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September 24, 2018

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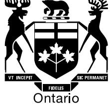
Re: Association of Ontario Midwives on behalf of Ontario Midwives v. Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care

HRTO File Number: 2013-16149-I

Please find enclosed a corrected Interim Decision of the Tribunal in this matter, dated September 24, 2018. The correction is noted at the end of the document.



HUMAN RIGHTS TRIBUNAL OF ONTARIO

B E T W E E N:

Association of Ontario Midwives on behalf of Ontario Midwives

Applicant

-and-

Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care

Respondent

INTERIM DECISION

Adjudicator: Leslie Reaume

Date: September 24, 2018

File Number: 2013-16149-I

Citation: 2018 HRTO 1335

Indexed as: **Association of Ontario Midwives v. Ontario (Health and Long-Term Care)**

APPEARANCES

Association of Ontario Midwives on behalf of Ontario Midwives, Applicant	)))))	Mary Cornish, Jennifer Quito, Lisa Leinveer, Shaun O'Brien, and Adrienne Telford, Counsel
Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care, Respondent	))))))	S. Zachary Green, Courtney Harris, Hayley Pitcher, Yashoda Ranganathan, and Daniel Huffaker, Counsel

INTRODUCTION

The Application and the Parties

[1] On January 1, 1994, midwifery became a regulated health profession in Ontario. For the first time in Canada, women with normal or low-risk pregnancies could choose an autonomous, publically-funded midwife as the primary-care provider for themselves and their newborns, in the place of a family physician or obstetrician.

[2] In this Interim Decision, I have used the word "gender" as well as "sex" in describing the prohibited ground of sex, and the words "woman" or "female" to describe midwives and their clients. It is important to acknowledge that there is one male midwife and members of the midwifery profession, as well as their clients, may self-identify as transgender or gender non-conforming.

[3] The Ministry of Health and Long-Term Care ("MOH") funds the midwifery program including compensation paid to midwives for their services and the expenses associated with their practices. This Application is about the compensation paid to midwives since regulation. It was filed by the Association of Ontario Midwives ("AOM") on behalf of more than 800 of its members in November, 2013 alleging that midwives have experienced gender-based compensation discrimination. The AOM is seeking, among other remedies, compensation retroactive to 1997.

The Applicant: The Association of Ontario Midwives

[4] The AOM, which has existed since the early 1980's, is the recognized representative of all of Ontario's registered midwives. All registered midwives in Ontario are members of the association. 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.

[5] The AOM negotiates with the MOH concerning, amongst other matters, the funding the MOH pays to midwives for their compensation and the expenses of delivering midwifery services. The AOM, and the midwives it represents, were instrumental in the movement to regulate midwifery and the ongoing development and growth of the midwifery program in Ontario.

The Respondent: The Ministry of Health and Long-Term Care

[6] The MOH is responsible for the midwifery program in Ontario. It is also responsible for key operations in health and long-term care in Ontario and the compensation paid to various health care professionals like midwives, nurses and physicians. The MOH has made significant investments in the midwifery program to support and grow the program and expand access to services.

The Process

The Pre-Hearing Process

[7] Interim Decision 2014 HRTO 1370 rejected the respondent's request to dismiss allegations based on the limitation period under the *Human Rights Code*, R.S.O. 1990, c. H.19, as amended (the "*Code*"). The request was dismissed and the Tribunal made important observations about how the MOH had characterization the AOM's allegations and the remedy sought.

[8] The Interim Decision found that the MOH had taken a compartmentalized approach to the history of compensation negotiations with the AOM, mischaracterizing the allegations and ignoring the systemic dimensions of the Application. The Tribunal found that the AOM was entitled to have its claim of historic, gender-based compensation discrimination, understood, considered, analyzed and decided in a complete, sophisticated and comprehensive manner.

[9] At the same time, the Tribunal noted at paragraphs 56 and 57, that the factual allegations, even if proven, might not lead to an order for full retroactive compensation:

> My finding that the Application is timely does not mean that, if it is successful, the individuals on whose behalf it has been brought will be entitled to compensation dating back to 1994 as claimed. Indeed, many of the arguments advanced by the respondent in this Request may well be relevant to the issue of appropriate remedy should a violation of the *Code* be established.
>
> The *Code* provides the Tribunal with a broad remedial discretion. An applicant must establish that the relief requested is appropriate in all the circumstances. This may include issues of whether compensation is available under contracts that have long since expired and have been superseded by fresh contracts, the application of the principle of laches and estoppel. I make these comments to underscore the scope of my finding that the Application as pleaded is timely, but also to signal the issues I expect the parties may need to address at the appropriate time in respect of the appropriate remedy should the allegations succeed.

[10] Following the release of the Interim Decision, the Application was deferred for a period of time while the parties engaged in efforts to resolve their dispute with a third party facilitator. The parties were unable to achieve an agreement. The hearing took place over several months commencing in September 2016, concluding with final submissions in June, 2017. In May, 2018, the Supreme Court of Canada released two new pay equity decisions involving pay equity legislation in Quebec. The parties requested an opportunity to comment on the implications of those decisions. They provided written submissions, which I have considered in rendering this Interim Decision.

[11] Throughout the pre-hearing process, the parties identified an extensive record of documents and a significant number of witnesses including several experts. I was assigned this case shortly before the hearing began in September 2016, and benefitted significantly from the work done in the pre-hearing phase by Executive Chair Gottheil and Member Catherine Bickley.

The Hearing Process

[12] The parties collaborated with the Tribunal to establish a process for preparing the evidence in chief of each witness by affidavit, focussing the oral testimony on cross-

examination, and scheduling some witnesses to deliver their testimony before a special examiner.

[13] The AOM relied on the following factual witnesses:

> Jane Kilthei; Vicki Van Wagner; Bobbi Soderstrom; Carol Cameron; Bridget Lynch; Remi Ejiwunmi; Elana Johnson; Katrina Kilroy; Madeleine Clin; Elizabeth Brandeis; Kelly Stadelbauer; John Ronson; Moshe Greengarten; Theresa Agnew; Margaret Anne McHugh; Maureen Silverman; Daya Lye; Nicole Roach; Rebecca Carson; and Jackie Whitehead.

And the following experts:

> Paul Durber; Hugh McKenzie; Dr. Pat Armstrong; Dr. Ivy Bourgeault

[14] The MOH relied on the following factual witnesses:

> Sue Davey; Laura Pinkney; Nancy Naylor; Melissa Farrell; Fredrika Scarth; David Thornley; Jodey Porter, Anne Premi; Martha Forestell; Ms. McHugh; Nicole Nitti; Tara Kiran; Susan Woolhouse; and MaryRose MacDonald.

And the following experts:

> Robert Bass; Dr. Richard Chaykowski; Dr. John Kervin; Dr. David Price; Dr. Lisa Graves; Dr. Candace Johnson

[15] The witnesses and experts testified over approximately 50 days in accordance with the pre-hearing agreement about the introduction of evidence. Each of the experts prepared a report and in some cases a subsequent report replying to the reports of other experts. The experts of the MOH testified in response to the AOM's experts. The MOH did not conduct a compensation study of its own or lead expert evidence for the purpose of validating its compensation practices.

[16] The proceedings were recorded. The complete record before me includes thousands of pages of transcripts, affidavits, exhibits and submissions by the parties. The parties filed substantial and extremely well-organized final submissions with hyperlinks to the documents referenced throughout the submissions. The parties also

returned after the last hearing date to coordinate all of the exhibits to ensure that the Tribunal's record was complete and accurate.

[17] I am extremely grateful for the cooperation and professionalism demonstrated by the lawyers who appeared for both sides as well as the witnesses who gave generously of their time to assist me in understanding the full context for the various positions taken by the AOM and MOH. The government witnesses who were involved in the regulation of midwifery played a vital role in developing the policy framework and marshalling the necessary resources to launch the program in a time of significant fiscal constraint. The midwives, Community Health Care Clinic ("CHC") physicians and nurse practitioners who testified left me with a renewed sense of appreciation for the complexities and challenges they face, the tremendous skill and empathy they bring to their work, and the enormous contributions they make to the health care system.

DECISION

[18] This is a lengthy decision because of the systemic nature of the claim and the necessity to conduct a thorough examination of the historical record. In 1993, the AOM and the MOH embarked on a remarkable collaboration, the result of which was that midwives took their place in the health care system at compensation levels that did not give rise to issues of gender discrimination. The principles and methodology adopted by the parties in 1993 embodied the values of understanding, mutual respect and dignity, the rights of midwives to realize equal treatment without discrimination, and the duty of the MOH to develop compensation practices and policies which proactively incorporate an awareness of their obligations under the *Code*.

[19] Since that time, the parties have achieved a number of funding contracts for the midwifery program. The AOM alleges that compensation for midwives has been eroded over time and affected by gender discrimination. By 2013, the parties had reached a complete impasse in what has been a long and complex history of negotiations.

[20] My decision is divided into two periods: from 1994 to 2005, there is insufficient evidence to support a finding of discrimination; from 2005 to 2013 when the Application was filed, there is sufficient evidence to support a finding of discrimination. My findings are based primarily on the extent to which the MOH has remained aligned with the intent of the 1993 principles and methodology and the impact on midwives where that has not been the case.

[21] I have deferred on the issue of remedy to give the parties an opportunity to reset their relationship, determine the appropriate level of compensation and general damages, and develop a methodology for maintaining appropriate and fair compensation for midwives moving forward.

Facts and Chronology

Introduction

[22] The factual chronology set out by the parties in their final submissions overlaps substantially. Appendix 6 of AOM's final submissions contains a copy of the original Application redacted to identify the facts that are specifically agreed to by the MOH, either in its pleadings or as part of its representations of statements contained in documents.

[23] In reviewing the facts, I have been particularly attentive to what the parties knew or ought to have known at the time that decisions were made and the impact of those decisions. I have indicated where facts are in dispute, as opposed to differing interpretations of those facts, but resolved only those factual disputes which were actually relevant to my Decision.

[24] The overview of the facts begins with some general observations about the role of midwives in the health care system, how midwives are compensated and the relationship between midwifery and gender. These facts are not in dispute. I use the term "funding agreement" rather than "compensation agreement" because the AOM negotiates with the MOH as independent contractors over the delivery of midwifery

services in Ontario. The funding agreements deal with issues which go well beyond wages and benefits. Following the overview, the facts are divided into two periods: 1994 to 2005 and 2005 to 2013.

Summary of Facts

[25] In 1985, the Government of Ontario established a task force to make recommendations on integrating midwives into the health care system. The findings of the Task Force are fundamental to any understanding of how the model of care and the funding principles for the midwifery program were developed.

[26] The regulation of midwifery was achieved through an extraordinary collaboration between the AOM and the MOH. The MOH relied heavily on the expertise and credibility of practising midwives and the AOM to develop the model of care and funding principles. The parties reached an initial agreement on compensation through a joint working group process in 1993. One of the fundamental principles established in advance of the joint working group was that compensation for midwives would reflect the overlapping scope of practice they share with senior nurses and family physicians.

[27] The parties agree that the initial compensation levels were "appropriate and fair" and did not give rise to any concerns about gender discrimination. The joint working group retained a compensation expert (Morton) to conduct an evaluation of the skill, effort, responsibility and working conditions (SERW) of midwives as compared to senior nurses and family physicians. That methodology, combined with some positional bargaining, produced an agreement on compensation levels which was not affected by the prevailing gender stereotypes about midwifery work.

[28] While the funding principles refer to senior nurses and family physicians generally, the joint working group refined the comparator to senior nurses and family physicians (1993 comparators) working in Community Health Centres ("CHC's"). CHC staff had their compensation set by the MOH. At the time, senior nurses were earning $42,000 to $56,000 and CHC physicians had two scales, one for under-serviced and

the other for non-underserviced. The rate used in 1993 was the non-underserviced rate of $80,000 to $115,000.

[29] Midwives were positioned between the two groups. A salary range was established at $55,000 to $77,000 with 12 annual pay increments of $2000.00. The entry level midwife was positioned just above the top salary of a CHC senior nurse and the highest compensation level for a midwife was positioned within $3000.00 or approximately 90% of the base salary of the entry level CHC family physician salary. Subsequent negotiations established the level of operating expenses and benefits at 16% percent of salary. The AOM benefits Trust Fund was established in late 1993. The fund is comprised of group health benefits, group RSP and a maternity/short term disability self-insurance plan. Liability insurance was fully funded by the MOH as well as the regulatory College.

[30] The midwifery program was launched in a time of significant compensation restraint. In their first funding agreement, midwives committed to social contract deductions of 4%. Midwives and their 1993 comparators experienced eleven years of wage freezes before new compensation agreements were achieved: midwives from 1994 to 2005; CHC nurses and physicians from 1992 to 2003. The introduction of nurse practitioners in 1999 did not directly change the alignment of midwives with their 1993 comparators, but resulted in some nurse practitioners earning more than midwives at lower levels of the grid.

[31] I note here that midwives have long taken the position that the senior nurses they were compared with 1993 were the same nurses who became nurse practitioners when the profession was regulated in 1999. The issue comes up from time to time in the chronology of events.

[32] A new funding agreement was reached in 1999 after several years of unexpectedly difficult negotiations over issues associated with the employment status of midwives, among other things. The 1999 agreement established the independent contractor model that exists today and transformed compensation from a salary model

to a “course of care” fee model. There were increases made to operational expenses at this time but not to compensation.

[33] In 1999, the MOH began investigating the consequences of wage freezes in the health care sector. A number of studies were undertaken at that time. Staff working in CHC’s, including senior nurses and physicians, received their first compensation increases in 2003.

[34] The AOM asked for compensation increases based on the cost of living allowance (“COLA”) in 2000. There was a provision in the original funding agreement which provided for COLA from time to time at the discretion of the MOH but the request was denied. The AOM continued to advocate for increases for midwives and in 2003, obtained a compensation study by Hay Group which was updated in 2004. Hay Group was to consider the ongoing relevance of the 1993 compensation principles and comparators and recommend appropriate increases for midwives. The AOM relied on the study in their negotiations with the MOH, highlighting the risks of underfunding midwives.

[35] In November, 2004, frustrated by delays, the AOM initiated the “Because Storks Don’t Deliver Babies” campaign and a threat to march on Queen’s Park. The MOH responded with a global funding package, the details of which were negotiation over the course of several months and resulted in the 2005 agreement.

[36] The 2005 agreement resulted in first year increases of 20 to 29% for midwives depending on experience level, and smaller increases of 1 to 2% in the other two years of the contract, increases to operational expenses, other funding and program enhancements, the grid was collapsed from 12 to 6 levels and a commitment was made to start the next round of negotiations by December 2007. AOM membership ratified the 2005 agreement. The AOM executive described the agreement both publically and to the membership in very positive terms but also hoped to achieve further increases in the next round of negotiations.

[37] CHC physicians had received increases from the MOH in 2003 of 8.7% and 7.4% depending on where they worked. In 2004, CHC physicians sought representation from the Ontario Medical Association ("OMA"). From 2004 onward, compensation increases for CHC physicians began to accelerate as a result of agreements achieved by the OMA in 2004, 2008 and 2012. The 2012 agreement resulted in decreases to compensation and since 2015 their compensation has been set unilaterally by the MOH in the absence of a contract with the OMA. In June 2015, CHC physician compensation was $177,673 to $205,775 in non-underserviced areas and $214,407 to $246,776 in underserviced areas.

[38] In their preparations for the 2008 negotiations, the AOM again engaged Hay Group (2008) to conduct a review of compensation levels and benefits for a broader range of public sector workers between 2005 and 2007. The AOM also commissioned a workload analysis to support their negotiations and developed a list of almost twenty negotiation priorities including significant compensation increases. There were delays because of changes in personnel. The MOH would not agree to the more significant increases the AOM was seeking, in part because of economic factors and compensation restraint.

[39] The AOM was concerned that midwives were losing their connection to the funding and compensation principles they had achieved in the 1993 agreement and asked the MOH to agree to a joint compensation study. The parties reached a three-year agreement in 2009 with smaller increases retroactive to April 1, 2008, a number of further program enhancements, and a commitment to a joint but non-binding compensation study. The study was to be completed before the next round of negotiations set to begin in September 2010. The AOM states, and the MOH does not dispute, that it gave up other things at the negotiation table to achieve the agreement on a joint compensation study.

[40] In the meantime, the OMA reached a four-year agreement ahead of the AOM, which was ratified in October, 2008. The AOM regarded this as an example of the MOH prioritizing the interests of physicians over midwives.

[41] The parties participated in a compensation study with Courtyard Group in the summer of 2010. It was the first joint compensation study since 1993. Courtyard's mandate was to make recommendations on an appropriate "total compensation" package for midwives and evaluate the ongoing relevance of the 1993 methodology. A steering group was formed with representatives from the AOM and the MOH who worked collaboratively with the consultants. Courtyard did not conduct a gender-based compensation analysis but it considered the 1993 Morton report and the 2004 Hay Group report.

[42] Courtyard rendered its final report in October 2010 recommending a 20% compensation adjustment for midwives. The report affirms the ongoing relevance of the original funding principles, including comparison with CHC physicians. Courtyard attributes the compensation gap to the irregular negotiations and a lack of adherence to the original funding principles. The MOH takes the position that the Courtyard report is flawed and that CHC physicians are no longer relevant to setting compensation for midwives.

[43] Following the release of the Courtyard report, the MOH advised the AOM that the 2010 negotiations would be governed by compensation restraint. In March, 2010, the Government passed compensation restraint legislation that applied to public sector employees. The Government did not re-open existing agreements, but on new contract negotiations, it imposed two years of zero increases. There was also a prohibition against making up any losses from the first and second year in the third year of the contract.

[44] The AOM argued that as independent contractors the legislation did not apply. The MOH agreed, but advised the AOM that they were captured by a broader compensation restraint *policy* that applied to all contractors, including midwives and physicians. The OMA was similarly affected by the policy in 2012. The four-year agreement reached in 2008 was not reopened. However, in 2012, the compensation restraint policy was applied to *decrease* compensation for physicians including CHC physicians.

[45] The AOM argued that the Courtyard report represented evidence of gender discrimination and urged the MOH to implement the report by applying the exclusion in the compensation restraint policy on the basis that it represented a pay equity adjustment. The MOH obtained advice about the position of the AOM and was advised that the *Pay Equity Act* did not apply to midwives as independent contractors. A risk was also identified that midwives might file a human rights complaint, however, the advice noted that midwives' comparators were mostly female and their relationship to obstetricians was not clear. The MOH did not make any further inquiries about whether the Courtyard Report represented evidence of gender discrimination against midwives, nor did it conduct any further compensation studies.

[46] There were a series of negotiations and attempts at compromise. The AOM began to explore the risks and benefits of a human rights application in 2011, choosing instead to engage in other strategies to pressure the MOH to implement the Courtyard recommendations. The AOM and MOH finally reached a funding agreement in 2013, which was subject to the AOM pursuing other actions on adjustment identified by courtyard the Courtyard recommendation. On November 27, 2013, the AOM filed this Application.

General Observations

Midwives and Their Role in Ontario's Health Care System

[47] Registered midwives are autonomous primary health-care providers who are specialists in providing comprehensive around-the-clock, on-call, care for women with low-risk pregnancies and their newborns until six weeks of age. Along with family physicians and obstetrician-gynecologists, they provide primary care in Ontario`s maternity health-care system. As well, like paediatricians and family physicians, they provide primary health care to newborn infants up to 6 weeks of age. The knowledge and skills of midwives overlap a number of professional scopes of practice, including family physicians, obstetricians, pediatricians, nurse practitioners, registered nurses and registered practical nurses, social workers and counsellors.

[48] Midwifery is one of 23 health professions regulated under the *Regulated Health Professions Act, 1991*, SO 1991, Chapter 18. The profession is also governed by the *Midwifery Act*, *1991,* SO 1991, Chapter 31. The scope of practice of each midwife is defined by legislation. 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. The development of the midwifery education program is set out in appendices 5 and 7 of the AOM's submissions and not contested by the MOH.

[49] The parties agreed from the outset on a model of care with three primary components: continuity, informed choice and choice of birthplace. A woman receives continuity of care from the same midwife throughout her pregnancy (pre-partum), during birth (intra-partum), and for six weeks after birth (post-partum) during which the midwife provides care for the woman and her baby. As described in the Philosophy of Midwifery Care in Ontario published by the College of Midwives, health care provided by midwives "is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional, cultural as well as physical needs." Appendix 8 of the AOM's submissions entitled "The Life and Work of a Midwife – A Demanding and Skillful Job" contains a summary of the evidence on the nature of midwifery work, which was not contested by the MOH.

[50] The model of care, endorsed and supported by both parties, creates onerous on-call obligations which interfere in a significant way with a midwife's ability to achieve work life balance. These obligations explain in part why midwives have evolved as independent contractors: they are unable to conform, for example, to the restrictions on hours of work in the *Employment Standards Act*, 2000, S.O. 2000, c.41. There are some benefits to being independent contractors, particularly in a context where the MOH maintains the supply of midwives at levels lower than demand; however, midwives are also excluded from the protections of the *Pay Equity Act*, RSO 1990, c. P.7 and the provisions of the *Labour Relations Act*, 1995, SO 1995, c. 1, Sched. A, which would permit the AOM to be recognized as their official bargaining agent.

[51] The model of practice adopted in Ontario is not a specialty of nursing nor do midwives work under the supervision of a physician. As specialists in normal pregnancy, they are as autonomous and responsible as physicians for the services they provide within their scope of practice. Nurses also play a key role in the maternity health-care system. However, they are not primary care providers through the pregnancy, birth and postpartum period. A woman does not require a referral from a physician to hire a midwife. If she chooses a midwife, she will not see a physician for obstetrical care unless there are complications which require a consult or transfer of care to a physician who specializes in obstetrics.

[52] The policy of the MOH is that family physicians and midwives are the right care providers for women with normal pregnancies. The MOH promotes midwives and physicians as equally competent providers of maternity care who provide those services based on different models of care. The choice to work with a midwife or physician is one that each woman makes for herself based on her own needs and circumstances.

[53] The parties agree that midwives play a vital role in the health care system in Ontario, having assumed work which was once the exclusive domain of family physicians and specialist obstetricians. At the time of regulation, family physicians were withdrawing from delivering babies because of the demands on their skills, practices and time, including the onerous on-call responsibilities which significantly undermined their work/life balance. As a result, the majority of women with normal pregnancies were being cared for by specialist obstetricians.

[54] The midwifery program has been delivering excellent outcomes and high rates of satisfaction since regulation. Demand for midwifery services has always exceeded the supply of midwives. The MOH values the midwifery program and continues to make investments to expand access to service across the province even during periods of financial restraint. In fact, one of the remarkable things about the program in Ontario is that it was launched during a period of significant financial restraint as the government was enacting the *Social Contract Act*, 1993, S.O. 1993 c.5. As a result of the investments made by the MOH and the ongoing work of practising midwives who

mentor, train and support each new graduate, the number of midwives has been growing year over year. Since regulation, their scope of practice been expanded to take advantage of their remarkable skill set and to respond to changing health care priorities, underserviced communities and vulnerable patient populations.

How Midwives Are Compensated

[55] Midwives work in practice groups, which receive funding for compensation, benefits, and the expenses associated with their practices. The funding flows from non-profit organizations called “transfer payment agencies” (“TPA’s”) to midwifery practice groups in accordance with the contracts set by the MOH. TPA’s are incorporated, community-based organizations which include hospitals, community health centres (“CHC’s”) and other non-profit agencies.

[56] While the MOH has the power to set funding levels unilaterally, it has, for the most part, negotiated with the AOM and relied on the expertise of midwives to establish those agreements. The first agreement was achieved in 1993 just prior to regulation. New agreements followed in 1999, 2005, 2009, 2013 and 2017. The 2017 agreement was reached without prejudice to the issues raised in this Application. All but the 1999 funding agreement included increases to compensation.

[57] Midwives were initially funded based on a salary model with operational and special expenses funded paid separately. From 1993 to 1999, their employment status was somewhat ambiguous. Midwives advocated for an independent contractor model, which was confirmed in 1999 with the full support of the MOH. At the same time, the salary model was re-designed and, since that time, midwives have been paid based on “courses of care” as a primary midwife and second attendant. Additional funding in the form of “case load variables” is provided for activities related to their practices, work on hospital committees and other aspects of their profession.

[58] The funding model is complex and expands with each contract as the profession has matured. In the 2008 negotiations, for example, the AOM had almost twenty priorities related to compensation and program enhancements.

[59] In 1993, midwives were earning $55,000 to $77,000. In 2010, Courtyard Group reported that midwives in a non-rural practice were earning base compensation of $81,712 to $104,847 depending on experience level. This includes an experience fee, on-call fee and retention incentive. They also receive benefits which are administered by the AOM, travel disbursements, overhead, funding for professional development, compensation for mentoring time and non-clinical activities and supplements and grants for special projects and rural and remote areas. Their liability insurance is funded by the MOH as is the AOM.

[60] The MOH provides funding for the education program and fully funds the College of Midwives and liability insurance for midwives. The College has been fully funded by the MOH since regulation because of the relatively small size of the profession and the important public interest role played by professional governing bodies.

Midwifery and Gender

[61] Midwifery and nursing have always been strongly identified with women's work: that was true at the time of regulation and remains true today. The AOM described midwifery as a gender "trifecta" of services provided by women, for women, in relation to women's reproductive health. In my view, that is a very apt description of the strong association which exists between midwives and gender.

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

[63] The parties disagree on the implications of the gender predominance of the nurses and physicians with whom midwives share an overlapping scope of practice. As Jane Kilthei testified, “gender is the water we swam in”: any comparison with physicians, particularly at the time of regulation, was synonymous with comparison to a male-dominated profession. The MOH, on the other hand, denies that gender has ever been a factor in determining compensation for midwives and that midwives have never had their compensation set in relation to a male comparator. The MOH also argues that CHC physicians have been female-dominated most of the material period covered by this Application and at the very least, the point at which midwives began to advocate for their first compensation increases.

Pre-Regulation Period

[64] Both parties included a section in their final submissions setting out the basic factual chronology of the events leading to the regulation of midwifery. The chronology of the MOH begins with review of regulated health professions in 1983. Consistent with the very different perspectives of the parties on the relevance of the historical period preceding the regulation of midwifery, the AOM chronology begins in 1865 when midwives were the primary maternity care providers in Ontario. That history is described in Appendix 7 of the AOM’s submissions. The Task Force Report also contains an extensive history of midwifery, none of which is disputed by the MOH. The position of the MOH is that many of the historical barriers experienced by midwives were removed as a result of regulation.

[65] Appendix 7 also contains a section on the negative attitudes and prejudices faced by midwives in the pre-regulation period and the chronology of the events leading up to 1992, including the campaign for regulation, the development of the education program and model of practice, and the implementation of pay equity in the health care sector generally. The vast majority of the facts set out in Appendix 7 are not disputed by the MOH with the following exceptions which arose either during the hearing or in the submissions of the MOH:

Paragraph 22, 95 and 96: none of the midwives who testified at the hearing had themselves been denied hospital privileges;

Paragraph 24: the MOH disputes the argument that female physicians work within and benefit from the established attitudes and place of privilege in the health care hierarchy that was "developed and controlled by men for men for over a hundred years;

Paragraph 13: that prejudices were so embedded in the health care system that they have affected the work and pay not only of the pre-regulation midwives, but also midwives over the years since then and to this day as they sought to integrate into the health care system;

Paragraph 35: that the Task Force recognized the male dominated physician led structure of maternity care in Ontario;

Paragraph 40, 107 and 108: the description of the CHC physician as a male job class for Pay Equity Act purposes and the description of Sue Davey engaging in a "pay equity exercise";

Para 62: the comparison between the structure of the midwifery education program and the structure of the McMaster and University of Calgary medical schools;

116 to 119: the relevance of the events which occurred in New Zealand.

The Historical Context Preceding Regulation

[66] The regulation of midwifery was preceded by many years of advocacy on the part of midwives, the organizations they formed and women consumers, many of whom identified the public funding of midwifery as an important feminist issue. The AOM and the midwives they represent were instrumental in achieving regulation and building the infrastructure which supports the delivery of midwifery services in Ontario. For many years, albeit through some difficult periods, the parties to this Application worked collaboratively to build the program, expand access to midwifery services and protect the model of care.

The Task Force on the Implementation of Midwifery

[67] In 1985, the Ontario government established the Task Force on the Implementation of Midwifery, chaired by Mary Eberts, to recommend a framework for

the regulation of the profession. The report of the Task Force, which was released in 1987, formed the backbone of the midwifery program in Ontario. The AOM's claims about gender-based discrimination in compensation cannot be fully understood without considering the history of midwifery in Ontario and the importance of the Task Force to the development of the midwifery program. The Task Force found that it is "universally acknowledged that the midwife is a specialist in "normal" reproductive care providing care to women with healthy, low-risk pregnancies".

[68] The Task Force examined a much wider historical context than the decade or two which preceded regulation. The report describes how male physicians came to be the preferred birth attendants of the upper classes in 18th century Europe and that by the 19th century, stereotypes of midwives as "ignorant, unkempt and addicted to gin" were promulgated by writers like Charles Dickens. The Task Force also found that the practice of midwifery, by women, was suppressed by the modern medical profession. The recommendations of the Task Force were grounded in the recognition that the regulation of midwifery "has to do with re-establishing a traditionally female occupation that developments in medicine and medical technology threatened to extinguish."

[69] Midwifery was not completely extinguished by the medical profession in Ontario. However, those who chose to practice prior to regulation, some of whom testified in this proceeding, did so in precarious circumstances up against attitudes that home births were unsafe and midwives should be practising under the supervision of a physician. The relationship between the work of midwives and the work of physicians was not well understood or represented in their compensation levels. For the AOM, the history of suppression and gender stereotyping that midwives experienced was a significant factor in the development of an autonomous model of practice and funding principles to support that model. The perceptions of midwives and the stereotypes associated with their work did not immediately disappear with regulation. A number of midwives testified in this proceeding that these perceptions have been a factor in their ability to achieve full integration into the health care system and work within the full scope of their practice.

[70] The members of the Task Force held extensive consultations and public hearings and visited midwifery schools, practices and regulatory bodies in various parts of the world. The members also investigated the existing system of reproductive care noting that in Ontario at that time physicians were withdrawing from low-risk maternity care with the result that care for those patients was increasingly being managed by specialist obstetricians. Submissions to the Task Force from medical associations described as some of the reasons for this decline, the inadequacies in obstetrical training received by many general practitioners, their desire for an easier lifestyle, and the risks associated with obstetrical care.

[71] What is most important for my purpose is the way the Task Force describes the skills of midwives and their relationship to nurses and physicians. The Task Force stressed that “midwifery is an autonomous profession, not a speciality of nursing”. The Task Force also recognized that the midwife “is expected to have diagnostic skills relating to both mother and baby that are at one level similar to the obstetrician”.

[72] In comparing midwives to physicians, the Task Force found a “striking” difference in the model of care provided by midwives and physicians; the similarity in the level of autonomy and responsibility they have for the care of women and babies under their care; their competency in assessing risks which is similar to an obstetrician; the extensive activities over which a midwife exercises independent clinical judgment within her scope of practice; the fact that at least 85% of pregnancies can be managed by either a midwife or a family physician; and that the midwife’s scope of practice is not delegated to her by a physician, “rather the authority for performing them originates with her”.

[73] The Task Force recommended a broad scope of practice for regulated midwives and the autonomy to enable them to practise as primary caregivers for women with low risk pregnancies, “and therefore a true alternative to physician care for a proportion of women.”

[74] At the time of the Task Force, the AOM and other midwifery organizations across Canada believed that home birth was as safe as hospital birth for properly selected women. However, the Task Force found that this belief was not shared by the Canadian and medical nursing profession, which were "virtually united in their opposition to planned home birth" and believed that "parents who choose home birth are misguided or poorly informed."

[75] The Task Force also considered the prevailing attitudes of physicians toward midwives in order to anticipate issues which might arise with integration into the health care system. The Task Force found it encouraging that there appeared to be a base of physician support for midwifery which would likely grow as physicians became more familiar with midwives. However, the study also supports the AOM's contention that the autonomous model of care and the overlapping scope of practice that midwives share with physicians were not very well understood in the period preceding regulation.

[76] There was no evidence presented at the hearing that these attitudes immediately disappeared as a result of regulation. Quite the contrary, some of the AOM witnesses testified about challenges to integration and to their personal and professional integrity, which they attributed to resistance from a male-dominated medical profession which either did not support licensing midwifery at all, or advocated for midwives to work under the supervision of a physician.

[77] The Task Force also recognized that it would be a challenge but also necessary for midwives to gain support from physicians "who are powerful figures in establishing and changing hospital protocols". The Task Force strongly recommended that midwives be recognized as an independent profession and not as "extended role nurses or physicians' assistants", that that they be fully integrated into the health care system and that midwives and physicians work collectively in the care of individual women. The Task Force recognized that midwives would need to gain the confidence of consumers, other health care providers and hospital boards and administrators "if they are to overcome their many years of isolation from the official health care system":

> No woman should be compelled to be cared for by a midwife instead of a physician, but the benefits of midwifery care should not be obscured by anxiety over its safety or confusion over the midwife's role". On the issue of compensation, the Task Force recommended that one of the characteristics of safe and effective midwifery practice would be to ensure fair compensation and reasonable working conditions for midwives […].

[78] The Task Force was not directed to recommend an appropriate level of compensation for midwives but did state that they should be paid at a fair and reasonable level that reflects their level of responsibility, the demands on their time, the difficulty of their work, the cost of participating in continuing education activities and the cost of professional liability insurance.

[79] The Task Force suggested positioning midwives between the starting salary for a nurse with a baccalaureate degree and the fees physicians were paid under OHIP for pregnancy, labour, birth and postpartum care: "in our view, nursing salaries would be inappropriate for midwives because of the nature of the midwife's level of responsibility, the difficulty of her work, and the greater (and less predictable) demands on her time." At that time, the OHIP fee schedule did not distinguish between general practitioners and specialists in obstetrics and gynaecology. They were paid the same rate and the choice of service provider was left to the patient. The Task force suggested a range of between $31,000 and $43,000 in 1987.

[80] To ensure full integration of midwifery in the health care system, the Task Force recommended that midwifery services, like physician services, be paid for exclusively by the government of Ontario on the basis that the "closest analogy to midwifery services is physicians services."

Developments in Pay Equity

[81] In addition to the announcement about the formation of the Task Force, in November 1985, the Attorney-General and Minister Responsible for Women's Issues introduced the "Green Paper on Pay Equity" committing the government to the

implementation of pay equity for women working in female dominated jobs and professions. The *Pay Equity Act,* which came into effect on January 1, 1988, recognized that "affirmative action" is required to "redress the system gender discrimination in compensation" of women's work in Ontario.

[82] Vicki Van Wagner testified that the period leading up to the regulation of midwifery was "a moment of optimism in the history of the women's movement". She described the work being done on pay equity, women's sexual and reproductive rights, violence against women and what it felt like to work alongside feminists in the MOH and the Women's Health Bureau: "we're all working on this together, all of these issues are integrated."

[83] At the same time, the economic outlook was poor and there were significant financial constraints on program development and compensation. Jodey Porter, who was an ADM in the Women's Health Bureau at the time, described it as a great achievement that the program was established and funded at that time.

[84] It was against this backdrop that the next steps were taken toward the regulation of midwives.

The Funding Principles and the 1993 Agreement

[85] This history is important to my findings because it establishes the funding principles for the midwifery program and the way those principles flowed through from the Task Force to the work of the MOH. It is also important because the MOH denies that gender was a factor in determining the appropriate level of compensation for midwives.

Interim Regulatory Council of Midwives (IRCM)

[86] In June 1989, the IRCM was appointed to develop standards of practice and certification requirements for midwives until a midwifery statute was enacted and the College of Midwives was established. The IRCM had thirteen members and was chaired

by Mary Eberts, the chair of the Task Force. The work of the IRCM is set out in detail in the parties' submissions. There is no dispute that the IRCM recommended an "equitable" formula for the funding of midwifery to be determined by reference to factors such as skill, education, working conditions and degree of responsibility. The IRCM also cited the Task Force recommendation that compensation for midwives fall between that of a senior nurse and a family physician.

The AOM's Principles of Funding

[87] In 1992-1993, the AOM developed a document called "Principles of Funding" which described the model of practice (the midwife follows the woman); positioning midwives between a senior salaried nurse and family physician; the objective factors to be considered in establishing the level of funding; special consideration for midwives working in under-services areas such as the north; and an equitable funding formula that takes into consideration overhead costs, costs of setting up a new practice, travel, part time practice and professional activities.

The Women's Health Bureau

[88] The Women's Health Bureau ("WHB") was the branch of the MOH initially tasked with developing the policy framework to support the public funding of midwifery. One of the priorities of the WHB was to ensure equitable access to midwifery services for women across the province.

[89] By the time the WHB of the MOH was assigned to develop the policy framework for implementing midwifery, the Task Force, followed by the IRCM, had already established the principles of funding to support a very specific model of care. The term "equitable compensation" was used to describe the proper positioning of midwives between senior nurses and family physicians. The MOH acknowledges that the Task Force and IRCM findings in this regard were taken very seriously by the WHB and in fact, the policy work done by the WHB was fully aligned with those recommendations. It was not until after the work of the WHB, when a joint working group of the MOH and the

AOM was formed to quantify compensation for midwives, that specific nurse and physician comparators were chosen and a formula was adopted for positioning midwives between those comparators.

The MOH’s Principles of Funding

[90] In 1993, the WHB developed its own principles of funding for midwifery in consultation with a number of stakeholders including the AOM, entitled “Principles of Funding for Midwifery”. The principles adopted the recommendations of the IRCM that midwives be paid as a primary care provider and that compensation fall between the level of a family physician and a senior salaried nurse. The principles also include a description of the model of practice and the importance of a funding model that ensures equality of access throughout the province.

The “Options Paper” References Pay Equity Principles

[91] Margaret McHugh, who testified at the hearing, was hired by WHB in the summer of 1993 as the Midwifery Implementation Coordinator. She developed an “Options Paper” on compensation for midwives as background information for the more senior level decisions required to finalize the midwifery program framework. The Options Paper was approved by Ms. McHugh’s ADM, Jodey Porter, who also testified in the hearing. The section of the final version of the paper entitled “Assumptions” contains the following statements: “Necessity to establish a fair and equitable pay level based on pay equity, reflecting responsibilities, working conditions and level of education”.

[92] Ms. McHugh was asked what she understood the term pay equity to mean in the context of the Options Paper:

> We understood it to mean that women had historically been underpaid and their work had been undervalued, and if we were going to establish a brand new, female exclusive-almost profession, that we had to ensure that that profession was not going to be discriminated against or that there wouldn't be bias against their payment method just by looking at other female-dominated professions and kind of going, "Oh, well, you know, you should be paid a small amount since you're women." So we had to make

> sure that that happened. It didn't necessarily mean that we were going to do a formal pay equity assessment under the [Pay Equity] Act. It meant that we were going to make sure that we were not underpaying midwives,that they were fairly and equitably paid according to their skills and experience and education, and not according to somebody's picking out something. It was going to be evidence-based.

[93] Ms. McHugh also testified that she did not recall anyone “pushing back” on the issue of pay equity. Ms. Porter also testified that if there was ever a pay equity issue it was resolved before it ever reached a higher level in the organization:

> It seemed resolved. No one, including IRCM or NC or AOM or Karyn, Dr. Kaufman, or any of the constituents or -- and frankly, the Minister's office was full of wonderful feminists with incredible background in the community. No one anywhere raised questions. Everyone seemed content with the process, and just the absolute miracle at the time this was going to happen, which we were very proud of.

[94] Ms. Porter also stated that:

> […] simply getting the profession in the field resolved issues of equity and gender equity and practice equity. I mean, it was against all opposition and there was opposition not just from doctors, but from all across the health care system.

[95] Ms. Porter was asked if midwives had complained that there was an enormous gap between them and a male-dominated profession. Ms. Porter responded that “it wouldn't have gone out the front door of the Ministry. It simply wouldn't in that environment.”

[96] McHugh testified that about her work on the regulation of midwifery at the WHB, including the attention paid to gender, the use of a gender analysis in the development of health policy and the fact that some attention was paid to ensuring that midwives were not underpaid “simply because it was a female-dominated profession”.

[97] The Options Paper was circulated to the decision-makers although it was not discussed at the Deputy Ministers' Committee meeting or the Minister's Policy Committee. Ms. McHugh testified that there was discussion about the fact that fair

compensation would fall between a senior salaried nurse and a family physician as reflected in the Principles of Funding. This is also reflected in the final minutes of the meeting. The Ontario Midwifery Program Framework Document for Cabinet which represented the decisions made at the meetings, referred to setting fair and appropriate compensation for midwives that should reflect the relative skill, effort, responsibility and working conditions for midwives in comparison to other health professions.

[98] Ms. Porter did not recall discussions about gender although she conceded that there may have been discussions that she was not a part of. Ms. Porter described this phase as a significant achievement and testified about the challenge of regulating midwifery in a time of fiscal restraint:

> This was a period, like today, in the health care system of severe fiscal restraint when we were cutting services right, left and centre, good services, essential services, but a time of just incredible zero-based budgeting exercises… I felt quite confident that in fighting for their autonomous scope of practice, that in fighting for their privileging in hospitals, and in fighting for the option of public funding, that I had justifiably exercised my mission in terms of women and women's health.

Joint Working Group and the Morton Report

[99] This history is important to my decision because it demonstrates the methodology that the AOM and the MOH developed to "make visible" the work of midwives and set their compensation in accordance with their SERW. It also demonstrates the commitment of the AOM and MOH to an ongoing and collaborative working relationship.

[100] A team comprised of MOH and AOM representatives was created to determine payment levels and develop a standard contract for payment of midwifery services. I refer to this group as the joint working group. The AOM representatives included Jane Kilthei, President of the AOM. The MOH representatives included Sue Davey who also testified at the hearing. The group met several times starting in May and working through the summer of 1993 to deal with a number of issues related to the funding of the midwifery program including compensation for midwives.

[101] The joint working group was assisted by a compensation expert named Robert Morton. The role of Mr. Morton's firm was described in its final report dated July 26, 1993 titled "Compensation for Midwives in Ontario: Summary Report prepared for the Midwifery Funding Work Group" ("Morton Report"):

> The Consultants' main task was to define, introduce, and manage a process to enable the Work Group to engage in worthwhile discussion to determine an appropriate and fair compensation level. The consultants were not asked to recommend a salary but to help inform the thinking of the Work Group so that the group could generate its own recommendations.
>
> The Consultants undertook research necessary for the working group to make an informed decision about the relative positioning of midwifery in terms of both job requirements and compensation within the context of the health and social service systems. While the process established for the project did not constitute a comprehensive and statistically valid job evaluation, it provided a framework for the Work Group to systematically and carefully examine comparator positions relative to the profession of midwifery.

[102] The terms "appropriate and "fair" were defined at the beginning of the project drawing on the principles already established before the joint working group began its work:

> The terms "appropriate" and "fair" were defined at the beginning of the project in order to set the guiding principles for investigation, research, and discussion.
>
> "Appropriate" was defined as setting a range that reflected the relative skill, effort, responsibility, and working conditions for midwives in comparison to related health care professions.
>
> "Fairness" was defined as a salary level which, not only considered the above factors, but also the general context in which compensation was to occur. This comparison was paramount since fairness can only be determined in relation to levels of pay for professionals working in the same economic market.

[103] The method adopted by the consultants is also described in the report:

> 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.
>
> 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", a comparison of job requirements based on job descriptions for the primary care nurse and family physicians in a Community Health Clinic and a list of core competencies for midwives. 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.*

[104] At a third working session aimed at deriving a salary range for midwives, the consultants presented current salary data in relation to professions in the health and social services field:

> This enabled the Work Group to consider the "market value" of the various positions. Again, the primary comparisons were with primary nurses and family physicians in a Community Health Clinic, but others, such as psychology, dentistry and pharmacy were considered.

[105] Mr. Morton conducted research into how the profession of midwifery compared to related health professions, and the working group refined the final comparators to salaried "senior primary care nurses/nurse practitioners" and physicians working in CHC's.

[106] Mr. Morton testified at the hearing. He is a registered psychologist and certified management consultant. Mr. Morton was careful to point out during his testimony that the project did not constitute a comprehensive and statistically valid job evaluation as that concept is understood under the *Pay Equity Act*. Mr. Morton is not a pay equity

specialist. However, he also testified that he was generally aware of the *Pay Equity Act* and considered it a “clear demarcation of the things one would generally look at in a compensation exercise.”

[107] Mr. Morton’s role was to gather information and structure the working group discussions and assist the members in making an informed judgment. Although skill, effort, responsibility and working conditions are foundational to an analysis under the *Pay Equity Act*, Mr. Morton testified that he would use those factors as part of any job evaluation.

[108] The parties achieved reached an agreement (“the 1993 agreement”) with the assistance of Mr. Morton, combined with some positional bargaining. There was no separate rate for on-call and there was a question left open about how much supervision and administration work midwives would do post-regulation. The agreement resulted in positioning the most senior midwives within approximately $3000.00 or 90% of the starting point on the salary grid for a CHC physician working in non-underserviced areas. Benefits in the amount of 16% of salary and operational expenses were negotiated separately and they were initially defined as “dependent contractors”.

[109] The joint working group continued to work together on program guidelines and specific contract provisions that would govern how compensation and operating expenses would be paid to midwifery practice groups. The initial funding contract was divided into “compensation” (salary only), “operating”, “special operating” and “non-recurring” expenses.

[110] Ms. Kilthei testified that she understood that the joint working group was engaged not in a technical job evaluation under the *Pay Equity Act* but in a pay equity exercise. The term pay equity exercise was also how the joint working process was described to the AOM’s members when they were asked to ratify the results of the process.

[111] The 1993 compensation agreement was part of a broader set of funding principles adopted to support the model of care. The difference between how midwifery

was valued for compensation purposes prior to and after regulation illustrates the power of the funding principles and the evidenced-based methodology the parties relied on in 1993. The average earnings of a midwife in a very busy practice in Toronto were approximately $20,000 prior to regulation. Their compensation more than tripled as a result of the principles and methodologies applied at regulation.

OMP Framework 1993

[112] The joint working group also developed the Ontario Midwifery Program Framework (“the OMP framework”), which describes the foundations of the program. The OMP framework provides a comprehensive description of the model of practice. It describes how midwifery aligns with the health care reform in Ontario and the withdrawal of family physicians from obstetrical care. It also describes the delivery of services and the relationship between midwifery practice groups and TPA’s.

[113] The OMP framework also describes the practice caseload expectations. In a typical practice group, each midwife working full time would provide a complete course of care throughout pregnancy, labour and birth, to 6 weeks post-partum for 40 women and their newborns. Additionally each midwife would be the secondary caregiver to another 40 women and their newborns. The model of practice requires two registered midwives to attend each birth. These caseload expectations have not changed.

[114] The compensation model is also described in the OMP framework. Midwives would be paid a salary which the parties agreed was “best able to support the model of practice and is most compatible with the community health approach to the program and service delivery.” The salary range was to be “subject to cost-of-living adjustments as determined from time to time by the Ministry of Health”. The initial group of registrants were placed on the 12-level salary grid in accordance with their level of experience.

[115] Operating expenses are also addressed in the OMP framework. It was anticipated that the details of the operating expenses would be similar to the Community

Health Centre Program. The OMP framework also stated "There may be some variation from other programs in the Ministry to accommodate the uniqueness of the Ontario Midwifery Program."

[116] The OMP framework also describes the Ontario Midwifery Program Quality Committee which was established, with representation from the AOM, to monitor implementation of the program and to "continue the collaborative approach which has characterized the development of the funding program". The quality committee will monitor program implementation and provide advice to the CHB.

[117] A cabinet submission was prepared describing the process for setting compensation on the same terms. The OMP framework document for Cabinet stated that the salary range for midwives was determined after a review of the job requirements and current salaries paid to a number of health and social service professionals and that it was found that the level of responsibility and skill required by a midwife would be somewhat more than that of a nurse but less than that of a physician.

[118] In its public statements about the launch of midwifery, the MOH referred to research demonstrating the improved health outcomes associated with midwifery. In describing the lower costs associated with the profession, the MOH cited lab tests, bed-day costs as a result of lower intervention rates and a de-emphasis on a "high-tech" approach to maternity care.

[119] The AOM ratified the OMP framework in October 1993. The materials developed leading up to ratification describe the joint working group process and the Morton report as a *pay equity exercise.* In December 1993, the AOM issued a newsletter (volume 9 number 3) to the membership describing the funding of the new midwifery program. The newsletter described the joint working group and the Morton report as a *pay equity exercise,* which was based on comparisons with primary care nurses and physicians in CHCs.

[120] As the parties moved into the post-regulation period, midwives took on significant responsibility for developing the program, building their practices and establishing relationships necessary for integration. By 1996, the new system was generally implemented. However, the parties would not participate in another joint compensation study for midwives until Courtyard Group was retained, 17 years later, in 2010.

Post-Regulation 1994-2005: 11 Years of Wage Freezes

[121] This period is characterized by 11 years of wage freezes, as well as the events leading up to the second funding agreement in 1999, which contained no compensation increases, and the third funding agreement in 2005, which gave midwives increases in the range of 20% to 29% in the first year of the contract.

[122] The midwives and their 1993 comparators had their compensation frozen for eleven years with no adjustments for COLA: midwives from 1994 to 2005; CHC staff 1992 to 2003. Although COLA was within the discretion of the MOH, midwives expected that their compensation would be monitored and they would receive adjustments from time to time. The early 1990's in Ontario were a time of economic recession and, after 1995, significant cuts to public services and public sector workers.

[123] While midwives remained an almost exclusively female profession, the representation of women in medicine and family medicine was increasing. By 2005, when midwives achieved their first compensation increases, women represented 31.6% of the medical profession and 36% of family practitioners generally. No statistics were available on CHC physicians until the year 2001, which show that over 50% of CHC physicians were female and that percentage was growing. Attrition from the midwifery profession varied from a low of 1% to a high of 7% between 1994 and 2005-2006.

Devolution

[124] During the period from 1995 to 1999, the parties were caught up in what turned out to be an unexpectedly long and complex process of developing a new funding model and moving from an interim central TPA at the start of regulation, to multiple local

TPA's. This was a period the parties referred to as "devolution". The parties reached an agreement in 1999 which changed the funding model but did not result in compensation increases. The devolution agreement also created the independent contractor model which exists today and which the parties have sought to strengthen with each successive contract. The AOM's "1998 Principles of Funding" states that a key priority during devolution was "the maintenance of at least the current range of compensation which will continue to acknowledge midwifery as a professional practice with a high degree of skill and responsibility."

[125] The compensation structure for midwives was changed to a course of care professional fee structure rather than a full-time equivalent salary structure. A "course of care" is defined as the provision of services to a woman for a period of 12 or more weeks during pregnancy, labour and birth and for up to six weeks postpartum for the woman and newborn. The course of care includes prenatal visits, attendance at the birth, postpartum visits, 24 hour access to midwifery services and practice administration. There was no increase in compensation but the new structure was designed to maintain the level of compensation.

[126] I have not set out in detail the various disputes which arose between the MOH and the AOM throughout the devolution process. Many of those issues were resolved years before this Application was filed. Midwives remained "aligned" with their 1993 comparators by virtue of wage freezes. There was no monitoring by the MOH of whether compensation for midwives remained aligned with their SERW.

[127] The AOM's "highest priority" during the devolution negotiations was to arrive at a contract relationship that protected the client-centred midwifery model of care. Midwives were overwhelmingly in favour of working as independent contractors. They did not want to become employees of the TPA's and work under the control of an employer or potentially a physician. The independent contractor model gave midwives the advantage of choosing practice partners, managing their caseload and having control over their clinical protocols. There were some tax advantages as well and the obvious advantages associated with the MOH managing the program in such a way that

demand constantly exceeded supply. However, unlike physicians, who could choose from among a number of clinic settings for their practices and compensation models, the midwives have only one setting and one compensation model. The MOH also supported the model of care and directed that an independent contractor status be created with midwives during the devolution process.

[128] Despite the difficulties they encountered, the AOM and the MOH reached an agreement. There was an interim funding agreement which took effect June 1, 1999. The new devolved contracts between practice groups and local TPAs took effect on April 1, 2000.

[129] In May 1999, the Ontario Midwifery Program issued new “Transfer Payment Agency Submission Guidelines” to TPAs, which described the AOM as follows:

> The AOM represents the professional interests of midwives. The AOM was instrumental in the implementation of regulated midwifery, including the development of the standards of practice, the model of practice and the methods of payment with the Ministry of Health

[130] Attached to guidelines was the September 1993 Ontario Midwifery Program Framework, which was described as “the policy framework for the funding of midwifery services in Ontario. It was developed by the CHPB (community health branch) and the AOM to articulate the Ontario model of midwifery practice as it relates to funding and to explain the rationale for the structure of the midwifery program.” To this point in the factual chronology, it appears that the MOH remains committed to the terms of the OMP framework and the positioning of midwives between their 1993 comparators.

First Compensation Increases and the 2005 AOM/MOH Funding Agreement

Investigating the Impact of Wage Freezes

[131] During the period from 2000 to 2005, midwives and their 1993 comparators achieved their first compensation increases in 11 years. CHC staff received increases in 2003; midwives in 2005. CHC physicians received an additional “bump” in their

compensation in 2004 when they obtained representation from the OMA. From that point on, CHC physicians were included in the OMA's agreements with the MOH.

[132] A number of events preceded the compensation increases that both groups received. Nurse practitioners received formal recognition in 1999 with a new compensation level that was higher than the CHC senior nurse to which midwives had been compared in 1993. Also in 1999, Dr. James McKendry issued a fact-finding report identifying concerns about physician supply, mix and distribution in Ontario. The report noted that Ontario was facing a significant shortage in certain specialties including obstetrics/gynecology. Dr. McKendry recommended increasing the supply of physicians, incentives and support programs, and developing more efficient and comprehensive models of care that incorporate other health professionals, such as nurse practitioners and midwives.

Compensation Increases for CHC Physicians

[133] From approximately 1999 to 2003, the MOH was investigating primary health care reform and the consequences of wage freezes on CHC employees and the CHC program. Various reports found that there were primary care provider shortages in many regions of Ontario and expanding programs like the midwifery program would assist in providing greater access to services.

[134] In 2001, the MOH initiated a strategic review of the entire CHC program. Sue Davey testified that there was anecdotal evidence that CHC's were having difficulty recruiting and retaining physicians in part because physicians were able to make more money in other parts of the health care system. The strategic review report recommended that the CHC program institute competitive salary scales and benefits for all CHC staff based on a number of findings: salaries had been frozen for all staff since 1992; physicians and nurse practitioners could earn more in other settings; a shortage of nurses and physicians which was compounding recruitment efforts; new physicians were graduating with increased debt loads; physicians were paid a single stipend for being on-call regardless of frequency; Hay Group performed a review in 1999 and

recommended an increase in most staff positions; and pay rates for physicians did not appear to be competitive.

[135] Sue Davey testified that the strategic review was very informative. In addition to compensation levels, the review panel also considered the role of CHC's in primary care in Ontario and recommended expanding existing CHC's as well as the CHC network in order to increase access to primary care.

[136] In addition to salary increases to CHC physicians, the MOH took a number of other steps to try and address the shortage of physicians including incentives, family health teams, expanding CHC's, introducing aboriginal health access clinics, expanding the scope of practice for some practitioners (pharmacists giving flu vaccinations for example), and significantly expanding the midwifery program.

[137] In 2003, the MOH made a submission to Cabinet in which it stated that "compensation levels at CHC's have fallen 10% to 15% below those available in other primary and community care organisations […] failure to address the salary inequity problems will compromise the ability of CHC's to meet the MOHLTC's other primary care renewal objectives." The Cabinet submission notes that CHC's have not received a COLA adjustment since 1992, while fee-for-service physicians, nurses and other professionals working in the institutional sector had received such adjustments. The submission states that: "Implementing salary adjustments will substantially reduce the disparity between institutional and community sector compensation levels and permit CHC's to recruit and retain the staff necessary to deliver responsive, high quality services". By this point, the CHC program itself was in jeopardy and CHC's would not be able to continue to meet ministry expectations and provide service to communities unless "the inequitable compensation of health professionals in CHC settings" was addressed.

[138] Hay Group was retained in 2003, to establish standardized salary scales which would address the recruitment and retention issues CHC's were facing. Dr. Thornley testified about the importance of having a third party assess the relationship between

salaries and recruitment and retention issues. Recommended increases for 8.7% and 7.4% were implemented.

[139] In 2004, for the first time, CHC physicians were included in the OMA's negotiations with the MOH for physician compensation. The 2004-2008 Framework agreement between the MOH and the OMA provided that the compensation of physicians in salaried models (including CHC's) should be harmonized with the compensation of other primary care doctors.

[140] Dr. Thornley testified that the purpose of harmonization was to prevent a gap between what a physician was earning and what they would expect to earn in another compensation model. The model was referred to in this proceeding as the "salary plus incentives model". This model proved to be complex, difficult to implement and monitor and not well aligned with the work of CHC physicians. In 2010, CHC physicians were returned to a salary mode although their salary was increased to roughly compensate for losing the incentives.

[141] There was no job evaluation of any kind conducted at this time. The increases paid to CHC physicians were not linked to their SERW. The purpose of the alignment, according to the MOH, was to remedy the recruitment and retention problems which CHC's were still experiencing despite the adjustments made in 2003 following the strategic review. Sue Davey put it this way: "it became important to be able to say that a primary care physician is a primary care physician is a primary care physician" and they should have the opportunity to make similar compensation doing similar jobs. The pressure on the MOH was to increase services and they wanted CHC's to be able to attract physicians in order to ensure that they could provide accessible service and comprehensive primary care to the patients of CHC's.

[142] It is notable that by 2004, CHC physicians were predominantly female. The MOH argues if the data demonstrates any connection to gender, CHC physicians achieved their greatest gains in compensation when they were predominately female. However, it is important to consider these gains in context. It is not disputed that, as they were

becoming more predominantly female throughout the 1990's and early 2000's, CHC physicians were falling behind their peers. Before they received their first compensation increase CHC physicians were the most female dominated and most undercompensated group of physicians in Ontario. In 2003, CHC physicians achieved increases of only 8 and 7%. It was not until they became part of the OMA negotiation framework that the principle was adopted that they should be aligned with other physicians which accelerated their compensation increases.

Compensation Increases for Midwives

[143] The MOH also studied the effects of wage freezes on midwives. The MOH established an Expert Panel on Health Professional Human Resources in 2000 and began a detailed examination of health workforce data including the provision of obstetrical care. The Ministry conducted research on the supply, demand, attrition and public cost of midwives which is summarized in a November 22, 2000 research paper. The paper estimated that the number of midwives practising in Ontario would double in four years (to 344) and triple by 2009 (to 524). The paper also forecasted an increase in the number of family physicians of just over 1% in total over the next nine years, which, as the MOH points out, is far below the rate of population growth. In November 2000 when the paper was completed, there were 176 practicing midwives in Ontario as compared to 9,771 general practitioners/family physicians. The paper also noted a need to increase the current production of family physicians.

[144] In December 2000, the Ministry sought Cabinet approval to more than double the budget of the midwifery program over four years in order to fund all new and existing registered midwives through that period. As the AOM points out, none of this money was budgeted for compensation increases.

Request for Increases Based on COLA

[145] The AOM established its own Compensation Review Task Force. Between November 2000 and January 2001, the AOM wrote to the MOH, "in the interests of

fairness and equity", seeking COLA. The AOM advised the MOH that they had negotiated a fair compensation level in 1993 but no longer felt that they were adequately compensated for their services. They were seeking a retroactive increase of 1.9% back to 1994. The also stated that the fixed component, which was negotiated in 1998 during the development of the devolution agreement, also required an adjustment based on COLA.

[146] Ms. Davey wrote to the AOM on January 10, 2001 declining the request for a compensation increase. She indicated that the funding allocated to the midwifery program was fully committed to existing services. She also stated as follows:

> […] the Ontario Midwifery Program and the Ministry of Health and Long-term Care remain committed to the fair compensation of midwives and will continue to monitor comparable professions to ensure that the scale remains in line with them. At present, for example, the ministry approved scale for nurse practitioners is $57,000 - $70,000.00.

[147] A meeting took place in January, 2001 with Ms. Davey and representatives from the AOM. The AOM provided a document entitled "Summary of Issues Relating to Midwives' Compensation" supporting their request for COLA.

[148] The MOH states that midwives were seeking an increase in compensation based on comparison with nurse practitioners, not with CHC physicians. I do not share this interpretation. In my view, they were expressing their point of view that the nurse practitioners who were regulated in 1999 were the same nurses that midwives had been compared with in 1993. There is no evidence that the AOM was abandoning comparison with CHC physicians in favour of comparison with nurse practitioners.

[149] There is no dispute that the actual CHC nurse comparator at the time of regulation was designated as a CHC Nurse II with a salary range of $42,000 to $56,000. That job still existed when nurse practitioners were regulated. Nurse practitioners, who also worked in CHC's, had a larger scope of practice and more responsibility than registered nurses and were positioned above the Nurse II position with a salary scale of $57,000 to $70,000.

The 2001 Insurance Crisis

[150] Liability insurance for midwives was fully funded by the midwifery program. The insurer notified the AOM that it intended to significantly increase insurance premiums for each midwife. There was a very tense period during which the AOM and the midwifery program worked to find a solution. In July, 2001 the Ministry provided $6,100,000 enhancement to the midwifery program to support new registrants and $3,200,000 for the renewal of midwives' professional liability premiums that year.

Investments in the Midwifery Program

[151] The MOH continued to invest in the midwifery program to fully fund the increasing number of new registrants as well as the increasing cost of insurance. From 1995-1996 to 2001-2002, the provincial budget for midwifery services rose from $6.2 million to $24 million. The Minister's announcements in 2001-2002 provided further assurance of funding increases to $39 million.

[152] On December 9, 2002, the AOM wrote to the Minister of Health acknowledging that other groups were ahead in line to receive compensation increases, but asking the Minister to engage in compensation review for midwives in 2003.

[153] In 2003, the MOH initiated an evaluation of the midwifery program which demonstrated the success of the midwifery program. The results of the program evaluation were excellent. They showed high levels of client satisfaction, high levels of breastfeeding, and lower rates of C-sections, use of forceps, use of vacuum extraction and trauma to the perineum. The program evaluation also showed low levels of fetal and neonatal mortality associated with midwifery clients.

[154] The report refers to an "obstetrical provider shortage" in Ontario which could become a crisis in a few years recommending that the rate of expansion of the midwifery program be increased. The report also recommended that expansion should continue to focus on communities under-serviced for obstetrical providers. The report makes no distinction between physicians and midwives as "obstetrical providers". The

report also noted that the midwifery program should continue to focus on removing the remaining barriers to integration such as hospital privileges and scope of practice issues. This was identified as an “urgent issue”

[155] Ms. Davey testified that the results of the program evaluation supported expansion of the program and expanded enrollment in the Midwifery Education Program. She also testified that the evaluation played a role in the increases to compensation that midwives achieved in 2005. Ms. Davey testified that she personally supported a compensation increase for midwives – she saw it as part of her role within the MOH to give her best advice to the government. She advised that it was important to keep midwives in the mix of providers. She testified that CHC’s had an increase, “so the environment was there” to support a compensation increase for midwives.

Preparation for Negotiations

[156] The AOM commissioned a report from Hay Group to support its negotiations with the MOH for a new funding agreement for the midwifery program. The MOH did not agree to fund the study. In July 2003, the AOM sent the report to the MOH with a request to discuss a new compensation package for midwives.

[157] Hay Group principal Moshe Greengarten testified that he used the Morton report as part of his preparation of the 2003 Hay Group report which was also updated in 2004: He concluded that the Morton report “was reasonable and produced a credible recommendation or results” in setting out “key principles for compensating Ontario midwives” and in particular, “reasonable, internal, or let’s say equity structure for the midwives as compared to other health care professionals.” Mr. Greengarten also concluded that pay levels for midwives pay levels should fall between the pay levels of a family physician and a nurse practitioner.

[158] Hay put forward two options for establishing a “fair and appropriate” job rate for midwives: to fix the job rate of midwives to 90% of the entry level CHC physician salary or to use the same methodology but increase income further by prorating to reflect

hours of work. The Hay Group report used a salary for CHC physicians which included COLA. That was a problem for the MOH, for obvious reasons, because CHC physicians had not received COLA and therefore the salary used by Hay Group was artificial. Hay Group prepared a second report to address this concern in 2004.

[159] In 2004, the AOM described, in detail for the MOH, the history of midwifery compensation and the risks of underfunding midwifery and also raised the fact that as an all women profession, the lack of parity raised an issue of equity for midwives.

[160] The MOH made submissions to Cabinet about the risks associated with the current funding model for midwives and committed to "undertake a consultative process" with the AOM to achieve an agreement on increased funding. A slide presentation dated September 27, 2004 contains details of the compensation history, including the original Morton report methodology, elements of the Hay Group reports from 2003 and 2004 and an environmental scan that indicates a current shortage of obstetrical care providers. A recommendation is made to provide midwives with a compensation increase.

[161] The AOM felt the MOH was delaying the negotiations. After a number of overtures to the MOH, the AOM initiated the "Because Storks Don't Deliver Babies" campaign in November 2004, advising the Minister's office that they were prepared to engage in job action to prevent more midwives from being "driven from the profession" because of compensation issues. The AOM scheduled a press conference and march on Queen's Park for December 14, 2004. On December 12, 2004, the MOH contacted the AOM and talks began.

[162] In response, the MOH offered global funding increases for 2005 to 2007 for the ongoing delivery of midwifery services. The global amount would be the subject of further negotiations with the AOM about how to apportion the funds within the midwifery program, including compensation increases for midwives. In a press release, the AOM stated that the new funding would allow the profession to "retain practising midwives and recruit the new talent necessary to grow the profession."

[163] It is clear that the 2005 agreement was the result of extensive negotiations between the parties. The AOM's Board minutes and communications with its members regarding the Minister's offer and the tentative agreement reached, describe the MOH's offer as a "victory" and the offer as a "reasonable offer". The AOM's position had been guided by the 2004 Hay Report and the goals established at the Fall 2004 Regional meetings. The political activities of the members had been successful. The AOM president highlighted that the top compensation level at Year 3 was 90% of the current CHC physician rate when the retention fee incentive, on-call fee incentive and secondary care fee incentives are included. The AOM Board did not raise any concerns about pay equity or gender in any of its minutes or communications to members regarding the Ministry's offer and the tentative agreement.

[164] Between January 2005 and May 2005, the MOH and AOM worked together to finalize an agreement. The new 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 course of care, a retention incentive for level six midwives and a secondary care fee. The total compensation increase was 20% to 29% depending on the position on the grid.

[165] The benefits were increased from 16% to 18%. There were also increases made to operational expenses and a new grant to support remote practice groups. The 2005 agreement contained a sign-back agreement of intent to revisit the agreement by December 1, 2007.

[166] The AOM's President commented on the fact that the AOM had not achieved everything it wanted in the agreement but that this was in keeping with the nature of negotiations, and that the remaining issues would be a priority for the next round of negotiations. While I heard some evidence that discussions had taken place about the fact that the effects of wage freezes could not be made up in one contract, there was nothing in the documentary evidence to confirm that this was a commitment going

forward on the part of the MOH. The 2005 funding agreement was ratified by the AOM membership and took retroactive effect to April 1, 2005.

[167] At the hearing, however, Elana Johnson, President of the AOM at that time, testified that the AOM stopped negotiating any further because of the Ministry's "intransigence". She also testified that the AOM felt there was still a very large pay gap to be addressed and that midwives were not in an equitable relationship to the CHC physician compensation structure.

[168] I do not consider this an issue of credibility. In my view, the communications with the public and AOM members are typical of kind of statements that are made prior to ratification and, in fact, the agreement *was a very positive outcome*. I accept that Ms. Johnson was conflicted – this was a very positive outcome, but she wanted to achieve more. There is no evidence of any communication about an ongoing pay gap between the MOH and the AOM between the 2005 agreement and preparations for the 2008 negotiations.

2009 Agreement and the Commitment to Engage in a Joint Compensation Study

[169] In the period between the signing of the 2005 agreement and the commencement of the 2008 negotiations, there is no evidence of any communications between the AOM and the MOH about compensation issues. Neither party initiated negotiations in December 2007 as provided for in the 2005 agreement.

[170] In early 2008, the MOH requested a "list of priorities" from the AOM. A document entitled "Creating Equity for Midwives in Ontario's Health Care System" was presented by the AOM in a meeting with MOH representatives on April 30, 2008.

[171] The AOM identified eighteen topics for discussion which I have set out here as an example of the extensive issues that the AOM and the MOH negotiate over in relation to the midwifery program:

- compensation, benefit and travel allowance increases;

- pregnancy and parental leave program;
- additional supports for rural and remote practices;
- modifications to the clinical audit process;
- improvements to case load variables;
- definition of a basic course of care;
- amendments to the funding agreement process;
- changes to the billable course of care that impact workload;
- dispute resolution process similar to physicians and nurses;
- limitation of liability, indemnity and opportunity to remedy;
- information technology;
- strengthening independent contractor status;
- continuing education;
- renegotiation commitment no later than December 1, 2010;
- retroactivity;
- new registrant funding; and
- IPC pilot funding.

[172] The AOM relied on a workload analysis and another Hay Group report which examined market changes between 2005 and 2007 for a variety of public sector workers (Hay Report 2008). The report is of limited relevance to my decision. It demonstrates that midwives were looking broadly at other groups for comparative information from the period 2005 to 2007. What is relevant is that the AOM did not ask Hay Group to consider whether the 2005 agreement left a gap in compensation unaddressed.

[173] The AOM also developed an analysis of about the changes to midwives' scope of practice and workload. The MEP curriculum had been substantially revised in 2007 to

reflect the increasing requirements needed for educating students to be midwives. In October 2009 the President of the AOM gave a presentation to the team of MOH negotiators which described the excellent clinical outcomes of midwifery and the ongoing unmet demand. She also provided a historical overview of the midwifery movements and the current funding model. She referred explicitly to the joint working group, the Morton report, the comparators chosen by the parties in 1993, and the proximity between midwives and their comparators (top midwife paid at 90% of the lowest level of pay for a CHC and a level 1 midwife slightly above a primary care nurse). She also indicated that 1993 comparator primary care nurses were now nurse practitioners.

[174] At the same meeting, the MOH explained the financial challenges facing the Ministry and the need to find creative, low-cost solutions; and the decision-making process which would require senior level approvals before an offer was made. The full context for the negotiation included the fact that midwives had received significant increases in 2005.

[175] There were delays in the negotiation process but meaningful discussions were had over a series of meetings. The AOM presented its rationale for another significant increase in compensation and framed its request as an equity issue for midwives. The MOH would not agree to more than 2% increases in each of the three years of the contract.

[176] There were meetings and letters between the AOM and the MOH as well as the Minister of Health. The AOM complained that the offer of the MOH was inequitable. Their documents referred to the 1993 funding principles and the need to close a gap that had developed since that time. They raised the connection between pay inequity and the sustainability of the profession.

[177] Throughout January and February 2009, the MOH and the AOM exchanged offers, counter offers, and revised offers until an agreement was reached at the end of February 2009. As part of the final agreement, the AOM sought a commitment to a

"compensation valuation review" on the basis that the value of compensation had deteriorated over the past 15 years and a comprehensive review was required. Ms. Kilroy testified that the AOM was trying to get the MOH to look at midwives' compensation in some methodical way. The compensation increase the AOM was seeking was based on comparable increases for nurses and physicians.

The 2009 Agreement

[178] In March 2009, the AOM Board presented the Ministry's offer of 2% per year plus an increase in benefits from 18% to 20%, retroactive to April 1, 2008, to its membership. The AOM Board presented a slide presentation to members about the proposed agreement which stated that it included "significant process achievements" including the increase to benefits; a parental leave program; rural and remote definitions and supplements; special second attendant fee for rural and remote; locum program for rural and remote; funding for professional development; funding for special projects; changes to caseload variables and the definition of course of care; travel disbursements; funding for equipment; funding for IT; and funding for new registrant equipment.

[179] The slide presentation also referred to a non-binding, "joint comprehensive review of midwifery compensation" which would be conducted by an independent third party to suggest where midwives should be and take into account historical increases for other related professions.

[180] The AOM Board also noted in the slide presentation what the negotiations had not achieved: "clinical audit reform and flexibility in funding to enable IPC pilot projects". On April 6, 2009, Ms. Kilroy reported to the AOM Board that the vote to ratify the negotiations agreement had a 97% approval rate from those members who responded. On May 7, 2009, the parties signed the agreement which set out terms of funding for AOM projects, the formation of the Joint Midwifery Advisory Committee, the scope and details of the compensation review, and a commitment to renegotiate no later than September 30, 2010.

[181] The AOM was informally recognized as similar to the OMA with respect to negotiations with the MOH.

Courtyard Compensation Review and the Imposition of Compensation Restraint

[182] In March, 2010, the Government introduced compensation restraint legislation which applied to public sector employees. In June 2010, Courtyard Group was retained in accordance with the terms of the 2009 agreement. A steering committee of three AOM members and three MOH members was formed to support the work of the consultants. The Courtyard report, which was non-binding and finalized in early October 2010, recommended a 20% increase in compensation for midwives at each level. The MOH refused to implement the report and applied a policy of compensation restraint to the 2010 round of negotiations.

Courtyard Compensation Review

[183] One of the achievements of the 2009 agreement was the establishment of a Joint Midwifery Advisory Committee (JMAC). The JMAC was intended to supplement, not replace, major negotiations between the parties. The JMAC was comprised of up to five members from the AOM and five members from the MOH. The 2009 agreement also provided that if the JMAC was unable to resolve an issue in dispute it could choose to engage a third party facilitator.

[184] The JMAC created a sub-committee with three members from the AOM (the president, executive director and director of policy and communications) and three members from the MOH (the midwifery program manager, a financial staff person from the midwifery program, a person from the MOH negotiations branch) to act as the steering committee for the review.

[185] The lead consultant for Courtyard, Mr. Ronson, testified at the hearing as well as two of three AOM representatives from the steering committee. None of the representatives from the MOH who participated on the steering committee testified in the hearing.

[186] Laura Pinkney worked in the Primary Health Care Branch (PHCB) from March 2007 to March 2013 as the Manager of Salaried Models and Programs and had oversight for the midwifery program and programs employing salaried physicians and nurse practitioners. Ms. Pinkney testified that she was the most senior manager who had the most direct involvement with the midwifery program during that period. Ms. Pinkney testified the MOH took a “hands off” approach to the compensation review in order to ensure the fairness of the independent third party led process. She explained that the MOH representatives were to provide the consultants with the information they were seeking to conduct the review, but not let the consultants do their work independently.

[187] The 2009 agreement stipulated that an objective, third-party consultant would conduct a review, the primary goal of which was to suggest an appropriate “total compensation” package for midwifery services based on available evidence. The agreement defined “total compensation” as: course of care fees (includes: operational, on-call, secondary care, retention, experience fee and rural and remote supplements) and all benefits or equivalent funding. The consultants would be directed to consider, among other things:

> Comparable relevant 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 Morton compensation report and the February 2004 Hay Compensation review report.

[188] The steering committee held several meetings with the consultants, reviewed the history of midwifery compensation, the AOM’s workload analysis, discussed the interviews to be conducted and the drafted the evaluation questions.

[189] The steering committee developed and agreed on the following evaluation questions for Courtyard around which the final report is organized:

> - Does the current compensation model recognize adherence to best practice guidelines and the achievement of the Ministry’s policy objectives?

- Does the current compensation model reflect the current scope of work performed?
- Does the current compensation model reflect the volume/complexity of work performed?
- Does the current compensation model reflect the costs of doing work?
- What is the value of benefits, or equivalent funding received by midwives?
- Does the current compensation model reflect the experience and training of midwives?
- Is the current compensation model comparable to other professions performing similar work?
- What market trends should be taken into consideration? Have compensation increases remained aligned with economic growth in Ontario?

[190] The process was an iterative one with the consultants working with the steering committee, conducting research and forwarding drafts in advance of several meetings. On September 29, 2010, Courtyard provided the Joint Committee with a draft three-page summary of its findings. The MOH provided further input following which the final version of the report was sent to the steering committee on October 8, 2010.

[191] 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. The word equity was used to describe the relationship between midwives and other health care professionals although it was not a pay equity report. The report acknowledged that even with the 20% adjustment, compensation would not be consistent with the original Morton principles (which would push the upper limits of compensation for experienced midwives even higher), but it would move the midwives much closer to where they should be relative to the CHC physicians' pay. The report also noted that the lack of regular negotiations had contributed to the compensation gap.

[192] The Courtyard report is fifty-four pages in length and organized around the evaluation questions established by the steering committee. It contains a significant amount of information and a number of charts which explain the methodology and the findings. One of the key findings relates to the ongoing relevance of the Morton Report:

> The compensation model principles established in the Morton Report of 1994, which have evolved somewhat since that time, appear to have served the public, the profession and the Ministry very well. There appears to be no appetite or need to change the fundamental model of compensation.

Testimony of Courtyard's Lead Consultant

[193] Mr. Ronson described the steering committee members as "a delight to work with", and "constructive" and found that they were not set up in adversarial "camps" but rather working together with the common purpose of answering the evaluation questions they had established at the outset.

[194] Mr. Ronson recalled there being disagreement on the scope of the jurisdictional review. The report contains a chart that looks at every jurisdiction in Canada, but the consensus of the steering committee was that Courtyard should focus on Alberta and British Columbia. The midwifery program in Ontario is unique and it was difficult to compare with other midwifery programs across the country. At the time of the review, Ontario had 480 practising midwives as compared to 145 in British Columbia and 65 in Alberta.

[195] Mr. Ronson received feedback from the MOH on the draft of the final report. He testified that he believed that he had responded to each of the points raised by the including questions about comparisons in education and training. Mr. Ronson testified that a lot of information had been provided to the consultants in between drafts, and that he was "struck" by the amount of clinical training midwives received which he described as significantly more than nurse practitioners. Once the feedback was incorporated into the final report there was no further communication between him and the MOH.

[196] Mr. Ronson testified that the lack of any regular negotiation process before 2005 had resulted in a failure to effectively monitor compensation levels. He noted in the report that the parties appeared to be on track in that respect and encouraged them to maintain regular negotiations. Mr. Ronson was aware the economic conditions and took them into consideration in the report, but no one advised him that midwives would be subject to zero compensation increases in their first two years. He testified that he would have suggested “we suspend the work immediately if that…was the case because we would be wasting time and money".

[197] On cross-examination, Mr. Ronson acknowledged that while he had “backed out” operational costs from the compensation of Alberta midwives, he had not accounted for the fact that Ontario midwives receive benefits and Alberta midwives do not. Mr. Ronson testified that there was no impact on his ultimate recommendation for a 20% increase that Alberta midwives did not receive the same benefit entitlements as Ontario midwives.

[198] Mr. Ronson also explained why he did not consider it appropriate to include the benefit to midwives of not having to pay their liability insurance. He also acknowledged that he was never advised that excess operational funds are not clawed back from practice groups. None of these issues were raised by the steering committee or the MOH before the final report was prepared. Mr. Ronson testified that if a liability insurance co-payment were to be included in the calculations, it would amount to a difference of $1,000.00 or $2000.00 per year.

The Reaction of the MOH to the Courtyard Report

[199] Ms. Pinkney testified that the purpose of the Courtyard review was to provide an independent report on to be used in the next round of negotiations. It is notable that Courtyard was retained for this purpose after the passage of the compensation restraint legislation.

[200] Ms. Pinkney testified about reaction of the MOH to Courtyard's recommendation: "The Ministry was shocked in terms of the amount that came out from that report. It certainly wasn't anything that we had been expecting." Ms. Pinkney indicated that the MOH had been looking at other midwifery programs in other parts of the country and "certainly didn't see anything to suggest the amounts that Courtyard report had come up with".

[201] Ms. Pinkney testified that the MOH did provide feedback that Courtyard did not include benefits, liability insurance, sustainability investment, new registrant equipment funding and equipment costs in their calculations. They raised some concerns about the comparison with other jurisdictions which seemed to be lacking. The Ministry sought from Courtyard a rationale or quantitative analysis for the 20% increase. There were also issues about how the educational differences had been evaluated.

[202] Ms. Pinkney testified that Courtyard added some information to the jurisdictional comparison but overall she did not feel that Courtyard had addressed the concerns raised by the MOH, particularly with respect to the issue of comparing compensation with Alberta midwives without including benefits and the lack of quantitative analysis.

Compensation Restraint Imposed on 2010 Negotiations

[203] The result of compensation restraint was that existing contracts would be honoured, but any new contracts would contain provisions for zero increases in the first two years, and a modest increase in the third. The third year increase could not be used to "catch-up" from the first two years. The legislation contained an exemption for the *Pay Equity Act* and human rights entitlements.

[204] The AOM wrote to its members about the context for the negotiations with the Ontario government which included the Throne Speech and budget acknowledging that "the AOM was entering into negotiations with the province at a time when the impact of the global economic downturn is still being deeply felt by the province." However, it was

not until after the release of the Courtyard report that the AOM was advised that compensation restraint would apply to the negotiations with the MOH.

[205] Ms. Pinkney testified that when negotiations commenced in October 2010, she was concerned that Courtyard had set a very high expectation on the part of the AOM at a time of compensation restraint. She testified that attempts were made to share the concerns about Courtyard at the JMAC but the AOM wanted immediate implementation. The MOH was prepared to look at a broad range of non-compensation items like leasehold improvements, home birth kits, increases to sustainability investments or the parental leave program.

[206] The AOM responded to the imposition of compensation restraint that midwives were not employees. The AOM was advised that a broader policy of compensation based on the legislation would be applied. Ms. Pinkney testified that at this point the AOM raised the issue of pay equity for the first time.

[207] The Negotiations Branch, which was leading the discussions on behalf of the MOH, sought advice from the Labour Secretariat on the AOM's position. The Labour Secretariat advised that it did not apply to midwives as independent contractors but the restraint policy did apply. They also gave the following advice:

- The use of the term "pay equity by the AOM referred to equity with other professionals not pay equity as under the *Pay Equity Act*";
- The comparators were nurses who were mostly female and physicians "who also were a fair percentage female"; […].

[208] The AOM did not raise the possibility of a *Code* application at this time, but the Negotiations Branch did advert to an "outside risk" in a slide presentation in November 2010 that the AOM could bring an "equity issue forward" under the *Code* but that nurse practitioners were a female-dominated group and the relationship between midwives and obstetricians was not clear.

[209] There were further discussions and meetings about the application of the constraint policy and the implications of the Courtyard report. The MOH cancelled further meetings to take additional time to review the Courtyard report. The MOH also requested that the 2009 agreement, which expired on March 31, 2011, be extended.

[210] The AOM met with the Minister on April 20, 2011 to discuss the Courtyard report which “reaffirms the principles of the Morton report”. The AOM described the 20% increase as a “pay equity adjustment for midwives”. The AOM also indicated that midwives would observe the *spirit* of wage restraint by accepting two years of zeros if the MOH followed the *spirit* of pay equity legislation and gave them a 20% increase in year three of the contract. Ms. Kilroy testified that the Minister noted that midwives make “$80,000 to $100,000” a year and said “that’s pretty good for a four-year undergraduate degree." .

[211] Following that meeting, the AOM wrote to the Minister on April 26, 2011 restating its reliance on Courtyard and urging the MOH to implement adjustment and highlighting that:

> The report reviewed various factors that determine appropriate compensation and concluded that a comparison to other health care providers in the same jurisdiction (namely nurse practitioners and CHC family physicians in Ontario), based on an analysis of education, scope of practice and level of responsibility, was the best method to measure compensation. These are the same measures the government requires in pay equity legislation.

[212] During the AOM's annual general meeting on May 9, 2011, members overwhelmingly passed a resolution to express their great disappointment and frustration with government’s unwillingness to acknowledge or address pay equity agreed to pursue various actions to protest and fight for pay equity.

[213] There were further efforts to negotiate a resolution. Ms. Pinkney testified that an offer was developed for a three-year agreement with zero increases the first year, zero the second and a 10% increase in the third. In the briefing materials, Ms. Pinkney’s

branch also provided information on the successful outcomes of midwifery, past compensation increases, a jurisdictional comparison of midwives in Ontario to midwives in other provinces. The PHCB also set out a spreadsheet with the cost of both options: zero, zero, 10% and zero, zero, 20% over three years.

[214] The rationale for the offer was that the MOH could not support the Courtyard report, but the report had raised expectations, and offering the AOM 10% in the third year was a way to find a balance. In the end, there was no authorization given to make the offer were not authorized to make the offer. Ms. Pinkney understood the rationale for this was the direction not to make up losses from the first and second year in the third year. An offer of two zero years and 2% plus a 3% quality improvement incentive was offered instead and rejected by the AOM.

[215] The AOM rejected the offer at the May 25, 2011 meeting with the MOH. The AOM asked for three things: an official MOH position on the Courtyard report; a "trigger" or "me too" provision to be added to their agreement so that any time any increases were provided to doctors and nurses, it would result in an equal adjustment for midwives; and, a provision for interest arbitration.

[216] The MOH prepared a briefing note providing an update on the negotiations with the AOM dated May 25, 2011. About the Courtyard report, it said:

> MOHLTC could consider whether conditional support could be provided to the compensation review report. Conditional support could acknowledge that there was a relativity issue, but that the MOHLTC did not agree with the comparators or the range of the differential and noted that the report was prepared without due regard to the dramatic economic downturn and current fiscal framework governing compensation increases.

[217] The MOH's position on the 2010/11 negotiations was explained in a Q and A document dated June 1, 2011. It describes the current state of negotiations and explains the AOM's position on the Courtyard Report and the MOH's concerns that the report "needs more work" and had not considered the economic climate. The MOH

indicated that the jurisdictional analysis needed to be improved and the MOH disagreed with the comparators used by Courtyard.

The AOM Considers Alternative Actions

[218] On the morning of Ms. Stadelbauer's scheduled testimony, the AOM disclosed a new document related to an August 19, 2011 AOM Board meeting entitled "Potential Strategies for Pay Equity". Ms. Stadelbauer described these as "very preliminary thoughts, early thoughts." The document is eighteen pages long and contains a list of six strategies, one of is was labelled "human rights action" a which are fully described throughout the document:

[219] The action plan indicates that the AOM intended to "threaten" the government prior to launching the complaint prior to filing the complaint. The goal was to have the government settle this issue before the next election. They identified risks, including the fact that other female-dominated professions have achieved better increases recently. The key message would be as follows:

> Midwifery, as an all-female profession, has been discriminated against by the Government of Ontario based on sex. This is reflected in the inequity of midwives pay vis-à-vis comparator professions (agreed upon by the government when the profession of midwifery was regulated).

[220] The AOM did not file a human rights application for more than two years, choosing instead to work on other strategies and return to negotiations in 2012.

[221] Funding to the midwifery program continued to increase to support existing midwives and ensure that all new midwifery graduates would be able to find work. New funds were approved in March 2012 for the establishment of two birth centre demonstration sites in Ontario.

[222] There was no resolution to the Courtyard adjustment. The AOM was told that compensation restraint continued to apply and that the MOH would not consider the

Courtyard adjustment. The AOM signed a final funding agreement in 2013 subject to notice that they intended to take legal action.

[223] On May 27, 2014, the AOM wrote to the Premier to advise of its intention to recommend to its members that they initiate legal action against the government before the Tribunal. In the letter, it said:

> In 2010, the Ministry of Health and Long-Term Care commissioned and worked with the Courtyard Group to produce a midwifery compensation review. The Courtyard Report found midwives receive at least 20% less compensation when compared to other health care providers with comparable levels of skills, scope of practice, responsibility, education and working conditions. The Courtyard Report attributed this gap in part to the government's lack of attention to ensuring regular negotiations with midwives. We believe this compensation gap is the result of the Ontario government's systemic sex-based discrimination against a female-dominated profession that provides care to women.

LEGAL PRINCIPLES

The Scope of the Claim

[224] The AOM argues on behalf of midwives that from 1994 to the present the MOH has violated their right to equal treatment without discrimination on the basis of sex under the *Human Rights Code*, and in particular under sections 3, 5, 9, 11 and 12 by:

> a. Failing to take proactive steps to prevent an inequitable compensation and funding system for midwives in Ontario, an historically disadvantaged and almost exclusively female profession vulnerable to compensation and funding discrimination;
>
> b. Establishing and maintaining an inequitable compensation and funding system for midwives in Ontario;
>
> c. Providing unequal and discriminatory compensation and funding to midwives in Ontario which served to undervalue their work and contributions and perpetuate the stereotypes and prejudices they faced and continue to face;
>
> d. Actively refusing to take any reasonable steps to investigate and remedy systemic gender discrimination in compensation when the issue was squarely raised by midwives in Ontario over the years; and

e. Failing to take steps to address within the Ministry's powers the gendered integration barriers midwives in Ontario faced.

[225] The AOM argues that sex was and continues to be a factor in the adverse treatment that midwives have experienced and is seeking compensation back to 1997.

The Interpretive Principles

Broad, Purposive Interpretation

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

[227] The specific provisions of the *Code* engaged by this Application affirm that every person has the right to equal treatment without discrimination with respect to employment and contracts. The word “equal” is a defined term in the *Code*. It means that an individual or group of individuals may be subject only to requirements, qualifications and considerations that are unrelated to a prohibited ground of discrimination.

[228] It is well established that the *Code,* like all human rights legislation, is to be given a broad, purposive interpretation to ensure that its purpose is fulfilled. The purpose is to remedy discrimination by focussing on the effect of the actions complained of rather than on the intent of the person accused of discrimination.

[229] In the 2014 Interim Decision, the Tribunal emphasized that a purposive approach relates to both the goals of achieving substantive equality and eliminating discrimination. The Tribunal cited Chief Justice Dickson in *Action Travail des Femmes*,

whose observations about the human rights legislation “remain among the most often cited and powerful statements of how human rights legislation must be interpreted”:

> Human rights legislation is intended to give rise, amongst other things, to individual rights of vital importance, rights capable of enforcement, in the final analysis, in a court of law. I recognize that in the construction of such legislation the words of the Act must be given their plain meaning, but it is equally important that the rights enunciated be given their full recognition and effect. We should not search for ways and means to minimize those rights and to enfeeble their proper impact. Although it may seem commonplace, it may be wise to remind ourselves of the statutory guidance given by the federal Interpretation Act which asserts that statutes are deemed to be remedial and are thus to be given such fair, large and liberal interpretation as will best ensure that their objects are attained. See s. 11 of the Interpretation Act, R.S.C. 1970, c. I-23, as amended.
>
> As Elmer A. Driedger, Construction of Statutes (2nd ed. 1983), at p. 87 has written:
>
>> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.
>>
>> The purposes of the Act would appear to be patently obvious, in light of the powerful language of s. 2. In order to promote the goal of equal opportunity for each individual to achieve "the life that he or she is able and wishes to have", the Act seeks to prevent all "discriminatory practices" based, inter alia, on sex. (at pp. 1133-34, emphasis added)
>
> See also *Ontario Human Rights Commission v. Simpsons-Sears Ltd.*, [1985] 2 S.C.R. 536 (“*O’Malley*”), at pp.546-47.

Statutory Provisions

Section 5 and the Pay Equity Act

[230] Section 5 of the *Code* provides that:

> Every person has a right to equal treatment with respect to employment without discrimination because of… sex…

[231] There is no dispute that section 5 of the *Code* includes systemic gender discrimination in compensation despite the existence of the *Pay Equity Act*. See *Nishimura v. Ontario (Human Rights Commission)*, 1989 CanLII 4317 (ON SC); *Reid v. Truro (Town),* 2009 NSHRC 2; *Canada Safeway Limited v. Saskatchewan (Human Rights Commission),* 1999 CanLII 12605 (SK QB); and *CUPE, Local 1999 v. Lakeridge Health Corp.,* 2012 ONSC 2051.

[232] Although the provisions of the *Pay Equity Act* are not directly applicable to the Application before me, the preamble to that *Act* acknowledges the existence of systemic gender discrimination in the compensation of employees in female job classes and the necessity for affirmative action to redress that discrimination. The AOM states in its submissions, and I agree, that:

> Systemic gender discrimination in compensation is an ongoing, pervasive factor affecting the compensation of women in Ontario. This fact has been established consistently in Ontario starting with the Green Paper, the *Pay Equity Act* itself, the Predominantly Female Sector studies and report, the subsequent legislative history documents, the jurisprudence of the Supreme Court of Canada and the Canadian Human Rights Tribunal, the Pay Equity Hearings Tribunal jurisprudence, particularly *ONA v. Haldimand Norfolk (No. 6)* and *ONA v. Women's College Hospital (No.4).*

[233] Both parties have also drawn on provisions of the *Pay Equity Act* for the purpose of interpreting the *Code.* The *Pay Equity Act* contains a prescribed, proactive, process for identifying and eliminating certain forms of systemic gender discrimination in compensation between employers and employees. Those specific requirements are not imposed by the *Code.* However, to the extent that the Pay Equity Hearings Tribunal and other adjudicators determining pay equity cases have made findings about what constitutes systemic discrimination in compensation and the historical factors, which contribute to differences in wages among workers in historically male or female jobs, those findings are of assistance in interpreting how those issues are considered under the *Code*.

[234] There is no dispute between the parties that issues raised related to the compensation of midwives falls within the expansive definition of “with respect to employment” in s. 5 despite their status as independent contractors.

Section 3

[235] 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 …

[236] The AOM also relies on the right to contract on equal terms, acknowledging the contractual nature of the employment relationship with the MOH, the history of negotiations and the contracts the parties have achieved since 1993. There is no dispute that this provision is engaged by the AOM’s allegations.

Section 11(1)

[237] Section 11(1) states:

> 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.

[238] The AOM argues that the imposition of various forms of compensation restraint on midwives since 1994 is an example of how a seemingly neutral rule of general application can have adverse consequences linked to the gender of midwives and the gendered nature of their work. This is often described as “constructive discrimination” as opposed to “direct discrimination”.

[239] While section 11 provides a statutory defence to constructive discrimination, the MOH does not rely on this defence. Instead, the MOH urges the Tribunal to find that the AOM has not met its burden to prove its case.

Section 9

[240] Section 9 of the *Code* provides that:

> No person shall infringe or do, directly or indirectly, anything that infringes a right under this Part.

Section 12

[241] 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.

[242] The AOM argues that midwifery represents a gender "trifecta" of services provided by women, for women, in relation to women’s reproductive health within a model of care that supports women’s empowerment and choice. The AOM argues that midwifery is so clearly identified with gender and so inseparable from gender that the profession itself takes on the protected characteristic of sex under the *Code*. In addition, the AOM argues that section 12 is engaged because of the association of midwives with women and reproductive care. The MOH does not take a position on how midwives describe their association with women and reproductive care. I have no difficulty accepting that this provision is engaged by the AOM’s allegations.

Policies of the Ontario Human Rights Commission

[243] The AOM has requested that the Tribunal consider the policies of the Ontario Human Rights Commission (OHRC). The OHRC has published several policies regarding claims of systemic discrimination. The *Code* recognizes the role of the OHRC in approving policies which can provide guidance in interpreting the *Code* (s. 30).

Section 45.5 requires the Tribunal to consider a policy approved by the Commission under section 30 if a party requests that it do so.

[244] I have considered the OHRC policies, particularly those which describe systemic discrimination. In the employment context, the policies of the OHRC affirm that employers and organizations like the MOH have the primary obligation to make sure their workplace is free from discrimination and that they are expected to act proactively to ensure that human rights are respected. In addition, where human rights complaints arise, they must respond to allegations of human rights violations in a timely and effective manner.

[245] At the same time, I recognize the submission of the MOH that the OHRC does not provide specific guidance on how to incorporate pay equity principles into compensation practices either with employees or independent contractors.

The Systemic Nature of the AOM's Allegations

[246] I have relied on the extensive description contained in the Interim Decision about the nature of the AOM's claim as one of systemic discrimination. In the Interim Decision, the Tribunal found that the respondent had taken a compartmentalized approach to the history of compensation negotiations with the AOM, mischaracterizing the allegations and ignoring the systemic dimensions of the Application.

[247] In *Haldimand Norfolk*, (1991) 2 PER 105, at paras 18 and 19, the Pay Equity Hearings Tribunal described how "deeply held attitudes" about women's work "often led people, without conscious decision-making, to give less value to the work". It is also an important principle in the human rights context that intention is not a factor in determining discrimination. That decision also describes how traditional job evaluation can reinforce and perpetuate these attitudes, "rewarding the skills and job content characteristics of male work and ignoring or giving less value to the skills and job content requirements of women's work".

Proving Discrimination under the *Code*

Burden of Proof and Standard of Proof

[248] There is no dispute that the burden to prove discrimination lies with the AOM and that the standard of proof is the balance of probabilities. This test is often described as “more likely than not”. The Supreme Court of Canada in *F.H. v. McDougall*, 2008 SCC 53, confirmed that in order to satisfy this standard, evidence must be “sufficiently clear, convincing and cogent.” Not all allegations of discrimination will be capable of proof on this standard, even where there is some evidence to support a person’s perception that discrimination is a factor in the adverse treatment that person has experienced.

The Three-Part Test for Discrimination

[249] Discrimination is not defined in the *Code*; however, it is found where a protected characteristic is connected to some form of adverse treatment experienced by the applicant. The three elements required to prove discrimination are well-established: identification with a prohibited ground; adverse treatment (sometimes referred to adverse impact or disadvantage); and, a connection between the adverse treatment and the ground. See *Moore v. British Columbia (Education)*, 2012 SCC 61.

Identification with the Prohibited Ground of Sex

[250] The respondent concedes the first part of the test, that midwives are almost exclusively women and therefore have a characteristic protected from discrimination under the *Code*.

Adverse Treatment

[251] The MOH does not concede that midwives have been subject to adverse treatment. This issue is resolved primarily on the basis of the facts, which I have addressed in my findings. There is no dispute that not every difference in treatment will amount to discrimination. To situate that argument in the context of this case, the application of compensation restraint to sex-segregated workers is clearly

disadvantageous, but that satisfies only the first two parts of the test. As I discuss further, below, there must also be proof that the act itself or the impact of that act is linked to sex.

Establishing a Connection

[252] There is a social context for this claim. The negative effects of gender on the compensation of sex-segregated workers are well known. The Government of Ontario has taken a number of steps to recognize and combat the gender wage gap. While this context is important, I cannot presume a connection between sex and adverse treatment solely from that context – even one as ubiquitous and well recognized as gender-based pay inequity. See also *Bombardier* at paragraphs 69, 88.

[253] The MOH has argued that there must be evidence that the adverse treatment is arbitrary or derived from stereotypes. These factors are often indicators of discrimination but they are not separate evidentiary requirements and they are not always present in cases of systemic or adverse impact discrimination. The Supreme Court in *British Columbia (Public Service Employees Relations Commission) v. BCGEU*, 1999 CanLii 652 (SCC) "*Meiorin"* at paragraph 39, described systemic discrimination as "resulting from the simple operation of established procedures…none of which is necessarily designed to promote discrimination". As the AOM stated in its Reply Submissions (Part B paras. 17 and 18):

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

[254] Assuming proof of adverse treatment, the question at this stage is whether the AOM has proven that sex is more likely than not, a factor in the adverse treatment experienced by midwives: *Peel Law Association v. Pieters*, 2013 ONCA 396 (*Pieters*) at para. 59. The MOH emphasizes that the adverse treatment must be *because of* sex, or *based on* sex, but those phrases have not been interpreted as a requirement to prove that the ground is the only or predominant factor or that there is a "causal" connection

between the two. It is also well established that there is no requirement to prove intention: the focus is on the effect of the respondent's actions on the applicant. See *Pieters,* para 60.

[255] These principles were reinforced in 2015 by the Supreme Court in *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39 at paras. 43-52 *(Bombardier)*. Proof of even a close relationship between the prohibited ground and the impugned conduct is not required. All the applicant is required to prove is that there is a connection between the prohibited ground and the adverse treatment. In *Bombardier*, the Supreme Court said that "for a particular decision or action to be considered discriminatory, the prohibited ground need only have contributed to it." at para 48.

[256] Finally, I note that a connection to sex may co-exist with other factors that are not discriminatory. In general, where the ground is determined to be a factor, the existence of other non-discriminatory explanations can be relevant to determining the appropriate remedy.

The Prima Facie Case

[257] In a human rights case, the burden of proof remains on the applicant throughout. However, that is a different concept than the evidential burdens, which apply to both parties.

[258] The traditional analysis is often described in this way: the applicant has the evidential burden to prove a *prima facie case;* once a *prima facie* case is established, the evidential burden shifts to the respondent to prove a credible, non-discriminatory explanation which rebuts the *prima facie* case; the evidential burden shifts back to the applicant to prove that the respondent's explanation is pre-textual. In *O'Malley,* above, the Supreme Court defined it as follows:

> (…) a *prima facie* case of discrimination 'is one which covers the allegations made and which, if they are believed, is complete and

> sufficient to justify a verdict in the applicant's favour in the absence of an answer from the respondent.'

[259] This is the conceptual way of describing the evidential burdens on the parties, but it does not align well with how the evidence is received and evaluated by the Tribunal. Only in cases where the respondent does not call evidence, as was the case in *O'Malley*, is it useful to treat this analysis as if each stage were a water-tight compartment.

[260] In this case, there is no dispute about the burden of proof. There is similarly no dispute that the case must be decided on the totality of the evidence. The MOH made a statement in its submissions that the AOM must prove that the evidence of the MOH is pre-textual. That is true, although in my view, the way it is articulated by the MOH on page 2 of its submission is more accurate. Where the respondent has led evidence of a credible non-discriminatory reason for the treatment complained of, the applicant must then prove that this evidence is pre-textual. The evidence of the MOH is not presumed to be credible. In addition, the MOH cannot rebut the evidence and arguments of the AOM by suggesting that possible alternative explanations might exist for the AOM's allegations, which the AOM must then prove to be pre-textual. The Tribunal must have some basis for finding that the explanations offered by the MOH are reliable enough to rebut the evidence of the AOM.

[261] I have considered the case before me on the totality of the evidence and as a result, I have not found it necessary to distinguish between the evidence which goes to the *prima facie* case and the evidence which goes to the AOM's overall burden to prove the case. This approach was affirmed by the Court of Appeal in *Pieters*, at paras. 83-84:

> After a fully contested case, the task of the tribunal is to decide the ultimate issue whether the respondent discriminated against the applicant. After the case is over, whether the applicant has established a *prima facie* case, an interim question, no longer matters. **The question to be decided is whether the applicant has satisfied the legal burden of proof of establishing on a balance of probabilities that the discrimination has occurred.** (emphasis added)

[262] I agree with the MOH that discrimination may be proven through circumstantial evidence but this does not change the burden on the applicant to prove discrimination through evidence, which is “tangibly related to the impugned decision or conduct.” See *Bombardier*, above, at para. 88. I also agree with the MOH, citing Justice Abella in *Moore*, that the test for proving discrimination does not change because the claim systemic in nature.

The Expert Evidence

[263] I have decided this case on the facts that were presented to me, the application of the legal principles which govern human rights adjudications and pay equity decisions describing the historic factors which affect women’s compensation. I did not find it necessary to rely on any of the experts in coming to my decision on liability. The expert evidence will very likely be relevant to remedy. A number of experts agreed that a job evaluation should be undertaken. Dr. Armstrong provides specific guidance about the benefits of a gender-based analysis in achieving and maintaining compensation levels that are free of gender discrimination.

[264] The AOM argues that the claim before this Tribunal constitutes a much broader pay equity claim stretching back to 1994. To support that position the AOM filed a pay equity report prepared by Paul Durber.

[265] Mr. Durber is a highly-regarded pay equity specialist who conducted a pay equity evaluation of midwifery compensation using the benchmarks established by the parties in 1993 with the Morton report. I cannot accept Mr. Durber’s methodology to support a finding that the *Code* has been breached back to 1997, although I would not rule out considering aspects of his report as relevant to remedy. The effect of relying on Mr. Durber’s report to establish liability under the *Code* would be to retroactively impose the statutory obligations under the *Pay Equity Act* onto the MOH. The *Code* does not prescribe a particular methodology for ensuring ongoing compliance. Each case must be decided on its own merit, in keeping with the legal principles which have developed

under the *Code*, bearing in mind that both pieces of legislation are directed at the same purpose of preventing and redressing gender discrimination.

[266] At this stage, I do not find it necessary to rely on the evidence of Hugh McKenzie, or the experts called by the MOH to rebut the evidence of Mr. Durber and Mr. McKenzie.

[267] I did not find it necessary to rely on the evidence of Dr. Ivy Bourgeault or Dr. Candace Johnson who was called in response to Dr. Bourgeault. The gendered history of midwifery, the model of care and history of the regulation of midwifery were very thoroughly described by the factual witnesses in this proceeding. The "structural embeddedness of medical dominance" and the caring dilemma associated with midwifery work were also addressed by the Task Force report and the factual witnesses who described the integration challenges they faced and the inherent conflict between the model of care and taking job action to address pay inequities.

[268] I also did not require expert evidence on the work of CHC physicians. Dr. David Price and Dr. Lisa Graves testified about the training and work of family physicians and the challenges they have faced over the past 20 years. No one disputed Dr. Price's comment that there had been an explosion of medical knowledge as well. Their evidence would be highly relevant to anyone conducting a job evaluation comparing CHC physicians to midwives for compensation purposes. That was not my role and I have not attempted to rate these jobs for comparison purposes.

[269] I will offer one observation about all of the experts who participated in this proceeding: their reports represent a rich source of guidance on how the MOH could reform its compensation practices to address compensation issues for midwives and other sex-segregated workers.

ANALYSIS

[270] This has been a long-standing, highly complex and contentious dispute. However, it is important to reinforce that this is not a public inquiry into Ontario's health care system generally or the midwifery program in particular. It is not my role to determine whether the government has made wise investments or policy choices.

[271] On that point, I have not addressed the AOM's claim that the MOH has failed to do its part to resolve the integration issues midwives have experienced. I cannot make findings, even about the role of the MOH, without evidence from the hospitals where midwives have been denied privileges or where they have been prevented from working within their full scope of practice. I understand the argument that compensation levels can affect how people are perceived in the health care system, but I have insufficient evidence to consider those allegations in this proceeding.

[272] I have not conducted a line-by-line, mirror comparison between midwives and any one group of health care providers or public sector workers since 1993. That was not the intent of the process the parties agreed to in 1993 and it does not help to explain my findings in this case. The question in this case, as in every case adjudicated under the *Code*, is whether there is evidence of adverse treatment which is connected to gender.

[273] As I indicated in the introduction to this Interim Decision, while I have considered all of the evidence and submissions filed in this case, I have also taken a step back from some of the details to consider the systemic nature and cumulative effects of policies and conduct on the compensation of midwives. In my view, the breach of the *Code* is all the more clear when the allegations are examined in this way.

Findings

[274] After 2005, and particularly the period following the release of the Courtyard report, the MOH unilaterally withdrawn from the principles established at regulation which protected the compensation of midwives from the effects of gender

discrimination. In 1993, the parties were aware of the pervasive nature of system discrimination in compensation, the stereotypes associated with women's work and the necessity to ensure that women are paid by reference to objective factors like SERW. The MOH's failure to maintain a perspective consistent with the principles set out in the *Code* in negotiations with the AOM after the Courtyard report it created a series of consequences, when considered together, constitute discrimination under the *Code*.

Gender was a Factor in the Development of the Funding Principles and the OMP Framework

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

[276] The regulation of midwifery was the result of a thoughtful, consultative process, rooted in principles of gender equality which recognized the level of skill, autonomy and responsibility inherent in the work of midwives. The funding principles and the OMP framework rely heavily on the history which preceded regulation and the principles developed by the Task Force, practising midwives and other experts.

[277] The principle that compensation for midwives should reflect the overlapping scope of practice of the family physician is based on a male comparator. The point of the principle and the 1993 Morton methodology was to ensure that midwives' compensation was not negatively affected by traditional assumptions and stereotypes about the value of "women's work". Family physicians were male-dominated at the time of the Task Force report and at regulation. In 2013, they were more than 50% male. The fact that both men and women were working as family physicians in CHC's at the time of regulation does not alter the nature of the principle, its effect, or its ongoing relevance to maintaining compensation levels for midwives. Given the findings of the Task Force about the suppression of midwifery prior to regulation, comparison with work

historically done by men was a significant factor in overcoming the stereotypes which would have undoubtedly affected the initial compensation levels set for midwives.

[278] It is clear that midwives, for whom gender is a ubiquitous aspect of their personal and professional identities, perceived the 1993 methodology as a pay equity exercise. Given their own personal experiences and perceptions that CHC physicians were predominantly male in 1993, and the reliance on principles that corresponded with the *Pay Equity Act*, it is not at all unreasonable for the AOM to have described the joint working group process in 1993 as a "pay equity exercise". In my view, it is perfectly reasonable for midwives to be operating from the perspective that their work was being valued in comparison to work which was, historically and still at that time, associated with men.

[279] The fact that not every person involved in the regulation of midwifery shares this perspective does not undermine the effect of these principles in proactively protecting midwives from gender discrimination. Ms. Porter, for example, defined the Morton report as a "one-time bracketing process" which was not related to gender. Her perspective may be explained by her role as a senior public servant, engaged in providing impartial advice to the government, and the important but time-limited role she played in the regulation of midwifery.

[280] The parties never agreed that this was a "one-time" process. The funding principles were also foundational to the implementation of the program. Ms. McHugh's evidence clearly demonstrates that she was paying close attention to the gender implications of funding midwifery and passing that insight up through the highest levels in the organization. The OMP framework was also reaffirmed by the MOH at the conclusion of the devolution process in 2000, which in my view, clearly rebuts the suggestion that positioning midwives between CHC nurses and physicians was a one-time exercise.

[281] I find that the original funding principles which were agreed on by the parties, followed by the joint working group and incorporated into the OMP framework, are connected if not imbued with gender. They worked against the prevailing stereotypes

about midwifery work and its association with women. I am confident that the AOM would have complained of gender discrimination and pay inequity if the joint working group had failed to adhere to those principles in favour of aligning midwives with exclusively female-dominated health care professions or their pre-regulation compensation levels.

The Role of a Comparators and Comparison

[282] I have already indicated that midwives were compared to male-dominated family physicians up to the point of the joint working group. Midwives made comparisons at the time of regulation which were based on work historically done by men in order to ensure that their compensation corresponded with the work itself and not the gender of the person doing the work.

[283] In *Withler v. Canada (AG)*, 2011 SCC 12, the Court emphasized that a comparator group approach may substitute a formal equality "treat likes alike" for a substantive equality analysis, that the use of mirror comparator groups may mean that the definition of the comparator group determines the substantive equality analysis and outcome, and that finding the "right" comparator group places an unfair burden on claimants. See *Withler,* paras. 55-60.

[284] I agree with the MOH that comparison with CHC physicians is an important part of evaluating the AOM's allegations of discrimination. I do not agree that I should conduct a line-by-line mirror comparison between how CHC physicians were treated by the MOH as compared to midwives. Nor do I agree that midwives, who are almost exclusively female, lose their access to the *Code* as soon as CHC physicians become female-dominated. That would not be in keeping with a broad and purposive interpretation of the *Code.* CHC physicians are family physicians who work in a particular setting. This was recognized by the MOH and the OMA who have worked to harmonize the compensation of pre-dominantly female physicians with their peers. The fact that CHC family physicians are now pre-dominantly female does not affect the underlying premise of the 1993 principles and comparisons.

[285] Following the guidance of the Court in *Withler,* I have taken an approach that takes account of the full context of the AOM's claims, in considering whether there is sufficient evidence to support a finding of discrimination. Comparison with family physicians, and CHC physicians in particular, is one aspect of that approach.

The 2005 Agreement

[286] Viewed in its entire context, the 2005 agreement was a significant achievement, made possible in large part because of the connection the parties maintained to the principles that governed the 1993 agreement. I make this finding for the following reasons.

[287] The AOM relied on a compensation report in the negotiations (2004 Hay Report) which validated the ongoing relevance of the Morton principles. The AOM complained that the MOH did not initiate a Hay Group study of midwifery compensation as it had done to establish increases for CHC staff. However, it is clear that the MOH incorporated both the Morton Report and the Hay Report in considering the risks of under-compensating midwives. The Hay Report was not a joint compensation study and it was reasonable for the MOH to expect to bargain over the results of that analysis. Positional bargaining was one of a number of tools the parties used to reach agreements in 1993 and 1999.

[288] There was a genuine negotiation process through which midwives negotiated significant increases in the range of 20% to 29% depending on experience level. The President of the AOM described this as an achievement in maintaining proximity to CHC physicians with the level 3 midwife remaining within 91% of the CHC physician.

[289] There is no record which establishes that the AOM viewed the 2005 compensation agreement as discriminatory, or reserved the right, as they did in later negotiations, to pursue an ongoing gap in compensation. There was some testimony that the AOM relied on conversations during the negotiation in which it was suggested that the losses sustained from eleven years of wage freezes could not be made up in

one contract. However, there is no language in the contract itself or the documents associated with the negotiation, which confirm an agreement to carry that issue over into the next round of negotiations. In addition, in the period between the signing of the 2005 agreement and the 2008 negotiations, the AOM made no overtures to the MOH about gender discrimination or unfairness in the 2005 agreement.

[290] I agree with the MOH that compensation for midwives was not set as a fixed percentage of CHC physician salaries. I also accept that there can be variance from time to time based on the market conditions associated with each profession or the health care priorities established by the MOH. As midwives and CHC staff were emerging from the effects of wage freezes after 2000, the AOM recognized that CHC staff had been waiting longer for compensation increases. The MOH is also entitled to make policy choices which prioritize the CHC program over the midwifery program or to choose to invest more funds in expanding access to midwifery services and less in compensation. The key question, from a human rights perspective, is whether those choices have the effect of creating an adverse impact on midwives that is connected to gender. The fact that midwives had to wait as long as CHC physicians to receive increases or that they did not maintain perfect alignment with them in 2005 is not sufficient to find a breach of the *Code*.

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

[292] My finding is that when the entire context of the 2005 agreement is considered, there is insufficient evidence of adverse impact connected to gender. If this matter is returned to me for the purpose of determining the remedy, I would begin my analysis of the compensation losses at this point.

The Courtyard Report

[293] The catalyst for this Application is the response of the MOH to the Courtyard report and the AOM's claims of gender discrimination. The response marks a significant departure from the collaborative working relationship the parties achieved at regulation and the principles they agreed upon for establishing appropriate and fair compensation levels.

[294] The AOM requested a joint compensation study because its own research revealed that by the time of the 2008 negotiations, midwives were underpaid by reference to the original funding principles and in relation to both nurse practitioners and CHC physicians. By 2008, some nurse practitioners were earning more than midwives and there was an increasingly significant gap between midwives and CHC physicians. Both parties agreed that the purpose of the report was to inform the next round of negotiations.

[295] Courtyard conducted a comprehensive review of the history of midwifery compensation. The consultants worked closely with the steering committee and obtained data on a number of comparators including: obstetricians, family health team physicians, nurse practitioners and CHC physicians. Courtyard clearly affirms the 1993 funding principles:

> The compensation model principles established in the Morton Report of 1994, which have evolved somewhat since that time, appear to have served the public, the profession and the Ministry very well. There appears to be no appetite or need to change the fundamental model of compensation.

[296] The response by the MOH to the Courtyard report constitutes sufficient evidence from which an inference can be drawn that midwives experienced adverse treatment and that gender is more likely than not a factor in that treatment. I make that finding for the following reasons.

Loss of CHC Physicians as a Comparator for Midwives

[297] After Courtyard, the MOH made explicit that the 1993 principles and methodology no longer informed the compensation practices of the MOH. The MOH unilaterally determined that CHC physicians were not appropriate comparators for midwives. The MOH did not conduct a study to validate that assumption which flies in the face of the 1993 agreement, to which the MOH was a party, and the Hay Group and Courtyard reports which confirmed the ongoing relevance of that comparator.

[298] The steering committee never raised this issue and nor did the MOH in providing feedback to Courtyard before the final report was completed. There is no evidence that would permit me to draw the inference that the MOH had arrived at this conclusion at any other time than after the Courtyard report was released.

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

Loss of the Methodology for Evaluating Compensation as "Appropriate and Fair"

[300] In 1993, the parties arrived at an equitable formula for funding midwives which accounted for their skills, education and training, level of autonomy and responsibility, among other factors. That formula has not been replaced with anything other than "looking" at other health care professions and conducting a jurisdictional scan of other midwifery programs across the country.

[301] There was an overemphasis by the MOH on jurisdictional comparators for midwives which was evident in the observation by the MOH that Courtyard's recommendation for a 20% adjustment did not correspond with what midwives were earning in other jurisdictions. The Morton report defines fairness as the "general context in which compensation occurs" and that fairness "can only be determined in relation to levels of pay for professionals working in the same economic market." This is not to suggest that a jurisdictional scan cannot be considered, but it cannot replace the principle that midwives must also be compared to other health care professionals working in the same economic market.

[302] At regulation, "appropriateness" was defined in relation to objective factors like SERW. Midwives no longer have a methodology to rely on in their negotiations with the MOH which ensures that their compensation is aligned with their SERW. The Supreme Court referred to this as "benefits routinely enjoyed by men – namely, compensation tied to the value of their work". See *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17, para. 38. Given the association of the work of midwives with women's work, the close alignment they now share with nurses can easily be construed as natural and appropriate, obscuring the ways in which they are like physicians. It has been a recurring theme for midwives that their autonomous model of practice has not been well understood. This problem was embodied by the comment attributed to a Minister of Health who reportedly said that compensation for midwives was "pretty good for a four-year degree".

Bargaining Strength and Gender

[303] The MOH argues that the difference in compensation paid to midwives and CHC physician is also a reflection of bargaining strength. The MOH relies on bargaining strength as a factor in its negotiations with midwives without examining the gender implications of that approach. The bargaining strength of midwives depends in large part on the MOH recognizing the connection between midwifery and gender and being informed about the effects of gender on the compensation of sex-segregated workers.

By contrast, the 1993 agreement was informed by a gender lens that gave full effective to what Chief Justice Dickson in *Action Travail des Femmes*, described as "rights of vital importance" which were not enfeebled by ignoring the adverse impacts of gender on women's compensation.

Failing to Resolve the "Flaws" in Courtyard

[304] The purpose of the Courtyard report was that it would guide the next round of negotiations in a context where the AOM was raising concerns about inequitable compensation paid to a group of almost exclusively female workers. The Courtyard report was the product of significant input by the parties and a careful review of the history of compensation. The MOH had an obligation to see that process through in order to validate whether the AOM was correct, that midwives were undercompensated as compared to other professionals in the health care system.

[305] The perceived deficiencies in the report were easily remedied by providing further guidance to the consultants. Instead, the MOH withdrew its support for the report and abandoned the entire history of compensation negotiations with the AOM.

[306] The criticisms of the Courtyard report are minor and could have been easily repaired. Mr. Ronson confirmed that not including midwives' benefits in comparing them to a small number of midwives in Alberta was inconsequential his findings. The report covers benefits, liability insurance, grants and sustainability investments. These were not characterized as compensation by the steering committee. Ms. Pinkney described sustainability investments as one of the "non-compensation" items the parties could negotiate in 2010. It was also not brought to Mr. Ronson's attention that midwives are able to retain excess operating funds. On this point, I agree with the MOH that the ability to retain excess operating funds is something I would consider if the matter is returned to me for a remedy decision.

[307] I find that the report is sufficiently compelling for the MOH to realize that the AOM's claim of gender discrimination may have some validity. In fact, by November

2010, the MOH had been advised that there was a risk that the AOM could file a human rights complaint, albeit one that would be difficult to prove. There was also an acknowledgment that the advice about the merits of the AOM's allegations was based on a lack of understanding of how midwives compare to physicians who are engaged in obstetrical care. The failure by the MOH to take reasonable steps to inquire into the AOM's allegations, repair any perceived deficiencies in the Courtyard report, and more fully consider the exemption under the legislation (and presumably for the policy) for human rights entitlements are important indicators of adverse impact.

[308] The MOH received brief advice on the matter which raised more questions than answers. Contrary to the Commission's policies, there is no evidence that the MOH took reasonable steps to understand and evaluate the allegations of discrimination. At the time of regulation, midwives were relied on by the MOH because of the extent of their expertise and their feminist perspective, their allegations of discrimination have been treated as a bargaining strategy rather than a cause for further investigation. The Courtyard report is an indication that gender discrimination may be an operative factor in the compensation of midwives which the MOH declined to investigate.

[309] The adverse impact on midwives of losing the connection to the 1993 principles is compounded by a failure on the part of the MOH to take reasonable steps to respond to the AOM's allegations that their compensation was falling behind based on the original funding principles. I agree with the principles set out by the AOM that the *Code* is not solely reactive and complaint-based but "intended to transform social relations and institutions to secure substantive equality in practice." The requirement to act proactively, monitor workplace culture and systems, take preventative measures to ensure equality, identify and remove barriers, take positive steps to identify and remedy the adverse effects of practices and policies that appear neutral on their face, is well-documented in the cases and Commission policies cited by the AOM. I agree with the AOM that it would diminish the fundamental nature of the rights and protections enshrined in the *Code* to have the right to have discrimination remedied but not prevented.

The Imposition of Compensation Restraint

[310] Instead of engaging in negotiations on the basis of both compensation restraint and the findings in the Courtyard report, the AOM was repeatedly advised that compensation restraint would govern the negotiations that followed the release of the Courtyard report. The MOH mischaracterized Courtyard's findings when it described the compensation adjustment as an impermissible "catch-up" in third year of a contract. The compensation adjustment recommended by Courtyard clearly represented past losses that had accumulated over time not a "catch-up" under the restraint policy. This mischaracterization serves as an ongoing rationale for imposing compensation restraint. By contrast, the 1993 principles permit the parties to account for economic circumstances in the definition of fair compensation.

[311] As Justice Abella found, "systemic discrimination in an employment context is discrimination that results from the simple operation of established procedures…none of which is designed to promote discrimination" (Abella Report pp. 9-10). Policies of general application, like compensation restraint, can have unintended adverse effects on people protected by the *Code*. In this case, the application of compensation restraint compounded the effects of midwives' losing their connection to the 1993 funding principles.

Physicians and Midwives are Different

[312] The AOM agrees that physicians and midwives are different. The AOM has never sought compensation equivalent to what is paid to family physicians. The differences between them were valued in 1993. Notably, Courtyard did not position midwives as close in proximity as Morton. In my view, this demonstrates that the alignment between midwives and CHC physicians can change but still remain within the fundamental principle that the compensation of midwives should reflect the overlapping scope of practice they share with physicians.

[313] Courtyard identified a significant compensation gap between midwives and physicians based on the existing compensation model and what the parties have historically agreed is included in compensation, particularly the purpose of comparisons with other health care providers. I agree with the MOH that compensation for midwives can be variable, although within some limits and that the ability to retain excess operating expenses is a factor that would be considered in determining an appropriate remedy in this case.

[314] The MOH argues that differences in compensation paid to CHC physicians and midwives are based solely on occupational differences and labour market forces. There is no evidence that compensation for physicians is tied to their SERW. CHC physicians were given increases because of recruitment and retention issues and after they obtained representation from the OMA, to harmonize their compensation with other physicians. These are reasonable explanations and an expert job evaluator would be in the best position to evaluate the impact of those explanations on the compensation gap. My finding, which is described in more detail below, is that there is sufficient evidence to find that sex was more likely than not, one of the factors that explains the difference in compensation levels between midwives and CHC physicians.

Proactive Prevention

[315] The MOH admits, contrary to the OHRC's policies, that it has taken no proactive steps to monitor the compensation of midwives for the impact of gender discrimination on the fairness of their compensation. By contrast, the MOH has continued to monitor compensation for CHC physicians for evidence of recruitment and retention issues and to ensure that their compensation is fair and aligned with other physicians.

[316] Both CHC physicians and midwives were significantly affected by eleven years of wage freezes. The MOH has been investigating and monitoring CHC physician compensation levels since at least 1999. CHC physicians received their first compensation increase in 2003 as a result of an extensive review of the CHC program. Since that time, they have received increases on an ongoing basis in an effort to

harmonize their compensation with other physicians working in other settings. Those compensation increases have sometimes been based on estimates or activities which do not align well with the CHC program, but nevertheless, are required to bring about appropriate and fair levels of compensation levels for CHC physicians. In my view, Sue Davey provided the best rationale for this practice, which is that at some point, it became important to say that "a physician is a physician is a physician" no matter what setting they are working in.

[317] The MOH is not required to engage in any one proactive strategy to monitor, identify and redress discrimination in the compensation of midwives. However, the MOH must take steps which are effective and proportional to its obligations under the *Code* to both prevent and remedy discrimination. The failure to act proactively is just one factor from which I have drawn an inference of discrimination. The reason the Commission publishes policies to guide employers in their obligations under the *Code* is that the probability of compliance is reduced without proactive action. The failure to be proactive can, and in this case does, explain why the *Code* was breached and like a failure to investigate a claim of discrimination, it can exacerbate the damages experienced by a victim of discrimination.

[318] The lack of proactivity in the monitoring of compensation levels for midwives is most evident in the lack of regular negotiations between the AOM and the MOH and the long gap between joint compensation studies. Those gaps explain in part the reaction of the MOH to Courtyard's findings. Midwives were not shocked by Courtyard's findings – in fact, quite the contrary. They had maintained continuity with the original funding principles in their preparations for each round of negotiation and therefore could see the compensation gap widening and took steps to redress it in the 2008 negotiations.

[319] While there is clearly a duty on an employer to prevent discrimination by taking proactive steps to ensure compliance, the *Code* does not refer to pay equity nor does it prescribe any process for developing a compensation model which is *Code*-compliant. I agree with the MOH that I should also consider that pay equity is a complex area of law and social policy and that there is limited information available about how to proactively

address issues of gender-based compensation discrimination outside of the *Pay Equity Act*.

[320] On that point, I note that the MOH was fully engaged as a partner in the 1993 agreement which is a template for a gender-sensitive, inclusive, human rights approach to proactively dealing with the effects of gender discrimination in women's compensation.

[321] In addition, the MOH is a branch of the provincial government which enacted proactive pay equity legislation in 1988 and has since gone on to recognize and make significant efforts to close the "gender wage gap" with respect to public sector workers. The MOH as an employer is subject to the terms of the *Pay Equity Act* and better positioned than other small employers, who may have no experience with pay equity principles, in determining how to achieve compensation which is free from discrimination. There is also nothing new about the concept of a "gender-based analysis" or gender lens in setting government policy.

Conclusion

[322] Midwives have, since 2010, attempted to negotiate in a context where the MOH no longer abides by the foundational principles established in 1993 or recognizes the effects of gender on compensation. This perpetuates the historic disadvantaged midwives have experienced as sex-segregated workers. It also undermines the dignity of midwives who now find themselves having to explain why they should be compared to physicians for compensation purposes more than 20 years after this principle was established. It is a denial of substantive equality that midwives must negotiation in a context where there is no recognition of the potential negative impact of gender on their compensation.

[323] I am not suggesting that the parties must forever abide by the specific methodology they agreed to in 1993. I have found in this decision, for example, that the 2005 agreement remains connected to the foundational principles in such a way that

there is insufficient evidence to find a breach of the *Code*. The parties are at liberty to negotiate a new compensation methodology which incorporates, among other things, the developments in the midwifery profession, the ongoing demand for services, the government's changing health care priorities, economic and labour market forces and the research which has amassed since 1993 on the effects of gender-based discrimination in compensation. However, what has happened in this case is that the MOH has unilaterally withdrawn from the 1993 principles and methodology, leaving the compensation of midwives exposed to the well-known effects of gender discrimination on women's compensation.

[324] For all of those reasons, I have concluded, on the balance of probabilities and on the totality of the evidence, that there is sufficient evidence from which to infer that midwives experienced adverse treatment and that sex is more likely than not a factor in the treatment they experienced and the compensation gap that has developed between midwives and CHC physicians since 2005.

Remedy Deferred

[325] I recommend that the parties take some time to work together to reset their relationship now that liability under the *Code* has been determined. In my view, the best way to achieve an enduring process for establishing and maintaining appropriate and fair compensation levels for midwives is for the parties to return to a state of cooperation with the original funding principles as their guide. I would also recommend that they adopt the necessary procedural enhancements to their negotiating relationship to maintain appropriate and fair compensation levels for midwives now and into the future.

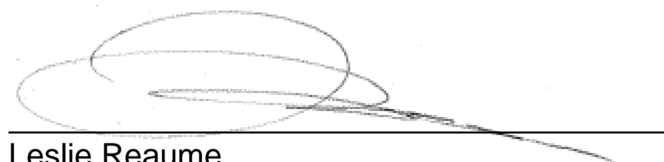
[326] The AOM has included a section in Part B from paragraphs 124 to 128 proposing that the Tribunal provide practical guidance on setting compensation free of gender and other forms of discrimination. Those are all recommendations that I would consider in determining an appropriate remedy if necessary, bearing in mind that it is not my role to develop a regulatory regime which would apply to all employers under the *Code*, but rather to craft a remedy which is appropriate in all of the circumstances of this case. The

specific requirements under the *Pay Equity Act* do not apply to the MOH in these circumstances but they serve as a useful guide for the kind of proactive measures the MOH could put in place to monitor compensation for midwives going forward. The parties are also at liberty to negotiate new principles and methodologies for ensuring fair and appropriate compensation for midwives.

[327] I remain seized of this matter and willing to assist the parties with further directions which will assist in their efforts to negotiate a remedy. I recommend that they retain a third party to conduct those negotiations.

[328] If the parties are unable to come to an agreement, either party may request that the Tribunal reconvene to determine the issue.

Dated at Toronto, this 24th day of September, 2018.

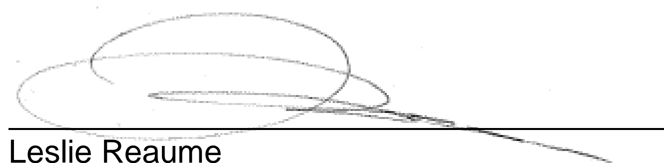


Leslie Reaume
Vice-chair

CORRECTION

The Decision released on September 24, 2018 incorrectly omitted the words "since 2005" at the end of paragraph 324. This has been corrected.

Dated at Toronto, this 24th day of September, 2018.



Leslie Reaume
Vice-chair