Court File No. 131/19

ONTARIO
SUPERIOR COURT OF JUSTICE
(Divisional Court)

IN THE MATTER OF the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1, as amended;

AND IN THE MATTER OF a decision of the Human Rights Tribunal of Ontario dated September 24, 2018 and a decision of the Human Rights Tribunal of Ontario dated February 19, 2020

B E T W E E N:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Applicant

- and -

ASSOCIATION OF ONTARIO MIDWIVES and
HUMAN RIGHTS TRIBUNAL OF ONTARIO

Respondents

FACTUM OF THE APPLICANT, THE MINISTER OF HEALTH

(Application for judicial review returnable April 7-9, 2020)

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PART I – STATEMENT IDENTIFYING APPLICANT AND TRIBUNAL

1. The Applicant, Her Majesty the Queen as represented by the Minister of Health ["Ontario"], applies for judicial review to set aside the decision of the Human Rights Tribunal of Ontario ["Tribunal"] dated September 24, 2018 finding Ontario liable for discrimination under the *Human Rights Code* ["the Liability Decision"] and to set aside the decision of the Tribunal dated February 19, 2020 making remedial orders ["the Remedy Decision"].

2. The Association of Ontario Midwives ["AOM"] applied to the Tribunal alleging that midwives have been subject to systemic sex discrimination in the compensation provided by Ontario for midwifery services since 1997. The AOM alleged that Ontario failed to ensure that midwives' compensation remained "aligned" with the salaries of family physicians working in Community Health Centres ["CHCs"]. When midwifery was first regulated in Ontario in 1993, the initial compensation of midwives was set in comparison with the salaries of nurses and physicians in CHCs. The AOM alleged that it was sex discrimination that the salaries of CHC physicians have increased more since 1993 than the compensation levels of midwives. The Tribunal found that sex was a factor in the treatment that midwives experienced and in the compensation gap that has developed between midwives and CHC physicians since 2005.

3. This case is not about midwives being paid less than physicians are paid to deliver babies. Midwives are not paid less than physicians are paid to provide maternity and obstetrical care. Nor does the principle of equal pay for work of equal value (or pay equity) have any application in this case, as the Tribunal did not find that the *value* of the work of midwives is substantially the same as the *value* of the work of CHC physicians. The Tribunal declined to assess the value of midwives' work as compared to the work of CHC physicians.

4. Instead, the Tribunal found that because midwives are a female-predominant occupational group, Ontario had a proactive obligation to ensure that their compensation

remained "aligned" with that of CHC physicians. Although CHC physicians are also a female-predominant group and the Tribunal found that CHC physicians have been majority-female since at least 2001, the Tribunal held that CHC physicians perform "work historically associated with men"[1] and that therefore it was sex discrimination that midwives did not receive pay increases after 2005 that were aligned with those received by CHC physicians.

5. Ontario submits that the Tribunal was unreasonable to find discrimination. Midwives and CHC physicians are paid differently because of differences in their work. They have different scopes of practice, different responsibilities and generally different patients. They also have a different history with respect to labour market pressures and recruitment and retention challenges. None of these differences has anything to do with sex. Where distinctions between occupations are not based on personal characteristics, they do not engage the anti-discrimination purpose of the *Code*. Differences in treatment between midwives and CHC physicians "relate essentially to the type of work they do, and not to the persons they are."[2]

6. The Tribunal misapplied the test for discrimination. It was the claimant's burden to prove that sex was a factor in the compensation of midwives. Ontario led substantial evidence, including expert evidence, on the occupational differences between midwives and CHC physicians that are relevant to compensation, and the particular recruitment and retention difficulties that applied to CHC physicians but not to midwives. The Tribunal disregarded or ignored all of this evidence because Ontario did not conduct a job evaluation "to validate how its seemingly reasonable explanations would be weighted in a compensation study comparing midwives and CHC physicians" and did not "validate, one way or the other, whether midwives

[1] Remedy Decision at para. 60.
[2] *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27 at para. 165 ["*Health Services*"].

remained appropriately paid despite increases paid to CHC physicians."[3] This conclusion reversed the onus and improperly required Ontario to disprove discrimination.

7. The Tribunal held that "what distinguishes the AOM's allegations from general allegations of unfairness is that midwives are sex-segregated workers, and as a result, they are vulnerable to the forces of gender discrimination on their compensation."[4] But the fact that midwives are predominantly female and are therefore vulnerable to sex discrimination is not sufficient to find that sex discrimination has occurred or to justify a remedy under the *Code*:[5]

> It cannot be presumed solely on the basis of a social context of discrimination against a group that a specific decision against a member of that group is necessarily based on a prohibited ground under the [human rights statute]. In practice, this would amount to reversing the burden of proof in discrimination matters. Evidence of discrimination, even if it is circumstantial, must nonetheless be tangibly related to the impugned decision or conduct.[6]

8. There was no such tangible evidence of sex discrimination in this case, and the Tribunal was therefore unreasonable to find that Ontario had breached the *Code*. As there is no appeal from decisions of the Tribunal, and no adequate alternative remedy other than judicial review,[7] Ontario requests that this Court set aside the decisions of the Tribunal.

PART II - FACTS

A. Midwives and CHC physicians have different scopes of practice

9. Midwives are regulated health professionals whose scope of practice is defined in the *Midwifery Act, 1991* as "the assessment and monitoring of women during pregnancy, labour

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[3] Remedy Decision at para. 119.
[4] Remedy Decision at para. 8.
[5] *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal*, 2007 SCC 4 at paras. 49 and 56 ["*McGill Health*"].
[6] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39 at para. 88 ["*Bombardier*"].
[7] *Lewis v. Re/Max Rouge River Realty*, 2010 HRTO 1977 at para. 4; *Selkirk Estate v. Ontario (Health)*, 2014 HRTO 53 at para. 10; *Beldjehem v. University of Ottawa (Telfer School of Management)*, 2014 HRTO 1080 at para. 8.

and the postpartum period and of their newborn babies, the provision of care during normal pregnancy, labour and postpartum period and the conducting of spontaneous normal vaginal deliveries."[8] Subject to certain limits,[9] midwives are as competent as family physicians to provide primary maternity and obstetrical care for clients with low-risk pregnancies and normal deliveries. However, if a midwife's client has health needs that fall outside the scope of practice of midwifery (such as strep throat, or a mood disorder, or a chronic disease),[10] that client will see a family physician or other appropriate provider for care of those needs.

10. While the scope of practice of midwives overlaps with the scope of practice of physicians in respect of the provision of low-risk maternity and obstetrical care, the scope of practice of medicine is not limited to such care. The scope of practice of medicine is the "assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction."[11] Physicians have the widest scope of practice among all health professionals. Family physicians, including CHC physicians, diagnose and treat conditions and prescribe medicine relating to every system in the body.[12]

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[8] *Midwifery Act, 1991*, S.O. 1991, c. 31, s. 3.

[9] Midwives must transfer care to a physician if their client has cardiac disease, renal disease, insulin-dependent diabetes mellitus or an HIV positive status: College of Midwives Standards of Practice: Consultation and Transfer of Care (ROP Tab 92, pp. 7347-7356). **Applicant's Record and Compendium ["AC"] Tab 68 pp. 754-763**.

[10] Kilthei transcript, 14 Sept 2016 at pp. 81-87 (ROP Tab 357, pp. 60144-60150) **AC Tab 38 pp. 451-457**.

[11] See *Medicine Act, 1991*, S.O. 1991, c. 30, s. 3.

[12] Price report at pp. 6-7 (ROP Tab 354, pp. 49961-2) **AC Tab 22 pp. 342-343**; Nitti affidavit at para. 23 (ROP Tab 235, pp. 33944-5) **AC Tab 10 p. 212-213**; Macdonald affidavit at para. 18 (ROP Tab 234, pp. 33932-33933) **AC Tab 7 pp. 198-199**; Woolhouse affidavit at paras. 32-38 (ROP Tab 229, pp. 33673-5) **AC Tab 14 pp. 247-249**; Graves report at paras. 14-18, 33 (ROP Tab 338, pp. 41880-1, 41884) **AC Tab 19 pp. 327-328, 331**

11. CHC physicians are salaried employees who practice family medicine at CHCs. They follow hundreds of patients of all genders and ages throughout their patients' lives.[13] The CHC patient population typically consists of people with complex needs, including refugees, urban Indigenous persons, uninsured persons, homeless persons, and those living with chronic disease, multiple addictions and mental illness.[14] The CHC population tends to be sicker than the average Ontarian, which adds to the complexity of work for the CHC physician.[15] Providing maternity care is only a small part of a CHC physician's work.[16]

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[13] Nitti affidavit at para. 23 (ROP Tab 235, pp. 33944-5) **AC Tab 10 p. 212-213**; Macdonald affidavit at para. 18 (ROP Tab 234, pp. 33932-3) **AC Tab 7 pp. 198-199**; Woolhouse affidavit at paras. 32-38 (ROP Tab 229, pp. 33672-33675) **AC Tab 14 pp. 247-249**.

[14] Price report at p. 6 (ROP Tab 354, p. 49961) **AC Tab 22 p. 342**; Kiran affidavit at paras. 16-18 (ROP Tab 239, pp. 34002-3) **AC Tab 6 pp. 190-191**; Nitti affidavit at paras. 8, 23 (ROP Tab 235, pp. 33941, 33944) **AC Tab 10 pp. 209, 212-213**; Woolhouse affidavit at paras. 17-20, 28, 30-38, 47 (ROP Tab 229, pp. 33667, 33672-5, 33678) **AC Tab 14 pp. 245-249, 251**; Macdonald affidavit at para. 35 (ROP Tab 234, pp. 33936) **AC Tab 7 p. 202**; Nitti transcript at pp. 39-42 (ROP Tab 380, pp. 64412-5) **AC Tab 45 pp. 532-535**; Woolhouse transcript at pp. 26-30 (ROP Tab 379, pp. 64161-5) **AC Tab 56 pp. 621-625**; Strategic Review of the Community Health Centre Program at pp. 3-4, 23, 29, 42 (ROP Tab 201, pp. 24951-2, 24971, 24977, 24990) **AC Tab 95 pp. 998-1002**; ICES Investigative Report, "Comparison of Primary Care Models in Ontario" at pp. III-IV (ROP Tab 290, pp. 57298-9) **AC Tab 75 pp. 860-861**.

[15] Price report at p. 6 (ROP Tab 354, p. 49961) **AC Tab 22 p. 340**

[16] Price report at pp. 4-5 (ROP Tab 354, p. 49959-60) **AC Tab 22 pp. 340-341** ; Graves report at paras. 18, 24-27, 29-33 (ROP Tab 338, pp. 41880-4) **AC Tab 19 pp. 327-328, 329-330, 330-331**; Nitti affidavit at paras. 12-14, 16, 20, 27, 45-47, 50, 52 (ROP Tab 235, pp. 33942-6, 33949-51) **AC Tab 10 p. 210-218**; CPG Infobase: Clinical Practice Guidelines Database (ROP Tab 235, pp. 33958-33970) **AC Tab 70 pp. 818-830**; Macdonald affidavit at para. 27 (ROP Tab 234, pp. 33932-4, 33936) **AC Tab 7 p. 201**; Kiran affidavit at paras. 14, 20-21, 23-24, 27, 32, 36-37 (ROP Tab 239, pp. 34002-9) **AC Tab 6 pp. 190-197**; Macdonald transcript at pp. 150-152, 158-159, 163, 166 (ROP Tab 379, pp. 64285-7, 64293-4, 64298, 64301) **AC Tab 41 pp. 472-480**; Woolhouse affidavit at paras. 29-43, 48, 51, 63 (ROP Tab 229, pp. 33672-6, 33678-9, 33681-2) **AC Tab 14 pp. 246-254**; Woolhouse transcript at pp. 18, 70-71 (ROP Tab 379, pp. 64153, 64205-6) **AC Tab 56 pp. 620, 626-627**; Nitti transcript at pp. 11-12, 24-26, 31-32, 35-36, 38-39, 42-46 (ROP Tab 380, pp. 64384-5, 64397-9, 64404-5, 64408-9, 64411-2, 64415-64419) **AC Tab 45 pp. 522-525, 527-532, 535-539**; Kiran transcript at pp. 138-141, 153-156, 188-189 (ROP Tab 380, pp. 64511-4, 64526-9, 64561-2) **AC Tab 40 pp. 460-467, 470-471**.

12. CHC physicians diagnose and manage complex medical issues from diabetes to heart disease to mental health and addictions. One CHC physician described her practice as follows:

> Most of the time, I deal with complex, chronic disease management. Comorbidities like heart disease, diabetes, hypertension, post-transplantation, lung disease, kidney disease, chronic Hepatitis C, complex psychiatric diagnoses (PTSD, depression, anxiety) that require medical treatment. I diagnose, assess, make a plan for treatment, prescribe, investigate and follow-up.[17]

13. The Tribunal noted the undisputed evidence that there has been an "explosion" in medical knowledge over the past twenty years relating to complex chronic disease and its management.[18] Patients now live longer with multiple complex comorbidities and multiple interacting medications, which has increased the complexity of family medicine.

14. Low-risk maternity and obstetrical care is at the less-complex end of the spectrum of medical complexity of issues encountered by family physicians.[19] The expert evidence was that the conduct of care of normal pregnancy follows a fairly routine and expected course with very specific guidelines available at a national level to guide care. The complexity of care in family medicine is not in managing a single condition on a daily basis, but in managing many conditions on a daily basis in all systems of the body and in all age groups, male and female.[20]

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[17] Nitti affidavit at para. 12 (ROP Tab 235, p. 33942) **AC Tab 10 p. 210**.
[18] Liability Decision at para. 268; Price report at p. 9 (ROP Tab 354, p. 49964) **AC Tab 22 p. 345**; Price transcript at pp. 171-173 (ROP Tab 402, pp. 68766-8) **AC Tab 49 pp. 560-562**; Graves report at paras. 24-27 (ROP Tab 338, pp. 41882-3) **AC Tab 19 pp. 329-330**.
[19] Nitti affidavit at paras. 38-40 (ROP Tab 235, pp. 33948-50) **AC Tab 10 p. 215-216**; Graves report at paras. 30-33 **AC Tab 19 p. 330-331**; Macdonald affidavit at para. 28 (ROP Tab 234, p. 33935) **AC Tab 7 p. 201**; Macdonald transcript at pp. 162-164 (ROP Tab 379, pp. 64297-9) **AC Tab 41 p. 477-479**; Graves transcript at pp. 40-41 and 91-96 (ROP Tab 395, pp. 67541-62 and 67592-7) **AC Tab 35 pp. 423-424, 428-433**.
[20] Graves report at para. 33 (ROP Tab 338, p. 41884) **AC Tab 19 p. 331**.

B. Midwives and CHC physicians have different educational requirements

15. The midwifery education program is a 4-year baccalaureate degree, and the minimum educational requirement to apply is a high school diploma.[21] By contrast, CHC physicians have graduated from medical school, for which a minimum of three years' prior university experience is a prerequisite.[22] The overall direct cost of obtaining a medical degree is about four times that of a midwifery degree, and because of the longer duration of the required education, a family physician must also incur at least twice the opportunity costs (lost earnings while in full-time training) compared to a midwife.[23]

16. Since 1994, new family physicians have also been required to complete a two-year residency in family medicine.[24] Family medicine residents must successfully demonstrate competence and skills in each of the "99 topics" of family medicine:[25]

> Abdominal Pain; Advanced Cardiac Life Support; Allergy; Anemia; Antibiotics; Anxiety; Asthma; Atrial Fibrillation; Bad News; Behavioural Problems; Breast Lump; Cancer; Chest Pain; Chronic Disease; Chronic Obstructive Pulmonary Disease; Contraception; Cough; Counselling; Crisis; Croup; Deep Venous Thrombosis; Dehydration; Dementia; Depression; Diabetes; Diarrhea; Difficult Patient; Disability; Dizziness; Domestic Violence; Dyspepsia; Dysuria; Earache; Eating Disorders; Elderly; Epistaxis; Family Issues; Fatigue; Fever; Fractures; Gastro-intestinal Bleed; Gender Specific Issues; Grief; Headache; Hepatitis; Hyperlipidemia; Hypertension; Immigrants; Immunization; In Children; Infections; Infertility; Insomnia; Ischemic Heart Disease; Joint Disorder; Lacerations; Learning (Patients, Self-Learning, Lifestyle); Loss of Consciousness; Loss of Weight; Low-back Pain; Meningitis; Menopause; Mental Competency; Multiple Medical Problems; Neck Pain; Newborn; Obesity; Osteoporosis; Palliative Care; Parkinsonism; Periodic Health Assessment/Screening; Personality Disorder; Pneumonia; Poisoning; Pregnancy;

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[21] Chaykowski 2014 report at pp. 60-63 (ROP Tab 349, pp. 49706-9) **AC Tab 16 p. 277-280**; Van Wagner transcript at p. 97 (ROP Tab 359, p. 60548) **AC Tab 54 p. 607**.
[22] Graves report at para. 34 (ROP Tab 338, pp. 41884-5) **AC Tab 19 pp. 331-332**.
[23] Chaykowski 2014 report at pp. 64-65 (ROP Tab 349, pp. 49710-49711) **AC Tab 16 pp. 281-282**.
[24] Graves transcript at pp. 29-44 (ROP Tab 395, pp. 67530-45) **AC Tab 35 pp. 412-427**; O. Reg. 865/93 under the *Medicine Act, 1991*, S.O. 1991, c. 30, s. 3(1) para. 4.
[25] Graves report at paras. 14-16, 38 (ROP Tab 338, pp. 41880, 41885-6) **AC Tab 19 pp. 327, 332-333**; College of Family Physicians of Canada, "Priority Topics and Key Features with Corresponding Skill Dimensions and Phases of the Encounter" (ROP Tab 338, pp. 41891-41994) **AC Tab 67 pp. 650-753**.

> Prostate; Rape/Sexual Assault; Red Eye; Schizophrenia; Seizures; Sex; Sexually Transmitted Infections; Skin Disorder; Smoking Cessation; Somatization; Stress; Stroke; Substance Abuse; Suicide; Thyroid; Trauma; Travel Medicine; Upper Respiratory Tract Infection; Urinary Tract Infection; Vaginal Bleeding; Vaginitis; Violent/Aggressive Patient; and Well-baby Care.

17. The management of normal pregnancy, labour and postpartum periods and the conduct of spontaneous normal vaginal deliveries is one of many competencies that must be acquired and successfully demonstrated during the family medicine residency.[26]

C. Midwives and CHC physicians are paid in different ways

18. Midwives are independent contractors who work in midwife practice groups. They are not obliged to participate in the publicly-funded Ontario Midwifery Program ["OMP"] and are free to charge privately for professional services outside the OMP.[27] Through the OMP, midwife practice groups are paid a bundle of fees for each "course of care" delivered to a client. A "course of care" means the provision of midwifery services to a person for a period of 12 or more weeks during pregnancy, labour and birth, and for up to six weeks postpartum for the client and newborn. A full-time midwife will provide services for approximately 40 clients per year as the primary midwife and will act as a second birth attendant for a further approximately 40 clients.

19. As of the hearing, for a midwife who provided 40 primary and 40 secondary courses of care per year, the sum of the experience fee, on-call fee, retention incentive and secondary care fee ranged from $79,360 to $102,560 per year, depending on the experience level of the midwife. Midwife practice groups also receive an "operating fee" of $744 per course of care, discussed below. Midwives also receive other funding from the MOH including benefits, travel disbursements, funding for professional development, mentoring and non-clinical

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[26] Graves report at para. 29 (ROP Tab 338, p. 41883) **AC Tab 19 p. 330**.
[27] Davey affidavit at para. 170 (ROP Tab 201, pp. 22231-2) **AC Tab 4 pp. 175-176** .

activities, grants for special projects, rural and remote incentives, funding for liability insurance and funding for the AOM.[28]

20. One component of the course of care fees is an "operating fee" for overhead expenses. Because midwives are independent contractors, they retain unspent operating fees as taxable income. The "representative claimant" midwives who were partners in their midwifery practices reported many thousands of dollars of taxable income each year from these funds.[29] Midwives also receive separate funding for benefits equal to 20% of four fees.[30] Unspent benefit monies are paid into the midwife's RRSP and are tax deductible.[31]

21. CHC physicians are employees. They are paid an annual salary plus benefits to perform all of their work as family physicians, and are not paid separately for the small proportion of

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[28] Scarth affidavit at para. 28 (ROP Tab 253, p. 36738) **AC Tab 12 p. 234**; The experience fee, on-call fee, retention incentive and secondary care fee per course of care ranged from $1,984 to $2,564 at the time of the hearing. A secondary care fee means compensation for the second attendant required at each birth. See Liability Decision at para. 59.

[29] In 2012, 2013 and 2014, Jacqueline Whitehead earned $16,240, $17,482 and $31,330 respectively in partnership income in addition to fees for courses of care and caseload variables: Whitehead, Midwifery Collective of Ottawa Financial Statement at pp. 199, 259, 321 (Exhibit 238) **AC Tab 96 pp. 1016-1018**; Whitehead transcript at pp. 48-54, 58 (ROP Tab 391, pp. 66745-51, 66755) **AC Tab 55 pp. 610-618**; In 2012, 2013 and 2014, Nicole Roach earned $4,293, $8,122 and $15,054 respectively in partnership income in addition to fees for courses of care and caseload variables: Roach, St. Jacobs Financial Statement at pp. 173, 191, 207 (ROP Tab 311, pp. 39688, 39706, 39722) **AC Tab 92 pp. 994-997**; Roach transcript at pp. 145-148, 151-152 (ROP Tab 391, pp. 66842-5, 66848-9) **AC Tab 50 pp. 563-568**; In 2012, 2013 and 2014, Rebecca Carson earned $5,825, $8,753 and $7,803 respectively in partnership income in addition to fees for courses of care and caseload variables: Carson, Financial Statements at pp. 144, 197, 253 (ROP Tab 318, pp. 39990, 40043, 40099) **AC Tab 65 pp. 646-648**; Carson transcript at pp. 93, 97, 101, 106-107 (ROP Tab 392, pp. 66974, 66978, 66982, 66987-8 **AC Tab 26 pp. 354-358**.

[30] An amount equal to 20% of the experience fee, on-call fee, retention incentive and secondary care fee is paid to the AOM Benefits Trust on behalf of each midwife. These benefit monies are taxable income in the hands of each midwife.

[31] Whitehead transcript at pp. 34-35, 65 (ROP Tab 391, pp. 66731-2, 66762) **AC Tab 55 pp. 608-609, 619**; Carson transcript at pp. 123-124 (ROP Tab 392, pp. 67004-5) **AC Tab 26 pp. 359-360**.

their work that involves providing low-risk maternity and obstetrical care.[32] As employees, CHC physicians cannot retain any of their employer's operating expenses as their own taxable income. As of June 2015, the annual CHC physician salary in non-underserviced areas was $177,673 to $205,775, plus benefits.[33]

D. Midwives and CHC physicians are both female-predominant groups

22. Midwives and CHC physicians are both predominantly female groups. The Tribunal held that by 2001, CHC physicians were over 50% female, and have been "predominantly female" since 2004.[34] By 2005, more than 60% of CHC physicians were female.[35] CHC physicians are more female-predominant than family physicians generally, and have become more female-predominant in the past 20 years, as have all family physicians and all physicians in Ontario.[36]

23. CHC physicians do not serve as a "male comparator" for female employees in CHCs under the *Pay Equity Act*. This means that nurses and other female-predominant health professionals who work in CHCs do not have their pay equity adjustments calculated with reference to the salaries of CHC physicians. Because CHCs had few or no male job classes as of July 1993 (the deadline in the *Pay Equity Act*), almost all CHCs that were in operation as of that date used the proxy method of comparison to provide for pay equity in the absence of any

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[32] By contrast, fee-for-service physicians bill separately for each insured service. A midwife is not paid less than a fee-for-service physician who bills OHIP for a course of low-risk insured maternity services: see Scarth affidavit at paras. 70-75 (ROP Tab 253, pp. 36749-50) **AC Tab 12 pp. 238-239**.

[33] In underserviced areas, the range is $214,407 to $246,776: Liability Decision at para. 37.

[34] Liability Decision at paras. 123 and 142.

[35] Scarth affidavit at paras. 77-91 (ROP Tab 253, pp. 36752-4) **AC Tab 12 pp. 240-242**; Thornley affidavit at paras. 9-13 (ROP Tab 244, pp. 34153-4) **AC Tab 13 pp. 243-244**.

[36] Bass 2014 report at pp. 62-66 (ROP Tab 346, pp. 45275-9) **AC Tab 15 pp. 261-265**.

male job classes that could serve as pay equity comparators. In almost all CHCs in operation in 1993, the physician position was not classed as a "male job class".[37]

E. History of changes to CHC physician compensation

24. From 1992 until 2003, the approved salary range for CHC physicians was frozen.[38] The Tribunal found that the salary range for CHC physicians in non-underserviced areas during this period was $80,000 to $115,000 per year.[39] This salary level led to substantial difficulties in recruiting and retaining family physicians to work in CHCs.

25. A review of the CHC program in 2001 reported that CHCs were experiencing recruitment and retention problems with respect to physicians. The physician position was identified as the one most likely to be vacant and most frequently identified as a barrier to the provision of service to clients of CHCs.[40] The number one reason for physician vacancies was remuneration. Physicians also had the highest turnover (nearly double the rate of the second-most frequent position); the most commonly given reason for physician turnover was "Salary too low." The review concluded that "MD pay rates do not appear to be competitive."[41]

26. The review also recommended that existing CHCs be expanded in size and that the number of CHCs in the province be increased.[42] However, the physician recruitment and

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[37] Davey affidavit at para. 174 (ROP Tab 201, pp. 22232-3) **AC Tab 4 pp. 176-177**; Davey transcript, 20 Oct 2016 at pp. 51-63 (ROP Tab 372, pp. 62900-62912) **AC Tab 28 pp. 370-382**.
[38] Liability Decision at para. 122; Davey affidavit at para. 178 (ROP Tab 201, p. 22234) **AC Tab 4 p. 178**; Thornley transcript at p. 116 (ROP Tab 381, p. 64701) **AC Tab 53 p. 605**.
[39] Liability Decision at paras. 28 and 122.
[40] Davey affidavit at para. 180 (ROP Tab 201, pp. 22234-5) **AC Tab 4 pp. 178-179**; Strategic Review of the CHC Program (2001) at pp. 48-51 (ROP Tab 201, pp. 24996-9) **AC Tab 95 pp. 1006-1009**.
[41] Davey affidavit at paras. 182-185 (ROP Tab 201, pp. 22236-8) **AC Tab 4 pp. 180-182**.
[42] Strategic Review of the CHC Program (2001) at pp. 55-57 (ROP Tab 201, pp. 24997-9) **AC Tab 95 p. 1013-1015**; Thornley transcript at p. 72 (ROP Tab 381, p. 64657) **AC Tab 53 p. 596**.

retention problems in CHCs were an impediment to expanding the program, because the CHCs needed physicians to provide medical service to their clients, and positions in new CHCs could not be filled given that there were vacancies in existing ones.[43]

27. In 2004, CHC physicians were included for the first time in the physician compensation agreement with the Ontario Medical Association ["OMA"]. The agreement provided that the compensation of physicians in salaried models (including CHCs) should be harmonized with the compensation of other primary care doctors. Harmonization meant that CHC physicians' compensation was linked to changes to the fee-for-service OHIP schedule of benefits.[44] Harmonization also meant that CHC physicians could become eligible for some of the incentives available to physicians in other practice settings to provide services that Ontario targeted as health priorities, such as care of serious mental illness, diabetes management, mammography, flu vaccines for patients over 65, palliative care, and colorectal screening.[45]

28. Ontario's objective in increasing CHC physicians' compensation was to align their compensation levels with those of other primary care physicians in order to support the ability of CHCs to recruit and retain physicians.[46] One MOH witness explained that "from a recruitment and retention perspective, if there was too large a gap between what a physician

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[43] Davey transcript, 20 Oct 2016 at p. 44-45 (ROP Tab 372, p. 62893-4) **AC Tab 28 pp. 367-368**.

[44] Davey affidavit at para. 193 (ROP Tab 201, pp. 22242-3) **AC Tab 4 p. 183-184** ; 2004-2008 Memorandum of Agreement between OMA and Ministry at Appendix E, p. 2 of 13 (ROP Tab 201, p. 25146) **AC Tab 58 p. 629**.

[45] Davey affidavit at para. 193 (ROP Tab 201, pp. 22242-3) **AC Tab 4 p. 183-184**; Overview: Harmonization of Community Health Centres (2009) (ROP Tab 201, pp. 25239-25245) **AC Tab 87 pp. 972-978**.

[46] Davey affidavit at paras. 194-199 (ROP Tab 201, pp. 22243-5) **AC Tab 4 pp. 184-186**; Pinkney affidavit at para. 164 (ROP Tab 224, p. 30980) **AC Tab 11 p. 231**; Pinkney transcript 4 Nov 2016 at pp. 38-41 (ROP Tab 377, pp. 63799-63802) **AC 46 pp. 547-550**; Naylor affidavit at para. 18 (ROP Tab 212, p. 29250) **AC Tab 9 p. 207**; Naylor transcript at pp. 44 (ROP Tab 376, pp. 63585) **AC Tab 44 p. 501**.

could expect to receive in other models, then it made retaining them more challenging…from the alignment perspective, we're trying to make sure that the doctors in CHCs are being paid fairly for doing the same work in order to maintain our ability to recruit and retain them."[47] The manager of the CHC program, partially quoted by the Tribunal,[48] testified as follows:

> …the salary physicians in Community Health Centres fell farther and farther behind, and so it became important to be able to say that a primary care physician is a primary care physician is a primary care physician, and they have the opportunity to make similar compensation doing similar jobs, so that the family physicians who were working in CHCs would no longer be paid substantially less. They needed to be harmonized. They needed to be being paid for the same things at the same, for the same amount of money.[49]

29. The attempt to introduce an incentive payment model into CHC physician compensation was not a success. It was administratively complex, did not fit with the mandate of CHCs to provide care for marginalized clients (including undocumented and uninsured clients who could not be counted for incentive purposes), and became perceived as inconsistent with the CHC model.[50] The most fundamental problem with the incentive model was that it did not rectify the longstanding problems in recruiting and retaining CHC physicians.

30. A survey conducted in March-April 2009 found a 21% physician vacancy rate in CHCs, that most CHCs experienced significant challenges with physician recruitment, and that the incentives model was the most significant barrier to physician recruitment, while the amount of compensation was the second most significant barrier.[51] By mid-2009, one-third of all CHC physician positions were vacant. A November 2009 report noted that "the difficulty of CHC

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[47] Thornley transcript at pp. 79-80, 207 (ROP Tab 381, pp. 64664-5, 64792) **AC Tab 53 pp. 597-598, 606** .
[48] Liability Decision at paras. 141 and 316.
[49] Davey transcript, 20 Oct 2016 at p. 48 (ROP Tab 372, pp. 62897) **AC Tab 28 p. 369**.
[50] Davey affidavit at para. 210 (ROP Tab 201, pp. 22248-9) **AC Tab 4 p. 187-188**.
[51] Salaried Model for Ontario's CHC and AHAC Physicians (May 2009) at p. 5 (ROP Tab 201, p. 25552) **AC Tab 93 p. 998**; see also the description of salary-linked adjustments and other payments in Thornley transcript at pp. 81-86 (ROP Tab 381, pp. 64666-64671) **AC Tab 53 pp. 599-604**.

physicians in claiming these new incentive payments is contributing substantially to substantial vacancy rates currently observed in CHC physician positions" and that "As of July l, 2009, approximately 96 out of 284 funded CHC FTE physician positions were vacant."[52]

31. As a result, as of April 1, 2010, CHC physicians were moved back to a pure salaried model. The salary ranges established as of that date were arrived at by combining the CHC physician base salary with an estimate of the incentives available in the previous model.[53]

32. The broader context to these changes to CHC physician compensation between 1993 and 2010 was the province-wide shortage of family physicians throughout the first decade of the 2000s.[54] In every year from 1999 until 2012, Ontario's family physician-to-population ratio was the lowest of any province in Canada or the second-lowest after PEI. By 2005-06, the number of medical graduates going into family medicine residencies had dropped to an all-time low.[55] By 2006, there was a "critical shortage" of family physicians in Ontario, resulting in increased wait times and inaccessibility in the healthcare system. By 2010, hundreds of thousands of patients were unattached, meaning they did not have a regular family physician.[56]

33. Ontario responded by increasing compensation to family physicians relative to other specialities to encourage more medical students to practice family medicine. These increases

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[52] Pinkney affidavit at para. 170-171 (ROP Tab 224, pp. 30981-2) **AC Tab 11 pp. 232-233**; Report to Physician-LHIN Tripartite Committee (2009) at p. 2 (ROP Tab 224, p. 32676) **AC Tab 91 p. 985**.
[53] Slide Deck re: Update on CHC Physician Compensation at pp. 8-9 (ROP Tab 224, pp. 32784-5) **AC Tab 94 pp. 999-1000**.
[54] Naylor affidavit at paras. 14-16 (ROP Tab 212, pp. 29248-9) **AC Tab 9 pp. 205-206**; Chaykowski 2014 report at p. 79 (ROP Tab 349, p. 49725) **AC Tab 16 p. 286**; Chaykowski 2015 report at p. 33-34 (ROP Tab 349, pp. 49810-1) **AC Tab 17 pp. 317-318**; Bass 2014 report at pp. 87-88 (ROP Tab 346, pp. 45300-1) **AC Tab 15 pp. 271-272**; McKendry report (1999) at p. vi (ROP Tab 212, p. 29757) **AC Tab 81 p. 886**.
[55] Price transcript at pp. 131-133 (ROP Tab 402, pp. 68726-8) **AC Tab 49 pp. 557-559**.
[56] Naylor affidavit at paras. 14-16 (ROP Tab 212, p. 29248-9) **AC Tab 9 pp. 205-206**.

were also designed to incent medical practices that would relieve pressure on ERs.[57] These policy interventions were successful: an authoritative health care policy study in 2012 found that the outcome of increased family physician payments was the reversal of the long decline in the number of family physicians in Ontario.[58]

34. After 2004, Ontario negotiated CHC physician salaries with the OMA. The OMA has significant bargaining power, given that its members perform vital, medically-necessary services that no other health care provider can perform.[59] Physicians enjoy substantially greater bargaining strength than other workers in Canada. In the years 2000-2010, Canadian doctors' compensation grew at a rate that substantially outpaced that of all other full-time Canadian workers, both male and female.[60]

35. Since 2012, CHC physician salaries have been reduced as part of provincial action on physician compensation generally.[61] Their salaries were reduced by 1.37% effective January 1, 2013, by 0.5% effective April 1, 2013, and by a further 2.65% effective June 1, 2015.[62]

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[57] Naylor affidavit at paras. 14-23 (ROP Tab 212, pp. 29248-51) **AC Tab 9 pp. 205-208**; Naylor transcript at pp. 22-28 (ROP Tab 376, pp. 63563-9) **AC Tab 44 pp. 489-495**; Price transcript at pp. 131-133 (ROP Tab 402, pp. 68726-8) **AC Tab 49 pp. 557-559**.

[58] ICES, Payments to Ontario Physicians (2012) at pp. VII-VIII (ROP Tab 212, pp. 30040-1) **AC Tab 76 pp. 866-867**; Naylor transcript at pp. 34-38 (ROP Tab 376, pp. 63575-9) **AC Tab 44 pp. 496-500**; Chaykowski 2015 report at pp. 33-34 (ROP Tab 349, p. 49810-11) **AC Tab 17 pp. 317-318**.

[59] Chaykowski 2014 report at pp. 76-78 (ROP Tab 349, pp. 49722-4) **AC Tab 16 pp. 283-285** ; Chaykowski 2015 report at p. 39 (ROP Tab 349, p. 49816) **AC Tab 17 p. 323**; Naylor transcript p. 141 (ROP Tab 376, p. 63682) **AC Tab 44 p. 517**.

[60] Bourgeault transcript at pp. 200-201 (ROP Tab 394, pp. 67441-2) **AC Tab 25 pp. 352-353**; Grant & Hurley, "Unhealthy Pressure: How Physician Pay Demands Put the Squeeze on Provincial Health-Care Budgets" (2013) (ROP Tab 334, pp. 41676-41702) **AC Tab 73**; Chaykowski 2014 report at pp. 76-77 (ROP Tab 349, pp. 49722-3) **AC Tab 16 pp. 283-284**.

[61] Naylor affidavit at para. 18 (ROP Tab 212, p. 29250) **AC Tab 9 p. 207**; Farrell affidavit at para. 84 (ROP Tab 246, p. 34849) **AC Tab 5 p. 189**.

[62] Farrell affidavit at para. 84 (ROP Tab 246, p. 34849) **AC Tab 5 p. 189**; Naylor affidavit at para. 18 (ROP Tab 212, p. 29250) **AC Tab 9 p. 207**; Info Bulletin to CHCs (2013) (ROP Tab 246, p. 35377) **AC Tab 78 p. 873**; Info Bulletin to CHCs (2015) (ROP Tab 246, p. 35381-35385) **AC Tab 77 pp. 868-872**.

F. The labour supply of midwives

36. Recruitment and retention challenges were the primary drivers of CHC physician salary increases between 2003 and 2012. If service providers cannot be recruited or retained to provide the needed services at existing compensation rates, then the service will not be provided, and Ontario's health policy objectives will not be met.[63] This difficulty in recruiting and retaining physicians to work in CHCs at prevailing salary levels while also expanding the number of CHCs in Ontario must be contrasted with the situation of midwives.

37. There has been a continuous, year-over-year rise in the number of midwives in Ontario since midwifery was regulated in 1994.[64] The number of registered midwives in Ontario has grown from 67 registered midwives in 1994 to 818 registered midwives in 2015.[65] This represents an increase of over 900%.[66] Ontario has the largest number of registered midwives in Canada and the largest publicly-funded midwifery program.[67]

38. From 2003/2004 to 2013/2014, the annual midwifery attrition rate has ranged from 1% to 7% and has trended downward over time.[68] Ontario has monitored the midwifery profession for attrition,[69] and since 2011, midwife attrition has never exceeded 3%. The Associate Deputy

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[63] Naylor affidavit at paras. 25-27 (ROP Tab 212, p. 29251) **AC Tab 9 p. 208**.
[64] Pinkney affidavit at paras. 24-25 (ROP Tab 224, p. 30939-40) **AC Tab 11 pp. 221-222**; Chaykowski 2015 report at p. 35-36 (ROP Tab 349, p. 49812-3) **AC Tab 17 pp. 319-320**; Scarth affidavit at paras. 64-66 (ROP Tab, p. 36748) **AC Tab 12 p. 237**.
[65] Scarth affidavit at para. 66 (ROP Tab, p. 36748) **AC Tab 12 p. 237**.
[66] Chaykowski 2014 report at p. 22 (ROP Tab 349, p. 49668) **AC Tab 16 p. 275**.
[67] Courtyard report at p. 15 (ROP Tab 224, p. 31885) **AC Tab 69 p. 778**.
[68] Chaykowski 2014 report at pp. 22, 26 (Figure 4) (ROP Tab 349, pp. 49668, 49672) **AC Tab 16 pp. 275-276**; Scarth affidavit at paras. 64-68 (ROP Tab 253, p. 36748) **AC Tab 12 p. 237**; Midwife attrition table (ROP Tab 253, p. 37030) **AC Tab 62 p. 643**.
[69] Scarth transcript 8 Dec 2016 at pp. 100-103 (ROP Tab 385, pp. 65405-8) **AC Tab 52 pp. 590-593**; Joint Book of Cabinet Documents (ROP Tab 207, pp. 26207, 26280, 26300, 26358, 26395, 26456-7, 26861-2) **AC Tab 80 pp. 880-884**; Briefing Note re: Midwifery Program (2004) at p. 2 (ROP Tab 253, p. 37033) **AC Tab 64 p. 645**; 2006-7 Results-Based Planning Report at p. 10 (ROP Tab 253, p. 37089) **AC Tab 59 p. 630**; 2004-5 Results-Based Plan at p. 3 (ROP Tab 253, p. 37096) **AC Tab 57 p. 628**; CHD015-0 Midwifery Services at p. 8 (ROP

Minister of Health testified that midwifery represented a "quite extraordinary retention success story," with a low attrition rate that is "quite extraordinary for health professionals" and "a very high transfer rate of midwifery graduates into practising midwifery positions."[70]

39. There is unmet demand for midwifery services in Ontario because the number of registered midwives is insufficient to provide service to every client who wants it.[71] While the health system aims to provide everyone with access to good prenatal and obstetrical care, which can be provided by either a physician or a midwife, there is no guarantee that the service will be provided by the client's preferred provider. Nevertheless, in an effort to address this unmet demand for midwives, Ontario's policy response has been to increase the number of midwives funded to provide services in the OMP. Each year, up to 90 new registrant midwives are added to the publicly-funded program, and every graduate is guaranteed funding to provide services. Midwifery graduates, unlike graduates of any other health professional program including physicians, are "effectively guaranteed a job and compensation upon graduation" with "a place for every midwifery graduate in a practice group."[72] As a result, the volume of services provided in Ontario has grown each year.[73]

Tab 253, p. 37110) **AC Tab 66 p. 649**; Draft Presentation on Midwifery Education Program Expansion at p. 4 (ROP Tab 253, p. 37117) **AC Tab 72 p. 834** ; Presentation re: 2006-7 New Practice Group Proposal Development Workshop at p. 8 (ROP Tab 253, p. 37129) **AC Tab 89 p. 981**.

[70] Naylor transcript at pp. 98-103 and 144-147 (ROP Tab 376, pp. 63640-44 and 63685-7) **AC Tab 44 pp. 506-511**; Davey transcript, 21 Oct 2016 at pp. 128-130 (ROP Tab 373, pp. 63209-11) **AC Tab 29 pp. 385-387**; Davey transcript, 2 Nov 2016 at pp. 78-79 (ROP Tab 375, p. 63537-8) **AC Tab 31 pp. 391-392**.

[71] Naylor transcript at pp. 104-106 (ROP Tab 376, pp. 63645-7) **AC Tab 44 pp. 512-514**; Chaykowski 2015 report at pp. 35-38 (ROP Tab 349, pp. 49812-5) **AC Tab 17 p. 319-322**; Courtyard report at p. 26 (ROP Tab 224, p. 31896) **AC Tab 69 p. 789**.

[72] Naylor transcript at p. 102 (ROP Tab 376, p. 63643) **AC Tab 44 p. 510**.

[73] Scarth affidavit at para. 57 (ROP Tab 253, pp. 36745-6) **AC Tab 12 pp. 235-236** ; Pinkney affidavit at paras. 24-25 (ROP Tab 224, p. 30939-40) **AC Tab 11 pp. 221-222**.

40. Increasing the compensation level for the existing number of midwives would not have increased the number of midwives providing service or the amount of service provided.[74] There was no evidence that the prevailing compensation levels were too low to attract or retain midwives to the program, and no evidence of midwives leaving Ontario in significant numbers or choosing to provide services outside of the provincial program, as they are free to do.[75] The manager of the OMP explained: "We were expanding the number of midwives. We were able to always recruit midwives into practice groups. There were always midwives lining up to go into the education program. That's not the case with physicians at the same time."[76]

G. History of compensation for midwives

41. On January 1, 1994, Ontario became the first province in Canada to regulate midwifery and the first province to fund midwifery services through the Ontario Midwifery Program ["OMP"].[77] With no other publicly-funded midwives in Canada, it was necessary to set midwives' initial compensation with reference to available comparators in other professions.

42. Various early documents, including the 1987 Task Force report on midwifery, the 1992 Interim Regulatory Council of Midwives report and the Ministry of Health ["MOH"] 1993

[74] Chaykowski 2015 report at pp. 33-38 (see in particular p. 36) (ROP Tab 349, pp. 49810-49815) **AC Tab 17 pp. 317-322**; Davey transcript, 1 Nov 2016 at pp. 55-56 (ROP Tab 374, pp. 63334-5) **AC Tab 30 pp. 389-390**; Davey transcript, 21 Oct 2016 at pp. 35-36 (ROP Tab 373, pp. 63116-7) **AC Tab 29 pp. 383-384**.
[75] Davey transcript, 2 Nov 2016 at pp. 78-80 (ROP Tab 375, pp. 63537-9) **AC Tab 31 pp. 391-393**; Davey affidavit at para. 170 (ROP Tab 201, pp. 22231-2) **AC Tab 4 p. 175-176**; Naylor transcript at pp. 98-103 and 144-147 (ROP Tab 376, pp. 63640-44 and 63685-7) **AC Tab 44 pp. 506-511**; Scarth transcript Dec 8 at pp. 100-103 (ROP Tab 385, pp. 65639-42) **AC Tab 52 pp. 590-593**; Farrell transcript 7 Dec 2016 at pp. 31-32 and 152-153 (ROP Tab 383, pp. 65110-11 and 65231-2) **AC Tab 34 pp. 404-405, 410-411**.
[76] Davey transcript, 1 Nov 2016 at p. 41 (ROP Tab 374, p. 63320) **AC Tab 30 p. 388**; Chaykowski 2015 report at p. 36-39 (ROP Tab 349, p. 49812-6) **AC Tab 17 pp. 320-323**.
[77] Midwifery Task Force Bulletin re: Proclamation of the Midwifery Act (1993) (ROP Tab 201, pp. 22974-5) **AC Tab 82 pp. 887-888**; Liability Decision at para. 1.

Principles of Funding, recommended that compensation level for midwives fall between the level of a family practitioner and a senior salaried nurse.[78]

43. In the summer of 1993, representatives of the AOM and the MOH formed a joint Work Group to consider and recommend to government a salary for midwives. The Work Group retained Robert Morton, a compensation consultant, to provide information and assistance in positioning the new salary of midwives at a fair and appropriate level.[79] With Morton's help, the Work Group compared the skill, effort, responsibility and working conditions of midwives with other professionals including CHC senior nurses and family physicians.

44. Morton did not recommend a salary level. His 1993 report ["the Morton Report"] records the agreement reached by the Work Group "on the relative positioning of midwifery in relation to primary care nurses and family practitioners in a Community Health Clinic."[80] The Work Group came to agreement that a fair and appropriate level of pay for midwives would be $55,000-$77,000 per year.[81] This salary range "split the difference" between the initial bargaining positions of the AOM and the MOH.[82] While this agreement resulted in the highest

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[78] Liability Decision at paras. 78-79, 86-87 and 90; MOH Principles of Funding (1993) (ROP Tab 298, pp. 38824-7) **AC Tab 83 pp. 889-892** ; AOM 1993 Principles of Funding (ROP Tab 201, pp. 22783-22785) **AC Tab 60 pp. 631-633**; Porter transcript at pp. 133, 135-137 (ROP Tab 389, pp. 66576, 66778-80) **AC Tab 48 pp. 553-556**; Davey affidavit at para. 10 (ROP Tab 201, p. 22178) **AC Tab 4 p. 168**; IRCM Models of Practice and Payment Committee Report (1992) at p. 10 (ROP Tab 201, p. 22686) **AC Tab 79 p. 875**; Ontario Midwifery Program Framework (ROP Tab 201, pp. 22912-22922) **AC Tab 86 pp. 961-971**; Report of the Task Force on the Implementation of Midwifery in Ontario at p. 166-7 (ROP Tab 201, p. 22407-8) **AC Tab 90 pp. 982-983**; Ontario Midwifery Program Framework Cabinet Document at p. 11-12 (ROP Tab 201, pp. 22946-7) **AC Tab 85 pp. 936-937**.

[79] Morton affidavit at paras. 5-13 (ROP Tab 242, p. 34042-3) **AC Tab 8 pp. 203-204**.

[80] Morton Report on Compensation for Midwives in Ontario at p. 2 (ROP Tab 201, pp. 22853) ["Morton Report"] **AC Tab 84 p. 897**; Liability Decision at paras. 100-105.

[81] Morton Report at pp. 1-3 (ROP Tab 201, p. 22852-4) **AC Tab 84 pp. 896-898**; Davey affidavit at para. 29 (ROP Tab 201, p. 22184) **AC Tab 4 p. 169**.

[82] Kilthei transcript, 15 Sept 2016 at pp. 115-116 (ROP Tab 358, pp. 60360-1) **AC Tab 39 pp. 458-459**.

midwife salary level equalling approximately 90% of the lowest CHC physician salary level,[83] compensation for midwives was not set as any fixed percentage of CHC physician salaries.[84]

45. The Work Group prepared a document called the OMP Framework that described the model of practice, the model of payment, and the agreed salary range. A Cabinet submission in September 1993 that sought approval for the salary range described the process for setting midwives' compensation as follows:[85]

> The salary range for midwives was determined after a review of the job requirements and current salaries paid to a number of health and social service professionals. Most specifically, the jobs of a primary care nurse in a community health centre (CHC) and a CHC family physician were compared with the job of a midwife. It was found that the level of responsibility and skill required by a midwife was somewhat more than that of a nurse but less than that of a physician. The recommended salary range for midwives reflects that assessment.

46. None of the Principles of Funding, the Morton Report, the OMP Framework or the Cabinet submission referred to pay equity, a "male comparator", or the sex predominance of family physicians. Robert Morton testified that if he had been asked to undertake a pay equity analysis, he would have declined the assignment as it did not fall within his expertise.[86] He was not asked to and did not determine the gender predominance of any jobs or compare job point values.[87] Susan Davey, an MOH participant in the Work Group, testified the Work Group did not identify any "male" comparator or conduct a pay equity analysis.[88]

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[83] Liability Decision at para. 29.
[84] Liability Decision at para. 290.
[85] Ontario Midwifery Program Framework Cabinet Document at pp. 11-12 (ROP Tab 201, pp. 22946-22947) **AC Tab 85 pp. 936-937**.
[86] Morton affidavit at paras. 4, 11-12 (ROP Tab 242, pp. 34042-3) **AC Tab 8 pp. 203-204**; Morton transcript at p. 11 (ROP Tab 381, p. 64596) **AC Tab 43 p. 487**.
[87] Morton affidavit at para. 11 (ROP Tab 242, p. 24043) **AC Tab 8 p. 204**.
[88] Davey affidavit at para. 40 (ROP Tab 201, pp. 22188) **AC Tab 4 p. 171**; Davey transcript, 20 Oct 2016 at pp. 16-17 (ROP Tab 372, pp. 62865-6) **AC Tab 28 p. 365-366** .

47. After its initial setting in 1993, the compensation level for midwives did not change until 2005, although the payment mechanisms were amended to support midwives' status as independent contractors. The pay levels were frozen because of compensation restraint.[89]

48. In 2003 and 2004, the AOM retained compensation consultants (the Hay Group) to prepare reports to support its position in negotiating pay increases with the MOH. Hay Group did not conduct any pay equity or gender-based analysis, did not conduct any job evaluation, and did not compare the value of a midwife's work to the value of any other job.[90] The Hay Group reports were premised on setting midwives' top pay level at 90% of an entry-level CHC physician salary to replicate the pay difference between the two professions in 1993.[91]

49. In an effort to commence salary negotiations, the AOM initiated a public campaign in November 2004, threatening job action, a press conference, and a march on Queen's Park. On the eve of the announced march, the MOH contacted the AOM to begin negotiations.[92] A new agreement was reached effective April 1, 2005 that increased fees for midwives by 20% to 29% depending on level of experience. Benefits and operating fees also increased. The Tribunal held that this agreement was "a very positive outcome" for the AOM even though the AOM had not achieved everything it wanted, and that the AOM did not raise any concerns about pay equity or gender in its board minutes or communications regarding the agreement.[93]

50. The AOM and MOH reached another agreement providing for compensation increases in 2009. The parties agreed at that time to a joint review to suggest an appropriate "total

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[89] Liability Decision at paras. 121-122.
[90] Greengarten transcript at pp. 164-167 **AC Tab 36, pp. 434-437**.
[91] Liability Decision at paras. 156-158.
[92] Liability Decision at para. 161.
[93] Liability Decision at para. 163-168.

compensation" package for midwifery services, and Courtyard Group was retained to conduct the review and prepare a non-binding report to inform the next round of negotiations.[94]

51. The Courtyard report recommended a one-time 20% increase to four course of care fees effective April 1, 2011 that was intended to "restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians."[95] The report was not a job evaluation or a pay equity report.[96] It did not refer to sex, gender or discrimination. The report's lead author admitted that he and the Courtyard Group were not "compensation experts" or experts in job evaluation.[97] He explained that the basis of his recommended pay increase was that it "felt fair" in a "generalized sense of fairness."[98]

52. Negotiations between the AOM and the MOH began after the release of the Courtyard report. The AOM sought a 20% pay increase consistent with the report's recommendation. The MOH believed that the Courtyard report was flawed (as set out below at paras. 165-168) and that the recommended increase was not supportable in an environment of province-wide compensation restraint, but recognized that the report had raised the AOM's expectations. The MOH made a counter-offer of a 2% fee increase plus a 3% quality improvement incentive, which was rejected by the AOM.[99] The resulting impasse in negotiations led to the AOM filing an application to the Tribunal in November 2013.[100]

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[94] Liability Decision at paras. 178, 187 and 199.
[95] Courtyard report at p. 43 (ROP Tab 224, p. 31913) **AC Tab 69 p. 806**; Remedy Decision at para. 136.
[96] Ronson transcript at pp. 84-85, 101-103 (ROP Tab 370, pp. 62715-6, 62732-4) **AC Tab 51 pp. 570-574**.
[97] Ronson transcript at pp. 65, 103 (ROP Tab 370, pp. 62696, 62734) **AC Tab 51 pp. 569, 574.**
[98] Ronson transcript at pp. 84, 103-104 (ROP Tab 370, pp. 62715, 62734-5) **AC Tab 51 pp. 570, 574-575**.
[99] Liability Decision at para. 213-217.
[100] Liability Decision at para. 19; Remedy Decision at para. 7.

PART III – ISSUES AND THE LAW

53. Ontario submits that this application raises the following issues:

A. What is the standard of review?

B. Did the Tribunal properly apply the test for discrimination?

C. Was it unreasonable for the Tribunal to find that midwives had experienced any adverse treatment related to their compensation?

D. Was it unreasonable for the Tribunal to find that sex was a factor in any adverse treatment related to the compensation of midwives?

E. Was the Tribunal's remedial decision reasonable?

54. Ontario submits that the Tribunal failed to correctly apply the test for discrimination and was unreasonable to find that midwives have experienced adverse treatment because of sex. The Tribunal compounded this error by granting unreasonable remedies.

A. The Tribunal's decisions were unreasonable

a. Reasonable decisions must be justified by the reasons and on the evidence

55. The standard of review of the Tribunal is reasonableness.[101] Reasonableness is concerned with "justification, transparency and intelligibility within the decision-making process" and with "whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law."[102] It is not enough for the outcome of a decision to be *justifiable*; it must also be *justified* by way of the reasons provided.

56. Although reasonableness is a deferential standard, the Tribunal is not infallible, and this Court has quashed a number of decisions of the Tribunal where they were unreasonable,

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[101] *Shaw v. Phipps*, 2012 ONCA 155 at para. 10 ["*Phipps*"]. This Court has consistently held that the reference to "patently unreasonable" in s. 48.5 of the *Code* means the most deferential standard of review in administrative law, which is reasonableness: see e.g. *Shaw v. Phipps*, 2010 ONSC 3884 at paras. 30-43 (Div. Ct.); *Audmax Inc. v. Ontario Human Rights Tribunal*, 2011 ONSC 315 at paras. 16-33 (Div. Ct.); See also *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65 at paras. 88-90 ["*Vavilov*"].

[102] *Vavilov* at para. 86.

including cases where the Tribunal misapprehended the evidence, failed to consider relevant evidence, or made unreasonable findings on the evidence.[103]

57. The Supreme Court has held that there are "two types of fundamental flaws" that render a decision unreasonable: "The first is a failure of rationality internal to the reasoning process. The second arises when a decision is in some respect untenable in light of the relevant factual and legal constraints that bear on it."[104] Both flaws are present in this case.

58. Rationality internal to the decision-making process means that the decision must be based on reasoning that is both rational and logical. A decision will be unreasonable if the reasons "fail to reveal a rational chain of analysis or if they reveal that the decision was based on an irrational chain of analysis", or "where the conclusion reached cannot follow from the analysis undertaken," or if the reasons read with the record "do not make it possible to understand the decision maker's reasoning on a critical point." Reasonable decisions do not employ "circular reasoning, false dilemmas, unfounded generalizations or an absurd premise." A reviewing court must be satisfied that the Tribunal's reasoning "adds up".[105]

59. A reasonable decision must also be justified in relation to the law and facts. A decision is unreasonable where the Tribunal "has fundamentally misapprehended or failed to account for the evidence before it" or "relied on irrelevant stereotypes and failed to consider relevant evidence" or "showed that [its] conclusions were not based on the evidence that was actually

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[103] See e.g. *Longueépée v. University of Waterloo*, 2019 ONSC 5465 at para. 63 (Div. Ct.); *City of Toronto v. Josephs*, 2018 ONSC 67 at paras. 39-46 (Div. Ct.); *L.B. v. Toronto District School Board*, 2017 ONSC 2301 (Div. Ct.); *Toronto Police Services Board v. Briggs*, 2017 ONSC 1591 at paras. 49 and 54 (Div. Ct.); *Aiken v. Ottawa Police Services Board*, 2015 ONSC 3793 at para. 41 (Div. Ct.) ["*Aiken*"]; *Crepe it Up! v. Hamilton*, 2014 ONSC 6721 at paras. 20 and 26 (Div. Ct.); *Walton Enterprises v. Lombardi*, 2013 ONSC 4218 at para. 46 (Div. Ct.) ["*Walton*"].

[104] *Vavilov* at para. 101.

[105] All quotes from *Vavilov* at paras. 102-104.

before [it]."[106] A tribunal acts unreasonably when it misapprehends or fails to consider relevant and important evidence.[107]

60. The principles of justification and transparency also require the Tribunal to "meaningfully account for the central issues and concerns raised by the parties." The reasons are "the primary mechanism by which decision makers demonstrate that they have actually *listened* to the parties," and the Tribunal's "failure to meaningfully grapple with key issues or central arguments raised by the parties may call into question whether the decision maker was actually alert and sensitive to the matter before it."[108] Reasons that "simply repeat statutory language, summarize arguments made, and then state a peremptory conclusion" are no substitute for statements of fact, analysis, inference and judgment.[109]

b. The Tribunal's reasons are not justified, transparent or intelligible

61. This Court has held that, by its nature, an allegation that a tribunal has misapprehended evidence will require engagement with the evidence and factual conclusions reached at first instance. This is not a question of the court "substitut[ing] its view of the facts" for that of the tribunal, but rather "simply perform[ing] the analysis necessary to determine whether there had been a misapprehension of the evidence".[110]

62. In this case, engagement with the evidence reveals that the Tribunal misapprehended and ignored important evidence, rendering its decision unreasonable. The Tribunal made fundamental errors by ignoring or discounting the extensive evidence, including expert

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[106] *Vavilov* at para. 126.
[107] *Navistar Canada Inc. v. Superintendent of Financial Services*, 2015 ONSC 2797 at para. 25 (Div. Ct.); *Rao v. The General Manager, Ontario Health Insurance Plan*, 2019 ONSC 3204 at para. 54 (Div. Ct.)
[108] *Vavilov* at paras. 127-128 (emphasis in original).
[109] *Vavilov* at para. 102
[110] *Marusic v. Law Society of Upper Canada*, 2017 ONSC 663 at para. 28 (Div. Ct.).

evidence, that demonstrated the non-discriminatory reasons why CHC physicians received salary increases between 2005 and 2010 that midwives did not receive.

63. The Tribunal compounded these evidentiary errors by reasoning in an internally incoherent way, using circular and illogical reasoning and drawing ungrounded inferences and peremptory conclusions. The resulting reasons "fail to provide a transparent and intelligible justification"[111] for the conclusion reached, rendering its decision unreasonable.

B. The Tribunal improperly applied the test for discrimination

a. The test for discrimination and the burden of proof

64. Under the *Code*, the burden of proof is on applicants to demonstrate that: (1) they have a characteristic protected from discrimination under the *Code*; (2) they experienced an adverse impact; and (3) the protected characteristic was a factor in the adverse impact. The onus of proving discrimination on a balance of probabilities remains on the applicant throughout.[112]

65. It is not enough to prove that an applicant is characterized by a protected ground, or that there is a history of disadvantage or discrimination against the group generally:

> It cannot be presumed solely on the basis of a social context of discrimination against a group that a specific decision against a member of that group is necessarily based on a prohibited ground under the [human rights statute]. In practice, this would amount to reversing the burden of proof in discrimination matters. Evidence of discrimination, even if it is circumstantial, must nonetheless be tangibly related to the impugned decision or conduct.[113]

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[111] *Vavilov* at para. 136.

[112] *Peel Law Association v. Pieters*, 2013 ONCA 396 at para. 56 ["*Pieters*"]; *Phipps* at para. 14; *Moore v. British Columbia (Education)*, 2012 SCC 61 at para. 33 ["*Moore*"]; *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593 at para. 109 ["*Tranchemontagne*"].

[113] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39 at para. 88 ["*Bombardier*"].

66. Discrimination may be proven through circumstantial evidence, but this does not shift the burden of proof or change the evidentiary standard.[114] The test for discrimination and the burden are the same whether the discrimination alleged is individual or systemic.[115]

67. The Court of Appeal has noted that "the law, while maintaining the burden of proof on the applicant, provides respondents with good reason to call evidence." The respondent's evidence is "often essential to accurately determining what happened and what the reasons for a decision or action were." A respondent therefore faces the tactical choice: "explain or risk losing." Where a respondent calls evidence providing a non-discriminatory explanation for any adverse treatment, the Court of Appeal has held that the burden is on the applicant to prove that the respondent's evidence is "false or a pretext."[116]

68. This standard from *Pieters* is the standard applied regularly by the Tribunal and by Ontario's courts in discrimination cases under the *Code*.[117] In this case, where Ontario led extensive evidence providing non-discriminatory explanations for its decisions, the burden was on the claimant to prove that this evidence was false or a pretext.

69. Instead, although the Tribunal purported to apply the *Pieters* standard,[118] the Tribunal found discrimination without rejecting Ontario's evidence as false, a pretext, incredible or unreliable, relying on a general societal context of sex discrimination in compensation. The Tribunal misapplied the law in so doing and reversed the onus.

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[114] *Phipps* at paras. 12 and 29-35.
[115] *Moore* at paras. 58-60.
[116] All quotes from *Pieters* at paras. 72-74.
[117] See e.g. *Cieslinski v. Aon Reed Stenhouse Inc.*, 2015 HRTO 644 at para. 135; *Rutledge v. The Travel Corporation (Canada)*, 2013 HRTO 1634 at paras. 8-9; *Clennon v. Toronto East General Hospital*, 2009 HRTO 1242 at para. 69, reconsideration refused in 2010 HRTO 1693; *Bennie v. Toronto (City)*, 2017 HRTO 508 at paras. 53-56; *Koitsis v. Ajax Automobile (2008) Inc.*, 2016 HRTO 1628 at para. 64; *Faghihi v. Black Swan Pub and Grill*, 2016 HRTO 1109 at para. 50; *Phipps* at para. 24; *Pieters* at paras. 16 and 105-108.
[118] Liability Decision at paras. 254 and 260-261.

b. The Tribunal misapplied the test for discrimination and misapplied the onus

70. The Tribunal misapplied the standard from *Pieters*.[119] The Tribunal made no finding that there was any direct evidence that sex was a factor in any of Ontario's decisions concerning the compensation of midwives after 2005, and in any event there was no such direct evidence. In all of the evidence and documents produced by Ontario, no MOH document stated and no MOH witness testified that sex was a factor in decisions about the compensation of midwives.

71. But neither did the Tribunal identify any circumstantial evidence that showed that sex was a factor or that the evidence provided by Ontario's witnesses was false, a pretext, incredible, or unreliable. While in *Pieters*, for example, the Tribunal found discrimination after it "found that the only explanation provided [by the respondent] had been proven false"[120], and in *Phipps*, the Tribunal "came to a reasoned decision explaining why [it] did not accept Constable Shaw's position as providing a credible non-discriminatory explanation for his conduct toward Mr. Phipps",[121] in this case there is no similar analysis or explanation rejecting as false any of the evidence of Ontario's witnesses.

72. Indeed, the Tribunal found that Ontario's position that "differences in compensation paid to CHC physicians and midwives are based solely on occupational differences and labour market forces" such as "recruitment and retention issues" were "reasonable explanations",[122] but nonetheless went on to find that sex was also "one of the factors that explains the difference in compensation levels between midwives and CHC physicians", without identifying any evidence that indicated even circumstantially that sex was a factor.[123]

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[119] Liability Decision at paras. 258-260.
[120] *Pieters* at paras. 16 and 105-108.
[121] *Phipps* at para. 24.
[122] Liability Decision at para. 314.
[123] *Bombardier* at para. 88.

73. This is not a case where a respondent was content to remain silent and rely on the applicant's burden, or to suggest only that "possible alternative explanations might exist" to explain its own conduct.[124] Ontario came to the Tribunal with extensive direct evidence that included contemporaneous MOH and Cabinet documents, evidence from senior managers in the MOH who were responsible for the programs at issue over the relevant period, and relevant expert evidence. Ontario led the very kind of evidence that the Court of Appeal has advised respondents to lead: "a rational and credible explanation for [its] actions other than discrimination."[125] None of this evidence was rejected by the Tribunal. Much of it, including Ontario's evidence of the "critical" shortage of family physicians and the vacant CHC physician positions after 2005, was not referred to at all by the Tribunal.

74. In the absence of a finding that any of Ontario's evidence was incredible, unreliable, false or a pretext, it was unreasonable for the Tribunal to discount these explanations without justification, and instead infer that sex must have been a factor, in addition to any other non-discriminatory factors, in the compensation of midwives. The Supreme Court has held that an allegation of systemic discrimination may not be proved by relying on intuition or a "web of instinct."[126] For this reason alone, the Tribunal's decision is unreasonable.[127]

75. Should the AOM argue that the test or standard of proof from *Pieters* was inapplicable in this case because of the systemic nature of the discrimination alleged, Ontario notes that the Tribunal adopted and purported to follow *Pieters*, and expressly held that the "test for proving discrimination does not change because the claim [is] systemic in nature."[128] If the Tribunal

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[124] Liability Decision at para. 260.
[125] *Phipps* at paras. 30-31.
[126] *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30 at para. 34.
[127] *Vavilov* at para. 102
[128] Liability Decision at paras. 254 and 260-262, following *Moore* at paras. 58-60.

stated one test but really applied a different one, that would mean that the written reasons are "neither transparent nor intelligible – two fundamental requirements of reasonableness."[129]

C. The Tribunal was unreasonable to find that midwives had suffered adverse treatment

76. It was not contested that, since midwives are almost exclusively female and therefore are characterized by the protected ground of sex, the first step of the test for discrimination was met. The dispute in this case was whether the claimant had established that the second step (adverse treatment) and third step (the connection between sex and the treatment) were met.[130]

77. The Tribunal was unreasonable to find that adverse treatment had been proved. The Court of Appeal has held that "the test for establishing discrimination under the *Code* is consistently expressed in the jurisprudence as requiring a distinction based on a prohibited ground that creates a disadvantage."[131] This principle has been consistently expressed in identical language by the Tribunal in many decisions.[132] The Court of Appeal has held that "it is only where making a distinction on a prohibited ground has the effect of creating a disadvantage that concerns about substantive inequality are engaged."[133] This focus on disadvantageous distinctions applies no less to claims of adverse effects discrimination than it does to claims of direct discrimination.[134]

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[129] *Ontario Nurses' Association v. Cambridge Memorial Hospital*, 2019 ONSC 3951 at para. 39 (Div. Ct.); *Vavilov* at para. 87.
[130] Liability Decision at paras. 250-256.
[131] *Tranchemontagne* at para. 74 and para. 77 (emphasis added).
[132] See e.g. *Carter v. Chrysler Canada Inc*., 2017 HRTO 168 at para. 93, aff'd 2019 ONSC 142 (Div. Ct.); *Konesavarathan v. Guelph (City),* 2016 HRTO 1453 at para. 11, aff'd 2018 ONSC 2146 (Div. Ct.); *Congdon v. Govinda Galleries*, 2013 HRTO 1230 at paras. 7-8; *Browning v. Northend Body Shop Ltd*, 2017 HRTO 1001 at para. 40.
[133] *Tranchemontagne* at para. 79 (emphasis added).
[134] *Ontario (Human Rights Commission) v. Simpsons Sears Ltd.*, [1985] 2 S.C.R. 536 at 551 ["*O'Malley*"]; *Tranchemontagne* at paras. 75 and 90; In *Bombardier* at para. 35, this principle was expressed as requiring a "distinction, exclusion or preference" that has the effect of nullifying or impairing the right to full and equal recognition.

78. This concept of a disadvantageous distinction is wholly absent from the Tribunal's reasons. Adverse treatment could undoubtedly arise under the *Code* where one employee is paid less than another "for the same, or substantially the same, work"[135] or for "substantially similar work,"[136] or where two occupational groups "have been doing substantially the same work"[137] and "the core function [of the two groups] is the same."[138] Unequal pay for work of equal value (pay inequity) could also be adverse treatment under the *Code*.[139]

79. But in this case the Tribunal made no finding that midwives and CHC physicians did substantially the same work or performed the same core function, and indeed all of the evidence (reviewed above at paras. 9-17) was to the contrary. Most of a CHC physician's work is the diagnosis and treatment of complex chronic disease, not providing low-risk obstetrical care. For example, during the period after 2005 when the Tribunal found that the "compensation gap" arose, CHC physicians were paid incentive payments for performing medical services such as primary care of serious mental illness, diabetes management, mammography, flu vaccines for patients over 65, palliative care, and colorectal screening.[140] None of these medical services are within the scope of practice of midwives.[141] Ontario did not treat midwives "adversely" or "disadvantage" them by failing to pay them for medical procedures and services that they did not and could not perform.[142]

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[135] *Garofalo v. Cavalier Hair Stylists Shop Inc.*, 2013 HRTO 170 at paras. 173 and 195.
[136] *Garrie v. Janus Joan Inc.*, 2014 HRTO 272 at para. 70, reconsideration allowed but not on this point: 2012 HRTO 1955.
[137] *Walden v. Canada (Social Development)*, 2007 CHRT 56 at para. 71 ["*Walden*"].
[138] *Walden* at paras. 118 and 136.
[139] *Nishimura v. Ontario (Human Rights Commission)*, 70 OR (2d) 347 (Div. Ct.).
[140] Davey affidavit at para. 193 (ROP Tab 201, pp. 22242-3) **AC Tab 4 pp. 183-184**.
[141] *Midwifery Act, 1991*, S.O. 1991, c. 31, s. 3.
[142] See paras. 9-10 above; see also Remedy Decision at para. 132.

80. Moreover, the Tribunal made no finding that the work of midwives and CHC physicians was of equal value or even of similar value. While the AOM led evidence from a job evaluator attempting to prove that the work done by midwives was close in "job value" to that done by CHC physicians,[143] the Tribunal expressly did not accept this evidence,[144] finding instead that it was not necessary to rely on any of the expert witnesses in coming to its decision on liability[145] and that it had "not attempted to rate these jobs for comparison purposes."[146]

81. Instead, the Tribunal held that "Midwives have been disadvantaged by the failure of the MOH to recognize the role of gender in their compensation, the overlapping scope of practice they share with physicians and the reasons for maintaining a physician comparator."[147] This reasoning was circular and unreasonable.

82. The Tribunal found the disadvantage step in the test for discrimination was met because Ontario failed to "recognize the role of gender" in midwives' compensation. This finding on the second step assumed the very conclusion that the test for discrimination is intended to determine: whether gender did in fact play a negative role in the compensation of midwives. It was equally circular to find that midwives were "disadvantaged" by Ontario's failure to recognize "the reasons for maintaining a physician comparator," which reasons were identified by the Tribunal as preventing midwives from being "at risk" of or "exposed to" sex discrimination.[148] The second step of the test for discrimination cannot be met by a purported failure to take steps to prevent the very discrimination that the test is intended to identify.

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[143] See Remedy Decision at para. 38. This evidence was contested extensively by the MOH. The Tribunal did not determine this controversy: see Liability Decision at paras. 263-269.
[144] Liability Decision at para. 265; Remedy Decision at paras. 147-154.
[145] Liability Decision at para. 263.
[146] Liability Decision at para. 268.
[147] Remedy Decision at para. 188.
[148] Remedy Decision at para. 20; Liability Decision at para. 323.

83. With respect to the finding that midwives were disadvantaged by Ontario's failure to recognize the "overlapping scope of practice they share with physicians", the Tribunal misapprehended the limited extent of this overlap, and in any event made no finding that midwives' compensation did not reflect the overlapping scope, as set out more fully below.[149]

84. It was circular to find that a failure to take steps to prevent discrimination was itself the disadvantageous treatment that met the second step and proved discrimination. In the result, all that the facts showed was that midwives are paid less than CHC physicians to do a very different job. This fact was insufficient to find that the second step in the discrimination test was met, and the Tribunal was unreasonable to find otherwise.

D. The Tribunal was unreasonable to find that sex was a factor in any treatment

a. The *Code* prohibits discrimination *because of* sex

85. Even if adverse treatment had been established, the AOM had to prove that the adverse treatment was, in whole or in part, because of sex. The Tribunal misapplied this principle.

86. Adverse treatment will be "because of" a protected ground where the protected ground was "at least one of the reasons for the adverse treatment."[150] Whether the third step is described as requiring the claimant to show that the treatment was "because of" the protected ground,[151] or that the protected ground is a "factor" in the treatment,[152] or that the prohibited ground "contributed to" the treatment,[153] or that there is a "connection" between the ground and the treatment,[154] the element to be proved is the same:

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[149] See paras. 148-154 below.
[150] *Stewart v. Elk Valley Coal Corp.*, 2017 SCC 30 at para. 43 ["*Elk Valley*"]; *Bombardier* at paras. 43-48; *O'Malley* at para. 18.
[151] *Addai v. Toronto (City)*, 2012 HRTO 2252 at paras. 61-77.
[152] *Moore* at para. 33.
[153] *Bombardier* at para. 48.
[154] *Pieters* at para. 59.

> It is not enough to impugn an employer's conduct on the basis that what was done had a negative impact on an individual in a protected group. Such membership alone does not, without more, guarantee access to a human rights remedy. It is the link between that group membership and the arbitrariness of the disadvantaging criterion or conduct, either on its face or in its impact, that triggers the possibility of a remedy. And it is the claimant who bears this threshold burden.[155]

87. Applicants cannot successfully argue that the third step is made out simply because they are members of a group identified by a prohibited ground which has experienced disadvantage. To do so is simply to repeat the first two steps of the test.[156] In its own decision in *Chuchala*, the Tribunal recognized the independent requirements of the third step:

> The applicant is, in essence, arguing that because he has a disability, he is able to make out a case of discrimination by simply demonstrating that the respondent treated him badly. However, the *Code* requires that the discrimination be linked to one of the prohibited grounds. That is, the applicant must allege that he was discriminated against <u>because of</u> his disability.[157]

88. That midwives are predominantly female,[158] that they are closely associated with the women for whom they provide services,[159] or that they are closely associated with women's health care[160] is evidence only that the first step of the test is met, but it cannot assist in determining whether the third step is met, since the third step is distinct and requires establishing that sex was "at least one of the reasons for the adverse treatment."[161]

89. Moreover, the existence in society of systemic sex discrimination in compensation[162] does not establish and cannot be used to infer that midwives in particular are underpaid because of sex. The AOM's own expert Dr. Armstrong agreed that one could not rely on the

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[155] *McGill Health* at paras. 49 and 56.
[156] If this were sufficient, the applicant in *Bombardier* would have successfully proven discrimination: see *Bombardier* at paras. 74 and 85.
[157] *Chuchala v. Szmidt*, 2010 HRTO 2545 at para. 15 ["*Chuchala*"] (emphasis added).
[158] Liability Decision at para. 2.
[159] Liability Decision at para. 242.
[160] Liability Decision at para. 61.
[161] *Elk Valley* at para. 43.
[162] Liability Decision at para. 321.

overall gender wage gap to ascertain whether a particular employee group was underpaid.[163] A "social context of discrimination against a group" cannot be used to presume that "a specific decision against a member of that group is necessarily based on a prohibited ground."[164]

b. Occupational status is not a protected ground

90. Occupational status is not a prohibited ground of discrimination under the *Code*. This means that a difference in treatment because of a person's occupation is not a difference in treatment that gives rise to discrimination under the *Code*.[165]

91. It is true that midwives are (sometimes) treated differently than physicians, but then all non-physicians are treated differently than physicians. Midwives and physicians are both in turn treated differently than other workers. Each of these and every other occupational group is, from time to time, treated differently than other occupational groups, whether because of economic conditions, labour market dynamics, changing priorities, or a myriad of other reasons. Distinctions between occupational groups, including in how much they are paid, are an ordinary and legitimate feature of the labour economy. The *Code* does not prohibit such distinctions, except where they are made on the basis of a protected ground.

92. The reason that occupational status is not a protected ground under the *Code* or a recognized analogous ground under the *Charter*[166] is because a person's occupation is not an immutable personal characteristic. Any given occupation is comprised of persons with a

[163] Armstrong transcript at pp. 195-197 (ROP Tab 393, pp. 67216-8) **AC Tab 23 pp. 346-348**; See also Chaykowski 2015 report at p. 8 (ROP Tab 349, p. 49785) **AC Tab 17 p. 296**.
[164] *Bombardier* at para. 88.
[165] *Peart v. Ontario (Community Safety and Correctional Services)*, 2014 HRTO 611 at para. 304, aff'd 2017 ONSC 782 (Div. Ct.); See also *Arnold v. Stream Global Services*, 2010 HRTO 424 at paras. 21-24 ["*Arnold*"].
[166] See e.g. *Health Services* at para. 165 (health care workers); *Deep v. Ontario*, [2004] O.J. No. 2734 at para. 100 (Sup. Ct. J.), aff'd [2005] O.J. No. 1294 at para. 6 (C.A.) (doctors); *Baier v. Alberta*, 2007 SCC 31 at paras. 65-66 (school employees); *Delisle v. Canada (Deputy Attorney General)*, [1999] 2 SCR 989 at para. 44 (RCMP officers).

variety of personal characteristics. The demographic profile of a particular occupational group is itself mutable, as the evidence of the changing sex predominance of physicians in Ontario in this case demonstrates. The nature of particular occupations can change too, becoming less or more in demand over time.[167] Treating occupational status as a proxy or *de facto* protected ground is inconsistent with the dynamic nature of the labour economy. Every individual is of equal value under the law. But not all jobs are of equal value at all times.

93. Ontario's evidence,[168] nowhere cited by the Tribunal, was that compensation changes are one policy tool among others to meet the diverse and changing health needs of patients within available public resources. Sometimes, meeting the needs of the patients requires changes to compensation, such as the increases to CHC physician salaries after 2003 to address recruitment and retention problems. Other needs, like unmet demand for a service, may be addressed by increasing the number of provider training opportunities in Ontario or by retaining new graduates by enabling their transition to the Ontario workforce.

94. If the fact that midwives are a female-dominated profession means that any treatment of midwives is *de facto* treatment because of sex, then any treatment perceived by a midwife as being "adverse" is prohibited by the *Code*. It would be impossible for Ontario to discharge its public policy responsibilities if this were the case, particularly as midwives are not the only female-dominated profession in health care or in the labour market generally.

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[167] Greengarten transcript at p. 148 **AC Tab 36 p. 436**.
[168] Naylor affidavit at paras. 25-27 (ROP Tab 212, p. 29251) **AC Tab 9 p. 208**; Naylor transcript pp. 77-78, 96-97, 139-140 and 144-147 (ROP Tab 376, pp. 63618-9, 63637-8, 63680-1, 63685-8) **AC Tab 44 pp. 502-552, 515-521**; Scarth transcript 8 Dec 2016 pp. 153-154 (ROP Tab 385, pp. 65458-9) **AC Tab 52 pp. 594-595**; Farrell transcript 2 Dec 2016 pp. 189-190 (ROP Tab 382, pp. 65004-5) **AC Tab 33 pp. 402-403**; Farrell transcript 7 Dec 2016 p. 32, 43-46 (ROP Tab 383, pp. 65111, 65122-5) **AC Tab 34 p. 405-409**.

95. In *Health Services*, the BC superior court rejected a similar discrimination claim based on substantially similar evidence to that presented in this case[169] that alleged that the adverse treatment of overwhelmingly female-dominated nurses was discriminatory on the basis of sex. The nurses argued that their adverse treatment under Bill 29 (which altered their collective agreements and restrained their compensation) demeaned them as female workers.[170] The Court rejected the argument that this differential treatment of female-dominated health care workers amounted to differential treatment on the basis of sex.[171] This decision was upheld by the BC Court of Appeal and the Supreme Court, which held that the actions complained of "relate essentially to the type of work [the claimants] do, and not to the persons they are."[172] Despite its similarity to this case, the Tribunal did not distinguish or cite *Health Services*.

c. Sex was not a factor in the difference in compensation between midwives and CHC physicians

96. The Tribunal found that "sex was more likely than not, one of the factors that explains the difference in compensation levels between midwives and CHC physicians."[173] This was the central determination in the case, because all of the other conclusions – that Ontario had failed to "monitor, identify and redress discrimination in the compensation of midwives"[174] and had left the "compensation of midwives exposed to the well-known effects of gender discrimination on women's compensation"[175] – were premised on a prior finding that midwives' compensation was discriminatory. In the absence of proof that midwives'

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[169] *Health Services and Support – Facilities Subsector Bargaining Assn v. British Columbia*, 2003 BCSC 1379 at paras. 161-162 ["*Health Services* BCSC"].
[170] *Health Services* BCSC at paras. 184-186.
[171] *Health Services* BCSC at paras. 174 and 181 [emphasis added].
[172] *Health Services and Support – Facilities Subsector Bargaining Assn v. British Columbia*, 2004 BCCA 377 at paras. 132-140; *Health Services* at para. 165.
[173] Liability Decision at para. 314; see also para. 324.
[174] Liability Decision at para. 317.
[175] Liability Decision at para. 323.

compensation was discriminatory, Ontario could not have been found liable under the *Code* for failure to "prevent" or "redress" or for leaving midwives "exposed to" such discrimination.

97. Because the finding that sex was "one of the factors that explains the difference in compensation levels between midwives and CHC physicians" was the critical finding in this case, it called most urgently for transparency, intelligibility and justification in the Tribunal's reasons, and for the Tribunal to demonstrate that it had "actually *listened* to the parties."[176]

98. The Tribunal's reasons do not meet the reasonableness standard on this central issue. The Tribunal "fundamentally misapprehended or failed to account for the evidence before it"[177] and "fail[ed] to reveal a rational chain of analysis."[178] The Tribunal either ignored or discounted all of the legitimate reasons that the compensation of CHC physicians increased faster than that of midwives between 2005 and 2010, and then, having given insignificant weight to those explanations, inferred without any supporting evidence that sex must have been "one of the factors" in the difference in compensation.

99. It is important to note exactly what the Tribunal characterized as the "the compensation gap that has developed between midwives and CHC physicians since 2005."[179] The Tribunal compared the "base compensation" paid to full-time midwives annually[180] to the annual salary of CHC physicians.[181] The Tribunal noted that the difference in compensation between midwives and CHC physicians had been smaller in 1993.[182] Since 2005, the difference between the highest compensation level for a midwife and the lowest salary for a CHC

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[176] *Vavilov* at paras. 127-128 (emphasis in original).
[177] *Vavilov* at para. 126.
[178] *Vavilov* at paras. 102-104.
[179] Liability Decision at para. 324.
[180] Liability Decision at para. 59.
[181] Liability Decision at para. 37.
[182] Liability Decision at para. 29.

physician has increased. The Tribunal referred to this change in the difference between the two occupations as "a significant compensation gap between midwives and physicians".[183]

100. CHC physicians are paid an annual salary for their work. No particular component of their annual salary is attributable to providing maternity care. The "compensation gap" that was said to have developed was the increase in difference between what midwives were paid to provide a full-time year of midwifery services as compared to what CHC physicians were paid to practice family medicine. After 2005, the salaries of CHC physicians rose faster than midwives' fees, at least until 2012 when CHC physician salaries began decreasing. The central issue before the Tribunal was whether sex was a factor in the compensation of midwives "falling behind" that of CHC physicians between 2005 and 2010.[184]

101. Ontario adduced an enormous volume of evidence, including contemporaneous governmental documents, evidence from senior managers who were directly responsible for the programs at issue over the relevant period, and expert evidence, to explain why CHC physicians received compensation increases starting in 2003.

102. There was an "explosion" in medical knowledge concerning the treatment of complex chronic disease over the past 20 years, with an aging patient population living longer with multiple comorbidities and multiple medications, which interact in ways that increase the complexity of family medicine and the knowledge demands on family physicians.[185]

103. Over the same time period, there was a province-wide shortage of family physicians. In every year from 1999 until 2012, Ontario's family physician-to-population ratio was either the lowest or second-lowest of any province in Canada. By 2006, this shortage was "critical",

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[183] Liability Decision at para. 313.
[184] Liability Decision at para. 309.
[185] See para. 13 above.

patients had difficulty accessing primary care, wait times increased, and hundreds of thousands of patients were unattached, meaning they did not have a regular family physician and were reliant on ER access to obtain primary care.[186]

104. The shortage of family physicians was particularly acute in CHCs and represented a substantial barrier to access to health care by CHC clients, who are typically from high-risk and disadvantaged populations.[187] By the early 2000s, many CHCs had physician vacancies or high rates of physician turnover. Low compensation was the most frequently given reason for physicians leaving CHCs. By July 2009, fully one-third of all funded CHC physician FTE positions (96 out of 284 funded positions) were vacant.[188]

105. Ontario sought to expand the number of CHCs in the province throughout the 2000s, consistent with its health priority of ensuring better access to comprehensive primary care for the vulnerable patients served by CHCs. However, Ontario could not recruit or retain family physicians to work even in the existing CHCs at prevailing compensation levels, let alone expand the number of CHCs in the province.[189] Nor could CHCs provide comprehensive primary care to their clients without physicians, since many of the medical services offered by CHCs could not be performed by non-physicians, because of the unique education, training, skills and scope of practice of physicians.[190]

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[186] See para. 32 above.
[187] Strategic Review of the Community Health Centre Program (2001) at pp. 48-55 (ROP Tab 212, pp. 29960-29967) **AC Tab 95 pp. 1006-1013**.
[188] See para. 30 above.
[189] See paras. 25-30 above.
[190] See paras. 9-17 above; see also Nitti transcript at pp. 31-32 (ROP Tab 380, p. 64404-5) **AC Tab 45 pp. 527-528**; Woolhouse transcript at pp. 70-71 (ROP Tab 379, p. 64205-6) **AC Tab 56 pp. 626-627**; Kiran transcript at pp. 177-178 (ROP Tab 380, pp. 64550-1) **AC Tab 40 pp. 468-469**; Macdonald transcript at pp. 177-178, 184-185 (ROP Tab 379, pp. 64312-3, 64319-20) **AC Tab 41 pp. 481-484**; Greengarten transcript at p. 34 **AC Tab 36 p. 431**; Darouge et al. "Roles of Nurse Practitioners and Family Physicians in Community Health Centres" (2014)

106. After 2004, CHC physician salaries came within the bargaining relationship between the MOH and the OMA, which sought to harmonize the salaries of CHC physicians with the compensation available to family physicians practicing in different settings. This fact enhanced the bargaining power of CHC physicians, because the OMA has significant bargaining power, given that its members perform vital, medically-necessary services that no other health care provider can perform.[191]

107. None of these facts applied to midwives. There was no expert evidence of an "explosion" in midwifery knowledge since 2000 comparable to the one that occurred in family medicine, and the Tribunal made no such finding. In 2010, the Courtyard report noted that "there haven't been many major changes to the clinical practice of midwifery in the last five years."[192]

108. There was no finding by the Tribunal of any vacancies, turnover, or difficulty recruiting midwives to midwifery practice groups or of any difficulties expanding the number of midwifery practice groups in Ontario, and the evidence was that no vacancies or recruiting difficulties existed.[193] Attrition among midwives is low.[194] Throughout all the years that Ontario was in last place or next-to-last place in Canada for family physicians per capita, Ontario had the largest number of registered midwives and the largest publicly-funded midwifery program in Canada.[195]

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at pp. 1020 and 1025 (ROP Tab 345, pp. 45003 and 45008) **AC Tab 71 pp. 831-832**; Durber transcript, 25 Jan 2017 at pp. 473-475 (ROP Tab 387, pp. 66175-7) **AC Tab 32 pp. 394-396**.

[191] See para. 34 above.

[192] Courtyard report at p. 24 (ROP Tab 224, p. 31894) **AC Tab 69 p. 787**.

[193] See paras. 37-39 above.

[194] Liability Decision at para. 123.

[195] Liability Decision at para. 194; Courtyard report at p. 15 (ROP Tab 224, p. 31888) **AC Tab 69 p. 778**.

109. CHC physicians' bargaining power was enhanced after 2004 by their association with the OMA. While physicians are the only professionals who are authorized to perform many vital medical services, midwives are not the only professionals who can provide low-risk obstetrical care. Most low-risk deliveries in Ontario are in fact conducted by physicians, not midwives (physicians also care for all high-risk pregnancies).[196] This fact has evident implications for the bargaining power of midwives relative to that of physicians. If midwives withdraw their services, physicians can provide comprehensive maternity care to the population. But if physicians withdraw their services, midwives cannot provide medical care.

110. All of these reasons for the increase in compensation of CHC physicians were based on facts that arose after 1993. They were not part of the original "1993 principles and methodology" because they did not exist in 1993. To the extent that the "alignment" between midwives and CHC physicians changed after 1993, it was because the facts had changed.

111. Some of these facts were noted by the Tribunal (such as the "explosion" in medical knowledge)[197] and some of them were ignored altogether (the Tribunal did not refer to the "critical shortage" of family physicians in Ontario by 2006[198] or the fact that one-third of all CHC physician positions were vacant as of 2009), but none of these facts were found to be false or a pretext, and none of Ontario's witnesses were found to be incredible or unreliable.

112. The Tribunal even acknowledged that Ontario had led "considerable evidence" from CHC physicians about their work, education and training to demonstrate how different they are from midwives"[199] as well as a substantial volume of expert evidence, including evidence about "the training and work of family physicians and the challenges they have faced over the

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[196] Chaykowski 2014 report at p. 80 (ROP Tab 349, p. 49726) **AC Tab 16 p. 287**.
[197] Liability Decision at para. 268.
[198] See para. 32 above.
[199] Liability Decision at para. 299.

past 20 years."[200] Nonetheless, the Tribunal concluded that it "did not find it necessary to rely on any of the experts in coming to [its] decision on liability" and that it "did not require expert evidence on the work of CHC physicians."[201]

113. Instead, while the Tribunal held that this evidence "would be highly relevant to anyone conducting a job evaluation comparing CHC physicians to midwives for compensation purposes", that was "not my role and I have not attempted to rate these jobs for comparison purposes."[202] The Tribunal even held that "recruitment and retention issues" and the need "to harmonize [CHC physician] compensation with other physicians" were "reasonable explanations" for the compensation increases received by CHC physicians, and that "an expert job evaluator would be in the best position to evaluate the impact of those explanations on the compensation gap,"[203] but did not explain why it was not the Tribunal's role to assess the impact of these reasonable, non-discriminatory explanations.

114. Without rejecting any of Ontario's reasons for why CHC physicians received compensation increases after 2005 that midwives did not receive, and indeed after finding that at least some of them were "reasonable explanations", the Tribunal went on to find "that sex was more likely than not, one of the factors that explains the difference in compensation levels between midwives and CHC physicians." The Tribunal failed to explain why the reasons offered by Ontario were not sufficient to account for the difference in compensation, and did not identify any evidence demonstrating that sex was one of the reasons in addition to the non-discriminatory ones. This peremptory conclusion that sex was one of the reasons for the

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[200] Liability Decision at paras. 14 and 263-269.
[201] Liability Decision at paras. 263 and 268.
[202] Liability Decision at para. 268.
[203] Liability Decision at para. 314.

difference in compensation failed to reveal a rational chain of analysis and does not make it possible to understand the Tribunal's reasoning on a critical point.[204]

115. The reason given by the Tribunal for ignoring or minimizing Ontario's explanations for the "compensation gap" was as follows:

> The MOH led considerable evidence from CHC physicians about their work, education and training to demonstrate how different they are from midwives. As I indicated previously, it is not my role to conduct a job evaluation. The MOH agreed at regulation [in 1993] that CHC physicians were an appropriate comparator. Morton, Hay and Courtyard all validated the ongoing relevance of the comparison. Until the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for compensation purposes, I find this position to be speculative. What makes the position of the MOH even more difficult to accept is that it promotes family physicians and midwives as comparable obstetrical providers, equally competent to care for women with normal pregnancies.[205]

116. While it was not the Tribunal's role to conduct a "job evaluation", it was the Tribunal's role to determine whether the evidence demonstrated that occupational differences between midwives and CHC physicians, rather than sex, were the reasons for the difference in compensation. Instead of engaging with the evidence concerning these differences, the Tribunal ignored it.[206] It was unreasonable for the Tribunal to decline to engage with the evidence demonstrating the differences between physicians and midwives because it was "not [its] role", but then to dismiss Ontario's position on those differences as "speculative". The occupational differences described above between CHC physicians and midwives were not speculative. They were established in the evidence that the Tribunal declined to assess.

117. The Tribunal engaged in illogical reasoning when it stated that "Until the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for

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[204] *Vavilov* at para. 103.
[205] Liability Decision at para. 299.
[206] See *Aiken* at para. 69, finding that a similar failure to "get into the merits" was unreasonable.

compensation purposes, I find this position to be speculative."[207] The question at the third step of the discrimination test was not whether midwives and CHC physicians were "not comparable". Any two jobs are comparable. The question was whether sex was a factor in the difference in their pay. To answer that question, the Tribunal needed to assess the evidence.

118. Moreover, while it is true that the MOH agreed when midwives were first regulated in 1993 that "CHC physicians were an appropriate comparator",[208] this does not justify ignoring the evidence explaining why CHC physicians received larger pay increases than midwives after 2005. Equally, the fact that Morton (in 1993) and Hay Group (in 2003-2004) compared midwives with CHC physicians is irrelevant to whether occupational differences between CHC physicians and midwives explained their divergence in compensation after 2005.[209] As for the Courtyard report (in 2010), it is addressed more fully below at paras. 157-177.

119. The Tribunal noted that CHC physicians received compensation increases after 2004 to harmonize their compensation with that of other family physicians in an effort to remedy recruitment and retention problems, partially quoting a Ministry witness who testified that "'it became important to be able to say that a primary care physician is a primary care physician is a primary care physician' and they should have the opportunity to make similar compensation doing similar jobs."[210] The Tribunal suggested that this principle should have been applied to midwives' compensation as well.[211] But while a CHC physician is a primary care physician, a midwife is not a primary care physician. The principle that CHC physicians should have the

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[207] Liability Decision at para. 299.
[208] Liability Decision at para. 299.
[209] Bass 2014 report at pp. 74 and 89 (ROP Tab 346, p. 45287 and 45302) **AC Tab 15 pp. 270, 273**.
[210] Liability Decision at para. 141. The full quote in context is repeated at para. 27 above.
[211] Liability Decision at paras. 315-316.

opportunity to make similar compensation to that of physicians who practice family medicine in other settings could have no application to midwives.

120. The Tribunal should have followed the approach that it took in its prior decision in *Arnold*, in which it held that "The *Code* does not prohibit wage premiums based on skill sets" and that a wage differential based on differences in skill sets "does not amount to discrimination on any prohibited ground in the *Code*."[212] In *Arnold*, the Tribunal held that it was not discriminatory to pay one group of workers more because they have a skill set (in that case, speaking French) that is in demand and in relative shortage. If it was "self-evident" in *Arnold* that speaking French was a skill set that legitimately merited a pay premium, it should have been similarly evident that practising medicine is a skill set that legitimately commands a wage premium. The Tribunal did not cite or attempt to distinguish *Arnold*.

121. The Tribunal held that "Until the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for compensation purposes, I find this position [i.e. how different CHC physicians are from midwives] to be speculative."[213] This was a reversal of the onus, requiring Ontario to prove with a job evaluation that midwives and CHC physicians were "not comparable", which in any event was the wrong question.[214] But it was also a misapprehension of the evidence concerning the limits of job evaluation.

122. Job evaluation assesses jobs by assigning points based on skill, effort, responsibility and working conditions, but it does not measure the market demand for a job or assess whether

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[212] *Arnold v. Stream Global Services*, 2010 HRTO 424 at paras. 21-24 ["*Arnold*"]
[213] Liability Decision at para. 299.
[214] While the Tribunal criticized Ontario for not "produc[ing] a job evaluation", neither the Morton Report nor the Courtyard report were formal job evaluations of the differences between CHC physicians and midwives: see Liability Decision at para. 101; see also Morton affidavit at paras. 10-13 (ROP Tab 242, p. 34042-3) **AC Tab 8 pp. 203-204** and Ronson transcript at p. 103 (ROP Tab 370, p. 62734) **AC Tab 51 p. 574**.

there is a shortage of providers willing to work for the prevailing wage.[215] Ontario's expert evidence on job evaluation, expressly not considered by the Tribunal,[216] was that "a job evaluation methodology…fails to consider and account for the range of labour market factors that determine earnings in professions such as CHC family physicians"[217] and that compensation comparators established initially through job evaluation "can become irrelevant because of a change in the supply and demand for labour."[218] The Tribunal gave no reasons for ignoring this expert evidence and holding instead that a job evaluation was the *only* permissible method by which Ontario could explain the differences in pay.

123. Even the AOM's own compensation consultant agreed that "sometimes the logic of the points system has to bend to the market reality that in-demand workers can go to a different workplace and make more money" and "the availability of other workplace options for such in-demand workers means you might have to pay them more to recruit or retain them than the strict points approach would otherwise indicate."[219] The Tribunal ignored this evidence.

124. The Pay Equity Hearings Tribunal has held that "Where a male job class of equal value to a female job class is paid an inflated rate because of a skills shortage, that difference is permissible, and no adjustment to the female job class rate is required."[220] A similar rule applies federally, where "a difference in wages between male and female employees

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[215] Kervin 2014 report at pp. 5-6 (ROP Tab 344, pp. 42582-3) **AC Tab 20 pp. 334-335**; Bass 2014 report at pp. 4-9 (ROP Tab 346, pp. 45217-22) **AC Tab 15 pp. 255-260**.
[216] Liability Decision at para. 263.
[217] Chaykowski 2014 report at pp. 89-95 (ROP Tab 349, pp. 49735-49741) **AC Tab 16 pp. 289-295**; see also Chaykowski 2015 report at pp. 9-28 (ROP Tab 349, pp. 49786-49805) **AC Tab 17 pp. 297-316**.
[218] Bass 2014 report at pp. 74 and 87-89 (ROP Tab 346, pp. 45287 and 45300-2) **AC Tab 15 pp. 270-273**.
[219] Greengarten transcript at pp. 146 and 255-256 **AC Tab 36 pp. 435, 442-443** ; Hay Group CHCs Salary Review Report at p. 18 (ROP Tab 190, p. 19720) **AC Tab 74 p. 862**.
[220] *Hudson v. Hamilton Police Association*, 2010 CanLII 61163 at para. 53.

performing work of equal value in an establishment is justified by...the existence of an internal labour shortage in a particular job classification".[221] The AOM's own pay equity expert agreed that this principle should apply in this case, but stated "I am not aware of such shortages with respect to family physicians."[222] The evidence, however, proved otherwise.

125. The Tribunal also ignored the expert evidence on the bargaining strength of physician and its impact on physician compensation. Bargaining strength is the ability of one party to obtain concessions from the other party by walking away from the negotiations.[223] Physicians enjoy substantial bargaining power relative to other professional groups because of the public's need for their services, because they provide critically-important services to the entire population, and because their services either cannot be substituted for easily, or cannot be substituted for at all.[224] Even the AOM's experts acknowledged this reality.[225]

126. Midwives as an occupational group, like almost every other group, do not wield the same bargaining strength as physicians. Physicians provide the majority of maternity care in Ontario: in 2011-2012, 93% of all births in Ontario were attended by a physician. Each year, family physicians in Ontario deliver as many or more babies as do midwives,[226] as well as providing many medically-necessary services that midwives cannot provide. Physicians are

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[221] Equal Wages Guidelines, 1986, SOR/86-1082, s. 16.
[222] Durber 2013 report at p. 58 (ROP Tab 260, p. 37460) **AC Tab 18 p. 326**; Durber transcript at pp. 480-483 (ROP Tab, pp. 66182-5) **AC Tab 32 pp. 397-400**.
[223] Chaykowski transcript 30 March 2017 at p. 79-82 (ROP Tab 400, p. 68396-9) **AC Tab 27 pp. 361-364**.
[224] Chaykowski 2014 report at pp. 76-78 (ROP Tab 349, p. 49722-4) **AC Tab 16 pp. 283-285**; Chaykowski 2015 report at p. 39 (ROP Tab 349, p. 49816) **AC Tab 17 p. 323** . See also Bass 2014 report at pp. 70-71 and 87-88 (ROP 346, pp. 45283-4 and 45300-1) **AC Tab 15 pp. 267-268, 272-272** ; Naylor transcript at p. 141 (ROP Tab 376, p. 63682) **AC Tab 44 p. 517**.
[225] Mackenzie transcript at pp. 153-154 (ROP Tab 388, pp. 66378-9) **AC Tab 42 pp. 485-486**; Bourgeault transcript pp. 129-130 (ROP Tab 394, pp. 67370-1) **AC Tab 25 pp. 350-351**.
[226] Chaykowski 2014 report at pp. 76-80 (ROP Tab 349, pp. 49722-49726) **AC Tab 16 pp. 283-287**; Born & Growing Annual Report (2012-14) at p. 42 (ROP Tab 219, p. 30758) **AC Tab 63 p. 644**; Chaykowski 2015 report at p. 45 (ROP Tab 349, p. 49822) **AC Tab 17 p. 324**.

authorized under statute to perform all of the same authorized acts as midwives. But no midwife can perform all of the authorized acts of a physician. This asymmetry results in differences in bargaining strength that impact compensation.

127. The bargaining strength that physicians enjoy relative to other workers in Canada is illustrated by a research paper that demonstrated that, in the years 2000-2010, Canadian doctors' compensation grew at a rate that substantially outpaced that of all other full-time Canadian workers, both men and women alike.[227] Physicians outpaced midwives in term of compensation gains for the same reasons that physicians outpaced all other workers in Canada, male and female, over the same period: because of the kind of work they do.

128. Ontario's expert evidence was that the bargaining strength of physicians does not come from their sex. To the contrary, physicians, including CHC physicians, obtained their largest compensation increases during the years in which they were the most female predominant.[228] In any event, even the *Pay Equity Act* expressly recognizes that differences in bargaining strength may lead to permissible differences in compensation increases.[229]

129. The Tribunal ignored all this evidence and concluded that "The bargaining strength of midwives depends in large part on the MOH recognizing the connection between midwifery and gender and being informed about the effects of gender on the compensation of sex-segregated workers."[230] This assertion was unsupported by evidence. The expert evidence, expressly dismissed as irrelevant and not considered by the Tribunal,[231] established the link

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[227] See para. 32 above.
[228] Bass 2014 report at p. 72 (ROP Tab 346, p. 45285) **AC Tab 15 p. 269**.
[229] *Pay Equity Act*, RSO 1990, c P.7, s. 8(2): "After pay equity has been achieved in an establishment, this Act does not apply so as to prevent differences in compensation between a female job class and a male job class if the employer is able to show that the difference is the result of differences in bargaining strength."
[230] Liability Decision at para. 303.
[231] Liability Decision at para. 263.

between physicians' wide scope of practice, their unique and non-substitutable role among health care providers, their corresponding bargaining power, and their compensation gains.

130. The Supreme Court has held that in human rights cases "the focus is always on whether the complainant has suffered arbitrary adverse effects based on a prohibited ground."[232] In this case, there was no link or connection between sex and the difference in compensation between CHC physicians and midwives, and it was not arbitrary treatment based on sex that CHC physicians received salary increases for reasons that did not apply to midwives.

d. CHC physicians have been majority-female since at least 2001

131. Another fact that demonstrated that sex was not a reason for the difference in compensation between midwives and CHC physicians was that both of these occupational groups are female-predominant and have been for many years.

132. Throughout the entire time period during which the Tribunal found that discrimination had occurred, CHC physicians were female-predominant. This fact, accepted by the Tribunal,[233] should have led to the rejection of a sex discrimination claim premised on a comparison with a purported "male comparator".[234] Instead, the Tribunal unreasonably dismissed this fact as immaterial, and treated female CHC physicians as constructively male or "proxies for male work"[235] for the purposes of comparisons with midwives.

133. The Tribunal stated that it did not "agree that midwives, who are almost exclusively female, lose their access to the *Code* as soon as CHC physicians become female-dominated."[236] This statement demonstrated a failure to "meaningfully grapple with key issues

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[232] *Moore* at para. 59; *Elk Valley* at para. 45.
[233] Liability Decision at para. 142.
[234] Liability Decision at para. 277.
[235] Remedy Decision at para. 102.
[236] Liability Decision at para. 284.

or central arguments raised by the parties."[237] No one argued that midwives should "lose their access to the *Code*." But access to a *remedy* under the *Code*, on the other hand, required proof that midwives have been subjected to discrimination because of sex.[238] If both midwives and CHC physicians were predominantly female groups after 2005, that fact should have been an important indicator that sex was not a factor in "the compensation gap that has developed between midwives and CHC physicians since 2005."[239]

134. Nor was it a question of sex-based comparisons with CHC physicians becoming inapposite "as soon as" CHC physicians become female-dominated. The Tribunal found that CHC physicians have been majority-female since at least 2001,[240] a decade before the Courtyard report that formed the basis of the Tribunal's remedy. The "male comparator" in this sex discrimination case has been a majority-female group for at least twenty years.

135. The Tribunal found that although the "principle that compensation for midwives should reflect the overlapping scope of practice of the family physician is based on a male comparator,"[241] the fact that "CHC family physicians are now pre-dominantly [sic] female does not affect the underlying premise of the 1993 principles and comparisons."[242] Even if it were true that a larger proportion of CHC physicians were male in 1993 than today,[243] this fact could not explain why CHC physicians should remain the "male comparator" for sex discrimination purposes today, 27 years later.

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[237] *Vavilov* at para. 128.
[238] *McGill Health* at para. 49.
[239] Liability Decision at para. 324.
[240] Liability Decision at para. 62.
[241] Liability Decision at para. 277.
[242] Liability Decision at para. 284.
[243] The Tribunal made no finding about the sex predominance of CHC physicians at any date prior to 2001, other than noting that "both men and women were working as family physicians in CHC's at the time of regulation" in 1993: Liability Decision at para. 277.

136. The Tribunal should not have assigned immutable sexes to whole occupational groups, particularly when this failed to correspond to the actual reality of the group and made invisible the contribution of the women who have performed the work for many years. To do so is the definition of stereotyping, which is the arbitrary attribution of presumed group characteristics.[244] By contrast, neither the *Canadian Human Rights Act* nor the Ontario *Pay Equity Act* assigns immutable sexes to whole professions. Under the *Canadian Human Rights Act*, the sex predominance of an occupational group is determined by examining its actual sex composition for the year immediately preceding the day the complaint is filed.[245] Under the *Pay Equity Act*, a "male job class" is one in which 70% or more of the members are male,[246] and the expert evidence (ignored by the Tribunal) was that jobs that had been "male job classes" can become gender-neutral or female job classes for pay equity purposes over time.[247]

137. In contrast, the Tribunal's reasoning is founded on an unstated stereotype, ungrounded in any expert evidence, that the work of family physicians is inherently male, no matter how many women actually perform that work or for how many years they have been performing it, and that female CHC physicians are really "proxies for male work."[248] The Tribunal did not rely on any expert evidence in coming to this conclusion, and ignored Ontario's expert evidence that CHC physicians should not be characterized as a male-predominant group.[249]

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[244] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497 at para. 48. See also *Vavilov* at para. 126.
[245] Equal Wages Guidelines, 1986, SOR/86-1082, s. 13.
[246] *Pay Equity Act*, RSO 1990, c. P.7, s. 1(1); *Hatts Off Specialized Services Inc. v. Employees of the Employer*, 2005 CanLII 60098 (ON PEHT) at paras. 19-22.
[247] Bass transcript 30 March 2017 at p. 66 (ROP Tab 400, p. 68383) **AC Tab 24 p. 349**; "Pay Equity Commission: The Space Toy Company" at p. 73 (ROP Tab 345, p. 44427).
[248] Remedy Decision at para. 102.
[249] Liability Decision at paras. 263-267; Kervin 2015 report pp. 7-9 and 20 (ROP Tab 344, pp. 42647-42649 and 42600) **AC Tab 21 pp. 336-339**; Kervin transcript p. 200 (ROP Tab 398, p. 68005) **AC Tab 37 p. 448**; Bass 2014 report p. 67 (ROP Tab 346, p. 45280) **AC Tab 15 p. 266**.

138. The Tribunal dismissed concerns about the appropriateness of using CHC physicians as a "male comparator" by invoking the Supreme Court's decision in *Withler* for the proposition that "a comparator group approach may substitute a formal equality 'treat likes alike' for a substantive equality analysis" and that "the use of mirror comparator groups may mean that the definition of the comparator group determines the substantive equality analysis."[250]

139. The Supreme Court has held that "To determine whether an employer is discriminating in remunerating male and female employees, comparisons must inevitably be made among groups of employees"[251] and that "Given the nature of its principles and objectives, pay equity cannot be achieved without proper comparators."[252] Whether or not a comparator is required in every discrimination case, this case was based on a comparison.

140. The AOM's pleadings,[253] its expert evidence,[254] and the remedies it sought were all predicated on CHC physicians being the "male comparator" for midwives. The Tribunal's central finding was that "sex was more likely than not, one of the factors that explains the difference in compensation levels between midwives and CHC physicians."[255] This finding could only have been made following a comparison between midwives and CHC physicians.

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[250] Liability Decision at para. 283; *Withler v. Canada (AG)*, 2011 SCC 12 at paras. 55-60.
[251] *Canada (Human Rights Commissions) v. Canadian Airlines International Ltd.*, 2006 SCC 1 at para. 1 ["*Canadian Airlines*"].
[252] *Canadian Airlines* at para. 14.
[253] See e.g. Applicant's Schedule A to Form 1 at para. 30: "In particular, substantial pay increases have been provided to the midwives' male comparator, the CHC physician, which were not proportionally provided to the midwives as required for pay equity purposes." (emphasis added).
[254] See e.g. Durber 2013 report at p. 4 (ROP Tab 260, p. 37406) **AC Tab 18 p. 325**: "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." (emphasis added)
[255] Liability Decision at para. 314.

141. It was neither formal equality nor a formalistic search for "mirror" comparators to note that it is problematic that the "male comparator" group for midwives was in fact made up predominantly of female employees. To the contrary, the longstanding and enduring female predominance of CHC physicians was itself a fact that demonstrated that the more recent divergence in compensation between the two groups did not arise because of sex.

e. "Losing the connection to the 1993 principles" was not because of sex

142. The Tribunal's findings were "based primarily on the extent to which the MOH has remained aligned with the intent of the 1993 principles and methodology and the impact on midwives where that has not been the case."[256] It described these as "the compensation principles and the objective criteria, evidence-based compensation methodologies and the choice of comparators, which the parties roughly maintained from 1993 to 2005,"[257] and found "a systemic failure on the part of the MOH to maintain its commitment to the benchmarks established in 1993 and maintained through the 2005 agreement."[258]

143. The 1993 documents referred to by the Tribunal contained few specifics about the level of pay for midwives, other than recommending that it should fall between that of nurses and family physicians, where in fact it remains today.[259] If the "1993 principles" meant that midwives' compensation should fall between that of a nurse and a physician, then that principle has never been departed from, and could not have formed the basis for liability. In any event, none of these documents stipulated that midwives' pay must never fall below some

[256] Liability Decision at para. 20.
[257] Remedy Decision at para. 5. In the Remedy Decision, the "1993 principles" are generally referred to as the "benchmarks".
[258] Remedy Decision at para. 99.
[259] Liability Decision at paras. 78-79 and 86-87; see paras. 19 and 21 above.

fraction or proportion of a CHC physician's salary. Indeed, the Tribunal found that "compensation for midwives was not set as a fixed percentage of CHC physician salaries."[260]

144. The purported importance of the "1993 principles and methodology" in setting midwives' compensation is even harder to understand given that the Tribunal held that midwives' compensation between 1994 and 2005 was not discriminatory.[261] From 1994 to 2005, midwives' compensation was frozen because of the application of compensation restraint, without any "evidence-based compensation methodologies".

145. When a new compensation agreement was negotiated in 2005, the methodology had little in common with what happened in 1993. In 2005, there was no joint compensation review, no job evaluation, and no analysis of overlapping scopes of practice. Instead, the parties engaged in positional bargaining and reached a deal after the AOM threatened to engage in job action and a march on Queen's Park.[262] Despite these differences in methodology, the Tribunal held that the 2005 agreement was "a significant achievement" that lead to "significant increases" in compensation, thus "maintaining proximity to CHC physicians."[263] It therefore appears that "align[ment] with the intent of the 1993 principles and methodology" means only that midwives must be paid some sufficiently large fraction of a CHC physician's salary.

146. The Tribunal found that the 1993 principles and methodology were necessary to avoid sex discrimination because "the original funding principles which were agreed on by the parties, followed by the joint working group and incorporated into the OMP framework, are connected if not imbued with gender."[264] There was no evidence to support this finding. There

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[260] Liability Decision at para. 290.
[261] Liability Decision at para. 292.
[262] Liability Decision at paras. 156-168.
[263] Liability Decision at paras. 286-289.
[264] Liability Decision at para. 281.

is no reference to "sex", "gender", "pay equity" or a "male comparator" in the AOM's or MOH's 1993 Principles of Funding,[265] in the OMP Framework developed by the Work Group,[266] in the Morton Report,[267] or in the Framework Document presented to Cabinet.[268] The Tribunal's cryptic conclusion that the 1993 funding principles were "imbued with gender" should not obscure the reality that none of these documents actually mentions sex or gender.

147. The most important of the 1993 documents were the Framework Document presented to Cabinet, in which Cabinet was asked to approve the initial compensation level of midwives,[269] and the Morton Report. Susan Davey, the author of the Cabinet submission, testified that she did not undertake an analysis to determine whether jobs were "male" or "female" or to identify a "male" comparator.[270] Robert Morton, the author of the Morton Report, testified that he was not asked to conduct a pay equity or gender-based analysis and would have declined had he been asked to do so.[271] The Tribunal ignored or discounted this direct evidence from the authors of the critical 1993 documents.

148. The Tribunal referred to "the fundamental principle that the compensation of midwives should reflect the overlapping scope of practice they share with physicians,"[272] which the

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[265] AOM 1993 Principles of Funding (ROP Tab 201, pp. 22783-22785) **AC Tab 60 pp. 631-633**; MOH Principles of Funding (1993) (ROP Tab 298, pp. 38824-7) **AC Tab 83 pp. 889-892**.
[266] Ontario Midwifery Program Framework (ROP Tab 201, pp. 22912-22922) **AC Tab 86 pp. 961-971** .
[267] Morton Report (ROP Tab 201, pp. 22849-22880) **AC Tab 84 pp. 893-924**.
[268] Ontario Midwifery Program Framework Cabinet Document (ROP Tab 201, pp. 22935-22970) **AC Tab 85 pp. 925-960**; Davey affidavit at paras. 42-54 (ROP Tab 201, pp. 22188-91) **AC Tab 4 pp. 171-174**.
[269] Ontario Midwifery Program Framework Cabinet Document (ROP Tab 201, pp. 22935-22970) **AC Tab 85 pp. 925-960**.
[270] Davey affidavit at para. 40 (ROP Tab 201, pp. 22188) **AC Tab 4 p. 171**; Davey transcript, 20 Oct 2016 at pp. 16-17 (ROP Tab 372, pp. 62865-6) **AC Tab 28 pp. 365-366**.
[271] Morton affidavit at paras. 11-13 (ROP Tab 242, p. 34043) **AC Tab 8 p. 204**.
[272] Liability Decision at para. 312.

Tribunal held was "based on a male comparator."[273] But the Tribunal made no finding that the compensation of midwives did *not* reflect this overlapping scope. Indeed, the Tribunal held that it had "not attempted to rate these jobs for comparison purposes."[274]

149. Having not considered any of the evidence concerning the extent to which the scope of practice of midwifery overlaps with that of physicians, and not having attempted to compare the work and scope of the two professions, it was not open to the Tribunal to conclude that the compensation of midwives did not reflect their overlapping scope of practice with physicians.

150. The Tribunal rejected the relevance of Ontario's "considerable evidence" about the differences between midwives and family physicians by stating that "What makes the position of the MOH even more difficult to accept is that it promotes family physicians and midwives as comparable obstetrical providers, equally competent to care for women with normal pregnancies."[275] This statement reveals a fundamental misunderstanding of the evidence.

151. Family physicians and midwives are equally competent to provide obstetrical care for women with normal pregnancies. But the scope of family physicians is not restricted to such obstetrical care, and midwives are not equally competent to provide the other medical services provided by family physicians. CHC physicians diagnose, treat and prescribe medicine for patients of all genders and ages for a wide range of complex chronic diseases, including diabetes, hypertension, psychiatric illness, tuberculosis, hepatitis B and C, HIV, asthma, heart disease, chronic obstructive pulmonary disease, renal failure, osteoarthritis and many others. Midwives do none of these things. The breadth of the scope of practice of family medicine is very wide, and it overlaps with the scope of practice of midwifery only in one particular area.

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[273] Liability Decision at para. 277.
[274] Liability Decision at para. 268.
[275] Liability Decision at para. 299; see also Remedy Decision at para. 34.

152. The Tribunal did not acknowledge that the scope of practice of CHC physicians is substantially wider than that of midwives. Every reference to the scope of practice of physicians refers only to the fact that their scope overlaps with that of midwives,[276] without identifying the limited extent of the overlap and the complexity and importance of the range of medical services provided by physicians that do not overlap with the scope of midwifery.

153. The Tribunal's written reasons gave no indication that family physicians provide any medical services other than obstetrical care to women with normal pregnancies. The words "complex chronic disease", so critical to understanding the care provided by CHC physicians, do not occur in the Tribunal's reasons. Instead, having decided that it "did not require expert evidence on the work of CHC physicians", the Tribunal went on to describe family physicians and midwives as two different but "equally competent providers of maternity care who provide those services based on different models of care,"[277] as though CHC physicians and midwives did essentially the same work but in different ways. This was a fundamental error.

154. Nor could the Tribunal have relied on the Courtyard report to determine that the compensation of midwives failed to reflect the overlapping scope of practice they share with physicians. The Courtyard report only examined the scope or work of CHC physicians in relation to the provision of low-risk maternity care.[278] Courtyard did not interview any CHC physicians or conduct a job evaluation of CHC physicians.[279] The author of the report was not

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[276] See e.g. Liability Decision at para. 51: "As specialists in normal pregnancy, [midwives] are as autonomous and responsible as physicians for the services they provide within their scope of practice." See also Liability Decision at paras. 26, 47, 48, 54, 63, 72-73, 277 and 312.
[277] Liability Decision at para. 52.
[278] Courtyard report at pp. 21-22 (ROP Tab 224, pp. 31891-2) **AC Tab 69 pp. 784-785**.
[279] Courtyard report at p. 46 (ROP Tab 224, p. 31916) **AC Tab 69 p. 809**.

qualified as an expert witness and admitted that he was not an expert in pay equity, compensation or job evaluation.[280]

155. The Tribunal noted that Ontario "did not call an expert to validate how its seemingly reasonable explanations would be weighted in a compensation study comparing midwives and CHC physicians" and that such an expert could "weigh those explanations and the impact of those decisions on the alignment between midwives and CHC physicians and validate, one way or the other, whether midwives remained appropriately paid despite increases paid to CHC physicians."[281] This was a reversal of the burden of proof.

156. Ontario had no obligation to adduce an expert job evaluation to "validate, one way or the other, whether midwives remained appropriately paid" relative to CHC physicians. It was the AOM's burden to prove that the compensation of midwives was discriminatory on the basis of sex, and it attempted to meet that burden through the job evaluation conducted by Mr. Durber, whose evidence was rejected by the Tribunal.[282] Given that the Tribunal did not accept the applicant's expert job evaluation evidence, it was unreasonable and a reversal of the onus for the Tribunal to find Ontario liable for discrimination because it did not call its own expert job evaluator to "validate, one way or the other" its compensation practices.

f. The decision not to implement the Courtyard report was not because of sex

157. The Tribunal found that "the response by the MOH to the Courtyard report constitutes sufficient evidence from which an inference can be drawn that midwives experienced adverse

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[280] Ronson transcript at pp. 65, 84-85, 103 (ROP Tab 370, pp. 62696, 62715-6, 62734) **AC Tab 51 p. 569-571, 574**.
[281] Remedy Decision at para. 119.
[282] Liability Decision at para. 265; Remedy Decision at paras. 147-154.

treatment and that gender is more likely than not a factor in that treatment."[283] This finding was unreasonable and unsupported by the evidence.

158. Assuming that Ontario's response to the Courtyard report was adverse treatment under the *Code*, the Tribunal should have asked whether sex was a factor in Ontario's decision not to implement Courtyard's recommendation. The direct evidence of Ontario's witnesses was that the sex of midwives was not a factor in Ontario's decision not to implement the Courtyard report.[284] The Tribunal made no finding that this evidence was false or a pretext.

159. The Courtyard report did not indicate that sex was a factor in midwives' compensation. The Courtyard report did not refer to pay equity, sex, gender or discrimination.[285] It was not an investigation into whether midwives had experienced sex discrimination. It did not analyse the sex predominance of any occupational group. The report's lead author, Mr. Ronson, agreed that he was not an expert in pay equity or gender-based analysis and had not been hired to provide a pay equity report, a human rights analysis or a gender-based analysis.[286]

160. Despite these facts, which were sufficiently evident that the Tribunal curtailed Ontario's cross-examination of Mr. Ronson on this point,[287] the Tribunal found that "The Courtyard report is an indication that gender discrimination may be an operative factor in the compensation of midwives which the MOH declined to investigate."[288] The Tribunal held that

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[283] Liability Decision at para. 296.
[284] Farrell 2 Dec 2016 transcript at p. 177 (ROP Tab 382, p. 64992) **AC Tab 33 pp. 401**; Pinkney affidavit at paras. 94-96, 109, 112 (ROP Tab 224, pp. 30957-30961, 30964-5) **AC Tab 11 pp. 224-230**; Pinkney transcript, 4 Nov 2016 at pp. 22-24 (ROP Tab 377, pp. 63783-5) **AC Tab 46 pp. 540-542**.
[285] Liability Decision at para. 191; Courtyard report (ROP Tab 224, pp. 31871-31924) **AC Tab 69 pp. 764-817**.
[286] Ronson transcript at pp. 84-85, 101-103 (ROP Tab 370, pp. 62715-6, 62732-4) **AC Tab 51 pp. 570-574**.
[287] Ronson transcript at p. 102 (ROP Tab 370, p. 62733) **AC Tab 51 p. 573**.
[288] Liability Decision at para. 308.

"Courtyard validated the ongoing relevance of CHC physicians as comparators and therefore implicitly maintained the link to gender."[289] This was an unreasonable inference given that the author expressly disclaimed having conducted any gender-based analysis.

161. Mr. Ronson admitted that he and Courtyard Group were not "compensation experts" or experts in job evaluation.[290] He was candid that the basis of his recommendation of a 20% pay increase for midwives was that it "felt fair" in a "generalized sense of fairness", and agreed that the report had used the word *equity* "not in any kind of a formal pay equity sense or anything like that" but rather "as a lawyer would use it…as in equitable remedies."[291]

162. Courtyard's recommended increase was intended to "restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians."[292] The report was not a job evaluation comparing the value of the work of midwives to the value of the work of CHC physicians; it did not attempt to assign a value to the work of CHC physicians at all. Nor did it examine the work of CHC physicians except in relation to maternity care.[293] The report did not consider the labour market demand for CHC physicians or the reasons why their salaries increased between 2005 and 2010.[294] Instead, it merely noted that "For family physicians working in Community Health Centres and in Family Health Teams, compensation is now well above that paid to midwives."[295]

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[289] Remedy Decision at para. 117.
[290] Ronson transcript at pp. 65, 103 (ROP Tab 370, pp. 62696, 62734) **AC Tab 51 pp. 569, 574**.
[291] Ronson transcript at pp. 84, 103-104 (ROP Tab 370, pp. 62715, 62734-5) **AC Tab 51 pp. 570, 574-575** .
[292] Courtyard report at p. 43 (ROP Tab 224, p. 31913) **AC Tab 69 p. 806** ; Remedy Decision at para. 136.
[293] Courtyard report at pp. 21-22 (ROP Tab 224, pp. 31891-2) **AC Tab 69 pp. 784-785**.
[294] See paras. 24-35 above.
[295] Courtyard report at p. 41 (ROP Tab 224, p. 31911) **AC Tab 69 p. 804**.

163. Given these facts, it was unreasonable for the Tribunal to give the Courtyard report the central importance that it did in finding sex discrimination and as a remedy. The Tribunal has no power to deal with general allegations of unfairness,[296] even where the party alleging unfairness is characterized by a protected ground under the *Code*.[297] The Tribunal held that "what distinguishes the AOM's allegations from general allegations of unfairness is that midwives are sex-segregated workers, and as a result, they are vulnerable to the forces of gender discrimination on their compensation."[298] But neither the fact that midwives are women nor that there is a societal context of systemic sex discrimination empowers the Tribunal to decide the fairness of midwives' compensation.[299] That it "felt fair" to Courtyard to "restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians"[300] is not an indication of sex discrimination.

164. Instead of analysing whether sex was one of the reasons why Ontario did not implement Courtyard's recommendation, the Tribunal assessed the sufficiency of Ontario's reasons for rejecting the report, as though it were conducting a judicial review of the merits of Ontario's decision not to implement Courtyard's recommendation. But the merits of Ontario's criticisms of the Courtyard report were irrelevant to the task before the Tribunal, except to the extent that those criticisms were found to be false or a pretext for sex discrimination.

165. In any event, Mr. Ronson's opinion that a 20% increase for midwives "felt fair" in a "generalized sense of fairness" was based on an erroneous understanding of the facts. Courtyard's mandate was to make recommendations on an appropriate "total compensation"

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[296] *Kasubeck v. General Dynamics Land Systems Canada*, 2017 HRTO 390 at paras. 166; *Forde v. Elementary Teachers' Federation of Ontario*, 2011 HRTO 1389 at para. 17.
[297] *Chuchala* at para. 15; *McGill Health* at para. 49.
[298] Remedy Decision at para. 8.
[299] *Bombardier* at para. 88; see paras. 64-65 above re: the test for discrimination.
[300] Courtyard report at p. 43 (ROP Tab 224, p. 31913) **AC Tab 69 p. 806**.

package for midwives.[301] As the Tribunal itself noted, Courtyard did not include in its assessment of midwives' compensation the fact that midwives retain excess operating funds as taxable income.[302] This is taxable income for midwives and represented thousands or even tens of thousands of dollars annually. One "representative complainant" midwife declared income of $31,330 on her 2014 tax return from retained operating fees,[303] over and above the fees that were considered as "compensation" by Courtyard. This amount greatly exceeded the compensation increase recommended in the Report ($20,969 at the top of the range), but it did not factor into Courtyard's analysis or recommendation at all.

166. In its liability decision, the Tribunal held that the ability of midwives "to retain excess operating expenses is a factor that would be considered in determining an appropriate remedy in this case."[304] The Tribunal did not explain how this fact could be relevant to remedy but not to liability. CHC physicians, as employees, have no ability to earn taxable income by retaining their employer's operating funds. If the Courtyard report was held to have "identified a significant compensation gap between midwives and physicians",[305] the fact that the report overstated the extent of that "gap" by omitting a significant source of midwives' income should have been relevant. Instead, the Tribunal compared only *some* of the income of midwives to *all* of the income of CHC physicians, and then held that the difference was a "significant compensation gap".

167. Mr. Ronson also admitted on cross-examination that while the report compared midwives in Ontario with those in Alberta and British Columbia, it failed to account for the fact that

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[301] Liability Decision at para. 41.
[302] Liability Decision at para. 306.
[303] See para. 20 above; Whitehead transcript at pp. 52-55 (ROP Tab 391, pp. 66749-52) **AC Tab 55 pp. 614-617**.
[304] Liability Decision at paras. 306 and 313.
[305] Liability Decision at para. 313.

Ontario midwives are also paid separately for benefits, in an amount equal to 20% of the fees he counted as "compensation", while those in the other provinces are not.[306] He agreed that his comparisons did not "attach any value to the value of the benefits provided in Ontario," but that "benefits are an element of total compensation, absolutely", and agreed that "it would have been better in these comparisons to attach a value to the benefits payments received by Ontario midwives."[307] He also agreed that the report did not account for the fact that Ontario midwives have their liability insurance fully paid by the province, which he agreed was an economic benefit that had an "impact on their total pay package."[308]

168. The Tribunal stated that "Mr. Ronson confirmed that not including midwives' benefits in comparing them to a small number of midwives in Alberta was inconsequential [to] his findings."[309] This was a misapprehension of the evidence. Mr. Ronson did not state that his error was inconsequential; he stated that the fact that Ontario midwives were paid for benefits while Alberta midwives were not paid for benefits had no impact on the report's recommendation. He did not state that that this difference *should not* have had an impact, and indeed he agreed that it was a fact that "needs to be taken into account."[310]

169. The Tribunal held that Ontario "had an obligation to see [the Courtyard] process through" and to remedy the deficiencies in the report. This was a misapprehension of the purpose of the report. The Tribunal held that the report was intended to provide non-binding recommendations "to be used in the next round of negotiations" between the MOH and the

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[306] Ronson transcript at pp. 119-123 (ROP Tab 370, pp. 62750-4) **AC Tab 51 pp. 576-580**.
[307] Ronson transcript at pp. 128-129 (ROP Tab 370, pp. 62759-60) **AC Tab 51 pp. 581-582** .
[308] Ronson transcript at pp. 130-131, 134-135 (ROP Tab 370, pp. 62761-66) **AC Tab 51 p. 583-584, 587-588**.
[309] Liability Decision at para. 306.
[310] Ronson transcript at p. 140 (ROP Tab 370, p. 62771) **AC Tab 51 p. 589**.

AOM.[311] That is what happened. Both parties took positions in the subsequent negotiations that were informed by the report, with the AOM seeking the full 20% increase recommended by Courtyard and the MOH counter-offering with a 5% increase.[312] The Tribunal's holding that the report "did not inform the positions taken by the MOH in the negotiations leading to the next contract"[313] was contrary to the evidence and to its own findings that the MOH did consider and respond to the Courtyard report in its negotiations with the AOM in 2011.[314]

170. Indeed, the process following the Courtyard report was not so different from the compensation negotiations that took place in 2005, which the Tribunal found were not discriminatory. In 2005, the parties engaged in positional bargaining following non-binding input provided by a compensation consultant.[315] The difference was that, unlike in 2005, the parties in 2010 did not come to an agreement.[316] Although the parties failed to reach agreement, this fact did not mean that the Courtyard report did not inform their negotiations.

171. The Tribunal's conclusion that Ontario "had an obligation to see that process through" can only mean that Ontario had an obligation to implement Courtyard's report, as if Courtyard had been a binding salary arbitration rather than a non-binding recommendation. The effect of the Tribunal's decision is that, because Courtyard was dealing with sex-segregated workers, it was not open to Ontario to reject the report's non-binding recommendation. Instead, Ontario was required to either "repair any perceived deficiencies in the Courtyard report"[317] or conduct

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[311] Liability Decision at paras. 39 and 199.
[312] Farrell affidavit at para. 83 (ROP Tab 246, p. 34849) **AC Tab 5 p. 189**; Pinkney transcript 4 Nov 2016 at pp. 24, 33-36 (ROP Tab 377, pp. 63785, 63794-7) **AC Tab 46 pp. 542-545**; Pinkney transcript 2 Dec 2016 at pp. 100-101 (ROP Tab 382, pp. 64915-6) **AC Tab 47 pp. 551-552**.
[313] Remedy Decision at para. 37.
[314] Liability Decision at paras. 205 and 213-217.
[315] Liability Decision at para. 287.
[316] Liability Decision at para. 19.
[317] Liability Decision at para. 307.

its own expert study that would "validate, one way or the other, whether midwives remained appropriately paid despite increases paid to CHC physicians."[318] No such obligation follows from the three-part *Pieters* test for discrimination that the Tribunal purported to apply.

172. The Tribunal held that Ontario's "criticisms of the Courtyard report are minor."[319] Ontario did not consider the report's flaws to be minor. In any event, the question before the Tribunal was not whether the report's flaws were major or minor, but whether sex was "one of the reasons"[320] why the MOH declined to implement the non-binding report. There was no evidence that sex was a factor, and the direct evidence from the managers of the midwifery program, supported by contemporaneous internal MOH documents, was that sex was not a factor in the decision.[321] The Tribunal made no finding that this explanation was false, a pretext, incredible or unreliable. Accordingly, it was unreasonable for the Tribunal to find that Ontario's response to Courtyard was adverse treatment because of sex.

173. The Tribunal found that "the report is sufficiently compelling for the MOH to realize that the AOM's claim of gender discrimination may have some validity."[322] But the AOM first made an allegation to Ontario of sex discrimination contrary to the *Code* on May 27, 2013, almost three years after the release of the Courtyard report.[323]

174. In other decisions, the Tribunal has consistently held that there is no requirement under the *Code* for respondents to investigate general allegations of unfairness.[324] Complaints arising

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[318] Remedy Decision at para. 119.
[319] Liability Decision at para. 306.
[320] *Elk Valley* at para. 43.
[321] See para. 158 above.
[322] Liability Decision at para. 307.
[323] Liability Decision at paras. 218-223; AOM BOD Documents (ROP Tab 177, pp. 18062-70) **AC Tab 61 pp. 634-642**.
[324] See e.g. *Kasubeck v. General Dynamics Land Systems Canada*, 2017 HRTO 390 at paras. 166 and 233-234 ["*Kasubeck*"]; *Chander v. Aon Reed Stenhouse*, 2014 HRTO 83 at para. 94.

under statutes other than the *Code*, or even allegations about violations of "human rights" or "discrimination" without particulars, do not trigger a duty to investigate.[325] The Tribunal did not cite or attempt to distinguish these decisions, and did not explain how Ontario could have had any obligation to investigate sex discrimination upon receiving the report, given that the report made no reference to sex or to discrimination.

175. It was also unreasonable for the Tribunal to refuse to modify its remedial orders to account for the flaws in the Courtyard report. First, it was unreasonable and unfair for the Tribunal to find in its Liability Decision that it "agree[d] with the MOH that the ability to retain excess operating funds is something I would consider if the matter is returned to me for a remedy decision,"[326] only to later hold in its Remedy Decision that it was "not prepared to speculate" about the impact of this proven fact because it was "never put to Courtyard by the steering group or repaired by the MOH when it had the opportunity to do so."[327]

176. Second, the Tribunal understated the impact of the erroneous comparison with midwives in Alberta and BC. The report itself relied on this comparison in giving its reasons for the recommended increase, and Mr. Ronson agreed on cross-examination that it would have been better had the report accounted for this difference which "needs to be taken into account."[328]

177. Third, it was unreasonable for the Tribunal to hold that Ontario could not rely on these flaws in the Courtyard report as mitigating the amount to be awarded as a remedy because Ontario did not give Courtyard an opportunity to "repair" its report. The Tribunal should have

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[325] *Naidu v. Whitby Mental Health Centre*, 2011 HRTO 1279 at para. 191 and paras. 201-202; *Falodun v. Andorra Building Maintenance Ltd*, 2014 HRTO 322 at para. 65 ["*Falodun*"]; *Kasubeck* at para. 234; *Bageya v. Dyadem International,* 2010 HRTO 1589 at paras. 155-157; *J.M. v. St. Joseph's Health Centre*, 2013 HRTO 1088 at paras. 78-81; *Patterson v. Hamilton Health Sciences-Chedoke et al.*, 2011 HRTO 1582 at para. 317.
[326] Liability Decision at paras. 306 and 313.
[327] Remedy Decision at paras. 120 and 140-141.
[328] Ronson transcript at p. 140 (ROP Tab 370, p. 62771) **AC Tab 51 p. 589**.

considered all relevant evidence before it in deciding its own remedy, rather than limiting consideration only to those matters expressly considered by Courtyard in 2010.

g. Province-wide compensation restraint was not because of sex

178. The Tribunal held that the application after 2010 of province-wide compensation restraint policies to midwives was adverse treatment because of sex, stating that "Policies of general application, like compensation restraint, can have unintended adverse effects on people protected by the *Code*. In this case, the application of compensation restraint compounded the effects of midwives' losing their connection to the 1993 funding principles."[329] The Tribunal found that Ontario should have considered more fully whether midwives should have been exempted from restraint under an exemption that applied to "human rights entitlements".[330]

179. As the Tribunal found elsewhere in its reasons, compensation restraint was applied to all broader public sector employees and contractors in the province, including both midwives and physicians.[331] Indeed, while the restraint policy applied to both midwives and physicians, the Tribunal found that "the compensation restraint policy was applied to *decrease* compensation for physicians including CHC physicians."[332] CHC physicians' salaries were reduced after 2012, while compensation for midwives has never been reduced.

180. The Tribunal held that even though CHC physician salaries were reduced following the Courtyard report, that fact was not a reason to reduce the Tribunal's order of retroactive monetary compensation.[333] The result is a one-way "benchmark" comparison whereby

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[329] Liability Decision at para. 311.
[330] Liability Decision at paras. 203 and 307.
[331] Liability Decision at paras. 43-44.
[332] Liability Decision at para. 44 (emphasis in original); see also para. 35 above.
[333] Remedy Decision at para. 144.

midwives must receive pay increases whenever CHC physicians get raises, but no adjustment to midwives is required when CHC physicians receive salary cuts.

181. The Tribunal found that "the application of compensation restraint"[334] was "evidence from which an inference can be drawn" that midwives experienced sex discrimination.[335] This finding could only have been based on a prior finding that the compensation of midwives was discriminatory. If the level of compensation of midwives was not discriminatory on the basis of sex in 2010, then a general policy that froze compensation at that level could not have been discriminatory either. The Tribunal noted elsewhere that an earlier period of general compensation freezes in the 1990s was not discriminatory precisely for this reason.[336]

182. The same logic must apply to compensation freezes after 2010. Compensation restraint after 2010 could only be discriminatory if the prevailing level of compensation in 2010 was discriminatory. Certainly, the fact that compensation was frozen after 2010 is not itself evidence that the prevailing level of compensation was discriminatory. That inference would be both illogical and internally inconsistent.[337]

183. The Tribunal's finding that it was one "important indicator[] of adverse impact" that Ontario did not "more fully consider the exemption under the legislation…for human rights entitlements"[338] was circular. The compensation restraint statute provided that "Nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the *Human Rights Code* or the *Pay Equity Act*."[339] If midwives had an entitlement under the *Code* to an

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[334] Liability Decision at paras. 310-311.
[335] Liability Decision at para. 296.
[336] Liability Decision at para. 291.
[337] *Vavilov* at paras. 102-104.
[338] Liability Decision at para. 307.
[339] *Public Sector Compensation Restraint to Protect Public Services Act, 2010*, SO 2010, c 1, Sch 24, s. 12(3).

increase in their compensation, then the restraint policy could not have been applied to prevent that increase. But the Tribunal's decision dated September 24, 2018 was the first time that any such entitlement under the *Code* had been established. It can hardly have been an "important indicator" of discrimination in 2010 that the MOH did not exempt midwives from the restraint policy because of a human rights entitlement that was not established until eight years later.

h. No "proactive" obligation to compare midwives to CHC physicians in perpetuity

184. The Tribunal was critical of Ontario for not taking any "proactive steps" to monitor the compensation of midwives for discrimination, contrasting this failure with Ontario's efforts "to monitor compensation for CHC physicians for evidence of recruitment and retention issues and to ensure that their compensation is fair and aligned with other physicians."[340]

185. The Tribunal's comparison was inapt and misapprehended the evidence. The evidence was that Ontario monitored *both* CHC physicians and midwives for evidence of recruitment and retention issues. Elsewhere in its reasons the Tribunal noted that the "Ministry conducted research on the supply, demand, attrition and public cost of midwives" and that "Attrition from the midwifery profession varied from a low of 1% to a high of 7% between 1994 and 2005-2006."[341] After 2005, attrition from the midwifery profession has never exceeded 5% per year, a rate that is "extraordinarily low" compared to other health professionals in Ontario.[342]

186. Ontario monitored both midwives and CHC physicians for recruitment and retention issues. The difference was in what that monitoring revealed: there was no evidence of any recruitment and retention problems for midwives or that any midwifery practice group experienced vacancies or difficulty retaining midwives,[343] but there was indisputable evidence

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[340] Liability Decision at para. 315.
[341] Liability Decision at paras. 123 and 143.
[342] See paras. 37-40 above.
[343] See paras. 37-40 above.

of severe recruitment and retention problems for CHC physicians, including a 33% vacancy rate for funded physician positions at CHCs as recently as July 2009.

187. The Tribunal also noted that Ontario monitored CHC physicians to ensure that "their compensation is fair and aligned with other physicians." This is true, but it could have no application to midwives, who are not "other physicians". Ontario sought to ensure that the compensation of CHC physicians was fairly aligned with that of other family physicians in order to reduce barriers for family physicians to work in CHCs and thereby to remedy the longstanding turnover and vacancy problems in CHCs.

188. The Tribunal engaged in circular reasoning in finding that "The failure to act proactively is just one factor from which I have drawn an inference of discrimination." An alleged "failure to act proactively" to "monitor, identify and redress discrimination in the compensation of midwives" could not itself be a factor from which to infer the existence of discrimination: a failure to "identify" or "redress" discrimination cannot itself be the fact from which the existence of the discrimination is itself inferred. The Tribunal's conclusion that "The failure to be proactive can, and in this case does, explain why the *Code* was breached"[344] was circular, because it assumed rather than demonstrated the existence of the very discrimination in compensation that Ontario was said to have failed to proactively prevent.

189. This Court and the Tribunal have held that there can be no failure of a duty under the *Code* to investigate discrimination unless the discrimination is proven to have actually taken place.[345] The Tribunal held in *Scaduto* that "the *Code* is not contravened by the failure to

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[344] All quotes from Liability Decision at para. 317.
[345] *Walton* at paras. 51-54; *Scaduto v. Insurance Search Bureau*, 2014 HRTO 250 at paras. 78-79 ["*Scaduto*"]; *Falodun* at para. 65; *Liu v. Metropolitan Toronto Condominium Corporation No.* 541, 2015 HRTO 637 at para. 50; *Steel v. Johnson Controls Automotive Canada LP*, 2015 HRTO 564 at para. 78; *Chander v. Aon Reed Stenhouse Inc.*, 2014 HRTO 83 at para. 94.

investigate discrimination that does not exist…It does not make sense to say to the respondent you have contravened the *Code* because you have failed to investigate the applicant's complaint, but had you investigated, you would not have found discrimination."[346] The Tribunal did not cite *Scaduto*, and made exactly the illogical inference rejected in *Scaduto*.

190. The Tribunal held that Ontario's failure to take "proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation" was "contrary to the OHRC's policies",[347] but it did not cite any particular Commission policies that tell employers to take proactive steps to monitor the compensation of female workers for the impact of gender discrimination, and in fact no such policies exist.

191. Elsewhere in its reasons, the Tribunal had correctly noted that none of the policies of the Ontario Human Rights Commission "provide specific guidance on how to incorporate pay equity principles into compensation practices either with employees or independent contractors."[348] The Tribunal also held that "the *Code* does not refer to pay equity nor does it prescribe any process for developing a compensation model which is *Code*-compliant",[349] that "there is limited information available about how to proactively address issues of gender-based compensation discrimination outside of the *Pay Equity Act*"[350] and that "The *Code* does not prescribe any particular methodology for ensuring ongoing compliance."[351]

192. Indeed, there is no OHRC policy or guideline and no prior decision of the Tribunal or of any court applying the *Code* that identifies any proactive obligation to conduct a gender-based analysis or to use a "male comparator" to set the pay of a group of female workers.

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[346] *Scaduto* at paras. 78-79.
[347] Liability Decision at para. 315.
[348] Liability Decision at para. 245.
[349] Liability Decision at para. 319.
[350] Liability Decision at para. 319.
[351] Liability Decision at para. 265.

193. While the *Pay Equity Act* includes a detailed code of rules, principles and obligations relating to compensation comparisons between male and female job classes, the Tribunal did not apply any of those rules or principles, and indeed held that it could not "retroactively impose the statutory obligations under the *Pay Equity Act* onto the MOH"[352] in this case. In any event, in CHCs, where the *Pay Equity Act* applies, the nurses and other female job classes have never been compared to physicians for pay equity purposes, because CHC physicians have never been classed as a comparable "male job class" under the *Pay Equity Act*.[353]

194. The Tribunal's invocation of an obligation on Ontario to take "proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation"[354] was a novel legal duty, not grounded in the text of the *Code* or any prior decision of the Tribunal, and imposed retrospectively on Ontario to find it liable for discrimination going back many years. The Tribunal's decision amounts to the proposition that, because of the "well-known effects of gender discrimination on women's compensation,"[355] compensation-setters have an obligation under the *Code* to monitor the compensation of sex-segregated workers, to ensure that their work is compared to a male comparator, and to use "objective criteria" and "evidence-based compensation methodologies"[356] to ensure that pay levels are "objectively rational, fair, and appropriate."[357] This is a novel legal duty imposed retrospectively for the first time in this case.

195. A finding that the *Code* imposes a positive obligation on persons who employ or contract with female workers to make gender-based comparisons or to proactively redress systemic sex

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[352] Liability Decision at para. 265.
[353] See para. 23 above.
[354] Liability Decision at para. 315.
[355] Liability Decision at para. 323.
[356] Remedy Decision at para. 5.
[357] Remedy Decision at para. 121.

discrimination could not be confined to the facts of this case. The *Code*, unlike the *Charter*, applies to everyone in Ontario, and applies to private actors no less than to the state. The Decision provides no guidance on how persons subject to the *Code* can go about discharging this novel obligation,[358] except to say that "Each case must be decided on its own merit."[359] The Tribunal's invocation of this new positive duty is unbounded in scope and incapable of principled application in future cases. It is therefore unreasonable.

196. In its Remedy Decision, the Tribunal denied that it had imposed a proactive obligation under the *Code*, holding "Fundamentally, it is the obligation of the MOH to ensure that its practices do not contravene the *Code*. If the MOH takes no steps to monitor the compensation it pays to sex-segregated workers, it has no basis for explaining how it determined that gender was not a relevant factor in what those workers were paid."[360] Under the *Pieters* test, however, the AOM bore the onus of demonstrating that sex was a factor in midwives' compensation. The Tribunal's holding that Ontario had an obligation to "ensure that its practices do not contravene the *Code*" and that without "monitoring" it could not explain "how it determined that gender was not a relevant factor in what those workers were paid" reversed the burden of proof, required Ontario to disprove that sex was a factor, and imposed a positive obligation of "monitoring" for sex discrimination in compensation, contrary to *Pieters* and *Bombardier*.

E. The Tribunal's remedies were unreasonable

197. If the Tribunal's decision finding Ontario liable for discrimination was unreasonable, then its remedies cannot stand and must be set aside. Even if the Tribunal had reasonably found discrimination, however, its remedial orders were unreasonable. As set out above, the

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[358] Liability Decision at para. 317.
[359] Liability Decision at para. 265.
[360] Remedy Decision at para. 59.

Tribunal found liability based on a novel obligation under the *Code* not previously recognized in any decision of the Tribunal or by any court applying the *Code*. In these circumstances, it was unjust to order retrospective remedies,[361] particularly as the defects found by the Tribunal could have been remedied by orders requiring Ontario to change the process for setting midwives' compensation. In any event, it was also unreasonable for the Tribunal not to discount the monetary remedies it ordered to account for the flaws in the Courtyard report or for the fact that CHC physicians received salary cuts after 2012.

198. While the Tribunal held that it was "not suggesting that the parties must forever abide by the specific methodology they agreed to in 1993" and that the "parties are at liberty to negotiate a new compensation methodology,"[362] the remedy ordered by the Tribunal was to maintain this comparison for all future negotiations, unless the AOM agrees otherwise.[363]

PART IV – ORDER SOUGHT

199. The Applicant requests that the Decision of the Tribunal be set aside with costs. The evidence available to the Tribunal "was such that it could not reasonably hold that there was a connection" between sex and the treatment complained of.[364] Remitting the case back to the Tribunal "would therefore serve no useful purpose."[365]

ALL OF WHICH IS RESPECTFULLY SUBMITTED

March 10, 2020

S. Zachary Green, Courtney Harris and Yashoda Ranganathan
Of counsel for the Applicant, the Minister of Health

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[361] *Canada (Attorney General) v. Hislop*, 2007 SCC 10 at paras. 99-100.
[362] Liability Decision at para. 323.
[363] Remedy Decision at para. 189.
[364] *Bombardier* at para. 98.
[365] *Vavilov* at para. 142.

Court File No. 131/19

ONTARIO
SUPERIOR COURT OF JUSTICE
(Divisional Court)

IN THE MATTER OF the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1, as amended;

AND IN THE MATTER OF a decision of the Human Rights Tribunal of Ontario dated September 24, 2018 and a decision of the Human Rights Tribunal of Ontario dated February 19, 2020

B E T W E E N:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Applicant

\- and -

ASSOCIATION OF ONTARIO MIDWIVES and **HUMAN RIGHTS TRIBUNAL OF ONTARIO**

Respondents

CERTIFICATE OF TIME OF THE APPLICANT

1. I, S. Zachary Green, of counsel for the Applicant, certify that no order under subrule 61.09(2) is required.

2. The Applicant, the Minister of Health, estimates 7 hours will be required for its oral argument.

March 10, 2020

S. Zachary Green
Of Counsel for the Applicant

SCHEDULE A

List of Authorities

1. *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27

2. *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal*, 2007 SCC 4

3. *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39

4. *Lewis v. Re/Max Rouge River Realty*, 2010 HRTO 1977

5. *Selkirk Estate v. Ontario (Health)*, 2014 HRTO 53

6. *Beldjehem v. University of Ottawa (Telfer School of Management)*, 2014 HRTO 1080

7. *Shaw v. Phipps*, 2012 ONCA 155 at para. 10, affirming 2010 ONSC 3884 (Div. Ct.)

8. *Audmax Inc. v. Ontario Human Rights Tribunal*, 2011 ONSC 315 (Div. Ct.)

9. *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65

10. *Longueépée v. University of Waterloo*, 2019 ONSC 5465 (Div. Ct.)

11. *City of Toronto v. Josephs*, 2018 ONSC 67 (Div. Ct.)

12. *L.B. v. Toronto District School Board*, 2017 ONSC 2301 (Div. Ct.)

13. *Toronto Police Services Board v. Briggs*, 2017 ONSC 1591 (Div. Ct.)

14. *Aiken v. Ottawa Police Services Board*, 2015 ONSC 3793 (Div. Ct.)

15. *Crepe it Up! v. Hamilton*, 2014 ONSC 6721 (Div. Ct.)

16. *Walton Enterprises v. Lombardi*, 2013 ONSC 4218 (Div. Ct.)

17. *Navistar Canada Inc. v. Superintendent of Financial Services*, 2015 ONSC 2797 (Div. Ct.)

18. *Rao v. The General Manager, Ontario Health Insurance Plan*, 2019 ONSC 3204 (Div. Ct.)

19. *Marusic v. Law Society of Upper Canada*, 2017 ONSC 663 (Div. Ct.)

20. *Peel Law Association v. Pieters*, 2013 ONCA 396

21. *Moore v. British Columbia (Education)*, 2012 SCC 61

22. *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593

23. *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39

24. *Cieslinski v. Aon Reed Stenhouse Inc.*, 2015 HRTO 644

25. *Rutledge v. The Travel Corporation (Canada)*, 2013 HRTO 1634

26. *Clennon v. Toronto East General Hospital*, 2009 HRTO 1242, reconsideration refused in 2010 HRTO 1693

27. *Bennie v. Toronto (City)*, 2017 HRTO 508

28. *Koitsis v. Ajax Automobile (2008) Inc.*, 2016 HRTO 1628

29. *Faghihi v. Black Swan Pub and Grill*, 2016 HRTO 1109

30. *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30

31. *Ontario Nurses' Association v. Cambridge Memorial Hospital*, 2019 ONSC 3951 (Div. Ct.)

32. *Carter v. Chrysler Canada Inc.*, 2017 HRTO 168, aff'd 2019 ONSC 142 (Div. Ct.)

33. *Konesavarathan v. Guelph (City)*, 2016 HRTO 1453 aff'd 2018 ONSC 2146 (Div. Ct.)

34. *Congdon v. Govinda Galleries*, 2013 HRTO 1230

35. *Browning v. Northend Body Shop Ltd.*, 2017 HRTO 1001

36. *Ontario (Human Rights Commission) v. Simpsons Sears Ltd.*, [1985] 2 S.C.R. 536

37. *Garofalo v. Cavalier Hair Stylists Shop Inc.*, 2013 HRTO 170

38. *Garrie v. Janus Joan Inc.*, 2014 HRTO 272, reconsideration allowed on a different point in 2012 HRTO 1955

39. *Walden v. Canada (Social Development)*, 2007 CHRT 56

40. *Nishimura v. Ontario (Human Rights Commission)*, 70 OR (2d) 347 (Div. Ct.)

41. *Stewart v. Elk Valley Coal Corp.*, 2017 SCC 30

42. *Addai v. Toronto (City)*, 2012 HRTO 2252

43. *Chuchala v. Szmidt*, 2010 HRTO 2545

44. *Peart v Ontario (Community Safety and Correctional Services)*, 2014 HRTO 611, aff'd 2017 ONSC 782 (Div. Ct.)

45. *Arnold v. Stream Global Services*, 2010 HRTO 424

46. *Deep v. Ontario*, [2004] O.J. No. 2734 (Sup. Ct. J.), aff'd [2005] O.J. No. 1294 (C.A.)

47. *Baier v. Alberta*, 2007 SCC 31

48. *Delisle v. Canada (Deputy Attorney General)*, [1999] 2 S.C.R. 989

49. *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2003 BCSC 1379

50. *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2004 BCCA 377

51. *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497

52. *Withler v. Canada (AG)*, 2011 SCC 12

53. *Canada (Human Rights Commissions) v. Canadian Airlines International Ltd.*, 2006 SCC 1

54. *Kasubeck v. General Dynamics Land Systems Canada*, 2017 HRTO 390

55. *Forde v. Elementary Teachers' Federation of Ontario*, 2011 HRTO 1389

56. *Chander v Aon Reed Stenhouse*, 2014 HRTO 83

57. *Naidu v. Whitby Mental Health Centre*, 2011 HRTO 1279

58. *Falodun v. Andorra Building Maintenance Ltd*, 2014 HRTO 322

59. *Bageya v. Dyadem International*, 2010 HRTO 1589

60. *J.M. v. St. Joseph's Health Centre*, 2013 HRTO 1088

61. *Patterson v. Hamilton Health Sciences-Chedoke et al.*, 2011 HRTO 1582

62. *Scaduto v. Insurance Search Bureau*, 2014 HRTO 250

63. *Liu v. Metropolitan Toronto Condominium Corporation No. 541*, 2015 HRTO 637

64. *Steel v. Johnson Controls Automotive Canada LP*, 2015 HRTO 564

65. *Canada (Attorney General) v. Hislop*, 2007 SCC 10

SCHEDULE B

Relevant provisions of Statutes, Regulations and By-laws

Midwifery Act, 1991

S.O. 1991, CHAPTER 31

SECTION 3

Scope of practice

3 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 provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries. 1991, c. 31, s. 3.

Medicine Act, 1991, S.O. 1991, c. 30

…

Scope of practice

3 The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction. 1991, c. 30, s. 3.

…

ONTARIO REGULATION 865/93

REGISTRATION

…

CLASSES OF CERTIFICATES OF REGISTRATION AUTHORIZING PRACTICE

INDEPENDENT PRACTICE

3. (1) The standards and qualifications for a certificate of registration authorizing independent practice are as follows:

1. The applicant must have a degree in medicine.
2. The applicant must have successfully completed Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination.
3. The applicant must have completed one of the following:
   i. A clerkship at an accredited medical school in Canada which meets the criteria of a clerkship in clause (a) of the definition of "degree in medicine" in section 1.
   ii. A year of postgraduate medical education at an accredited medical school in Canada.
   iii. A year of active medical practice in Canada which includes significant clinical experience pertinent to the applicant's area of medical practice.
4. The applicant must have certification by examination by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada. O. Reg. 865/93, s. 3 (1).

…

Pay Equity Act, R.S.O. 1990, c. P-7

Interpretation, posting and miscellaneous

Definitions
1 (1) In this Act,

…

“male job class” means, except where there has been a decision that a job class is a female job class as described in clause (b) of the definition of “female job class”,

(a) a job class in which 70 per cent or more of the members are male, or
(b) a job class that a review officer or the Hearings Tribunal decides is a male job class or a job class that the employer, with the agreement of the bargaining agent, if any, for the employees of the employer, decides is a male job class; (“catégorie d’emplois à prédominance masculine”)

…

Exceptions

8 (1) This Act does not apply so as to prevent differences in compensation between a female job class and a male job class if the employer is able to show that the difference is the result of,

(a) a formal seniority system that does not discriminate on the basis of gender;

(b) a temporary employee training or development assignment that is equally available to male and female employees and that leads to career advancement for those involved in the program;

(c) a merit compensation plan that is based on formal performance ratings and that has been brought to the attention of the employees and that does not discriminate on the basis of gender;

(d) the personnel practice known as red-circling, where, based on a gender-neutral re-evaluation process, the value of a position has been down-graded and the compensation of the incumbent employee has been frozen or his or her increases in compensation have been curtailed until the compensation for the down-graded position is equivalent to or greater than the compensation payable to the incumbent; or

(e) a skills shortage that is causing a temporary inflation in compensation because the employer is encountering difficulties in recruiting employees with the requisite skills for positions in the job class.

Idem

(2) After pay equity has been achieved in an establishment, this Act does not apply so as to prevent differences in compensation between a female job class and a male job class if the employer is able to show that the difference is the result of differences in bargaining strength.

Equal Wages Guidelines, 1986, SOR/86-1082

Made under the ***Canadian Human Rights Act*, R.S.C. 1985, c. H-6**

…

Complaints by Groups

12 Where a complaint alleging different wages is filed by or on behalf of an identifiable occupational group, the group must be predominantly of one sex and the group to which the comparison is made must be predominantly of the other sex.

13 For the purpose of section 12, an occupational group is composed predominantly of one sex where the number of members of that sex constituted, for the year immediately preceding the day on which the complaint is filed, at least

(a) 70 per cent of the occupational group, if the group has less than 100 members;

(b) 60 per cent of the occupational group, if the group has from 100 to 500 members; and

(c) 55 per cent of the occupational group, if the group has more than 500 members.

…

Reasonable Factors

16 For the purpose of subsection 11(3) of the Act, a difference in wages between male and female employees performing work of equal value in an establishment is justified by

(a) different performance ratings, where employees are subject to a formal system of performance appraisal that has been brought to their attention;

(b) seniority, where a system of remuneration that applies to the employees provides that they receive periodic increases in wages based on their length of service with the employer;

(c) a re-evaluation and downgrading of the position of an employee, where the wages of that employee are temporarily fixed, or the increases in the wages of that employee are temporarily curtailed, until the wages appropriate to the downgraded position are equivalent to or higher than the wages of that employee;

(d) a rehabilitation assignment, where an employer pays to an employee wages that are higher than justified by the value of the work performed by that employee during recuperation of limited duration from an injury or illness;

(e) a demotion procedure, where the employer, without decreasing the employee's wages, reassigns an employee to a position at a lower level as a result of the unsatisfactory work performance of the employee caused by factors beyond the employee's control, such as the increasing complexity of the job or the impaired health or partial disability of the

employee, or as a result of an internal labour force surplus that necessitates the reassignment;

(f) a procedure of gradually reducing wages for any of the reasons set out in paragraph (e);

(g) a temporary training position, where, for the purposes of an employee development program that is equally available to male and female employees and leads to the career advancement of the employees who take part in the program, an employee temporarily assigned to the position receives wages at a different level than an employee working in such a position on a permanent basis;

(h) the existence of an internal labour shortage in a particular job classification;

(i) a reclassification of a position to a lower level, where the incumbent continues to receive wages on the scale established for the former higher classification; and

(j) regional rates of wages, where the wage scale that applies to the employees provides for different rates of wages for the same job depending on the defined geographic area of the workplace.

Public Sector Compensation Restraint to Protect Public Services Act, 2010

S.O. 2010, CHAPTER 1
SCHEDULE 24

…

Conflict with this Act

12 (1) This Act prevails over any provision of a compensation plan and, if there is a conflict between this Act and a compensation plan, the compensation plan is inoperative to the extent of the conflict. 2010, c. 1, Sched. 24, s. 12 (1).

Same

(2) This Act prevails over any other Act and over any regulation, by-law or other statutory instrument. 2010, c. 1, Sched. 24, s. 12 (2).

Exception

(3) Nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the *Human Rights Code* or the *Pay Equity Act*. 2010, c. 1, Sched. 24, s. 12 (3).

Same

(4) Nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement provided under section 42 or 44 of the *Employment Standards Act, 2000*. 2010, c. 1, Sched. 24, s. 12 (4).

Same

(5) Nothing in this Act shall be interpreted or applied so as to prevent the application of the insurance plan under the *Workplace Safety and Insurance Act, 1997* after the effective date to an individual to whom the insurance plan did not apply on the effective date. 2010, c. 26, Sched. 16, s. 1.

…

Court File No.: 131/19

MINISTER OF HEALTH AND LONG-TERM CARE
Applicant

-and-

ASSOCIATION OF ONTARIO MIDWIVES and HUMAN RIGHTS TRIBUNAL OF ONTARIO
Respondents

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Proceeding commenced at Toronto

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