Mediator, Beverly Mathers' Report and Recommendations

January 6, 2026

His Majesty The King in Right of Ontario as represented by the Ministry of Health (the MOH or the Ministry)

- and –

The Association of Ontario Midwives (the AOM)

Overview of Negotiations and Mediator Scope

The Parties

1. The Association of Ontario Midwives (AOM) represents the interests of midwives in Ontario. The AOM is not a certified bargaining agent under the Ontario Labour Relations Act, 1995. Rather, midwives' contractual relationship with the Ministry (MOU) is governed by the "Memorandum of Understanding between the AOM and the MOH", which recognizes the AOM as the representative of midwives in Ontario for contract negotiations.

2. The Ministry of Health provides public health care services for the province of Ontario. The MOH submits that it recognizes and values the health services that midwives provide to Ontario residents. They are a valued provider in the province's maternal-newborn care system, providing care to women during normal pregnancy, labour, and post-partum period and conducting spontaneous normal vaginal deliveries, as well as providing care to their newborn babies (up to 6 weeks). The Ministry recognizes the important work of midwives and the immense impact they have on the lives of parents and their newborn who put their trust in midwifery care.

3. The AOM, in October 2025, represented 1043 midwives, including approximately:
   - 881 active registered midwife (RM) members and 17 active Indigenous midwives (IM) working under the exception clause of the Midwifery Act.
   - 138 inactive RMs and 3 inactive IMs.
   - 767 General Registrants and New Registrants work in the Course of Care model of care in Midwifery Practice Groups.
   - 75 midwives work in Expanded Midwifery Care Models.
   - 22 midwives work in Indigenous Midwifery Programs, including 17 IM working.

4. Where do Midwives Practice?

Midwives in Ontario are primary care professionals who provide government-funded care in Midwifery Practice Groups (MPGs), Indigenous Midwifery Programs (IMPs) and Expanded Midwifery Care Models (EMCMs). Midwife means "with woman," reflecting a model of care based on relational continuity of client- and family-centred care and informed choice to support client autonomy. The model of care also includes choice of birthplace, including out-of-hospital birth and evidence-based use of medical interventions, as well as minimizing hospital admissions and lengths of stay. Most midwives are independent contractors, and some who work in IMPs and EMCMs are employees of Community Health Centres, Family Health Teams, Indigenous health organizations and hospitals.

RMs working in MPGs provide comprehensive around-the-clock, on-call, care for pregnancy, labour, birth and postpartum and newborn care. Along with family physicians and obstetricians, midwives provide primary care in Ontario's perinatal health-care system. Like pediatricians, family physicians, and nurse practitioners, they provide primary health care to newborn infants. The knowledge and skills of midwives overlap with those of other professional scopes of practice, including family physicians, obstetricians, pediatricians, nurse practitioners, registered nurses and registered practical nurses, social workers, and counsellors.

A midwife who is Indigenous may practice as either an RM (regulated by the College of Midwives of Ontario) or an Indigenous Midwife within the exemption clause of the Midwifery Act. IMs practicing under the exemption are governed by their respective community or Indigenous organization and provide care to meet the needs of Indigenous communities including comprehensive sexual and reproductive health care throughout the lifespan and care for babies and children. Funding for IMPs was first negotiated in 2017. There are now 14 IMPs delivering various models of care including on-call models that provide intrapartum care and non-on-call models where IMs provide pre- and postnatal care as well as other care and services to meet the needs of their communities.

Since 2017, EMCMs have provided a variety of models of care "to expand and maintain alternative midwifery funding mechanisms, which will improve access to high quality, client-focused, community-based primary health care." The existing 33 EMCMs deliver care through a variety of models, including an Alongside Midwifery-Led Unit at Oak Valley Health, hospitalist roles and several diverse programs through CHCs, FHTs, hospitals

and midwife-led not-for-profit organizations. Midwives in some EMCMs provide expanded scope care under medical directives for care currently outside of their scope of practice.

5. Number of babies delivered/caught by Midwives

   According to statistics provided by the MOH, midwives deliver/catch approximately 11% of babies in Ontario. Family physicians deliver approximately 5%, down from 6% in 2020/2021, and Obstetricians deliver approximately 74-75% of Ontario's babies.

   The MOH and hospital policies determine midwives' scope of practice and when care must be transferred to another provider. The MOH has determined that midwives provide low-risk obstetrical services. These services overlap with those of other providers. In their brief at Paragraph 163, the MOH states that in 2024-2025, approximately 39.5% of midwifery clients were transferred to the OB-GYN for their deliveries.

   The AOM does not dispute this number; however, they advise that 93% are transferred back to the care of the midwife following delivery or after a consultation. Further, the AOM states midwives could transfer clients less often without unnecessary limits on their scope of practice by hospitals or physicians.

Negotiations Protracted

6. The mediator first acted as "facilitator" for these protracted negotiations. The AOM described these negotiations in their submissions. I have summarized:
   - In November 2023, six months before the 2023/2024 contract expired, the parties began bargaining a multi-year contract.
   - After nine (9) bargaining sessions, the parties ratified a one-year interim arrangement that would provide a normative 3% fee increase (with an understanding that bargaining was ongoing and proposals could be tabled retroactively to April 1, 2024, when bargaining resumed) and a lump sum of up to $2.5 million payable to Ontario midwives. The MOH also invested a one-time 3% increase in the midwifery compensation elements of AOM programs (i.e., the Rural and Remote & Far North Sustainability Program and the Parental Leave Program) and continued one-time funding for IT support for 2024-2025. The arrangement included enhancements for the Indigenous Midwifery Program. Global Professional Liability Insurance was agreed to be implemented on April 1, 2024.

- The interim arrangement provided the parties with an opportunity to have the recommencement of bargaining informed by:
    - The outcome of the 2024 Ontario Medical Association (OMA) year one arbitration award, and
    - The Compensation Expert's release of the Joint Compensation Study expected to be completed by September 2024.
- The Kaplan Arbitration award (The Crown in Right of Ontario v Ontario Medical Association, 2024 CanLII 86115 (ON LA))[1] was issued on September 12, 2024.
- Negotiations recommenced in November and December 2024 and January 2025.
- With rumours of a provincial election, I recommended to the parties on January 27, 2025 –

    Prior to the conclusion of the negotiation day, January 20, 2025, I recommended the parties begin an immediate review of current service agreement and Interim Agreement between the parties dated March 1, 2024 to identify the specific, required funding allocations to move forward on April 1, 2025 until the parties conclude bargaining.

    It is with the aforementioned facts in mind that I recommend to the parties they negotiate a bridging agreement as soon as possible to ensure stability in the sector as they diligently negotiate a renewal multi-year service agreement.
- The Provincial Election was called on January 28, 2025 for an election on February 27, 2025, commencing the writ period. Bargaining dates were postponed.
- Following the election, the parties signed an Addendum to the Interim Agreement to ensure stability in the sector into the next fiscal year until bargaining could resume and conclude.
- Bargaining resumed in May, July, and August 2025, but the Ministry did not provide a financial response to the AOM proposals.
- The parties agreed to pause negotiations until:
    - The outcome of the 2025 Ontario Medical Association (OMA) year two, three and four arbitration award, and
    - The release of the Price Award for the Participating Hospitals and the Ontario Nurses' Association.
- The Price Arbitration award - Participating Hospitals v Ontario Nurses' Association[2] was issued on September 3, 2025.

[1] The Crown in Right of Ontario v Ontario Medical Association, 2024 CanLII 86115 (ON LA), http://canlii.ca/t/k6rnn.

[2] Participating Hospitals v Ontario Nurses' Association, 2025 CanLII 116898 (ON LA), https://canlii.ca/t/kf7nz

- The Kaplan Arbitration award - The Crown in Right of Ontario v Ontario Medical Association[3] was issued on September 17, 2025.
- Bargaining resumed on October 29, 2025 with the Ministry providing a complete offer to the AOM to settle the contract. Bargaining reached an impasse in early November. The parties agreed to mediation and the mediation process.

Mediator Scope

7. The mandate for the Mediator is set out in the Memorandum of Understanding Appendix "B"- Joint Process for Negotiations between the Association of Midwives and the Ministry of Health, 2023-2024.

8. The Facilitator will determine the procedure and rules governing the facilitation process in consultation with the parties which will be conducted on a without prejudice basis.

   If the Parties are unable to reach an agreement after having received assistance from the Facilitator for a period of up to 60 days, and if mutually agreed by both Parties, a third-party Mediator may be engaged to present a non-binding recommendation regarding compensation related disagreements. The Parties and the Mediator will determine the procedure and rules governing this process, including any limitations on the scope of the mediation. For greater certainty, unless the Ministry agrees, the mediation shall be conducted with the principle that the ministry sets the budget for the funding of the health care system including midwifery services. Any recommendation or report arising from the Mediator shall remain confidential to the Parties at this stage.

   8.1 Upon receiving any recommendation from the Mediator, the parties shall resume negotiations as soon as possible, including using a Facilitator as described above.

   8.2 If after negotiations have resumed the Parties are unable to come to agreement, the Mediator's recommendations may be made public by either Party with reasonable notice to the other Party.

[3] The Crown in Right of Ontario v Ontario Medical Association, 2025 CanLII 94270 (ON LA), https://canlii.ca/t/kfgc1.

8. The AOM submits that care must be taken not to exacerbate the discriminatory and unconstitutional effects of the deficient mediation process by narrowly interpreting the mediator's jurisdiction with respect to "compensation related disagreements". Rather, a broad and purposive interpretation ought to apply: any disputes between the parties that are somehow related or connected to compensation ought to come within the scope of mediation.

9. The Ministry submits that unless they agree, the mediation shall be conducted with the principle that the ministry sets the budget for the funding of the health care system including midwifery services. Therefore, per the parties' agreement, and proposal that sets the budget for the funding of the health care system (i.e. non-compensation related proposals) fall outside the scope of mediation unless otherwise agreed.

   The Ministry does not agree to expand the scope of this mediation. Respectfully, it would be inappropriate for a third party to make recommendations with respect to Government's funding of the health care system. The provincial government bears the ultimate responsibility for the delivery of publicly funded health care. Midwifery is only one program of many health services required by and delivered to the people of Ontario. The Government, and Ministry must make determinations to ensure funding is allocated appropriately and according to priority across a whole health care system while ensuring the publicly funded health care system remains sustainable.

Factors

10. The parties have agreed that the mediator shall consider the following factors when making her non-binding recommendations:

    a. The achievement of a high quality, patient-centered sustainable publicly funded health care system.

    b. The principle that compensation for midwives should be fair and appropriate (in the context of such comparators and other factors the mediator considers relevant).

    c. The economic situation in Ontario.

    d. Economic indicators, including, but not limited to, the cost of midwife practice.

    e. Ontario's ability to attract and retain qualified midwives.

Historical Overview

11. Midwives have been regulated since 1994. Most Ontario midwives work in a community-based "course of care" model. The "course of care" model is the one that the AOM and the Government agreed on in 1999. The key components of the "course of care" model aligned with the foundational principles of midwifery philosophy - "continuity of care", "informed choice," and "choice of birthplace".

    The continuity of care principle provides that midwives offer complete care throughout pregnancy, labour, birth, and the first six weeks following birth. Typically, midwives will work in teams, and two midwives will attend births. To maintain the continuity of care principle, midwives arrange their practices such that a client can contact a midwife in the practice 24 hours a day, 7 days a week with urgent concerns. The continuity of care principle results in midwives being on-call at times to ensure coverage for the clients of their practice group. The informed choice principle results in midwives spending more time with clients to support them to make informed decisions about their care. Flowing from the choice of birthplace principle, midwives provide birthing care in the setting the client chooses: their home, a hospital or birth center or at the practice group's clinic.

12. The Ministry sets out the model of compensation. Midwives working in the course of care model are self-employed, as independent contractors. Midwives form "midwifery practice groups" (MPGs), which enter into contracts with transfer payment agencies (TPAs) to receive compensation. Payment is through a billable course of care system, and midwives receive compensation, including funding for benefits from the Ministry, which funds health and dental benefits, and contributions to a Group Retirement Savings Plan administered by the AOM Benefits Trust. The Ministry separately provides funding to the AOM for access to parental leave benefits administered by the AOM Benefits Trust. Payment is made based on a full course of care (i.e., the period from when a client enters midwifery care through to discharge at six weeks postpartum). The resulting full-time equivalent for a midwife in the course of care model was determined to be services provided to 40 clients per year as the primary midwife and acting as a second birth attendant for approximately 40 clients.

Gender-Based Compensation Discrimination

13. "The MOH agreed at regulation that CHC physicians were an appropriate comparator."[4] The parties negotiated contracts, and then in 2013, the midwives collectively launched a legal action against the Ontario government for gender-based discrimination in their compensation. The AOM alleged that compensation for midwives had eroded over time

[4]2020 HRTO 165 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/hvb9p.

and was affected by gender discrimination. By 2013, the parties had reached an impasse in long and complex historical negotiations. The Human Rights Tribunal of Ontario (HRTO) in 2018 determined that the midwives had been subjected to discrimination in their compensation from 2005 to 2013[5]. The Tribunal remitted the remedy back to the parties to negotiate redress.

14. In 2020, the HRTO[6] ordered the Ontario government to remedy this discrimination through several measures, including retroactive pay and other actions aimed at preventing discrimination from policies and practices.

[3] In the Interim Decision, the Tribunal dismissed the allegations of discrimination arising from the period between the first funding contract in 1993, and the 2005 funding contract (in effect from April 1, 2005 to March 31, 2008).The Tribunal found discrimination after the parties achieved the 2005 agreement, based in part on the fact that midwives were gradually moving out of alignment with the comparators that historically informed how the parties defined "fair and appropriate" compensation levels.

[4] Midwives are occupationally segregated by gender: they are predominantly women, providing reproductive care to women and their newborns, in an area of health care that was once dominated by male physicians. They are independent contractors who have a long history of negotiating with the MOH over compensation paid to individual midwives as well as myriad other issues associated with the funding and delivery of midwifery services through the Ontario Midwifery Program (the "OMP").

[5] From 1993 through the 2005 agreement, the negotiations between the parties were informed by objective criteria like skill, effort, responsibility and working conditions ("SERW") which overlapped to some extent with pay equity principles, and other evidence-based compensation methodologies. The parties reached agreements on positioning midwives between the senior nurses and family physicians with whom they share an overlapping scope of practice. Their specific comparators have been senior nurses (later nurse practitioners) and family physicians employed in Community Health Clinics (CHC's). For the purpose of simplicity in this Decision, I refer to the compensation principles and the objective criteria, evidence-based compensation methodologies and the choice of comparators, which the parties roughly maintained from 1993 to 2005, as the compensation "benchmarks".

[5] 2018 HRTO 1335 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/hvb9p.

[6] 2020 HRTO 165 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/j5f8b.

[6] After 2005, the MOH gradually lost touch with the benchmarks, particularly the principle that CHC physicians were relevant comparators for midwives. The MOH did not monitor how changes in the compensation of CHC nurses and physicians affected the alignment of midwives with their comparators, eventually repudiating physicians as a comparator altogether. The MOH did not develop an alternative methodology for compensating midwives based on their SERW and their relationship with family physicians and obstetricians in delivering low-risk maternity and newborn care. In fact, the MOH has not conducted a study of midwives' work and pay since 2010.

[7] In 2010, the parties participated in a non-binding joint compensation review ("Courtyard") which revealed the consequences of the gradual erosion of the compensation benchmarks. Courtyard recommended a 20% adjustment to the fees individual midwives earn for their services, which would apply for midwives at each of the six levels of experience effective April 1, 2011. Courtyard repositioned midwives between CHC nurse practitioners and physicians based, in part, on the original 1993 formula, a subsequent study conducted by Hay Group for the AOM in 2004, and the information gathered during the review. Courtyard also recommended regular negotiations going forward based on the benchmarks. When the Courtyard report was released, the MOH disagreed with the findings and methodology, despite having been a full and active participant in the process. The parties reached an impasse in their negotiations which eventually led to the filing of this Application and the signing of subsequent contracts in 2013 and 2017 without prejudice to pursuing this Application.

....

DECISION

[9] I have determined that the appropriate remedy in this case is for the parties to reinstate the lost compensation benchmarks and implement the adjustment as recommended by Courtyard as of April 1, 2011. I have ordered retroactive compensation back to that date based on the Courtyard report. I have explained in the Decision the reasons for finding that Courtyard represents the best evidence for determining remedy, including full implementation of the 20% adjustment, and why the evidence does not support an adjustment prior to this date.

[10] I have also ordered compensation for injury to dignity, feelings, and self-respect ("injury to dignity"), in the amount of $7500.00 per eligible midwife. While each of the midwives who testified as part of the factual context of this case also gave evidence about how they were personally affected by the issues raised in the Application, five representative midwives were called for the purpose of establishing the quantum of

compensation for injury to dignity. The MOH did not dispute that an order for all midwives could be based on the testimony of the representative applicants.

[11] I have also made orders to promote ongoing compliance with the Code, to ensure that the benchmarks, or an alternative methodology agreed on by the parties, continue to inform their negotiations and the understanding of the MOH about the impacts of gender on the compensation of midwives as sex-segregated workers.

...

[157] I am ordering the MOH to reinstate the lost compensation benchmarks in accordance with the recommendations in the Courtyard report effective April 1, 2011. The 20% adjustment is to be implemented as a Code-related adjustment and therefore covered by the exemption in the compensation restraint legislation which the MOH applied to its negotiations at the time. These adjustments are in excess of any other increases negotiated between the parties and will require an adjustment to the course of care fee, retroactive to April 1, 2011, recalculation of the percentage increases negotiated in the 2013 and 2017 contracts, and an adjustment to course of care fee for all midwives, going forward from the date of the Decision.

...

[187] The primary remedial order from a compliance perspective is to reinstate the benchmarks through joint, collaborative, and regular compensation studies, which account for the SERW of midwives and their comparators and take a gender-sensitive approach to determining compensation levels.

...

[189] The parties are ordered 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. I have set out below, the minimum requirements for the study (and the updates), subject to the parties agreeing on an alternative approach:

a. The joint study will include a SERW analysis and account for the specialized and autonomous nature of the work of midwives and their onerous on-call duties, among other things; the 1993 principles and methodology; the comparators set out in the Courtyard report; and, any other comparators deemed appropriate by the parties and compensation expert;

b. The study will be conducted by a compensation expert, agreed upon by the parties, who is experienced in pay equity, pay equity job evaluation methodologies and

gender-based analysis. The compensation expert is not restricted to applying any specific compensation methodology;

c. As with previous joint studies, the expert will be informed by the equal participation of the parties on a steering committee;

d. The expert will consider any issues raised by the MOH and AOM as members of the steering committee. The expert will have access to the Tribunal's Decisions and the full record of the proceeding;

e. The expert will be chosen, and the study will commence, no later than three months after the date of this Decision and is to be completed no later than four months after it is commenced;

f. the study will inform the negotiations between the parties but will not be binding on them;

g. the study will be updated prior to the start of the negotiations leading to each new contract;

h. the cost of the study and updates will be paid by the MOH; and

i. the parties will jointly retain and pay for a third-party facilitator to resolve any disagreements arising out the development or implementation of the study and any updates.

15. These decisions were upheld by the Ontario Divisional Court on June 26, 2020[7] and an appeal to the Ontario Court of Appeal was dismissed on June 13, 2022[8].

16. The parties have, for approximately the last five (5) years, been conducting the Joint Compensation Study (JCS) as ordered by the HRTO. The JCS remains "in process."

17. The AOM states in their brief –

> It is discriminatory and punitive for the MOH to rely on the ongoing JCS to deny midwives fair and appropriate compensation increases consistent with their comparators and wage settlement trends, including Bill 124 redress, in the healthcare and broader public sectors. It is taking the Tribunal's key human rights remedy – which was intended to remedy systemic gender discrimination in midwives' compensation – and using it against midwives as justification to deny them normative compensation increases.

[7] Ontario v. Association of Ontario Midwives, 2020 ONSC 2839, https://canlii.ca/t/j8f65.

[8] *Ontario (Health) v. Association of Ontario Midwives*, 2022 ONCA 458, https://canlii.ca/t/jprf6.

18. The MOH states in their brief –

> The Tribunal did not make a determination that further adjustments may be owing to Ontario midwives in order to address gender discriminatory pay. The Tribunal set out a process to be followed by the parties to reinstate the benchmarks, so that MOH recognizes the role of gender in the compensation of Ontario's midwives. Particularly, the Tribunal confirms that "the study will inform the negotiations between the parties but will not be binding on them." 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." The work of the JCS continues to be ongoing. The recommendation of the Compensation Expert are not yet available to inform this round of negotiations between the Ministry and the AOM.

19. It is within this complex history that the parties have reached an impasse in bargaining. They are now seeking recommendations on their proposals to assist their decision-making to reach a bargaining conclusion.

Position of the Parties in Brief

AOM Proposals

20. Term – April 1, 2024 to March 31, 2028

    Normative Compensation increase of 3.5% in year 1 (2025-26), 3% in year 2 (2026-27) and 2.75% in year 3 (2027-28). To be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, and Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R") and the midwife income portion of Parental Leave and Locum grants.

    Bill 124 Redress of 8.75% retroactive to April 1, 2024. Retroactive redress to be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R"). Code-protected leave payments (parental and disability) would also be covered by this redress amount in a lump sum retroactive payment through a methodology agreed to by the Parties.

Equity adjustment of 5% - The equity adjustment on all midwives' compensation to be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, and Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R "). Code-protected leave payments (parental and disability) would also be covered by this equity adjustment in a lump sum retroactive payment through a methodology agreed to by the Parties.

Benefits Funding - The AOM proposes a 3.5% increase to benefits funding – from 20% ($21,243,634) to 23.5% ($24,961,270). The AOM proposes an additional $916,100 to the existing grants that fund parental leave, wellness, and Indigenous health supports. The AOM proposes the following non-monetary improvement: the ability for the AOMBT to create a reserve with unused grant funding.

Targeted Premiums:

Retention premium - The retention premium for Level 6 midwives increase to $125/BCC, for Level 5 midwives to receive a premium of $100/BCC and for Level 4 midwives to receive $75/BCC (+3% on all x 3 years).

Faster access to care: - Increasing the on-call premium for both employee and MPG models.

On call premium - MPG midwife:

2025-26 - $880/BCC

2026-27 - $906/BCC

2027-28 - $933/BCC

On call premium - Salary midwife

2025-26 - $35,200/year

2026-27 - $35,256/year

2027-28 - $37,344/year

Freeing up hospital beds: New incentive fee for Out-of-Hospital Birth for midwives who attend home, clinic and birth centre births.

Out of hospital birth premium:

2025-26 - $300/ home, clinic or birth centre birth

2026-27 - $309/ home, clinic or birth centre birth

2027-28 - $318.37/ home, clinic or birth centre birth

Improving access to care at home and relieving pediatric pressures: New incentive for Early Discharge from hospital.

Early discharge premium:

2025-26 - $50.00/ discharge < 24 hours

2026-27 - $51.50/ discharge < 24 hours

2027-28 - $53.05/ discharge < 24 hours

Optimizing midwives' scope of practice: New premium to incentivize midwives maintaining primary care within full scope of practice by adding a premium payment of $105/BCC to the Fee Schedule for all BCCs from eligible practices.

Full scope premium:

2025-26 - $105/BCC x 500 mw x 32 BCCs, $1,680,000

2026-27 - $108.15/BCC x 550 mw x 32 BCCs, $1,903,440

2027-28 - $111.39 x 605 mw x 32 BCCs, $2,156,510

Supporting community-based practice: Sustainability Investments in Midwifery Practice Groups - The AOM proposes an increase of 3% annually to the operational fee, travel disbursements, equipment disbursements for midwives and MPGs, second attendant supplement and birth kits.

Increases to AOM grants - 3% increases in each year for AOM grants to keep pace with rising costs and ability to provide government-funded programs and services to midwives

- Renewal and Restoration Grant (Indigenous Midwifery).
- HHR Capacity Grant.
- Professional Development.
- Rural and Remote & Far North Sustainability Program (Locum).
- Midwifery Clinical Practice Guideline Development and Related Knowledge Translation Activities.
- Supporting Midwifery Research Capacity Building.

- Parental Leave*.
- Retention and Wellness Investment*.
- Wellness Spending Account for Indigenous Midwives*.

*See proposal on Benefits for further detail about proposals regarding these grants

MOH Proposals

21. A term from April 1, 2025 to March 31, 2028.

    Compensation increases of 2.7% effective April 1, 2025; 2.0% effective April 1, 2026 and 2.0% effective April 1, 2027.

Overview

22. The Report will summarize the submissions of the parties in support of their proposals.

23. In the Ministry's view, the JCS is not completed; therefore, it cannot influence the outcome of negotiations this round. In their view, increases should be the current trending normative labour relations increases, from the summer/fall of 2025, disregarding the OMA and ONA outcomes, where, in the MOH's opinion, there is a clearly demonstrated retention and recruitment issue.

24. On the other end of the spectrum, the AOM argues that while the JCS is not complete and cannot influence this negotiation, the outcome of the HRTO continues to set their comparator. Therefore, the OMA outcome should be their comparator. They also detail a profession in crisis with significant retention and recruitment issues.

AOM Submissions

25. The AOM's submission focuses on the impact gender and gender discrimination continue to have on midwives' work and the current retention and recruitment "crisis" in the profession in Ontario. They say –

    > The midwifery profession in Ontario is at a crisis point. The AOM surveyed its members in 2021 and learned that one in three midwives is considering leaving practice within the next 5 years. They indicated they would stay in the profession with improved and equitable pay, as well as better system integration, more flexible funding models and improved opportunities to work in different ways.

It is with this history and viewpoint that they submit their monetary proposal package.

26. Compensation should be Fair and Appropriate in the Context of Comparators and Other Factors

The AOM discusses in detail the HRTO outcome (Remedial and Liability Decisions) and, in their view, the key aspects of the decision for these negotiations. Simply stated, the AOM agrees that the mediator can not interpret or implement a JCS that has not been completed. Therefore, the mediator must maintain alignment with the HRTO decisions to ensure gender discrimination is not perpetuated and prevent the gender wage gap from widening in the absence of a new JCS. The HRTO ordered the MOH to reinstate the 1993 benchmarks and to adhere to its obligations under the *Code*.

> [41] This case crystallized during the negotiations between the parties after the release of the Courtyard's recommendations. 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*. 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[9].

The AOM submits that, for at least this round of negotiations, their comparator should remain the CHC family physician for the above reasons. This means the outstanding 1.8% increase negotiated by the OMA in year 3 (2023) above the 1% negotiated by the AOM; the normative and redress increases awarded by Arbitrator Kaplan on September 12, 2024, and the normative increases awarded on September 17, 2025.

The AOM argues that the factors: retention and recruitment; doctors are not employees, but they are not independent contractors either; prices govern not total compensation; administrative duties must be addressed; overhead; redress/catch-up after 2021; impact of inflation; and Bill 124 considered by Arbitrator Kaplan when awarding Redress/Catch-Up equally apply to midwives.

Midwives, like physicians, are independent contractors; however, the ministry determines how they are paid and, in the case of midwives, caps the number of clients. Midwives, like family physicians, cannot set their own price to cover their costs. Midwives must cover the costs of running their own practice, e.g., rent, medical

[9] 2020 HRTO 165 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/j5f8b.

equipment, administrative staff, computers, and software when inflation escalates costs above the rates reimbursed by the TPA.

The AOM submits that, although Bill 124 did not apply to them, the MOH would only agree to 1% total compensation and did not consider any exemptions for human rights entitlements. When Bill 124 was found unconstitutional by the Courts, the unions reopened their collective agreements to renegotiate or arbitrate new compensation outcomes. Unionized healthcare workers and the OMA have received redress for Bill 124.

Inflation, the AOM argues, impacted midwives as it did other public sector workers, including their physician comparators. "The eroding impact of inflation on midwives' real wages and purchasing power cannot be understated." Inflation has persisted and is entrenched now in prices.

The AOM puts forward –

> Arbitrator Kaplan emphasized that the MOH's position of no redress for significant inflationary pressures would have put Ontario doctors further behind economically at the end of the 2021-24 contract than they were at the beginning. Physicians received a total of 4.8% in compensation increases over the course of the 2021-24 contract while inflation totaled 15.1% in the same time. (In contrast, midwives only received a total of 3% for the same three-year period.)
>
> Arbitrator Kaplan also emphasized that catch up and redress amounts had been negotiated and awarded across the OPS and broader public sector where Bill 124 had applied. As such, Arbitrator Kaplan ruled that as a matter of fairness and the replication principle, it was necessary for physicians to receive similar increases.

27. Retention and Recruitment

The AOM documents set out the retention and recruitment issues. The AOM states that in 2024, 6.83% of midwives left the profession while the profession grew by only 1.69%. From 2020-2024, the average attrition rate from the profession was 5.5%, contrasting with the average growth rate of 2.21%. 2024 saw the highest-ever number of midwives resigning their registration with the College of Midwives, with 60 resignations received by the third quarter. Currently, 13% of Ontario's midwives have "inactive" status, meaning they are on leave from practice either for medical or parental leaves or working in a non-clinical capacity. There are two Midwifery Education Programs in Ontario that can graduate 90 midwives per year.

Data from the Midwifery Education Program shows that in 2023, 24% of McMaster University graduates and 22% of Toronto Metropolitan University graduates did not register in Ontario.

The AOM argues that the midwife shortage is related to burnout and disability leaves. Midwifery Practice Groups cannot plan for growth despite an increase in community need because MPG budgets have remained stagnant since 2020, and there have been no calls for new or expanded MPG proposals. In fact, the AOM notes an increase in MPG closures over this period, representing a reduction in access to midwifery services. MPGs cannot retain their New Registrant midwives into their General Registrant (GR) years due to a lack of GR caseload, yet at least 33 MPGs (over one-third) advertise vacancies for General Registrant positions.

The AOM agrees with the MOH that there is a distribution problem; however, the AOM says there is also a significant retention and recruitment issue.

There is a growing number of MPGs unable to fill positions; 33 MPGs are advertising vacancies for General Registrant positions. Of the 33 MPGs seeking midwives, 43 permanent and 35 temporary positions are available. As of December 23, 2025, there are 78 current vacancies. Thirteen (13) MPGs are attempting to recruit New Registrants even after most of the New Registrants have been hired in MPGs. This is compounded by hiring in EMCMs, in a profession with a finite number; these hires were recruited from MPGs.

The AOM also reports that attrition is impacting the availability of rural and remote locum midwives. In four of the last five years, locum days were unable to be used because there is a lack of available locum midwives to provide coverage. For example, in 2024-25, 44 midwives required locum coverage days that could not be used due to a shortage of midwives to provide locum coverage. This leads to increased burnout among rural and remote midwives, who are unable to take breaks when no one can cover.

When an unanticipated leave occurs, work in an MPG must be reprioritized, locums (where possible) are contracted, and client caseloads are reallocated. If there is very short notice, midwives who are on vacation or otherwise off call may have to come back to provide on-call coverage. When this is not possible, the midwives remaining in the practice must carry the extra caseload, leading to burnout. This has consequences not only for the retention of the remaining midwives but also for the ability to operate MPGs and keep practices open. For example, recently one MPG unexpectedly lost 40% of the midwives in their group, resulting in the need to revise their business plan and close one of their two clinic locations as the MPG could no longer generate adequate operating income to cover expenses.

There is an increasing trend in the number of MPGs closing. From 2021-2025, there have been 6 MPG closures. Four (4) out of the 6 MPGs closed between 2024 and 2025.

The AOM describes these trends as unsustainable.

28. Economic Climate

The AOM states inflationary pressures continue in 2025. While the rate of inflation was at 2.2% in October 2025, without actual de-inflation, there remains a pressing need to address the entrenched higher costs of living, higher operational expenses, and loss of purchasing power experienced by midwives.

The AOM says that recent inflationary decreases are largely driven by reductions in gas prices; when these are removed, the October 2025 inflation rate increases to 2.6%, above the Bank of Canada's target rate of 2%. Further, it is widely anticipated that inflation will increase because of the Trump tariffs. The Ontario government is predicting inflation will be 2% in 2026, 2% in 2027, and 2% in 2028. However, these projections remain below the Bank of Canada's most recent forecasts for the Canadian CPI inflation rate of 2.1% in 2026 and 2.1% in 2027.

Inflation impacts midwives through the increased costs of running their practices. Like physicians, midwives are responsible for the costs of running community-based clinics, including administrative staffing, rental costs, utilities, furniture, equipment, renovation costs, and other operational expenses. For midwives working in MPGs, an operational overhead fee accompanies each billable course of care (BCC). From 2019 to 2023, the fee was $744, and in 2023 it increased to $800 per BCC. This 7.5% increase did not sufficiently address the 16.4% inflation during that same period. The fee has not increased since 2023, leaving midwives to cover the shortfall. Without increases, midwives must cover the difference, amounting to a pay cut.

Midwives must employ and retain administrative staff. The average hourly wage in Ontario increased by approximately 5% in 2023 and 5.2% in 2024.

The AOM acknowledges the impact of US tariffs on slowing economic growth, disrupting the industrial sector, and raising the cost of living for Ontarians. Real GDP, the broadest measure of economic activity, is projected to rise 0.8% in 2025, 0.9% in 2026, 1.8% in 2027, and 1.9% in 2028. This follows real GDP growth of 6.1% and 4.1% in 2021 and 2022, respectively, and 1.7% and 1.5% in 2023 and 2024, respectively.

The Ontario government has experienced consistent revenue growth and budget surpluses in recent years. In the current fiscal year (2025-2026), the province has projected revenue of $223.1 billion, $3.2 billion above the forecast in the 2025 Budget.

The 2025 budget also maintains a $1.5 billion contingency fund to offset additional expenses that may materialize before the end of the fiscal year. In its 2023 budget, the Treasury Board set aside $3.9 billion in its contingency fund to pay for expenses such as Bill 124 redress and catch-up compensation arising from the Bill 124 court decision. Similar planning was incorporated into the 2024 budget. The 2025 budget includes significant investments in the healthcare sector.

The AOM emphasizes that I should consider the gendered impact of considering the province's financial situation in the compensation analysis. Midwives should not be denied normative and equitable compensation increases that are provided to their physician comparators. Midwives should not be responsible for subsidizing essential public services by accepting substandard compensation.

The MOH delayed responding to the AOM's November 2024 proposal for approximately one year. The prejudice of the MOH's delay is obvious and should not be borne by midwives: the AOM's proposal was made during a period of unquestionable economic strength. It was only recently that Ontario downgraded its economic outlook from strong to resilient because of the imposition of US tariffs in spring 2025.

29. Sustainability of the Health Care System

According to the AOM, midwives contribute not only to improved patient and caregiver experience and improved population health but also to reduced per capita health care costs. Midwifery care outcomes support a stable health system by preserving hospital capacity through avoiding hospital visits, reducing hospital stays and promoting earlier discharge, reducing unnecessary medical procedures and interventions, reducing surgical waitlists, easing pressure on Emergency Departments, providing the right care in the right place, and promoting public health and access to care for at-risk expectant families and other communities of need.

The AOM states that the MOH manages the supply of caseload for MPGs and funded positions for IMPs and EMCMs, as well as the distribution of midwifery services across the province. This management partly considers consumer demand/need across the province, as well as attempts to ensure the success of Midwifery Practice Groups (MPGs) to leverage past government investments (preventing MPGs from being in direct competition with each other). As a strategy, the MOH maintains midwife supply below demand. Data collected through BORN-Ontario indicates that each year in Ontario, approximately 6,000 people seeking midwifery care are initially unable to be accommodated because practices are full. About 30% of these prospective clients will eventually receive midwifery care during their pregnancy (delayed access), but over 4,000 are unable to access midwifery care at all.

Because pregnancy, labour and delivery are unpredictable, unscheduled, and the Ontario Midwifery Program is a managed program with tight controls on volume of services, a course of care fee is a method that, to some degree, stabilizes funding for midwives or at least minimizes a penalty to midwives when clients' care requires consultation or transfer to an obstetrician. The model of payment was developed for midwives to be able to invoice a course of care for 12-weeks of care, regardless of gestational age at the time of admission to care and regardless of the outcome of the birth, to protect midwives from unpaid work, although as described below, there is no mechanism for midwives to be paid for care less than 12 weeks, resulting in unpaid work for courses of care that do not meet the 12 week threshold such as early pregnancy loss.

The AOM stresses that midwifery is not interchangeable with existing health human resources for physician care. It is a model of care that is in high demand, delivering valued benefits to the nearly 30,000 families who access it each year. Primary care providers typically refer their pregnant patients to another provider by 20 weeks of pregnancy, so the assertion that the bulk of prenatal and postpartum care could be done by existing health human resources is wrong and ignores the ongoing primary care crisis in Ontario. Hospitals are struggling to manage with nursing staff and bed shortages, impacting patient flow. In many hospitals, midwives, who typically do not use labour and delivery nursing support, are often told they cannot transfer to a postpartum unit due to a lack of available beds or that they cannot receive assistance, such as breaks, from the nursing staff.

The MOH's definition of low-risk does not reflect the demographics of people who use midwifery care in Ontario. One quarter of midwifery clients are 35 years of age and older, with almost 5% aged 40 years or older. Midwives autonomously manage inductions of labour (when their scope of practice is not restricted by hospitals or physicians), making the "spontaneous labour" category too narrow to capture these midwifery clients. Clients can move in and out of risk categories throughout their pregnancies; they may begin as low risk but develop complications, many of which can be managed under midwifery care, at times in consultation with a specialist physician. Midwifery care is well -suited for clients across risk strata, with evidence that the risk of adverse neonatal outcomes is consistently lower than for clients with a physician as MRP.

In reply to the MOH's comment that 39.5% of midwifery clients are delivered by obstetricians, the AOM points out that 93% of those clients are transferred back to the midwife.

The AOM submits that there are fewer than 900 midwives actively practicing in Ontario. The province's annual midwifery budget is estimated at approximately $208.9M in 2025-

26. This represents a 0.23% of the total healthcare budget for Ontarians, which is over $90 billion. A 1% increase to the midwifery budget costs the MOH approximately $2M, or a 0.002% increase to the total healthcare budget.

30. Comparator and Settlement and Arbitrable Trends

The AOM provides that relevant comparators provide objective data in support of replicating a free bargaining outcome. They are the terms and conditions of employment prevailing in the labour market for similar healthcare professionals doing similar work.

The midwives' comparators, as confirmed by the HRTO, are physicians – specifically family physicians employed at CHCs and FHTs (blended salary model), as well as obstetricians, and Nurse Practitioners employed at CHCs. As noted by the HRTO, the Nurse Practitioners serve as a baseline, above which midwives' compensation should be maintained.

They argue that -

> the MOH seeks to replace the parties' benchmark comparators – which were determined by the HRTO and two levels of court to be fair and appropriate based on an extensive evidentiary record tested under cross-examination – with less appropriate and less comparable workers in different sectors of the economy. Moreover, the MOH does not establish a "firm factual basis" for "compelling circumstances" which render the benchmark physician comparators suddenly inappropriate.

Further, the AOM points me to the HRTO Liability Decision[10] in support of their position –

> [299] The MOH led considerable evidence from CHC physicians about their work, education and training to demonstrate how different they are from midwives. As I indicated previously, it is not my role to conduct a job evaluation. The MOH agreed at regulation that CHC physicians were an appropriate comparator. Morton, Hay and Courtyard all validated the ongoing relevance of the comparison. Until the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for compensation purposes, I find this position to be speculative. What makes the position of the MOH even more difficult to accept is that it promotes family physicians and midwives as comparable obstetrical providers, equally competent to care for women with normal pregnancies.

[10] 2018 HRTO 1335 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/hvb9p.

The AOM provided settlement trends in the healthcare sector for OMA-represented physicians and the ONA-represented nurses as evidence of relevant labour market trends in Ontario.

- Arbitrator Kaplan awarded physicians in Ontario a normative increase of 3%, in addition to 6.95% for redress/catch-up for real losses experienced as a result of Bill 124 impacts and high inflation for the first year of the contract, April 1, 2024. Normative increases for Years 2, 3, and 4 were left open for the parties to negotiate, but were ultimately awarded by the Board in its 2025 decision and targeted increases for specific health care programs and benefits.
- Arbitrator Price's award in *Participating Hospitals v ONA*, the two-year contract commencing April 1, 2025, for approximately 62,000 nurses, nurse-practitioners, and allied healthcare professionals in 71,000 full-time and part-time positions at 127 Participating Hospitals in Ontario. Arbitrator Price awarded general wage increases of 3% in 2025 and 2.25% in 2026 for RNs and RPNS, and NPs, and other compensation gains, i.e., the removal of grid steps and benefit improvements.

The AOM provides three reasons why the mediator should not consider any comparator other than the OMA physicians:

i. The MOH expressly delayed the AOM's negotiations on the basis that it required Arbitrator Kaplan's OMA interest arbitration decision on physician compensation (eventually released mid-September 2025) before responding to the midwives' compensation proposal.

ii. It is absurd for the MOH to, on the one hand, deny the appropriateness of midwives' physician comparators based on asserted differences in the SERW of these primary care professions (notwithstanding the MOH acknowledges their overlapping scopes of practice), yet on the other hand the MOH says nothing about the extreme differences in the work, employers, and sectors of the economy of its preferred comparators.

iii. The Tribunal emphasized that the MOH "remains free" to set midwives' compensation "unilaterally" where it reaches an impasse with the AOM, "so long as its actions comply with the *Code*". The MOH is responsible for ensuring its compensation practices are non-discriminatory.

31. Other Jurisdictions

The AOM describes midwifery compensation in BC. Midwives there received the following increases in part to address recruitment and retention issues: April 1, 2022 -

3.24%; April 1, 2023 - 6.75%, and April 1, 2024 - 2% plus potentially another 1%. Additionally, the contract included, for the first time, 52% funding for operational overhead, recognizing the costs of running their practices.

The AOM goes on to advise the mediator that the Tribunal ordered that the MOH's focus "should be on comparing midwives to other primary health care providers in the same economic market, as compared to other jurisdictions."[11]

32. The AOM acknowledges the prevailing economic realities asserted by the MOH; however, it maintains that those realities do not negate its capacity to provide meaningful redress. After more than a decade of constrained wage increases, compounded by political considerations that have suppressed compensation growth for midwives, the MOH has the means to address this longstanding imbalance. The relief sought does not reflect a disregard for economic conditions, but a necessary correction to sustained and systemic undercompensation.

Ministry Submissions

33. The Ministry's submission focuses on the current Ontario economy and its impact on government expenditures, which fund the public health care system. The government is committed to protecting the health care system; therefore, it must have a measured financial approach for the next three years. It is with this viewpoint that they offer normative public-sector increases to the midwives.

34. Economic Climate

The MOH states the economy has changed:

a. Inflation is lower at about 1.8%. The Bank of Canada has lowered its benchmark rate eight times since June 2024 to curb and reverse high inflation. The MOH's offer to midwives now exceeds inflation.

b. The economy is softening. Trade tensions and tariff risks persist. This impacts Ontario's export environment.

c. There is rising unemployment. Ontario's unemployment rate is higher than Canada's unemployment rate. Job loss in the industrial sector has occurred and may continue.

[11] Ontario v. Association of Ontario Midwives, 2020 ONSC 2839, https://canlii.ca/t/j8f65.

d. Per Capita GDP has declined, and economic growth has been modest recently. This measure has fallen in 8 of the past 10 quarters.

e. Real GDP, reflecting economic growth, has been moderate and experienced fluctuations.

f. Ontario's debt remains sensitive to interest rate changes.

35. Sustainability of the Health Care System

Health care spending must be managed responsibly. The Ministry argues that the cost of midwifery services under the Course of Care model exceeds that of an OB-GYN. Some of the fees are duplicated in the system e.g., when care is transferred to an OB-GYN and for rostered primary care patients whose team is receiving monthly payments.

The Ministry sets out that midwives are not the only profession providing low-risk obstetrical services. These are services that are provided by both Family Physicians and OB-GYNs. However, the current "course of care" fee model for midwifery services imposes significant limitations on the program's scalability. The course of care model, as established in collaboration with the AOM, results in fewer patients being cared for per midwife than other providers. This is because the course of care fee model results in midwives spending a greater amount of time with clients and having availability for a smaller number of patients than that of physicians. The course of care fee model funds midwives based on 48 hours of dedicated service per client, plus access to 24/7 on-call. The model results in a greater cost of providing services to low-risk patients than other providers.

The Ministry reviewed the cost of care provided by an OB-GYN to a pregnant person and their newborn for the same period of time, to which a Midwife provides care, for similar services (low-risk obstetrical care). The cost of provision of care for a pregnant person under the Midwifery course of care model is significantly greater than the cost of that care by an OB-GYN.

Additionally, the MOH advises that there can be funding overlap between multiple providers for pregnancy-related health services to the same midwifery client. This often results in double payment across providers. For example, most of the prenatal and postpartum care a midwifery client receives would have been included in the standard monthly payments the primary care team already receives for patients rostered to it.

36. Labour Market Assessment

The MOH argues that for other services, i.e., physicians, there is urgent and growing demand, with insufficient human resources to meet it. Specifically, the Ministry says the

number of RMs has increased steadily; the number of Ontario births has remained steady; growth in low-risk pregnancies, in particular, is not expected; and midwives are not the predominant providers of deliveries in Ontario, and the system has alternatives to midwifery. The Ministry has offered growth for the Indigenous Midwifery Program.

37. Comparator

The Ministry argues physicians are not the appropriate comparator. While the work of midwives and physicians intersects, it differs in terms of skill, effort, responsibilities, and working conditions. The JCS is not complete and cannot be relied upon for these negotiations.

To support its position, the Ministry provides a history of Midwifery Compensation Policies. The Ministry stated –

> The Tribunal did not make a determination that further adjustments may be owing to Ontario midwives in order to address gender discriminatory pay. The Tribunal set out a process to be followed by the parties to reinstate the benchmarks, so that MOH recognizes the role of gender in the compensation of Ontario's midwives. Particularly, the Tribunal confirms that "*the study will inform the negotiations between the parties but will not be binding on them*." 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*."

The Ministry provides arbitration examples to support their position that historic relationships are not permanent for the purpose of comparators. They set out examples such as Interns and Residents salary relationship to doctors, Registered Technologists (OPSEU) in public hospitals, and wage parity to Registered Nurses (ONA), Registered Nurses in nursing homes, and wage parity with Registered Nurses in hospitals (both represented by ONA), etc. In these cases, the historical comparator has changed over time through settlements and arbitrated outcomes.

In summary, the MOH states –

> The Ministry has set out examples where an arbitrator makes a definitive finding of comparability between two classifications and subsequently the "parity" principle is relied upon by one of the parties in future arbitration proceedings. This "parity" principle being relied upon is challenged by the other party and the subsequent arbitrator does not feel confined by "res judicata" or "issues of equity or fairness" or "equal pay for work of equal value". That subsequent arbitrator "replicates" what he

or she felt in all the circumstances would have been the result of free collective bargaining.

Physicians are not an appropriate comparators for midwives. Though their work is intersecting, there are key differences with respect to the skill, effort, responsibility and working conditions of these professions. Even if it were the case that physicians were a historic comparator for the purposes of compensation increases, there are demonstrated reasons why the midwife's relationship to physicians should not continue.

38. Settlement and Arbitrable Trends

The Ministry states arbitrators are followers of freely negotiated settlements, and the mediator must look to the settlement and arbitrable trends and provides caselaw to support their position.

The Ministry submits the mediator should appropriately consider the current economic situation in her recommendations, which no one is describing as temporary. While recent layoffs and closures make it clear that the economy is in trouble, many are saying the complete impacts of the slowdown are not yet reflected in the economic data which has an embedded time lag.

Further, the Mediator should be aware that there have been a significant number of settlements in 2025 and following that fall in the low 2% range, and certainly for 2026 and 2027. While not many settlements or awards extend into 2026 and even fewer into 2027, the increases in those years are lower than the current trends established in 2024.

The ministry submitted that interest arbitration decisions consistently support replication as an objective, evidence-based process, and that such a process reflects the economic environment. When considering the principle of replication, note that arbitrators necessarily look to the economic environment and prevailing economic conditions rather than subjective notions of fairness or social judgment.

The ministry encourages the mediator to consider "total compensation," which encompasses all compensation items that accrue to employees including wages and all other forms of employee benefits, both direct and indirect, that represent a cost to the employer. Any premium increases must be considered as part of the whole, not in isolation e.g., on-call and early discharge. Further, some premium proposals are intertwined and compensated through the course of care model, which was negotiated based on a bundle of services.

The ministry provided new bargaining outcome trends in healthcare, and the public and broader public sectors over the last three months, noting that increases are now lower than the arbitration awards for the OMA and ONA. The ministry submitted that the following recent CUPE settlement and SEIU award for the Hospital Master Groups are particularly relevant points of reference, reflecting outcomes the parties have achieved in the health care sector in a changed economic environment.

- A negotiated settlement dated November 23, 2025, between CUPE and Participating Hospitals provided wage increases on September 29, 2025 of 2.25%, September 29, 2026 of 2%, and September 29, 2027 of 1.75%. The settlement also included other compensation improvements to vacation entitlement, standby premium increases, and benefits.

- An arbitration award (Arbitrator Kaplan) dated December 15, 2025 provided wage increases January 1, 2026 of 2.25%, January 1, 2027 of 2%, and January 1, 2028 of 1.75%. The award also included other compensation improvements to vacation entitlement, standby premium increases, and benefits.

39. Retention and Recruitment

The Ministry says – The current conditions for the provision of Midwifery services are unlike those that determined the recent compensation outcomes for other health sector providers, which provided an above-normative increase, particularly with respect to Ontario's physicians. Specifically, in these other health sector outcomes, there was a determination of an urgent and growing demand for services such as primary care or access to care in emergency departments and insufficient human resources to meet the demand. In the Participating Hospitals and ONA (unreported award dated April 25, 2023), Arbitrator Kaplan determined the terms and conditions for Registered Nurses and Nurse Practitioners at 127 Participating Hospitals in Ontario. Arbitrator Kaplan awarded compensation increases in recognition of the evidence that there was a nursing recruitment and retention crisis in Ontario's hospitals. In both cases, Arbitrator Kaplan accepted there were shortages and in the case of family medicine, a growing demand that must be addressed by wage increases as part of the solution.

Further, the Ministry does not forecast a significant increase in demand for low-risk obstetrical care, nor in the overall number of births. Midwives provide care for approximately 19% of pregnant people who give birth; others provide the remainder of the care. Of those pregnant individuals care for by a midwife, approximately 39.5% of those clients had their baby delivered by an OB-GYN.

The Ministry advises that even if there were to be a greater demand in low-risk obstetrical care, which is not projected, Ontario has the health human resources to address this demand within the current Ontario Midwifery Program. The number of midwives in Ontario has continued to grow year over year, as provided by the Ministry in the table and statement below.

Workforce in Ontario	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Midwives	652	611	647	732	770	787	796	815	809	832	898

Between 2018 and 2024, the number of registered midwives who are currently practising in the profession at some capacity increased by 16.6% (or 128 midwives). This does not include registrants that are not practising (i.e., on leave, seeking work in the profession or working outside the profession). Contrary to the AOM's assertions regarding a labour and supply issue, the midwifery workforce has significantly increased since 2014. From 2023 to 2024 alone, the profession increased by 66 midwives.

40. Other Jurisdictions

Midwives are well compensated in comparison to other Canadian midwives. The Ministry provides examples only from Alberta and British Columbia (BC). Neither province compensates midwives under the course of care model. The Ministry assumes their 2.7% offer into their calculations, concluding that Ontario midwives earn more than those in Alberta and marginally less than those in BC.

41. The ministry concludes their submission with the following:

> It is an arbitrable principle that arbitrators must be sensitive to the broader economic realities and avoid decisions that would fall out of step with prevailing market conditions. The Ministry submits the mediator should consider that the Government's offer to midwives is that of a normative increases. The Ministry submits it would not be appropriate to provide further investments to an already costly program (where there currently does not exist an access to care issue from a low risk obstetrical care perspective). This is particularly the case given the competing demands on limited health care dollars, and the government's commitment to enhancing access to care.

Discussion

42. I am mindful that this is the first time the parties have engaged in mediation and utilized the language in the Memorandum of Understanding (MOU). The limitations (monetary recommendations only are within scope) of the terms of the MOU make it problematic for a mediator to provide meaningful recommendations that will assist them to satisfactorily conclude negotiations for a multi-year contract. Normally, monetary and non-monetary proposals are considered together to provide a fulsome, connected and balanced bargaining outcome. My recommendations will only provide a monetary lens.

43. The parties have a complicated legal history (Human Rights Tribunal of Ontario and subsequent appeals) that significantly impacts their decision-making. The Joint Compensation Study has been underway for approximately 5 years, with the Compensation Experts Report unavailable to inform this round of negotiations. This continues to be "the elephant in the room".

44. Both parties have an interest in moving forward from the findings of gender discrimination in women's compensation. Ultimately, the JCS will assist when a new and/or updated comparator is determined, and the parties determine whether a wage gap is to be remedied.

45. In the meantime, I must consider the needs of the parties to conclude these negotiations, considering my mandate and the agreed factors, while not perpetuating the findings of the HRTO.

46. To complicate matters, I must consider the following factors that impact the labour relations environment:

    - Bill 124 was determined to be unconstitutional. Many other public sector workers have received redress; the midwives have not.
    - The parties dispute whether there is a significant retention and recruitment issue.
    - The impact of the changes in Ontario's economic situation on these negotiations.
    - The impact of delay and timing of the negotiations.

Findings

47. Before I make recommendations regarding the parties' outstanding monetary proposals, including which proposals are within the scope of this mediation, I must determine whether there is a significant retention and recruitment issue. I must consider the

principle that midwives' compensation should be fair and appropriate. Therefore, I must consider the HRTO's decisions when determining who the midwives' comparator is for these negotiations.

Retention and Retention

48. I conclude that there is a retention and recruitment issue.

The ministry numbers illustrate 932 midwives are billing in 2024-25 in MPGs. MPGs advertise their vacancies on the AOM website. Of these 932 positions, the AOM submits that there are currently 78 vacancies, 43 permanent and 35 temporary positions, equalling an 8.37% vacancy rate in a small profession. Additionally, there are midwives in small rural and remote practices who are unable to have annual leave because there is an insufficient number of midwives working as locums to cover their leave.

This is a small workforce; growth in the profession is only 1-2% annually, which is insufficient to sustain it. The AOM provided statistics from the College of Midwives of Ontario's data that demonstrate an attrition crisis: 60 (5.5%) resignations in the first three quarters of 2024-2025. This number is almost double for the individual full years of 2015-16, 2016-17, 2017-18, 2018-19, 2019-20, 2020-21, 2021-22, and 2023-2024.

This retention and recruitment issue may not be as significant as that of ONA-nurses or OMA-physicians; however, the real impact of the crisis is disguised by midwives within MPGs taking on additional courses of care to cover absences/vacancies by cancelling vacations and time off. While the ministry data shows a 92% utilization rate, this rate does not reflect utilization covered by midwives other than those assigned to the course of care.

The Ontario Midwifery Program has experienced minimal growth over the last five years; however, the data provided indicates a significant waitlist for midwifery care. The ministry manages the number of courses of care available to the Midwifery Program. These numbers have not changed in at least 5 years. The ministry, in its submission, says that to determine a recruitment and retention issue, there must be "a determination that there was an urgent and growing demand for services such as primary care or access to care in emergency departments and insufficient human resources to meet the demands." In this tightly managed sector, as set out above, it is not possible to assess recruitment and retention based on this factor, except by reviewing data collected through BORN-Ontario. It is important to note that, unlike primary care physicians, where a patient can be waitlisted for an indeterminate amount of time, clients seeking midwifery care are only seeking care for approximately 9 months, the duration of a normal pregnancy.

This data indicates that, each year in Ontario, approximately 6,000 people seeking midwifery care are initially unable to be accommodated because practices are full. About 30% of these prospective clients will eventually receive midwifery care during their pregnancy (delayed access), but over 4,000 are unable to access midwifery care at all. This data demonstrates an unmet growing demand for services.

This is a new retention and recruitment crisis. Only two Ontario universities are providing the Midwifery Education Program. They can graduate 90 new registrants annually. These programs report that almost 25% of new registrants annually register outside of Ontario.

While compensation alone will not resolve the crisis, the ministry can work with the AOM to correct the other drivers of recruitment and retention.

Impact of HRTO Decisions

49. The Ministry stated –

> The Tribunal did not make a determination that further adjustments may be owing to Ontario midwives in order to address gender discriminatory pay. The Tribunal set out a process to be followed by the parties to reinstate the benchmarks, so that MOH recognizes the role of gender in the compensation of Ontario's midwives. Particularly, the Tribunal confirms that "*the study will inform the negotiations between the parties but will not be binding on them*." 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*."

The Ministry states that its proposal is compliant with the *Code* –

> The Ministry submits that the compensation study is not done in order to inform this round of negotiations. However, the Ministry does submit that it has put a gender lens on the negotiations with midwives. It has reviewed the economic situation, the impact this has had on broader wage trends, and particularly, the wage trends in the broader public service which would include both male and female job classes. It has offered midwives a compensation adjustment in line with those trends. It has reviewed the physicians' compensation adjustments and the reasons for those adjustments, and found that conditions around recruitment and retention was a factor in those outcomes, and such conditions do not exist for Midwives. This is a non-discriminatory reason for a difference in compensation.
>
> The Ministry submits that the Mediator does not need to name a specific comparator in coming to her recommendation. As both parties submitted, the mediator should

consider the principle of replication in coming to her recommendation - "replicate" the agreement the parties would have settled for in a free bargaining environment, avoiding a strike or lockout. The Ministry has provided the range of factors the Mediator should consider in coming to this agreement, including wage trends in the broader public service.

50. On the other hand, the AOM says the mediator need not look at labour market trends and any other comparator beyond the OMA decision. The CHC physicians are covered by the OMA decision and remain their comparator until the JCS is completed. As set out above, the AOM pointed me to the HRTO Liability Decision paragraph 299, which simply stated that until the JCS (job evaluation) is complete, the CHC physicians are the appropriate comparators.

51. I have reviewed the HRTO and Court decisions. I find no reason to deviate from these decisions based on the following paragraphs:

Liability Decision[12]

> [299] The MOH led considerable evidence from CHC physicians about their work, education and training to demonstrate how different they are from midwives. As I indicated previously, it is not my role to conduct a job evaluation. The MOH agreed at regulation that CHC physicians were an appropriate comparator. Morton, Hay and Courtyard all validated the ongoing relevance of the comparison. Until the MOH produces a job evaluation which concludes that midwives and CHC physicians are not comparable for compensation purposes, I find this position to be speculative. What makes the position of the MOH even more difficult to accept is that it promotes family physicians and midwives as comparable obstetrical providers, equally competent to care for women with normal pregnancies.
>
> [301] There was an overemphasis by the MOH on jurisdictional comparators for midwives which was evident in the observation by the MOH that Courtyard's recommendation for a 20% adjustment did not correspond with what midwives were earning in other jurisdictions. The Morton report defines 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." This is not to suggest that a jurisdictional scan cannot be considered, but it cannot replace

[12] 2018 HRTO 1335 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/hvb9p.

the principle that midwives must also be compared to other health care professionals working in the same economic market.

[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. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17, para. 38. 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. It has been a recurring theme for midwives that their autonomous model of practice has not been well understood. This problem was embodied by the comment attributed to a Minister of Health who reportedly said that compensation for midwives was "pretty good for a four-year degree".

Remedial decision[13]

[118] During the merits hearing, the MOH called witnesses to explain the various increases given to physicians to address issues like recruitment and retention, or the disparity between the lowest paid, female-dominated CHC physicians and their counterparts working in other models. Some of these strategies turned out to be ineffective in addressing the problems they were intended to resolve. 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.

52. I have reviewed the HRTO documents and the parties' submissions regarding other labour market comparators, and settlements, and trends. I have noted the following caselaw statements regarding comparability and their applicability in the matter at hand.

Arbitrator Price (Participating Hospitals v Ontario Nurses' Association, 2025 CanLII 89205 (ON LA)[14] noted that –

[13] 2020 HRTO 165 (CanLII), Association of Ontario Midwives v Ontario, https://canlii.ca/t/j5f8b.

[14] Participating Hospitals v Ontario Nurses' Association, 2025 CanLII 89205 (ON LA), https://canlii.ca/t/kf7nz.

> [55] The principle of comparability is closely related to replication, the presumption being that, where industry norms can be identified, parties would be unlikely to have deviated too far from what their similarly situated peers have agreed to: *Ontario Nurses' Association v. Strathroy Middlesex General Hospital*, 2012 CanLII 14936 (Goodfellow) at p. 8. The parties' own history can also provide guidance as to the bargain that the parties themselves would have struck if left to their own devices.

In Ontario Nurses' Association v. Strathroy Middlesex General Hospital,[15] Arbitrator Goodfellow said –

> Here, as I have recently observed elsewhere, in this most normative of sectors (Hospitals) in this most normative of industries (Health Care) the most important marker has become "comparability": what is the "norm" amongst comparable groupings of employees in comparable workplaces. Where such a norm exists, depending upon its strength, it will be taken either as a starting point or, in some instances, as something very close to a finishing point, barring something extraordinary. In this way, the wheel is not reinvented and certainty and predictability are afforded.

I have noted that the parties paused these negotiations twice to ensure bargaining was informed by the outcomes of the Ontario v Ontario Medical Association, Kaplan decisions.

To ensure the parties remain *Code* compliant and that the wage gap, if any, does not widen, I find that the comparator should remain the CHC physician until the job evaluation is completed.

Recommendations

1. AOM Proposal - Term – April 1, 2024 to March 31, 2028

   MOH Proposal – Term - April 1, 2025 to March 31, 2028.

   I recommend that the parties agree to a term encompassing the changes set out below and the Interim Arrangement from April 1, 2024 to March 31, 2028.

2. AOM Proposal - Normative Compensation increase of 3.5% in year 1 (2025-26), 3% in year 2 (2026-27) and 2.75% in year 3 (2027-28). To be applied to six (6) Courses of Care

[15] Ontario Nurses' Association v Strathroy Middlesex General Hospital, 2012 CanLII 14936 (ON LA), https://canlii.ca/t/fqqtk

Fees – Experience, On-Call, Secondary, Retention, and Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R") and the midwife income portion of Parental Leave and Locum grants.

MOH Proposal - Compensation increases of 2.7% effective April 1, 2025; 2.0% effective April 1, 2026 and 2.0% effective April 1, 2027.

The AOM has already received a 3% increase for April 1, 2024 to March 31, 2025, through the interim agreement signed on March 1, 2024. The 3% applies to each of the Experience, On-Call, Secondary, Retention, and Benefits, and the Rural and Remote and Far North Experience Fee Supplements in the TPA-MPG Agreement and to midwife salary funding in Expanded Midwifery Care Models (EMCMs), Indigenous Midwifery Programs (IMPs), Schedule Q, and Schedule R.

I have determined that the appropriate comparator is the CHC physicians covered under the OMA agreement. Arbitrator Kaplan (Ontario v Ontario Medical Association, 2025 CanLII 94270 (ON LA)),[16] in his award dated September 17, 2025, awarded general normative increases of 2.8% in Year 2, 2.5% in Year 3, and 2% in Year 4.

Therefore, **I recommend** that the parties agree to general normative increases:

April 1, 2025 – March 31, 2026 – 2.8% retroactive increase.
April 1, 2026 – March 31, 2027 – 2.5% increase.
April 1, 2027 – March 31, 2028 – 2% increase.

Further, these normative increases in each year will apply to each of the Experience, On-Call, Secondary, Retention, and Benefits and the Rural and Remote and Far North Experience Fee Supplements in the TPA-MPG Agreement and to midwife salary funding in Expanded Midwifery Care Models (EMCMs), Indigenous Midwifery Programs (IMPs), Schedule Q, and Schedule R, and the midwife income portion of Parental Leave and Locum grants.

3. AOM Proposal - Bill 124 Redress of 8.75% retroactive to April 1, 2024. Retroactive redress to be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R"). Code-protected leave payments

[16] Ontario v Ontario Medical Association, 2025 CanLII 94270 (ON LA), https://canlii.ca/t/kfgc1.

(parental and disability) would also be covered by this redress amount in a lump sum retroactive payment through a methodology agreed to by the Parties.

Before making a recommendation for this proposal, I must first determine if the factors Arbitrator Kaplan used to award the Redress/Catch-up are relevant to the midwives.

Recruitment and Retention, and Midwives are Seeing Fewer Clients

As set out above, I have determined there is a recruitment and retention issue.

Is the issue as severe as the physicians experience? It is difficult to compare the crisis. Midwives are currently providing 92% utilization of available courses of care. I do not think this reflects the true extent of the issue. As the AOM points out, other midwives are taking over the care of clients whose primary care midwife has vacated a caseload for a variety of reasons, e.g. illness, parenting leave, resignation. To do this, they are accepting the care of additional clients and cancelling vacations or leaves and/or accepting additional on-call and cancelling time off. There are insufficient locum midwives to cover the requested leave, resulting in midwives who need time off in small rural and remote practices to cancel their plans and continue working. This will exacerbate the retention and recruitment crisis.

The Ministry's BORN-Ontario data indicates that each year in Ontario, approximately 6,000 people seeking midwifery care are initially unable to be accommodated because practices are full. Only about 30% of these prospective clients will eventually receive midwifery care during their pregnancy (delayed access), but over 4,000 are unable to access midwifery care at all. This data demonstrates an unmet growing demand for services.

Resignation rates have doubled in 2025. The vacancy rate is currently at least 8.37% in a profession with small numbers.

Arbitrator Kaplan, in the ONA and OMA decisions, asked whether compensation can be a key driver of recruitment and retention? In this case, compensation can be a key driver in recruitment and retention. Midwives' compensation increases have not kept pace with inflation. From 2013-2024, midwives received 10.8% cumulative increases versus 29.5% inflationary rate increase. As the ministry points out, midwives also received a 20% increase in 2020 awarded by the HRTO; however, this was compensation for historic (2005-2012) gender wage discrimination. Midwives have been waiting since 2013 for a

new job evaluation to determine if the systemic gender wage discrimination persists and redress.

Midwives are Not Employees, but They Are Not Independent Contractors Either

Like Arbitrator Kaplan, I do not entirely accept the Ministry's independent contractor paradigm. Running an MPG is like running a small business, except midwives (like physicians) cannot set their own prices, and unlike physicians, midwives' courses of care are capped at 40 per fiscal year.

Midwives can set their own hours; however, they must be available (for periods of time) to provide 24/7 call and deliver babies regardless of time of day. Their work is highly regulated and tightly controlled within a government program. They must also pay the overhead costs of running a practice out of their compensation package.

Price Governs Not Total Compensation

It is true that these negotiations are about setting price, and my mandate is to make monetary recommendations to assist the parties in satisfactorily concluding these negotiations; however, I understand and am not indifferent to the ministry's submissions on total compensation. I do not accept that because midwives are well paid, this means they should not receive both labour-market-appropriate normative compensation increases and redress/catch-up for past losses, as established and described in this report.

Administrative Duties Must be Addressed

All professionals perform some administrative duties; this is part of the professional practice. Midwives have described their administrative burdens differently from physicians. MPGs have not received sufficient, dedicated funding for IT support to ease their administrative burdens. This includes hardware (computers/tablets) and medical software. This increases time spent using outdated equipment and/or sharing equipment. As small practices, midwives are also responsible for maintaining medical records and ensuring all aspects of their practice are working to meet regulatory requirements, for example, refrigerate temperatures, snow removal, etc.

Overhead

The ministry asserts that overhead is already covered by the Course of Care model. That is true, every Course of Care includes an Operational Fee. The AOM states –

> Like physicians in private practice, midwives are also responsible for costs for running community-based clinics, including administrative staffing, rental costs, utilities, furniture, equipment, renovation costs and other operational expenses. For midwives working in MPGs, an operational overhead fee accompanies each billable course of care (BCC). From 2019 to 2023, that fee was $744, and in 2023, the AOM negotiated an increase to $800 per BCC. This 7.5% increase did not begin to address the staggering inflation during that same period of 16.4%. The fee has not increased since 2023, leaving midwives to cover the shortfall as inflation rose an additional 4.4% in 2024 and 2025. Without increases to cover these escalating costs, midwives must cover the difference, essentially amounting to a pay cut.

The ministry has offered only normative wage increases; these will not adequately reimburse midwives for the costs of running their practices.

Arbitrator Kaplan addressed the impact of high inflation in R v Ontario Medical Association, 2024 CanLII 86115 (ON LA)[17] –

> The fact that inflation may now be easing is not an answer to the impact of this period of high inflation. Arbitrator Gedalof further noted in *Extendicare (10 Collective Agreements) v Canadian Union of Public Employees*, 2023 CanLII 44040 (ON LA) https://canlii.ca/t/jxbk7 that even though the inflation rate may decrease, "reduced inflation moving forward does not address the wage losses that have already occurred, and any rate of inflation that continues to exceed wage increases, as is the case here, further erodes wage loses." Arbitrator Steinberg referenced this passage in *Omni Health care v United Food and Commercial Workers, Local 175*, 2023 CanLII 59171 (ON LA), https://canlii.ca/t/jz107, commenting at paragraph 20 that without addressing the impact of inflation, "[t]he loss of real wages will be gone forever."

Redress/Catch-up After 2021

The OMA negotiations for the 2021-2024 settlements occurred under the shadow of Bill 124. The AOM and MOH entered a three-year contract (April 1, 2020 to March 31, 2023) on December 19, 2019. The contract contained increases of 1% total compensation for each year of the three-year moderation period, even though Bill 124 did not apply, and

[17] R v Ontario Medical Association, 2024 CanLII 86115 (ON LA), https://canlii.ca/t/k6rnn

there was no human rights exemption. The contract, like the OMA contract, did not contain a reopener if Bill 124 were found unconstitutional because the *Act* did not apply.

The OMA agreement covered 2021 to 2024 with 1% total compensation per year for the first two years of the moderation period. In addition, the third year included a unique gainsharing agreement with both upside and downside potential. Arbitrator Kaplan described the third year as –

> The third year is a little more complicated because a curated approach was required to address circumstances unique to physician expenditures; the result of patient behavioural changes directly associated with the pandemic. Accordingly, the parties developed what they believed was a mutually beneficial formula for compensation in the Year 3. The parties referred to this as a gainsharing agreement. The parties agreed, given decreased government expenditures on physician services, that the Year 3 increase (2023-24) would be determined based on the difference between what actual expenditures would have been in Year 3 has there not been a pandemic, a number arrived at based on historic increases in utilization, and actual expenditures. This approach did not, however, provide for additional inflationary or normative increases.[18]

Ultimately, the parties agreed to a third-year increase of 2.8%, leading to an overall total compensation increase of 4.8% (4.9% compounded). But for Bill 124, the parties would have negotiated normative increases for 2021 to 2024.

The physicians, like the midwives, found that bargaining when Bill 124 was in effect was a barrier to negotiating increases above 1% in total compensation.

As stated by Arbitrator Kaplan –

> Once Bill 124 was declared unconstitutional, and an even playing field restored, there was remediation across the OPS and broader public sector where Bill 124 had applied. In our view, and in the same way that it would have been completely inappropriate for Ontario doctors to have received increases well beyond other health care workers when Bill 124 was in effect – a point that was made perfectly clear in the bargaining that led to their negotiated agreement – it would be equally inappropriate and unjustifiable for them not to be treated generally the same when Bill 124 was successfully challenged and then repealed. Achieving some symmetry is required by replication.[19]

[18] R v Ontario Medical Association, 2024 CanLII 86115 (ON LA), https://canlii.ca/t/k6rnn.

[19] R v Ontario Medical Association, 2024 CanLII 86115 (ON LA), https://canlii.ca/t/k6rnn.

Inflation and Bill 124

AOM negotiations for the 2020 to 2023 contract were completed prior to inflation becoming a significant factor, rising to 6.8% in 2002, 3.9% in 2023. From 2021 to 2024, inflation total 15.1%. As with the physicians, there is no mathematical equation that puts Ontario's midwives anywhere but further behind economically at the end of the 2020 to 2023 period and the one-year 2023/2024 agreement that followed, than they were at the beginning of the time period. As Kaplan said, "That result, if allowed to stand, i.e., if the OMA's redress/catch-up claims were completed ignored as requested by the Ministry, would be neither fair nor reasonable, particularly when compared to other health care workers in general and other public sector and broader public sector employees."[20]

The need to address inflation in collective agreements was widely recognized in settlements and arbitration awards as set out above. The 3% increase agreed in the Interim agreement for midwives does not begin to address the redress/catch-up compensation eventually received by other health care groups.

The AOM received 4% uncompounded (1% per year for 2020, 2021, 2022 and 2003) over 4 years.

As set out in the Kaplan award[21] -

> To repeat, during that 2021-24 period, the OMA received, uncompounded, 4.8%. On the other hand, PARO received 9.25% (for two years, with the third year outstanding), ONA, 14.2%, CUPE/SEIU 12.65% and OPSEU 11.75% (retroactive). In 2024, ONA, CUPE/SEIU and OPSEU received a normative increase of 3%, so a total for these three groups over the period in question was 17.2%, 15.65% and 14.75%. Yet, the Ministry's position is that physicians, whose compensation is further reduced by overhead, should receive a total of 7.8% for that same four-year period: zero inflation redress/catch-up. This is not tenable; nor would it be fair or reasonable as required by the BAF. Notably, none of these other groups have had their incomes reduced by overhead (which was also impacted by inflation), and all these other groups received their redress/catch-up compensation retroactively. We are presented with a classic and compelling case for a normative increase plus redress/catch-up on account of unprecedented inflation in the pervious PSA. The issue is not the entitlement but the quantum.

[20] R v Ontario Medical Association, 2024 CanLII 86115 (ON LA), https://canlii.ca/t/k6rnn.

[21] R v Ontario Medical Association, 2024 CanLII 86115 (ON LA), https://canlii.ca/t/k6rnn.

Overall, after a thorough review of the principles relied upon by Arbitrator Kaplan, I find that a case has been made for redress/catch-up on account of inflation and Bill 124's impact during the prior agreements.

Also, in support of the finding for redress/catch-up is the need to maintain *Code* compliance. As set out above, the CHC physicians are the appropriate comparator. The HRTO said that, as one explains the reasons for physician increases, it must also explain how it maintained the benchmarks in its negotiations with midwives. A review of redress for Bill 124 and the impact of inflation is in keeping with the principle that midwives must also be compared to other health care professionals working in the same economic market. These reasons provide additional support for a recommendation for redress/catch-up for midwives.

The AOM requested Redress/Catch-up for the 6.95% awarded to OMA-physicians, plus an additional 1.8% the physicians received in 2023 under the gainsharing agreement effective April 1, 2024.

I recommend that the parties agree to Redress/Catch-up in the amount of 6.95% for all the reasons set out above, retroactive to October 1, 2024. Retroactive redress to be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R"). Code-protected leave payments (parental and disability) would also be covered by this redress amount in a lump sum retroactive payment through a methodology agreed to by the Parties.

The additional 1.8% requested by the AOM and received by the OMA-physicians under the gainsharing agreement is **not within the scope of mediation**. Both parties encouraged the mediator not to interpret the outcome of the JCS. Any recommendation regarding an adjustment for gainsharing would be an interpretation of the JCS.

4. AOM Proposal - Equity adjustment of 5% - The equity adjustment on all midwives' compensation to be applied to six (6) Courses of Care Fees – Experience, On-Call, Secondary, Retention, and Benefits and the Rural and Remote and Far North Experience Fee Supplements and on compensation funding (including benefits) for salaried models (i.e., EMCMs, IMPs Schedule "Q", and Schedule "R "). Code-protected leave payments (parental and disability) would also be covered by this equity adjustment in a lump sum retroactive payment through a methodology agreed to by the Parties.

This proposal is **outside the scope of mediation**. Both parties encouraged the mediator not to interpret the outcome of the JCS. Any recommendation regarding an equity adjustment would be an interpretation of the JCS.

5. Benefits Funding - The AOM proposes a 3.5% increase to benefits funding – from 20% ($21,243,634) to 23.5% ($24,961,270). The AOM proposes an additional $916,100 to the existing grants that fund parental leave, wellness, and Indigenous health supports. The AOM proposes the following non-monetary improvement: the ability for the AOMBT to create a reserve with unused grant funding.

   During negotiations, the AOM and its Benefits Trust provided extensive information regarding the insufficiency of the existing benefits amount. In 2023, the MOH proposed that funding for midwives' benefits be transitioned to a new global funding model rather than being funded through 20% of midwives' compensation. The 2023 MOU includes a shared commitment to this change. The MOH funded the AOM Benefits Trust (AOMBT) to explore the requirements and processes for transitioning to this new funding model. The 20% benefits funding covers both health and dental coverage, as well as a group retirement savings plan.

   The AOMBT presented detailed information to the ministry from their exploration of global funding, including the insufficiency of existing funding to cover the high rates of midwives' short- and long-term disability leaves and the waiting period of three months before midwives received any disability payments. The AOMBT presented about midwives' inability to adequately save for retirement through the existing benefit funding and the high proportion of midwives at risk of retiring into poverty.

   It is notable that midwives must wait three months to receive any short-term disability, which is below any industry standard.

   Recent settlements and awards for ONA and Participating Hospitals, CUPE and Participating Hospitals, and SEIU and Participating Hospitals have included other compensation enhancements, including benefit improvements. In the 2025 OMA Kaplan award, the arbitrator noted rising medical costs and escalating drug prices[22]. In this award, the physicians received a funding increase to the Physician Health Benefit Program in Years 2, 3, and 4 by the general increase.

[22] The Crown in Right of Ontario v Ontario Medical Association, 2025 CanLII 94270 (ON LA), https://canlii.ca/t/kfgc1.

I recommend, based on replication, that, effective April 1, 2026, benefits funding be increased by 3.5% to a total of 23.5% and an additional $916,100 be added to the existing grants that fund parental leave, wellness, and Indigenous health supports.

The AOM non-monetary proposal for the AOMBT to create a reserve from unused grant funding is **outside the scope of mediation**.

6. The AOM proposes Targeted Premiums:

   a. Retention premium - The retention premium for Level 6 midwives increase to $125/BCC, for Level 5 midwives to receive a premium of $100/BCC and for Level 4 midwives to receive $75/BCC (+3% on all x 3 years).

      I recommend that, effective April 1, 2027, based on the recruitment and retention crisis, the parties agree to increase the retention premium for Level 6 midwives to $75/BCC (currently $44.16), and add a new retention premium for Level 5 midwives to receive a premium of $60/BCC and for Level 4 midwives to receive $45/BCC.

   b. Faster access to care: - Increasing the on-call premium for both employee and MPG models.

      On call premium - MPG midwife:

      2025-26 - $880/BCC

      2026-27 - $906/BCC

      2027-28 - $933/BCC

      On call premium - Salary midwife

      2025-26 - $35,200/year

      2026-27 - $35,256/year

      2027-28 - $37,344/year

      I do not recommend increasing the on-call premiums further. This would be a duplication that neither accounts for the bundled cost approach of the course of care model nor for current economic conditions.

   c. Freeing up hospital beds: New incentive fee for Out-of-Hospital Birth for midwives who attend home, clinic and birth centre births.

      Out of hospital birth premium:

      2025-26 - $300/ home, clinic or birth centre birth

2026-27 - $309/ home, clinic or birth centre birth

2027-28 - $318.37/ home, clinic or birth centre birth

This proposal is a new premium. This is a ministry policy decision and is **outside the mediator's scope.**

d. Improving access to care at home and relieving pediatric pressures: New incentive for Early Discharge from hospital.

Early discharge premium:

2025-26 - $50.00/ discharge < 24 hours

2026-27 - $51.50/ discharge < 24 hours

2027-28 - $53.05/ discharge < 24 hours

This proposal is a new premium. This is a ministry policy decision and is **outside the mediator's scope.**

e. Optimizing midwives' scope of practice: New premium to incentivize midwives maintaining primary care within full scope of practice by adding a premium payment of $105/BCC to the Fee Schedule for all BCCs from eligible practices.

Full scope premium:

2025-26 - $105/BCC x 500 mw x 32 BCCs, $1,680,000

2026-27 - $108.15/BCC x 550 mw x 32 BCCs, $1,903,440

2027-28 - $111.39 x 605 mw x 32 BCCs, $2,156,510

This proposal is a new premium. This is a ministry policy decision and is **outside the mediator's scope.**

7. Supporting community-based practice: Sustainability Investments in Midwifery Practice Groups - The AOM proposes an increase of 3% annually to the operational fee, travel disbursements, equipment disbursements for midwives and MPGs, second attendant supplement and birth kits.

I recommend that, effective April 1, 2025, the normative increases in each year be applied to the operational fee, travel disbursements, equipment disbursements for midwives and MPGs, second attendant supplement, and birth kits.

8. Increases to AOM grants - 3% increases in each year for AOM grants to keep pace with rising costs and ability to provide government-funded programs and services to midwives

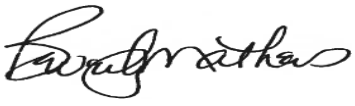
    - Renewal and Restoration Grant (Indigenous Midwifery).
    - HHR Capacity Grant.
    - Professional Development.
    - Rural and Remote & Far North Sustainability Program (Locum).
    - Midwifery Clinical Practice Guideline Development and Related Knowledge Translation Activities.
    - Supporting Midwifery Research Capacity Building.
    - Parental Leave*.
    - Retention and Wellness Investment*.
    - Wellness Spending Account for Indigenous Midwives*.

    *See proposal on Benefits for further detail about proposals regarding these grants

    Other than as previously recommended, this proposal is not direct midwife compensation and is **outside the mediator's scope.**

Thank you to the parties for your thoughtful presentations and replies. I am willing to providing any necessary clarification for my recommendations and look forward to working with you in mediation to resolve the contract.

DATED at Burlington, Ontario, this 6th day of January, 2026.



Beverly Mathers, Mediator