently with the range of factors and with unpredictability.</p>
2. CHC Nurse Practitioner [NP]	7	100	<p><i>Breadth of knowledge:</i> Much of the subject-matter theory is comparable to that required of the midwife – given that both are health sciences professionals. The NP may also need business-related knowledge for NP-led practice, but that is not required for a Community Health Centre [CHC] role. Comparable knowledge is also required of roles, inter-professional relationships, ethics and conflict resolution. However, the NP would not require the same knowledge of organisational practices given no apparent requirement for hospital practices. The NP encounters a broad range of cultural and socio-economic issues and differences partly as the result life-span nature of the practice and the probable population mix (since the CHC usually is established to give less privileged</p>

			<p>populations access to primary health care).</p> <p><i>Level of thinking:</i> Planning is involved in the work, for example a plan of care, monitoring of chronic care conditions, health promotion, recognizing patterns of socio-economic and cultural conditions affecting health, policy issues that intersect with them and measures to alleviate health disadvantage. There is, however, more professional support available to the NP in both the CHC and the community.</p>
			<i>Continued on the next page</i>
<i>Job</i>	<i>L e v e l</i>	<i>P o i n t s</i>	<i>Explanation</i>
CHC Nurse Practitioner [NP] (continued)			<p><i>Education:</i> The work requires training and certification as a registered nurse and a further two years of graduate training for the “Extended Class” certification as a CHC Nurse Practitioner.</p> <p>Overall, the knowledge appears to meet the definition of “level 7” of the plan, in terms of “advanced knowledge at a professional level” with the need for analysis and assessment. While specialisation is clear, the extent to which the work required the breadth of thinking evident in level eight is not clear. The best fit appears to be approximately equal to the midwife, with the practical complexities and autonomous experience of the latter balancing the greater education required of the CHC Nurse Practitioner</p>
3. Family physician , CHC	10	142	<p><i>Breadth of knowledge:</i> The physician deals with a range of illness and chronic and other conditions that have the same range as the NP, given the primary health care for the same population. Knowledge is deeper in the same subjects that are studied by the NP. Assessing the condition of clients goes beyond physical and mental health to social determinants of health, though without the same depth of knowledge of health promotion as evident in the NP. Some physicians have the same depth of knowledge of pregnancy and birth as the midwife; some may also have studied obstetrics and have a deeper technical knowledge. An understanding of business would be less required than for the midwife, given her autonomous practice (in which she may be a partner with other midwives – the general pattern).</p> <p><i>Level of thinking:</i> The physician is trained to screen for issues that he can detect despite clients inability or unwillingness to describe clearly. As one interviewee said, illnesses are not presented according to “the book”. Experience enables the physician to see patterns and variations and to deal with difficult issues up to the level of specialization that other practitioners may have to treat. While the other practitioners also understand health policy, the physician is more formally required to think in those terms within the clinic.</p> <p><i>Education:</i> The family physician is recognised as a specialty within medicine. Education includes a baccalaureate-level preparation for medical school, a level in medicine and two years of post-graduate study including residency.</p> <p>The required knowledge is greater in some respects than the other two health practitioners, who nonetheless require greater experience in health promotion. The range of exposures to illness and disease is both wide and authoritative. The work requires an academically trained specialist in a broad field of family</p>

			medicine with often special populations. A knowledge of other specialisations is required to make referrals and to interpret other physicians' diagnoses to the client and family. Level 10 is the best fit.
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## Rating three Primary Health Care Jobs – Midwives' Report

### FACTOR: PROBLEM SOLVING SKILLS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	5	70	<p><i>Basis for analysis – complexity &amp; context:</i> Information is not always clear without intense observation, testing or screening, on-going clinical assessment and questioning. Factors in the woman's condition may not be evident at first without observation and enquiry over a period of time. Risks may be difficult to estimate, and their solution may be more complex to match with health care skills. The complexity of practice in hospital can be that the autonomy and skills of the MW may not be recognized, making their exercise in the client's interests more difficult. The philosophy of midwifery (e.g., continuity of care and client decision-making) add complexity to working out solutions in conjunction with the client especially given the need to plan ahead with factors that often require adjustments. The MW also must deal with practice members on practice issues and complex cases and participate in audits of the experience with practice. Note that the midwife is enabled by legislation to provide a full range of diagnoses within her scope of practice and well as to decide with the client on prescriptions of a widening range of the pharmacopeia.</p> <p><i>Creative or analytical skills needed for solutions:</i> Variations between clients requires adaptation of methods such as explanation, presenting alternatives and implications. The unexpected (&amp; emergent) requires skills in recognizing when particular steps need to be taken at various stages of pregnancy, especially during the intra-partum phase. Understanding whether the limits of experience and practical ability have been reached may be tested in emergency situations, where the alternatives of transfer need to be weighed against factors such as urgency and seriousness of symptoms. Creative skills are required in encouraging women to ensure their health and readiness for birth, to deal with the birth experience in the most constructive way, to decide on needs for pharmacopeia, and to provide counsel during all phases of pregnancy. In addition, analytical skills are required for proper diagnosis of conditions and illness and an understanding of implications for the health of the woman and fetus and later the newborn, &amp; early parenting.</p> <p><i>Extent to which skills are used autonomously &amp; authoritatively:</i> While the minority of births take place at home, the midwife is ultimately accountable for applying skills to ensure the welfare of mother and child in such a setting. Similarly, in the hospital setting, the midwife has the scope of practice to be the primary health care worker. During the pregnancy and for six weeks after the birth, the MW has the responsibility for the plan of care and its adjustment as the professional working with the woman and baby. Skill is required to meet needs and decisions &amp; changing circumstances.</p> <p><i>Rating:</i> Diagnostic skills are involved, and while there may be recurring patterns in conditions and needs of the client, the complexity of factors, constant monitoring and unpredictable changes in some client conditions or situations require adjustment of plans. The work is more demanding than level 4, but requires fewer creative skills than level 6. In view of individual situations &amp;</p>

			creativity needed, level 5 is best fit.
2. CHC Nurse Practitioner [NP]	(see next page)		<i>Basis for analysis – complexity &amp; context:</i> The population covered by a CHC presents a variety of health needs, usually complicated by conditions rooted in the variety of socio-economic and cultural circumstances, frequently complicated by barriers to good health such as poverty, cultural and language barriers. The NP has the skills to deal with the health issues, but must modify approaches to clients in light of their varying individual and family situations. ... Continued on the next page
<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
CHC Nurse Practitioner [NP] (Continued)	4	56	<p><i>Creative or analytical skills needed for solutions:</i> The NP uses skills in the setting of the programs of the CHC and can mobilise program resources such as social workers, dietitians, the physician and others in initiatives to deal with both acute and chronic health matters and find solutions to challenges to health. Monitoring of the health of individuals and families, and sometimes of the social groupings to which they belong, is necessary, especially for chronic conditions (which affect a higher proportion on average than in the Canadian population as the result of the usual higher incidence of poverty). Adjustments are needed for plans of individual care. Health promotional efforts afford a range of creativity. The NP also participates in reviewing CHC practices and policy.</p> <p><i>Extent to which skills are used autonomously &amp; authoritatively:</i> The NP as a professional has a scope of practice that includes assessment, treatment, screening, use of diagnostic procedures and tests as well as determining the use of a range of pharmacopeia. It is also necessary to work as part of a health care team within the CHC. Collaboration is an aid to ensuring comprehensive services rather than a limitation on the NP's work. Seeking resources within the community to partner in improving health is an example of creativity.</p> <p><i>Rating:</i> The work is conducted with somewhat less autonomy than that of the midwife. The patterns of issues appear to be approximately as recurring as those encountered by the midwife. Nonetheless, the NP has a range of tools for dealing creatively and with team members with the issues. Overall, the skills are about as varied and demanding as those exercised by the midwife.</p>
3. Family physician, CHC	6	84	<p><i>Basis for analysis – complexity &amp; context:</i> There is a wide range of health conditions and issues that are presented in the family medical practice, with a range of skills for uncovering the nature of those conditions and issues. It appears that the physician has less time than either of the other two jobs to delve in the social determinants of the health of clients, but has the ability to deal decisively with a wide range of acute conditions and to work with the NP on continuing chronic conditions.</p> <p><i>Creative or analytical skills needed for solutions:</i> In addition, the physician uses skills and knowledge of medicine to assess where CHC practices and policies, as well as health strategies, are meeting client needs. Deep analytical skills are required to diagnose health issues and determine treatments. Some clients present a number of health problems simultaneously, which adds to the challenge of deciding courses of treatment. Other team members may need to take on roles, for example in relation to chronic conditions and socio-economic</p>



			<p>or mental and emotional challenges facing clients. Other specialist, technical and community resources may be called upon to deal with the challenges.</p> <p><i>Extent to which skills are used autonomously &amp; authoritatively:</i> The physician exercises autonomous skills with respect to medical duties and to assessments of policy and practice within the CHC – the latter being subject to collaborative effort and discussion within the health care team. Policy skills are required in relation to clinical practice and community programs.</p> <p><i>Rating:</i> The physician's skills cover a wider range of conditions and issues with decisive problem solving than either of the other two health care professionals. The skills level appears to be consistent with skills required for research into courses of treatment and thought about medical practice generally within the CHC than the other two jobs. Input into CHC clinical and program strategy is implied, warranting level 6.</p>
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### Rating three Primary Health Care Jobs – Midwives' Report

#### FACTOR: INTERPERSONAL SKILLS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	5	84	<p><i>Nature and intent of the interpersonal skills required:</i> Skills are directed to establishing a trusting client-professional relationship within which the client can understand current and likely future circumstances in order to make decisions and help plan a pregnancy, antepartum, intrapartum and post-partum care, and the midwife can provide the best advice in light of clarity on medical and technical matters on the one hand and the physical, mental cultural and other considerations on the side of the client such as her values and preferences. The skills include those of understanding of an empathy with the state of being of the client, communicating observations about the pregnancy and its evolution, developments into labour, providing guidance and encouragement for the most successful delivery possible as defined by the client and for early parenting afterward.</p> <p><i>Requirements for communication out of the ordinary:</i> Each client has to be met where she is, and communication skills are needed to build a picture of the many factors that impinge on health during pregnancy, that is, a mutual openness needs to be nurtured as part of a long-term professional relationship. The intimacy of the personal situations of the client, and the nature of the insights of the midwife, pose particular challenges for communication, requiring skills to ensure continuing informed decision making by the client and autonomy for the midwife. Communication in both the home and hospital may pose special challenges, that is, in the latter the midwife's exercise of her skills may have to be communicated with greater sensitivity than in the home. There are still challenges in establishing that autonomous role in the institutional setting, where the decisions of the client also may need to be communicated authoritatively. In the event of referrals (e.g., to an obstetrician), the midwife remains in a supportive role, requiring particularly sensitive communications skills, including advocating for the client and her</p>

			<p>wishes.</p> <p><i>Requirements for functioning in a multi-cultural situation:</i> There may be a mix of cultures and languages among clients, and certainly of varying expectations on the part of clients and their families with respect to midwifery care. These intersect with the pregnancy.</p> <p><i>Rating:</i> Strong skills are required for establishing empathy and a trusting relationship over a long term on intimate and personal matters. Special challenges are involved in ensuring that the client can make informed decision: bearing in mind the many factors at play in pregnancy, delivery and early parenting, with wellness and health in view during that time. Special challenges are involved in protecting the autonomy of both client and midwife in the hospital birth situation. While outcomes are critical as required for level 6, most of the requirements are those found at level 5 of the job evaluation plan</p>
2. CHC Nurse Practitioner [NP]	(see next page)		<p><i>Nature and intent of the interpersonal skills required:</i> Interpersonal skills are required in the assessment of the health of clients, both in terms of episodic or acute issues and chronic health conditions. As many clients may be disadvantaged, empathy for and empowerment of clients are required to establish the trust necessary to enable them to take an energetic and motivated role in their health. ...Continued on the next page</p>
<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
CHC Nurse Practitioner [NP]	5	84	<p>Establishing plans of care that are appropriate for the circumstances of the client takes skill in explanation and motivation, particularly in relation to chronic conditions likely to be suffered by many clients.</p> <p>Health promotional efforts require collaboration with a variety of individuals and groups – both within and outside the CHC. Insight is required to relate health and other factors and other roles.</p> <p><i>Requirements for communication out of the ordinary:</i> There may be barriers to communications arising from the socio-economic and cultural situations of clients, for example, poverty and disadvantage, language, culture and issues of integration into society and access to health and social services. These take particular skills of listening and insight to establish a professional relationship conducive to improving the health of clients in their social circumstances. In the instance of chronic conditions (for example), continuing relationships are required, and interpersonal skills and empathy are needed. Dealing with mental and physical health issues that may be interwoven requires interpersonal skills. Working as part of a health team is complex, given varying scopes of practices and disciplines that enable wider perspectives but demand a collaborative approach. [Note that many of these skills are also found in the role of the midwife.]</p> <p><i>Requirements for functioning in a multi-cultural situation:</i> This is noted above, and is consistent with the mission of CHCs of recognising that improving primary health care requires bearing in mind the social determinants of health.</p>

			<p><i>Rating:</i> While the issues may not be so critical as those deal with by the midwife, the skills are those of counselling and bringing clients to participate in improving their own health and that of their family or grouping. By and large, level 5 is the best fit given the openness of this work to clients and the community and the persuasiveness involved in both promotional work and collaborative relationships within the CHC.</p>
<p>3. Family physician , CHC (continued on next page)</p>	5	84	<p><i>Nature and intent of the interpersonal skills required:</i> Skills are required in enabling clients to be clear and open about their physical and mental health issues, to understand and agree to courses of treatment, and to recognise the implications for the ways in which they lead their lives in some instances (for example in relation to chronic conditions). [Note: With the exception of the chronic care dimension of health, many of these skills are found in midwifery work.] Continuity of care requires skills to maintain and build relationships. There is less emphasis in this work on health promotion and the social determinants of health, and so less complexity in the interpersonal skills as a result. Nonetheless, interpersonal skills are required in providing advice, taking referrals from other CHC staff and in referring continuing and longer-term care activities to colleagues.</p> <p><i>Requirements for communication out of the ordinary:</i> As with the NP and the midwife, clients may present under conditions of disadvantage, necessitating skills to ensure a relationship that empowers and validates the client.</p> <p><i>Requirements for functioning in a multi-cultural situation:</i> There are likely barriers of social disadvantage, cultural and language differences and the complications for health that they pose, but which may require special interpersonal skills in making enquiries that will clarify mental and physical health issues and enable decisions.</p>
Job	Level	Points	Explanation
<p>Family physician , CHC (continued)</p>			<p><i>Rating:</i> The authoritative nature of the physician's work, and the time generally available in the practice for any one encounter with a client may impede the opportunities for complex and empathetic communication, which is nonetheless required. The physician tends not to be involved in health promotion to the same extent as the NP. Situations, however, are as stressful for the client as with the NP.</p> <p>Overall, the skill mix is approximately equal to the other two primary health care workers. Major issues faced by clients can require significant decisions on their part and by health care practitioners, for example.</p>

## Rating three Primary Health Care Jobs – Midwives' Report

### FACTOR: PHYSICAL SKILLS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	5	70	<p><i>Nature of the skill required:</i> The work involves many physical skills for examining the physical health of the client, exploring the specific health of the vagina and internal parts of the body involved in pregnancy and birth; assessing for any abnormalities of both these parts of anatomy and fetus and newborn; performing precise physical manipulations and procedures during pregnancy to examine health, to limit complications, to aid in the birth of the baby, to prevent damage to the perineal area, perform episiotomies and repair tears by suturing, to deal with a variety of emergency situations such as hemorrhage and various abnormal positioning of the fetus and presentation of the baby (e.g., with cord or feet or shoulder coming first). Skill is required to ensure safety and avoid harm in such procedures and testing.</p> <p><i>Training or experience required to acquire the skill:</i> An important part of training, both at the university level and on-going education, is devoted to gaining the dexterity and expertise required for such procedures which are essential to the assessment and ongoing care of the client before, during and after giving birth. In addition, there is a requirement to use varying equipment during assessments and labour, a requirement which requires both expertise and training.</p> <p><i>Requirement for speed and/or precision:</i> Precision is the key to these skills, as pain or harm can ensue without it. There is some requirement for sureness of physical actions during labour and delivery, both in normal circumstances and in case of emergencies – and some speed in both.</p> <p><i>Need for adaptation/variation in use of skills:</i> The variations in circumstances and conditions, for example during emergencies or abnormal situations, require adaptation to the client's needs. Some situations push the boundaries of training and expertise (emergencies for instance). (Note that midwives are trained in emergency skills and must re-train every 2 years in these skills, a CMO requirement.)</p> <p><i>Rating:</i> The highest level of competency appears to be required, given the variety of physical coordination, precision, sureness and sometimes speed as well as ongoing education to update skills and meet urgent circumstances.</p>
2. CHC Nurse Practitioner [NP]	(see next page)		<p><i>Nature of the skill required:</i> The work requires the application of physical tests and procedures to clients, in order to assess the physical state of the person, for example to examine the individual in a dextrous fashion but with sensitivity and respect to limit pain. Coordination is required at the same time observations are made. Testing equipment is used. Work includes repairing fractures and breaks in bones.</p>

			<p><i>Training or experience required to acquire the skill:</i> The use of procedures requires training during university and afterward to be certified in the profession.</p> <p><i>Requirement for speed and/or precision:</i> Precision rather than speed is generally required.</p> <p><i>Continued on the next page</i></p>
<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
CHC Nurse Practitioner [NP] (Continued)	4	56	<p><i>Need for adaptation/variation in use of skills:</i> It is not clear that adaptation is required to a significant extent, given the generally recurring procedures that are used.</p> <p><i>Rating:</i> The procedures used are less numerous and less physical in nature in comparison with the midwife. The main requirement is for training and expertise in that range of procedures. Overall, it appears that there is a significant difference between the two jobs, particularly given the potential for harm in the midwife's work. Level 4 appears to be the best fit given the formal training required.</p>
3. Family physician , CHC	5	70	<p><i>Nature of the skill required:</i> The range of procedures used by the physician is approximately similar (though a little broader) than the NP; although some procedures are likely delegated to the NP, the physician nonetheless must possess that range of physical skills. We note, however, that the physician for one of the CHCs "manages births", which (conservatively since the other job description does not call for such a responsibility<sup>139</sup>) would make the physical skills closer to those of the midwife for the delivery itself.</p> <p><i>Training or experience required to acquire the skill:</i> Formal training and updating is required, as with the CHC Nurse Practitioner and midwife.</p> <p><i>Requirement for speed and/or precision:</i> Precision is required rather than speed.</p> <p><i>Need for adaptation/variation in use of skills:</i> Level 5 would give the benefit of the doubt to the job by making it the equivalent of the midwife on the basis of births.</p>

<sup>139</sup> We also note that the rate at which family physicians actually attend births is much lower than the percentage of those who are the primary care providers for pregnant women. A higher percentage of midwives who are the primary care providers also attend the births.

### Rating three Primary Health Care Jobs – Midwives' Report

#### FACTOR: RESPONSIBILITY FOR PEOPLE LEADERSHIP

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	3	45	<p><i>Nature of leadership of others:</i> Most midwives have preceptor duties, for students acquiring their practical experience during the baccalaureate training. This work requires establishing a relationship with the student, mentoring her, evaluating her performance and ensuring that she reaches the proficiency required. In addition, there are human resources issues involved in the midwifery practice, i.e., in respect of any administration and support staff or contract services required to run the practice. The MW also participates as an autonomous professional in deciding on issues of coordination, including managing hospital privilege issues, and may delegate some of those duties to one person who may have the role of head midwife at a hospital where members of the practice (and perhaps others) have privileges. Moreover, coordination of practice issues is shared between members of the practice (as partners). These include ensuring quality assurance and performing peer assessments (set out in regulation).</p> <p>Most midwives also have mentoring duties, for new graduates acquiring their practical experience in their first year of registration with the College of Midwives. This work requires establishing a relationship with the new registrant, mentoring and evaluating her performance and ensuring that she reaches the proficiency to succeed as a general registrant.</p> <p><i>Other comments:</i> Note that midwives are generally in group practices, with the average size of about six MW in a practice. The greater the number of MW, evidently the more complex the leadership issues. This rating is based on that lower average, rather than the maximum. This rating also does not include the role of head midwife at a hospital, but does consider the management of hospital privileges since the MW is responsible for that role given her autonomy and delegation of responsibilities.</p> <p><i>Rating:</i> The most time-consuming aspect of leadership appears to be the preceptorship and mentoring, meeting obligations for ensuring effective learning opportunities for a student and registrant during any one year. However, the most demanding aspect of leadership appears to be the partnership responsibilities of the practice as well as the quality assurance role with respect to peers. These latter features appear to warrant level 3 in the job evaluation plan.</p>
2. CHC Nurse Practitioner [NP]	2	30	<p><i>Nature of leadership of others:</i> Mentoring of students is part of the work, as is quality assurance, though that is generally directed at self-learning and assessment rather than peer-assessment (as within a midwifery practice).</p> <p><i>Other comments:</i> Note that the NP does not have responsibility for a practice, and the MW does. There are contributions to human resource work within the CHC, however, such as hiring and evaluations of primary health</p>

			<p>care staff.</p> <p><i>Rating:</i> This work appears to have more occasional leadership roles than the MW. Level 2 appears to be reasonable.</p>
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<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
3. Family physician , CHC	4	60	<p><i>Nature of leadership of others:</i> The work involves more regular supervision of medical residents (in the case of one job description), mentoring of students, with more influence in CHC processes and systems, including those with human resources implications and coordination of home visits and examination of new pharmaceuticals. Review of performance of staff from a medical point of view (that is, quality assurance) can be involved. There is an authoritative role in terms of the medical and clinical aspect of CHC issues.</p> <p><i>Other comments:</i> The range of duties may differ across CHCs, for example, where there is a medical director to whom the physician reports. In those circumstances, the physician would have “influence” rather than direct responsibility.</p> <p><i>Rating:</i> The leadership responsibilities appear to be more than those of the NP and of the MW. They would, however, be equal to midwives exercising a coordinating role, for example in policy development or human resources issues within a midwifery practice. <sup>140</sup>Level 4 would be the best fit.</p>

<sup>140</sup> Note that midwifery human resources responsibilities for the midwifery practice are shared with other professionals. Where there are more pronounced leadership roles being exercised within the practice, a higher rating would be warranted, equal to that of the CHC family physician, who has analogous clinical leadership within the CHC.



## Rating three Primary Health Care Jobs – Midwives' Report

### FACTOR: RESPONSIBILITY FOR RESOURCES

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	3	45	<p><i>Physical and informational resources involved &amp; responsibilities:</i> The midwife, as practice partner, is responsible for the physical infrastructure of the practice as well as for her own equipment. Information resources include her own practice files as well as input to the BORN system and the resources required to do so. There may also be contractual resources involved.</p> <p><i>Financial resources involved &amp; responsibilities:</i> For the practice, there is a budget for support and infrastructure, including rent for which as a practice partner the MW is jointly responsible. In addition, she is responsible for her own overhead costs (such as travel).</p> <p>The practice partners are legally responsible for fulfilling the requirements of the Funding Agreement that they have with a transfer payment agency. There is also responsibility for handling a volume of information that is confidential in nature.</p> <p><i>Rating:</i> The partnership responsibilities fit with level 3 in the job evaluation standard, which refers to the effectiveness of the practice as a whole. Moreover, there are significant information resources involved, which as for all three professionals warrants level 3.</p>
2. CHC Nurse Practitioner [NP]	3	45	<p><i>Physical and informational resources involved &amp; responsibilities:</i> The NP is required to collect statistical information within the CHC, to keep client files according to standards, oversees the collection of library and promotional materials and their use and distribution.</p> <p><i>Financial resources involved &amp; responsibilities:</i> The NP ensures that resources are available for nursing procedures to be undertaken as required by Practice Standards. Note that the NP has responsibility for pharmaceuticals being prescribed, formulated and sold. She also has responsibility for volumes of confidential information.</p> <p><i>Rating:</i> While the administrative responsibilities of the NP are less than those of the midwife (either as partner or professional in her practice), there are significant responsibilities for personal information as well as for pharmaceuticals. The best fit for this job is level 3.</p>
3. Family physician , CHC	3	45	<p><i>Physical and informational resources involved &amp; responsibilities:</i> These responsibilities appear to parallel those of the NP, for example, participating in the preparation of informational materials, reviewing summary statistics, and providing advice on physical and information resources and systems.</p> <p><i>Financial resources involved &amp; responsibilities:</i> These responsibilities parallel those of the NP and involve more confidential information, given the greater</p>

			<p>volume likely of clients.</p> <p><i>Rating:</i> Approximately level 3, given CHC-wide nature of the responsibilities</p>
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### Rating three Primary Health Care Jobs – Midwives’ Report

#### FACTOR: RESPONSIBILITY FOR OUTCOMES

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	6	90	<p><i>Complexity of client situations, needs:</i> All health matters relating to pregnancy of the client and to post-partum condition of mother and child; all factors bearing on physical and mental health, including nutrition, condition of the person and socio-economic and mental factors; possible risks and outcomes as well as the unpredictable, narrowed so far as assessment and history can do so; nature of any complications; specialist advice on matters beyond scope of practice; policies and practices of the hospital should birth take place there; coordination with other health care providers; management of continuing care and changing conditions of mother and fetus.</p> <p><i>Extent of assessment required:</i> There is comprehensive initiative assessment and ongoing monitoring, reassessment and adjustment of the plan of care; taking preventive measures and measures to treat illness or conditions that arise, with close observation of mother and fetus (later, newborn) with corrective measures possible, as well as assessment of complications and emergent situations, especially during intra-partum period.</p> <p><i>Impacts of the service offered:</i> The well-being of mother and child are directly affected as is the effectiveness of the midwifery service to each client; the ability of the woman to make her own decisions in the pregnancy and in self-care are affected.</p> <p><i>Rating:</i> Level 6 appears appropriate, given the changing situation of clients, their complexity and the sensitivity required to ensure well-being and the directness of the impact on the birth experience.</p>
2. CHC Nurse Practitioner [NP]	5	75	<p><i>Complexity of client situations, needs:</i> Direct and autonomous services include health needs of clients in respect of episodic illness, chronic conditions and general state of health, including interventions for particular issues such as immunisation, broken bones and minor injuries. Promoting health is a complex matter requiring understanding (from the social determinants of health perspective) of the client’s situation. Given the variety of the situations, services need to be tailored to be consistent with peoples’ needs. Addressing chronic conditions in particular is dependent on these issues.</p> <p><i>Extent of assessment required:</i> A comprehensive assessment of the client’s mental and physical condition can be required as the basis for an on-going</p>

			<p>relationship. Testing and screening as well as observation of individuals in their circumstances are required to keep the assessment profile up to date and adjusted with change.</p> <p><i>Impacts of the service offered:</i> The intensity of the primary care relationship appears to be less than that of the midwife, particularly in respect of the opportunities for significant intervention in the well-being of the client (in the MW case, also the well-being of child).</p> <p><i>Rating:</i> While the CHC Nurse Practitioner is autonomous with respect to primary health care, her work appears to have less impact on the client. The best fit appears to be level 5 in the job evaluation plan.</p>
<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
3. Family physician , CHC	6	90	<p><i>Complexity of client situations &amp; needs:</i> The physician deals with the widest scope of health issues of clients, and deals with acute and chronic mental and physical health matters. As such, the complexity of issues is likely broader than that of the NP, though not so intense or deep in terms of the patient-client relationship as that of the midwife. Moreover, while consideration of the social determinants of health should be borne in mind by the physician, they come to bear more specifically in the practice of the NP.</p> <p><i>Extent of assessment required:</i> A broad range of tests and assessments are required to ensure well-being and to address issues. Some may require referral to other primary care providers and to specialists or community resources – decisions made by the physician with respect to his clients.</p> <p><i>Impacts of the service offered:</i> Given the breadth of services and assessments made, the impacts are seen to be equal to those of the midwife.</p> <p><i>Rating:</i> The responsibility for services appear to be approximately equal to that of the midwife, but less than level 7, where the nature of services in the CHC would more likely be found.</p>

### Rating three Primary Health Care Jobs – Midwives’ Report

#### FACTOR: RESPONSIBILITY FOR SERVICES TO PEOPLE

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	4	60	<p><i>Extent of autonomy in delivering services:</i> The midwife is directly responsible (with a second midwife) for delivering primary health care to approximately 40 women in the course of a year, as well as serving as second midwife for the same number of births. The quality of the services is a function of her expertise, her assessment of the health condition of the client both initially and in the ongoing relationship, the effectiveness of any collaboration or consultation (including referral) with other primary health care providers, the nature of her collaboration in a hospital setting and her enabling the client to make decisions appropriate both to her needs and wishes and her condition.</p> <p><i>Extent to which work contributes to others’ delivery of services:</i> The midwife influences the outcomes of other midwives in the practice through peer review, case consultations and advice and collaboration in the running of the practice itself. Through maintenance of records and consultation, she also enables other professionals to continue care in the instances of referral or transfer and hospital delivery where there is collaboration in the delivery.</p> <p><i>Rating:</i> While the partnership responsibilities meet some of the requirements of level 5, the fact of sharing does mean that “control” is shared. Moreover, given that each of the midwives in the practice is an autonomous practitioner, the nub of responsibilities is the midwife’s own practice, for which she is entirely accountable without supervision. Level #4 is the best fit.</p>
2. CHC Nurse Practitioner [NP]	4	60	<p><i>Extent of autonomy in delivering services:</i> The NP has the same autonomy as the midwife, and provides continuity of care for clients. She also has the responsibility of collaborating with other members of the CHC care team. She also has the longer-term accountability for care for clients with chronic conditions.</p> <p><i>Extent to which work contributes to others’ delivery of services:</i> The NP has the same accountability for continuity of care and therefore for the ability of others to contribute to care of clients as required. She is not so involved with peer review on a regular basis, however.</p> <p><i>Rating:</i> Overall, as an autonomous professional, level #4 is also appropriate.</p>
3. Family physician , CHC	5	75	<p><i>Extent of autonomy in delivering services:</i> The autonomy is seen as being parallel to that of the other two primary care providers and can decide referrals, and has a wider scope of practice. The work is more specialized, but mostly in acute rather than chronic care cases.</p> <p><i>Extent to which work contributes to others’ delivery of services:</i> The physician has similar responsibilities for communication within the CHC, with a</p>

			<p>somewhat greater responsibility for medical advice on the programs of the CHC. There are obligations to consult with other professionals, e.g., to the NP within her scope and to specialists.</p> <p><i>Rating:</i> Given that the physician is recognized as a specialist, level 5 appears appropriate.</p>
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### Rating three Primary Health Care Jobs – Midwives' Report

#### FACTOR: EMOTIONAL DEMANDS

<i>Job</i>	<i>L e v e l</i>	<i>P o i n t s</i>	<i>Explanation</i>
1. Midwife [MW]	4	25	<p><i>Intensity of emotional situations:</i> The intimacy of the relationship during and after pregnancy means that the midwife is required to empathise with the conditions and needs of the client, to share in the difficulties of pregnancy, the pain and sometimes complications of childbirth, and the grief where there is loss. Moreover, the stakes involved in providing the service, and the potential risks involved are also taxing. The intensity and pressures of labour and the tension around any complication and emergency are emotionally draining. Cases of emergency can involve trauma.</p> <p>There are continued stresses in dealing with other professionals, especially in hospital settings (where most births with midwives take place). It is notable that a guide has been prepared to enable better integration of midwives into hospital practice.</p> <p><i>Frequency or duration of emotional efforts:</i> There are continuing issues in the ante-partum period. The need to provide continuity of service and to be on-call for a number of clients expecting to give birth is fatiguing. It is not clear how many weeks of the year such an on-call status may pertain, but it appears to be for more than half of the year, given the partnership with a second midwife. [In solo practices – of which there are a number, clearly the length and duration of being on call is much longer.] The disruption of family and social life can therefore be considerable over protracted periods of time.</p> <p><i>Rating:</i> The highest level of emotional demand is considered appropriate, i.e., level #4</p>
2. CHC Nurse Practitioner [NP]	3	19	<p><i>Intensity of emotional situations:</i> Given the often disadvantaged client population, where poverty and mental health issues are likely to present themselves, and the difficulty of treating the non-physical aspects of health without significant effort and decisions by clients for self-care, the emotional effort can be considerable. Stories from the client population can be searing and difficult emotionally. [Note that these stresses apply in many circumstances to the midwife.]</p> <p><i>Frequency or duration of emotional efforts:</i> Efforts are frequent and lasting.</p> <p><i>Rating:</i> Given that encountering traumatic and crisis situations is probably less frequent than the experience of the midwife, and the risks and unpredictability of client situations are also less likely, the emotional effort appears best placed at level #3, given greater supports available within the CHC for dealing with the emotional effort.</p>
3. Family physician CHC	3	19	<p><i>Intensity of emotional situations:</i> The scope of situations is possibly about the same as the NP, given less exposure to community situations (with less involvement in chronic care and health promotion), but could be deep given</p>

			<p>implication with all aspects of health and exposure to the same stories of life difficulty or trauma from the same population.</p> <p><i>Frequency or duration of emotional efforts:</i> Seen as approximately the same as the CHC Nurse Practitioner.</p> <p><i>Rating:</i> Seen as less than the midwife (where risks appear higher), despite being involved in obstetrical issues, given less opportunity for intensity. About = to the NP</p>
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### Rating three Primary Health Care Jobs – Midwives’ Report

#### FACTOR: SENSORY DEMANDS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	4	25	<p><i>The nature and intensity of use of the senses:</i> The key to professional judgements exercised is the empirical observation of the condition of the client (and fetus or baby), as well as noticing the factors that could account for the condition. Observation takes the form of listening, watching and feeling with the hands or with the aid of medical devices. Smell may also be involved in detecting some conditions. The observations are likely to be intense, and certainly have to be precise for certainty. Sensing the stage at which a pregnancy has achieved is the result of assembling all of the outward, and in some instances internal, signs and sounds of either the pregnancy or labour. Close observation and sometime exploration with hands and fingers may be required to confirm or correct what is occurring.</p> <p><i>Frequency and duration of their use:</i> Sensory perceptions are more or less constant, though most intense during labour, therefore about 80 times a year (as primary and second midwife).</p> <p><i>Rating:</i> The maximum level (#4) appears warranted.</p>
2. CHC Nurse Practitioner [NP]	3	19	<p><i>The nature and intensity of use of the senses:</i> There are parallels between the NP and the midwife, given the need to observe with and without the aid of medical devices. Similar use of senses, albeit without the intensity apparent in midwife work, is required.</p> <p><i>Frequency and duration of their use:</i> The frequency may be lower, given the likely recurring nature of many of the most intense sensory efforts.</p> <p><i>Rating:</i> Appears to warrant a lower level than the midwife, i.e., level #3</p>
3. Family physician , CHC	4	25	<p><i>The nature and intensity of use of the senses:</i> The pressure to observe clients in rapid succession is likely taxing on the senses, with adjustment from one client to another requiring a fresh examination of their condition and issues.</p> <p><i>Frequency and duration of their use:</i> Likely constant</p>

			<i>Rating:</i> Appears to be approximately equal to that of the midwife, even though the intensity is not so deep, but is constant.
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## Rating three Primary Health Care Jobs – Midwives’ Report

### FACTOR: PHYSICAL DEMANDS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	3	19	<p><i>Nature and intensity of physical efforts:</i> The midwife exerts physical effort in taking tests and examining the client, using equipment, and most of all in delivering babies. Heavy effort may be involved in positioning and manipulating physically the client while supporting her during labour and in “catching” the baby and performing initial procedures with both mother and child. Providing clinical care to women in the home environment (such as delivery of the infant and suturing) is generally done without equipment that allows for ergonomic positioning (adjustable height for the bed, lighting). Some procedures during birth can be physically demanding.</p> <p>Additional cleaning duties are required in the out-of-hospital environment, which also involves physical effort.</p> <p>There are further demands for physical effort as the result of sleep interruption and uncertain work schedules; periods of time without food/sleep due to intense periods of active work.</p> <p><i>Frequency and duration of efforts:</i> Efforts are periodic except during labour where they can be of longer duration.</p> <p><i>Rating:</i> Meets the requirements of level 3 of the job evaluation plan. It is not clear that “very heavy” work is required nor that it is “very constraining” as set out in level 4.</p>
2. CHC Nurse Practitioner [NP]	3	19	<p><i>Nature and intensity of physical efforts:</i> Some of the efforts of the NP parallel those of the midwife, such as physical efforts of making physical assessments and performing some tests. These efforts do not appear to be so intense as the midwife, however, but may involve frequent standing and use of hands at various tasks. There is some walking to homes and community meetings.</p> <p><i>Frequency and duration of efforts:</i> The level of effort appears to be continuing.</p> <p><i>Rating:</i> While the efforts may be at level #2, they are continuing, so warrant level #3</p>
3. Family physician , CHC	3	19	<p><i>Nature and intensity of physical efforts:</i> There are also efforts to assess patients, with much standing and use of hands – more or less parallel to the efforts of the NP.</p> <p><i>Frequency and duration of efforts:</i> Continual</p> <p><i>Rating:</i> Equal to that of the NP</p>

## Rating three Primary Health Care Jobs – Midwives' Report

### FACTOR: WORKING CONDITIONS

<i>Job</i>	<i>Level</i>	<i>Points</i>	<i>Explanation</i>
1. Midwife [MW]	3B	25	<p><i>Exposure to disagreeable conditions:</i> There may be disagreeable or difficult conditions in the home (can include insect infestations, communicable diseases, second hand smoke), as well as exposure to blood, urine and feces (including meconium) during labour.</p> <p><i>Potential risks and hazards in the environment:</i> There is some risk to health in being exposed to contagious illness from clients and some risk of injury as the result of physical efforts during delivery. May require a MW to travel by car in adverse weather conditions to attend a birth.</p> <p>There are risks associated with sleep deprivation (physical toll on the body; e.g., increased risk of accidents). There is also risk of injury in attending births in unsafe homes or buildings – both exposure to violence and health hazards such as excessive mould.</p> <p><i>Frequency and duration:</i> Exposures are periodic but can be of long duration, as in labour and delivery.</p> <p><i>Rating:</i> Level 3B appears appropriate, given the fact of on-call work and exposure to disagreeable conditions.</p>
2. CHC Nurse Practitioner [NP]	2A	13	<p><i>Exposure to disagreeable conditions:</i> The NP is exposed to some disagreeable substances (including mucous and bodily fluids) and procedures with clients.</p> <p><i>Potential risks and hazards in the environment:</i> There is some risk to health in being exposed to contagious illness from clients.</p> <p><i>Frequency and duration:</i> The exposures are periodic.</p> <p><i>Rating:</i> Appears to be less than the midwife in terms of intensity and frequency of exposures</p>
3. Family physician , CHC	2B	19	<p><i>Exposure to disagreeable conditions:</i> Appears to be approximately the same as the CHC Nurse Practitioner</p> <p><i>Potential risks and hazards in the environment:</i> Also about the same as the NP</p> <p><i>Frequency and duration:</i> Given the number of interviews with clients, the frequency appears to be greater than that of the NP</p> <p><i>Rating:</i> While level 2 is warranted, exposures are frequent = level 2B</p>

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## ANNEX 7 – EVALUATIONS OF THE MIDWIFE'S WORK – 1994 to 2013

## Evaluations of the Midwife's work – 1994 to 2013

This review takes several points of reference in examining retrospectively the work of the Ontario midwife [MW] since approximately the year of establishing a compensation relativity in 1994 (the beginning at regulation) and the subsequent regulation of the profession within the public health system. These points of reference are:

1. The current evaluation set out in Annex 6 takes the full range of MW work as it has been presented through interviews, review of literature and standards, existing regulations – particularly relating to scope of practice (e.g., Authorized Acts, prescribing and diagnosing authorities), “quality assurance” as the result of the *Excellent Care for All Act 2010* and related peer review regulations – as well as the average size of a midwifery practice (that is, six professionals).
2. In accordance with pay equity practice, I have re-examined the work on a periodic basis the relative value of the work, both with regard to the initial portrait at the point of regulation in 1994 with an update to 1996, when the competencies of the midwife went beyond the “core competencies” of the entry level; and with regard to the comparator job of the Community Health Centres family physician. An approximate period for such a review would be every three or four years, or when there have significant changes in the work. This period of time is consistent with practices suggested for maintaining fairness and equity in compensation by a number of authorities (for example, the Canadian Human Rights Commission).
3. As explained in the Report, these evaluations have been conducted using a gender-neutral comparison system – the Equitable Job Evaluation Factor Plan (at Annex 9). It is a publicly available system produced and tested for broad applicability and gender neutrality by the New Zealand Department of Labour. It consists of twelve factors. (Examples are Knowledge Skills, Problem Solving and Interpersonal skills.) These follow the mandatory pay equity criteria of skill, effort, responsibility and working conditions – aspects of work to be valued.
4. Note that pay equity practice suggests that a job be established for at least six months and performed normally for a year, and not be a recruitment level as referred to in the 1993 Morton Report “Compensation for Midwives”. It references entry-level “core competencies”<sup>141</sup>. For this reason, I take the “base year” for these evaluations over time to be 1996, that is the end of the first review period after entry of midwives into the funded system.
5. In addition, I have worked back from the current documentation about the midwife's work. It is (as indicated by the bibliography) both more fulsome than Morton, and consists largely of materials written since that time (in addition to interview material). Unfortunately, the analysis in the Morton Report was not sufficiently systematic to enable me to construct information for evaluation under all pay equity criteria and to use 1993 as a base year.

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<sup>141</sup> The terms used are “Core competencies: a Foundation for Midwifery Education”.

6. The work of the male comparator, the CHC family physician, was well established within the primary health care system by 1993 and can serve as a continuous point of reference without necessitating re-evaluation on a periodic basis for purposes of this analysis as it is always 100% of the potential points that an MW could receive, that is the *current evaluation* based on a consideration of all of the literature. Put another way, it was not considered necessary to establish whether a *different rating* for the physician was warranted in the 1996-2013 period.
7. As noted elsewhere in the Report, a “conservative” approach to these values was taken, such that if there was a benefit of the doubt to be given to the work of the physician, it was given. Where it was considered reasonable to see some time for a change to settle in to midwifery work, any change to the evaluation was ascribed to the later point in time.
8. The table below, then, presents six time periods at the end of each of which a reassessment of the value of MW work could be performed, periods that also coincide with changes that are noted in the Table. The resulting evaluations would be a series of “steps back” from the full value taken in 2013 shown in Annex 6. These periods would be 1994-1996, 1997-1999, 2000 -2002, 2003-2005, 2006-2008 and 2009 to the present. Two of these periods (more precisely 2003 and 2010) also mark approximately times when public studies were conducted on the profession as part of reviews of MW compensation. At many other points, legislation, regulation and standards demonstrate changes to the work.
9. In consequence, I see a total of *six* changes to *five* evaluation factor ratings during these periods:
  - Knowledge Skills (one change upward) (Factor #1)
  - Problem Solving (two changes upward) (Factor #2)
  - Responsibility for Leadership of People (one change upward) (Factor #5)
  - Responsibility for Organisational Outcomes (one change upward) (Factor #7)
  - Sensory Demands (one changes: one upward) (Factor #10)
10. Any resulting movement in the value of the midwife will appear in the table as a percentage of the current estimated value for the family physician. These begin at a midwife job value worth **81%** of the CHC family physician as of 1994, ending at **91%** of that value as of 2013. Two columns show current points of midwife and family physician. Here is the summary (changes in **bold**):

<b>SUMMARY TABLE</b>		<b>MIDWIFE RATINGS</b>				
<i>Factor</i>	<i>1996</i>	<i>1999</i>	<i>2002</i>	<i>2005</i>	<i>2008</i>	<i>2013</i>
1, Knowledge	86	86	86	86	<b>100</b>	100
2, Problem Solv Skills	42	<b>56</b>	56	56	56	<b>70</b>
3, Interpers. Skills	84	84	84	84	84	84
4, Physical Skills	70	70	70	70	70	70
5, Leadership Resp	30	<b>45</b>	45	45	45	45
6, Resource Resp	45	45	45	45	45	45
7, Outcomes Resp	45	45	45	45	<b>60</b>	60
8, People Service Resp	90	90	90	90	90	90
9, Emotional Demands	25	25	25	25	25	25
10, Sensory Demands	19	19	19	<b>25</b>	25	25
11, Physical Demands	25	25	25	25	25	25
12, Working Conditions	25	25	25	25	25	25
<b>TOTAL POINTS</b>	<b>586</b>	<b>615</b>	<b>615</b>	<b>621</b>	<b>650</b>	<b>664</b>
<b>% of Family Physician (726)</b>	<b>81%</b>	<b>85%</b>	<b>85%</b>	<b>86%</b>	<b>90%</b>	<b>91%</b>

TABLE OF CHANGES TO JOB DEMANDS &amp; WORTH FOR THE MIDWIFE, 1996-2013

1994 to 1996	1997 to 1999	2000 to 2002	2003 to 2005	2006 to 2008	2009 to 2013	M W p o i n t s	Ph ys. p o i n t s
<b>General:</b> Group practices apparent; slotting in of MW to salary steps by their experience (done initially). Hospital by-laws enable hospital privileges. Baccalaureate program (est. 1993) & preceptorship required	Graduates from university require mentoring & more planning, assessment and reporting of graduates' practice of midwifery	More extensive genetic testing offered to clients (2001/2). More recognition of non-clinical issues as well as reporting responsibilities	Changes occur in Billable Course of Care – scope (additional drug), and requirements for provincial accountability requirements. Joint statement with Society of Obstetricians & Gynaecologists (natural childbirth); infant screening + specialised training	2007 Workload Report by AOM confirms increase in non-clinical workload (+ hours) MW enabled to assist at Caesarian section operations (2008); pre-natal screening + options counseling; CPR requirements increase	Changes to Midwifery Act & Regulations: to convey diagnosis ; certification in intubation = increased skills; to be applied; blood sampling significant increase in pharmacopeia; BORNE data demands; DNA testing	Listed under each of the twelve factors listed from page four to page six TOTALS are shown on page seven.	
<b>Particular factor highlights:</b> Confirming	Greater management devolved to individual	More screening (e.g., more specialised	<b>Sensory demand:</b> Further additions to scope, drugs, tests, involvement in cord	<b>Knowledge issues:</b> Survey notes that many non-	<b>Problem solving is wider:</b> Quality		

challenges of problem solving, collaboration with other professions; establishing group practices (all not shown in Morton Report). Hours then: 48.25 per course of care (1993)	midwife within practices & other practice responsibilities (e.g., resources, policy & care issues); greater reporting required	genetic tests) and consequently more screening and counselling	blood banking	clinical requirements cannot be claimed from MOHLTC (i.e., over 70%), laryngeal mask airway use, training in resuscitation. Workload Report shows increase of hours to 55.48/ course of care	assurance legislation confirms peer review (leader-ship + admin.) in 2010-12; diagnosis brings MW closer to doctor know-ledge; role as autonomous primary care provider confirmed.
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1994 to 1996	1997 to 1999	2000 to 2002	2003 to 2005	2006 to 2008	2009 to 2013	Maximum points	Points
<p><b>(1) Knowledge Skills:</b> These may be a step below current rating, given later additions, i.e., <b>86 points</b> (-15 from current rating)</p>	Stays the same	Stays the same	Stays the same	Specialisation in obstetrics recognized (e.g., assisting in C-sections); Increase K.S. to <b>100 pts</b> – DEPTH of know-ledge; also educational program Increase		100 points	142 points
<p><b>(2) Problem Solving Skills:</b> Estimate one degree lower than current rating – inter-professional problems not so clear: i.e., <b>42 pts</b> (-28 points from current rating)</p>	Increased interprofessional collaboration adds to problem-solving. Increase rating to <b>56 points</b> (-14 points from current rating)	Stays at present rating (some increase in problems, + integration into the health system, some greater complexity, but not sufficient to raise by a level)	Stays at same level until major changes from 2009 to 2013		A number of changes – diagnoses, wider subject-matter for counselling (see “general” above) suggest one more level for	70	84



1994 to 1996	1997 to 1999	2000 to 2002	2003 to 2005	2006 to 2008	2009 to 2013	MW points	Phys. points
<b>(5) Leadership Responsibilities</b> : As students emerged in 1993 through the University program, midwives were called upon to provide leadership, + practice mgt issues, suggesting a rating on this factor of <b>30</b> points (- 15 from current rating)	Given the emergence of more practice issues for most MW, should recognize the overall human resource demands of the work – then keep same to present, i.e., <b>45</b> pts (+ 15 points)	Stays the same	Stays the same	Stays the same	Stays the same	<b>45</b>	<b>60</b>
<b>(6) Resource Responsibilities</b> : As administrative and professional practices are est'd, & MW is required by MOHLTC to have obstetrical	There is more integration into the health system, through practice administration, & more individual responsibilities, but not a higher	There are more data and reporting requirements and accountabilities, however, insufficient to rate at the higher level.	Same rating through to the present, given the requirements at level three.	Stays at the same level.	Stays at the same level.	<b>45</b>	<b>45</b>

equipment; personal & confidential information resource responsibilities warrant <b>45 points</b>	level.						
<b>(7) Responsibility for Organisational Outcomes:</b> Growth of midwifery & CMO standards demonstrate responsibilities, rate at <b>45 points</b> (-15 from current rating)	Keep the same until 2006-8 as noted for 1996.	Same to 2006-8	Stays the same	MOR and BORNE reporting & accountability systems and subsequent requirement for annual review for quality assurance (pursuant to the <i>Excellent Care for All Act 2010</i> and its regulations of 2012 demonstrate greater responsibility for outcomes. Increase to <b>60 points</b> . Note that responsibility is confirmed by 2007 replacement by COM of 6 protocols for care at all phases.	<b>60</b>	<b>75</b>	
1994 to 1996	1997 to 1999	2000 to 2002	2003 to 2005	2006 to 2008	2009 to 2013	Ph vs. points	
<b>(8) Responsibility for Services to People:</b> The initial legislation established the autonomy and professional role, in line with the philosophy of midwifery, which have remained constant. Keep at current value of <b>90 pts</b> .							<b>90</b>
<b>(9) Emotional Demands:</b> While this feature of work was not specifically documented in the Morton Report, it is set out well in the literature and the standards for midwifery. Keep at current value of <b>25 pts</b> . (One should note that the unpredictability of childbirth has							<b>25</b>
							<b>19</b>

not altered during this time period.) The stresses of continually being on call are a major feature of work noted in all reports, helping to warrant the maximum points under this factor.							
<b>(10) Sensory Demands:</b> Some testing is noted in Morton, and observation of maternal and fetal condition would have been required. Reasonable to rate at the same level as the Nurse Practitioner, i.e., <b>19 pts</b> (- 6 points from current rating)	Keep the same	Keep the same	Additional tests that the MW had to conduct require more observation and more senses. Others were added later, but this is a reasonable date to recognise a qualitative shift in the work. Add <b>6 pts</b> (= <b>25 points</b> altogether)	Keep the same	Keep the same	<b>25</b>	<b>25</b>
<b>(11) Physical Demands:</b> Overall physical effort involved especially, in birth (up to 80 a year) + other frequent demands & efforts would not alter during the period. Keep at current value of <b>25 points</b> .						<b>25</b>	<b>19</b>
<b>(12) Working Conditions:</b> Note that because of being on-call for extended periods, the maximum rating is warranted, i.e., high risk with hours is frequent = <b>25 points</b>	Keep the same	Keep the same	Keep the same	Keep the same	Keep the same	<b>25</b>	<b>19</b>
						Totals given on next page	

1994 to 1996	1997 to 1999	2000 to 2002	2003 to 2005	2006 to 2008	2009 to 2013	Med. points	Phys. points
CHANGE FROM BASE (1996):	+ 29 POINTS [Two factors]	No change	+ 6 POINTS [One factor]	+29 POINTS [Two factors]	+ 14 POINTS [One factor]		
<b>TOTAL is 586</b> points or <u>81%</u> of family physician total evaluation	<b>615</b> points or <u>85%</u> of family physician	<b>615</b> points	<b>621</b> points or <u>86%</u> of the family physician	<b>650</b> = <u>90%</u> of the family physician	<b>664</b> = <u>91%</u> of the family physician	<b>664</b>	<b>726</b>

**DURBER REPORT: Examining The Issue Of Equitable Compensation For Ontario  
Midwives**

**ANNEX 8 -- BIBLIOGRAPHY**  
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11. "Ontario's Action Plan For Health Care: Better patient care through better value from our health care dollars," [http://www.health.gov.on.ca/en/ms/ecfa/healthy\\_change/docs/rep\\_healthychange.pdf](http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)
12. at [www.cewh-cesf.ca/healthreform](http://www.cewh-cesf.ca/healthreform)
13. "Establishing Midwife-led "Birth Centres in Ontario : Application Guidelines", Ministry of Health of Ontario, July 2012 at [http://www.health.gov.on.ca/en/public/programs/ihf/docs/birthcentres\\_guidelines.pdf](http://www.health.gov.on.ca/en/public/programs/ihf/docs/birthcentres_guidelines.pdf)
14. Auditor General's 2002 Report, "4.11–Ontario Midwifery Program" at [http://www.auditor.on.ca/en/reports\\_en/en02/411en02.pdf](http://www.auditor.on.ca/en/reports_en/en02/411en02.pdf)

15. Auditor General's 2000 Report, "MOHLTC: Ontario Midwifery Program" at [http://www.auditor.on.ca/en/reports\\_en/en00vfm/311en00vfm.pdf](http://www.auditor.on.ca/en/reports_en/en00vfm/311en00vfm.pdf)
16. "Master Contract – Ministry, Transfer Payment Agency and Midwifery Practices"

## **ANNEX 9 – JOB DESCRIPTIONS CHC Nurse Practitioner and CHC Family Physician (2)**



**SOUTH-EAST OTTAWA COMMUNITY HEALTH CENTRE****JOB DESCRIPTION****POSITION TITLE:**

Nurse Practitioner

**PROGRAM:**

Health Services

**REPORTS TO:**

Health Services Manager

**JOB SUMMARY**

The nurse practitioner [R.N. (E.C.)] provides primary health care with a strong emphasis on health promotion and disease prevention within the scope of practice and standards of care outlined in the Expanded Nursing Services for Patients Act and Regulations and the Practice Expectations Specific to Registered Nurses in the Extended Class. S/he diagnoses and manages common health problems and diseases both independently and in collaboration with the client and the physician. The Nurse Practitioner functions as part of an interdisciplinary team to address issues in the community that affect health. S/he is responsible and accountable for her/his practice.

**RESPONSIBILITIES****1. Health Assessment and Diagnosis:**

- Provides ongoing, comprehensive primary health care to clients of all ages within the scope of the R.N. (E.C.) including assessments, diagnosis, counselling, screening, referral, education, treatment and follow-up
- Spends sufficient time with the client to determine the presence of existing and potential health problems, with a major focus on lifestyle, psychological, socio-cultural, and environmental risk factors that may influence the client's health status. The R.N. (E.C.) deals with these personally or by referral to or in consultation with other service providers and programs in the community
- Supports clients and their families to take responsibility for their health by involving them in risk factor and health promotion identification, goal setting, and the choice of interventions for disease treatment and prevention, and health promotion

- Determines the need for, orders and interprets screening and diagnosis laboratory tests and chest and limb X-rays and diagnostic ultrasounds
- Keeps complete, accurate and timely records of client visits, using the charting format established by the Centre, which will provide information to assist other practitioners in continuing client care
- Sees clients at the Centre with scheduled and urgent appointments in the Community through outreach and home visits, during regular and extended hours of service

## **2. Therapeutics:**

- Initiates and manages the care of clients and/or monitors the ongoing therapy of clients with chronic stable illnesses by providing pharmacological, complementary and counselling interventions
- Prescribes designated drugs

## **3. Health Promotion and Disease Prevention:**

- Implements strategies to promote health and prevent disease with individuals, families and groups

## **Community Health:**

- Synthesizes information from individual clients to identify broader implications for health within the family and the community
- Counsels individuals and families on health-related and lifestyle issues
- Promotes awareness of the Centre's program and participation by the community

## **Team and Centre Responsibilities:**

- Promotes and participates in an interdisciplinary provider model. Collaborates with both providers and clients to ensure management, referrals and information
- Provides consultation services to community groups, agencies and centre staff
- Supervises and trains nursing and nurse practitioner students on placement at the centre and participates in the training of other health professions students

- Participates in the development and the evaluation of policies, protocols, and procedures to improve client care and/or to promote cooperative and efficient staff functioning
- Collects statistical information as required by the Centre
- Participates in the development, planning and evaluation of treatment, education, counselling and health promotion programs
- Helps to maintain the client reference library, previewing hand-outs and tests, and participating in the preparation of new materials for client education
- Participates in the organization, coordination and presentation of clinical case conferences, in cooperation with health services staff and other staff of the Centre
- Maintains an awareness of the financial position of the Centre as it influences the provision of primary care and health education
- Participates in the hiring, orientation and evaluation of primary care staff
- Participates in joint SEOCHC staff and inter-CHC meetings
- Participates in Board activities, including presentations or involvement in subcommittees as requested

#### Confidentiality:

- Maintains client confidentiality and acts in an ethical and professional manner in accordance with the codes of behaviour prescribed by the College of Nurses and in accordance with the Centre's policies

#### Professional Development:

- Maintains and develops professional competence through professional development
- Stays current and aware of opportunities to implement new methods of client assessment and treatment

## **ACCOUNTABILITY**

- As a member of the Health Services Team to work within her/his scope of practice and to obtain appropriate consultation related to medical diagnosis, treatment and referral beyond the scope of practice
- As a R.N. (E.C.), to the professional governing body (the College of Nurses of Ontario)
- As an employee of SEOCHC, to the Board of Directors of SEOCHC, through the Executive Director

## **QUALIFICATIONS**

Baccalaureate in Nursing.

Successful completion in the R.N. (Extended Class) with the College of Nurses of Ontario.

Nursing experience working with seniors, low income families, multicultural population and youth.

Member of the Registered Nurse Practitioners Association of Ontario (RNPAO) with professional liability coverage.

Fluency in both official languages is highly desirable.

Familiarity with the use of computers is desirable.

REVISED JUNE 2008

## SOUTH-EAST OTTAWA COMMUNITY HEALTH CENTRE

# JOB DESCRIPTION

**POSITION TITLE:** Family Physician

**PROGRAM:** Health Services

**REPORTS TO:** Health Services Manager

### **JOB SUMMARY**

The family physician is to provide a full range of primary health care services to clients of the SEOCHC. These services will be of a continuous and comprehensive nature, in keeping with the standards set by the College of Family Physician of Canada.

### **RESPONSIBILITIES**

#### **1. Client Related:**

- a) Provides ongoing continuous and comprehensive primary medical care to clients of all ages who seek primary health care services including appropriate assessments and diagnosis, counselling, screening, referral, education, treatment and follow-up.
- b) Provides complete obstetrical care to clients of the Centre or on a shared care basis of clients of other CHC's in Ottawa when required.
- c) In accordance with the philosophy of primary health care, encourages clients and their families to take responsibility for their own health by involving them in risk factor and health problem identification, goal setting and the choice of intervention for disease treatment and prevention, and health promotion.
- d) Maintains client confidentiality and acts in an ethical and professional manner, in accordance with profession code of ethics and in accordance with the policies of the Board of Directors of SEOCHC.
- e) Keeps complete, accurate, and timely records of client visits, using the charting format established by the Centre, which will provide information to assist other practitioners in continuing the client's care.
- f) Sees clients at the Centre with scheduled and non-scheduled appointments, and in the Community through outreach and home visits, during regular and extended clinic hours.
- g) Shares on-call duties with the Centre's physicians, at the other Community Health Centres or in the Community.

## 2. **Clinic Related:**

- a) Provides appropriate support and consultation to other primary care staff.
- b) Co-ordinates the implementation and review of the Nurse Practitioner protocols. Provides medical authorization of their use.
- c) Co-ordinates University of Ottawa, Department of Family Medicine, Resident Programme at the Centre, and is the primary supervisor of residents placed at the Centre. Supervises medical students when necessary.
- d) Co-ordinates medical quality assurance and improvement initiatives.
- e) Develops mechanisms for ongoing nursing peer review and quality of care assurance in consultation with the Health Manager and the nursing staff.
- f) Serves as consultant for day to day clinical problems and medically related administrative problems to the Health Manager.
- g) In consultation with the Health Manager and the Board, develops policies, procedures and protocols for client management.
- h) Participates in clinical case conferences.
- i) Promotes an inter-disciplinary approach in the provision of client care.
- j) Co-ordinates:

On call coverage schedule  
Home visits for physicians  
Availability of medication for dispensing to clients  
Coordinating pharmaceutical representatives.

- k) Maintains an awareness of the financial position of the Centre as it influences the provision of primary care and health education programming.
- l) Provides input into the development of effective systems for client and staff scheduling and clinical records maintenance.
- m) Participates in the hiring and the orientation of primary care staff.
- n) Participates in the evaluation of primary care staff.
- o) Assists with maintenance of client references and resources, previewing hand-outs and texts, and participating in the preparation of new materials for client education.
- p) Participates in staff continuing health education activities and maintenance of a program for continuing staff education, in consultation with Centre staff.
- q) Assist in providing input to the educational experience of students of disciplines other than medicine.

## 3. **Centre Related:**

- a) Participates in the development and the evaluation of Centre policies, protocols and procedures to improve client care and/or to promote co-operative and efficient staff functioning.
- b) Acts as a medical resource to staff at SEOCHC.
- r) Ensures that encounter forms, day sheets and/or other statistics have been recorded

and participates in review of summary statistics.

- s) Participates in joint SEOCHC, staff and inter-CHC meetings as appropriate given rotation schedule.
- t) Participates in Board activities, including presentations or involvement in sub-committee, as requested.
- u) Participates in the evaluation of the Centre's primary health care programs.
- v) Facilitates open communication among Centre staff members.
- w) Acquaints clients with the other services at the SEOCHC, and makes referrals as is appropriate.

#### **4. Community Related:**

- a) Participates in the Board's efforts to identify primary health care needs of the Centre's clients, and of the Community.

Participates in the development of primary care and health education programs, based on the Centre clients and Community identified health needs.

Participates in Community outreach activities, related to primary health care.

Initiates and maintains functional relationships with relevant Community professionals, agencies and services.

Promotes awareness of and participation by the Community in the Centre's programs.

### **ACCOUNTABILITY**

The family physician is accountable:

As a member of the Health Services Team to provide consultation to other team members per the Centre's policies, procedures and protocols.

As physician, to the professional governing body (the College of Physicians and Surgeons, College of Family Physicians of Canada).

As a physician, to maintain clinical competence through continuing education.

As an employee of the South-East Ottawa CHC, to the South-East Ottawa Services Board, through the Health Manager.

As a community preceptor of University of Ottawa to the Chairman of Family Medicine.

### **QUALIFICATIONS**

Family Practice Certification.

Academic Appointment, Department of Family Medicine, University of Ottawa.

Licensed by the College of Physicians and Surgeons of Ontario and certified by the College of Family Practice of Canada.

Minimum five (5) years of experience in primary care (excluding internship and residency) including community health and/or family practice preferred.

Sensitivity to the needs of seniors and low-income multicultural groups essential.

Has or is eligible for hospital privileges in an Ottawa area hospital.

Fluency in both official languages preferred.

Familiarity with “use of computers” an asset.

REVISED MAY 2008





## Access Alliance Multicultural Community Health Centre

<b>POSITION:</b>	Community Family Physician
<b>CLASSIFICATION:</b>	MOH Physician Scale
<b>BARGAINING UNIT:</b>	NO
<b>SUPERVISOR:</b>	Clinical Health Services Manager
<b>DATE APPROVED:</b>	March 1999
<b>REVISED:</b>	June 2006
<b>UNION APPROVAL (If Req):</b>	No

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### POSITION SUMMARY

Together with other staff of the Centre, this position works within the context of the Centre's mission and strategic directions, to ensure that client primary medical care and health needs are met in holistic, innovative and effective ways. Specific functional areas of responsibility include medical assessment, diagnosis and management of common health problems and diseases both independently and in collaboration with the client and other providers and non-providers of the Centre. This position works within an interdisciplinary team for clinical practice as well as program planning, implementation and evaluation. The position is responsible and accountable for meeting and maintaining the standards of practice as prescribed in all legislation and regulations that apply to the position, but not limited to, The Canada Health Act, The Medicine Act, The Regulated Professions Act, and the Health Insurance Act.

### SPECIFIC RESPONSIBILITIES

#### Client Care

1. Provide ongoing comprehensive primary medical care of all ages including assessments, diagnoses, counseling, screening, referral, education, treatment and follow-up.
2. Provide care to selected client group at secondary care level such as palliative care, addiction medicine, needs of special groups, etc.
3. Initiates and manages the medical care of clients and/ or monitors the ongoing therapy of clients with chronic stable illness, where necessary and appropriate in consultation, collaboration with other members of the team, by providing interventions, including the prescribing of drugs, and by providing referrals to other appropriate specialist consultants.
4. Ensures appropriate population screening within the client population and immunizations for the same.
5. May determine the need for, order and interpret screening and diagnostic laboratory and imaging tests.
6. Monitors client health maintenance, and, in cooperation with client and other members of the team develops health care plans and recommendations concerning treatment, disease prevention, and health promotion options.
7. Ensures appropriate, comprehensive treatment and continuity of care by maintaining complete and accurate client records.
8. Sees clients during regular and extended hours at the Centre on both scheduled and an urgent basis and also in the community through outreach and home visits where necessary and appropriate.

9. Provides after hours on call service in accordance with the current on-call schedule.
10. Participates in primary health care program and service delivery within the broader community context in partnership with other institutions and agencies as may be required from time to time.

#### **Clinical Team/ Case Conference:**

1. Attends, participates in and if required, leads regular case conferences to ensure appropriate interdisciplinary review and discussion of complex cases.
2. Participates in ensuring that centre-wide triage system is efficient and effective through monitoring the Clinical triage system and recommending and implementing appropriate changes.
3. Initiates or participates in the implementation of new methods of client assessment and therapeutic techniques.
4. participates in collaborative practice with RN (EC's)

#### **Program Planning and Evaluation:**

1. Initiates, participates in, or leads program development, delivery and evaluation, and does committee work within the context of the Centre's core program areas in collaboration of other clinical and health promotion staff.
2. Participates in program development, delivery and evaluation, and may also do committee work within the broader community context in partnership with other institutions and agencies as may be required from time to time.

#### **Education, Research and Professional Development:**

1. Initiates appropriate liaison with education and other institutions to promote the availability of the Centre as a learning site for students of medicine.
2. Creates and annual plan for accommodating, supervising and evaluating a specified number of medical students.
3. Assists medical students by collaborating on the development of learning plan and implement the learning plan through individual student instruction and interdisciplinary client care.
4. Participates in the supervision and education of students in health care professions other than medicine as may be required, and promotes interdisciplinary approach to client care during the period of supervision.
5. Creates an annual learning and development plan for her/ himself which may include attendance at conferences, presentation of papers, maintenance of membership in appropriate bodies/ organizations in addition to those that are mandatory.
6. Participates in clinical research with colleagues internal and external to the Centre.
7. Maintains as current all licenses, certificates and standards as may relate to the ability to practice.

#### **Administration:**

1. Initiates or participates in the development of clinical policies, procedures and protocols, including medical directives. Initiates or participates in the development of clinical policies, procedures and protocols.
2. Participates in quality assurance initiatives including chart audits and peer reviews.
3. Ensures that all manuals, policies and procedures relative to clinical practice are current and complete through full review on not less than an annual basis and discussion with the appropriate staff.
4. Participates in the recruitment and retention of Centre staff, including training, supervision and evaluation of the same.
5. Ensures all clinical encounter forms are completed on line in complete and timely manner.
6. Participates in Centre and Board committees, work groups, projects, etc., as may be required from time to time.
7. Other duties as delegated by the Executive Director or Community Health Program Coordinator.

**SKILLS/ ABILITIES**

- ❑ Demonstrated ability to work effectively in an interdisciplinary, team based setting;
- ❑ Demonstrated superior communication skills, both written and oral;
- ❑ Demonstrated superior interpersonal skills with clients and colleagues;
- ❑ Demonstrated ability to be flexible and responsive in an ever changing environment, and
- ❑ Commitment to working with low-income, multilingual and multiracial communities.

**QUALIFICATIONS/ EXPERIENCE**

- ❑ License in general practice/ family practice; CCFP preferred;
- ❑ Registration with the College of Physicians and Surgeons of Ontario;
- ❑ Thorough familiarity with primary health care therapeutic methods and practices based upon a health promotion/disease prevention model;
- ❑ Significant prior community-based primary care experience;
- ❑ Experience with computer software programs and keyboarding skills;
- ❑ A second language preferred.