CITATION: Ontario v. Association of Ontario Midwives, 2020 ONSC 2839
DIVISIONAL COURT FILE NO.: 131/19
DATE: June 26, 2020

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Backhouse, Pattillo, Lederer JJ.

BETWEEN:	
Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care, Applicant	*S. Zachary Green, Courtney Harris and Yashoda Ranganathan* for the Applicant
and:	
Association of Ontario Midwives, Respondent	*Mary Cornish, Adrienne Telford and Lara Koerner Yeo* for the Association of Ontario Midwives
and:	
Human Rights Tribunal of Ontario, Respondent	*Jason Tam and Brian A. Blumenthal* for the Human Rights Tribunal of Ontario
	HEARD at Toronto: April 21, 22 and 23, 2020

The Court

Liability Decision

Overview

[1] The Applicant, her Majesty the Queen in right of Ontario as represented by the Minister of Health and Long-Term Care ("MOH"), applies for judicial review of the September 24, 2018 decision (the "Liability Decision") and the February 19, 2020 decision (the "Remedy Decision") of the Human Rights Tribunal of Ontario (the "Tribunal").

[2] The Association of Ontario Midwives ("AOM") applied to the Tribunal in 2013 alleging that the setting of compensation for midwives by the MOH was discriminatory on the basis of sex

and therefore violated Section 5 of the *Human Rights Code,* R.S.O.1990, c.H.19, as amended ("the *Code*").

[3] Over approximately 50 days of hearing, the Tribunal heard from twenty factual witnesses and four expert witnesses called on behalf of the AOM and fourteen factual witnesses and six experts called on behalf of the MOH. The record contains many thousands of pages of transcripts, affidavits, exhibits and submissions by the parties.

[4] Until 1994, midwives were excluded from the healthcare system as operated by the Province of Ontario. At the time of regulation, the parties recognized the historic sex-based disadvantage and unequal treatment of midwives within the health sector and their acute vulnerability to systemic gender discrimination in compensation.

[5] At the time of regulation, the AOM and MOH collaborated with the assistance of compensation consultants (Morton) who engaged in systematic and careful research into how the profession of midwifery compared to related health professions. As a result, the parties agreed to principles and methodology which allowed the midwives to take their place in the healthcare system at compensation levels that did not give rise to gender discrimination. One of the fundamental principles established was that compensation for midwives would reflect the overlapping scope of practice they shared with senior nurses (now nurse practitioners) and Community Health Clinic ("CHC") physicians. The Tribunal found that gender was a factor in the development of the funding principles and methodology. The Tribunal found that the point of the principles and methodology was to ensure that midwives' compensation was not negatively affected by traditional assumptions and stereotypes about the value of "women's work."

[6] The ongoing relevance of the 1993 compensation principles and comparators was affirmed by a further compensation study in 2004 – the Hay Report. The Tribunal found that discrimination was not present in the parties' 2005 agreement because the parties maintained their connection to the principles that governed the 1993 agreement.

[7] By 2008, the AOM's research revealed that an inequitable compensation gap had developed between midwives and their CHC physician comparator. It was a term of the parties' 2009 compensation agreement that a joint non-binding compensation study would be conducted by an objective third-party consultant. The resulting Courtyard Report affirmed the ongoing relevance of the original funding principles including the CHC physician comparator and recommended a 20% increase in midwives' compensation to address the misalignment that had developed between midwives and their comparators.

[8] The MOH then withdrew from the process and unilaterally determined that the comparator of the CHC physicians was not an appropriate comparator for midwives. The MOH did so without devising an alternative methodology for compensating midwives based on the value of their work.

[9] The Tribunal found that discrimination based on gender contributed to the MOH's decision to withdraw from the joint Courtyard compensation review process and to unilaterally impose its view of the appropriate compensation to be paid to midwives. The Tribunal found that this left

midwives to negotiate compensation with no recognition of the potential negative impact of gender on their compensation. The MOH then went on to impose compensation restraint on the midwives. The Tribunal found that the systemic nature and cumulative effects on midwives' compensation of the MOH's policies and conduct after 2005 and particularly following the release of the Courtyard Report were a clear breach of the *Code*.

[10] The MOH submits that the Tribunal erred in finding that the AOM met its onus of establishing that midwives have been subject to adverse treatment in their compensation and that sex was a factor. It submits that occupational differences and differences in bargaining strength between CHC physicians and midwives explained their differences in compensation and the Tribunal should have found that the MOH had provided reasonable non-discriminatory explanations for the compensation gap.

[11] Despite MOH's extensive arguments that the Tribunal's decisions are unreasonable and should be quashed, we have concluded that the MOH's arguments mischaracterize the history of compensation negotiations with the AOM, fail to engage with the allegations of adverse gender impacts on midwives and ignore the systemic dimensions of the claim. We are not persuaded that it was unreasonable for the Tribunal, based on the record before it, to find that the MOH's policies and conduct towards the midwives led to systemic gender discrimination in compensation.

[12] For the reasons set out below, we find that the Tribunal's decisions were reasonable and the application should be dismissed.

Factual Background

Early History

[13] The history of midwifery in Canada goes back well before Confederation. Prior to 1865, midwives were the primary maternity care providers in Ontario. Midwives were excluded from the health care system, as operated by the Province of Ontario, until 1994. Even so, midwives practiced in this province without recognition for over a century in less than ideal circumstances. Their legal status was uncertain.

[14] In 1985, the Ontario government established the Task Force on the Implementation of Midwifery, to recommend a framework for the regulation of the profession. The Task Force Report describes how male physicians came to be the preferred birth attendants of the upper classes in 18th century Europe and that by the 19th century, stereotypes proliferated of midwives as "ignorant, unkempt and addicted to gin". The Task Force also found that the practice of midwifery, by women, was suppressed by the modern medical profession. The result of this history was that at the time of regulation in 1994, 99% of Ontario births were performed in hospitals under the control of the medical system which was developed by and dominated by men. The Tribunal found that the recommendations of the Task Force were grounded in the recognition that the

regulation of midwifery "has to do with re-establishing a traditionally female occupation that developments in medicine and medical technology threatened to extinguish." [1]

[15] The Tribunal found that midwifery was not completely extinguished by the medical profession in Ontario. However, it found that those who chose to practice prior to regulation, some of whom testified in this proceeding, did so in precarious circumstances up against attitudes that home births were unsafe and midwives should be practising under the supervision of a physician. The relationship between the work of midwives and the work of physicians was not well understood or represented in their compensation levels. The Tribunal found that for the AOM, the history of suppression and gender stereotyping that midwives experienced was a significant factor in the development of an autonomous model of practice and funding principles to support that model.

[16] The Tribunal found that the perceptions of midwives and the stereotypes associated with their work did not immediately disappear with regulation. A number of midwives testified in this proceeding that these perceptions have been a factor in their ability to achieve full integration into the health care system and work within the full scope of their practice.[2] They attribute this to resistance from a male-dominated medical profession which either did not support licensing midwifery at all, or advocated for midwives to work under the supervision of a physician.

[17] In considering this background, the Tribunal stated:

> The AOM's claims about gender-based discrimination in compensation cannot be fully understood without considering the history of midwifery in Ontario and the importance of the Task Force to the development of the midwifery program. [3]

Regulation of Midwifery-the 1993 Methodology

[18] Midwifery has been a regulated health profession in Ontario since January 1, 1994. Since then, the MOH has funded a public midwifery program that allows women with low-risk pregnancies to choose midwives, rather than physicians, as the primary-care providers for themselves and their newborns. The AOM has existed since the early 1980s and was instrumental

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in developing the Ontario Midwifery Program ("OMP") in partnership with the MOH in the 1990s. The AOM is the recognized representative of registered midwives in Ontario, and it negotiates with the MOH concerning midwives' compensation and other employment-related interests.

[19] The Tribunal found that midwives are occupationally segregated by gender, as they are predominantly women, providing reproductive care to women and their newborns, in an area of health care once dominated by male physicians. The Tribunal found that at the time of regulation, the AOM and MOH recognized the historic sex-based disadvantage and unequal treatment of

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[1] Liability Decision at para. 68.
[2] Liability Decision at paras. 69, 76.
[3] Liability Decision at para. 67.

midwives within the health sector and their acute vulnerability to systemic gender discrimination in compensation.

[20] At the time of regulation, medicine was male-dominated and still strongly identified with men's work. At that time, physicians as a whole were 75.2% male. Today, some parts of the medical profession remain male-dominated while others have seen significant growth in the representation of women. CHC physicians, for example, have been more than 50% female since at least 2001.

[21] Midwifery is not a specialty of nursing nor do midwives work under the supervision of a physician. They are as responsible as physicians for services they provide within their scope of practice. Unlike nurses, they are autonomous primary health-care providers who are specialists in providing comprehensive, around-the-clock, on-call, care for women with low-risk pregnancies and their newborns until six weeks of age. The knowledge and skills of midwives overlap a number of professional scopes of practice, including family physicians, obstetricians, pediatricians, nurse practitioners, registered nurses and registered practical nurses, social workers and counsellors.[4] The parties agree that midwives play a vital role in the healthcare system, having assumed the work which was once the exclusive domain of family physicians and specialist obstetricians.[5] The Tribunal noted that the MOH promotes midwives and physicians as equally competent to provide maternity care for women with normal pregnancies.

[22] Because the MOH disputes the Tribunal's finding that the founding methodology and principles for setting midwives' compensation were based on gender, the evidence relied upon by the Tribunal is set out here in some detail.

[23] The report of the Task Force on the Implementation of Midwifery, which was released in 1987, formed the backbone of the OMP. The Tribunal found that what was most important for its purpose was the way the Task Force described the skills of midwives and their relationship to nurses and physicians. The Task Force stressed that "midwifery is an autonomous profession, not a specialty of nursing". The Task Force also recognized that the midwife "is expected to have diagnostic skills relating to both mother and baby that are at one level similar to the obstetrician".

[24] The Task Force was not directed to recommend an appropriate level of compensation for midwives but did state that they should be paid at a fair and reasonable level that reflects their level of responsibility, the demands on their time, the difficulty of their work, the cost of participating in continuing education activities and the cost of professional liability insurance. The Task Force suggested positioning midwives between the starting salary for a nurse with a baccalaureate degree and the fees physicians were paid under OHIP for pregnancy, labour, birth and postpartum care: "[I]n our view, nursing salaries would be inappropriate for midwives because

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[4] Liability Decision at para. 47.
[5] Liability Decision at para. 53.

of the nature of the midwife's level of responsibility, the difficulty of her work, and the greater (and less predictable) demands on her time."[6]

[25] The Women's Health Bureau of the MOH was assigned to develop a policy framework for implementing midwifery. The Options Paper prepared by the Women's Health Bureau Midwifery Implementation Coordinator, Margaret McHugh, emphasized the necessity of establishing "a fair and equitable pay level [for midwives] based on pay equity, reflecting responsibilities, working conditions and level of education." Ms. McHugh testified that she did not recall anyone [in the MOH] "pushing back" on the issue of pay equity.[7] She understood "pay equity" to mean that:

> …women had historically been underpaid and their work had been undervalued and if we were going to establish a brand-new, female-exclusive, almost, profession, that we had to ensure that that profession was not going to be discriminated against or that there wouldn't be bias against their payment method just by looking at other female-dominated professions and kind of going, "Oh, well, you know, you should be paid a small amount since you're women." So we had to make sure that that happened. It didn't necessarily mean that we were going to do a formal pay equity assessment under the [Pay Equity] Act. It meant that we were going to make sure that we were not underpaying midwives, that they were fairly and equitably paid according to their skills and experience and education, and not according to somebody's picking out something. It was going to be evidence-based.[8]

[26] A team comprised of MOH and AOM representatives was created to determine payment levels and develop a standard contract for payment of midwifery services (referred to by the Tribunal as the "joint working group" or "Work Group"). Ms. Kilthei, then President of the AOM and a member of the joint working group, testified that she understood that it was engaged not in a technical job evaluation under the *Pay Equity Act ("PEA")*[9] but in a pay equity exercise. The term "pay equity exercise" was also how the joint working process was described to the AOM's members when they were asked to ratify the results of the process.[10]

[27] The Tribunal also considered the evidence of Jodey Porter, Ms. McHugh's Assistant Deputy Minister in the Women's Health Bureau at the MOH at the time of regulation, who defined the Morton report as a "one-time bracketing process" which was not related to gender. She conceded that there may have been discussions that she was not part of. The Tribunal concluded that the fact that not every person involved in the regulation of midwifery shared the perspective

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[6] Liability Decision at para. 79.
[7] Liability Decision at para. 93.
[8] Liability Decision at para. 92.
[9] R.S.O. 1990, c.P.7.
[10] Liability Decision at para. 110.

that the process was a pay equity exercise did not undermine the effect of these funding principles in proactively protecting midwives from gender discrimination.[11]

[28] The joint working group was assisted by a compensation expert named Robert Morton who was retained to conduct an evaluation of the skill, effort, responsibility and working conditions ("SERW") of the midwives as compared to senior nurses and family physicians to fix the midwives' compensation. Mr. Morton testified that, while not a "pay equity specialist", he was generally aware of the *PEA* and its required analysis of the SERW of male and female positions and considered it a "clear demarcation of the things one would generally look at in a compensation exercise".[12]

[29] The Morton consultants engaged in "systematic and careful research into how the profession of midwifery compared to related health professions with respect to the dimensions [of SERW]", surveying "25 consumers, midwives, nurses, physicians and educators…to establish perceived similarities and differences between related jobs and that of Midwifery" in order to inform the relative positioning of midwifery job requirements and compensation.[13]

[30] "Appropriate and fair" compensation was based on the joint working group and Interim Regulatory Council of Midwives' principles: "Appropriate" was defined as setting a range that reflected the relative skill, effort, responsibility, and working conditions for midwives in comparison to related health care professions. "Fairness" was defined as a salary level which, not only considered the above factors, but also the general context in which compensation was to occur. This comparison was paramount since fairness can only be determined in relation to levels of pay for professionals working in the same economic market.[14]

[31] Deriving an "appropriate and fair salary" range for midwives based on salary data for health care and social services professions "enabled the Work Group to consider the 'market value' of the various positions", with primary comparisons made with CHC nurses and physicians.[15] The joint working group documents specifically connected "pay equity" with their SERW factor analysis comparing midwives, and CHC nurses and physicians stating it was:

> … those specified in legislation, (i.e. the Pay Equity Act) that is [SERW]. They are considered an industry standard in many countries and were recently used by the Ontario government to determine pay equity across all job classes in the Ontario Public Service.[16]

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[11] Liability Decision at para. 279.
[12] Liability Decision at para. 106.
[13] Liability Decision at para. 103.
[14] Liability Decision at para. 102.
[15] Liability Decision at para. 104.
[16] Affidavit of Jane Kilthei at para. 241, Tribunal Record at 2174.

[32] The Tribunal extensively reviewed the various reports leading up to regulation which referred to "equitable compensation" to describe the proper positioning of midwives between senior nurses and family physicians. The Tribunal found that gender was a factor in the development of the funding principles and framework of the OMP and that the point of the principles and the 1993 Morton methodology was to ensure that midwives' compensation was not negatively affected by traditional assumptions and stereotypes about the value of "women's work".[17] The Tribunal stated:

> Midwifery is a profession imbued with gender. That connection was expressed at the time of regulation in a number of ways: in expanding women's choices in reproductive care; in the development of the model of care and practice; and in the adoption of principles and an evidence-based methodology for ensuring that midwives were paid fairly and appropriately.[18]

[33] The Tribunal found that with the assistance of Mr. Morton's firm and some positional bargaining, the parties adopted in 1993 the principles and methodology which embodied the values of understanding, mutual respect and dignity, the rights of midwives to realize equal treatment without discrimination, and the duty of the MOH to develop compensation practices and policies which proactively incorporate an awareness of their obligations under the *Code*.[19]

[34] The Tribunal found that the midwives perceived the 1993 methodology as a pay equity exercise, and that this was reasonable given their own personal experiences and perceptions that CHC physicians were predominantly male in 1993 and the reliance on principles that corresponded with the *PEA*. The Tribunal found that it was reasonable for midwives to be operating from the perspective that their work was being valued in comparison to work which was, historically and still at that time, associated with men. The Tribunal did not, however, accept the AOM's contention that there was an agreement that CHC physicians were the primary comparator.[20]

[35] The Tribunal found that the history of the joint working group and the Morton Report was important to its decision because it demonstrated the methodology that the AOM and the MOH developed to "make visible" the work of midwives and set their compensation in accordance with their SERW. It also demonstrated the commitment of the AOM and MOH to an ongoing and collaborative working relationship.[21]

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[17] Liability Decision at para. 277.
[18] Liability Decision at para. 275.
[19] Liability Decision at paras. 275, 277, 281, 18.
[20] Liability Decision at paras. 278, Remedy Decision at para. 33.
[21] Liability Decision at para. 99.

[36] While the Tribunal found that the Morton process "did not constitute a comprehensive and statistically valid job evaluation, it provided a framework for the Work Group to systematically and carefully examine comparator positions relative to the profession of midwifery."[22]

[37] The Tribunal found that the difference between how midwifery was valued for compensation purposes prior to and after regulation illustrates the power of the funding principles and the evidenced-based methodology the parties relied on in 1993. Prior to regulation, the average earnings of a midwife in a very busy practice in Toronto were approximately $20,000. In the initial 1994 compensation agreement, the entry-level salary for a midwife was just above the top salary for a CHC nurse, while the top salary for a midwife was approximately 90% of the entry-level salary for a CHC physician. Midwives' compensation more than tripled as a result of the principles and methodologies applied at regulation.[23]

[38] The Tribunal found that the 1993 principles and methodology were not a "one-time" process. It held that the funding principles were foundational to the implementation of the OMP. The Tribunal found that the OMP framework was also reaffirmed by the MOH in 2000 which clearly rebutted the suggestion that positioning midwives between CHC nurses and physicians was a onetime exercise.[24]

[39] The Tribunal found that the fact that midwives' pay is no longer so situated in relation to that of CHC physicians was central to the AOM's application. The Tribunal based its findings primarily on the extent to which the MOH remained aligned with the intent of the 1993 principles and methodology and the impact on the midwives where that was not the case.

No Breach of the *Code* from 1993 to 2005

[40] This was a period of significant "compensation restraint", and beginning in 1994, midwives would experience eleven years of wage freezes. In a 1999 agreement between the AOM and the MOH, midwives moved from a salary model to a "course of care" model and were re-classified from dependent to independent contractors. Increases were made to operating expenses for midwives, but not to compensation. CHC workers, including senior nurses and physicians, also experienced eleven years of wage freezes – in their case, starting from 1992. Being earlier in line than midwives for a compensation increase, CHC physicians received their first raise in 2003 (which was either 8.7% or 7.4%, depending on where they worked) while midwives would wait until 2005.

[41] To support them in the negotiations that would lead to the 2005 agreement with the MOH, the AOM commissioned a compensation study (the Hay Report) to consider the ongoing relevance of the 1993 compensation principles and comparators and recommend an appropriate increase for the midwives. Hay Group principal Moshe Greengarten testified that he concluded that the Morton

[22] Liability Decision at paras. 106–107.
[23] Liability Decision at para. 111.
[24] Liability Decision at paras. 279–280.

report "was reasonable and produced a credible recommendation or results" in setting out "key principles for compensating Ontario midwives" and in particular a "reasonable, internal, or let's say equity structure for the midwives as compared to other health care professionals." Mr. Greengarten also concluded that pay levels for midwives should fall between the pay levels of a family physician and a nurse practitioner. The Hay report put forward two options for establishing a "fair and appropriate" job rate for midwives: to fix the job rate of midwives to 90% of the entry level of a CHC physician salary or to use the same methodology but increase income further by prorating to reflect hours of work.[25]

[42] The three-year agreement the AOM and the MOH reached after negotiations in 2005 included a first-year increase of 20 to 29% for midwives depending on their experience level, as well as 1 to 2% increases in the remaining years of the contract.

[43] Meanwhile CHC physicians, who had received increases of 7.4 to 8.7% in 2003, sought representation from the Ontario Medical Association ("OMA") in 2004, and increases to their compensation accelerated between 2004 and 2012. In 2012, the MOH applied compensation restraint to reduce their salaries.

[44] The Tribunal found that discrimination was not present when the 2005 agreement between the parties was made because of the connection the parties maintained to the principles that governed the 1993 agreement.

[45] The Tribunal found that at that time, the MOH incorporated both the Morton Report and the Hay Report in considering the risks of under-compensating midwives. The Hay Report was not a joint compensation study and the Tribunal found that it was reasonable for the MOH to expect to bargain over the results of that analysis. Positional bargaining was one of a number of tools the parties used to reach agreements in 1993 and 1999. There was a genuine negotiation process through which midwives negotiated significant increases in the range of 20-29% and maintained proximity to CHC physicians with the level 3 midwives remaining within 91% of the CHC physicians. The Tribunal found that there is nothing in the record which established that the AOM viewed the 2005 compensation agreement as discriminatory.[26]

[46] The Tribunal found that from 1993 through to the 2005 agreement, the negotiations between the parties were informed by objective criteria like SERW which overlapped to some extent with pay equity principles, and other evidence-based compensation methodologies. The parties reached agreements on positioning midwives between CHC nurses and CHC physicians with whom they share an overlapping scope of practice. Their specific comparators were senior nurses (later nurse practitioners as confirmed in the Hay report) and family physicians employed in CHCs.

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[25] Liability decision at paras. 157–158.
[26] Liability decision at paras. 287–289.

[47] The imposition of wage freezes leading up to the 2005 agreement had an adverse impact on midwives, but the Tribunal held that there was insufficient evidence to connect that impact to gender. A policy of general compensation restraint, including the social contract deductions, was applied to midwives after they achieved equitable compensation. Because they achieved compensation free of gender discrimination in 1993, the wage freeze did not create a disproportionate impact on midwives connected to gender.[27]

Signs of Trouble

[48] After 2005, the AOM came to be concerned that a gender gap in compensation had developed between midwives and their CHC physician comparator.

[49] The MOH did not monitor how changes in the compensation of CHC nurses and CHC physicians affected the alignment of midwives with their comparators. The MOH did not develop an alternative methodology for compensating midwives based on their SERW and their overlapping scope of work with family physicians and obstetricians in delivering low-risk maternity and newborn care. From regulation in 1993 until the joint Courtyard review in 2010, the MOH did not conduct a study of midwives' work and pay.

[50] In the AOM's 2008 negotiations with the MOH, the AOM's priorities included significant compensation increases. The AOM framed its request for a significant increase as an equity issue for midwives. The MOH would not agree to more than 2% increases in each of the three years of the contract. The AOM complained that the offer of the MOH was inequitable and raised the connection between pay inequity and the sustainability of the profession.[28] The AOM sought the commitment of the MOH to a joint compensation valuation review to look at midwives' compensation in a methodical way because its own research revealed that by the time of the 2008 negotiations, midwives were underpaid by reference to the original funding principles and in relation to both nurse practitioners and CHC physicians. The Tribunal found that by 2008, some nurse practitioners were earning more than midwives and there was an increasingly significant gap between midwives and CHC physicians. It is not in dispute that the AOM gave up other things at the negotiating table in 2008 to achieve MOH's agreement to a joint compensation study.[29]

Courtyard Review

[51] The parties agreed that the joint compensation study was to be conducted by an objective, third-party consultant. The primary goal of the non-binding review was to suggest an appropriate "total compensation" package for midwifery services based on available evidence and to evaluate the ongoing relevance of the 1993 methodology to inform the next round of negotiations.[30]

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[27] Liability Decision at para. 291.
[28] Liability Decision at para. 176.
[29] Liability Decision at paras. 39, 294.
[30] Liability Decision at para. 187.

[52] A steering group made up of equal members of both the AOM and MOH worked collaboratively with the consultants. Courtyard did not conduct a gender-based compensation analysis but it considered the 1993 Morton report and the 2004 Hay Group report.

[53] The steering committee endorsed CHC nurse practitioners and physicians as appropriate comparators. During the review process and in providing feedback to Courtyard before the final report was completed, the MOH never objected that CHC physicians were not appropriate comparators for midwives.

[54] The Courtyard Report was the product of significant input by the parties. The joint process was described by the Tribunal as "collaborative", "iterative" and "constructive". The following evaluation questions were established by the steering committee: 1) Does the current compensation model reflect the current scope of work performed? 2) Does the current compensation model reflect the volume/complexity of work performed? 3) Does the current compensation model reflect the cost of doing the work? 4) What is the value of benefits, or equivalent funding received by midwives? 5) Does the current compensation model reflect the experience and training of midwives? 6) Is the current compensation model comparable to other professions performing similar work? 7) Does the current compensation model reflect adherence to best practice guidelines and the achievement of the Ministry's policy objectives? 8) What market trends should be taken into consideration? 9) Have compensation increases remained aligned with economic growth in Ontario? [31]

[55] Courtyard established a comprehensive evidence-based framework flowing from the evaluation questions and relying on established compensation practices. This methodology included frequent meetings, email communications, review of background documents and data, stakeholder interviews, data analysis and a cross-Canada jurisdictional review.

[56] Courtyard rendered its final report in October 2010. The Report is fifty-four pages in length organized around the evaluation questions established by the steering committee. It contains a significant amount of information and a number of charts which explain the methodology and the findings.[32] Courtyard found that with CHC physicians now earning $181,233 and the top midwife earning $104,847, there was a pay gap (not including benefits) of about $76,000, up from $3000 at the time of regulation. Courtyard found that nurse practitioners are now paid the same as the lowest level midwife and in some practice settings such as hospitals they may be paid significantly more.

[57] One of the key findings in the Courtyard Report was its affirmation of the ongoing relevance of the original funding principles, including comparison with CHC physicians.[33] It noted that the original Morton model was based, amongst other things, on "ensuring pay is equitable compared to other professions performing similar work". The Report found a

[31] Liability Decision at paras. 189–190, 193.
[32] Liability Decision at para. 192.
[33] Liability Decision at para. 295.

misalignment of the midwives' compensation based on these principles. It recommended a 20% increase in compensation "to restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians." The Report attributed the compensation gap to irregular negotiations and lack of adherence to the original funding principles.

[58] The Tribunal found that the extent of the misalignment between midwives and their comparators was revealed by the review. In the Remedy Decision, the Tribunal found:

> [122] Courtyard illustrates how midwives gradually shifted out of alignment with their comparators after the 2005 agreement was achieved. Courtyard represents the best evidence of both the consequences of losing the benchmarks, and what compensation losses flow from reinstating them. While Courtyard recommended an "equity" adjustment of 20% for midwives at each of the six levels as of April 1, 2011, it is equally important that Courtyard reinstated the methodology of aligning midwives between their comparators and recommended regular negotiations going forward on that basis.
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> …
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> [124] The study proceeded with the full cooperation of the parties and an active steering group made up of equal numbers of representatives for the MOH and the AOM. As noted above, the President of the AOM and the Manager of the OMP participated as members of the steering committee. Mr. Ronson, the lead consultant on Courtyard, testified in detail about the important role of the steering committee in developing the evaluation questions and framework for the study. He was also clear that he was serving two clients and that it was critically important that the clients "had their fingerprints" on the study as early as possible in the process.
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> …
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> [128] The report validates the comparison with nurse practitioners and repeats the methodology of finding an equitable relative positioning between midwives and their comparators. It also considers the ongoing role of obstetricians in low-risk maternity care, consistent with Morton. As a result, Courtyard represents the best evidence of what the alignment would be between midwives and their comparators based on the continuation of the previous methodologies, negotiated through a joint compensation process. It also resets compensation at the appropriate level before the application of compensation restraint.
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> [129] Courtyard includes a jurisdictional scan which revealed only two provinces where midwives work in comparable models. At the time of the review, Alberta had 65 midwives while British Columbia had 145 compared to 480 midwives working in Ontario. The relevance of a jurisdictional scan will change over time with the maturity of midwifery models in other parts of Canada. In 2010, Courtyard placed the appropriate emphasis on comparing midwives to other primary health care providers in the same economic market, as compared to the other jurisdictions, a principle the parties also agreed on in 1993.

[59] The Tribunal found that the MOH had every opportunity to participate through the steering committee and review of draft reports. Mr. Ronson testified that he responded to the points raised by the MOH after its review of the draft report and that the input of the MOH made the report stronger although it did not change its conclusion.[34]

MOH's response to Courtyard Report

[60] The MOH's response to Courtyard's recommended increase was to unilaterally withdraw from the process. The MOH took the position that the 1993 principles and methodology no longer informed the compensation practices of the MOH and unilaterally determined that CHC physicians were not appropriate comparators for midwives. The MOH did not conduct an alternate study to validate that assumption or to investigate the concerns raised by the AOM about inequitable compensation paid to a group of almost exclusively female workers based on their gender and the results of the Courtyard review.

[61] When the Courtyard Report was released, the MOH raised concerns about the methodology and its recommendations. The Tribunal found that the deficiencies in the report perceived by the MOH could have been easily remedied by providing further guidance to the consultants.[35]

Imposition of policy of compensation restraint

[62] The MOH then imposed a policy of compensation restraint on the negotiations with the AOM. The policy was derived from legislation which had come into effect in March 2010, several months before the Courtyard review took place, and which did not explicitly apply to the midwives as independent contractors. The imposition of compensation restraint was not raised during the Courtyard review. The Tribunal found that the Courtyard Report was sufficiently compelling for the MOH to realize that the claim of gender discrimination in the compensation of midwives had some validity which the MOH declined to investigate. The Tribunal found that this compounded the adverse impact on midwives of losing the connection to the 1993 principles.[36]

[63] The AOM first considered a human rights application in 2011 but chose instead to pursue other strategies. The parties reached a funding agreement in 2013 but without prejudice to the AOM's right to pursue legal action. In November 2013, the AOM launched the application that led to the decisions under review.

MOH's Evidence that CHC physicians and midwives are different

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[34] Remedy Decision at para. 141.
[35] Liability Decision at paras. 305–306.
[36] Liability Decision at para. 309.

[64] To support its position that CHC physicians were not appropriate comparators, the MOH led considerable evidence at the hearing from CHC physicians about their work, education and training to demonstrate how different they were from midwives. The Tribunal was not persuaded by this evidence that CHC physicians were not appropriate comparators. In light of the 1993 agreement to which the MOH was a party and the Hay Group and Courtyard Reports which both confirmed the ongoing relevance of the CHC physician comparator, the Tribunal found that it would be speculative to conclude that CHC physicians were not appropriate comparators without a job evaluation which confirmed this.[37]

[65] The MOH argued that the difference in compensation paid to midwives and CHC physicians is also a reflection of bargaining strength. The Tribunal held that this argument failed to examine the gender implications of that approach. The Tribunal held that the bargaining strength of midwives depended 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.[38]

[66] The Tribunal did not conduct a line-by-line, mirror comparison between midwives and any one group of health care providers or public sector workers since 1993, finding that that was not the intent of the process the parties agreed to in 1993. The Tribunal held that the question in this case, as in every case adjudicated under the *Code*, is whether there is evidence of adverse treatment which is connected to gender.[39]

[67] 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 treatment and that gender is more likely than not a factor in that treatment. The Tribunal found, in light of the findings in the Courtyard Report, that the MOH's failure to investigate the AOM's claims of gender discrimination compounded the adverse impact on midwives of losing the connection to the 1993 principles.[40]

[68] The Tribunal stated:

> [302] At regulation, "appropriateness" was defined in relation to objective factors like SERW. Midwives no longer have a methodology to rely on in their negotiations with the MOH which ensures that their compensation is aligned with their SERW. The Supreme Court referred to this as "benefits routinely enjoyed by men – namely, compensation tied to the value of their work". See *Quebec (Attorney General) v.*

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[37] Liability Decision at para. 299.
[38] Liability Decision at para. 303.
[39] Liability Decision at para. 272.
[40] Liability Decision at para. 296.

Alliance du personnel professionnel et technique de la santé et des services sociaux, 2018 SCC 17, para. 38.

[69] The Tribunal found that this perpetuates the historic disadvantage midwives have experienced as sex-segregated workers. It also undermines the dignity of midwives who now find themselves having to explain why they should be compared to physicians for compensation purposes more than 20 years after this principle was established. The Tribunal found that it is a denial of substantive equality that midwives must negotiate in a context where there is no recognition of the potential negative impact of gender on their compensation.[41]

[70] The Tribunal found that the parties are not required to abide by the specific methodology they agreed to in 1993 and are at liberty to negotiate a new compensation methodology. However, it found that what has happened in this case is that the MOH has unilaterally withdrawn from the 1993 principles and methodology, leaving the compensation of midwives exposed to the well-known effects of gender discrimination on women's compensation.[42]

MOH-No Proactive Steps

[71] The MOH admits, contrary to the Ontario Human Rights Commission's policies, that it has taken no proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation. The Tribunal noted that by contrast, the MOH has continued 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.[43]

[72] The Tribunal held that the MOH is not required by the *Code* to engage in any one proactive strategy to monitor, identify and redress discrimination in the compensation of midwives. However, it held that the MOH must take steps which are effective and proportional to its obligations under the *Code* to both prevent and remedy discrimination. The Tribunal found that the MOH's failure to do so compounded the adverse impact on midwives of losing the connection to the 1993 principles.[44]

[73] The failure to act proactively is a factor from which the Tribunal drew an inference of discrimination.[45]

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[41] Liability Decision at para. 322.
[42] Liability Decision at para. 323.
[43] Liability Decision at para. 315
[44] Liability Decision at para. 317.
[45] Liability Decision at para. 317.

[74] The Tribunal held that the MOH's failure to maintain a perspective consistent with the principles set out in the *Code* in negotiations with the AOM after the Courtyard Report created a series of consequences, when considered together, constitute discrimination under the *Code*.[46]

[75] The Tribunal found that there was sufficient evidence on a balance of probabilities and on the totality of the evidence from which to infer that midwives experienced adverse treatment and that sex is more likely than not a factor in the treatment they experienced and the compensation gap that has developed between midwives and CHC physicians since 2005.[47]

Jurisdiction

[76] Pursuant to ss. 2 and 6(1) of the *Judicial Review Procedure Act*[48], the Divisional Court has jurisdiction to hear an application for judicial review.

Standard of Review

[77] Section 45.8 of the *Code* states:

> Subject to section 45.7 of this Act, section 21.1 of the *Statutory Powers Procedure Act* and the Tribunal rules, a decision of the Tribunal is final and not subject to appeal and shall not be altered or set aside in an application for judicial review or in any other proceeding unless the decision is patently unreasonable.

The MOH submits, based on *Shaw v. Phipps*[49], that the standard of review on its application is reasonableness. In support, it relies on the recent decision of this court in *Intercounty Tennis Association v. Human Rights Tribunal of Ontario*[50].

[78] The Tribunal, together with the AOM, submits the recent decision of *Canada (Minister of Citizenship and Immigration) v. Vavilov*[51], overrules *Shaw v. Phipps* such that the legislated standard of judicial review set out in s. 45.8 of the *Code* of "patently unreasonable" applies.

[79] In *Dunsmuir v. New Brunswick*[52], the Court reduced the then existing three standards of review (correctness, reasonableness and patent unreasonableness) by collapsing the two standards of reasonableness into a single form of reasonableness review.

[80] In *Shaw v. Phipps,* this court held, having regard to *Dunsmuir*, that when s. 45.8 of the *Code* is read purposively and in light of the general principles of administrative law, the "patently

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[46] Liability Decision at para. 274.
[47] Liability Decision at para. 324.
[48] R.S.O. c. J.1.
[49] 2010 ONSC 3884 (Div. Ct.), upheld 2012 ONCA 155.
[50] 2020 ONSC 1632.
[51] 2019 SCC 65 ("*Vavilov*").
[52] 2008 SCC 9, [2008] 1 S.C.R. 190.

unreasonable" standard in s. 45.8 was equivalent to reasonableness. Following *Shaw v. Phipps*, the standard of review applied to Tribunal decisions has been reasonableness.

[81] In *Vavilov*, the Supreme Court directed that the presumptive standard of review in judicial review applications is reasonableness which standard can be rebutted where a legislature has indicated that a different standard should apply.

[82] In *Intercounty Tennis* referred to above, the Tribunal submitted, as it has before us, that *Vavilov* overruled *Shaw v. Phipps* such that the patently unreasonable standard in s. 45.8 should now apply. In response, the court held that the principle in *Shaw v. Phipps* still applies and the words "patently unreasonable" in the *Code* are to be given the meaning ascribed to them in *Shaw v. Phipps* – namely, reasonableness. In reaching that decision, the court considered the reasoning in both *Shaw v. Phipps* and *Dunsmuir* in light of *Vavilov*. It noted that while *Vavilov* sought to address certain issues that had arisen in respect of judicial review post *Dunsmuir*, it did not identify *Dunsmuir*'s merger of the reasonableness and patent unreasonableness standards as being one of them.

[83] The court further noted that to re-introduce the standard of patent unreasonableness would be contrary to the stated purpose of *Vavilov* which is to clarify and simplify the law of judicial review. Finally, it noted that a return to patent unreasonableness would also give rise to rule of law concerns as identified in Paragraph 42 of *Dunsmuir* set out below:

> Moreover, even if one could conceive of a situation in which a clearly or highly irrational decision were distinguishable from a merely irrational decision, it would be unpalatable to require parties to accept an irrational decision simply because, on a deferential standard, the irrationality of the decision is not clear *enough*. It is also inconsistent with the rule of law to retain an irrational decision. As LeBel J. explained in his concurring reasons in *Toronto (City) v. C.U.P.E.*, at para. 108:
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> > In the end, the essential question remains the same under both standards: was the decision of the adjudicator taken in accordance with reason? Where the answer is no, for instance because the legislation in question cannot rationally support the adjudicator's interpretation, the error will invalidate the decision, regardless of whether the standard applied is reasonableness *simpliciter* or patent unreasonableness . . . .
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> See also *Voice Construction Ltd. v. Construction & General Workers' Union, Local 92*, [2004] 1 S.C.R. 609, 2004 SCC 23, at paras. 40-41, *per* LeBel J.

[84] The Tribunal submits that *Intercounty Tennis'* reasoning is not justified in light of *Vavilov* and its directive to respect legislative intent concerning the standard of review. Further, it submits that *Shaw v. Phipps* is no longer good law as *Vavilov* has done away with the contextual analysis.

[85] The Supreme Court held, well before *Vavilov*, that when a legislature has specified a standard of review, the legislative choice must be respected. See: *R. v. Owen*, 2003 SCC 33 at para. 32. In *Canada (Citizenship and Immigration) v. Khosa*[53] the Court stated at para. 18:

> In cases where the legislature has enacted judicial review legislation, an analysis of that legislation is the first order of business. Our Court had earlier affirmed that, within constitutional limits, Parliament may by legislation specify a particular standard of review: see *R. v. Owen*, 2003 SCC 33, [2003] 1 S.C.R. 779. Nevertheless, the intended scope of judicial review legislation is to be interpreted in accordance with the usual rule that the terms of a statute are to be read purposefully in light of its text, context and objectives.

[86] While *Vavilov* did away with *Dunsmuir's* use of the contextual analysis in determining the standard of review, *Shaw v. Phipps* was not decided on that basis. Rather, the court in *Shaw v. Phipps* interpreted s. 45.8 of the *Code* in accordance with the Court's direction in *Dunsmuir* set out above to conclude that the standard of review is reasonableness. In our view, nothing in *Vavilov* affects that holding.

[87] Finally, the Tribunal relies on a number of British Columbia and Alberta cases where the legislated standard of patent unreasonableness still survives. For the above reasons, however, we do not consider those cases to be relevant.

[88] We agree with *Intercounty Tennis*' holding in respect of the standard of review. The standard of review in respect of the Tribunal's decision is reasonableness.

Requirements under *Vavilov*

[89] Counsel for the MOH made submissions about the requirements under *Vavilov* for a reviewing court to find a decision reasonable: A reasonable decision is one that is based on an internally coherent and rational chain of analysis and that is justified in relation to the facts and law that constrain the decision maker.[54] It is not ordinarily appropriate for a reviewing court to fashion its own reasons in order to buttress the administrative decision.[55] To be reasonable a decision must be based on reasoning that is both rational and logical and the reviewing court must be satisfied that "there is a line of analysis within the given reasons that could reasonably lead the tribunal from the evidence before it to the conclusion at which it arrived."[56]

[90] In regard to this, it is important to remember that this is a judicial review of a specialized tribunal which has brought its institutional expertise and experience to bear on the issue of human rights law and systemic discrimination on the basis of sex. These are issues involving its home

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[53] 2009 SCC 12.
[54] *Vavilov* at para 85.
[55] *Vavilov* at para. 96.
[56] *Vavilov* at para. 102.

statute. As the subject-matter expert in human rights and sex-based discrimination, the Tribunal's decisions are entitled to substantial deference. This is also prescribed by the legislature: s. 45.8 of the *Code* states that the Tribunal's decision is "final" and "shall not be altered or set aside …unless [it] is patently unreasonable". As set out above, we have interpreted this as a standard of "reasonableness".

[91] The Court in *Vavilov* also makes clear that a reasonableness review is anchored "in judicial restraint and respect [for] the distinct role of administrative decision makers". The Tribunal's reasons are to be read as a whole and "not to be assessed against a standard of perfection". It is not a "line-by-line treasure hunt for error. It need not "respond to every argument or line of possible analysis" or include all "jurisprudence or other details the reviewing judge would have preferred". Nor must they make "an explicit finding on each constituent element, however subordinate, leading to [the Tribunal's] conclusion." A decision is reasonable where the reasoning process is "transparent, intelligible and justified" and the outcome is one that "falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law". [57] The SCC also cautions that in areas within the purview of the Tribunal: "It is the Tribunal's task to evaluate the evidence, find the facts and draw reasonable inferences from the facts", and to interpret the *Code* "in ways that make practical and legal sense in the case before it, guided by the applicable jurisprudence". Such findings and reasonings should not be interfered with "absent exceptional circumstances."[58]

The Law

[92] S.5(1) of the *Code* states:

> *S.5(1)*Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability.

[93] The *Code* is human rights legislation whose purpose relevant to this claim is to redress systemic gender discrimination in the compensation of employees employed in female job classes in Ontario. It applies to, among others, all employers in the public sector.

[94] The Tribunal noted that the *Code* is to be given a broad, purposive interpretation to ensure that its purpose is fulfilled. The purpose is to remedy discrimination by focusing on the effect of the actions complained of rather than on the intent of the person accused of discrimination.[59]

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[57] *Vavilov* at paras. 15, 18, 75, 86; 91-94, 100, 125, 128; *Dunsmuir v. New Brunswick*, 2008 SCC 9, at para. 47.
[58] *Stewart v. Elk Valley Coal*, 2017 SCC 30, para 20-22, 27.
[59] Liability Decision at para. 228.

[95] The Tribunal observed that the Preamble of the *Code* reflects the kinds of experiences the legislation is directed at remedying. It speaks not just to equality in relation to the law, but also to the values of understanding, mutual respect and dignity and the need to ensure that every citizen has the opportunity to contribute fully to the community. The analysis of a claim of discrimination under the *Code* must be animated by these important principles. Like all human rights legislation, the *Code* is directed at achieving substantive equality and enshrines positive rights, not just access to a remedy where a breach can be found.[60]

[96] The Tribunal cited Chief Justice Dickson's observations in *Action Travail des Femmes*[61] about how human rights legislation must be interpreted:

> "Human rights legislation is intended to give rise, amongst other things, to individual rights of vital importance, rights capable of enforcement, in the final analysis, in a court of law. I recognize that in the construction of such legislation the words of the *Act* must be given their plain meaning, but it is equally important that the rights enunciated be given their full recognition and effect. We should not search for ways and means to minimize those rights and to enfeeble their proper impact. Although it may seem commonplace, it may be wise to remind ourselves of the statutory guidance given by the federal *Interpretation Act* which asserts that statutes are deemed to be remedial and are thus to be given such fair, large and liberal interpretation as will best ensure that their objects are attained. See s. 11 of the *Interpretation Ac*t, R.S.C. 1970, c. I-23, as amended.

The Applicable Test

[97] Discrimination is not defined in the *Code*. There is no dispute however that the three-part test set out in *Peel Law Association v. Pieters*[62] was correctly stated by the Tribunal:

- identification with a prohibited ground;
- adverse treatment (sometimes referred to as adverse impact or disadvantage); and
- a connection between the adverse treatment and the ground.

[98] The Tribunal discussed the framework for its analysis in the following way:

> The Prima Facie Case

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[60] Liability Decision at para. 226.
[61] Liability Decision at para. 229, citing *Action Travail des Femmes v. C.N.R. Co.*, [1987] 1 SCR 1114 at p 1134.
[62] *Peel Law Association v. Pieters*, 2013 ONCA 396.

> [257] In a human rights case, the burden of proof remains on the applicant throughout. However, that is a different concept than the evidential burdens, which apply to both parties.
>
> [258] The traditional analysis is often described in this way: the applicant has the evidential burden to prove a prima facie case; once a prima facie case is established, the evidential burden shifts to the respondent to prove a credible, non-discriminatory explanation which rebuts the prima facie case; the evidential burden shifts back to the applicant to prove that the respondent's explanation is pretextual. In O'Malley, above, the Supreme Court defined it as follows: (…) a prima facie case of discrimination 'is one which covers the allegations made and which, if they are believed, is complete and sufficient to justify a verdict in the applicant's favour in the absence of an answer from the respondent.'[63]

[99] The MOH in its factum states the following:

> 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[64] has held that the burden is on the applicant to prove that the respondent's evidence is "false or a pretext.

[100] Central to the MOH's application is its assertion that it provided non-discriminatory explanations for the differences in compensation which were accepted by the Tribunal and that the AOM failed to prove that the explanations were false or a pretext. As will become apparent, we do not accept that characterization of the Tribunal's Decision.

Analysis

[101] We make some general observations at the outset of our analysis about the systemic nature of this claim.

Systemic Nature of Claim

[102] The MOH has argued this judicial review application on the basis that gender and the systemic nature of the claim are nonexistent. The overarching position of the MOH is that gender has never been a factor in determining compensation for midwives and that midwives' compensation was never set in relation to a male comparator from which it follows that there was

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[63] Liability Decision at paras. 257–258.
[64] *Pieters* at paras. 72–74.

no basis for a finding that there was discrimination on the basis of sex. The MOH submits that the Tribunal's finding that there was adverse discrimination and that gender was a factor were conclusory and without a logical chain of analysis.

[103] The MOH argues that paying midwives less than CHC physicians does not adversely affect them because they are different and cannot be properly compared to physicians.

[104] The Tribunal's findings about the systemic nature and cumulative effect of the MOH's repudiation of the principles and norms which historically governed the setting of midwives' compensation are pivotal to understanding its conclusion of discrimination on the basis of sex under the *Code*.

[105] As noted by the Tribunal, systemic discrimination and systemic gender discrimination in compensation ("SGDC") in particular, are often subtle and hidden and require a comprehensive, sophisticated analysis of its effects on complainants. The SCC in *Action Travail* describes systemic discrimination as "discrimination that results from the simple operation of established procedures…none of which is necessarily designed to promote discrimination", and the hallmark of which is its "structural and largely invisible nature."[65]

[106] The Tribunal describes SGDC as arising from "deeply held attitudes…about women's work" which lead employers and compensation-setters to give less value to the work", often "without conscious decision-making". These unconscious attitudes are often hidden and embedded in seemingly neutral compensation policies and practices. For example, "traditional job evaluation", without a gender-based analysis, can reinforce and perpetuate these attitudes, "rewarding the skills and job content characteristics of male work and ignoring or giving less value to the skills and job content requirements of women's work". As stated by Justice Evans in *PSAC*, "systemic discrimination is the result of the ongoing application of wage policies and practices that tend to either ignore or undervalue work typically performed by women." Evans J. emphasized that: "to understand the extent of such discrimination…it is important to examine the pay practices of the employer as they affect the wages of men and women" as "comprehensively as possible."[66]

[107] The Tribunal found that it was the systemic nature and cumulative effect of policies and conduct on the compensation of midwives which resulted in differential treatment and discriminatory impact.[67]

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[65] Liability Decision at para. 311; *Association of Ontario Midwives v. Ontario (Health and Long-Term Care)*, 2014 HRTO 1370 ("Dismissal Decision") at paras. 30–33, 37; *CN v. Canada (Cdn Human Rights Commission*), [1987] 1 SCR 1114; *Action Travail* at 1138–39.

[66] Liability Decision at para. 247; *Haldimand Norfolk*, (1991) 2 PER 105, para 18-19; *Canada (AG) v. Public Service Alliance of Canada*, [2000] 1 FC 146 at paras. 117–18: *Centrale des syndicats du Québec v. Quebec (Attorney General)*, 2018 SCC 18, [2018] 1 SCR 522 ("CSQ") at paras. 2–3, 34.

[67] Liability Decision at para. 273.

[108] Systemic discrimination is a continuing phenomenon which has its roots deep in history and in societal attitudes.[68]

[109] We now turn to consider the issues raised by the MOH.

Misapplication of the test for discrimination

[110] The MOH submits that the Tribunal misapplied the test for discrimination. The parties agree that the Tribunal correctly stated the well-established three-part *Pieters* test for discrimination and the burden of proof.

[111] The parties also agree that the first element of the test is met in this case. As found by the Tribunal, midwifery has "always been strongly identified with women's work".[69] Midwives are occupationally segregated by gender, they are predominantly women, providing reproductive care to women and their newborns, in an area of health care once dominated by male physicians. At issue is whether the Tribunal's application of the second and third elements of the test to the evidence before it was unreasonable.

Second part of *Pieters*' test: Was the Tribunal's decision that midwives suffered adverse treatment unreasonable?

[112] The MOH submits that the Tribunal's decision that midwives suffered adverse treatment is unreasonable because:

1) the Tribunal's finding was based on the MOH having failed to "recognize the role of gender" in midwives' compensation and the MOH having failed to recognize "the reasons for maintaining a physician comparator." It is submitted that these reasons were circular: The test cannot be met by a purported failure to take steps to prevent the very discrimination that the test is intended to identify;

2) it did not attempt to rate the jobs of midwives and CHC physicians for comparison purposes;

3) it did not attempt to compare the work and scope of the two professions and did not consider any of the evidence as to the scope overlap;

4) it made no finding that the compensation of midwives did not reflect "the fundamental principle that the compensation of midwives should reflect the overlapping scope of practice they share with physicians;"

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[68] Dismissal Decision at para. 32, citing *Public Service Alliance of Canada v. Canada (Department of National Defence)*, [1996] 3 FC 789, 1996 CanLII 4067 (FCA).
[69] Liability Decision at para. 61.

5) it was unreasonable to find that 20 years after regulation a divergence in compensation between midwives and physicians was discriminatory.

[113] The MOH's argument is disingenuous. First, the Tribunal made a clear finding in the Liability Decision that the application of compensation restraint to sex-segregated workers was discriminatory:

> [251] The MOH does not concede that midwives have been subject to adverse treatment. This issue is resolved primarily on the basis of the facts, which I have addressed in my findings. There is no dispute that not every difference in treatment will amount to discrimination. To situate that argument in the context of this case, the application of compensation restraint to sex-segregated workers is clearly disadvantageous, but that satisfies only the first two parts of the test. As I discuss further, below, there must also be proof that the act itself or the impact of that act is linked to sex.

[114] Second, the Tribunal accepted the joint Courtyard Report which analyzed the occupational differences between midwives, physicians and nurse practitioners and found the ongoing relevance of the original funding principles, including comparison with CHC physicians. The Tribunal considered the MOH's evidence that CHC physicians were different and rejected its submission that they were no longer an appropriate comparator. This was not unreasonable, given that the MOH's Manager of the OMP was part of the steering committee which endorsed CHC physicians as an appropriate comparator for the Courtyard review and all three of the compensation reviews had come to the same conclusion. The Tribunal found adverse treatment in the following:

(a) The Courtyard Report illustrates how midwives gradually shifted out of alignment with their comparators after the 2005 agreement was achieved.[70]

(b) The Courtyard report represents the best evidence of both the consequences of losing the benchmarks, and what compensation losses flow from reinstating them.[71]

(c) Courtyard represents the best evidence of what the alignment would be between midwives and their comparators based on the continuation of the previous methodologies, negotiated through a joint compensation process. The finding of misalignment of midwives' compensation was based on what their pay would have to be to be equitable compared to other professions performing similar work. It also resets compensation at the appropriate level before the application of compensation restraint.[72]

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[70] Remedy Decision at para. 122.
[71] *Ibid.*
[72] Remedy Decision at para. 128.

(d) The Tribunal found adverse treatment from the MOH having unilaterally abandoned the framing methodology and failing to use a proactive prevention approach and gender lens to ensure its compensation setting was free from the well-known effects of SGDC. It found midwives were "disadvantaged by the failure of the MOH to recognize the role of gender in their compensation" and the necessity to consider the discriminatory effects of its policies and practices on midwives as sex-segregated workers.[73]

(e) The MOH unilaterally abandoned CHC physicians as the appropriate comparator, and by 2010 repudiated the principle of comparison with physicians altogether notwithstanding: (1) their clear overlapping scope of practice with midwives; (2) the MOH promoting midwives as equally competent providers of low-risk maternity care, along with family physicians and obstetricians; and (3) the need for a physician comparator which is closely associated with "male work" in order to keep "midwives from slipping back into a place where the objective evaluation of their SERW is at risk of being replaced by stereotypic attitudes about women's work". Moreover, the MOH did not replace the framing methodology with an alternative *Code* compliant methodology for setting midwives' compensation. [74]

(f) The MOH subjected midwives to a compensation process which positioned them too closely to predominantly female nursing work and midwives in other provinces, notwithstanding the parties' recognition under the framing methodology of their overlapping scope of practice with physicians and that this would unfairly obscure the value of midwifery work, the latter of which was "affected by prevailing gender stereotypes". During the same period, the MOH afforded CHC physicians a relative alignment process with other predominantly male primary care providers and the medical profession more generally, which generated substantial pay increases despite fiscal restraints.[75]

(g) The MOH did not afford midwives regular negotiations and joint compensation studies, unlike the bargaining processes afforded to CHC physicians through their connection to the male predominant membership and leadership of the OMA.[76]

(h) The MOH failed to take proactive steps to monitor midwifery compensation for the impact of discrimination and align midwives with other primary care providers. At the same time the MOH proactively monitored and increased CHC physician compensation to ensure that they had compensation equity with other family physicians and that CHC physicians' recruitment and retention issues were

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[73] Liability Decision at paras. 274, 315–322; Remedy Decision at paras. 187–188, 191.
[74] Liability Decision at para. 284; Remedy Decision at paras. 6, 20, 34.
[75] Liability Decision at paras. 27, 37, 62, 139–142, 300–302, 316; Remedy Decision at para. 20.
[76] Liability Decision at para. 318

addressed. The MOH failed to scrutinize how the increases it paid to CHC physicians "resulted in a shifting alignment between midwives and their comparators" and the MOH refused to "validate" whether midwives' compensation was in fact free of sex discrimination despite changes in the compensation of their comparators.[77]

(i) The MOH permitted an inequitable compensation gap to increase between midwives and their CHC physician comparator – their proxy for male work. The MOH attempted to justify the compensation gap on occupational differences and market factors, including the greater bargaining strength of CHC physicians, without examining the gender implications of that approach.[78]

(j) The MOH improperly rejected the results of the joint Courtyard process – "despite having been a full and active participant" – and failed to "repair any perceived deficiencies in the Courtyard Report" even though they "were easily remedied by providing further guidance to the consultants". The MOH then refused to conduct its own compensation study to validate its position that CHC physicians were no longer a valid comparator and to determine whether midwives remained fairly compensated.[79]

(k) Contrary to established human rights jurisprudence and the OHRC's policies, the MOH failed to take seriously and take reasonable steps to investigate midwives' allegations of discrimination, including their concerns that they were falling behind their comparators. The MOH failed to investigate these concerns even in the face of Courtyard's recommendation of a 20% "equity adjustment" to midwifery compensation.[80]

(l) The MOH instead imposed compensation restraint on midwives in 2010 in the absence of first applying a pay equity adjustment to ensure *Cod*e compliance. Moreover, the MOH failed to "more fully consider the exemption… for human rights entitlements" under the wage restraint legislation and policy for midwives as a sex-segregated profession. [81]

[115] We do not consider the Tribunal's findings of adverse treatment "circular reasoning" as characterized by the MOH.

[116] There is no merit to the MOH's submission that its response to the Courtyard Report was no different than the process it followed in 2005 which the Tribunal found was not discriminatory.

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[77] Liability Decision at paras. 126, 139–142, 277, 297, 312, 316; Remedy Decision at paras. 6, 36, 118.
[78] Liability Decision at para. 277; Remedy Decision at para. 102.
[79] Liability Decision at paras. 99, 305, 307; Remedy Decision at paras. 7, 118.
[80] Liability Decision at paras. 45, 173–177, 191, 206, 304, 307–309.
[81] Liability Decision at paras. 43–44, 182, 307, 310–311; Remedy Decision at para. 31.

The Courtyard Report cannot be said to have informed the compensation negotiations with the AOM in 2011 in any meaningful sense when the MOH had withdrawn from the process and disavowed the 1993 methodology and CHC physicians as a comparator.

[117] The MOH's submission that it was unreasonable for the Tribunal to find that 20 years after regulation a divergence in compensation between midwives and physicians was discriminatory mischaracterizes the reasons of the Tribunal. It was the systemic nature and cumulative effect of the MOH's policies and conduct over time on the compensation of midwives that the Tribunal found was discriminatory.[82] Divergence in compensation was the impact of those policies and conduct. Discriminatory treatment is broader.

[118] It is the Tribunal's task to evaluate the evidence, find the facts and draw reasonable inferences from the facts. The factual findings and inferences set out above fall within a range of possible, acceptable outcomes which are defensible in respect of the facts and law and are entitled to significant deference. The Tribunal's finding that midwives suffered adverse treatment is reasonable.

Third part of *Pieters*' test: Was the Tribunal's decision that sex was a factor unreasonable?

[119] The MOH submits that the Tribunal made no finding that there was any direct or circumstantial evidence that sex was a factor in any of the MOH's decisions concerning the compensating of midwives after 2005. It submits that the Tribunal did not identify any evidence that sex was one of the reasons, in addition to the non-discriminatory ones put forth by the MOH. It submits that the finding that sex was a factor was a peremptory conclusion which failed to reveal a rational chain of analysis and makes it impossible to understand the Tribunal's reasoning on a critical point.

[120] We reject this submission. The Tribunal found that the MOH recognized at the time of regulation the historic sex-based disadvantage and unequal treatment of midwives within the health sector and their acute vulnerability to systemic gender discrimination in compensation. The Tribunal found that the MOH agreed to a methodology to ensure that midwives' compensation would be appropriate and fair and free from gender discrimination. The Tribunal found that the MOH then gradually lost touch with those principles and methodology, eventually abandoning the CHC physicians as a comparator altogether, without developing an alternative methodology for midwives' compensation that ensured that they would be paid for the value of their work, a benefit routinely enjoyed by men. The Tribunal rejected the MOH's assertions that occupational differences were a full explanation for the compensation gap between midwives and CHC physicians. As stated above, it was the systemic nature and cumulative effect of the MOH's policies and conduct over time on the compensation of midwives that the Tribunal found made gender more likely than not a factor in the midwives' adverse treatment and the breach of the *Code* clear.

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[82] Liability Decision at para. 273.

[121] The MOH submits:

(a) there was no evidence to support the Tribunal's finding that the original funding principles were imbued with gender;

(b) it was unreasonable for the Tribunal to infer from the MOH's negative response to the Courtyard Report that gender was more likely than not a factor;

(c) the AOM failed to prove that MOH's rebuttal evidence was false or a pretext;

(d) it was unreasonable for the Tribunal to ignore the expert evidence that demonstrated that midwives and CHC physicians were different;

(e) the Tribunal reversed the onus and required the MOH to disprove discrimination by producing a job evaluation;

(f) it was unreasonable for the Tribunal to find that female-dominated CHC physicians could be a basis for a comparator upon which discrimination on the basis of sex could be found;

(g) it was unreasonable for the Tribunal to hold there was a proactive obligation on MOH and use that as a basis for finding that sex was a factor in the discrimination;

(h) it was unreasonable to find imposing province-wide compensation restraint was adverse treatment because of sex.

(a)*Was there evidence to support the Tribunal's finding that the original funding principles were imbued with gende*r?

[122] The MOH argues that because the words "sex", "gender", "pay equity" or a "male comparator" do not appear in the evidentiary record leading up to regulation, there was no evidence to support the Tribunal's finding that the original funding principles were imbued with gender which the MOH described as a "cryptic conclusion". The MOH further submits that the midwives' initial compensation was set with reference to the comparators of CHC nurse and CHC physician because there were no other publicly funded midwives in Canada available at that time to act as comparators.

[123] The MOH's submission ignores the overwhelming evidence the Tribunal relied upon to come to the conclusion that the original funding principles were imbued with gender.

[124] The Tribunal found that the process leading up to the establishment of the methodology and principles agreed upon by of the AOM and the MOH to make visible midwives' work at the time of regulation was accurately described as a "pay equity exercise". The Tribunal relied upon the AOM documentation and evidence including Ms. Kilthei's testimony about the central importance of addressing the equitable positioning of midwives.

[125] The MOH's argument that CHC nurse and CHC physicians were chosen as comparators for midwives' initial compensation because there were no other publicly funded midwives in Canada available to act as comparators does not accord with the facts. The parties agreed in 1993 that the appropriate emphasis should be on comparing midwives to other primary health care providers in the same economic market, as compared to other jurisdictions, a principle that the Courtyard Report confirmed, continued to be appropriate.[83]

[126] The evidence relied upon by the Tribunal summarized in paragraphs 18 to 39 above makes it clear that the Tribunal's finding that the original funding principles were imbued with gender was anything but a "cryptic conclusion". The MOH's argument was rejected by the Tribunal.

[127] The assessment of the evidence is a function that lies at the heart of the expertise of the Tribunal. The MOH's submission amounts to nothing more than a disagreement with the Tribunal's evidentiary findings in regard to which we find nothing unreasonable.

(b)Was it unreasonable to infer from the MOH's response to the Courtyard Report that gender was more likely than not a factor in adverse treatment?

[128] The MOH submits that it was unreasonable for the Tribunal to infer that withdrawing from the connection to the 1993 principles and its decision not to implement the Courtyard Report were based on sex because:

(i) the report was not a job evaluation;

(ii) it was non-binding;

(iii) CHC physicians were no longer an appropriate comparator;

(iv) there were deficiencies with the report including:

a. midwives' benefits not being included when comparing them to midwives in Alberta;

b. not accounting for midwives' retention of excess operating funds included in their taxable income as part of their compensation;

c. not accounting for midwives having their liability insurance paid by the province;

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[83] Remedy Decision at para. 129.

(v) the direct evidence of the MOH's witnesses was that the sex of midwives was not a factor in its decision not to implement the Courtyard Report, on which the Tribunal made no finding;

(vi) the Courtyard Report was not a pay equity report, human rights analysis or a gender based analysis;

(vii) Mr. Ronson testified 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."

[129] We reject the argument that it was unreasonable for the Tribunal to draw an inference that gender was a factor from the MOH's disavowal of the 1993 methodology and withdrawal from the Courtyard process. Its criticisms of the Courtyard Report were minor and would have been easily remedied by providing further guidance to the consultants.

[130] The fact that the Courtyard Report was non-binding is not an answer to the MOH's withdrawal from the process which it had agreed to during bargaining. Its abandonment of the CHC physicians as comparators which it had endorsed during the review left the midwives without an alternative methodology that ensured that they would be paid for the value of their work. The MOH was not criticized for not implementing the Report. Rather, the purpose of the Report was to inform the next round of negotiations. It was always expected that there would be positional bargaining as had been the practice in past negotiations. The CHC physician comparator was only disavowed by the MOH after the recommendation was made of a 20% increase in midwives' compensation.

[131] As to the MOH's submission that CHC physicians were no longer an appropriate comparator, the Tribunal found that aside from obstetricians, midwives and family physicians are the only two professions who provide "comparable" and "equally competent" obstetrical care to women with normal pregnancies. The Tribunal found that there was an overemphasis by the MOH on comparing midwives to what midwives were earning in other jurisdictions. The Tribunal found that this was contrary to the Morton report defining fairness as the "general context in which compensation occurs" and that fairness "can only be determined in relation to levels of pay for professionals working in the same economic market." The Tribunal found that comparing midwives to nurse practitioners and midwives from other provinces risks perpetuating SGDC by comparing highly sex-segregated professions with each other.[84] In the face of this evidence, the Tribunal's finding of fact that CHC physicians are appropriate comparators was reasonable.

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[84] Liability Decision at paras. 299, 301; *Moore v. British Columbia (Education)*, 2012 SCC 61, at para 31.

[132] The fact that the MOH's witnesses testified that the sex of midwives was not a factor in its decision not to implement the Courtyard Report is of no import. As noted by the Tribunal, systemic discrimination and SGDC in particular, is often subtle and hidden and "results from the simple operation of established procedures…none of which is necessarily designed to promote discrimination and the hallmark of which is its structural and largely invisible nature."[85]

[133] There is no requirement in the *Code* that before the Tribunal could adopt the findings of the Courtyard Report or draw an inference from it that there is discrimination on the basis of sex that it had to be a job evaluation, pay equity report or a human rights or gender based analysis.

[134] The Tribunal found that the Courtyard Report was a joint collaborative compensation review conducted by an objective third-party consultant. A comprehensive evidence-based framework was established flowing from the evaluation questions established by the steering committee and relying on established compensation practices and a methodology that included a review of background documents and data, stakeholder interviews, data analysis and cross-Canada jurisdictional review. The result was a fifty-four page Report containing a significant amount of information and a number of charts which explain the evidence-based methodology and the findings. The Report concluded that midwives' pay was misaligned and inequitable compared to other professions performing similar work.

[135] With respect to the MOH's submission that the Courtyard Report was simply Mr. Ronson's idea of what "felt fair" in a "generalized sense of fairness", this is an example of the MOH extracting one or two answers during cross-examination and ignoring the rest of the extensive evidence. The Tribunal found that Mr. Ronson used the term "equity" in the sense of "equitable remedies" which is consistent with the 1993 methodology that midwives' compensation be "fairly and equitably" set and be "evidence based." The Tribunal found that the recommendation was based on all the circumstances set out in the Report and not a loose impression of what the consultants felt was "fair".[86] There was nothing unreasonable in these findings.

[136] The MOH had taken no proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation. The Tribunal found that the MOH did not conduct a compensation study or lead expert evidence for the purpose of validating its compensation practices and obtaining a new recommendation based on correcting the perceived Courtyard "flaws".[87]

[137] The Tribunal found that the parties are not required to abide by the specific methodology they agreed to in 1993 and are at liberty to negotiate a new compensation methodology. But it found that what has happened is that the MOH has unilaterally withdrawn from the 1993 principles and methodology which ensured that midwives' compensation was tied to the value of their work, a benefit routinely enjoyed by men, leaving historically disadvantaged sex-segregated midwives

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[85] *Action Travail* at 1138–1139.
[86] Remedy Decision at para.136.
[87] Liability Decision at para. 15.

to negotiate in a context where there is no recognition of the potential negative impact of gender on their compensation.

[138] It was in these circumstances that the Tribunal concluded that the MOH's response to the Courtyard Report constituted sufficient evidence from which an inference could be drawn that midwives experienced adverse treatment and that gender was more likely than not a factor in that treatment.

[139] It was the Tribunal's task to evaluate the evidence, find the facts and draw reasonable inferences from the facts. In our view, the inferences drawn by the Tribunal were open to it on the evidence and were reasonable.

(c)Did AOM fail to prove that the MOH's rebuttal evidence was "false or a pretext"?

[140] As noted above, the MOH submits that the extensive evidence it led before the Tribunal refuted the second and third elements of the *prima facie* case of discrimination.

[141] The MOH references the evidence it called regarding the differences between CHC physicians and midwives, the history of changes to CHC physicians' compensation and the reasons therefore and the evidence of its experts. For example, it cites Dr. Chaykowski's evidence that supply of CHC physicians has been a problem that has affected their pay increases overtime which is in contrast to the supply of midwives. It cites Mr. Bass's evidence that compensation relations are not static. It cites expert evidence on job evaluation that "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." It submits that the plethora of evidence it led as to the non-discriminatory reasons it gave salary increases to the CHC physicians between 2005 and 2010 which did not apply to midwives was never rejected as false or a pretext as the test in *Pieters* requires. Instead, the MOH submits that the Tribunal found discrimination without rejecting the MOH's evidence.

[142] The Tribunal expressly rejected that a complainant must "eliminat[e] every conceivable possibility before an inference of discrimination may be made".[88] The Tribunal noted that there is no strict requirement that the AOM prove each of the MOH's explanations is "false or a pretext" in order to succeed with the discrimination claim: "There may be many reasons" for the MOH's acts and omissions and "[i]t is not essential that the connection between the prohibited ground of discrimination and the impugned [acts and omissions] be an exclusive one."[89]

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[88] Liability Decision at paras. 33, 45–47.

[89] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39, at paras. 41, 44–45, 52; *Pieters* at para.73; Liability Decision at para. 256.

[143] In *Moore* "the sole reason" for the adverse treatment of special needs students was "financial".[90] Yet, disability was still found to be a factor and a *prima facie* case of discrimination was made out.

[144] The Tribunal correctly found that a connection to sex may co-exist with other factors that are not discriminatory. The Tribunal did not accept that the explanations proffered by the MOH provided a full explanation for the compensation gap which it found developed.[91]

[145] The MOH submits that the Tribunal accepted that its position that differences in compensation paid to the CHC physicians and midwives were based solely on occupational differences and labour market forces such as recruitment and retention issues were reasonable explanations. It submits that nonetheless, the Tribunal went on to unreasonably find that sex was also a factor without identifying any evidence that indicated sex was a factor.

[146] The MOH mischaracterizes the findings of the Tribunal when it submits that the Tribunal accepted that the MOH had established that differences in compensation paid to CHC physicians and midwives are based solely on occupational differences. The Tribunal did not accept the MOH's assertion that occupational differences were a full explanation for the compensation gap between midwives and CHC physicians. The Tribunal found that there was no evidence that compensation for physicians is tied to the value of their work (their SERW). The Tribunal recognized that compensation for midwives was not set as a fixed percentage of CHC physician salaries and that there could be variance from time to time based on the market conditions associated with each profession or the health care priorities established by the MOH. Indeed, the Courtyard Report's finding of an inequitable compensation gap did not position the midwives' compensation as close to CHC physicians as had Morton. The Tribunal found: "While the MOH explained the reasons for physician increases, it did not explain how it maintained the benchmarks in its negotiations with midwives, while it was increasing compensation paid to physicians.[92]

[147] The MOH submits that there must be evidence that the adverse treatment is arbitrary or derived from stereotypes. The Tribunal correctly held that adverse treatment that is arbitrary or derived from stereotypes are often indicators of discrimination but they are not separate evidentiary requirements and they are not always present in cases of systemic or adverse impact discrimination.

[148] The MOH submits that the Tribunal was unreasonable to find discrimination because midwives and CHC physicians are paid differently because of differences in their work. It submits that the principle of equal pay for work of equal value (or pay equity) has no application in this case as the Tribunal did not find that the value of the work of midwives is substantially the same

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[90] *Moore* at paras. 45–46.
[91] Remedy Decision at para. 119.
[92] Remedy Decision at para. 118.

as the value of the work of CHC physicians. The MOH submits that contrary to *Bombardier* [93], the Tribunal in this case found that the MOH had a proactive obligation to ensure that midwives' compensation remained aligned with that of CHC physicians not because of discrimination but because midwives are a female-predominant group.

[149] The compensation principles and methodology that the MOH and AOM had agreed upon did not assume that the occupation of midwives was substantially the same as that of CHC physician.[94] It was the MOH's abandonment of the CHC physician comparator without developing an alternative methodology for compensating midwives based on their SERW and the overlapping scope of practice they shared with CHC nurses and CHC physicians that the Tribunal found was discriminatory. The Tribunal found that this left midwives' compensation exposed to the well-known potential negative impact of gender discrimination on a sex segregated occupation such as the midwives.

[150] The Tribunal did not presume sex was a factor based solely on midwives being a female-dominant group. The Tribunal found, based on the evidence of the history and ongoing prejudices, stereotyping and barriers midwives faced, that the midwives in this case "are sex-segregated workers", "vulnerable to the forces of gender discrimination on their compensation, and continue to "require an evidence-based methodology for establishing the value of their work" which they were denied.[95]

[151] To rebut the *prima facie* case of gender discrimination, the Tribunal correctly found that it is not enough that the non-discriminatory justification plays a role in the compensation gap. Rather, to be effective in setting aside the *prima facie* finding of discrimination, it has to displace gender as a factor. If it does, the question of whether that justification is false or a pretext would arise. If it does not, sex (gender) remains a factor and that is enough for a finding of discrimination to be sustained. This raises a question as to what constitutes "a factor".

[152] In *Pieters*, the Court of Appeal considered the Divisional Court's decision below which had held that to prove a *prima facie* case of discrimination it was necessary that there be a "causal link or nexus" between the arbitrary distinction based on the prohibited ground and the disadvantage suffered." The Court of Appeal found that the addition of the word "causal" before the word "nexus" was unacceptable:

> I do not think it acceptable, however, to attach the modifier "causal" to "nexus". Doing so seems to me to elevate the test beyond what the law requires. The Divisional Court's requirement of a "causal nexus" or a "causal link" between the adverse treatment and a

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[93] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39, [2015] 2 S.C.R.789.
[94] Liability Decision at para. 312.
[95] Remedy Decision at paras. 8, 34.

> prohibited ground seems counter to the evolution of human rights jurisprudence, which focuses on the discriminatory effects of conduct, rather than on intention and direct cause.[96]

[153] The Court of Appeal concluded:

> All that is required is that there be a "connection" between the adverse treatment and the ground of discrimination. The ground of discrimination must somehow be a "factor" in the adverse treatment.[97]

[154] What follows from this is that a "factor", as required by the test in *Pieters* and *Shaw v. Phipps*, does not have to be a direct cause of the disadvantage suffered. The Tribunal considered this and went on to point out that the principles enunciated in *Pieters* were reinforced by the Supreme Court of Canada in *Bombardier*.[98]

[155] In *Bombardie*r, the Supreme Court rejected reliance on a "causal connection" as a requirement in finding that discrimination was present. In doing so it referred to *Pieters* and went on to note

> …for a particular decision or action to be considered discriminatory, the prohibited ground need only have contributed to it.[99]

[156] The Supreme Court likened this situation to a civil case where the plaintiff must establish on a balance of probabilities that there is a causal relationship between the defendant's fault and the injury suffered:

> The Quebec courts have defined this causal relationship as requiring that the damage be a logical, direct and immediate consequence of the fault. This rule therefore means that the cause must have a [translation] "close" relationship with the injury suffered by the victim.

And concluded:

> A close relationship is not required in a discrimination case under the [Quebec *Charter of human rights and freedoms*] however. To hold otherwise would be to disregard the fact that, since there may be many different reasons for a defendant's acts, proof of such a relationship could impose too heavy a burden on the plaintiff.
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> Evidence of discrimination, even if it is circumstantial, must nonetheless be tangibly related to the impugned decision or conduct. [100]

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[96] *Pieters* at para. 60
[97] *Pieters* at para. 59
[98] Liability Decision at para. 255. 9
[99] *Bombardier* at paras. 47– 49.
[100] *Bombardier* at paras. 50–51, 88.

[157] To remain a "factor", sex (gender) need only be "connected to" or "tangibly related to" the adverse treatment, in this case the gap in compensation between CHC physicians and midwives.

[158] The submission of the MOH that it had provided a reasonable explanation for the difference in compensation between CHC physicians and midwives is focused on the lack of government intent to discriminate on the basis of gender and on its legitimate motives in giving increases to physicians. There is no need to prove discriminatory intent to establish that gender is a factor in adverse discrimination. The Tribunal properly focused its analysis not on whether the MOH was engaged in direct discrimination but whether there was an adverse effect on the midwives and whether the effect was connected to sex.[101]

[159] The Tribunal adopted the following submission of the AOM:

> In other words, "business as usual" often adversely impacts marginalized groups. Thus, a substantive norm which may appear reasonable and rational to dominant culture may nevertheless have adverse effects on a *Code*-protected group, such as women.[102]

[160] The Tribunal held that the MOH permitted an inequitable compensation gap to develop between midwives and their CHC physician comparator. The Tribunal found that the MOH attempted to justify this on occupational differences and market factors including the greater bargaining strength of CHC physicians. The Tribunal held that it did so without examining the gender implications of that approach including the connection between midwifery and gender, and the gender of their comparators.

[161] The Tribunal found that the MOH failed to be informed of the effects of gender on compensation of the sex-segregated profession of midwives and the structural embeddedness of medical dominance and caring dilemma associated with midwifery. In this regard, we note the evidence of Laura Pinkney, the MOH manager who led the compensation setting for midwives after 2005. Ms. Pinkney had no training in gender based analysis, human rights based analysis or in identifying systemic gender discrimination, was not familiar with the term "occupational sex segregation" or with the concept of systemic gender discrimination in compensation and never applied any policy aimed at identifying whether there was any systemic gender discrimination in midwifery compensation.[103] As a result, the MOH was shocked by the amount that came out of the Courtyard Report, unlike the midwives who the Tribunal found were not shocked because they had maintained continuity with the original funding principles for each round of negotiation and could see the compensation gap widening.

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[101] *Moore*; *Bombardier* at 69, 88.
[102] Liability Decision at para. 253.
[103] Tribunal transcript, evidence of Laura Pinkney (Nov 4/16) at 63804, 63815-16.

[162] The Tribunal found that the MOH's response to the Courtyard Report marked a significant departure from the collaborative working relationship the parties had achieved and the principles they agreed upon for establishing appropriate and fair compensations levels.[104] It held that this constituted sufficient evidence from which an inference can be drawn that midwives experienced adverse treatment and that gender is more likely than not a factor in that treatment.[105]

[163] We reject the MOH's argument that the Tribunal misapplied the test for discrimination and reversed the onus, requiring the MOH to prove that sex was not a factor.

[164] The Tribunal held:

> I have considered the case before me on the totality of the evidence and as a result, I have not found it necessary to distinguish between the evidence which goes to the prima facie case and the evidence which goes to the AOM's overall burden to prove the case. This approach was affirmed by the Court of Appeal in Pieters, at paras. 83-84:
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> > After a fully contested case, the task of the tribunal is to decide the ultimate issue whether the respondent discriminated against the applicant. After the case is over, whether the applicant has established a prima facie case, an interim question, no longer matters. The question to be decided is whether the applicant has satisfied the legal burden of proof of establishing on a balance of probabilities that the discrimination has occurred. [106]

[165] The Tribunal considered the MOH's evidence that there was a reasonable explanation for the differential treatment of midwives and that sex was not a factor and concluded, as it was entitled to do, that the explanations were not a full answer and that sex was one of the factors that explains the compensation gap between midwives and CHC physicians identified by the Courtyard Report. These findings are entitled to deference.

[166] The Tribunal's finding that the applicant had satisfied the legal burden of proof of establishing on a balance of probabilities that the discrimination has occurred is amply supported by the evidentiary record. There is no basis to set its factual findings aside.

(d) *Was it unreasonable for the Tribunal to ignore the expert evidence that demonstrated that midwives and CHC physicians were different*?

[167] The MOH submits that the Tribunal ignored its expert evidence that demonstrated the midwives and CHC physicians were paid differently because of differences in their work, education and training, scopes of practice, and differences in bargaining strength and different histories with respect to recruitment and retention, expressly stating that it was not necessary to rely on any experts in coming to its decision on liability.

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[104] Liability Decision at para. 293.
[105] Liability Decision at para. 296.
[106] Liability Decision at para. 261.

[168] It was open to the Tribunal not to rely on expert evidence. It is worth emphasizing that none of the expert evidence relied upon by the MOH included its own compensation study to validate its position that CHC physicians were no longer a valid comparator and to determine whether midwives remained fairly compensated.

[169] The MOH's argument misses the point. It was undisputed that midwives and physicians are different. The Tribunal stated in its reasons that the AOM has never sought compensation equivalent to what is paid to family physicians and that it was the differences between them that were valued in 1993.[107] The Tribunal accepted that there were occupational differences and market factors but found that gender remained a factor. The Tribunal found it was the parties' history of setting compensation for the midwives that was relevant to the claim. The Tribunal properly relied on the historical record and the factual witnesses to determine the 1993 founding principles and methodology, the extent to which the MOH remained aligned with the intent of the founding principles and the impact on the midwives where that was not the case.

(e)Did the Tribunal reverse the onus and require the MOH to disprove discrimination?

[170] The MOH submits that the Tribunal reversed the onus and required the MOH to disprove discrimination by rejecting the MOH's evidence demonstrating that CHC physicians were no longer an appropriate comparator "[u]ntil the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for compensation purposes."

[171] After the Courtyard Report was released, the Tribunal found that the MOH failed to investigate the midwives' allegations of discrimination, even in the face of Courtyard's recommendation of a 20% "equity adjustment" to midwifery compensation. Instead of applying a gender-sensitive evaluation mechanism, the MOH asserted that CHC physicians were no longer appropriate comparators because of alleged occupational differences that arose since 1993. Yet, as found by the Tribunal, the MOH did not lead any expert evidence or study to rebut "the ongoing relevance of the comparison" which was validated in the 1993 Morton Report, the 2004 Hay Report and again in the 2010 Courtyard Report and to determine whether midwives remained fairly compensated. There is no merit in the argument that this is a reversal of the burden of proof. It simply provides one reason why the Tribunal did not find the MOH's non-discriminatory evidence was persuasive to fully explain the compensation gap.

[172] The MOH also complains that notwithstanding the Tribunal's rejection of the expert job evaluation evidence tendered by the AOM as not relevant to liability, the Tribunal then went on to unreasonably assume that the difference in compensation between CHC physicians and midwives was adverse treatment under the *Code*, thereby both reversing the onus and ignoring or misapprehending the evidence.

[173] The Tribunal gave cogent reasons for both declining to adopt the recommendations of the Durber report obtained by the AOM and accepting the Courtyard Report. It was open to the

[107] Liability Decision at para. 312.

Tribunal to make these findings. We reject the submission that the Tribunal assumed that the difference in compensation between CHC physicians and midwives was adverse treatment under the *Code.* Rather, the Tribunal found adverse treatment in the midwives' gradual move out of alignment with the comparators that historically informed how the parties defined fair and appropriate compensation levels.[108]

(f)Was it unreasonable to find female dominated CHC physicians could be the basis for a comparator from which discrimination on the basis of sex could be found?

[174] The MOH makes the following submissions regarding the gender of CHC physicians:

(a) The Tribunal unreasonably held that sex was a factor in the difference in compensation between midwives and CHC physicians after 2005 even though the Tribunal found that "CHC physicians…have been more than 50% female since at least 2001" and "by 2004, CHC physicians were predominantly female".

(b) The Tribunal unreasonably ignored the evidence that CHC physicians were predominantly female (or at least not male predominant) at all times since midwives were first regulated in Ontario.

(c) Even though the Tribunal found that CHC physicians were female-dominated at all times that it found sex discrimination, it unreasonably and inconsistently held that the "principle that compensation for midwives should reflect the overlapping scope of practice of the family physician is based on a male comparator".

[175] The Tribunal held that given the suppression of midwifery prior to regulation, comparison with work historically done by men was a significant factor in overcoming the stereotypes which would have otherwise undoubtedly affected the initial compensation levels set for midwives. The Tribunal in its Liability Decision gave the following reasons for finding that the CHC physicians were and remained a male comparator despite their female predominance:

> [277] The principle that compensation for midwives should reflect the overlapping scope of practice of the family physician is based on a male comparator. The point of the principle and the 1993 Morton methodology was to ensure that midwives' compensation was not negatively affected by traditional assumptions and stereotypes about the value of "women's work". Family physicians were male-dominated at the time of the Task Force report and at regulation. In 2013, they were more than 50% male. The fact that both men and women were working as family physicians in CHCs at the time of regulation does

[108] Remedy Decision at para. 3.

> not alter the nature of the principle, its effect, or its ongoing relevance to maintaining compensation levels for midwives.
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> [278] It is clear that midwives, for whom gender is a ubiquitous aspect of their personal and professional identities, perceived the 1993 methodology as a pay equity exercise. Given their own personal experiences and perceptions that CHC physicians were predominantly male in 1993, and the reliance on principles that corresponded with the Pay Equity Act, it is not at all unreasonable for the AOM to have described the joint working group process in 1993 as a "pay equity exercise". In my view, it is perfectly reasonable for midwives to be operating from the perspective that their work was being valued in comparison to work which was, historically and still at that time, associated with men.
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> …
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> [282] I have already indicated that midwives were compared to male-dominated family physicians up to the point of the joint working group. Midwives made comparisons at the time of regulation which were based on work historically done by men in order to ensure that their compensation corresponded with the work itself and not the gender of the person doing the work.
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> ...
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> [284] ...Nor do I agree that midwives, who are almost exclusively female, lose their access to the Code as soon as CHC physicians become female-dominated. That would not be in keeping with a broad and purposive interpretation of the Code. CHC physicians are family physicians who work in a particular setting. This was recognized by the MOH and the OMA who have worked to harmonize the compensation of pre-dominantly female physicians with their peers. The fact that CHC family physicians are now pre-dominantly female does not affect the underlying premise of the 1993 principles and comparisons.

[176] The MOH submits that the Tribunal did not rely on any expert evidence in coming to the conclusion that predominantly female CHC physicians were a male comparator and ignored the MOH's expert evidence that CHC physicians should not be characterized as a male-predominant group. The MOH points out that under the *Canadian Human Rights Act*, 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. Under the *PEA*, a male job class is one in which 70% or more of the members are male and the expert evidence which the MOH submits was 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.

[177] The Tribunal correctly observed that the *Code* does not refer to pay equity nor does it prescribe any process for developing a compensation model which is *Code*-compliant or provide rules to determine the sex of an occupational group. The Tribunal also correctly found that the provisions of the *PEA* are not directly applicable to midwives. In determining whether midwives

had experienced adverse treatment in their compensation on the basis of gender under the *Code*, the Tribunal was not obliged to apply the rules in the *Canada Human Rights Act* or *PEA* or develop a regulatory regime under the *Code* for determining a sex discrimination case.

[178] In this case the Tribunal did not need to fashion the rules for appropriate comparators because the parties chose CHC physicians as a comparator whose work was historically performed by men. The point of this was to ensure that midwives' compensation was not negatively affected by traditional assumptions and stereotypes about the value of "women's work." CHC physicians are family physicians; family physicians were male dominated at the time of the Task Force and regulation and continue to be so. CHC physicians who are now predominantly female have had their compensation harmonized by their connection to their peers. Using a broad and purposive approach, there was nothing unreasonable about the Tribunal's conclusion that CHC physicians acted as a male proxy or comparator notwithstanding their increasing female-predominance. It did not require expert evidence for doing so.

[179] The Tribunal found that the midwives were also moving closer in alignment with nurses which it found was related to gender:

> [64] …Given the association of the work of midwives with women's work, the close alignment they now share with nurses can easily be construed as natural and appropriate, obscuring the ways in which they are like physicians.

[180] The MOH makes other arguments: that the decision is unreasonable because it fails to address the numerical breakdown of CHC physicians, that the Tribunal does not explain what it means by "predominantly female", and that the Tribunal in its Decision uses family physicians and CHC physicians interchangeably.

[181] CHC physicians are family physicians who work in a particular setting and whose incomes have been harmonized. To refer to CHC physicians and family physicians interchangeably does not make the Tribunal's decision unreasonable. The parties continued to agree on the relevance of the comparators up until the Courtyard Report was released which reaffirmed their appropriateness. The Tribunal gave cogent reasons based on the history and evidence in this case for why CHC physicians being female does not affect their ongoing relevance to maintaining equitable compensation for midwives. There is no merit to the argument that it was unreasonable to find that female dominated CHC physicians could be the basis for a comparator from which discrimination on the basis of sex could be found.

> *(g)Was it unreasonable to hold there was a proactive obligation on the MOH and use that as a basis for finding discrimination on the basis of sex?*

[182] The MOH submits that the Tribunal unreasonably held that the MOH had breached a positive requirement under the *Code "*to act proactively, monitor workplace culture and systems, take preventative measures to ensure equality, identify and remove barriers, take positive steps to identify and remedy the adverse effects of practices and policies that appear neutral on their face", independent of any demonstration that sex was a factor in any adverse treatment experienced by midwives.

[183] As quasi-constitutional legislation, the *Code* must be interpreted liberally and purposively to ensure it fulfils its objectives. *Code* rights must "be given their full recognition and effect" and courts "should not search for ways and means to minimize those rights and to enfeeble their proper impact". It is well-established that the *Code* does not merely require that discrimination, once identified, be remedied. Rather, the *Code* places a proactive duty on respondents "to prevent all 'discriminatory practices' based, *inter alia*, on sex". [109]

[184] In the Liability Decision the Tribunal correctly states the obligation to be proactive under the *Code* :

> [309] Like all human rights legislation, the Code is directed at achieving substantive equality and enshrines positive rights, not just access to a remedy where a breach can be found. … [T]he Code is not solely reactive and complaint-based but "intended to transform social relations and institutions to secure substantive equality in practice." The requirement to act proactively, monitor workplace culture and systems, take preventative measures to ensure equality, identify and remove barriers, take positive steps to identify and remedy the adverse effects of practices and policies that appear neutral on their face, is well documented in the cases and [OHRC] policies.… it would diminish the fundamental nature of rights and protections enshrined in the Code to have the right to have discrimination remedied but not prevented.

[185] The Tribunal found that the MOH has a positive and continuing legal duty under the *Code* to proactively secure conditions of substantive equality even in the absence of a formal human rights complaint. In the employment context, this means that employers must take positive steps to design workplace standards from the outset that are inclusive and non-discriminatory. As stated by the SCC in *Meiorin*, employers "must build conceptions of equality into workplace standards."[110]

[186] The OHRC's policies make clear that it "takes vigilance and a willingness to monitor and review numerical data, policies, practices and decision-making processes and organizational culture" to ensure that an organization such as the MOH is "not unconsciously engaging in systemic discrimination". The OHRC policies further provide that "[i]t is not acceptable from a human rights perspective for an organization to choose to remain unaware of systemic discrimination or to fail to act when a problem comes to its attention." [111]

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[109] *CN v. Canada (Canadian Human Rights Commission) (Action Travail des Femmes)* 1987 CanLII 109 (SCC), [1987] 1 SCR 1114 at 1134 ("*Action Travail*"); *British Columbia (Public Service Employee Relations Commission v. BCGSEU (Meiorin)*, 1999 CanLII 652, SCC, [1999] 3 SCR 3 at paras. 39–42, 68.
[110] *Ibid.* at para. 68.
[111] OHRC (2013), "A policy primer: Guide to Developing Human Rights Policies and Procedures" pp. 2–4, 6–8; OHRC (2005), "Policy & Guidelines on Racism & Racial Discrimination", p. 33.

[187] As noted by the Tribunal in the Liability Decision:

> [317]...the reason the [OHRC] publishes policies to guide employers in their obligations under the Code is that the probability of compliance is reduced without proactive action.

[188] Central to the Tribunal's liability finding was the MOH's admission that it had taken "no proactive steps" to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation.[112] Consistent with the well-established jurisprudence, OHRC policies, and extensive evidence before it, the Tribunal found that the MOH "must take steps which are effective and proportional to its obligations under the *Code* to both prevent and remedy discrimination."[113] The Tribunal found that the MOH's inaction on monitoring the compensation of midwives was in stark contrast to evidence that the MOH had proactively "continued 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."[114]

[189] The Tribunal's findings in this regard are reasonable. Indeed, they are consistent with the SCC's decision in *Moore*[115] and the Canadian Human Rights Tribunal's decision in *Caring Society*[116], two cases concerning systemic discrimination in government funding policies. *Moore* and *Caring Society* make clear that governments have a proactive human rights duty to prevent discrimination which includes ensuring their funding policies, programs and formulas are designed from the outset based on a substantive equality analysis and are regularly monitored and updated. Such jurisprudence is directly at odds with the MOH's position that it can wait before acting until midwives – a deeply sex-segregated profession that is highly susceptible to systemic gender discrimination in compensation – have proven that the MOH's conduct constitutes sex discrimination.

[190] It is also well-established that the *Code* imposes a related duty on the MOH to investigate a complaint of discrimination where, as here, one has been made. This includes a duty to take reasonable steps to address allegations of discrimination, including acting promptly, taking a complaint seriously, having a complaint mechanism in place and communicating actions to the complainant. Failure to do so can cause or exacerbate the harm of discrimination.

[191] The Tribunal's finding that the MOH's failure to take reasonable steps to respond to the AOM's pay equity concerns compounded the adverse impacts experienced by midwives was reasonable and consistent with the jurisprudence. Prior to the Courtyard Report, "the AOM was

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[112] Liability Decision at para. 315.
[113] Liability Decision at para. 317.
[114] Liability Decision at para. 315.
[115] *Moore v. British Columbia (Education)*, 2012 SCC 61, [2012] 3 SCR 360.
[116] *First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada*), 2016 CHRT 2.

raising concerns about inequitable compensation paid to a group of almost exclusively female workers". When the Courtyard Report was issued the Tribunal found that it was "sufficiently compelling" to trigger the MOH's duty to inquire into the AOM's claim of sex discrimination. The Tribunal found that the MOH, contrary to the case law and OHRC policies, took no reasonable steps "to understand and evaluate the allegations of discrimination". The Tribunal reasonably concluded that "[t]he failure by the MOH to take reasonable steps to inquire into the AOM's allegations, repair any perceived deficiencies in the Courtyard Report, and more fully consider the exemption under the [wage restraint] legislation (and presumably for the policy) for human rights entitlements are important indicators of adverse impact."[117]

[192] We reject the MOH's submission that finding a proactive obligation on the MOH to prevent and remedy discrimination was unreasonable.

[193] The MOH submits that the Tribunal's decisions are unreasonable because the *Code* does not prescribe any process for achieving compensation free from discrimination.

[194] The Tribunal agreed with the MOH that the *Code* does not refer to pay equity or prescribe any process in a complex area of law and social policy for developing a compensation model which is *Code* compliant. However, the Tribunal reasonably noted that the MOH was "fully engaged as a partner in the 1993 agreement which is a template for a gender-sensitive, inclusive, human rights approach to proactively dealing with the effects of gender discrimination in women's compensation." It also reasonably found that the MOH is a branch of the provincial government which enacted proactive pay equity legislation and better positioned than other small employers in determining how to achieve compensation which is free from discrimination.[118]

[195] The MOH complains that it was unreasonable for the Tribunal to hold that "contrary to the Ontario Human Rights Commission's ("OHRC") policies, that [the MOH] has taken no proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation" without identifying the specific OHRC policies.[119]

[196] The MOH's complaint that the Tribunal's decision is unreasonable because it does not identify the specific OHRC policies is disingenuous. The MOH is a sophisticated party. It was fully engaged as a partner in the 1993 agreement which the Tribunal found was a template for a gender-sensitive, inclusive, human rights approach to proactively dealing with the effects of gender discrimination in women's compensation.[120] It conducted a study in gender discrimination which resulted in the *PEA* which applies to its employees. The MOH acknowledged that it was aware of the OHRC's policies and guidelines that "set standards for how employers should act to ensure compliance with the *Code*." This argument lacks any merit.

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[117] Liability Decision at paras. 304, 307–309.
[118] Liability Decision at paras. 319–321.
[119] Liability Decision at para. 315.
[120] Liability Decision at paras. 320.

(h)Was it unreasonable to find imposing province-wide compensation restraint was adverse treatment because of sex?

[197] The MOH argues that compensation restraint after 2010 could only be discriminatory if the prevailing level of compensation in 2010 was discriminatory. It submits the Tribunal engaged in circular reasoning. It further submits that the exception under the compensation restraint statute for a right or entitlement under the *HRC* or the *PEA* could not apply because the Tribunal's decision in this case that the midwives had an entitlement under the *Code* was not made until September 24, 2018 and as independent contractors, the *PEA* had no application.

[198] Unlike the situation in 2005 where the Tribunal found that imposing a policy of general compensation restraint was not discriminatory because it was imposed after the midwives had achieved equitable compensation, the Tribunal found that after 2005 an inequitable compensation gap developed which it found amounted to discrimination and we have found that reasonable.

[199] The compensation restraint statute did not apply to midwives as independent contractors. The MOH's argument that the exceptions did not apply to the midwives because their claim was not adjudicated upon until 2018 is also overly formalistic. The MOH knew that a compensation gap had been identified in the joint 2010 Courtyard Report. They rejected the conclusion and without validating whether the midwives were undercompensated and there was a gender gap, they imposed wage restraint. We find nothing unreasonable in the Tribunal's conclusion that the application of compensation restraint in these circumstances compounded the gender discrimination.

Remedy Decision

The Law

[200] Section 45.2 of the *Code* provides the Tribunal with broad remedial discretion to order remedies that are fair, effective and responsive to the circumstances of this case.

[201] Pursuant to s. 45.2(1) 3 of the *Code*, the Tribunal has the power to make an order directing any party to do anything that, in the opinion of the Tribunal, the party ought to do to promote compliance with the *Code*. Pursuant to s. 45.2(2) of the *Code*, this power extends to future practices and may be exercised even if no order under s. 45.2(1) 3 was requested.

[202] In *Giguere v. Popeye Restaurant,*[121] the Tribunal found that any order under this section "should be reflective of the facts in the case, should be remedial, not punitive and should focus on ensuring that the key objects of the *Code*, to eradicate discrimination and to ensure future compliance, are achieved in the particular circumstances".

[121] 2008 HRTO 2 at para. 91.

[203] In *Xu v. Ottawa Hospital*,[122] a panel of the Divisional Court, on an application for judicial review of an OHRT decision, held:

> The Adjudicator's fashioning of an appropriate remedy is owed a particularly high degree of deference. (*1147335 Ontario Inc. v. Torrejon*, 2012 ONSC 1978, [2012] O.J. No. 1485 (Ont. Div. Ct.) at para. 10; *P.S.A.C. v. Canada Post Corp.* (2010), [2011] 2 F.C.R. 221 (Fed. C.A.) at para. 301, dissent adopted in *P.S.A.C. v. Canada Post Corp.*, 2011 SCC 57, [2011] 3 S.C.R. 572 (S.C.C.)).

Background to Remedy Decision

[204] After the liability decision was released, the Tribunal deferred a decision on the remedial issues and recommended the parties engage in collaborative negotiations guided by their benchmarks and the Tribunal's findings to determine the appropriate relief. This was unsuccessful. The Tribunal noted that the parties expressed a need for clarity and finality in the calculation of lost wages, and they were given an opportunity to provide additional evidence or commission other studies or negotiate a remedy between them. In further submissions, both parties urged the Tribunal to determine remedy on the evidence that was led at the hearing rather than present further evidence from a compensation expert to inform the remedial award.

[205] The Tribunal noted that the MOH did not make submissions on what the appropriate level of compensation should be. The Tribunal observed that the MOH does not support the implementation of Courtyard, but it also did not undertake a different study to validate its impressions of Courtyard. The AOM submitted that the Tribunal should adopt the recommendations of the Durber report which the AOM had commissioned. The Durber report used a pay equity analysis going back to 1993 and concluded that midwives' compensation should be raised to 91% of the maximum rate of CHC physicians.[123]

[206] The Tribunal found that "any assessment of lost income, even based on the best available evidence, will nevertheless be an estimate" and that the "*Code* does not prescribe a process for establishing a specific level of compensation in a case such as this".[124]

[207] The Tribunal held thsat regardless of what level of precision is applied to calculating lost income, the first principle is that the benchmarks must be reset to recognize the systemic nature of the discrimination in the compensation practices of the MOH.[125]

[208] The Tribunal held that the Courtyard joint compensation review revealed the consequences of the gradual erosion of the compensation benchmarks. It held that Courtyard repositioned

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[122] 2013 ONSC 762, 3030 O.A.C. 201 (Div. Ct.), at para. 42.
[123] Remedy Decision at para. 155.
[124] Remedy Decision at para. 112.
[125] Remedy Decision at para. 112.

midwives between CHC nurse practitioners and CHC physicians based, in part, on the original 1993 formula, a subsequent study conducted by the Hay Group for the AOM in 2004, and the information gathered during the Courtyard review. It observed that Courtyard also recommended regular negotiations going forward based on the benchmarks.[126]

[209] The Tribunal:

(a) declined to give a prospective remedy only;

(b) declined to adopt the recommendations of the Durber report, finding that it was inconsistent with the facts of the case and that it would be imposing a new compensation methodology onto the parties' past negotiations;

(c) implemented the recommendations of the Courtyard Report of a 20% increase in compensation effective April 1, 2011;

(d) awarded $7500.00 in compensation to each eligible midwife for injury to dignity;

(e) ordered the MOH to work with an expert to implement a gender-based analysis which will assess the gender impacts of the policies and practices associated with compensating midwives working as independent contractors and compensated by the MOH;

(f) ordered the parties to participate in a new joint study, which will cover the period from 2014 to 2020, and will serve as a baseline for reinstating the benchmarks. After the first compensation study is completed, it will be updated prior to each new round of negotiations. The study will inform the negotiations between the parties but will not be binding on them. The study will be updated prior to the start of the negotiations leading to each new contract;

(g) ordered the reinstatement of the benchmarks through joint, collaborative, and regular compensation studies, which account for the SERW of midwives and their comparators as set out in the Courtyard Report and take a gender-sensitive approach to determining compensation levels.

Position of MOH on Remedy Decision

[210] The MOH submits that the Remedy Decision was unreasonable for the following reasons:

(a) It was unjust to order a retrospective remedy;

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[126] Remedy Decision at para. 7.

(b) It was unreasonable to retrospectively adjust midwives' compensation back to April 1, 2011 to implement the Courtyard Report.

(c) It was unjust not to discount the monetary remedies the Tribunal ordered to account for the flaws in the Courtyard Report or for the fact that physicians received salary cuts after 2012.

(d) It was unreasonable to order that midwives must be compared to CHC physicians in perpetuity unless the AOM agrees otherwise.

(e) It was unreasonable to order damages of $7500 for injury to dignity to each eligible midwife.

Analysis

(a) Was it unjust to order a retrospective remedy?

[211] The MOH submitted that ordering a retrospective remedy was unreasonable because liability was based on a novel obligation under the *Code.*

[212] The Tribunal gave a reasoned analysis of why a purely prospective remedy was not appropriate: there was no substantial change in, or good faith or reasonable reliance by the MOH on human rights law, including the well-established principle that "compensation-setters are ultimately responsible for ensuring that their practices comply with the *Code*"; a "retroactive remedy for lost income would not encroach on the legislative role of the government"; and a "purely prospective remedy would constitute a 'hollow victory' and leave midwives without a remedy with respect to their compensation losses".[127]

[213] We find nothing unreasonable in regard to these findings.

(b) Was it unreasonable to retrospectively adjust midwives' compensation back to April 1, 2011 to implement the Courtyard Report?

[214] The Tribunal gave the following reasons for determining that midwives' compensation should be adjusted as at April 1, 2011. In terms of not making the adjustment date back to 2005 as the AOM sought, it determined that although the loss of the benchmarks evolved over time after 2005, there was no finding of discrimination in relation to the 2005 agreement and no evidence that the AOM viewed the 2005 agreement as discriminatory. It observed that the only condition placed on the 2008 agreement was that the parties would engage in a joint compensation study to inform the next round of negotiations. With respect to making the adjustment date April 1, 2011, it found that there was a significant change in the base salary of CHC physicians in 2010. It

[127] Remedy Decision at paras. 67–68.

observed that as at April 1, 2011, the Courtyard Report was completed and, as the parties had agreed, was to inform the 2011 negotiations but the MOH withdrew from the process.[128]

[215] In our view, these reasons are a rational and logical basis for choosing the date of April 1, 2011 as the adjustment date and there is nothing unreasonable about them.

(c) Was it unjust not to discount the monetary remedies it ordered to account for the "flaws" in the Courtyard Report or for the fact that physicians received salary cuts after 2012?

[216] The Tribunal gave the following reasons in its Remedy Decision for finding that the perceived deficiencies raised by the MOH did not render the Courtyard Report unreliable for the purpose of determining a remedy:

> [133] I do not agree that the perceived deficiencies raised by the MOH render the Courtyard Report unreliable for my purposes. The parties have expressed a need for clarity and finality in the calculation of lost wages, and they were given an opportunity to provide additional evidence or commission other studies or negotiate a remedy between them. In my view, implementing Courtyard will give the parties a clear basis for expeditiously calculating the award and bringing finality to this dispute.
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> [134] Contrary to the objections of the MOH, Courtyard did consider all the elements which go into funding individual midwives and midwifery practices, including benefits, malpractice insurance, and the various grants, supplements and reimbursements they receive to pay their expenses. Courtyard then correctly concluded that some of those funding elements would need to be "backed out", as Mr. Ronson put it, in order to arrive at an accurate comparison with other health care practitioners working in models who also receive benefits and have their expenses covered by their employer.
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> [135] The comparators used in the report were based on the findings from previous reports as well as conversations with the stakeholders interviewed throughout the project. It is not accurate to say that Courtyard improperly relied on nurse practitioners as a comparator. At the time of the Morton report nurse practitioners had not achieved regulation. The principle the parties adopted at the time was that midwives should be compared to senior nurses working in CHCs. The Hay Report of 2004 validated that nurse practitioners, the most senior nurses working in CHC's at that time, were the appropriate nurse comparator.
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> [137] Most of the concerns raised by the MOH relate to the jurisdictional comparisons. The comparisons were limited in any event by the different practice models in other provinces and the small number of midwives practicing in those models as compared to Ontario. The primary comparators the parties agreed on for the Courtyard study were CHC physicians and nurse practitioners.

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[128] Remedy Decision at paras. 145.

…

> [138] Mr. Ronson acknowledged that he did not add in 20% benefits for Ontario midwives or "back out" 20% for Alberta midwives in his calculations. He testified on reexamination that this issue had no impact on his overall recommendation for a 20% adjustment. Even adding in the 20% benefit, some midwives in Ontario would still be earning less than Alberta midwives. Only at the highest level would Ontario midwives exceed Alberta midwives.
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> [139] Mr. Ronson was also cross-examined on the fact that Alberta and BC midwives are responsible for a $1000.00 to $2000.00 co-payment for their insurance coverage. Mr. Ronson conceded that he should have taken the co-payment into account in comparisons with Alberta and BC but again, this is relevant only to comparison with a small number of midwives in other jurisdictions and it constitutes a differential of $1000.00 or $2,000.00. Courtyard accounted for liability insurance for midwives and their comparators.

[217] We find nothing unreasonable in these findings.

Retaining Excess Operating Funds as Income

[218] The MOH submits that it was unreasonable for the Tribunal not to discount the monetary remedies for the fact that Courtyard did not consider excess operational funds retained by midwives as income, particularly when in the Liability Decision the Tribunal stated:

> [306]…On this point, I agree 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.

[219] The Tribunal did consider this issue in the Remedy Decision and gave the following reasons:

> [140] As I indicated earlier, Courtyard was criticized by the MOH during the merits hearing for failing to account for excess operational funds. This issue was never raised with Mr. Ronson who "backed out" operational expenses from the total course of care fee in order to make an appropriate comparison with CHC employees who have their operational expenses covered by their employer. The steering committee was fully aware of this and had ample opportunity to raise this if it was a concern.
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> [141] The Courtyard review was an iterative process and the MOH had every opportunity to participate through the steering committee and review of draft reports. Mr. Ronson testified that he responded to the points raised by the MOH after its review of the draft report and that the input of the MOH made the report stronger…[but] did not change the overall recommendations. I am not prepared to speculate about the impact of the perceived deficiencies in the report which were never put to Courtyard by the steering group or repaired by the MOH when it had the opportunity to do so.

[220] Although midwives are required to declare excess operating funds as taxable income, the Tribunal found that it has never been treated by the parties in compensation negotiations as part of the income of midwives or in comparisons with CHC employees. The Tribunal noted that this issue was never raised with Morton, Hay or Courtyard. The Tribunal concluded that the issue should be left to the parties to address either through their negotiations on operational expenses or in future compensation studies.

[221] We find nothing unreasonable in the Tribunal's reasons in this regard.

Discount for Physicians' salary cuts after 2012

[222] The MOH argued that the Tribunal unreasonably failed to discount the Courtyard 20% recommended increase on account of salary cuts imposed on CHC physicians after the Courtyard Report. The Tribunal reasonably found that it was not necessary to do the same for midwives for that period because unlike the physicians, they received no increases when their 2008 contract was extended on March 31, 2011, and therefore, have already done their part for compensation restraint.

Occupational Differences

[223] The Tribunal made no deduction to the Courtyard recommendation to account for the position of the MOH that midwives and physicians are paid differently because of occupational differences, holding: "No one disputes that midwives and physicians are different. What is disputed is the value the MOH attaches to those differences for compensation purposes."[129]

[224] The Tribunal held that it is the role of a compensation expert, not the Tribunal, to evaluate how differences in SERW, recruitment and retention, bargaining strength, and more specific factors like the retention of excess operational funds, benefits, grants, and the funding of liability insurance, should be incorporated into determining a specific compensation level for midwives.

[225] The Tribunal held:

> I also disagree with the MOH that Courtyard did not provide enough explanation for the 20% recommendation. The report clearly indicates that the recommendation was one based on the judgment of the consultants informed by the observations and conclusions that were drawn throughout the study, with the full participation of the MOH and the AOM. Importantly, the recommendation was intended to restore midwives to their historic position of being compensated at a level between that of a nurse practitioner and family physician. This is consistent with the findings in the Interim Decision and the emphasis in this Decision on restoring the benchmarks to remedy the discrimination. Courtyard acknowledges that the outcome is not completely consistent with the Morton principles.

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[129] Remedy Decision at para. 142.

> Nevertheless, it was recommended based on all the circumstances set out in the report and not a loose impression of what the consultants felt was "fair".[130]

[226] The Tribunal sets out the many specific reasons it found Courtyard the best remedy in this case:

> (a) Joint nature of the study;
>
> (b) Courtyard accounted for all of the funding midwives receive;
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> (c) Courtyard incorporated Morton and Hay 2004;
>
> (d) The jurisdictional comparisons;
>
> (e) The history of midwifery in Ontario; and
>
> (f) The timing of the Report.[131]

[227] The Tribunal held:

> …I am satisfied that the MOH has had ample opportunity to conduct a study of midwives' work and pay, either to inform its own practices or for the purpose of determining this remedial award. As a result, I have relied on Courtyard and not made any deduction from the recommendation for a 20% adjustment, to account for the explanations of the MOH as to why increases were made to compensation for CHC physicians in the period between the 2005 agreement and the Courtyard review in 2010.[132]

[228] We note that Mr. Ronson expressed the opinion in his testimony before the Tribunal that he expected that neither party would be happy with the recommendation. We further note that an internal memorandum from the MOH's Labour Relations Steering Committee was in evidence before the Tribunal which considered what position to take in regard to the Courtyard Report. While noting the disagreements it had with the report, the memorandum stated:

> …That said, the Ministry does not advise that we undertake a second compensation review. There is merit to the claim that midwives deserve a significant increase after several years of no or minimal increases. A second review will not likely achieve a much lower amount. A second report carries the risk of another 20% recommendation with additional consulting costs. The government will definitely need to address a second report with similar results as the first.[133]

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[130] Remedy Decision at para. 136.
[131] Remedy Decision at paras. 123–132.
[132] Remedy Decision at para. 120.
[133] Exhibit 160 dated July 20, 2011, 33521-33524 of Trial Record.

[229] The Tribunal's reasons for finding the Courtyard Report to be the best evidence available and for rejecting the MOH's submissions that discounts should be made were transparent, intelligible and justified. The parties failed to take advantage of the opportunity the Tribunal provided to engage in collaborative negotiations to determine the appropriate relief. The Tribunal noted that the parties expressed a need for clarity and finality in the calculation of lost wages, and they were given an opportunity to provide additional evidence or commission other studies or negotiate a remedy between them. In further submissions, both parties urged the Tribunal to determine remedy on the evidence that was led at the hearing rather than present further evidence from a compensation expert to inform the remedial award.

[230] The circumstances in which the Tribunal adopted the recommendations of the Courtyard Report were:

(a) the Tribunal adjourned the proceedings to give the parties an opportunity to resolve the remedy in negotiations;

(b) the MOH declined to do its own compensation review;

(c) both parties urged the Tribunal to determine remedy on the evidence that was led at the hearing rather than present further evidence from a compensation expert to inform the remedial award; and

(d) the parties had jointly collaborated in the Courtyard review which the Tribunal found was the best evidence of lost income.

[231] In these circumstances, we find nothing unreasonable about the Tribunal adopting the recommendations of the Courtyard Report.

(d)Was it unreasonable to order that midwives must be compared to CHC physicians in perpetuity unless the AOM agrees otherwise?

[232] It is a mischaracterization to say that the Tribunal ordered that midwives must be compared to CHC physicians in perpetuity unless the AOM agrees otherwise. The Tribunal found that the MOH "remains free to negotiate compensation with the AOM or set compensation unilaterally where they reach an impasse, so long as its actions comply with the *Code*."[134]

[233] The Tribunal also noted that the parties are at liberty to negotiate a new compensation methodology.

[234] While the Tribunal ordered that the joint study must include "the comparators set out in the Courtyard Report", it is also to include "any other comparators deemed appropriate by the

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[134] Remedy Decision at para. 64.

parties and the compensation expert".[135] The purpose of the joint study is to "inform the negotiations between the parties" and is non-binding.

[235] In the Liability Decision the Tribunal found that the losses arising from the discrimination were caused by 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. The Tribunal found that the redress for systemic discrimination requires systemic remedies and that the remedy should include orders which address the flaws and assumptions in the compensation practices of the MOH.[136]

[236] The Tribunal held:

> …In CSQ the Supreme Court noted that: "women in workplaces without male comparators may suffer more acutely from the effects of pay inequity precisely because of the absence of men in their workplaces.".[137]
>
> The MOH denies, contrary to the evidence of the history of this matter, that midwives ever had a male comparator, which has been disadvantageous to midwives in their negotiations with the MOH. Because of the circumstances of this case, I have directed the MOH to reinstate the benchmarks, including an appropriate physician comparator, to address the need for ongoing comparison with male work or proxies for male work in future compensation studies.[138]

[237] The Tribunal held that regardless of what level of precision is applied to calculating lost income, the first principle is that the benchmarks must be reset to recognize the systemic nature of the discrimination in the compensation practices of the MOH.

[238] The Tribunal observed that to return midwives to the place they would have been but for the discrimination, is to bring the parties back to a state where they are working together to ensure that midwives are fairly and appropriately paid, using the benchmarks as their guide, and with the MOH adhering to its obligations under the *Code*. The Tribunal concluded that implementation of the Courtyard Report, combined with the orders made to promote compliance with the *Code*, brings the parties as close as possible to that state.[139]

[239] The parties agreed upon the benchmarks as their founding methodology to ensure that midwives' compensation did not give rise to gender discrimination. The appropriateness of the benchmarks has been reaffirmed in two subsequent compensation reviews. We have concluded that there was nothing unreasonable in these circumstances about the Tribunal ordering that the

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[135] Remedy Decision at para. 189.
[136] Remedy Decision at para. 95.
[137] *CSQ* at para. 29.
[138] Remedy Decision at paras. 101–102.
[139] Remedy Decision at para. 41.

benchmarks, or an alternative methodology agreed on by the parties, continue to inform their negotiations and the understanding of the MOH about the impact of gender on the compensation of midwives as sex-segregated workers. As was noted above, systemic discrimination is a continuing phenomenon which has its roots deep in history and in societal attitudes.

(e) Was the Tribunal unreasonable to order damages of $7500 for injury to dignity to midwives?

[240] The AOM submitted before the Tribunal that $7500 per year per midwife was an appropriate award for compensation for injury to dignity to recognize the harm done by the violation of the *Code*. The MOH argued that $5000.00 in total per midwife would be appropriate.

[241] Section 45.2(1)1 of the *Code* gives the Tribunal discretion to direct the MOH to pay monetary compensation to a party whose rights were infringed for loss arising out of the infringement, including compensation for injury to dignity.

[242] The guiding principles governing an award of compensation for injury to dignity, were set out in the Tribunal's decision. The Tribunal held that there was no principled basis for calculating compensation for injury to dignity on an annual basis as sought by the AOM.

[243] The Tribunal found that there were no cases from this tribunal which are comparable to this case where hundreds of applicants have successfully proven allegations of gender discrimination in compensation levels over a period of several years.

[244] At the federal level, the Tribunal considered the case of *Walden*[140], which awarded $6000.00 in "pain and suffering" damages pursuant to section 53(2)(e) of the *Canadian Human Rights Act*[141], to each of the individual complainants who testified about the impact of their employer's long-standing, discriminatory classification and pay. The decision not to award damages to all complainants based on the testimony of the representative complainants was overturned by the Federal Court in *Canadian Human Rights Commission v. Canada (Attorney General)*[142]. The Federal Court did not comment on the quantum of damages awarded by the Tribunal.

[245] The Tribunal reviewed the evidence of the five representative applicants called by the AOM to testify in support of its request for damages for injury to dignity. Counsel for the MOH did not challenge their evidence.

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[140] *Walden et al. v. Social Development Canada, Treasury Board of Canada and Public Service Human Resources Management Agency of Canada*, 2009 CHRT 16.
[141] R.S.C. 1985, c. H-6, as amended.
[142] 2010 FC 1135.
[143] Remedy Decision at para. 176.

[246] The Tribunal found that there were some similarities between this case and the 2009 *Walden* decision: "On the one hand, ten years have passed since that decision was made; on the other, the 52 nurses in the 2009 Walden decision were found to be doing the same core work as the doctors in the CPP program without recognition of their professional status as nurses."[143]

[247] Having considered the appropriate criteria, the range of awards given in other cases and the testimony of the representative applicants, the Tribunal found that $7500.00 per eligible midwife was an appropriate award of compensation for the violation of the inherent right to be free from discrimination and for injury to dignity. In determining that amount, the Tribunal considered the substantial number of midwives who would be eligible for this award and held that it does not in any way trivialize or diminish respect for the *Code* or effectively create a licence to discriminate.

[248] We find this decision reasonable.

Conclusion

[249] The Tribunal's decisions in respect to Liability and Remedy fall within a range of possible, acceptable outcomes which are defensible in respect of the facts and law. The reasoning process is transparent, intelligible and justified. As we have noted earlier, the Tribunal's decisions are entitled to substantial deference. The application for judicial review is dismissed.

Costs

[250] The MOH is not seeking costs of its application. The Human Rights Tribunal is not seeking costs. In the absence of an agreement on the AOM's costs, the AOM shall have 14 days after the release of these Reasons to make brief written submissions on costs. The MOH shall have 14 days thereafter to respond with brief written submissions. Submissions are to be submitted electronically.

Nancy Backhouse J.

Backhouse J.

Pattillo J.

Lederer J.

Date: June 26, ,2020

CITATION: Ontario v. Association of Ontario Midwives 2020 ONSC 2839
DIVISIONAL COURT FILE NO.: 131/19
DATE: June 26, 2020

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Backhouse, Pattillo, Lederer JJ.

BETWEEN:

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

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REASONS FOR JUDGMENT

Released: June 26, 2020

THE COURT