In the matter of an application under section 34 of the *Human Rights Code* to the Human Rights Tribunal of Ontario

THE ASSOCIATION OF ONTARIO MIDWIVES ACTING ON BEHALF OF COMPLAINANT ONTARIO MIDWIVES ("AOM")

Applicant

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTRY OF HEALTH AND LONG TERM CARE ("MOHLTC")

Respondent

SCHEDULE "A" TO FORM 1 APPLICATION

STATEMENT OF MATERIAL FACTS AND REMEDIAL REQUESTS

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INTRODUCTION

1. This application claims that the respondent Ministry of Health and Long-Term Care ("MOHLTC" or "Ministry") has and continues to set a discriminatory compensation/fee structure, through its past and current actions and funding directives, for the complainant registered midwives providing maternal and newborn care to Ontario women and newborns within the Ministry's Ontario Midwifery Program ("OMP").

2. This inequitable compensation is sex-biased and fails to provide pay equity or sex-based equal treatment with respect to employment and contracts. Such discrimination by the MOHLTC violates the midwives' fundamental human right to pay equity, and is contrary to the *Human Rights Code,* particularly sections 3, 5, 9, 11 and 12.[1] Such discrimination also arises because of the relationship of midwives with Ontario women, a protected group under the *Code.* This is because pregnancy and birth is a biological, genetic and gendered female experience.[2]

1. The Parties

a. Applicant Association of Ontario Midwives

3. The applicant Association of Ontario Midwives ("AOM") is the recognized representative of Ontario's registered midwives and has existed since the early 1980s. All registered midwives in Ontario are members of the AOM. The AOM advocates for the professional and employment interests of its members, provides public education, and promotes accessibility of midwifery care for women in Ontario. It represents the interests of midwives and the profession of midwifery regarding funding for midwifery services and does this by negotiating with the MOHLTC concerning, amongst other matters, the funding the Ministry pays to midwives for their compensation.

4. The applicant AOM is bringing this application on behalf of registered Ontario midwives.

b. Complainant Midwives

5. Registered midwives are autonomous primary health-care providers who are specialists in providing comprehensive around-the-clock, on-call, maternity care for women in low-risk pregnancies and their newborns until six weeks of age.[3]

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1 *Human Rights Code*, R.S.O. 1990, Chapter H.19.

2 Pat Armstrong, Kate Laxer, Hugh Armstrong, "Conceptual Guide to the Health Care Module: Conceptualizing Health Care Work", accessed at www.genderwork.ca

3 Note: Some Aboriginal Midwives because of their unique status are exempt from the above-noted licensing requirements and are not covered by the compensation structures at issue in this

Along with family physicians and obstetrician-gynecologists, they provide primary care in Ontario's maternity health-care system.[4]

6. Midwives provide such medical care in accordance with the *Midwifery Act, 1991*[5] and the *Regulated Health Professions Act, 1991*[6]. They have a specialist baccalaureate degree; one year of postgraduate mentoring and practice; and engage in ongoing education and upgrading as required by the extensive standards, guidelines and protocols of the College of Midwives of Ontario ("CMO").[7]

7. The Ministry describes the medical care provided by midwives as follows:

Midwife means "with woman". To midwives and their clients, pregnancy and birth are normal, healthy life events. Midwifery promotes normal childbirth and the prevention of health problems. In 1994, midwifery became an integrated part of the Ontario healthcare system and is provided free of charge to residents of the province. Midwives provide care in both the hospital and home setting.

A midwife is a primary caregiver, which means that she can provide all the care necessary for a healthy woman and her baby throughout pregnancy, birth and for six weeks afterward. Midwives refer women and babies to family doctors or specialist doctors like obstetricians and pediatricians if the care becomes complicated. Even if care is transferred to a doctor at the birth, midwives will remain involved in the care as a support to the mother and baby. As primary caregivers, midwives do the following:

(a) *care for healthy, pregnant women and their babies*;

(b) *see women for all prenatal visits and give prenatal education;*

(c) *order laboratory and ultrasound testing if needed;*

(d) *arrange for consultations with or transfers to doctors if needed;*

(e) *give some medications during pregnancy, labour, birth and the postpartum (after birth) period if needed;*

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application. See Association of Ontario Midwives, "Aboriginal Midwives - transforming care and healing communities" , accessed at <http://www.ontariomidwives.ca/care/aboriginal>

4 Nurses also play a key role in the maternity health-care system. However, they are not primary care providers through the prenatal, antenatal and postpartum period. See Courtyard Group Ltd., "Compensation Review of Midwifery", September 2010 [Courtyard Report]

5 *Midwifery Act, 1991,* S.O. 1991, Chapter 31.

6 *Regulated Health Professions Act, 1991,* S.O. 1991, Chapter 18.

7 Internationally trained midwives and midwives practicing prior to regulation are not required to have university degrees as their clinical experience is assessed to ensure it is equivalent.

(f) *take responsibility for primary care during labour, birth and postpartum including delivering the baby;*

(g) *examine the newborn and care for mothers and babies for six weeks after the birth.*[8]

8. Midwifery has grown from 68 registered midwives at the time of regulation in 1994 to nearly 700 registered midwives in 2013, of which approximately 659 are practising at this time.[9] At the time of filing this Application, 531 registered midwives have signed consents (Form 27) filed with this application authorizing the AOM to bring this application on their behalf.[10] Additional midwives will continue to file consents as the application proceeds and as new graduates enter the profession.

c. The Ministry of Health and Long-Term Care

9. The Ministry is responsible for key operations in health and long-term care in Ontario through its stewardship role. The Ministry has described itself as becoming less involved in the actual delivery of health care, and more involved in planning and establishing levels of funding and funding models for health care.[11]

10. The Ministry has also described itself as being more involved in: establishing overarching strategic directions and priorities for Ontario's health system; developing legislation, regulations, standards, policies, and directives to support those strategic directions; monitoring and reporting on the performance of the health system and on the health of Ontarians; and ensuring that ministry and system strategic directions and expectations are fulfilled.[12]

11. The Negotiations and Accountability Management Division of the Ministry (reporting to the Assistant Deputy Minister) is responsible for the stewardship, funding and managing of the Ontario Midwifery Program ("OMP"). This includes setting the compensation of midwives. The OMP is a government-managed,

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8 Ministry of Health and Long-Term Care, "Midwifery in Ontario: What is a Midwife?", accessed at http://www.health.gov.on.ca/en/public/programs/midwife/ ; Ontario Hospital Association, College of Midwives of Ontario & Association of Ontario Midwives, "Resource Manual for Sustaining Quality Midwifery Services in Hospitals", September, 2010.

9 Registered Midwives in Ontario, 1994-2013, prepared by AOM; List of Midwifery Practice Groups in Ontario and Number of Midwives – prepared by AOM..

10 Listing of Midwives who have executed HRTO Form 27 consents as of November 14, 2013. This form lists 530 midwives. As of November 26, 2013, 531 midwives filed Form 27 consents.

11 Ontario Ministry of Health and Long-Term Care, "About the Ministry" <http://www.health.gov.on.ca/en/ministry/#>

12 Ibid

community-based system of providing maternity care to Ontario women by registered midwives.

12. According to the *Midwifery Act 1991,* the scope of practice for midwives is:

> *The assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provisions of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.*

13. As described in the Philosophy of Midwifery Care in Ontario, health care provided by midwives "is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs".[13]

14. In midwife-led maternal care, the midwife is the most responsible health-care professional in planning, organizing and delivering maternal and newborn care. In physician-led models of maternal care, an obstetrician or family physician has those responsibilities and is supported by registered nurses and registered practical nurses. Demand for midwifery services in Ontario is high with only four out of 10 women wishing a midwife-led birth being able to access such care.[14]

15. The Ministry, through contractual directives and policies, including the Transfer Payment Agency ("TPA") template agreement, sets the compensation of Ontario's registered midwives.[15] These directives and policies are contained in the contracts between the Ministry and approximately 18 local TPAs as well as between those TPAs and the midwifery practice groups.

2. Midwifery is Women's Work

16. Midwifery is "women's work" performed by women and for women. It is the case that 99.9% of Ontario's registered midwives are women. Midwifery was 100% female dominated until a male midwife was registered in 2013.[16] It is the most exclusively female-dominated profession in Ontario.[17]

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13 College of Midwives of Ontario , "Philosophy of Midwifery Care in Ontario," accessed at <http://www.cmo.on.ca/downloads/Philosophy.pdf>

14 Unaccommodated client data is collected by the MOHLTC in its Midwifery Outcomes Reports ("MOR").

15 Template Funding Agreement between Transfer Payment Agency and the Midwifery Practice Group, 2013 – MOHLTC Version, subject to dispute by AOM

16 There was one male registered midwife for period January 1, 1994 to April 1, 1997. See CMO register, <www.cmo.on.ca>

17 Health Professions Database 2010 Stat Book, Table 2- Regulated Health Professionals by Sex – 2010 [Health Professions Database 2010]

17. As well, the job content of the work – health care for women and newborns, including vulnerable populations, is most characteristic of classic “women’s work.” Midwifery involves complex, overlapping and multi-level skills that are frequently invisible to those not doing the work. Often called upon to perform tasks simultaneously, midwives are always doing “caring” work, which is integrated into the specific medical tasks required throughout the "course of care" for each woman and her newborn. Midwifery care is associated with building confidence in women, providing enriching, personalized care that requires fewer medical interventions, and empowering women to feel valued and in control.

18. The combination of complex technical medical skills with the type of continuous caring, nurturing and comforting work typical of midwifery work is not typical of men’s work.[18]

19. Midwifery work is for the exclusively female experience of childbirth. Midwives take the needs of the woman as the core tenet of their model of care, and work to engender healthcare by emphasizing continuity of care, informed choice, and choice of birth place. Midwifery, above all other professions, is not only associated with women, but is acutely tied to empowering their health care needs, which have otherwise been historically undervalued.

20. This model of care is different from that of other healthcare professionals such as Obstetricians, who may care for female clients with regards to childbirth, but who do not operate within a model of care that is focussed on engendering healthcare, and as such, are not associated with women in the same way as midwives.

21. The government-managed model of midwifery practice in Ontario involves providing primary maternity care services in the community based on three main principles: continuity of care, informed choice and choice of birth place. The compensation structure for midwives was developed by the MOHLTC to reflect and support these principles.

22. The MOHLTC describes these principles as follows:

Continuity of Care

Midwives usually work in small groups and are on 24-hour call. A pregnant woman will get to know a small group of midwives (2-4) to ensure that the she is comfortable and familiar with the caregivers who will attend her birth. Generally, two midwives will attend each birth and share the care throughout the pregnancy, labour, birth and after the birth for six weeks. They will offer education, counselling, advocacy and emotional support. Each midwife will take the time to

18 See discussion of this type of work in the context of nursing in the Pay Equity Hearings Tribunal decision in *ONA v. Haldimand Norfolk (No.6),* 2. P.E.R. 105 and *Women’s College Hospital*, (No.4), 3. P.E..R. 6 at para. 27.

build a relationship of trust and safety with each woman. If medical problems develop during pregnancy, labour, birth or postpartum, midwives work closely with specialist physicians and nursing staff.

Informed Choice

Midwives encourage each woman to take an active part in her care throughout her pregnancy and birth and will provide information to each woman so that she can make choices about her care. Midwives provide sufficient time during prenatal care to discuss questions about important issues like nutrition, birth plans, breastfeeding and parenting. Midwives recognize and support the mother as the main decision-maker.

Choice of Birthplace

The pregnant woman chooses whether she wants to give birth in a hospital or at home under the primary care of the midwife. Midwives are trained to attend births in both places as well as to help individual women choose the safest place for them. Many women who opt to have a hospital birth spend time at home with their midwife before going to hospital.

A midwife's training prepares her to be responsible for decisions about labour, delivery, postpartum and newborn care both at home or in hospital. A midwife works closely with other community midwives, doctors and nurses to maintain a high standard of care.[19]

23. In addition to the above principles, midwifery is also based on the following principles: spending sufficient time with women so that they can make informed choices about care, appropriate use of technology and evidence-based practice.

3. Important Reference Documents

24. Throughout this Schedule, important reference documents have been footnoted for ease of reading. Hard and electronic copies of these documents are contained on a USB Key which is being provided to the Tribunal and the Respondent as well as in hard copy volumes. These documents are organized by volumes, as set out in Schedule B- List of Important Documents.

19 Ministry of Health and Long-Term Care, "Midwifery in Ontario: What are the Principles of Midwifery Care?" <http://www.health.gov.on.ca/en/public/programs/midwife/>

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PART 1 SUMMARY OF APPLICATION

1. Inequitable Midwifery Compensation is Sex Discrimination

25. Pay equity or the right to be free from sex-based discrimination in compensation is a fundamental human right guaranteed by the *Human Rights Code* and the *Pay Equity Act.*

26. The compensation for midwifery work is determined by the MOHLTC and embedded in the policies and contractual arrangements between the Ministry and the various TPAs that administer the Ontario Midwifery Program on a local basis, as well as in the contracts between TPAs and the midwives' practice groups.[20]

27. At the time midwifery was regulated, the Ministry relied on a 1993 report by Robert Morton and Associates, "the Morton report" to set the compensation for midwives.[21] This report reflected the consensus of the joint AOM/Ministry Midwifery Funding Work Group. The report included a modified "pay equity analysis," i.e. it considered the skill, effort, responsibility and working conditions ("SERW") of the entry-level midwife relative to the male-dominated Community Health Centre ("CHC") salaried physician. It also compared the midwifery work to the CHC senior primary care nurse/nurse practitioner. The report also included consideration of a market analysis as well as the results of discussions between Ministry and the AOM. CHCs are a Ministry program that delivers community-based, interdisciplinary primary health care across the province with a focus on vulnerable client populations.[22]

28. As a result, the Ministry set the compensation for midwives at the start of regulation on January 1, 1994 at approximately 63% of the maximum rate of the male-dominated CHC family physician or 82% of the start rate.[23] The midwifery

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20 "Compensation" includes all payments and benefits paid or provided to or for the benefit of a person who performs functions that entitle the person to be paid a fixed or ascertainable amount. See *Pay Equity Act*, s.1(1).

21 Robert Morton and Associates, "Compensation for Midwives in Ontario: Summary Report prepared for the Midwifery Funding Work Group", July 26, 1993 [Morton Report] and Midwifery Funding Work Group, "Ontario Midwifery Program Framework", September, 1993 [Midwifery Program Framework]

22 See Dr. Chandrakant P. Shah and Dr. Brent W. Moloughney, "A Strategic Review of the Community Health Centre Program", May, 2001 [A Strategic Review] for a detailed review of this Program and the work of CHC physicians and nurse practitioners

23 The CHC physician had two grids at the time of the Morton report: one grid for urban areas and one for rural areas, with the rural areas grid substantially higher. Morton and the Ministry used the lower urban grid for comparison purposes despite the fact that midwives work in the same under-serviced areas. As well, the salary grid for the CHC physician set out in Appendix D of the Morton Report did not include the $5353 annual on-call allowance. When that on-call allowance is included, the percentage proportional calculations between the midwife and the CHC physician is

compensation was to be substantially greater than the CHC senior primary care nurse/nurse practitioner.

29. Since 1994, the SERW associated with midwifery care have increased substantially without commensurate increases in their compensation and discriminatory pay equity gaps have arisen starting as of January 1, 1997. In fact, the Ministry, despite its 1993 agreement to provide annual cost of living increases to midwives, froze the compensation of midwives from 1994 to 2005 and thereafter provided inadequate increases relative to the value of the work and the compensation afforded to others.

30. In particular, substantial pay increases have been provided to the midwives' male comparator, the CHC physician, which were not proportionally provided to the midwives as required for pay equity purposes.

2. Expert Reports of Inequitable Compensation and Pay Equity Gaps

31. Pay equity and economist experts Paul Durber and Hugh Mackenzie in their reports filed with this application have identified the above-noted pay equity gaps.[24] Durber carried out a systemic pay equity comparison of the work (SERW) and pay of Ontario's registered midwives since 1994 relative to the male-dominated CHC family physician and the CHC nurse practitioner.[25] On the basis of his pay equity analysis, Durber found that sex bias was operating in the setting of the midwives' compensation by the Ministry. Taking into account Durber's pay equity analysis, Mackenzie analysed midwives' compensation over the period of 1994 to 2013, both in relation to the above-noted comparators and in relation to other economic contextual factors, such as the cost of living index during the period.

32. As a result of changes in the SERW of midwifery work since the 1993 Morton entry-level analysis, Durber identified the following pay equity adjustments required for Ontario midwives over the period from 1994 to present, to address the pay equity gaps:

(a) <u>Period of Pay Equity Review - January 1, 1994 to December 31, 1996</u>

Pay equity adjustment to midwives' compensation required from the 1993 rate of 63% of maximum rate of CHC physician to 81% of CHC physician maximum rate, effective on January 1, 1997.

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reduced to 82% from 90% of the maximum rate of the CHC non-underserviced base pay and 62% rather than 65% for the minimum rate.

24 Paul Durber, "Examining the Issue of Equitable Compensation for Ontario's Midwives", November 24, 2013 [Durber Expert Report] and Hugh Mackenzie, "Midwives' Compensation in Ontario 1994 to 2103: Comparative Analysis and Implication of Pay Equity", November 22, 2013 [Mackenzie Expert Report] at pg 9.

25 Durber Expert Report, supra

(b) Period of Pay Equity Review - January 1, 1997 to December 31, 1999

Pay equity adjustment to midwives' compensation are required from 81% of the maximum rate of CHC physician to 85%, effective on January 1, 2000.

(c) Period of Review - January 1, 2000 to December 31, 2002

As still 85% of maximum rate of CHC physician, pay equity adjustment to midwives' compensation to that proportional value should continue during this period.

(d) Period of Review - January 1, 2003 to December 31, 2005

Pay equity adjustment to midwives' compensation required from 85% of maximum rate of CHC physician to 86%, effective on January 1, 2006.

(e) Period of Review - January 1, 2006 to December 31, 2008

Pay equity adjustment to midwives' compensation from 86% of the maximum rate of CHC physician to 90%, effective on January 1, 2010.

(f) Period of Review - January 1, 2009 to December 31, 2012

Pay equity adjustment to midwives' compensation from 90% of the maximum rate of CHC physician to 91%, effective on January 1, 2013.

33. The above-noted adjustments are effective on the 1st day of the year following the Durber review period.

34. As set out below, it has also been identified that midwives received inequitable benefits in comparison with the CHC physicians. While the CHC physicians have received at least 20% of the value of their salary in benefits since 1994, the midwives received only 16% as of January 1, 1994, increased to 18% in 2005 and increased to 20% in 2008. Accordingly, a pay equity adjustment is required to address this aspect of the midwives' inequitable compensation as well. Moreover, because benefits are set as a percentage of compensation, the actual value of benefits received has suffered.

35. Mackenzie's analysis of the actual monetary pay equity adjustments required as a result of the above-noted Durber analysis (excluding the money owing for the differential in benefits) is set out below:

Year	Midwives	CHC Physician Maximum	Durber relative value	Durber relative value pay	Pay Equity Adjustment Required
1994	77,000	123,119	63%	77,000	**-**
1995	77,000	123,119	63%	77,000	**-**
1996	77,000	123,119	63%	77,000	**-**
1997	77,000	123,119	81%	99,726	**22,726**
1998	77,000	123,119	81%	99,726	**22,726**
1999	77,000	123,119	81%	99,726	**22,726**
2000	77,000	123,119	85%	104,651	**27,651**
2001	77,000	123,119	85%	104,651	**27,651**
2002	77,000	123,119	85%	104,651	**27,651**
2003	77,000	138,699	85%	117,894	**40,894**
2004	77,000	141,904	85%	120,618	**43,618**
2005	93,600	147,217	85%	125,134	**31,534**
2006	93,600	150,449	86%	129,386	**35,786**
2007	96,400	152,753	86%	131,368	**34,968**
2008	98,360	155,399	86%	133,643	**35,283**
2009	100,440	155,399	90%	139,859	**39,419**
2010	102,560	209,035	90%	188,132	**85,572**
2011	102,560	217,687	90%	195,918	**93,358**
2012	102,560	215,021	91%	195,669	**93,109**
2013	102,560	216,830	91%	197,315	**94,755**

3. Violation of Midwives Right to Equal Treatment in Employment

36. The above-noted inequitable compensation violates midwives' human right to equal treatment in employment and is contrary to section 5 of the *Code* as it:

(a) delivers inequitable and significantly lower compensation to Ontario's midwives than their professional work is worth because they are women, they work for women, and because pregnancy and birth is a biological, genetic and gendered female experience. This discrimination is highlighted by fact that they are paid substantially less than comparable male-dominated work funded by the Ministry and government;

(b) is substantially less than it should be as a result of the stereotypes, prejudice, systemic barriers and disadvantage that continue to cause a gendered "compensation penalty" or "discount" for midwifery work;

(c) is substantially less than it should be as a result of the Ministry's gendered and unequal bargaining and compensation practices that have favoured the male-dominated profession of physicians and denied midwives regular and fair negotiation processes;

(d) is substantially less due to the Ministry's failure to perform its stewardship role of planning for and establishing levels of funding in the health system that are free from sex-based discrimination.

37. Midwives' right to contract on equal terms pursuant to section 3 of the *Code* is also violated as this unequal compensation is embedded in the MOHLTC's contractual requirements governing the midwives.

38. The work of midwives is typified by a gendered trifecta of: work by women, for women and as it relates to women's health. This highly gendered context renders midwives particularly vulnerable to the Ministry, which determines both their compensation levels, and the process by which their pay is determined.

39. Inequitable compensation for midwives is influenced by the fact that midwives are providing medical care to "women" and therefore have an "association, relationship or dealings" with persons who are identified by a prohibited ground of discrimination. As a result, this unequal treatment regarding compensation also violates section 12 of the *Code.*

40. Undervaluing midwifery work by providing lower compensation than the work is worth not only undervalues midwives as women but also undervalues women's health care. Undervaluing midwifery work contributes to the inequities in the provision of health care for women and reinforces the lower value accorded at times to the wishes of women with respect to their health-care needs. As recognized by the Ontario government, Ontario women have experienced unequal access and treatment with respect to their health care and particularly their care related to pregnancy, birth and the postpartum period.[26]

41. After years of midwives being excluded from the funded health-care system, the Ontario government took important steps to seek equity starting in 1986, when it began looking to integrate the female-dominated midwifery profession into the hierarchical maternity health-care system, which was controlled by the male-dominated profession of physicians. Effective January 1, 1994, this included legislating, for midwives, their autonomous professional primary care status; providing public funding for Ontario women to access their services; and setting their compensation within that hierarchy based on a modified pay equity analysis.

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26 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987: Executive Summary & Summary of Recommendations", 1987 [Task Force Report]; Ontario, "Echo: Improving Women's Health in Ontario: Sharing the Legacy – Supporting Future Action, 2009-2012." [Echo]

42. However, these primary equality steps were not sufficient to ensure that midwives were protected from discrimination as they moved to integrate into the patriarchal health-care system after January 1, 1994.

43. Despite some progress, midwives have continued to struggle to properly provide midwifery care to women, facing challenges such as:

(a) gaining access to hospital privileges;

(b) working in hospitals to the full scope of their practice as provided for in legislation and regulation; and

(c) enduring marginalization, stereotyping and prejudice concerning the value of their work.[27]

44. The Ministry did not support midwives sufficiently to address the difficulties in integrating (as a new, small, almost exclusively female health profession) into a male-dominated patriarchal medical system. The Ministry's unequal treatment contributed to those difficulties and stereotyping and prejudice.

45. The hierarchical structure of the health care system with the male-dominated profession of physicians at the top has been documented and analyzed in many reports and articles cited in this application including the works of health care and gender experts, Dr. Pat Armstrong, Dr. Lynn Bourgeault and Dr. Karen Grant. While there are increasing numbers of women physicians generally and in Community Health Centres, the profession is still male-dominated. This is particularly highlighted in the decision-making structure of the Ontario Medical Association, which has few women in leadership positions, and which is the Ministry's bargaining partner for physician and CHC compensation.[28]

46. Mr. Durber in his report has also addressed the issue of the male dominance of the profession of physicians, both from a historical perspective and from the perspective of the OMA, which bargains its compensation.

47. As specifically recognized by the *Pay Equity Act,* Pay Equity Hearings Tribunal jurisprudence and academic research, it is likely that sex stereotyping and

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27 Karen Kaufman and Bobbi Soderstrom, "Midwifery Education in Ontario: Its Origins, Operation and Impact on the Profession", *Reconceiving Midwifery*, Eds. Ivy Lynn Bourgeault et al. (Montreal: McGill-Queens University Press, 2004) at pg 190; Task Force Report, supra at pp. 8-10; Ministry of Health and Long Term Care, "Ontario Midwifery Program Hospital Integration Survey", 2011 [OMP Hospital Integration Survey]

28 The composition of the OMA Board and Executive and Chair of OMA council as of 1992 was 100% male. In 2013, 5 out of 6 members of the Executive are men, (approx. 83%) of the Executive and 17 out of 19 members of the Board of Directors (89.5%) are men. See Chart OMA Leadership Gender Breakdown with a sampling of years and the names and sexes of the members. Source: Issues of the Ontario Medical Review.

prejudice will pervade the evaluation and pay of jobs that are strongly identified with one sex or the other.[29] Midwives are the occupation most highly identified with women since they are almost exclusively female and also work for women.

48. Citing expert Don Treiman in the Pay Equity Hearings Tribunal decision, *ONA v. Haldimand Norfolk*, "it is likely that predominantly female jobs will be undervalued relative to predominantly male jobs in the same way that women are undervalued relative to men." Relying on research and evidence including that of Dr. Pat Armstrong, the Tribunal stated "gender is a factor in the value placed on activities and work performed by men and women and therefore in the setting of wages. Wage discrimination in the setting of women's wages is pervasive."[30]

49. While the government decided that Ontario women could choose to have either a doctor or a midwife provide their maternity and infant care to six weeks of age, they did not have in place the necessary mechanisms to ensure that midwives were given the respect, opportunities and compensation that such a structure warranted, including full access to hospitals where a significant portion of their work takes place.

50. Despite clear evidence that midwives have and continue to provide excellent maternal and newborn care outcomes, midwives have not received the compensation warranted by the value of their work. Yet the male-dominated profession of physicians has been able to substantially increase its compensation over the same time period.[31]

51. Physicians were able to gain increased compensation from the Ministry through laws, agreements and structures that facilitated significantly more favourable bargaining regimes and contracts and through the willingness of the Ministry to provide such compensation.

52. The inequitable compensation and benefits received by Ontario's midwives cannot be separated from the patterns of systemic gender discrimination that infuse the history of discrimination and prejudice against midwifery work in Ontario and the discrimination women have experienced in the health-care system. (See Part 2 – History of Discrimination Against Midwifery and Women's Health Care below.)

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29 *ONA v. Haldimand Norfolk (No.6) supra* at par. 19 and *Women's College Hospital*, (No.4), supra at para. 17; Ronnie J. Steinberg, "Social Construction of Skill" (1990) 17:4 Work and Occupation 449 [Social Construction of Skill] ; Pat Armstrong, "Equal Pay for Work of Equal Value: Expert Report prepared for the Public Service Alliance of Canada in the Federal Court of Canada proceeding, *Public Service Alliance of Canada and Nycole Turmel v. Her Majesty the Queen in Right of Canada*" (June 2008) [Armstrong Expert Report] at pg 26

30 *Women's College Hospital*, (No.4), supra at paras. 16- 17

31 Office of the Provincial Auditor, Ontario Midwifery Program Evaluation, 2000.

53. Primarily through the actions of the male-dominated profession of physicians and the legal system's sanctioning of physician-led maternity care, midwives were excluded from Ontario's health care system and its funding for maternity care services from 1865 until 1994. Such exclusion oppressed women both as consumers of midwifery and health care and also as midwife professionals providing maternal medical care.[32]

54. Over this period of time, Ontario midwives suffered great losses as a result of their exclusion from the publically funded health-care system and experienced low or no pay when they practised midwifery "alegally"[33] before regulation. Prior to regulation in the early 1990s, practising midwives in an urban setting earned approximately $20,000 or less annually.[34]

55. Both female midwives and women consumers campaigned to further women's health care by integrating midwifery into Ontario's health-care system, which was controlled by the male-dominated profession of physicians. This campaign culminated in the Ontario government's decision to regulate midwifery effective January 1, 1994 and to establish the Ontario Midwifery Program, which provided public funding for midwifery services.

56. Leading up to the start of regulated midwifery services, the Ministry worked with the AOM to address various funding issues, including compensation through a joint Midwifery Funding Work Group. The Ministry hired management consultant Robert Morton to do a compensation review to assist the Ministry to determine a fair and equitable compensation level of midwives when they started practising as regulated midwives in 1994.[35]

57. The Morton report, dated July 1993, used a modified rough pay equity analysis, along with other factors to initially set the midwives' compensation in a way which reflected their skills, effort, responsibilities and working conditions (based on their entry-level competencies) relative to male-dominated and other professional health-care work.

58. SERW are the criteria used in Ontario's *Pay Equity* Act to compare male- and female-dominated work to ensure compensation free of systemic gender discrimination.[36] The Ministry recognized the need to do a systematic analysis of the SERW of the midwifery work relative to male-dominated work when setting the compensation structure for midwives who performed classic and undervalued "women's work."

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32 Ivy Lynn Bourgeault, *Push!: The Struggle for Midwifery in Ontario* (Montreal: McGill-Queen's University Press, 2006) at pg 20

33 Ibid at pg 45

34 Ibid at pg 190.

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

59. This analysis was used as the basis for the negotiations between the Ministry and the AOM through the joint Midwifery Funding Working Group. This resulted in the Ministry setting the compensation for midwifery provided in its Ontario Midwifery Program at a salary scale that was more than the female-dominated primary care nurse practitioner. The top range of midwifery salary was set at approximately 63% of the maximum pay of the CHC physician for non-underserviced areas ($118,000 plus on-call fee of $5323) and 82% of the lowest paid CHC physician ($80,000 plus on-call fee of $5323).[37]

60. The new salary scale determined by the Ministry ranged from $55,000 to $77,000 per annum, and was divided into 12 pay scales based on years of service with prior unregulated service to be credited when authorized.

61. This salary scale represented a very rough start toward pay equity using a proportional value method, which came into force as a method under the *Pay Equity Act* in January 1, 1993. It resulted in the midwives receiving a significant pay equity adjustment from their pre-regulation compensation.

4. Unlawful Actions of the MOHLTC

62. In summary, the Ministry, aware of the historical systemic disadvantage and unequal treatment of the female profession of midwifery did not take the necessary proactive pay equity compliance steps post-1994 to ensure that midwifery compensation was free of sex-based discrimination. The Ministry also did not ensure such compensation, which it set on an ongoing basis, was not influenced by ongoing sex and gender-based stereotypes and prejudice that disadvantaged midwives and favoured the male-dominated profession of physicians and other male work. In this regard, the Ministry:

(a) failed to rigorously monitor changes in the work (SERW) of midwives and their compensation and their relevant comparators, particularly the work of the male-dominated CHC family physician.

(b) failed, in an ongoing way, to make visible and value the female work of midwifery. Although the Ministry stated it valued the work of the midwives, it failed to incorporate those statements of value into the compensation paid to midwives.

(c) devalued, when setting midwifery compensation, the evidence of the benefits of midwifery while favouring the value and worth of the work of the male-dominated profession of physicians. This occurred despite the fact that the

37 Hay Group, "Association of Ontario Midwives: Compensation Review", February, 2004 [Hay Report, 2004] at pg. 6; The higher grid for the CHC physician in 1993 who worked in underserviced areas was $117,766 to $135,830 on top of which is added the on-call allowance. The lower grid was $80,295 to $117,766 before adding in the on-call allowance. See A Strategic Review, supra

OMP's objectives include ensuring an "equitable funding mechanism that supports the integration of midwifery services into the health care system" and the Ministry's *Excellent Care for All Act* stating that "health care providers will be paid based on how well they make quality their main job."[38]

(d) ignored, despite policies that stipulate funding be "equitable and appropriate" and "consistent with the demand for and underlying value of the service,"[39] the high demand for midwifery services and the shortages of midwife providers and also failed to accord the appropriate compensation for the value of midwifery services that were consistently found to be of very high value and highly consistent with the objectives of the government's primary health-care reform.

(e) failed, despite midwives meeting all the Ministry's objectives for a reformed primary health-care system, to reward midwives appropriately while substantially rewarding the male-dominated profession of physicians over the relevant period.

(f) failed to incorporate a sex- and gender-based pay equity analysis into its compensation setting funding practices.

(g) failed to have mechanisms in place to support and protect the midwifery profession from ongoing systemic prejudice and discriminatory barriers faced as a result of being a new small female profession being integrated into the health-care system, where they provided care in a manner that challenged the status quo.

(h) refused to contract with midwives on equal terms by outright refusing to negotiate pay-equity compliant compensation levels with their bargaining agent, the AOM.

(i) Refused to contract with midwives on equal terms by failing to have a negotiations process with the AOM in place to address required changes in compensation to ensure pay equity while at the same time engaging in negotiations with the Ontario Medical Association ("OMA"), the professional association of physicians, with respect to increasing their compensation and addressing changes in their work;

(j) failed to actively, promptly and diligently ensure the compensation system continued to provide pay equity for midwives by conducting an ongoing pay equity analysis that reflected the significant SERW changes to their work since the Morton analysis (based on entry-level competencies) took place, and failed to address the lack of pay equity for midwives;

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38 *Excellent Care for All Act*, 2010, S.O. 2010, C. 14

39 Ontario Midwifery Program Evaluation, supra

(k) took advantage of the “caring dilemma” experienced by midwives and their professional requirements, i.e., midwives were conflicted about asserting their right to pay equity if it would impact the right of women to accessible and inclusive maternity and newborn care;

(l) failed to adequately investigate and properly respond to and address the complaints made by the AOM on behalf of its members since 1994 about the inequitable gendered compensation midwives were receiving as a result of the Ministry’s actions and instead denied that midwives were entitled to any pay equity entitlements as they were independent contractors;

(m) failed to adequately respond to the 2003 and 2004 Hay Consultants reports on midwifery compensation and the Ministry's 2010 Courtyard Report, which it jointly commissioned with the AOM, all of which identified substantial pay equity gaps;

(n) failed to accord sufficient value to women’s health care by failing to pay midwives, who provide care for the gendered experience of pregnancy and birth, compensation which reflects the value of their work;

(o) adopted an arbitrary and opportunistic approach by:

(i) treating midwives as being bound by compensation restraint laws while also arguing midwives were independent contractors and therefore not covered by the *Pay Equity Act.*

(ii) agreeing to negotiate with midwives when it suited the Ministry's agenda and declining to negotiate or refusing to characterize negotiations as such when it did not, though at all times it characterized such OMA interactions as "negotiations."

(p) failed to exempt from restraint laws and policies required to ensure midwifery compensation is free of sex-based discrimination even though such laws and policies provided an exemption for adjustments required to comply with the *Pay Equity Act* or the *Human Rights Code*.[40] This had an adverse effect on midwives who performed women’s work since they were frozen at compensation levels that were not pay equity compliant;

(q) failed to engage in any appropriate pay equity/human rights analysis with the AOM or otherwise so as to carry out appropriately its proactive *Human Rights Code* obligations;

(r) permitted the midwives' pay equity gap to widen substantially over nearly 20 years, while at the same time arguing it is too costly to close it because the gap is so large.

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40 *Pay Equity Act*, R.S.O. 1990, c. P.7 and *Human Rights Code*, R.S.O. 1990, c. H. 19

5. Losses and Relief Claimed

63. The impact of the above-noted Ministry actions is and was that the gender of the midwives and the women for whom they work substantially lowered their pay relative to the value of their work – that is, the midwives' compensation was discounted as a result of their gender – an unlawful gender penalty.

64. The systemic discrimination that infuses midwives' compensation acts as a barrier to their full and equal participation and integration into Ontario's health-care system and more generally in society. As stated by the Pay Equity Hearings Tribunal, fair pay is not only necessary to meet the necessities of life but also guarantees a sense of dignity and recognition for the value of the work women perform.[41]

65. As a result of the above-noted unequal treatment, Ontario's registered midwives

(a) have incurred large economic pay losses and other damages requiring compensation and restitution (See Part 6 – Discriminatory Impact of Unequal Treatment).

(b) have suffered injury to their dignity, feelings and self-respect requiring further compensation (See Part 6 – Discriminatory Impact of Unequal Treatment).

(c) require public interest future compliance remedies to ensure such discrimination, losses and injury will not reoccur (See Part 8 – Remedies Sought for Past Discrimination and Future Compliance).

PART 2 HISTORY OF DISCRIMINATION AGAINST MIDWIFERY AND WOMEN'S HEALTH CARE

1. Health-Care System and Professions are Sex Stratified

66. The discrimination against midwives starts with the sex stratification of the health-care system and its professions. Midwifery and the women who provide such medical care were subjected to extensive discrimination, stereotyping and prejudice historically in Ontario and elsewhere in Canada, much of it at the hands of the male-dominated profession of physicians. As stated by the Ontario government agency Echo: Improving Women's Health in Ontario, "women as a whole have had less access to health care and poorer health outcomes than men."[42]

67. The health-care professions are and have been sex segregated with the male-dominated profession of physicians clearly at the top of the hierarchy. Women

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41 *ONA v. Haldimand Norfolk*, supra.

42 Echo, supra

were not allowed to study medicine at the University of Toronto until 1906.[43] Medical domination of health care has and continues to form part of Ontario's patriarchal health-care system. This includes the over representation of physicians in the Ministry hierarchy and the Ministry's close links to their representative organization, the OMA.

68. The health-care compensation market is shaped by historical customs, prejudices and ideologies. The market is not gender neutral. Embedded in it are cultural assumptions and compensation practices and structures about what constitutes skills and responsible work, which favour male work and particularly the work of the physicians who have been at the top of the hierarchy. Authority is "part of the male sex role. Everyone sees the authority associated with male work but the authority associated with women's work is often invisible." This is particularly true where the authority, like with the midwife, is exercised in an alternative form of collaborative work organization. As societies continue to "value aspects of maleness more highly than femaleness, women are more likely to experience structural inequalities in opportunities and access to resources." [44]

69. Pay equity comparisons make visible the unacknowledged skills, effort, responsibility and working conditions found in jobs historically performed by women and focuses on the way "cultural ideas about gender reflect power differences and constitute power resources that advantage men – employers and employee alike whose claims about what constitutes skill have become part of our taken for granted reality." Cultural assumptions about what constitutes skill and responsibility are embedded in compensation systems.[45]

2. Male-Dominated Physicians and Female-Dominated Midwives and Nurses

70. As of 2010/11, Ontario physicians as a whole are 65% male with family physicians being 60% male. Family physicians in Canada have ranged from originally being exclusively male to approximately 83% male in 1978 to about 73% male in 1993 and to approximately 60% male in 2010.[46]

71. The medical organizations within medicine that negotiate on behalf of the medical profession, such as the OMA, are also highly male dominated. [47]

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43 See "Critical to Care – The Invisible Women in Health Services" by Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon, Toronto: University of Toronto. Press, 2008, excerpts

44 Social Construction of Skill, supra at 457-459; Armstrong Expert report, supra

45 Social Construction of Skill, supra p. 454. See also Armstrong Expert Report, supra

46 Health Professions Database 2010, supra; Figure 5 - Gender Distribution of Physicians , Family and Specialist by sex < www.cihi.ca>

47 Health Professions Database 2010, supra

72. From 1997 to 2012, midwives in Ontario were 100% female. There is currently one male midwife in Ontario, which means midwives are 99.9% female-dominated.[48]

73. Nurses in Ontario are highly female-dominated with 94.8% female as of 2011. The extended class of nursing, the nurse practitioner, is 95% female predominant.[49]

74. Both nurse practitioners and midwives provide high-quality and cost-effective primary care in areas that have traditionally been the domain of the male-dominated medical profession. Their distinct knowledge and care is on an equal footing with physicians in many respects and in a number of aspects produces better outcomes.[50] As well, some skills such as providing medical care at a home birth are unique to midwives.

3. Pre-Regulation History Up to 1984

75. Childbirth in Ontario up to 1865 was managed and led predominantly by midwives rather than by doctors.[51] Before 1865, Ontario's *Medicine Act* made it possible for midwives to practice midwifery without a license to practice medicine.[52]

76. In 1865, the Ontario government eliminated this exemption at the urging of the male-dominated profession of physicians who denigrated the skills and competence of such midwives. This change to the law rendered midwifery "alegal" since it was neither illegal nor legal.[53]

77. This "alegal" status served to discourage women from pursuing this work and denied many Ontario women access to midwife-led maternity care.[54] It also

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48 College of Midwives of Ontario, Public Registry, accessed at <www.cmo.on.ca>

49 Canadian Nurses Association, "2010 Workforce Profile of Nurse Practitioners in Canada", November 2012 accessed at <http://www.cna aiic.ca/~/media/cna/page%20content/pdf%20en/2013/07/26/11/07/2010_np_profiles_e.pdf>

50 Lusine Poghosyan et al, "Nurse Practitioner Workforce: A Substantial Supply of Primary Care Providers", (2012) 30:5 Nursing Economics 268 at pg 269.

51 *Push!*, supra at pp. 43-44;

52 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin)

53 *Push!*, supra at pg. 45; Judi Coburn, "I See and am Silent": A Short History of Nursing in Ontario", *Women at Work in Ontario, 1850-1950*, Eds. Janice Action et al (Toronto: Canadian Women's Educational Press, 1974) [I See and am Silent] ; Barbara Ehrenreich and Deirdre English , *Witches, Midwives & Nurses, A History of Women Healers*, 2nd ed. New York: The Feminist Press, City University of New York, 2010) [*Witches, Midwives & Nurses*] at pg 68.

54 *Push!*, supra at pg 45;

served to perpetuate stereotypes and prejudices about midwives and reinforced the low value accorded to the wishes of women with respect to their health-care needs. This served to perpetuate the stereotype that women were not competent to make decisions regarding their own health care. It also furthered the prejudice that women were not competent to act as health-care providers, and that their health-care skills and knowledge were not as valuable, if valuable at all, in comparison to those of physicians.

78. By the early 20th century in Ontario, the male-dominated profession of physicians had gained control of managing childbirth and came to be regarded as superior birth attendants primarily because of the above-noted stereotypes and prejudices that continued to be put forward by the medical profession. This was part of the process of "medicalizing" normal childbirth. Physicians spearheaded the notion that childbirth was dangerous and required their superior scientific knowledge and that midwives were incompetent and that it was unsafe for midwives to provide maternity care.[55] As noted above, at this time women had only just gained access to medical school in Ontario.

79. Many myths surfaced about the health care provided by midwives and many of these myths were perpetuated by the male-dominated profession of physicians and some by the nursing profession – e.g., that midwives were under-educated, lacked modern medical knowledge, were quacks, charlatans, outdated and dangerous to the health of women and their babies.[56] As set out later in this application, these prejudices continue to affect midwives and their work and pay.

80. The legal exclusion of midwives from the health-care system and its public funding continued up to the regulation of midwives by the Ontario government in 1994. This exclusion was also reinforced by the government's historical and ongoing decision to give the male-dominated profession of physicians exclusive control over admitting privileges to hospitals as provided by the *Public Hospitals Act* until it was amended in 1993.[57]

81. Despite the above-noted exclusion, some midwives continued to practise in Ontario without legal recognition for more than a century. Midwives were either not paid or were privately paid low compensation by the women they provided service to. Some regarded it as an unpaid community or family task rather than "employment."

82. In the 1960s and '70s, a confluence of the feminist and consumer movements resulted in a resurgence of interest in midwifery as an occupation and as an empowering health-care choice for women.

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55 Ibid, at pp 45-47;

56 Ibid at pp 46-47; I See and am Silent, supra at pg. 127; *Witches, Midwives & Nurses*, supra at pg 86.

57 R.R.O.1990, Reg 965, s. 11(1)(c)

83. A number of strategies were employed by doctors to prevent midwives from becoming part of the publicly funded health-care system. As a group, physicians were hostile to midwives and held stereotypes and prejudices about their work.[58] Over the years leading up to midwifery regulation in 1994, a small, vocal group of doctors wrote articles about the horrors of midwifery-attended childbirth.[59] Midwives continue, at times, to encounter this hostility despite 20 years of integration in the health-care system.[60]There are still hospitals in Ontario that refuse to accredit midwives, refuse to permit midwives to work to their full scope of practice and/or refuse to permit inter-professional hospital committees to include midwives.[61]

84. In 1983, the College of Physicians and Surgeons of Ontario passed a rule preventing doctors from attending home births. This rule remained in effect for many years and served to reinforce the view that home births were dangerous and that midwives were irresponsible for providing such care.[62]

85. Over the 20th century, the female-dominated nursing profession, which was also trying to establish its own professional standards and wages, established an "unequal and uneasy" alliance with the doctors, initially favouring physician managed childbirth with nursing support. This led to the nursing profession's early opposition to midwife-led maternity care and later their desire for only autonomous nurse-midwives to be regulated.[63] As a result of the above history, 99% of Ontario births prior to regulation were performed in hospitals under the control of the male-dominated profession of physicians.[64]

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58 *Push!*, supra at pp 45-47; I See and am Silent, supra at pp 133-135; *Witches, Midwives & Nurses*, supra at pp 85-87

59 *Push!*, supra at 45-47. See "Quebec MDs spurn legalizing midwifery", *The Globe and Mail*, (11 May 1989) which quotes the President of the Quebec Corporation of Physicians in response to a Government proposal to legalize midwifery "You might as well make prostitution legal. More people are asking for prostitutes than midwives" and the response of the President of the Quebec Federation of General Practitioners "It's like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers." .

60 Rob McKenzie, "Sarnia Doctor Urges Midwifery Get Test Run Before Being OKed", *London Free Press* (17 October 1986) In this Article Dr. Rob Brown, then president of the medical staff at St. Joseph's Hospital in Sarnai stated that home biths conducted by midwives show "gross idregard " and "disdain for..the baby". He then stated that he has disdain for midwives dueing a midwifery task force meeting presided over by Chairperson Mary Eberts;

61 Daniel Wolgerenter, "Controversy Lingers over role of Midwife", *Toronto Star* (29 June 1998) ; Lillian Newbery, "Specialists' group opposed to home births, probe told", *Toronto Star* (9 October 1986)

62 *Push!*, supra at pg 74

63 Ibid at pg 4

64 Task Force Report, supra at pg 10,

86. While physicians were earning more than $100,000 annual incomes at that time, the average earnings of a midwife in a very busy practice in Toronto was approximately $20,000[65] prior to regulation, while other practices fared much worse.

4. Relationship of Midwives to Women and Their Health

87. The exclusion of midwives from the government-managed and funded health-care system also flowed from the systemic prejudices and misunderstanding of the health-care needs of women and the undervaluing of women's health care and the failure to provide sufficient resources to meet that care.

88. The traditional biomedical approach to women's health and childbirth, which did not taken into account cultural, social or emotional factors, reflected the "white male domination of the profession."[66] These concerns about the treatment women received from physicians and the gaps in medical research lead to a comprehensive social model of women's health that was embraced by Health Canada in its 1999 Women's Health Care Strategy.[67]

PART 3 GOVERNMENT DECISION TO REGULATE AND FUND MIDWIFERY: 1985 to 1994

1. Introduction

89. Pre-regulation, the Ontario government's exercise of control over midwifery was carried out primarily through coroner's inquests and prosecutions. A high-profile inquest in 1985 provided an opportunity for the midwifery community to show the dangers of excluding midwives from the health-care system and the need to address the medical profession's control over maternity care.[68] The inquest jury recommended that midwifery be legalized in Ontario and integrated as a funded and integral part of Ontario's health-care system. This included midwives having hospital admitting privileges, requiring compulsory malpractice insurance and providing women with a choice of home or hospital births.[69]

90. Following this inquest and women's community activism in support of midwifery and female-centred women's health care, the Ontario government started the

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65 *Push!*, supra at pg 190;

66 See Karen R. Grant, "Why Women's Health? Issues and Challenges for Women's Health Research in Canada in the 21st Century A Position Paper", December 6, 2002 [Why Women's Health].

67 Health Canada, "Women's Health Strategy", 1999 <http://www.hc-sc.gc.ca/ahc-asc/pubs/_women-femmes/1999-strateg/index-eng.php#commitment>

68 Task Force Report, supra

69 *Push!*, supra at pg. 17;

process of recognizing midwifery, thereby changing the male dominance of maternity care.

2. The Midwifery Task Force

91. On January 23, 1986, the Minister of Health Murray J. Elston announced in the legislature the following:

(a) The government intended "to establish midwifery as a recognized part of Ontario's health care system" as a regulated health profession. The government was then engaged in a review of the health professions.

(b) While the development of midwifery had been hampered by its "uncertain legal status" in Ontario, midwifery is "viewed as a safe and integral element of health care" in many other jurisdictions, and demand was increasing in Ontario.

(c) A midwifery task force chaired by Mary Eberts would be established to recommend and report within one year on how midwifery should be integrated into the health-care system.[70]

92. At this time, Canada was one of only a small number of countries in the world that did not have a recognized midwifery system.[71]

93. In 1987, the Report of the Task Force on Implementation of Midwifery in Ontario recommended that Ontario enact a Midwives Act in which the midwife's scope of practice, whether in hospitals, clinics or homes, be defined consistently with the following international definition of midwife:[72]

[The midwife] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her responsibility and to care for the newborn and the mother. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.

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70 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 31st Parl, 1st Sess (23 January 1986) (Hon. Murray Elston)

71 Elzabeth Allemang, Women at the Centre of Care: Historical Roots of the Ontario Midwifery Model, CMO Education Day November 14, 2012

72 Task Force Report, supra at pg 4. Also adopted by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians; used by the World Health Organization;

94. In reaching this conclusion the task force relied on extensive research and consultation. It found that some women had "come to believe that maternity care was overly controlled by the predominantly male medical profession – obstetricians who regard every pregnancy and birth as a potentially pathological event". Women "believed that midwives would provide more holistic care, in which pregnancy and birth would be regarded as healthy events, greater attention would be paid to their psychosocial and social needs, and resorting to such medical interventions as caesarean sections would be less frequent."[73]

95. The task force recognized that steps needed to be taken to overcome "many years of isolation from the official health care system" midwives experienced and that the integration of midwifery required "government support."[74] It was stated that such government support should include the following:

(a) The "level of remuneration (for midwives) should take into account the level of midwives' responsibility, the demands on their time, and the difficulty of their work."

(b) "Nursing salaries would be inappropriate for midwives because of the nature of the midwives' level of responsibility, the difficulty of their work and the greater (and less predictable) demands of her time." That midwives' remuneration should fall somewhere between physicians and nurses.

(c) That midwives carry professional liability insurance, "otherwise midwives cannot be fully responsible for their actions, physicians will be reluctant to cooperate with them, and hospitals will not grant them staff privileges."[75]

96. The OMA opposed the creation of a funded and regulated autonomous midwifery profession, which was exclusively comprised of female incumbents at the time. It lobbied to continue with a medical-led model with nurses supporting doctors in providing maternity care. The task force report noted that the OMA's submission opposed the introduction of midwifery as it felt that "the medical profession can meet the evolving needs in maternity care and that a more active role for nurses will solve any present problems by the extended role nurse performing the functions of the midwife."[76] Nurses also opposed an autonomous midwifery profession and sought an autonomous nurse-midwife model.[77]

97. This task force reported its findings in the same year the Ontario Legislature passed the *Pay Equity Act* effective January 1, 1988. This law explicitly recognized that "affirmative action" needed to be taken "to redress the systemic

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73 Ibid at pg 7

74 Ibid at pg 8;

75 Ibid at pp. 8-9

76 Ibid at pg at 238.

77 *Push!*, supra at pg 47

gender discrimination in compensation" of women's work in Ontario. (See Part 4 below.)

3. *Midwifery Act, 1991* and *Regulated Health Professions Act, 1991*

98. In April and May 1991, respectively, the Ontario Government introduced the *Midwifery Act, 1991*[78] and the *Regulated Health Professions Act, 1991*[79] (*RHPA*), which included midwifery. Both of these laws received royal assent in November 1991. The *Midwifery Act* and relevant provisions of the *RHPA* were proclaimed December 31, 1993. A College of Midwives of Ontario was to regulate midwifery in a manner consistent with how other health professionals are regulated.

4. The Role of Women as Midwives and Consumers in Integration

99. The integration of midwifery was inextricably connected to women and their health-care needs as recognized by Minister of Health Frances Lankin. On May 29, 1991, Lankin stated in the legislature that the *Midwifery Act:*

> *…gives legal recognition to midwives. This reversal in policy is largely due to the efforts of hundreds of individual women and a smaller number of practising midwives who through public education, lobbying and education of other health professionals demonstrated the need and the consumer demand for midwives. Thanks to them, women will soon have the choice of obtaining care from a midwife, a choice available to women virtually everywhere except Canada.*[80]

100. In addition to the major role midwives and consumers had in ensuring that regulation and funding became a reality, they were also "instrumental in the development of the model of practice in Ontario."[81]

5. Midwifery Model of Practice

101. The autonomous model of midwifery practice was developed by the Interim Regulatory Council on Midwifery (IRCM), working with the Midwifery Task Force of Ontario (the consumer organization) and the AOM. This model guided the integration of midwifery into Ontario's health-care system and the compensation for such work. The scope of midwifery practice was defined by the IRCM's Standards of Practice and Guidelines.

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78 *Midwifery Act, 1991*, S.O. 1991, Chapter 31, proclaimed January 1, 1994;

79 *Regulated Health Professions Act, 1991*, S.O. 1991, Chapter 18;

80 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin) supra

81 Midwifery Program Framework, supra at pp. 1-2

102. The three principles of midwifery – continuity of care, informed choice and choice of birthplace were essential for facilitating the most effective health care for women and their babies and also served to substantially lower health-care costs from the physician-led model. As stated by the IRCM:

> *Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiological process…Care is continuous, personalized and non-authoritarian…Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives…The mother is recognized as the primary decision maker. Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.*[82]

103. As noted above, the midwifery model of practice aims to engender health care by putting women and their needs at the centre of their health care in contrast to the traditional authoritarian medical-led model, which pathologized birth.

104. The Ministry mandated a government-managed, community-based midwifery group practice model to:

(a) help realize the model of care by autonomous midwives through peer review, consultation and the shared care approach; and

(b) facilitate midwifery services being available to women throughout Ontario.

105. The Ministry rejected the fee-for-service system used to compensate physicians in favour of a course-of-care fee that encouraged continuity of care and taking time with women during their pregnancy, so that women could make properly informed choices about that care. The Ministry also chose this model of compensation as it helped to control costs, which was difficult to do with the fee-for-service model.[83]

6. Professional Education and Entry to Practice Competencies

106. New registered midwives are required to have a four-year baccalaureate education with half the time devoted to a theoretical component and the other half to a clinical component. Students are assigned to a midwifery practice for the clinical component. All students are required to be on call during the clinical component and at some other times during their studies. A two-year bridging program allowed nurses to become registered midwives. There is also a two-year post-baccalaureate program for qualified health-care providers.

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82 *Push!*, supra at 165;

83 Midwifery Program Framework, supra pp. 8-9

107. Like other health professions, there is a regular review process for the midwifery education program to ensure that it is appropriately updated. As well, new registrants are required to be formally mentored by practising midwives for a period of one year.

108. A pre-registration program began in October 1992 at the then Michener Institute for Applied Health Sciences with 76 registrants. The IRCM's Entry Level Core Competencies document from March 1993 was the basis for the education program. Such competencies reflected the "fundamental knowledge and skills expected of a new graduate of a midwifery school." This document required the midwife to:

Give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important tasks in counselling and education, not only for women but also within the family and the community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.[84]

109. In addition to the above-noted entry-to-practice competencies, the CMO subsequently developed numerous standards, guidelines and policies to regulated the work of midwives and set out skill, responsibility, effort and working conditions (SERW) requirements effective 1994.[85]

7. Hospital Admitting Privileges

110. In 1993, despite opposition from physicians, the regulations of the *Public Hospitals Act ("PHA")* were amended.[86] As a result, one of the significant discriminatory barriers facing midwives was removed: they were now allowed to independently admit, discharge and write orders in hospital both on an outpatient and inpatient basis. This opened up the way for midwives to be able to offer hospital births in addition to home births.

111. These amendments followed recommendations made by both the AOM and the IRCM to the *PHA* advisory committee. Both of these entities argued that if hospital admitting privileges were not available, then this would *de facto* limit regulated midwifery care to home births. Since 99% of births at that time

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84 Morton Report, supra at Appendix B;

85 College of Midwives of Ontario, "Policies, Guidelines, Standards & Statements" accessed at <http://www.cmo.on.ca/binder.php>

86 *Public Hospitals Act*, R.S.O. 1990, Chapter P.40

occurred in the hospital setting, this was seen as marginalizing the midwifery profession. Facilitating hospital midwifery care allowed midwives to fully perform within their scope of practice and facilitated independent admission of women who chose to give birth under midwifery care in a hospital setting.[87]

112. However, other barriers remain. Midwives are not included in the definition of "medical staff" in the *PHA* and therefore are excluded from decision-making on applications for privileges.[88] As well, amongst other rights denied to midwives, they do not have the same right to appeal a refusal for hospital privileges as physicians do under the *PHA*.

113. Further, decision-making remained with the physicians on the *PHA* Medical Advisory Committees ("MAC"), which govern medical-related hospital practices that affect midwives in their professional work. As a result, midwives may be excluded from decision-making relevant to their practice. As well, hospitals (with a few exceptions) do not have a Midwifery Chief of Staff, though they have a Physician Chief of Obstetrics or a Physician Chief of Family Medicine. While Chiefs are paid positions, most Midwifery Chiefs or Head Midwives are not paid by either the hospital (who claim the OMP should pay) or the OMP (who claim the hospital should pay).

114. As well, some hospital Medical Advisory Committees have denied privileges to licensed midwives and restricted the scope of midwives as defined by legislation and the CMO. For example, as a result of MAC directions, midwives in some hospitals are not permitted to maintain primary care where an epidural is required or chosen**.** The government has been unwilling to appropriately address these structural barriers despite the resultant potential decrease to patient safety, reduced access to midwifery care, and increased costs to the health-care system due to double payment to the physicians for work midwives are already paid to do.

115. There is also the issues of medically unnecessary transfers of care. These types of transfers restrict a woman's right to a midwife as her primary care provider during a low risk labour and birth, as a result of hospital policies set by the MAC which are not evidence-based, motivated by safety, nor patient-centred. This violates the premise that childbearing belongs to the woman, and that she is the primary decision maker for her care.[89] More importantly, these medically unnecessary transfers of care have the potential to decrease patient safety, as

87 *Push!*, supra at pg. 179;

88 R.R.O. 1990, Reg. 965, s. 11(1)(c)

89 Association of Ontario Midwives, "Maintaining Primary Care for Clients who Access Induction, Augmentation and Epidural", January 2011 accessed at http://www.aom.on.ca/Communications/Position_Statements/Maintaining_Primary_Care.aspx;

evidence demonstrates that each transfer of care increases the likelihood for communications breakdown, thereby potentially compromising care. [90]

116. All of the above actions or omissions have meant that the midwife remains structurally and procedurally subordinate to the male-dominated physicians and has contributed to the failure to appropriately recognize the expertise and value of the female midwives.

8. Liability Insurance

117. The AOM secured liability insurance coverage for midwives, which removed a significant barrier that midwives had faced in the integration process. For a number of technical reasons, the insurance provided by Healthcare Insurance Reciprocal of Canada (HIROC) is managed through the AOM with funding for the insurance premium provided by the Ministry.

9. Ontario Midwifery Program Framework

118. In December, 1992, Minister of Health Frances Lankin announced that the Ontario government was committed to managing and funding midwifery services. The Ontario Midwifery Program Framework was developed by a working group formed by the Ministry's Community Health Branch and the AOM.

119. From May until August 1993, representatives of the AOM and the Community Health Branch met to develop the Ontario Midwifery Program Framework. This included the compensation for midwives. (See Part 4 - Initial Setting of Compensation of Midwives below). The framework dated September 1993 formed the basis of the government's "Ontario Midwifery Program" announced along with public funding on October 1, 1993. The framework was approved by the AOM after undergoing a vote by AOM members. The framework was implemented as of January 1, 1994. This framework:

(a) Provided that the "Ontario Midwifery Program is designed to be supportive of this model of practice and to be consistent with the standards of practice as developed by the College."

(b) Adopted a government controlled community-based management system to support and enhance the group practice model and to help ensure access for those women who have not had access in the past.

(c) Established an interim central provider of midwifery programs for the next four years, the Lebel Midwifery Care Organization of Ontario ("LMCO").

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90 *Push!*, supra at pg 183;

(d) Established a compensation structure for midwives and a separate payment of the operating expenses related to the provision of midwifery services.[91]

120. The framework described the context for funding and regulation as reorienting maternity health care away from a focus on illness and intervention:

During the 1980's large numbers of both family physicians and obstetrician/gynaecologists stopped practising obstetrics. A survey of family medicine residents at McMaster University in 1988 showed only 20% of newly graduated family physicians starting practices which included obstetrics. With fewer family practitioners providing obstetrical services for low-risk pregnancies, higher cost specialists are being used more often and pregnancy and birth have become increasingly illness and intervention oriented. The introduction of midwifery funding in Ontario will help to re-orient care for low-risk pregnancy and birth by supporting a community-based approach which supports greater consumer involvement. [92]

121. The framework further noted that autonomous midwifery services would improve health outcomes and emphasize wellness and health maintenance:

Research has shown that midwifery care achieves improved health outcomes for both the child and the mother (e.g. fewer low-birth weight babies, lower C-section rate). Midwives also have lower associated costs (e.g. lab tests, bed-day costs) as a result of a lower intervention rate and a de-emphasis of the high-tech approach. There is also a lower rate of pharmaceutical use.

As the health system attempts to emphasize wellness and health maintenance, midwifery services are well positioned to support these efforts in the area of maternal and child health.[93]

PART 4 INITIAL MINISTRY SETTING OF COMPENSATION OF MIDWIVES

1. Background: Pre-Regulation Compensation of Midwives

122. Prior to 1994, the compensation received by midwives came from payments made by women who hired the midwives directly and privately and some midwives provided their services at no cost.

123. A key component of the equitable integration of midwifery into Ontario's health-care system was the setting of an equitable compensation for midwifery services.

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91 Midwifery Program Framework, supra at pg 2;

92 Ibid

93 Ibid

Compensation is a reflection of societal value and sets the basis for the position of a profession within the physician-led health profession hierarchy. Prior to regulation, midwives as women working for women had been subjected to many barriers, stereotypes and prejudice, which had lowered or denied them compensation and the ability to properly practise on equal terms with physicians.

2. The 1987 *Pay Equity Act* – Combatting Systemic Gender Discrimination in Compensation

124. The setting of compensation for midwives came as women were struggling to enforce their rights to be free from pay discrimination and prejudice. The 1987 *Pay Equity Act* provided a mechanism for redress of that discrimination through the comparison of male and female job classes on the basis of SERW and the required adjustment by employers of the compensation (pay and benefits) for such female job classes to comparably valued male job classes. Systemic gender discrimination in pay is also a violation of the *Human Rights Code* which prohibits discrimination in employment.[94]

125. The *Pay Equity Act* is based on the recognition that Ontario has a segregated workforce, and that many women are clustered into jobs typified by "women's work," which was seen as a discriminatory label that accompanied discriminatory wage setting. The estimated wage gap at that time was 38%.[95]

126. Early Pay Equity Hearings Tribunal decisions under the *Pay Equity Act* documented the history of systemic gender discrimination with respect to women's work, particularly in the health-care sector. These decisions mandated the need to properly make visible and value undervalued women's work through the comparison of female-dominated work with that of male-dominated work based on the criteria of SERW using a gender neutral comparison system and then ensuring comparable but dissimilar work is paid comparably.[96]

127. The Pay Equity Hearings Tribunal, relying particularly on the evidence of pay equity expert Dr. Pat Armstrong, noted that the process must be able:

> *to analyze and rectify systemic patterns of wage discrimination." To do this, "particular attention must be paid in valuing the work of female job classes to ensure the comparison system remedies the historical undervaluation of women's work…*
>
> *The Act recognizes that gender biases have existed and the gender neutral comparison system must work to consciously remove these biases. Gender bias*

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94 *Nishimura v. Ontario (Human Rights Commission)*, (1989) 62 D.L.R. (4th) 552

95 Ontario, Minister Responsible for Women's Issues, Green Paper (Toronto: 1985) at pg.(ii);

96 *ONA v. Haldimand Norfolk (No.6),* supra and *Women's College Hospital*, (No.4), supra

can enter at different points in the process: in collecting information on job classes; in the selection and definition of sub-factors by which job classes may be evaluated; in weighting of factors and in the actual process of evaluating jobs ... The purpose of using a gender neutral comparison system is to remove the arbitrariness and gender biasing in the valuing of work" and "ensure that each component which forms part of the comparison system is gender neutral. Bias in one means the system as a whole is not gender neutral. Gender bias must be eliminated from all parts of the comparison system.[97]

128. The Tribunal noted some of the "frequently overlooked aspects of women's work," many of which are relevant to midwifery work. These characteristics relevant to midwifery work are set out below and also relied upon in the Durber report:

... skill characteristics in the areas of communication, co-ordination, emotional work in crisis situations, fine motor movement, operating and calibrating technical equipment, establishing and maintaining record-keeping systems, and writing and editing others' correspondence and reports; effort characteristics such as concentration, stress from inflexible deadlines, lifting people, listening for long periods of time, sitting for long periods of time, getting work accomplished without resort to formal sources of control and authority, and performing multiple tasks simultaneously; responsibility characteristics such as protecting confidentiality, caring for patients, clients and inmates, representing the organization through communications with the public, preventing damage to technical equipment and instruments, and actual or proximate (as opposed to formal or ultimate) responsibility; and working conditions characteristics such as exposure to disease and human waste, emotional overload, stress from communication with difficult and angry clients, working in open office spaces, and stress from multiple role demands..][98]

129. At the time that the AOM and the Ministry were starting to address the issue of the compensation of midwives, the health-care sector had either completed or was still completing their initial obligations to make the above-noted comparisons and to determine what adjustments if any were necessary to achieve pay equity under the *Pay Equity Act.*

3. The 1993 Morton Report and Analysis

130. Throughout the discussions with the Ministry in developing compensation for midwives, efforts were made to include a pay equity lens in the compensation setting process for the soon-to-be-registered midwives. There was a need to strive to ensure that this new almost-exclusively female profession entered the

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97 *ONA v. Haldimand Norfolk (No.6)*, supra, at paras 116 and118;

98 *Women's College Hospital, (No.4)*, supra. The Tribunal cited as support for this Social Construction of Skill, supra at pg. 14;

health-care system on equitable terms based on an evidence-based analysis of their work and that of other relevant health professions.[99]

131. As noted in the Ontario Midwifery Funding Framework, "to determine the salary scale, outside consultants (Robert Morton and Associates) were brought into the process to survey midwives and other health professionals and to take the working group “through a pay equity exercise” that evaluated midwives in comparison to primary care nurses and to physicians working in Community Health Centres in the areas of skill, effort, responsibility and working conditions."[100]

132. As stated by the Ontario Midwifery Funding Framework, the Morton report:

(a) provided a sound method for establishing the relationship between the job of a midwife and comparator professions;

(b) was a fair and objective process in terms of substance and content of the outcome;

(c) used a refined set of rating scales which defined the essential elements of the key factors to evaluate the SERW;

(d) started with the recommended caseload based on international standards, which was 80 births a year;

(e) analyzed the midwifery work based on the Transitional Council of the College of Midwives March 1993 entry-level “Core Competencies: A Foundation for Midwifery Education: Recommendations of the MIPP to the IRCM" as well as on the baccalaureate education and the stress of on-call work;

(f) adopted the perspective of a community-based health service rather than the medical profession's fee-for-service model based on the Schedule of Benefits for Physician Services under the *Health Insurance Act*, which sets a fee that includes both compensation and operating expenses;[101]

(g) compared the entry-level midwife to the male-dominated CHC physician using a detailed job description;

(h) compared the midwife to the primary care nurse in the CHC using a detailed job description as well;[102]

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99 Midwifery Program Framework, supra at pp. 2-3

100 Morton Report, supra. See also Midwifery Program Framework, supra at pp. 2-3

101 See also discussion in *Push!*, supra at pg 202;

102 At the time of the analysis, it is not clear that the senior primary care nurse or nurse practitioner compensation had been subjected to any pay equity analysis and accordingly the position's pay

133. With respect to the CHC physician, the Morton report appears to have used the pay grid of $80,000 to $118,000, which was the lower level salary grid used to compensate CHC physicians in non-underserviced areas. The higher pay grid for underserviced areas was $117,766 to $135,830. The $80,000 to $118,000 figures did not include the CHC physicians' on-call compensation of $5453. As well, it did not address the fact that CHC physicians were generally started at the maximum rate rather than the minimum rate as the CHCs were funded for physicians to be paid at the maximum rate.[103]

134. At the time Community Health Centres were originally created in the 1970s and '80s, the compensation for physicians was separated into two grids, one for urban centres and one for rural centres. After the original 57 centres were expanded in the 1990s, this compensation grid was changed to reflect "under-serviced" and "non-underserviced" centres. The non-underserviced centres are those in the GTA, Hamilton, London, Ottawa and Windsor. All other centres are designated "underserviced." Some centres with a satellite location designated as "underserviced" will have physicians on two separate grids.[104]

135. The Morton report summarized its "method to establish compensation level " as follows:

An endeavour such as setting a salary range for a new profession is a matter of informed judgement. The Consultants sought to inform the judgements to be made through systematic and careful research into how the profession of midwifery compared to related health professions with respect to the dimensions of skill, effort, responsibility and working conditions. Toward this end, they surveyed approximately 25 consumers, midwives, nurses, physicians and educators, by telephone, to establish perceived similarities and differences between related jobs and that of Midwifery. Information regarding the relative skill, effort, responsibility and working conditions gained from this research, as well as a proposed framework for comparing jobs, was brought to the Work Group for review, discussion and confirmation in an initial working session. General agreement was reached, by the Work Group, that the system would provide a sound method for examining the relationship between the job of the midwife and those of comparator professions. In order to further assess the comparison method, the consultants sought the perspectives of people in other health professions to confirm its validity. This resulted in what the consultants considered to be a fair and objective outcome in terms of the process and content of the exercise.

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may have been lower than it should have been as a result of systemic gender discrimination in compensation.

103 MOHLTC Handbook for Developing A Community Health Centre: Phase II: Needs Assessment & Proposal Development. Association of Ontario Health Centres, Rev. September 2000 and attached Appendix Community Health Centre Program Approved Salary Ranges.

104 Ibid

During a second working session, the consultants presented a refined set of rating scales which emerged from discussions in the first session. The process included defining the essential elements of each of the key factors such as education, breadth of knowledge and responsibility in decision-making. In addition, the consultants presented a comparison of "Authorized Acts" (Appendix A), a comparison of job requirements (Appendix C) based on job descriptions for a primary care nurse and a family physician in a Community Health Clinic and a list of core competencies for midwives (Appendix B). These comparisons were further informed by considering relevant dimensions of other related professions such as psychology and social work. The outcome of this session was agreement on the relative positioning of midwifery in relation to primary care nurses and family practitioners in a Community Health Clinic.

A third working session aimed at deriving a salary range for midwives was then undertaken. The consultants presented current salary data (Appendix D) which they had collected in relation to professions in the health and social service fields. This enabled the Work Group to consider the "market value" of the various professions. Again, the primary comparisons were with primary care nurses and family physicians in a Community Health Clinic, but other, such as psychology, dentistry and pharmacy were considered. The group then worked toward a preliminary decision on a salary range for midwives in Ontario.

At a fourth and final working session, the Work Group revisited issues and reached agreement on the above noted salary range.[105]

136. Based on the above discussions and agreement, the Morton report recommended compensation on a salary basis with a salary range starting at $55,000 and extending up to $77,000, and that progression through this range would be based on 11 annual increments of $2,000.

137. The following matters should be noted about the report:

(a) While midwives serviced all of the areas covered by the CHCs, the report did not address the issue of whether midwives should be paid more for working in the “underserviced” areas although this warranted more pay for the CHC physicians.

(b) The report also did not address the issue of benefits that were to be addressed separately by the Ministry.

(c) As the midwives were not yet working in their new regulated practice group setting, the Morton job comparison analysis left a "?" for what their responsibilities were for "supervision" and "administration" while providing credit for those job features to the CHC physician and CHC primary care nurse.

105 Morton Report, supra at pp. 2-3

(d) The report also did not state what consideration was given to fact that the midwives worked for approximately 44 hours per week and the CHC nurse and physician had a 35-hour work week. Nor did the report address the on-call fees for the midwives.[106]

4. The Ontario Midwifery Funding Framework Compensation and Contractual Terms

a. Compensation

138. The Ministry adopted the above-noted Morton recommendations with respect to the setting of compensation. The September 1993 Ontario Midwifery Funding Framework provided that:

(a) "Midwives will be compensated on a salary basis. This approach to compensation is best able to support the model of practice and is most compatible with the community health approach to program and service delivery."

(b) This salary will be "subject to cost-of-living adjustments as determined from time to time by the Ministry of Health."

(c) "All transfer payment agencies receiving funds from the Ontario Midwifery Program will be required to contract or employ midwives in accordance with this salary range and the following terms for its application."

(d) The compensation range will have 12 steps in total, including the starting step, and each step will represent an equal fixed dollar increment (i.e., the range of $55,000 to $77,000 will have 11 annual increments of $2,000).

(e) The first step is considered to be the entry level for a newly registered midwife with less than one year's experience in active practice.

(f) Progress through the range commensurate with the number of years of active practice. Each step represents one year of active practice.

(g) The initial group of registrants will be placed on the range according to their level of experience. This will be determined in accordance with the definition of active practice used by the Michener Institute in determining the level of experience for the pre-registration program.

(h) Midwives entering the Ontario health system from other jurisdictions will be placed on the range in accordance with a determination of their years of active practice (or its equivalency) in a model of practice similar to that of Ontario.

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106 Hay Report 2004, supra at pg 6

(i) "Compensation of midwives" is to be handled separately from the "operating expenses" incurred by midwives in providing the midwifery health-care services to women. This was consistent with the government-controlled, community-based management of midwifery services and is similar to the salaried status of CHC physicians and CHC primary care nurses.

(j) Compensation was based on caseload expectations of 80 births a year, with the midwife attending as either the primary or secondary caregiver. This is because midwives generally work within a shared-care approach, and each midwife will act as the primary caregiver in 40 cases per year by providing complete courses of care, but will also be the secondary caregiver to another 40 women and their infants.[107]

b. Expenses and Liability Insurance

139. With respect to "midwifery services expenses," the framework provided that the "operating expenses of the midwifery practice group related to the provision of midwifery services determined to be acceptable for funding will be included in the funding arrangements. This was to be similar to how such expenses were handled for the CHC program with variation to accommodate the uniqueness of the Ontario Midwifery Program."[108]

140. Liability insurance is mandatory for midwives and for physicians as a result of the requirements of the CMO and the College of Physicians and Surgeons of Ontario. Midwives have received full reimbursement for insurance costs from the Ministry since 1994. This insurance was provided through a series of contractual relationships with insurance companies. The current company is HIROC.

141. As stated by the MOHLTC with respect to its reimbursement of almost all of a physician's liability insurance premiums, "the Government understands that liability protection is a necessary part of practising medicine." It is also essential, responsible and ethical to ensure there is adequate compensation available to any patients who require such coverage in case of a significant adverse event.[109]

142. The annual insurance premium for midwives ($33,112.96 in 2012/13) is fully funded as an operational expense of the individual midwife. Like physicians, midwives must have liability insurance to practice and like physicians, midwives receive reimbursement for insurance premium costs.

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107 Midwifery Program Framework, supra pg. 9

108 Ibid, at pg 10

109 Ministry of Health and Long Term Care, "Medical Liability Protection Reimbursement program" accessed at <https://www.health.gov.on.ca/en/pro/programs/ohip/mlp/>

143. The Ministry's Medical Liability Protection ("MLP") Reimbursement Program covers the cost of physician's insurance premiums over and above the 1986 base fees, which results in the physicians only paying a low fee. In 2012, obstetricians paid an annual insurance premium of $49,416. However they were reimbursed for $44,516 of these fees through the MLP, and only paid the difference of $4,900. Similarly family doctors with an obstetrics practice paid $8,784 in fees, were reimbursed for $7,584 of these fees, and effectively paid $1,200.[110]

c. Initial Funding Contractual and Practice Group Relationships - The LMCO

144. The basic structure for the delivery of midwifery services was to be carried out by midwives in practice groups. Each practice group enters into a contract with a Ministry-appointed TPA. This contract sets out the compensation to be paid to midwives as directed by the MOHLTC in its contract with the TPA. The Ministry funds the compensation of midwives through the TPA.

145. Midwives were initially characterized as "dependent contractors:"[111]

> *"Midwives are dependent contractors. They are contractors for service in terms of controlling their own business but they are dependent on one source for funding of their midwifery activities (i.e., the Ontario Midwifery Program) and are therefore dependent economically."*[112]

146. The government established the LMCO in 1993 as the central transfer payment organization to be responsible for the overall administration of the OMP with funding directly from the Community Health Branch of the Ministry of Health.[113] The Funding agreement between LMCO and the Ministry set out the compensation to be paid to midwives, which was then reflected in the funding agreement between the LMCO and the "practice group."

147. The LMCO/Midwifery Practice Group agreement provided that:

> (a) The LMCO will pay to the practice group as funding compensation for midwifery services during each fiscal period a range of remuneration that is a salary starting at $55,000 with a maximum rate of $77,000.

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110 Ministry of Health and Long Term Care, "Medical Liability Protection Reimbursement program: Frequently Asked Questions", accessed at http://www.health.gov.on.ca/en/pro/programs/ohip/mlp/faq.aspx

111 Midwifery Practice Financial & Business Manual, 1995

112 Ibid

113 Lebel Midwifery Care Organization of Ontario , "Midwifery Funding: Background Information" [Background Information]

(b) "The rate of compensation shall increase by a fixed amount ($2,000) after each year of full time service completed by the midwife, to the maximum rate in the Table."

(c) "In keeping with the principles of the social contract, if the amount payable for a midwife in 1994/1995 is projected to be greater than $30,000 the amount payable in that fiscal year will be reduced by 4.4%; but if the reduction results in the amount payable for that midwife in that fiscal year being less than $30,000, the amount payable will be $30,000."

(d) Funding to the midwifery program is divided into "compensation," "operating," "special operating" and "non-recurring." Compensation is only paid to practice groups for approved Ministry midwifery positions.

(e) The LMCO will also pay an amount equal to 16% of the amounts paid for compensation for the cost of a benefit package.[114]

148. As of January 1994, midwifery became a fully regulated profession and a government-controlled and funded service for Ontario women.

149. The LMCO's summary of the status of midwifery at the time of regulation is as follows:

(a) The College of Midwives' standards require two midwives at a birth, and most midwives organize their work in a shared care arrangement within a practice group. Funding for midwifery services is flowed to the practice group, not to individual midwives.

(b) Funding to a midwifery practice group begins when the practice enters into a contract with LMCO (or, in the future, another agency) to provide midwifery services in a Ministry-approved catchment area. The practice group is funded for the set-up costs, operating expenses (rent, travel, etc.) and individual compensation (not salary, as midwives are not employees).

(c) The compensation level of a midwife is between that of a senior salaried nurse and a family physician and reflects the level of responsibility as a primary care provider and the demanding nature of a midwife's work.

(d) Pregnant women can book directly with a midwife; a physician's referral is not required. A woman who chooses midwifery care for her pregnancy, delivery and postpartum care will not normally see a physician; the midwife is the primary care provider.

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114 Funding Agreement between Lebel Midwifery Care Organization of Ontario and Midwifery Practice Group, 1994

(e) In line with the Ontario model of midwifery practice, midwives are required to be on call 24 hours a day, seven days a week. Usually a client will be cared for by two midwives in a shared-care arrangement and in no situation will a client see more than four midwives during her course of care. A great deal of information-sharing takes place during clinical appointments, which last approximately 45 minutes.

(f) Midwives provide comprehensive postpartum care to women and their newborns; they make several home visits in the days and weeks following the birth.[115]

150. As of proclamation, there were 68 midwives in 21 practice groups serving Ontario women in specific government-designated catchment areas from Kingston to Niagara, as well as the communities of the Grey-Simcoe area, Guelph, Huntsville and the surrounding area, Kitchener-Waterloo, London, North Bay and the surrounding area, Ottawa, Peterborough, Sarnia, Sudbury and Thunder Bay. Each midwife working full time provides care in a shared-care arrangement to 80 women and their newborns throughout pregnancy, birth and the postpartum period on an annual basis. A midwifery practice made up of four midwives provides care to 160 women each year.[116]

151. It was understood that for many years to come, the demand for midwifery services will far exceed the availability.[117] The Ministry requires practice groups to track this excess demand by regularly submitting to the Ministry an unaccommodated client report.

d. Contractual Status of Midwives

152. From 1993 until January 31, 1999, midwives were described by the Ministry as being on a "salary" and as "dependent contractors." While midwives were not employees, neither were they independent contractors like the medical profession who offer their services in a fee-for-service basis.

"Midwives are dependent contractors. They are contractors for service in terms of controlling their own business but they are dependent on one source of funding of their midwifery activities (i.e., the Ontario Midwifery Program) and are therefore dependent economically."[118]

153. When the Ministry decided to move from the central LMCO to community-based TPAs, the Ministry insisted that midwives be described as "independent

115 Background Information", supra at pg 2

116 Ibid

117 Ibid

118 The Midwifery Practice Financial and Business Manual, supra at pg. 1

contractors" in the new funding agreements, the first of which took effect on June 1, 1999.[119]

154. The title of "independent contractor" was chosen to best reflect needs of the model of practice, the autonomy of midwives and the extraordinary working conditions of midwives, which requires 24/7 on-call work and continuity of care. Such conditions were much longer than the prescribed hours under the *Employment Standards Act*, *2000* and did not fit within a standard employment relationship.[120] It also reflected the system of mutual support on which midwifery is based with the TPA relating to midwives as a collective and the midwives relating to one another within the group for their day to day professional accountabilities.[121]

155. The term "independent contractor" does not however, accurately portray the degree to which midwives in many respects are constrained more like employees in their work and compensation:

(a) The midwifery practice group is constrained in the amount of clients that midwives can take on, since caseload is preapproved.

(b) Contrary to this model, a fee-for-service physician is not constrained in the number of patient they can take on, nor the kinds of service they can bill for.

(c) While a fee-for-service physician may "set up a shingle" anywhere in the province, a midwife may not practice unless she joins a practice group. The availability of practice group placements however, is controlled by the Ministry, who can approve or disapprove new placements. Midwives cannot create a new practice group without TPA and Ministry approval with regards to where, catchment area and caseload.

(d) Midwifery practice groups take on the risk of a small business, but unlike other small businesses including physician-based practices, there is no ability to increase income with effort (no commensurate reward for effort); the practice cannot grow or expand without MOHLTC approval nor can the practice bill for additional services.

156. The funding framework, contractual agreements, combined with the provisions of the *Midwifery Act, 1991* and relevant provisions of the *RPHA, 1991* and the control of the funding for education placements establishes a high degree of

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119 Agreement between Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care and the Transfer Payment Agency, effective April 1, 2000

120 *Employment Standards Act, 2000*, S.O. 2000, Chapter 41

121 Association of Ontario Midwives "AOM'S 1999 Practice Guide", 1999

government control over the practice of midwifery. The Ministry controls the size of the midwifery profession, where midwives practise throughout the province, the size of their practice and their ability to withdraw their services as a result of their professional obligations of care and the exigencies of caring for women during pregnancy and childbirth.

PART 5 THE MINISTRY FAILURE TO PROVIDE PAY EQUITY – THE DEVELOPMENT OF POST-REGULATION PAY INEQUITIES

1. Introduction

157. As of January 1, 1994, the regulation and funding of midwifery offered Ontario women a choice in how prenatal care and childbirth is conducted so that those who wish to be cared for by midwives during pregnancy, labour and delivery had this option. Midwives now shared with doctors the provision of autonomous maternity and newborn health care as well as public funding for such services.

158. However, as noted above, midwives continued to experience unequal treatment, particularly with respect to the male-dominated profession of physicians. This was particularly reflected in the differences between the Ministry's ongoing relationship with the AOM and with the OMA with respect to the setting of compensation.

159. Over the next nearly 20 years, the midwifery profession would steadily increase in number. Yet compared to physicians, the midwifery profession remained very small. This, combined with the ongoing questioning of the value of their work as set out below, placed the AOM and its members in a very precarious position. Many misperceptions of care persisted. For many years, the OMP was considered a pilot project and many worried the MOHLTC might cancel it. Both the AOM and midwives worried that if they were too assertive and “rocked the boat” the profession might be eliminated and Ontario women would lose an important health-care choice.

2. Comparison of the Male-Dominated OMA Bargaining with the AOM Bargaining/Consultations

160. The male-dominated profession of physicians has historically exerted significant influence over the utilization and distribution of health-care resources with the medical profession getting the most resources at the top of the health profession hierarchy.[122]

122 See Canadian Institute for Health Information, CIHI Annual Report, 2012-2013, July 12, 2013. See also Tom Archibald and Colleen M. Flood, The Physician Services Committee - the Relationship Between the Ontario Medical Association and the Ontario Ministry of Health and Long Term Care, Working Paper No. 2 - Defending the Medicare Basket, March, 2004

161. During the period since 1994, the MOHLTC failed to negotiate increased compensation for the midwives for 11 years. At the same time, the Ministry continued to negotiate with the OMA about physician compensation and recognized the OMA as the exclusive representative of physicians. This recognition was set out in successive agreements reached with the OMA. It is also back-stopped by the *Ontario Medical Association Dues Act, 1991* and the *Health Insurance Act*.[123]

162. Although the AOM was only able to reach three funding agreements during the period of 1994 through 2013, only two of these agreements, for 2005 and 2008, resulted in an increase in compensation. In contrast, the OMA achieved six agreements during that period, each of which resulted in an increase in compensation, with the exception of the last one, which included a small short-term decrease.

(a) April 1, 1997 to March 31, 2000

(b) April 26, 2000 to March 31, 2004

(c) April 1, 2004 to March 31, 2008

(d) re-opener 2007 agreement

(e) April 1, 2008 to March 31, 2012

(f) April 1, 2012 to March 31, 2014.[124]

163. When the Conservative party came to power in 1995, it briefly decided not to continue recognizing the OMA as its bargaining partner. This lead to litigation by the OMA challenging the failure to recognize it as the bargaining representative under section 2(d) of the *Canadian Charter of Rights and Freedom* and different physician specialty groups threatening to withdraw their services. This lead to the

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123 *Ontario Medical Association Dues Act, 1991*, S.O. 1991, chapter 51; *Health Insurance Act,* R.S.O. 1990, c. H.6, s. 5

124 Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 1, 1997 to March 31, 2000; Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 26, 2000 to March 31, 2004; Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 1, 2004 to March 31, 2008; Memorandum of Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, 2007; Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 1, 2008 to March 31, 2012; Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 1, 2012 to March 31, 2014.

Ministry, in settling the litigation, agreeing to a Memorandum of Agreement with the OMA for the period April 1, 1997 to March 31, 2000.

164. This agreement recognized that the Ontario government has historically "consulted and negotiated with the OMA as the representative of the medical profession in Ontario." It formally recognizes the OMA as "exclusive representative of physicians practising in Ontario" including with respect to "the negotiation of physician compensation for physician services funded in whole in or in part directly or indirectly by the Minister."[125] It continued the Physicians Services Committee as a structured ongoing process for communications.[126]

165. The agreement also provided for key bargaining rights for the physicians that are not provided to the AOM:

(a) Assistance from a facilitator after a period of bilateral negotiation. It allows this facilitator to make confidential recommendations to the parties.

(b) If no agreement is reached, a neutral conciliator will step in who is empowered to write a written report with non-binding public recommendations for resolving any outstanding issues.

(c) The MOHLTC will not advise the Government of Ontario to unilaterally implement proposals until after both the facilitation and conciliation phases have been concluded.

(d) Requires the Ministry to negotiate with the OMA over all non-fee-for-service or blended compensation template agreements.

(e) The Ministry acknowledges the OMA's role in providing the government with advice about health-care policy and system issues as if affects physicians, and agrees to consult with the OMA over such matters.[127]

166. The agreement also provided for substantial increases to physician compensation. However, it appears that the salaried compensation for CHC physicians was not increasing during this period of time as the OMA focussed on fee-for-service compensation increases at that time.[128]

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125 Memorandum of Agreement between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care, April 1, 1997 to March 31, 2000.

126 Ibid at pg 2

127 Steven Barrett, "Re-Chartering the OMA/Government Relationship", November 26, 2012 accessed at http://healthydebate.ca/opinions/oma-representation-rights.

128 As set out early in this application, Hugh Mackenzie's analysis has not increased the compensation of CHC physicians from that set out in the 1993 Morton report until 2003.

167. As noted in the research, the Ministry responded to physician pressures by increasing their compensation.[129] Pressure from the midwives did not lead to such increases.

168. The above agreement and the successor OMA agreements referred to in this application stand in sharp contrast to the Ministry-AOM processes that have been in place since 1994.

169. Contrary to the broad control and bargaining power given to the male dominated physician profession, the Ministry retains complete control of the significantly smaller midwifery profession, including with respect to the structure and terms of compensation and the timing, content and parameters of any discussions/negotiations. This includes with respect to where and how midwives practice and integrate into the health-care system and the growth of the profession, practice groups and clinic space. The Ministry treats midwives as employees when convenient (for example with respect to employee wage restraint laws) but as independent contractors when trying to avoid responsibilities.

170. Midwives have no ability to withdraw services without breaching CMO standards and jeopardizing the care of women and their newborns. Nor are midwives afforded the contractual right to be included in discussions regarding future directions for maternal newborn care as are physicians under OMA agreements.

3. 1994 to 1996 Period

171. The first period of work and pay that Durber reviewed was 1994-1996, and a pay gap was identified. As a result of conducting a proper pay equity analysis based on the work of midwives during this period, the need for a pay adjustment as of January 1, 1997 was identified. See Durber report, Annex 7.

172. The first evidence of Ministry control after the start of regulation was that the Ministry failed to increase the compensation of midwives based on the cost-of-living increases as agreed to in the September, 1993 Ontario Midwifery Funding Framework. In fact, the midwives have never received increases that were described as cost-of-living increases. Instead the Ministry froze their compensation from 1994 to 2005. In contrast, the OMA was able to negotiate substantial increases over this period of time.

173. During this review period, midwives as a group were establishing the infrastructure of a self-regulated profession with insufficient support from the

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129 See Unhealthy Pressure: How Physician Pay Demands Put the Squeeze on Provincial Health Care Budgets by Hugh M. Grant and Jeremiah Hurley, The University of Calgary School of Public Policy Research Papers, Vol. 6, Issue 22, July, 2013 where it states at pg 22: *"the public payer has experienced persistent problems in controlling the level of utilization, or services provided and thus the overall spending on physician services."*

MOHLTC. Many midwives, in addition to doing all the listed tasks in their own practices, were deeply involved with the establishment of an education program, a self-regulating college and a functional professional association. Midwives were also preoccupied with many different new responsibilities, many of which were not considered in the original Morton analysis. This included:

(a) setting up their group practices and administering them;

(b) learning and implementing the detailed CMO standards, guidelines and practices;

(c) continuing education to ensure ongoing competency, including emergency skills courses; and

(d) preceptoring the students who were being educated as midwives in the new baccalaureate program and then mentoring the new graduates for one year.

174. By 1996, the new system was generally implemented and it was time for the Ministry to evaluate midwifery work at this more mature stage. Yet the Ministry did not evaluate those skills and responsibilities, which had not been evaluated in the original Morton analysis, and then consider whether they required a change to the compensation fees. Instead of considering whether an increase in compensation was required, the Ministry continued to freeze midwives' compensation.

175. While the original Morton analysis did not use a full pay equity comparison process, ongoing pay equity compliance as set out in the Durber report, did require the use of a systematic pay equity comparison process, which could be used to monitor the work and pay of the midwives as compared to other health-care professionals, particularly: the male-dominated CHC physician and the CHC senior primary care nurse/nurse practitioner. This meant analyzing the skill, effort, responsibility and working conditions of the work to be compared.

176. The Durber report, using the "Equitable Job Evaluation Factor Plan: Working Towards Gender Equity", has carried out the sex- and gender-based pay equity analysis that the Ministry should have done since 1994.[130] This plan evaluates and compares work using the following factors:

(a) Knowledge Skills

(b) Problem-Solving Skills

(c) Interpersonal Skills

130 Department of Labour Wellington, New Zealand, "Equitable Job Evaluation Factor Plan: Working Towards Gender Equity", 2007

(d) Physical Skills

(e) Responsibility for People Leadership

(f) Responsibility for Resources

(g) Responsibility for Organizational Outcomes

(h) Responsibility for Services to People

(i) Emotional Demands

(j) Sensory Demands

(k) Physical Demands, and

(l) Working Conditions.

(See Durber report, Annex 3 for the text of this plan which was created by the New Zealand Pay Equity Unit.)

177. The Durber report's Annex 2 - Features of Women's Work highlights characteristics of women's work, which Durber was careful to consider where appropriate in order to make visible and valued often overlooked work performed by women.

178. In considering the appropriateness of the use of the Equitable Job Evaluation Factor Plan: Working Towards Gender Equity, Durber compared the professional standards relating to the three professions with the MOHLTC's values, strategies and missions and compared these to the 12 plan evaluation factors noted above. This comparison highlights that the plan is reflective of these values and standards. (See Annex 4 of the Durber report –"Appropriateness of the Equitable Job Evaluation Factor Plan - Working Towards Gender Equality Re: Primary Health Care Values".)

179. In evaluating the work of the midwife, the CHC physician and the CHC nurse practitioner, Durber relied on extensive work documentation, which is highlighted in the body of his report, in the Bibliography in Annex 8 and in the job descriptions set out at Annex 9. In addition, Annex 5-A (Features of Work – CHC Physician, Annex 5-B – Features of Work – Midwife, Annex 5-C, Features of Work – Nurse Practitioner) set out a detailed analysis of the work of three professions, based on the work characteristics for the professions noted in the Morton report, supplemented with subsequently available information.

180. The ratings on each job evaluation factor by Durber based on the current period from 2008-2013 are set out in Annex 6 of the report along with the rationale for the rating. Annex 6 then converts those ratings into job evaluation "points" based on the weightings of the factors used in the Equitable Job Evaluation Factor Plan.

The total of these points is then used to determine the proportionate value of the midwife and the male comparator, the CHC physician and the CHC nurse practitioner. At the current time, the proportionate relationship between the midwife and the CHC physician should be 91% as set out in Annex 6.

181. The first period of work and pay that Durber reviewed captured the work of the midwives from January 1, 1994 to December 31, 1996 as they started integration into the funded system. Ensuring the equitable integration of the midwives into the funded health system was a key objective of the MOHLTC Ontario Midwifery Program.

182. As noted above in Part 1, the Durber report found that the midwives as a result of a pay equity analysis of their work (SERW) for the period 1994 to 1996 should have received, (as of January 1, 1997) 81% of the compensation of the CHC physician. (See Durber report including Annex 5B, Features of Work – Midwives, Annex 6, Ratings by Factor and Annex 7 –Evaluations of the Midwife's Work, 1994-2013.)

183. The allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians, and yet it remained at the lower 16% instead of 20%. However, the midwifery compensation was still frozen at the rate set in late 1993.

4. Pay Equity Gaps – 1997 to 1999 Period

184. As identified above, the pay equity gaps, (exclusive of benefits) for this period are:

Pay equity gap 1997: $22,726

Pay equity gap 1998: $22, 726

Pay equity gap 1999: $22,726

185. During the period 1997 to 1999, midwives continued their significant contributions to the development of midwifery services and primary health care in Ontario. The Durber report Annex 7 refers to the increasing value of their work, including their increasing supervisory and non-clinical responsibilities. As Durber notes, these contributions had increased midwives' value in relationship to the CHC physician.

186. At the same time, the Ministry in 1998 initiated discussions with the AOM concerning its intention to devolve the administration from the centralized LMCO TPAs to local TPAs. During these discussions, AOM staff member Wendy Katherine and AOM President Bridget Lynch raised with the Ministry's Sue Davey the issue of the inequitable compensation being paid to midwives.

187. In response, the Ministry said they were not willing to discuss any increase in compensation. Instead they wanted to discuss how to change the compensation

structure from what the Ministry viewed as being too “employee” focussed, to one which was based on an "independent contractor" status.

188. Accordingly, the compensation structure for midwives was changed to a course of care professional-fee structure rather than a full-time equivalent salary structure with no increase in compensation. Midwives were now to be compensated per course of care for a woman based on the MOHLTC's estimate that a midwife working full time will care for approximately 40 primary clients and 40 as a second midwife. These course-of-care fees were $2,150 per billable course of care ("BCC") at the maximum level.

189. This new compensation structure and devolved administration structure were set out in the second funding agreement, which came into effect on April 1, 2000.[131]

190. The Ministry still did not have any mechanism in place to properly analyze and monitor the work and pay of midwives relative to their male comparator’s work and pay and that of other health-care professionals.

191. There was a sense at this time that the AOM had to play "nice" to get anywhere whereas the OMA did not. Given the history that has been outlined above about the historical vulnerability of the midwifery profession and the degree to which others in the health-care system opposed and continued to oppose the existence of midwifery, midwives felt very vulnerable. There was a concern that the OMP could be ended at any time. However, the AOM hoped that if it acted with integrity and consideration of the needs of the health-care system and the Ministry, midwives would be treated in kind. However, that was not the case.

192. While the Ministry was refusing to consider increases to the compensation of the midwives, the Ministry was negotiating with the OMA for the male-dominated profession of physicians. The Ministry and OMA entered into an agreement in 2000, which went from 2000 to 2004.

193. This Agreement included the following:

(a) fee schedule increases effective as follows: April 1, 2000 – 1.95% and 2% on April 1, 2001, 2% on April 1, 2002 and 2% on April 1, 2003;

(b) obligation of MOHLTC to meet with OMA in March 2003 to negotiate whether the 2% on April 1, 2003 could be increased;[132]

(c) a Maternity Leave Benefits Plan;

(d) hospital on-call coverage and after hours premium codes; and

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131 Agreement between MOHLTC and TPA, effective April 1, 2000, supra

132 Agreement between the OMA and MOHLTC, April 26, 2000 to March 31, 2004, supra at para. 3.

(e) obligation of Minister of MOHLTC to meet regularly with the OMA. [133]

194. As well, the agreement provided that the OMA would be recognized as the representative of non-fee for service physicians such as the CHC physicians.

195. As noted above in Part 1, the Durber report found that as a result of a pay equity analysis of their work for the period 1997 to 1999, midwives should have received 85% of the compensation of the CHC physician as of January 1, 2000. The allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians yet it remained at the lower 16% instead of 20%. The Ministry still had the midwifery compensation frozen at the rate set in late 1993.

5. Pay Equity Gaps – 2000 to 2002 Period

196. As identified above, the pay equity gaps, (exclusive of benefits) for this period are:

Pay equity gap 2000: $27,651

Pay equity gap 2001: $27, 651

Pay equity gap 2002: $27,651

197. During the period up to May 2000, the government carried out an audit of the Ontario Midwifery Program, which noted that midwives had attended 3,800 births and there were with 180 midwives. Subsequent to this report, the Ministry agreed to institute a formal data management system to assist in monitoring midwifery outcomes and cost effectiveness.[134] This was the Midwifery Outcomes Report ("MOR") system.

198. By letters dated November 1, 2000, December 15, 2000 and January 9, 2001 AOM President Lynch wrote to Davey, Co-ordinator, Community Health Branch requesting that the Ministry address the need to provide midwives with equitable compensation.[135]

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133 Ibid at para. 15 and April 26, 2000 Letter of Understanding, re: Meetings with the Minister of MOHLTC

134 Ontario Midwifery Program Evaluation, supra

135 Letter dated November 1, 2000 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch; Letter dated December 15, 2000 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch; Letter dated January 9, 2001 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch

199. By letter dated January 10, 2001, Davey responded to the AOM's letter from Lynch declining the request for an increase in the fee per course of care for midwives. Davey stated that "currently the funding allocated to the Midwifery program is fully committed to existing services." However, the Ontario Midwifery Program and the Ministry of Health and Long-Term Care "remain committed to the fair compensation of Ontario midwives and will continue to monitor comparable professions to ensure that the pay scale remains in line with them. At present, for example, the ministry approved scale for nurse practitioners is $57,000 to $70,000."[136]

200. These would be repeated themes in the Ministry's responses to the AOM that there was no available money for compensation increases and that requests for compensation increases were met with the response that the Ministry had made investments in midwifery infrastructure or education.

201. Further, the Ministry continued to add more work, particularly with respect to the administration and reporting requirements of its devolved administration service structure. These increased requirements are reflected in Durber's report and particularly Annex 7.

202. During the period 2002 to 2003, the Ministry carried out an Ontario Midwifery Program Evaluation. While the AOM provided information to the review about the inequitable compensation received by midwives relative to their value and contribution to the Ministry's primary health-care objectives, the Ministry evaluation did not address the issue of the adequacy or equity of the midwives' compensation.[137]

203. However, the evaluation did establish that midwives were achieving better health outcomes than family physicians on five different measures: The rate of C-sections, operative vaginal deliveries, episiotomies, discharge from hospital within 48 hours and breastfeeding at six weeks.[138]

204. As noted above in Part 1, the Durber report found that as a result of a pay equity analysis of their work for the period 1997 to 1999, midwives should have received 85% of the compensation of the CHC physician as of January 1, 2000.

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136 Letter dated January 10, 2001, from Sue Davey, Co-ordinator, Community Health to Bridget Lynch, President of Association of Ontario Midwives

137 Ministry of Health and Long-Term Care, "Ontario Midwifery Program Evaluation: Presentation to the Association of Ontario Midwives Conference, Barrie", May 13 2004 [Presentation to AOM, 2004]

138 Ibid

205. During the period 2000 to 2002, the Durber report found, based on analyzing the midwifery work, that the proportional relationship with the CHC physician continued during this period at 85%.

206. The allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians, yet it remained at the lower 16% instead of 20%. The Ministry also still had the midwifery compensation frozen at the rate set in late 1993.

6. Pay Equity Gaps – 2003 to 2005 Period

207. As identified above, the pay equity gaps for this period are:

Pay equity gap 2003: $40,894

Pay equity gap 2004: $43,618

Pay equity gap 2005: $31,534

208. In April, 2003, the Ministry initiated a new mandatory system of data entry by midwives that had to be completed in order for midwives to be compensated, which again contributed to the extensive non-clinical responsibilities of midwives required by the Ministry.

209. While the Ministry increased the CHC physicians' compensation as of 2003 to $138,699.09 (including the on-call payment), midwives still had no relief from their inequitable compensation.

210. While physicians' contracts and compensation were being renegotiated and substantially increased, the Ministry was ignoring the inequitable compensation it was paying to midwives for midwifery services and substantial outstanding pay equity adjustments were being accumulated. Midwives had been too trusting and accommodating and the Ministry was taking advantage of their small numbers, and the fact that CMO standards concerning continuity of care did not permit the withdrawal of care. Midwives were also greatly concerned about the impact on clients of any withdrawal on their care – i.e., their "caring dilemma."

a. The 2003 and 2004 Hay Compensation Review Reports

211. With the Ministry not carrying out its pay equity maintenance responsibilities, the AOM hired the Hay Health Care Consulting Group ("Hay Group") who prepared a June 2003 "Compensation Review" report, later updated in 2004. The Hay Group carried out research and presented findings and recommendations for an appropriate level of midwifery compensation (current and ongoing) as well as recommendations with respect to the percentage amount of the midwifery fee level necessary to sustain midwifery benefits at the ratio 75:25 (e.g., health benefits and RRSP), which had been eroded.

212. While the Hay report did not carry out a proper pay equity analysis as done by Durber, they did conclude that the midwives were substantially underpaid by a number of measures. The findings included the following:

(a) Midwives on average earn approximately $60,000 per year. The midwife grid remained at the 1993 rate of $55,000 to $77,000.

(b) CHC physicians earned for non-underserviced areas $106,216 (min) to $127,971 (max) and for underserviced areas and $124,848 (min) to $150,419 (max) (note: which did not include on-call payment).

(c) The Ministry pays CHC physicians 20% of their salary for benefits as compared to 16% for midwives. For midwives this comes to $9,600.

(d) CHC physicians are not restricted from supplementing their income by billing fee for service outside of services performed in the CHC. Midwives have no alternative method of billing to supplement their income.

(e) Midwives worked 22% longer per week than the CHC primary care nurse/nurse practitioner or CHC physician (44 hours versus 36 hours). If this difference in hours had been calculated by Morton, the entry level for midwives set in 1993 at $55,000 was really equivalent to $45,100, which is only 7% higher than the CHC senior primary care nurse/nurse practitioner.

(f) Therefore, it is only after seven years of experience that a midwife begins to earn more than the CHC senior primary care nurse/nurse practitioner for the same hours of work per week.

(g) When the hourly compensation differences are considered, the top of the pay scale for the midwife is 35% below the minimum of the physician pay scale and 13% higher than the top of the nurse pay scale. [139]

213. The Hay report also addressed the issue of on-call pay.[140] The CHC salary used for the basis of comparison includes an on-call allowance of $5,000. That $5,000 does not adequately reflect midwives' onerous on-call schedule. The on-call schedule required by the Ministry for midwives amounts to an average of 4,400 on-call hours. This amounts to 110 on-call hours per course of care. That 110 on-call hours per course of care represents an average rate of $125 per BCC or $1.14 per hour.[141]

214. Even though it was not a proper pay equity analysis, the Hay report still identified a $26,000 pay gap and recommended the following:

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139 Hay Report 2004 supra at pp. 6-11;

140 Ibid at pg 18

141 Note: the ONA on-call rate covering hospital registered nurses funded by the health care system was $3.30 per hour with significantly less onerous on-call responsibilities.

(a) The job rate or maximum rate for midwives, factoring in an appropriate on-call rate, should be increased to $2,575 per BCC, or $103,000 annually based on an average of 40 BCC per year. This was $26,000 more than midwives at the maximum rate were being paid. The base rate should be $2,720 per BCC, or $81,000 per year, plus an on-call rate of $550 per BCC or $22,000 per year. These amounts were calculated as follows:

(i) The base was calculated using a three step method. First, initial base rate was calculated using the Morton report formula of 90% of the minimum amount paid to the CHC family physician based on a 35-hour work week.[142] This included the CHC family physician's on-call amount.

(ii) The on-call portion of the above billable course of care rate had to be recalculated since the on-call duties of the midwife were much more onerous than that of the CHC family physician. This should be done by subtracting the on-call portion of the base rate, calculated at $5,000 and adding back a new on-call amount, which was calculated to be $22,000 per year.

(b) The pay grid of start and 11 steps should be collapsed to one rate, which would work out to $103,000 as this was consistent with other professional independent contractor compensation structures.

(c) $2,150 per billable course of care was too low as it was virtually the same amount that midwives' compensation would have been if annual cost of living adjustments had been applied to midwives' compensation maximum from 1994 to 2003. The cost-of-living adjusted annual salary as of 2003 for midwives would have been $90,480.[143] As noted above, the Ministry's 1993 funding framework had provided that the compensation of midwives should have been increased in accordance with the cost of living. (See also the expert report from Hugh Mackenzie, which sets out the annual cost-of-living increases since 1994 and the compensation of midwives from 1994 if it had been adjusted for such cost of living adjustments.)

(d) The amount paid for midwives' benefits should be increased to 20% (as paid to the CHC physician) from 16%.

215. In order to ensure better compensation practices moving forward, the Hay report recommended:

(a) an annual review by the Ministry of the compensation it was paying to midwives;

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142 Note the calculation of 90% of the CHC minimum salary as the Morton salary did not take into account the $5353 on-call payment received by CHC physicians.

143 Hay Report 2004, supra at pp 7 and 17;

(b) annual adjustments to the midwifery pay scales; and

(c) audits every four years to make sure that these adjustments are still in line with market levels and to ensure the integrity of the pay scale is maintained.[144]

216. The Hay report recommended separately that the operations fee be adjusted annually by an appropriate inflationary factor to appropriately reflect changes in the costs of operating a midwifery practice.[145]

217. The AOM provided a compensation proposal to the Ministry in early 2003 that proposed collapsing the midwifery grid to one single rate as recommended by Hay. It also proposed increasing the midwives' compensation as recommended above by the Hay report.

218. On July 24, 2003, AOM President Remi Ejiwunmi wrote to MOHLTC Minister Tony Clement requesting a meeting to discuss a new "fair and equitable" compensation for midwifery after the years of frozen compensation. This letter enclosed the Hay report.[146]

219. The AOM again raised the issue of compensation at meetings with the Ministry. In early 2004, the AOM provided an updated Hay report to the Ministry. No action was taken by the Ministry nor any response provided to address the report's findings or the inequitable compensation.

220. On May 26, 2004 the Ministry finally wrote back to the AOM and made no mention of the Hay report. The Ministry has never provided the AOM with its response to the Hay report or its justification for failing to act on its recommendations, including those recommendations regarding regular reviews of compensation.

221. However, in a speech during the May 2004 AOM annual conference, then Minister of Health and Long-Term Care George Smitherman stated that the Ministry was planning for a significant expansion of midwifery services. He also stated:

I don't want to be anything but entirely direct when I suggest that the challenge of both expanding the quantity of services…and trying in one fell swoop to address compensation pressures…is near impossible.

144 Ibid at pg 21

145 Ibid at pg 22

146 Letter dated July 24, 2003, from Remi Ejiwunmi, president of Association of Ontario Midwives to The Honourable Tony Clement, Minister of Health and Long-Term Care

222. Once again the Ministry seemed to be responding to requests for equitable compensation by focusing instead on the expansion of services.

223. AOM President Elana Johnson approached the Minister of Health George Smitherman directly at this meeting regarding the issue of inequitable compensation. He stated that she should contact his staff to get talks started.

224. At this same meeting, the MOHLTC presented a PowerPoint presentation "Ontario Midwifery Program Evaluation," which noted that a key program objective is to "provide an equitable funding mechanism that supports the integration of midwifery into the funded health care system." The findings included data indicates that current costs for midwifery care in the home and hospital settings with "better clinical outcomes are less expensive and comparable to hospital obstetrical services by physicians As well, the data also "indicated that current costs for midwifery in the home and hospital settings with better clinical outcomes are less expensive or comparable to hospital obstetrical services by physicians."[147]

225. By letter dated May 28, 2004, AOM President Elana Johnson wrote to Sue Davey, Senior Manager, Community Health Branch confirming that the parties would be discussing compensation in the upcoming negotiations. [148]

226. On August 19, 2004, the Minister announced a $7-million increase to the Ontario Midwifery Program to fund 55 new midwives positions. The Minister stated: "what better way to invest our precious health care dollars than in support of midwives who help to bring us such wonders." Yet the issue of midwifery compensation was not addressed.[149]

227. AOM President Johnson met with MOHLTC Assistant Deputy Minister, George Zegarac on September 22, 2004 and the issue of inequitable compensation was raised by the AOM along with attrition concerns. The AOM, relying on the Hay report requested that the government needed to ensure midwives maintained an appropriate proportionate relationship with CHC physicians.

228. MOHLTC representatives acknowledged that a significant compensation gap had evolved between midwives and CHC physicians and CHC nurse practitioners since the original Morton report comparison. However, MOHLTC representatives, including Davey repeatedly stated that they were unable to make up for the 10 years of no compensation increases in one round of discussions, but that there needed to be a good enough start.

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147 Presentation AOM. 2004 , supra at slide 23

148 Letter dated May 28, 2004, from Elana Johnson, President of Association of Ontario Midwives to Sue Davey, Senior Manager, Community Health

149 Notes for Remarks by the Honourable George Smitherman, Minister of Health and Long-Term Care, August 19, 2004

229. The MOHTLC did not move to establish a process to resolve the issue of inequitable compensation.

230. In the face of the Ministry delays, insufficient compensation and concerns about attrition, the AOM decided to launch its "Because Storks Don't Deliver Babies" public campaign. Some midwives were starting to consider leaving the profession as the compensation they were receiving was insufficient to meet their household expenses. This was particularly a problem because the extensive on-call requirements required midwives to incur substantial expenses such as child care costs. As well, some midwifery families chose to solve the significant logistical dilemmas of on-call child care by having a parent at home, which then reduced the families' financial resources and ability to fund retirement and other family requirements.

231. Midwives were experiencing abuse at hospitals and silence from the MOHLTC.[150] The stories of these hardships became part of the campaign by the AOM to obtain equitable compensation.

232. AOM President Johnson wrote to Jason Grier, Executive Assistant to the MOHLTC Minister on November 24, 2004 to request a clear response to their request for equitable compensation and timely negotiations.[151] The letter set out that the AOM was embarking on a public campaign with respect to the issue and would be holding a media conference on December 14, 2004.

233. Immediately before an AOM campaign rally that was to be covered by the CBC, MOHLTC OMP Program Coordinator Wendy Katherine[152] called Johnson and advised that the government was prepared (if the rally was cancelled) to put the following money on the table, but that the amount was basically not negotiable: increase in total midwifery program budget of $5.3 million in 2005-06; $8.0 million in 2006-07; and $9.0 million in 2007-08. This included money for the expansion of midwifery positions and other infrastructure costs. At that time, the Ministry agreed to adjust midwife compensation recognizing it was inequitable. The Ministry agreed the equity gap was significant and claimed this was a "first step" in closing the gap.

234. Subsequently, in the winter of 2005, the AOM and the Ministry continued to meet to discuss compensation. In March 2005, the Ministry offered the AOM a one-time 20% increase, retroactive to April 1, 2005. The Ministry was not prepared to consider any prior retroactivity date. The proposal also did not address the fact that the midwives were still not in an equitable relationship to the male-dominated CHC physician compensation structure.

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150 See Representative Statements of Midwives

151 Letter dated November 24, 2004, from Elana Johnson, president of Association of Ontario Midwives to Jason Grier, Executive Assistant to the Minister of Health and Long-Term Care

152 Wendy Katherine had left the AOM to take up a position at the OMP as Program Co-Ordinator.

235. The Ministry's compensation structure collapsed the levels of payment from 12 to six with the start rate at $71,600 and the top rate of $92,600 in the first year, increasing to a range of $74,600 to $96,400 in the third year. This included an on-call payment of $300 per BCC as well as a retention incentive only for level six and a secondary care fee. The benefits were increased to 18%. There were also some increases with respect to operational expenses.

236. As a result of the compensation increase, the Ministry increased the course-of-care fees for each midwife by 20% to 29%, depending on the grid step, and granted 1% to 2% annual increases since that date, but prohibited midwives from moving up experience levels over the course of the 2005 to 2008 contract. This resulted in each midwife receiving a one-time increase in 2005 to her compensation over the duration of her contract. She did not move up the grid during this period as the grid was frozen, which represented an economic loss for each midwife.

237. The Ministry did not provide any justification as to:

(a) why it chose $92,600 as the job rate for midwives, when the Hay report advised that this job rate should be $103,000; or

(b) why it offered an on-call rate of $300 to the midwives, when the Hay report advised that this figure should be $550.

238. The Ministry did not collapse the grid to one rate as proposed by the Hay report. The Ministry advised that it was essential that there be recognition for the six different levels of experience. This was despite the fact that the CHC physician did not have that number of steps and the family physician and obstetrician/gynecologist were paid one fee regardless of level of experience. As well, newly hired CHC physicians generally are started at the maximum rate of their pay gap (as the CHC receives funding based on the maximum rate) whereas Ministry rules for midwives would prevent that.[153]

239. The AOM felt that there was no alternative at that time but to stop further disputing the Ministry's position, given its intransigence, and Minister Smitherman's promise that further progress to close the gap would be made in the next round of negotiations. The government's funding position was then set out in the Transfer Payment Agency-Midwifery Practice Group Funding Agreement.[154]

240. By letter dated June 28, 2005, the Ministry's Davey wrote to AOM President Johnson with respect to the conclusion of the review of the above-noted agreement and the parties' agreement to revisit the agreement no later than

153 A Strategic Review, supra

154 Template Funding Agreement between Transfer Payment Agency and Midwifery Practice Group, 2005

December 31, 2007 or earlier if there is a substantive change in the workload involved in the midwifery course of care.[155] The finalized funding agreement was dated July, 2005.[156]

241. Minister Smitherman's letter faxed August 8, 2005 to AOM President Johnson confirmed the above-noted funding for increased compensation. The letter noted that midwives were playing an "increasingly important role" in ensuring women were receiving the primary health care they needed during pregnancy, labour and birth.[157]

242. However, the Ministry had still failed to conduct any comparative pay equity analysis. As a result, the midwives continued to suffer from a large pay equity gap between their pay and that of their male comparator, the CHC physician. This gap was now greater not only because of increases the Ministry had provided to the CHC physician, but also because of the increase in the SERW of the midwives as of 2005.

b. Increases to CHC Physician Compensation

243. In 2004, the CHC physicians lobbied within the OMA to obtain a separate internal committee that could more effectively advance their interests within the OMA structure and to the MOHLTC for compensation increases. This committee represented alternative payment physicians such as those in CHCs. This internal OMA committee was then successful in obtaining a very substantial increase in CHC physician compensation in the 2005 agreement with the MOHLTC.[158] This increase in compensation included moving to a salary plus incentives model. As well, physicians with more than 5 years of experience also received an additional $5000 Service Recognition Payment. Those with more than 30 years experience received an additional $10,000 payment.

244. As well, as a result of the OMA agreement, the funding for CHC physician's compensation was protected and flowed directly to the CHC rather than through the relevant Local Health Integration Network (LHIN). Monies for CHC physician compensation could not be used for other purposes by the CHC. [159]

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155 Letter dated June 28, 2005, from Sue Davey, Senior Manager, Ministry of Health and Long-Term Care, Community Health Division to Elana Johnson, President of Association of Ontario Midwives

156 Association of Ontario Midwives, "2006 Guide – The 2005 Funding Agreement", 2006

157 Letter dated August 8, 2005, faxed from the Honourable George Smitherman, Minister of Health and Long-Term Care to Elana Johnson, President of the Association of Ontario Midwives

158 Agreement between OMA and MOHLTC, April 1, 2004 – March 31, 2008, supra**.** See also Q&A: Service Recognition Payment Program.

159 Commmunity Annual Planning Submission (CAPS)- Multi-Sector Service Accountability Agreement, Questions and Answers dated April 12, 2008 - Question 2.9

245. As noted above in Part 1, the Durber report found that as a result of a pay equity analysis of their work for the period 2003 to 2005, midwives should have received 86% of the compensation of the CHC physician as of January 1, 2006. The allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians. While it had moved to 18% of salary, it still was not the 20% provided to CHC physicians.

7. Pay Equity Gaps – 2006 to 2008 Period

246. As identified above, the pay equity gaps for this period are:

Pay equity gap 2006: $35,786

Pay equity gap 2007: $34,968

Pay equity gap 2008: $35,283

247. Over the period 2006 to 2008, the value of midwifery work continued to grow as summarized in the Durber report. This included the work detailed in the AOM 2007 workload analysis based on a survey of midwives.[160] As well, during this period, the specialized skills the midwives had were increasing as they were now able to assists at C-sections, amongst other matters which are detailed in the Durber report - Annex 5 B and Annex 7.

248. While midwives continued to work in the same underserviced areas as CHC physicians, they were not compensated for this feature. In contrast, CHC physicians receive more money as a result of being placed on the higher underserviced CHC wage grid.

249. The 2006 Provincial Perinatal Report was released and again detailed the excellent health outcomes that midwives were achieving for women and their newborns.[161] As well, during that year, the Ministry released data that showed midwives continued to produce excellent outcomes on a number of maternity care indicators.[162]

250. The September 6, 2006 report from the Ontario Maternity Care Expert Panel – Emerging Crisis, Emerging Solutions ("OMCEP") detailed the importance of valuing maternity care providers, the rising intervention rates, the need to expand

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160 Association of Ontario Midwives, "Ontario Midwifery Workload Study 2007: Executive Summary", 2007

161 Provincial Perinatal Surveillance System Committee, "Tailoring Services to Pregnant Women and their Babies in Ontario: 2006 Provincial Perinatal Report", 2006

162 Ontario, "Ontario Midwifery Program, Ministry of Health and Long-Term Care: Ontario Midwifery Clinical Database". APHEO Conference, October 16-17, 2006

the scope of practice of midwifery and the escalating crisis of shortages in such providers.[163]

251. During this period of time, there were ongoing attempts by physicians to control and restrict the practice of midwifery, as evidenced by the Ontario College of Family Physicians (OFCP), OMA and SOGC submissions to the Health Professions Regulatory Advisory Council ("HPRAC").[164]

252. In August 2008, HPRAC issued its report, Interprofessional Collaboration – Scope of Practice Review: Midwifery. This report noted the key findings of the Multidisciplinary Collaborative Maternity Care Project Background Research ("MCP2"). It also cited the findings of the above-noted OMCEP Report.[165]

253. The AOM relied on the its 2007 workload survey and analysis[166] to request a compensation increase because the average hours required to provide a course of care had increased to 54.25 (from 48.25 hours in 1993).

254. The Ministry's Wendy Katherine asked the AOM to forward its "list of priorities," which it did by letter dated April 30, 2008 from the AOM's Johnson to Katherine with the subject heading: "Creating Equity for Midwives in Ontario's Health Care System."[167] This letter identified substantial compensation increases as a key priority along with a parallel process for regular negotiations and a dispute resolution process similar to those available to physicians and nurses. The AOM sought recognition of it as the official negotiation partner and an obligation to not change the funding agreement or midwifery workload in between contracts.

255. In the first "Funding Contract Review" meeting dated May 27, 2008 with the Ministry, the AOM provided the Ministry with a document, "Market Changes in

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163 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006

164 Ontario Medical Association, Submission to the Health Professionals Advisory Council, Respecting Issues Related to Midwifery Scope of Practice, July 2008; Gerace, Rocco. Letter to Barbara Sullivan, Chair, Health Professions Regulatory Advisory Council Regarding Scope of Practice Expansion Proposals. August 21, 2008; Submission from the Ontario College of Family Physicians (OCFP) to The Health Professions Regulatory Advisory Council (HPRAC) In Respect to The College of Midwives of Ontario Scope of Practice Review, August 15, 2008.

165 Health Professions Regulatory Advisory Council, Interprofessional Collaboration – Scope of Practice Review: Midwifery, August 2008.

166 Association of Ontario Midwives, "Funding Agreement Proposals", October 21, 2008

167 Letter dated April 30, 2008 from Elana Johnson, President of the Association of Ontario Midwives to to Wendy Katherine, Coordinator of Ontario Midwifery Program.

Compensation, 2005-2007, Hay report, January 2008" which the Ministry agreed to review.[168]

256. However, the MOHLTC subsequently advised the AOM that it needed to delay the funding agreement review meetings due to major organizational change in Ministry. As a result, it was not until late October 2008 that the Ministry would meet with the AOM. By then midwives had been substantially prejudiced as a result of the global recession, which had started by that time and was repeatedly referred to by the Ministry as the reason why midwives could not get similar compensation increases given to doctors and nurses. The government had not set aside adequate money to fund the provision of equitable compensation for midwives.

257. In the interval, the Ministry had instead made bargaining with the OMA a priority and came to an agreement with the OMA in September 2008 as a global financial crisis was in the process of developing.

258. The OMA-Ministry agreement running from April 1, 2008 to March 31, 2012 provided for a 12.25% fee component increase – October 1, 2008, 3%; October 1, 2009, 2%; October 1, 2010, 3%; and September 1, 2011, 4.25%.[169]

259. The CHC physician compensation in that agreement again increased substantially. During the period 2006 to 2008, the CHC physician compensation increased from $150,499 to $155,399. This new OMA agreement took them from $155,399 in 2009 to $217,687 in 2011. Effective April 1, 2009, Community Health Centre (CHC) physicians will receive "monthly incentives and bonus payments" including a "three percent General Fee Payment (3% GFP) applies to these eligible incentives and bonuses per the 2008 Physician Services Agreement negotiated between the Ontario Medical Association and the Ministry".[170]

260. After giving the physicians a very substantial compensation increases, the Ministry then advised the AOM that the economic difficulties required midwives to be part of compensation restraint policies that were not applied equally to other health professionals.

261. Just as the Ministry was failing to adequately address the value of midwifery work, the benefits of their work in facilitating normal childbirth without unnecessary interventions was being recognized by some health-care providers. A Joint Policy Statement on Normal Birth was issued in December 2008 by the

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168 Hay Group Health Care Consulting, "Market Changes in Compensation, 2005-2007", January 2008.

169 Ontario Medical Association, "Tentative Agreement Reached!", Vol. 13, No. 24, September 15, 2008

170 Ministry of Health and Long-Term Care, "Community Health Centre (CHC) Payment and Reporting Guide", April 1, 2009

Society of Obstetricians and Gynaecologists of Canada ("SOGC"), the Association of Women's Health, Obstetric and Neonatal Nurses of Canada ("AWHONN Canada"*), the Canadian Association of Midwives ("CAM"), the College of Family Physicians of Canada ("CFPC") and the Society of Rural Physicians of Canada ("SRPC").

262. Noting the rise in caesarean section rates, the statement highlights the professional associations' concern about the increase of intervention during childbirth, as it introduces unnecessary risks for mother and baby. The statement cites research that social and cultural changes had fostered insecurity in women regarding their ability to give birth without technological intervention. Recommendations are included to support best practice and serve to promote, protect, and support normal birth.[171]

263. The Durber report's pay equity analysis for the period 2006 to 2008 found that midwives should have received 90% of the compensation of the CHC physician as of January 1, 2009. The allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians. While the Ministry had increased midwifery benefits to 18% of salary, it still was not the 20% provided to CHC physicians. As well, because of the steady increase in the cost of maintaining the same benefit package over time, the package was eroding, particularly with respect to the RSP component. Setting aside retirement income is critically important for midwives as independent contractors.

264. The Ministry still did not have in place any pay equity monitoring process that properly evaluated the SERW of the midwives relative to other appropriate work, including the male comparator, the CHC physician.

265. Instead, the Ministry proposed a compensation package providing minimal increases. The Ministry compensation offer flew in the face of the ongoing evidence that midwifery was producing highly successful maternity health outcomes.

(a) Midwives were doing 10% of births with 98% satisfaction rate and 40% of women wanting midwives were being turned away. There had been 85,000 midwife-attended births since 1994 with 20,000 at home.

(b) Midwife-led care had been proven to be safe with research and data showing excellent clinical outcomes resulting in reduced incidence of C-sections, epidural, forceps and episiotomy, greater feelings of control during labour and

171 The Society of Obstetricians and Gynaecologists of Canada, the Association of Women's Health, Obstetric and Neonatal Nurses of Canada, the Canadian Association of Midwives, the College of Family Physicians of Canada and the Society of Rural Physicians of Canada, "Joint Policy Statement on Normal Childbirth", December 2008 accessed at <http://sogc.org/wp-content/uploads/2013/01/gui221PS0812.pdf> at p. 1;

delivery, a shorter length of hospital stay and exceptionally high and sustained breastfeeding rates.

(c) Midwives were the only maternity care provider whose numbers were growing significantly.[172]

266. As well, 2008-09 Government Estimates show that the Ministry's transfer payments made to "physicians and practitioners" equalled $9,625,294,100 while the Estimates for transfer payments made to midwifery services was $88,534,900. Every 1% increase to physicians has a dramatically large impact on the overall Ministry budget than a 1% increase to midwives. The Ministry had sufficient funds for a large increase as a result of OMA negotiations for the male dominated profession of physicians but not to fund the necessary monies to address the midwives' inequitable compensation.[173]

267. While midwives, female consumers and the feminist movement have helped and continue to help to build the midwifery profession and equitable access to midwifery services across Ontario, the Ministry has subjected them to ongoing evaluation to keep demonstrating repeatedly that the profession is productive, efficient and effective.[174] No other health-care profession has been subjected to such a level of evaluation.

268. In April 2012, the MOR database was replaced by the Better Outcomes Registry Network ("BORN") database. Although BORN collects data from all maternal newborn care providers, midwives remain the only profession whose payment of invoices is contingent on the submission of data to (previously) MOR and (currently) BORN. As well, the increased reporting requirements were not being accounted for in midwifery compensation.

8. Pay Equity Gaps –2009 to 2012 Period

269. As identified above, the pay equity gaps for the period 2010 to 2012 are:

Pay equity gap 2010: $93,158

Pay equity gap 2011: $93,109

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172 Presentation to AOM, 2004, supra

173 Ministry of Finance, "Ministry of Health and Long-Term Care- The Estimates, 2008-09 Summary" accessed at <http://www.fin.gov.on.ca/en/budget/estimates/2008-09/volume1/MOHLTC.html>

174 Karen Born and Andreas Laupacis , "Are Ontario's Primary Care Models Delivering on Their Promises?", March 29, 2012 accessed at <http://healthydebate.ca/2012/03/topic/community-long-term-care/comparing-primary-care-models> and Institute for Clinical Evaluative Sciences, "Comparison of Primary Care Models In Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10", March 2012

Pay equity gap 2012: $94,755

270. Negotiations began in around October 2009. When it became clear that the Ministry's lead negotiator was not in a position to discuss equitable compensation, AOM President Katrina Kilroy wrote to Ron Sapsford, Deputy Minister of MOHLTC on January 21, 2009 requesting an urgent meeting to discuss the need to "fairly fund midwifery in Ontario." The letter noted that the Ministry's negotiation team had offered midwives a "compensation increase of half of what physicians and nurses settled for in the past year and no catch up for the lack of increases for 11 years from 1994 to 2005."[175]

271. On January 5, 2009, it was announced that the Ontario government had reached an agreement with the Ontario Provincial Police Association to pay the male-dominated OPP officers 2.34%, 2.25% and 2% along with pay equity adjustments for civilian employees.

272. The AOM met with Health Minister David Caplan on January 29, 2009 and provided to him a document dated January 26, 2009 requesting equitable compensation for midwives.[176]

273. The MOHLTC made a presentation to the AOM dated February 23, 2009 and proposed 2% for base fees, 2% for operational expenses for 2008 and 1% in 2009-11 with increase in benefits to 20%.[177] The offer did not address the substantial pay equity adjustments owing.

274. The AOM and the MOHLTC entered into a new Memorandum of Understanding signed May 7, 2009.[178] It provided for an increase in the course of care fees of 2% annually as of April 1 of 2008 and 2009; introduced the experience fee for rural/remote supplements and operational fee supplements for small rural or remote practices. It also increased the benefits from 18% to 20% of salary and

175 Letter dated January 21, 2009, from Katrina Kilroy, President of the Association of Ontario Midwives to wrote to Ron Sapsford, Deputy Minister of Health and Long-Term Care at pg. 1

176 Association of Ontario Midwives,"Agenda: Association of Ontario Midwives Meeting with Hon. David Caplan, Minister of Health and Long-Term Care", January 26, 2009; Association of Ontario Midwives, "Comparative Compensation + Benefits Document : Midwifery and Other Health Care Providers"

177 Ministry of Health and Long Term Care, "Presentation to the Association of Ontario Midwives", February 23, 2009

178 Memorandum of Understanding between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives, May 7, 2009

included a parental leave program, a program already funded by the Ministry for other health-care professionals.[179]

275. While the stated goals of the MOHLTC and the AOM were the same, positive maternity new born health outcomes, the AOM and the MOHLTC continued to disagree as to how those goals should be reflected in the compensation of midwives.

276. As a result of the persistence of the AOM, the Ministry finally agreed in Article 7 of the May 7, 2009 AOM-MOHLTC Memorandum of Understanding ("MOU") to jointly retain an independent third party to conduct a compensation review of midwifery services – to be completed prior to September 2010. The Ministry refused to agree to a binding process. The AOM persisted precisely because it did not agree that midwives were receiving equitable pay, even after the 2% increases.

277. The MOU committed the Ministry to begin the next round of negotiations by September 30, 2010. The Ministry also informally recognized the AOM as being similar to the OMA in their role in negotiations; the Ministry stated that negotiations would need to change to become similar to other negotiations undertaken by the Ministry, and unilaterally announced the Ministry's Negotiations Branch was now the lead in negotiations rather than just the Primary Care Branch. Communications from the Ministry explicitly referred to the "new contract negotiation changes."

278. At the request of the AOM, the Ministry agreed in the MOU to the creation of the Joint Midwifery Advisory Committee ("JMAC") with five AOM representatives and five Ministry representatives, with meetings four times per year.

279. The JMAC Terms of Reference provide that:

(a) The purpose of the JMAC is to "discuss issues and concerns of either party as they arise, be proactive in resolving issues and to build and maintain a productive working relationship."

(b) The JMAC is "intended to supplement major negotiations between the parties – it is not intended to replace those negotiations."[180]

(c) Disputes could be brought to JMAC for resolution with the option for a third-party facilitator if JMAC was unable to resolve with parties required to "use their best efforts to resolve issues and disputes in a collaborative manner."

280. The first meeting of JMAC took place on May 29, 2009 and the AOM placed compensation review for midwives on the agenda.

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179 Courtyard Report., supra at pg 29

180 Midwifery Contracts and Funding Advisory Committee, "Terms of Reference" Schedule A.

281. On March 25, 2010 the Ontario government introduced the *Compensation Restraint to Protect Public Services Act, 2010.* This act received Royal Assent on May 18, 2010, and was effective March 25, 2010. The law freezes compensation structures for non-bargaining employees of the broader public sector and the Ontario public sector for two years. Specifically, the Act prohibits increases to rates of pay, pay ranges, benefits and other payments in effect on March 24, 2010 unless as a result of an employee's length of time in employment or office; an assessment of performance; an employee's successful completion of a program or course of professional or technical education.[181]

282. On April 22, 2010, Saad Rafi, MOHLTC Deputy Minister wrote a memorandum to Chief Executive Officers/Senior Administrators (including the AOM) advising that the "Government's fiscal plan provides no funding for compensation increases" and its purpose is to control "compensation of public sector employees."[182]

283. The above-noted Act specifically provides in s. 12(3) that "nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the *Human Rights Code* or the *Pay Equity Act.*

284. Despite this exemption, the government took the position in its discussions with the AOM that the midwives could not have their compensation increased because of this Act. The Ministry in other contexts insisted that midwives were independent contractors and not "employees" and therefore were not covered by "employee protections" like collective bargaining. Yet here they were to be covered by compensation restraints which only applied to "employees."

a. Joint Compensation Review – The Courtyard Report

i. Introduction

285. The Compensation Review was conducted jointly by the parties, funded by the Ministry and ended in the release of the Courtyard Group report in September, 2010. After a detailed investigation, the report recommended a one-time equity adjustment to midwifery compensation (i.e., experience fee, retention fee, secondary care fee, on-call fee) that would raise the income of midwives at each experience level by 20% effective April 1, 2011.

286. While the Courtyard report acknowledged that this was not completely consistent with the original Morton principles (which would push the upper limits of compensation for experienced midwives even higher), it would move the midwives much closer to the CHC physician pay. Again, this report did not

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181 *Compensation Restraint to Protect Public Services Act, 2010,* S.O. 2010, C. 1

182 Memorandum dated April 22, 2010, from Saad Rafi, Deputy Minister of Health and Long-Term Care to Chief Executive Officers/Senior Administrators, Transfer Payment Agencies regarding compensation restraints.

conduct the full gender-based pay equity analysis as conducted by Durber. The report did criticize the lack of regular negotiations with midwives and noted this contributed to their inequitable compensation.[183]

287. Despite the Ministry's joint participation in the compensation review process as detailed below, the government subsequently rejected the report's recommendation without any reasonable justification or explanation, and refused to put its concerns in writing.

ii. Scope of Review and Process

288. A Joint Steering Committee process (similar to that which created the 1993 funding framework) was set up in the spring of 2010 to conduct the compensation review process with three Ministry and three AOM representatives. The Ministry selected its representative, choosing two from the OMP and one from the Negotiations Branch. The Courtyard Group was chosen from a Ministry-approved list of consultants.[184] The AOM was not allowed to propose any additions to that list. The MOHLTC funded the Courtyard Group for this work.

289. The Ministry Request for Proposal dated July 6, 2010 detailed the requirements as:

> *"the development of a report that suggests the appropriate "total compensation" for midwifery based on evidence which will include but not be limited to comparable, relevant and both current and historical compensation levels and factors of nurses, doctors and other relevant health care providers; comparable and relevant midwifery compensation models in other jurisdictions; and the initial 1993 Morton compensation report and the February 2004 Hay compensation review report."* [185]

290. The joint Steering Committee developed the following evaluation questions:

(a) Does the current compensation model recognize adherence to best practice guidelines and the achievement of the Ministry's policy objectives?

(b) Does the current compensation model reflect the current scope of work performed?

(c) Does the current compensation model reflect the volume/complexity of work performed?

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183 Courtyard Report., supra at pg 3;

184 Email dated February 25, 2010 from Melanius Finney, Program Analysis, Ontario Midwifery Program, Primary Health Care Branch, Ministry of Health and Long-Term Care to Kelly Stadelbauer, Association of Ontario Midwives regarding choice of third party consultant

185 Courtyard Report, supra at pg 3

(d) Does the current compensation model reflect the costs of doing work?

(e) What is the value of benefits, or equivalent funding received by midwives?

(f) 6. Does the current compensation model reflect the experience and training of midwives?

(g) 7. Is the current compensation model comparable to other professions performing similar work?

(h) 8. What market trends should be taken into consideration? Have compensation increases remained aligned with economic growth in Ontario? [186]

291. The Courtyard Report's methodology included:

(a) reviewing the Morton report, as well as the Hay Group report;

(b) reviewing published information on midwifery programs across Canada and conducting interviews with officials in Alberta and British Columbia to understand the rationale for their compensation models;

(c) conducting stakeholder interviews and engaging in data analysis with regards to the historical fee schedules and salaries; and

(d) reviewing its review methodology with the Steering Committee in order to obtain feedback and guidance regarding the direction of the review.[187]

292. A cross-Canada jurisdictional review was included at the insistence of the Ministry and over the objections of the AOM. The AOM stated such a review was not relevant to a pay equity analysis as the comparison needed to be jurisdiction specific. The AOM pointed out to the Ministry that the government's own Pay Equity Commission website (www.payequity.gov.on.ca) says "An employer cannot rely on external market information for valuing and comparing job classes and rates. For pay equity purposes, the employer is required to evaluate job classes and establish job rates of similarly valued male and female job classes within the establishment". The Courtyard report issued in September 2010 set out overviews with respect to midwifery services in Ontario, midwifery education, and the current compensation model. It also did a jurisdictional review of midwifery services in other provinces of Canada and an overview of the scope, volume and complexity of the work performed by midwives, and comparisons to other professions.

186 Ibid at pg 3;

187 Ibid at pg 14

iii. Overview - Better Health Outcomes with Midwifery Care

293. The Courtyard report noted that the health outcomes for mothers and babies cared for by midwives are better than the provincial average, when comparing women of a similar risk profile. This included the fact that:

(a) Interventions amongst midwifery clients are often lower than the provincial average, and cited a study where the proportion of women who had an epidural in a level 1 hospital in 2006/7 was 35.4%, but only 1.1% among midwifery clients.

(b) The proportion of midwifery clients using any form of anesthetic decreased by nearly 5% since 2003/4.

(c) The use of vacuum or forceps is much lower amongst midwifery clients with a rate of 6.7%, whereas all other low-risk pregnancies had a rate of 13.9%.

(d) There are higher breastfeeding rates amongst midwifery clients. For example, the rate of breastfeeding six weeks postpartum was consistently reported at 91% in 2006/7 to 2008/9, whereas the same proportion of all women breastfeeding their babies at discharge from hospital was only 59%.

(e) The proportion of low birth weight babies amongst midwifery clients is lower (3%) than the provincial average (6.7%).[188]

iv. Overview - Maternity Care and Compensation History

294. The Courtyard report recognized physicians and nurses also provide maternal and newborn care in Ontario. It noted the proportion of family physicians that practice obstetrics has declined significantly in the past decade because of the perception that attending births is too disruptive of personal life. The report observed that between obstetricians, family physicians and midwives, only midwives are guaranteed to provide intrapartum care upon graduation and registration.[189]

295. The Courtyard report noted that the fee schedule for midwives as set by Ministry based on the Morton report, remained constant for over 11 years and then with the exception of the more substantial increase in 2005, there were only 1% to 2% annual increases since that date.[190]

v. Investigative Findings

296. In answer to the above-noted investigation questions, the report concluded as follows:

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188 Ibid at pg 7

189 Ibid at p 8

190 Ibid at pp. 11-12

(a) The direct linkage between compensation and adherence to practice guidelines is quite strong in midwifery as compared to other professions.

(b) The legal scope of midwifery changed to include:

(i) More controlled acts such as communicating a diagnosis and identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a midwife is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks postpartum.

(ii) Prescribing authority for additional drugs designated in the regulations.

(iii) Intubation beyond the larynx of a newborn (not yet operationalized pending regulations).

(iv) Putting an instrument, hand or finger beyond the anal verge.

(v) Taking blood from fathers and donors for the purpose of tests.

(c) The above expanded scope of practice reflects an increase in the level of responsibility given to midwives, as well as a shift in terms of the accountability of midwives and much larger scope of practice than nurse practitioners with respect to maternity care.

(d) The use of the course of care funding model and the organization of midwifery services as a provincially managed program have an impact on the manner in which some midwives practice.

(e) While midwives that actively practice in a hospital setting are increasingly participating in interprofessional team meetings, hospital committees and other initiatives, it is unclear if they are being compensated for this type of work on par with other professions performing similar work inside the hospital.

(f) The requirement that new midwives practice under the guidance and mentorship of an experienced midwife for one year places a significant demand on the relatively small population of practicing midwives.

(g) Administrative activities performed by midwives are considered to be above and beyond the normal requirements and are compensated through a billable caseload variable. It can be challenging for smaller practices to secure the necessary support staff to ensure these administrative activities are conducted in a thorough and proactive manner.

(h) Managing midwifery practice schedules to accommodate high volumes of clients as well as student placement requires a significant amount of dedicated resources.

(i) With respect to the complexity and demand for midwifery work,

(i) The demand for midwifery services in Ontario is unmet.

(ii) Midwives are increasingly delivering babies in hospital settings. The complexity of such hospital based work is significant as a result of the potential use of more complicated labour and pain management techniques.

(iii) An increase in the non-clinical workload of the profession is significant.

(j) With respect to costs of providing midwifery care, the report contains a chart outlining the costs of the profession and noted that other professions do not necessarily incur all of the same costs as midwives.

297. The report contains several charts illustrating the types of benefits/disbursements provided for CHC family physicians, family health teams and nurse practitioners.

298. With respect to the experience and training of midwives, the report noted that:

(a) The Midwifery Education Program ("MEP") has continually expanded to reflect the evolving role of midwives in maternity care in Ontario.

(b) Additions to the clinical scope of practice within the *Midwifery Act* have also led to expansions in the type and content of courses provided. For example, recent additions to the prescribing authority of midwives have been reflected in updates to the pharmacology related curriculum.

(c) In 2007, the MEP underwent a significant update when the program was expanded to 90 students. An additional term of interprofessional and community placements was added to the third year.

(d) While the majority of students at the inception of the MEP program were unregulated midwives, current students applying to the program often had a previous undergraduate or graduate level degree, and the decision to enter the profession has been based on significant contemplation and consideration of multiple options.[191]

299. With respect to the current compensation model comparable to other professions performing similar work, the report contained the following chart:

191 Ibid at pg 32

Profession	Salary Range	Comments
Midwife – Urban Practice	$81,713 to $104,847	Range reflects levels one to six, for a midwife practicing in an urban setting, attending 40 births as the primary provider, and 36 births as the secondary attendant.
Nurse Practitioner – MOHLTC Funded	$78,054 to $89,203	In 2008/09 adjustment were made to all primary health care funding models to bring compensation to this level.
Nurse Practitioner – Hospital Funded	$90,000 to $120,000	Salary funding is derived from hospital global budgets and varies by organization.
CHC Family Physician	Salary 1: $181,233 to $209,035 Salary 2: $217,575 to $252,815	Salary 1 - communities not designated as underserviced. Salary 2 – Northern or designated underserviced communities. Salaries include $5454/physician per FTE/year received for providing 24/7 coverage.
FHT Family Physician – Blended Salary Model (as of April 1, 2008)	Level 1: $137,204.11 Level 2: $155,564.74 Level 3: $173,925.38	Salary levels are dependent on patient roster size. Physicians are eligible for additional service premiums and incentives (outlined below).

300. With respect to market trends and the aligning of compensation increases to Ontario's economic growth, the report noted that:

(a) The consumer price index must be taken into account. This figure was an increase of 33.5% overall between 1994 and 2009.

(b) The average weekly earnings of individuals working within the health and social assistance industry, as based on the North American Industry Classification System should be considered. It was reported that income levels

increased by 48% between 1994 and 2009. Also, that annual public sector salaries of individuals working within health and social service institutions increased by 78.5% between 1994 and 2009.[192]

vi. Recommendations: Existing Negotiation Model

301. The report concluded that:

(a) The intermittent and irregular negotiations between the midwifery profession and the Ministry hurt the compensation of midwives. It noted that there were no true negotiations between 1994 and 2005 and no compensation increases during this time either. It stated that it was critical to establish a pattern of regular negotiations.

(b) Delays by the Ministry contributed to the midwives' compensation being settled just after the economic downturn in 2008/9. This resulted in the OMA and the Ontario Nurses' Association ("ONA") settling multi-year contracts with the Ontario government with income increases averaging about 3% annually, while the midwives were required to have a much smaller increase of 2%.[193]

302. The report recommended that:

(a) regular negotiations on other elements of compensation and any annual changes in compensation should take place in 2011 and at regular intervals thereafter to avoid similar pay gaps emerging in the future.

(b) Changes in compensation obviously reflect the pattern of wage settlements with other professions and the general economic climate.[194]

vi. Recommendations: Existing Compensation Model

303. The Report found that:

(a) Compensation increases for midwives fell well below those of salaried health and social assistance employees as well as public sector salaries in health and social services over the same period.

(b) The original Morton compensation model, where the compensation of the midwife fell above that of the nurse practitioner, but below that of the CHC physician, had not been adhered to.

(c) Nurse practitioners at the bottom end of the compensation range were paid the same as level 1 midwives; and in some practice settings such as

192 Ibid at pg 39

193 Ibid at pp. 11-12

194 Ibid, Courtyard Group Ltd. at 44

hospitals they may have been paid significantly more. It also noted that at the top end of the range, nurse practitioner pay may again exceed that of level 6 midwives.

(d) Family physicians working in CHC and in family health teams enjoyed compensation that was well above that paid to midwives.[195]

304. Midwives continued to have difficulty in integrating into the hospital system and their integration was hindered by actions taken by physicians. Prior to the regulation of midwifery, both family doctors and specialists (i.e., obstetricians) provided low-risk primary care. When midwives – experts in low-risk birth – were regulated, there was no system-level analysis of how the introduction of this new profession would impact on obstetricians, who would now be expected to move their focus from providing low-risk care, to high-risk care. This lack of analysis meant that no system-level mechanism was put into place that would appropriately support obstetricians moving into a specialist, consultative relationship with midwives.

305. Obstetricians have, in more than half of Ontario hospitals, succeeded in placing scope of practice restrictions on midwives, which effectively result in low-risk women coming under the care of those specializing in high-risk care. These scope-of-practice restrictions force medically unnecessary transfers of care from the midwife as the primary care provider to the obstetrician and result in the double billing of the health-care system. In fact, according to data from the government's own survey of midwifery practice groups on the matter of hospital integration, 52% of midwifery practice groups have medically unnecessary restrictions placed on their college-regulated scope of practice.[196]

306. Moreover, the health human resources trend lines in maternity care clearly demonstrate that family physicians providing maternity care have plummeted over the past 20 years, as obstetricians have flattened out. Meanwhile, midwives are growing nearly exponentially.[197]

b. Post-Courtyard Negotiations

307. After the release of the Courtyard report, the Ministry and the AOM were to start negotiations by September 30, 2010 in accordance with the May 2009 MOU. The Ministry delayed the start of those negotiations until the end of October at which time the AOM met with lead negotiator Alex Lambert.[198] At that time, Lambert

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195 Ibid, Courtyard Group Ltd. at pg 36

196 OMP Hospital Integration Survey", supra.

197 Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions, supra at 17.

198 Alex Lambert was Manager, Negotiations at the MOHLTC from May 2009 to June 2012 (3 years and 2 months). According to his LinkedIn profile, he "Negotiated, on behalf of province, funding agreements covering Ontario's physicians, laboratories, and other healthcare providers. Acted as

stated that the government could not implement the Courtyard recommendations complaining that the Ministry had assigned the wrong staff to represent the Ministry. Subsequently, the Ministry replaced Lambert with Mary Fleming, Director of Primary Care, as the lead negotiator, who then needed time to come up to speed. This delayed the negotiations even further and the December 2010 meeting was cancelled.

308. By email dated January 28, 2011, Fleming advised AOM negotiator Neil Patton that the Ministry of Finance had requested that the Labour Relations Secretariat meet with the AOM. A meeting took place with Secretariat representatives on February 1, 2011. At that meeting, the AOM was told there could be no increases because of the compensation restraint legislation.

309. The Ministry cancelled further meetings as they required additional time to review the Courtyard report. These meetings were to be rescheduled for May 2011. By letter dated March 24, 2011**,** Fleming requested an extension of the MOU from April 1, 2011 as negotiations had not been completed and the contract expired on March 31, 2011.[199]

310. By letter dated March 28, 2011 from the AOM's Executive Director Kelly Stadelbauer to Fleming, the AOM again raised concerns about the Ministry's negotiation delays and urged the timely resumption of negotiations.[200]

311. In a meeting of the AOM with Minister of Health Deb Matthews dated April 20, 2011, AOM President Kilroy and Stadelbauer advised the Minister that it was critical that the serious pay equity issue had to be resolved along with the unnecessary restrictions on privileges and scope which were a serious barrier to women accessing care. Minister Matthews stated in the meeting that she thought midwives were pretty well paid compared to Alberta midwives and that their salary was “pretty good for a 4 year degree”, and that compensation issues for midwives were not a priority for the government.

312. The AOM advised that they were willing to accept a compensation increase of 0% in 2010/11 and 0% in 2011/12 if the government would address the substantial pay equity gaps. They noted it was unacceptable that a small group of professional women in a caregiving health profession with relatively little power in the system was being told again and again to be good and wait their turn.

Director, Negotiations Branch for a 4 month period January through April 2012. Seconded to OMA Negotiations team in February 2012, through to departure in June.” Accessed November 13, 2013 at www.linkedin.com/pub/alex-lambert/10/216/bbb.

199 Letter dated March 24, 2011**,** from Mary Fleming, Director, Primary Health Care Branch, Ministry of Health and Long-Term Care to Kelly Stadelabauer, Executive Director of Association of Ontario Midwives

200 Letter dated March 28, 2011 from Kelly Stadelbauer, Executive Director of Association of Ontario Midwives to Mary Fleming, Director, Primary Health Care Branch, Ministry of Health and Long-Term Care

313. This was particularly concerning since the government took a different approach to the compensation for the male-dominated Ontario Provincial Police ("OPP") with whom it negotiated. The government had just agreed to a 5.075% increase for the OPP for 2011, a salary freeze in 2012 and 2013 but catch up in 2014 when they must be paid the same as the highest paid police in the province. A May 7 2013 Letter from R. Philbin, Superintendent Commander, Municipal Policing Bureau, to Mayors of OPP Policed Municipalities regarding the OPP Framework Agreement, indicates that the projected salary increase for 2014 for the OPP will be 8.55%. In 2012, the government paid a first-class OPP constable with a high school education and six weeks of police college $87,240.[201]

314. The AOM also pointed out to the Minister that ongoing unnecessary restrictions on scope of practice and inappropriate delays in getting hospital privileges were constant barriers faced by the midwives, which also affected how their work was viewed and compensated.

315. The AOM stated that leadership was needed from the Minister to close the pay gap. While not stating that this would close the pay equity gap, the AOM proposed a 16% equity adjustment in 2011/12 and 0% regular increase in 2011/12 and 12/13 or two 0% years and then 20% in 2012/13.

316. On May 6, 2011 Susan Fitzpatrick, MOHLTC Assistant Deputy Minister called the AOM to say that they were postponing the negotiations scheduled for the following week and that the government was looking at a number of scenarios given the difficult environment. Despite the recommendation of the Courtyard report that regular negotiations were essential for arriving at fair compensation, the Ministry continued to stall and delay.

317. At the same time as the Ministry was delaying addressing the pay inequities facing the female midwives, the government continued to agree to compensation contracts that gave large increases to male-dominated positions. As an example, the government gave 9.75% to male dominated positions, such as correctional services officers, including 4% bonus.[202]

318. The Ministry then set up new AOM negotiation dates for May 24-26 2011. These turned out to be the last negotiation dates until 2013. At that time, the AOM presented the Ministry with its summary of compensation increases that had been given to other public sector employees. The MOHLTC Assistant Deputy Minister Fitzpatrick attended the meeting on May 26, 2011. Ms. Fitzpatrick

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201 May 7 2013 Letter from R. Philbin, Superintendent Commander, Municipal Policing Bureau to Mayors of OPP Policed Municipalities regarding OPP Framework Agreement. Antonella Artuso, "OPP can expect hike in 2014", *Sudbury Star* (16 May 2011) accessed at <http://www.thesudburystar.com/2011/05/16/opp-can-expect-85-pay-hike-in-2014-6>

202 Karen Howlett and James Bradshaw, "Ontario Prison Guards Get a Raise in a Time of Restraint", *The Globe and Mail* (26 May 2011) accessed at <http://www.theglobeandmail.com/news/politics/ontario-prison-guards-get-a-raise-in-a-time-of-restraint/article580779/>

advised at this meeting that the reason that compensation could not be addressed was due to fiscal constraints caused by a rapidly growing health care budget. She acknowledged that midwives were valued and midwifery care provided good outcomes at a lower cost. The Ministry proposed 0%, 0% and up to 5% in year 3 tied to meeting specific clinical outcomes.

319. The government continued to refuse to address the issue of pay equity. Midwives refused to agree to any agreement which did not address pay equity.

320. During the AOM's annual general meeting in May 2011, members expressed great disappointment with government's unwillingness to acknowledge or address pay equity and agreed to pursue various actions to protest and fight for pay equity. Health Minister Deb Matthews sent written "Minister's Greetings" to the AOM praising the role of midwifery in the health-care system.[203]

321. On June 1, 2011 more than 1,000 midwives and supporters rallied at Queen's Park and another 100 midwives and supporters rallied at Premier McGuinty's constituency office in Ottawa. AOM President Kilroy made a speech entitled-"You cannot separate the worth of women from the worth of midwives."[204]

322. In a letter from Premier Dalton McGuinty dated June 30, 2011 to Juana Berinstein, AOM Director of Policy and Communications, responding to an AOM letter, the Premier avoided the issue of pay inequities while stating that the government was "committed to supporting midwives and to enabling them to provide the best possible midwifery service. We fully recognize the significant contribution that midwives make to the health care system and to the well-being of thousands of Ontario women and men."[205]

323. In July 2011, the Ministry was still proposing a deal of 0% in 2009/10 and 2010/11 and up to 5% in 2011/12 with significant part of the 5% tied to meeting specific clinical outcomes. The negotiations were then suspended by the Ministry until after the October, 2011 provincial election.

324. At the same time as the Ministry was resisting paying equitable compensation to midwives, on July 20, 2011, professor Michael C. Klein, a family physician doing maternity care, noted that the "maternity care system is going to collapse in the

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[203] Minister of Health and Long-Term Care, Greetings to Association of Ontario Midwives, May 2011

204 Katrina Kilroy, Rally for Pay Equity Speech, delivered June 2, 2011. See also Catherine Porter, "Ontario midwives rally for a raise they deserve", *Toronto Star* (2 June 2011) <www.ontariomidwives.ca/images/uploads/documents/thestaPorter.pdf. See also Association of Ontario Midwives, "Midwifery: Benefits to Hospitals and the Health Care System">

205 Letter dated June 30, 2011 from Premier Dalton McGuinty to Juana Berinstein, Director of Policy and Communications, Association of Ontario Midwives

next 10 years or so" since the average age of obstetricians in Canada is 58 and a mere 11% of family physicians attend births while demand outpaces supply.[206]

325. During the September-October 2011 provincial election campaign, Premier McGuinty, by letter dated September 2, 2011 to Kilroy and Berinstein, responded to campaign questions from the AOM. "We believe that midwives should be able to work in accordance with the full scope of their practice in all environments, including hospitals. We also believe that midwives should be fairly compensated for the important work they do. We support recognizing midwives and their compensation relative to other health care professionals." It stated that the Premier "thanks the midwifery community for delivering quality and patient-centred care to Ontarians." [207]

326. Midwives hoped that this commitment would actually translate into action and not merely be a campaign promise which was not lived up to.

327. After the October, 2011 election, AOM ED Stadelbauer wrote on October 24, 2011 to ADM Fitzpatrick about the fact that midwives have been working without a contract since March 31, 2011 and that it was necessary to return to the negotiations table immediately.[208]

328. During this period, there were several informal meetings with Ministry staff. The government maintained that the midwives had to abide by the spirit of the compensation restraint law. The Ministry would not apply any "pay equity" or "human rights" adjustment exemption even though the AOM stated that it was not asking for a regular compensation increase but for a pay equity adjustment.

329. By letter dated October 24, 2011 from the AOM to Susan Fitzpatrick, the AOM again asked for a resumption of negotiations but received no official response.[209] While some discussions took place, no negotiation meetings were set up as Ministry representatives advised they were too busy in negotiations with the male-dominated OMA.

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206 Ann Douglas, "Maternity Care System on Brink of Collapse, Warns Physician", *Toronto Star* (20 July 2011) accessed at http://www.thestar.com/life/parent/2011/07/20/maternitycare_system_on_brink_of_collapse_warns_physician.html

207 Letter dated September 2, 2011 from Premier Dalton McGuinty to Katrina Kilroy, President of Association of Ontario Midwives and Juana Berinstein, Director of Policy and Communications, Association of Ontario Midwives regarding response to AOM election campaign questions

208 Letter dated October 24, 2011 from Kelly Stadelbauer, Executive Director, Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management

209 Letter dated October 24, 2011 from Kelly Stadelbauer, Executive Director, Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Managament.

330. In 2011, average income of physicians in Ontario was $470,038.[210] The CHC physician income (i.e., maximum in non-underserviced grid) had increased in 2011 to $217,687.

331. On December 14, 2011 AOM Director Berinstein met with Ministry policy staff Michelle Rossi who advised that government was concerned that they needed to move forward first with the OMA negotiations. The AOM said that they wanted a separate binding pay equity review process and could not settle without it.

332. During this period of time, the AOM also requested mediation, which was refused. As well, the AOM continued to have discussions with the Ministry to try to resolve the issues.

333. The AOM again wrote to ADM Fitzpatrick by letter dated January 19, 2012 and asked to return to the negotiation table.[211] The AOM again highlighted the Courtyard report's finding that delays in negotiation exacerbated inequities. The AOM clearly stated that its members were frustrated and at their wits end, and that midwives have been more than patient". As well, the AOM wrote to Premier McGuinty by letter dated January 19, 2012 asking for him to follow up on his campaign promise to provide equitable compensation to midwives.[212] Premier McGuinty responded by letter dated January 25, 2012 to AOM President Kilroy deferring to Minister Matthews to respond.[213]

334. With negotiations stalled, the government would not allow JMAC to be convened citing that the Terms of Reference provided it would not convene during negotiations. The Ministry explained that JMAC could not meet during negotiations in the same way that the Physician Services Committee ("PSC") could not meet during OMA/MOHLTC negotiations. However, since negotiations were not in fact occurring and major midwifery issues needed to be addressed, the parties agreed to set up a new committee in January 2012, the Midwifery Contracts and Funding Advisory Committee ("MCFAC").

335. The MCFAC Terms of Reference provided that the committee's purpose is to "to provide a forum for discussing issues and initiatives related to midwifery contracts and funding." It is chaired by the Director of Primary Health Care Branch and is to meet four times per year.[214]

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210 Why Women's Health, supra at Figure 4.

211 Letter dated January 19, 2012, from Kelly Stadelbauer, Executive Director of Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister- Negotiations and Accountability Management Division

212 Letter dated January 19, 2012, from Katrina Kilroy, President of Association of Ontario Midwives to Premier Dalton McGuinty.

213 Letter dated January 25, 2012 from Premier Dalton McGuinty to Katrina Kilroy, President of Association of Ontario Midwives

214 Terms of Reference" Schedule A, supra

336. By letter dated February 13, 2012, ADM Fitzpatrick responded to ED Stadelbauer advising that the Ministry would need to extend the MOU "given that negotiations have not resumed."[215] By letter dated March 29, 2012, Fleming stated that further to Fitzpatrick's letter dated February 13, 2012, the Ministry confirms continuation of the MOU.[216]

337. The Ministry developed the Ontario Action Plan for Health Care in early 2012 with three priorities:1) keeping Ontario healthy; 2) Faster access to stronger family health care and 3) Right Care, Right Time, Right Place. The Plan provided that "We will engage providers to improve care and support Ontarians in taking charge of their own health. Quality, consistent care organized around patients and based on the best evidence". Yet despite the midwives meeting these objectives, the Ministry did not apply this policy to the setting of the compensation of midwives. [217]

338. By letter dated June 26, 2012, Minister Matthew wrote to AOM President Lisa M. Weston concerning the "contract negotiations" but did not address the compensation inequities.[218] There were still no negotiation meetings.

339. On August 6, 2012, the AOM's Stadelbauer and Weston met with the Minister's policy staff Rossi and Brigid Buckingham. They stated that with a binding pay equity review, they could move forward on the other issues. The AOM emphasized the need for regular negotiations and for negotiations to resume immediately, but the government would not come to the table.

340. On September 26, 2012 the Ministry announced the government's plans to table legislation for a mandatory two-year wage freeze. This freeze did not ever become law as the legislature was prorogued when the Premier resigned.

341. By letter dated September 27, 2012 to Premier McGuinty, the AOM again repeated its strong objection to the two-year delay in negotiations and again asked for a return to negotiations to deal with all matters except wage parity. The AOM requested the pay equity issue be dealt with by the creation of an objective and specific process to facilitate pay equity/wage parity. In doing so, it noted that "the midwifery profession, made up of female front line workers serving women clients, does not have access to labour legislation to mandate fairness, and

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215 Letter dated March 15, 2012, from Kelly Stadelbauer, Executive Director, Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division; Letter dated February 13, 2012, from Susan Fitzpatrick, Assistant Deputy Minister to Kelly Stadelbauer, Executive Director of Association of Ontario Midwives

216 Letter dated March 29, 2012 from Mary Fleming, Director of Primary Health Care Branch to Kelly Stadelbauer, Executive Director of Association of Ontario Midwives

217 Ontario, "Ontario's Action Plan for Health Care", 2012

218 Letter dated June 26, 2012, from Deb Matthews, Minister of Health and Long-Term Care to Lisa Weston, President of Association of Ontario Midwives

therefore we rely on your government to negotiate fairly and in good faith with us, including negotiating in a timely manner." [219]

342. In October 2012, the AOM launched its "Born Without a Contract" campaign, urging government to come to the table to negotiate a fair contract and address pay equity.[220]

343. On October 4, 2012, the AOM's Weston and Berinstein met with Ministry policy advisor Rossi. Rossi advised that the Ministry's practice of directly negotiating with the midwives, which was unique, presented a significant obstacle, as the government did not want to contradict its own directives. The AOM responded that midwives needed to negotiate a contract and also secure a process to address pay equity. Rossi said that the 5% increase based on meeting performance measures was off the table.

344. By email dated October 18, 2012 from MOHLTC representative Buckingham to the AOM's Berinstein, Buckingham, while ignoring the request for increased compensation, continued to set out its "overview of our demonstrated commitment to the midwifery practice here in Ontario."

We recognize the significant contribution that midwives make to the well-being of thousands of Ontario women and newborns and we remain committed to supporting midwives in the provision of the highest standard of midwifery services. We continue to work not only in sustaining the practice of midwifery in Ontario but are committed to the growth of this valued service to women and their babies.

We are also proud of our record to date in support of midwives, including the fact that more than twice as many women have access to midwifery services since 2003, from about 8,000 to over 18,000 in 2010-11 and funding for the midwifery program has increased during this same period by 400%.

As you know, the MOU between the Ministry of Health and Long-Term Care and the AOM that expired on March 31, 2011 is extended until a new agreement is reached. Since our government took office in 2003, midwives compensation is, on average, 38% higher (salary ranges have increased from $55-79K in 2003 to $95K-123K). This is the first increase in compensation for midwives since the profession was regulated in 1994

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219 Letter dated September 27, 2012 from Lisa Weston, President of Association of Ontario Midwives to Premier McGuinty

220 The campaign was covered by Carol Mulligan of the Sudbury Star and included an interview with Cathy Fulton-Breathat, a midwife and AOM member. Carol Mulligan, "Ontario Midwives Rallying for New Contract", *The Sudbury Star* (22 October 2012) < www.thesudburystar.com/2012/10/22/ontario-midwives-rallying-to-ask-province-to-bargain-for-new-contract>

345. It is noted that the references in the above letter to a midwifery compensation range of $95K-123K is completely inaccurate. There is no such range. As well, the Ministry continues to respond to requests for increased compensation by referring to increased infrastructure funding.

346. The AOM conducted a provincial day of action dated October 19, 2012 with respect to the pay inequities facing Ontario's midwives.

347. By email dated October 19, 2012, the AOM ED Stadelbauer responded to Buckingham again strongly objecting to the delays and expressing the AOM's frustration with the lack of negotiations or a review process to address midwives' inequitable compensation. She stated:

Thank you for the support you have expressed for midwifery services in Ontario. It is true that we have seen the commitment of this government to growing midwifery in Ontario since 2003; however, AOM members and leadership are extremely disappointed that it is now two years since we have started negotiations of our next agreement, and despite our repeated request, the government refuses to engage in dialogue with midwives. Such a delay does not demonstrate that this government values midwives. Sustaining the practice of midwifery in Ontario and growing this valued service to women and their babies requires a commitment to the infrastructure and the working conditions that support midwives. The current MOU does not address issues related to infrastructure and working conditions. As you know, the government's own consultant in the 2010 Courtyard Compensation Review report strongly recommended regular and timely negotiations in order to ensure appropriate government stewardship of the midwifery in Ontario. This recommendation has been ignored.

We are also exasperated that despite many discussions with Ministry staff and the production of an independent third party Ministry commissioned report, your email repeats a position that denies there is an issue in midwifery compensation. The lack of commitment to the original framework for midwifery compensation (the Morton Report), and the refusal to recall that there were 11 years of no compensation increases is incomprehensible to our members. Continuing this position further does not demonstrate that the government values midwives and the contributions that they make to the health care system.

Since the government took office in 2003, midwifery compensation has not kept pace with other public sector workers and, specifically, has fallen well behind comparable health professions. The 38% figure you cite is over an 8 year period, and includes a one-time increase to begin to rectify the 11 previous years of no increases each year since the inception of midwifery; that is, midwives have effectively had a 38% increase compensation in 17 years, which averages less than 2% per year. In June 2012, the Minister cited that the government provided an 85% increase in compensation for physicians over the same 8 year period. The government's consultant in 2010, based on the evidence they gathered for

their report, stated that midwives were at least 20% behind where they should be in compensation. No doubt, the government's delays in addressing this wage parity issue for midwives, despite the Premier's promise in September 2011 to do so, has exacerbated the wage parity issue beyond what the Courtyard report identified.

We look forward to working with you during the next few weeks to determine how midwives can return to the negotiations table. We note that the Premier stated in his recent resignation speech. "To this end, I've asked the Lieutenant Governor to prorogue the legislature to allow those discussions with our labour partners." We trust that the government will begin to demonstrate how it values Ontario midwives by including the AOM in these discussions.

348. While the AOM was unable to get the Ministry to engage in negotiations, the Ministry was concluding a Memorandum of Agreement with the OMA which was signed November 7, 2012 and expires on March 31, 2014, and which included some short-term cutbacks.[221]

349. The CHC physicians proposed that the MOHLTC collapse the two wage grids so that all CHC physicians are paid on the basis of the higher grid. Family physicians in the Aboriginal Health Access Centres ("AHAC") had already achieved that goal of having only one grid and moving all physicians to the higher grid. While the Ministry did not agree to this request for the CHC physicians in these negotiations, the OMA is currently in negotiations with the MOHLTC since their agreement is near expiry, and they are again making this request for CHC physicians.

350. The CHC physicians were the only physicians who took a direct decrease in salary compensation for the term of the agreement – namely 1.37% as of January 1, 2013 and 0.5% as of April 1, 2103. Other physicians had reductions in fees.

351. Following the "Born Without a Contract" actions, Minister Matthews met with the AOM on December 4, 2012**.** The AOM raised three main issues: the need for a binding pay equity review distinct from contract negotiations so they did not have to negotiate for fairness, a process for negotiating a contract and a mechanism to address midwifery infrastructure issues to enable the continued growth of the profession. The Minister agreed to a review of compensation (but not to a binding pay equity review), a contract, and enabling midwifery growth. She directed the AOM to address these issues at MCFAC, with Melissa Farrell, Director of Primary Care, as the lead.

352. On December 6, 2012, a MCFAC meeting took place. The AOM expected, as per the Minister's direction just two days prior, that a pay equity review, dates for

221 Memorandum of Agreement with the OMA which was signed November 7, 2012 and expires on March 31, 2014,

negotiating a new contract, and issues relating to midwifery growth would be addressed by Farrell at that meeting. They were not. Farrell stated she was not given the direction that the AOM leadership had understood from the December 4 meeting with the Minister. The AOM requested the Minister provide direction in writing.

353. The Minister did provide a follow up letter to the December 4 meeting dated January 24, 2013 to AOM President Weston, stating:

(a) The Ministry could not agree to a binding compensation review and instead wished to discuss the Courtyard report.

(b) The Ministry has "concerns regarding the report" but "we strongly believe that midwives should be compensated fairly for what they do."

(c) The Ministry has "established the Midwifery Contracts and Funding Advisory Committee (MCFAC) where conversations regarding fair compensation will take place."

(d) The 38% increase in compensation and increase in annual funding and increase in graduates.

(e) "Consistent with Ontario's 2010 Budget Policy Statement and the 2012 Budget, transfer payment funding recipients across the province, including midwives have not received increases relating to compensation."

(f) "The Government is continuing to ask all of its partners to continue restraint in order to help meet our fiscal targets and return to a balanced budget."

(g) The Ministry is not able to commit to a fee increase at this time. MCFAC is the process for changes in funding.

(h) The Ministry will establish two birth centres.[222]

354. By letter dated December 24, 2012 from ADM Fitzpatrick to Stadelbauer, Fitzpatrick refers to the fact that there will be no funding for incremental compensation increases for new collective agreements.[223] She states that while the government is keeping existing contracts intact as a respect for collective bargaining, Ontario is "expecting its bargaining partners to meet the following criteria for two years: no increases in compensation and no movement through the grid." Compensation for non-executives who are not governed by collective

222 Letter dated January 24, 2013 from Deb Matthews, Minister of Health and Long-Term Care to Lisa Weston, President of Association of Ontario Midwives

223 Letter dated December 24, 2012 from Susan Fitzpatrick, Assistant Deputy Minister to Kelly Stadelbauer, Executive Director of Association of Ontario Midwives

agreement "should live within fiscal restraints." Fitzpatrick notes that if agreement can't be reached, the government will impose administrative restraints.

355. Midwives continue to provide safe, excellent care. The Ministry's own Midwifery Outcomes Report (the database the Ministry administered up to 2012 to collect data about the quality and type of services provided during midwifery care) bears this out. Midwifery rates of intervention are lower than provincial low-risk averages:[224]

Indicator	Year	Midwifery Rate	Provincial Rate
C-section Births	2009/10	15.4%	28.3%
Live Births Induced	2009/10	16.7%	25.2%
Regional Anesthesia for Vaginal Birth (Epidural and Spinal)	2009/10	19.0%	62.5%
Instrumental Delivery (includes forceps and vacuum)	2009/10	6.8%	13.6%

356. Midwifery clients have short hospital stays because midwives continue to provide care in a woman's home or in the community: in 2010/11 for example, 58.5% of midwifery clients who had a vaginal birth were discharged within the first 24 hours after birth; almost half of these within the first six hours. This compares with a province-wide figure of 8.2% of women with low-risk pregnancies who were discharged within 24 hours after a vaginal birth in 2006/07.

357. Recent studies have shown that, when properly screened and attended by a regulated midwife, home births in Ontario are at least a safe as hospital births.[225]

358. Evidence increasingly shows the long-term benefits to children and adults of being breastfed as a baby.[226] Breastfeeding promotes optimal growth and development, including cognitive development. In addition, breastfeeding protects against childhood obesity and reduces infant mortality. Absence of breastfeeding increases the risk of childhood diseases and of hospitalization related to a wide range of acute and chronic diseases such as respiratory and middle ear infection, diabetes, obesity and sudden infant death syndrome.

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224 Better Outcomes Registry and Network Ontario (BORN), "Distribution of Type of Birth by Health Care Provider Type", 2012 and 2013; BORN, "Rate of Assisted Vaginal Delivery", 2012-2013

225 See Eileen K. Hutton et al, "Outcomes Associated with Planned Home and Planned Hospital Births in Low-Risk Women Attended by Midwives in Ontario, Canada, 2003–2006: A Retrospective Cohort Study" (2009) 36:3 Birth 180 <http://www.aom.on.ca/files/Communications/Reports_and_Studies/Birth_Ontario_Home_Birth_Hutton_Sept_09.pdf; and Patricia Janssen et al, "*Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician.* (2009) 181 Canadian Medical Association Journal 377>

226 Recommendations for a Provincial Breastfeeding Strategy for Ontario, December 21, 2009

359. Breastfeeding generates long-term savings for the health-care system and the economy as a whole.

Percentage of Midwifery Clients Who Did Any Breastfeeding

Birth	96.0%
Three days	96.5%
10 days	95.3%
Discharge	91.7%

Distribution of live born, term infants who were breastfed at discharge from hospital

(Ontario 2012 -13)

	Midwifery Care	**Ontario**
Breast milk only	83.4%	61.4%
Combination	12.0%	27.2%
Formula Only	4.1%	11.3%
Other or Missing Data	2.7%	11.2%[227]

360. An Ontario study by Eileen Hutton, RM on the safety of planned home and hospital births attended by midwives concluded:

"*Midwives who were integrated into the health care system with good access to emergency services, consultation, and transfer of care provided care resulting in favorable outcomes for women planning both home or hospital births."*[228]

361. As noted above in Part 1, Durber found that as a result of a pay equity analysis of their work for the period 2009 to 2012, midwives should have received 91% of the compensation of the CHC physician as of January 1, 2013. Durber found the allocation for benefits for midwives should have been at least as high as the percentage allocated to the CHC physicians.

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227 BORN, "Distribution of Live born, term infants who were breastfed on discharge from Hospital", 2012-2013

228 Hutton et. al, supra

362. In a letter dated March 1, 2013 to Premier Kathleen Wynne from Weston, Stadelbauer and Berinstein, the AOM again pointed out that contract negotiations and wage equity commitments remain unaddressed.[229] The AOM stated it was looking forward to working closely with the Premier to finalize negotiations process and address wage parity.

363. In an April 18, 2013 MCFAC meeting, the issue of "wage parity," "Courtyard report questions" and "process and timeline to address wage parity" were on the agenda at the request of the AOM.[230] The AOM highlighted its concerns that the lack of regular good faith negotiations with set time frames had left midwives at a serious disadvantage with respect to their compensation and with respect to feeling valued and heard. Farrell stated that MCFAC was now to be the place where changes could be addressed.

364. The AOM also indicated that it needed a dispute resolution process similar to the process afforded to the OMA by government in order to have fair and effective negotiations.

365. At the MCFAC meeting on April 19, 2013, the following occurred:

(a) The Ministry advised it would "evergreen" the contract, which would not allow the AOM an opportunity to negotiate its terms. The Ministry said that as a result the AOM members were not working without a "contract." The AOM advised that it did not consent to the “evergreening" as it was a unilateral action by the Ministry. Also, that since this was a unilateral action by the Ministry, that it would further erode the likelihood that the Ministry would address midwifery compensation issues in the future in a regular and timely manner.

(b) The AOM again stressed the need to implement the Courtyard report recommendations. The Ministry referred to concerns with Courtyard’s jurisdictional review. The AOM requested the Ministry note its concerns in writing. Farrell stated the Ministry was not willing to do so.

(c) The AOM responded that the 20% gap would be a higher number now, and that the CHC physicians had received a 5% increase, and that the Quebec midwives had received a pay equity adjustment.

(d) The AOM also noted that jurisdictional comparisons were not relevant to a pay equity analysis, as the analysis was carried out based on pay equity criteria of SERW and not on what other jurisdictions paid to midwives. As well,

229 Letter dated March 1 2013, from Lisa Weston, Kelly Stadelbauer and Juana Berinstein to Premier Kathleen Wynne

230 Midwifery Contracts and Funding Model Advisory Committee, Agenda, April 18, 2013

comparing midwifery professionals in Ontario to other underpaid female midwifery professionals across Canada is not an appropriate pay equity process.

(e) Farrell stated that the Ministry was not intending to review the Courtyard report as the report is now outdated and that the Ministry would not be doing a new review.

(f) The AOM referenced Premier McGuinty's commitment to address pay equity 2.5 years ago and expressed the midwives' frustrations with the delays and inaction.

(g) In response to the AOM's request as to what the next steps with respect to the report were, Farrell referred to the Minister's comments that "we cannot commit to any increase."

(h) The AOM repeated that the issue was a pay equity issue and asked whether the Ministry would engage in a process to address the issue. Farrell stated that there was no plan to do so.

366. By letter dated April 23, 2013 to the AOM, Premier Wynne stated that a “fair and inclusive society is the foundation of a more prosperous Ontario” and that she "fully recognizes significant contributions” made by midwives. The letter did not address whether or how the government would address pay inequity.

367. By letter dated April 23, 2013, Weston wrote to MOHLTC Farrell concerning the April 19, 2013 meeting stating:

(a) Midwives are frustrated by the lack of regular negotiations over the last 20 years and that there is no current indication that the Ministry's pattern is changing.

(b) "Midwives are not willing to accept that the pay equity gap, experienced as a female dominated profession, providing care to women, has no remedy. It is untenable for the Ministry to not acknowledge or concretely plan to address the gender-based discrimination faced by midwives” and made reference to rights under the *Human Rights Code*.

(c) The actions of the Ministry do not reflect Ministry statements that the Ministry values the contributions of midwives.

(d) “The Ministry must acknowledge and provide a concrete solution for ameliorating gender-based discrimination and the lack of contract that midwives have experienced which have resulted in a wage parity gap."

(e) “Midwives must have commitments to regular negotiations and access to arbitration if a decision cannot be reach at the negotiations table.”

(f) That the Ministry provide a list of negotiation items for the next meeting on April 29, 2013.

(g) Re: wage parity – a commitment and concrete action plain with timelines for acknowledging and addressing the wage parity gap experienced by midwives as a female-dominated profession providing care to women who have not had access to regular good faith negotiations with the Ministry since 1995.

(h) Commitment to negotiation and access to arbitration – that the MOHLTC commit to negotiations in good faith no later than September 2014 to negotiate needed changes to the contract that would come into effect on April 1, 2016.

368. On April 29, 2013 the MOHLTC proposal to the AOM provided that:

(a) The Ministry was unable to increase compensation because of restraints;

(b) The Ministry will engage in negotiations in the fall of 2013 for a contract for 2014/15.

369. The Ministry's letter dated April 29, 2013 to the AOM refers to "pay increases," "compensation grid" and "compensation review" rather than to "fees" although it offers no increase. It also noted that the Courtyard report was not binding. The letter did not provide a detailed response to the report. While the MOHLTC states that it continues to value midwives, who play an "integral role in the province's health care system," it was not prepared to attach any compensation increase value to that contribution.[231]

370. At the MCFAC negotiation meeting on April 29, 2013, the following took place:

(a) Ministry ADM Fitzpatrick stated that: "the government is giving us no flexibility on negotiations. We cannot engage on that Courtyard report." "We have no ability to negotiate" with respect to the Courtyard report." There is to be "no budget growth" relating to "compensation."

(b) When Stadelbauer asked if it was the Ministry's position that midwives are already paid fairly, Fizpatrick stated that she did not think that was the Ministry's position, but that there was a need to get the budget under control. Fitzpatrick stated "You're going to have to wait."

(c) Fitzpatrick then stated that the Ministry had made investments in midwifery.

231 Letter dated April 29, 2013 from Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division to Association of Ontario Midwives

(d) Elizabeth Brandeis, AOM Vice-President responded that the Ministry is inappropriately applying a broad compensation restraint mandate to a group that has been historically and systemically neglected.

(e) Then, Berinstein raised the "gender component to how midwives are compensated – pay equity."

(f) ADM Fitzpatrick responded: "This is not to be expressed as a pay equity issue – you know that – our lawyers will not allow us to speak about it as pay equity."

(g) Berinstein responded that while midwives were not technically covered by the *Pay Equity Act* as they were not employees, they were a female-dominated profession that needs an objective process to determine if its compensation is equitable.

(h) ADM Fitzpatrick responded: "I would caution against referring to this as pay equity – that legislation was referring to women working for the minimum wage and that isn't your situation. Some people could look at you and say that it is very fair compensation. If you compared yourself to a support worker, they could probably say yours is a very good compensation."

(i) Brandeis asked if they could have some mechanism to look at the systemic underpayment based on gender and equity. Fitzpatrick advised that looking at the pay gap and implementing it are two separate things, and that the AOM would not want a second report that could not be implemented because "not no money per se, there's a compensation policy." Fitzpatrick then stated that “pay equity isn't the route…I don't see a day when you are going to get your 20% increase but I do see a day when your increases will come about based on who needs the most and you'll probably be in a position to argue that you deserve a little more. I don't think the notion of catch up is realistic…I think a plan where you will get regular increases is more likely."

(j) The AOM told Fitzpatrick that the membership felt very strongly that there is an issue of pay equity and that it will be moving forward through various process, legal and otherwise, to pursue pay equity.

371. The AOM reluctantly recommended that its members accept the Ministry offer and also pursue legal action to attain its member’s rights to pay equity as the only avenue of recourse given the Ministry's position.

372. On May 10, 2013, Weston wrote to Fitzpatrick:

We strongly disagree with the simplistic description of the background provided in your letter of April 29, 2013. There is an important distinction between a small annual compensation increase (which is what the government brought to the table in 2011 for year 3), and the necessity for wage parity adjustment as recommended by the Courtyard report. The former are increases that are

contingent upon relative increases of other public sector workers, economic conditions, and cost of living changes while the latter is intended to correct for long standing discrimination experienced by a female-dominated profession providing care to women and infants. Cost of living increases are separate and distinct from the need to adjust wages for the sake of relative parity and the consistent erosion of midwifery compensation over the past twenty years relative to similar health care professionals. Your discussions and your letter of April 29, 2013 fail to appreciate this crucial distinction.

The small increase offered in 2011 for the third year of the contract did not address the wage parity gap, was contingent upon meeting targets, and yet again paled in comparison to the increases provided to other public sector workers at that time including physicians (5%, 3%, 4.25% 2009-2011, plus a $5,000 bonus to family physicians who provide labour and delivery to more than 5 women) and the OPP (5%,0%,0%, 8.5% 2012-2014, giving the OPP parity with the highest paid jurisdiction), thereby exacerbating the wage parity issue detailed in the Courtyard report. The government's "take it or leave it"' approach did not acknowledge or address the gender-based discrimination experienced by midwives in our contract negotiations; as expressed through a lack of regular negotiations, a lack of contract and compensation that is not aligned with their education, scope of practice, working conditions, or level of responsibility in Ontario's health care system.

From our initial negotiations meeting in October 2010, the Ministry has refused to discuss any recognition or implementation of the recommendations made in the 2010 Courtyard report. We understood, when agreeing in the Memorandum of Understanding of 2009 to undertake a compensation review, that this review would be a recommendation report. The extensive work that went into that report was done by both sides, including the Ministry, in good faith with the objective of arriving at data that both sides could rely on. It is almost three years later, and despite the Ministry's participation in the process, the report has been ignored, shelved and dismissed by the government. Such behavior lends itself to the conclusion that the government agreed to undertake the review merely to delay the issue and never intended to enter into good faith contract negotiations with us on the issue of wage parity for midwives. As late as January of this year Minister Matthews wrote to us as follows:

"As discussed, the Ministry cannot commit to a binding compensation report. Rather it would be more prudent to review and discuss the existing report completed in 2010. As you are aware, the Ministry has concerns regarding the report, but we strongly believe that midwives should be fairly compensated for the work they do. The Ministry has established the MCFAC where conversations regarding fair compensation will take place."

And yet, our meetings subsequent to this letter (March 18, April 18, April 19 and April 29, 2013) have not yielded a good faith review and discussion of the existing report. We have seen no evidence that the Ministry is interested in such

a review or discussion. In fact, as noted above, you stated that the government is not willing to commit to a process for wage parity adjustment as recommended by the Courtyard report and that the government is not willing to close the wage parity gap that currently exists for midwives. It is impossible to reconcile your statements with the Minister's letter.

At every turn over the last twenty years, midwives have been told to be patient and wait, and the situation of eroding compensation would be addressed. In 2005, then-Minister Smitherman told the AOM that although the inequity existed, it could not be addressed all at once; we would need to patient and wait for "the next time." We heard this from Minister Caplan in 2009, and we heard it from you again at Monday's meeting.

Midwives have been patient, collaborative, and offered various solutions to resolve the situation of fair compensation. We have met with staff in the Premier's office and the Health Minister's office to try to work with the government to find creative solutions to this difficult and long-standing issue in our contract negotiations. We understand that your answer to us on April 29 is the government's final word on this matter. As we are left with no other options, we will take any and all additional steps necessary to address the contract discrimination experienced by midwives.

373. By letter dated May 27, 2013, Weston and Berinstein wrote to Premier Wynne advising that the AOM intended to recommend legal action against the government to address the inequitable compensation gap. The letter noted that, while the government acknowledged the gap, it refuses to constructively work with the AOM to address it. The AOM stated it would welcome a commitment on the Ministry's part to redress the compensation gap and failing that, the AOM would proceed with litigation.[232]

374. By letter dated May 27, 2013, the Weston and Berinstein wrote to Minister Matthews:

(a) Contrary to the MOHLTC Minister's statement that it was prudent to review the Courtyard Group report, this had never happened and the Ministry had never come forward with specific concerns about the report or a plan to address any such concerns. The AOM noted that Ministry staff had contributed to the report, provided information, supervised the Courtyard consultants and agreed to the final draft.

(b) Contrary to the Minister's statement that the issue of fair compensation would take place in the MCFAC meetings, there had been no meaningful conversation about it and the Ministry, on April 29, 2013, had said that while it acknowledged the gap it was not going to redress it.

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232 Letter dated May 27, 2013, from AOM's Lisa Weston and Juana Berinstein to Premier Wynne, supra

(c) As an almost exclusively female-dominated profession providing care to women, midwives are experiencing systemic gender-based discrimination with respect to our contract and this discrimination has resulted in a significant and growing compensation gap.[233]

375. As a result of the government's actions, the AOM had exhausted its good faith efforts to persuade the Ministry to provide equitable compensation. Having warned the Ministry that it intended to seek a legal remedy for the pay inequity, the AOM signed the funding agreement dated June 3, 2013.

376. Midwives were in an impossible position. The contract did not uphold their rights and yet if they did not sign the contract, they would not be able to provide care, essentially jeopardizing the care of pregnant women and threatening their licensure, as the CMO defines withdrawal of care, or abandoning clients, as unprofessional conduct that can be disciplined.

377. As a result, the AOM decided to prepare to pursue and file a Human Rights Complaint in order to obtain an adjudication of the human rights of midwives to compensation free of sex-based discrimination.

378. The Ministry cancelled the MCFAC meetings scheduled for June 12 and July 24, 2013. Premier Wynne responded by letter dated July 25, 2013 to the AOM's letter requesting that the Premier address the issue of midwifery inequitable compensation by referring the matter to Minister Matthews. Minister of Labour Yasir Naqvi in a letter to the AOM dated July 26, 2013 praised Ontario's *Pay Equity Act* as one of the most progressive statutes in the world but offered no pay equity redress mechanism for midwives. [234]

379. On September 9, 2013, the AOM met with Ministry representatives in a MCFAC meeting. At that meeting, Farrell advised that the MOHLTC had decided not to "negotiate" with the AOM for funding agreement terms. These terms govern the compensation, practice and work of Ontario midwives.

380. On September 23, 2013 Farrell sent an email to Stadelbauer suggesting that the AOM's legal counsel look at a government website that "provides information regarding union certification."[235]

381. By letter dated October 7, 2013, Weston and Stadelbauer wrote to Fitzpatrick, to express concern about the above-noted Ministry position and its contrast to the

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233 Letter dated May 27, 2013, From Lisa Weston and Juana Berinstein to Deb Matthews, Minister of Health and Long-Term Care;

234 Letter dated July 25, 2013 from Premier Kathleen Wynne to Lisa Weston and Juana Berinstein, Association of Ontario Midwives; Letter dated July 26, 2013 from Yasir Naqvi, Minster of Labour to Lisa Weston, Kelly Stadelbauer and Juana Berinstein, Association of Ontario Midwives

235 Email dated September 23, 2013 from Melissa Farrell, Director, Primary Health Care to Kelly Stadelbauer, Association of Ontario Midwives

much more favourable bargaining process afforded to the male-dominated medical profession, represented by the OMA.[236]

382. Subsequently, the Ministry sent out the Template Funding Agreement to the TPAs without first getting agreement from the AOM on the changes it had made to the text. No such action would have been taken if the Ministry had been dealing with the OMA.

383. In light of the Ministry's repeated failure to address midwives' inequitable compensation, the AOM retained Mr. Durber to do a pay equity analysis. The conclusions of Mr. Durber's November 24, 2014 report include the following:

(a) *Given the extent of the pay equity gap, and the results of value comparisons, there exists significant wage discrimination adversely affecting midwives in their compensation, that is, it is not free from sex bias.*

(b) *This disadvantage is strongly associated with sex given the sex predominance of the two professions involved in comparisons, the nature of women's work (as expressed in midwifery) and the gender neutral approach taken to valuing their work and that of the CHC family physician.*

(c) *Such discrimination and disadvantage run counter to public policy and human rights and pay equity principles.*

(d) *Redressing the undervaluing and under-compensation of midwives should be based on the proportionate relationship in value and compensation between the midwife and CHC family physician during the period from the end of 1996 to the present.*

(e) *The proportions as set out here range from 81% in January of 1997 to 91% beginning on January 1st 2013.*[237]

PART 6 DISCRIMINATORY IMPACT OF COMPENSATION INEQUALITIES ON MIDWIVES

1. Compensation Losses

384. In summary, after many years of efforts to gain equitable compensation, the unequal compensation treatment by the Ministry with respect to midwives is set out in stark monetary terms in the estimates of losses set out by Mr. Hugh

236 Letter dated October 7, 2013 from Lisa Weston and Kelly Stadelbauer, Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister- Negotiations and Accountability Management Division

237 Durber Expert report, supra at para. 143.

Mackenzie in his November 22, 2013 expert report based on the Durber pay equity analysis. The Mackenzie report concludes as follows:

(a) *Establishing Pay Equity effective 1997 and maintaining Pay Equity throughout the period 1997 to 2013 through periodic re-evaluations of the relative value of the duties and responsibilities of the male comparator CHC physicians and midwives as outlined in the Paul Durber Pay Equity analysis, 2013 pay for midwives would be $197,315 -- $94,800 higher than the current actual midwives' compensation.*

(b) *Even without considering the updated Pay Equity analysis, midwives' compensation has fallen far behind the comparative basis established by the Morton Report for 1994. If the relationship implicit in the Morton Report – 63% of the CHC physician maximum – had been maintained, instead of midwives' annual rate of compensation in 2013 of $101,704, it would have reached $136,000.*

(c) *Had midwives' compensation been adjusted to reflect changes in the cost of living, as was provided for in the 1993 midwives' compensation Framework, midwives' compensation would have reached $110,600 -- $8,000 higher than the current level.*

(d) *Since 1994, Midwives' compensation has increased by 33%. Over the same period, the male-dominated CHC physicians' maximum compensation (the CHC physician maximum) has increased by 76%. The CHC minimum has increased by more than 119%.*

(e) *Midwives' compensation has increased at a much lower rate than that of the (female-dominated) job category of nurse-practitioner. Up to the point where both midwives' and nurse-practitioners' compensation were frozen in 2009, midwives' compensation had increased by 33%; nurse-practitioners' by 59%.*

(f) *It appears from a comparison of midwives' actual and inflation-adjusted 1994 compensation that the adjustments in 2005 and from 2005 to 2009 had the effect not of re-establishing the Morton Report's 1994 relationship to the comparative health care providers, but merely of restoring the real (inflation-adjusted) value of their 1994 compensation level.*

(g) *Midwives' compensation has fallen well behind the key general comparator, average wages and salaries in the health care and social services sector. Whereas midwives' compensation increased by 33% over the 20-year period, average weekly wages and salaries in the health and social services sector have increased by 64%.*

(h) *Over the period 1994 to 2013, the compensation of midwives in Ontario declined in real terms (after adjusting for inflation). Midwives' compensation has increased by 33%; inflation was 44%.*[238]

385. In addition, the Mackenzie report also estimates the compensation losses arising from the unequal benefits which midwives were also receiving. The Mackenzie report contains an estimated total summary of the compensation losses. A proper accounting will be necessary based on compensation records in the possession of the Ministry to finalize the compensation losses owing.

2. Impact on Midwives of Ministry Delay in Addressing their Pay Equity Claims

386. Given the Ministry's ongoing failure to promptly and properly investigate the AOM's claim that its compensation funding for midwives and its processes and mechanisms for negotiations is inequitable and to have in place a pay equity compliance mechanism, the Ministry should be required to make the necessary retroactive payments to put the midwives in the position that they would have been if the Ministry had properly considered the human rights allegation at the time and taken the necessary corrective action.

387. The Ministry's failure to investigate and address the complaint also exacerbated the injury to dignity, feelings and self-respect experienced by midwives, thus warranting additional compensation.

3. Injury to Dignity, Feelings and Self-Respect of Midwives.

388. The midwives have experienced prolonged injury to their dignity, feelings and self-respect as a result of the serious and persistent Ministry conduct detailed in this application, which resulted in midwives being underpaid for their services because of their gender, the gender of their clients and the gendered nature of their work. The effects experienced by the complainant midwives are particularly serious and include the following: humiliation, hurt feelings, loss of self-respect and confidence; loss of dignity; loss of self-esteem; loss of confidence; the experience of victimization and vulnerability.

389. Filed with this proceeding are statements from six midwives, which are representative examples of the injuries to dignity, feelings and self-respect that the complainant midwives have suffered.[239]

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238 Mackenzie Expert Report, supra at pp 2-3. Note: these calculations do not include impact of inequitable benefits. See. Chart 2 of the Mackenzie report for a graphic demonstration of the inequitable compensation faced by midwives as a result of the above-noted Ministry actions.

239 Statements of Maureen Silverman, RM, Rebecca Carson, RM, ,Daya Lye, RM, Jackie Whitehead, RM,Nicole Roach, RM, Tracy Pearce-Kelly, RM

390. As highlighted by the Supreme Court of Canada in *NAPE*,[240] the conditions in which a person works are highly significant in shaping the psychological, emotional and physical elements of a person's dignity and self-respect. This is because a person's employment is an essential component of their sense of identity, self-worth and emotional well-being. As the court stated:

For many people what they do for a living, and the respect (or lack of it) with which their work is regarded by the community, is a large part of who they are. Low pay often denotes low status jobs, exacting a price in dignity as well as dollars.[241]

391. This is particularly true for midwives whose work takes up so much of their lives because of its on-call responsibilities.

PART 7 KEY LEGAL PRINCIPLES RELIED UPON BY THE APPLICANT

392. This application claims that the respondent Ministry has violated the *Human Rights Code* and in particular sections 3, 5, 9, 11 and 12 flowing from its setting of an inequitable compensation structure for Ontario's midwives

393. The key legal provisions, principles and jurisprudence relied upon by the applicant include the following:

Section 5 - Right to Equal Treatment With Respect to Employment Without Discrimination Based on Sex

394. Section 5 of the *Code* provides that:

Every person has a right to equal treatment with respect to employment without discrimination because of… sex…

395. It is clearly established by the Human Rights Tribunal of Ontario that the term "with respect to employment" encompasses a broad range of relationships relating to employment. Protection is not limited to "employment" relationships in the traditional sense, so long as there is some nexus or link in the chain of discrimination between the respondent and the complainant. *Toronto (Metropolitan) Commissioners of Police v. Ontario Human Rights Commission*, [1979] O.J. No. 4459 and *Payne v. Otsuka Pharmaceuticals Co Ltd.* (2001), 41 C.H.R.R. D/52.

396. The *Code* must be interpreted in a liberal and purposive manner. This has included providing protection to independent contractors and subcontractors from unequal treatment. This is particularly so where the person is dependent on the respondent and is not permitted to perform the work for anyone else. An entity

240 *Newfoundland (Treasury Board) v. N.A.P.E.*, 2004 SCC 66 at para.40;

241 Ibid at para.48

responsible for a person being treated unequally will therefore be held liable under the Code even if the entity is not the person's direct employer. *Davey v. Ontario (Health and Long-Term Care),* 2013 HRTO 419, *Garofalo v. Cavalier Hair Stylists Shop Inc.,* 2013 HRTO 170, and *Srouji v. Direct IME*, 2012 HRTO 449, *Dopelhamer v. Workplace Safety and Insurance Board*, 2010 HRTO 765, *Halliday v. Van Toen Innovations Incorporated*, 2013 HRTO 583 and *Shinozaki v. Hotlomi Spa*, 2013 HRTO 1027

397. Compensation is a central component of a person's employment conditions. As recognized in *NAPE*, the conditions in which a person works are highly significant in shaping the psychological, emotional, and physical elements of their dignity and self-respect.

398. Pay equity or the right to be free from sex-based discrimination in compensation, is a fundamental human right guaranteed by the *Human Rights Code* and the *Pay Equity Act. Campe v. Borland Canada, 2010 HRTO 1257* and *Morin v Brink's Canada Limited,* 1995 Canlii 879, *Sacco v. John Howard Society of Peel Halton Dufferin 2012* 1185 and 2251.

399. Sex-based pay or compensation discrimination has been found to be a violation of the right to equal treatment in employment under human rights laws. *Nishimura* v. Ontario (*Human Rights*) [S.C. Ont. 11 C.H.R.R. D/246, *Reid v. Truro (Town) 2009 NSHRC 2, Canada Safeway Limited v. Saskatchewan (Human Rights Commission)* (1999) 34 CHRR D/409 and *CUPE v. Local 1999 v. Lakeridge Health Corp.* 2012 O.J. No. 2451. The existence of the separate *Pay Equity Act* does not take away from the quasi-constitutional obligations under the Human Rights Code to ensure that women do not receive unequal treatment with respect to compensation.

400. It is recognized in law in Ontario that "it is desirable that affirmative action be taken to redress gender discrimination in the compensation of employees employed in female job classes in Ontario." See Preamble, *Pay Equity Act*.

401. The failure to ensure women's work is paid proportionately equally on the basis of skill, effort, responsibility and working conditions with men's work is a violation of the right to equal pay for work of equal value guaranteed by ILO Convention 100 and the right to non-discrimination in employment and occupation set out in ILO Convention 111.

402. In addition to the approach of comparing female work to specific male comparators in order to identify gender discrimination in compensation, such discrimination can also be identified by determining whether the compensation for an occupation or industry is lower than it would have been because of gender considerations. This includes looking at the feminized nature of the work performed, eg. caring work. See *Australian Municipal, Administrative, Clerical and Services Union and others Australian Business Industrial,* February 1, 2012

(AM2011/50) [2012] FWAFB 1000 and *Australian Municipal, Administrative, Clerical and Services Union and others,* [2011] FWAFB 2700 May 16, 2011.

403. In order to combat systemic discrimination, it is essential to look to past patterns of discrimination and to destroy those patterns in order to prevent the same type of discrimination in the future. *Action Travail des Femmes v. Canadian National Railway* (1987), 40 D.L.R. (4th) 193 (S.C.C.),

404. Obligation holders under human rights law have a pro-active obligation to act to prevent and eradicate discrimination without waiting for complaints. They should ensure that work policies, standards and rules are designed for equality from the outset. *British Columbia (Public Service Employee Relations Commission) v. B. C. Government and Service Employees Union (BCGEU* [1999] 3 S.C.R.3.

405. There is a duty to take reasonable steps to address allegations of work discrimination and a failure to do so may itself result in liability under the *Code: Moffatt v. Kinark Child and Family Services*, [1998] O.H.R.B.I.D. No. 19, *Laskowska v. Marineland of Canada Inc.*, 2005 HRTO 30 (CanLII), 2005 HRTO 30 (CanLII). This includes acting promptly, taking a complaint seriously, having a complaint mechanism in place and communicating actions to the person or entity which complained. *Abdallah v. Thames Valley District School Board*, 2008 HRTO 230 (CanLII), 2008 HRTO 230 (CanLII), at para. 87

Section 3 - Right to Contract on Equal Terms Without Discrimination Based on Sex

406. Section 3 of the Code provides that:

Every person having legal capacity has a right to contract on equal terms without discrimination because of … sex …

407. The unequal treatment of an independent contractor is considered to be a violation of the right to contract on equal terms. Contractual terms which result in discrimination will violate section 3 of the *Code*. *Davey v. Ontario (Health and Long-Term Care)*, 2013 HRTO 419

Section 11(1) Constructive or Indirect Discrimination

408. Constructive or indirect discrimination is described in s. 11(1) of the Code which states:

11. (1) A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,

(a) the requirement, qualification or factor is reasonable and bona fide in the circumstances; or

(b) it is declared in this Act, other than in section 17, that to discriminate because of such ground is not an infringement of a right. R.S.O. 1990, c. H.19, s. 11 (1).

409. Actions which are not discrimination on their face but which adversely impact on women will constitute an infringement of Part 1 of the *Code*. Re: *Ontario Human Rights Commission and Simpson Sears Ltd. (1985) 2 S.C.R. 536; British Columbia (Public Service Employee Relations Commission) v. B. C. Government and Service Employees Union (BCGEU* [1999] 3 S.C.R.3 and *Andrews v. Law Society of British Columbia,* (1989) 1 S.C.R 143.

Section 9 – Infringing Right Directly or Indirectly

410. Section 9 of the *Code* provides that:

No person shall infringe or do, directly or indirectly, anything that infringes a right under this Part.

411. A party will be found to infringe any provision of the *Code* whether their action is taken directly or indirectly. *Forrester v. Peel (Regional Municipality) Police Services Board* 2006 HRTO 13 and *D. M. v. Ontario (Ministry of Health and Long Term Care* 2013 HRTO 1034. .

Section 12 - Prohibition against Associational Discrimination.

412. Section 12 of the Code prohibits discrimination because of association and provides that:

A right under Part I is infringed where the discrimination is because of relationship, association or dealings with a person or persons identified by a prohibited ground of discrimination. R.S.O. 1990, c. H.19, s. 12.

413. Discrimination because of association with women who are persons identified by a prohibited ground of discrimination constitutes discrimination within the meaning of s.12.

414. Where organizations are so imbued with the identity or character of their membership, or so clearly representative of a group that is identified by a prohibited ground under the Code, that they cannot be separated from their membership, the organization itself takes on the protected characteristic. *Brillinger v. Brockie [1999] O.H.R.B.I.D. No.12*.

Injury to Dignity, Feelings and Self-Respect

415. Monetary compensation as a remedy for injury to dignity, feelings and self-respect recognizes that the injury to a person who experiences discrimination

can be psychological in nature, and engages more than quantifiable losses such as lost wages. Damages under the *Code* must not be so low as to trivialize the social importance of the Code by effectively creating a license fee to discriminate.

416. Failure to pay equitable compensation and recognize the professional expertise of women will justify a significant order for compensation for injury to dignity, feelings and self-respect *Walden v. Canada (Social Development)*2009 CHRT 15 (Canlii)

417. The Tribunal has applied two criteria in making the global evaluation of the appropriate damages for injury to dignity, feelings and self-respect: the objective seriousness of the conduct and the effect on the person who experiences the discrimination. The more prolonged the discrimination, the greater injury. *Arunachalam v. Best Buy Canada* 2010 HRTO 1880, at paras. 52-54.

PART 8 REMEDIES SOUGHT FOR PAST DISCRIMINATION AND FUTURE COMPLIANCE

1. Introduction

418. The applicant, on behalf of the complainant midwives seeks all necessary remedies to ensure that midwives including those who retired from midwifery are made whole and a process is put in place to ensure midwives' ongoing compensation is free from sex-based discrimination contrary to the *Human Rights Code*.

2. Declaration of *Code* Violation

419. The applicant seeks a declaration that the respondent Ministry has violated the *Human Rights Code* and in particular sections 3, 5, 9, 11 and 12.

3. Monetary Compensation and Restitution/Damages

420. The applicant seeks the following monetary compensation on behalf of Ontario midwives:

(a) The Ministry shall pay to the complainant midwives retroactive compensation back to the date they would have been entitled to such compensation as if the *Code* had not been violated in order to rectify the unequal compensation they received.

(b) The Ministry shall also locate and pay to all midwives who performed midwifery services (and not just the complainant midwives) that were paid an inequitable rate compensation back to the date they would have been entitled to such compensation as if the *Code* had not been violated in order to rectify the unequal compensation they received

4. Injury to Dignity, Feelings and Self-Respect Compensation

421. The applicant seeks that the Ministry shall pay to the complainant midwives appropriate compensation commensurate with the significant, persistent and ongoing injury to their dignity, feelings and self-respect arising from the above-noted *Code* violations.

5. Interest

422. The applicant seeks that the Ministry shall pay pre-decision interest on all monies owing as set out above up to the date of decision, calculated in accordance with section 128 of the *Courts of Justice Act,* R.S.O.1990, c.43 and the *Hallowell House Limited* [1980] OLRB Rep. January 35 decision principles.

423. The Ministry shall pay post-decision interest on any accumulated principal and interest calculated in accordance with section 129 of the Courts of Justice Act and the *Hallowell* principles.

6. Remedies for Future Compliance with the Code

424. To prevent similar discrimination from happening in the future, the applicant seeks the following:

(a) The Ministry will set the compensation/fees for registered midwives in in accordance with the *Code* and the analysis provided by experts Paul Durber and Hugh Mackenzie.

(b) The Ministry will set up and follow an equitable compensation bargaining structure for the AOM for midwives similar to that engaged in by the Ministry with the OMA.

(c) The Ministry will establish regular pay equity evaluation processes with the government accountable for implementing the results and subject to review and monitoring by an independent third party with expertise in pay equity and approved by the applicant and Tribunal. Where agreement cannot be reached, adjudication of the necessary pay equity compliant compensation will be made by such third party. All such third party fees and costs to be paid by the Ministry.

(d) The Ministry will adopt and implement a sex- and gender-based analysis approach to the setting of midwifery compensation.

(e) Ministry staff will complete the Ontario Human Rights Commission's online training Human Rights 101 (available at www.ohrc.on.ca/hr101) or equivalent training on basic principles of human rights and confirming to the applicant's counsel that this has been done within 60 days of the decision.

(f) The Ministry will retain a human rights expert agreeable to the applicant and the Tribunal who will:

(i) Assist with the review and revision of the Ministry's compensation funding and bargaining policies and that a revised policies will be distributed to appropriate Ministry employees.

(ii) Train MOHLTC employees up to the Deputy Minister involved in the setting of midwifery compensation with respect to the revised policy, the *Code* and how to provide achieve and maintain pay equity.

(iii) Similarly train Ministry of Finance employees who handle midwifery funding.

(g) The Ministry will communicate to all appropriate Ministry staff, to Ministry of Finance staff, to midwifery Transfer Payment Agencies and to appropriate health care professional stakeholders who work with midwives a summary of the decision of the Tribunal, such summary to be approved by the applicant and the Tribunal.