HUMAN RIGHTS TRIBUNAL OF ONTARIO

B E T W E E N:

The Association of Ontario Midwives

Applicant

-and-

The Ministry of the Attorney General as represented by the Ministry of Health and Long-Term Care

Respondent

DECISION ON REMEDY

Adjudicator:	Leslie Reaume
Date:	February 19, 2020
File Number:	2013-16149-I
Citation:	2020 HRTO 165
Indexed as:	**Association of Ontario Midwives v. Ontario (Health and Long-Term Care)**

APPEARANCES

Association of Ontario Midwives, Applicant	)	Mary Cornish, Adrienne Telford, Lara Koerner Yeo, Counsel and Kelly Stadelbauer and Juana Berinstein, Representatives of AOM
The Ministry of the Attorney General as represented by Ministry of Health and Long-Term Care, Respondent	)	Zachary Green, Courtney Harris and Yashoda Ranganathan, Counsel with Adam Kanji (Student-at-Law).

INTRODUCTION

[1] This is a Decision on Remedy further to the liability findings made by this Tribunal in the Interim Decision, 2018 HRTO 1335, dated September 24, 2018. The Association of Ontario Midwives (the "AOM") filed this Application on November 27, 2013, on behalf of more than 800 individual midwives. The AOM alleged discrimination contrary to the *Human Rights Code,* R.S.O, 1990, c. H.19, as amended (the "*Code"*), against the Ministry of Health and Long-Term Care (the "MOH") with respect to its compensation practices back to 1994, the year after midwifery became a regulated health profession.

[2] In the Interim Decision, I 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 and acknowledged that members of the midwifery profession, as well as their clients, may self-identify as transgender or gender non-conforming. I have done the same in this Decision.

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

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

[5] From 1993 through the 2005 agreement, the negotiations between the parties were informed by objective criteria like skill, effort, responsibility and working conditions

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

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

[7] In 2010, the parties participated in a non-binding joint compensation review ("Courtyard") which revealed the consequences of the gradual erosion of the compensation benchmarks. Courtyard recommended a 20% adjustment to the fees individual midwives earn for their services, which would apply for midwives at each of the six levels of experience effective April 1, 2011. Courtyard repositioned midwives between CHC nurse practitioners and physicians based, in part, on the original 1993 formula, a subsequent study conducted by Hay Group for the AOM in 2004, and the information gathered during the review. Courtyard also recommended regular negotiations going forward based on the benchmarks. When the Courtyard report was released, the MOH disagreed with the findings and methodology, despite having been a full and active participant in the process. The parties reached an impasse in their negotiations which

eventually led to the filing of this Application and the signing of subsequent contracts in 2013 and 2017 without prejudice to pursuing this Application.

[8] As the Tribunal found in the Interim Decision, what distinguishes the AOM's allegations from general allegations of unfairness is that midwives are sex-segregated workers, and as a result, they are vulnerable to the forces of gender discrimination on their compensation. While the MOH has denied that gender was ever a factor in setting compensation for midwives, the evidence from the merits hearing is clear that the benchmarks embody both the general concept of what is "fair and appropriate", and what those terms mean in relation to the gendered nature of the midwifery work. The maintenance of a physician comparator makes visible the overlapping scope of practice that midwives share with a historically male profession.

DECISION

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

[10] I have also ordered compensation for injury to dignity, feelings, and self-respect ("injury to dignity"), in the amount of $7500.00 per eligible midwife. While each of the midwives who testified as part of the factual context of this case also gave evidence about how they were personally affected by the issues raised in the Application, five representative midwives were called for the purpose of establishing the quantum of compensation for injury to dignity. The MOH did not dispute that an order for all midwives could be based on the testimony of the representative applicants.

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

ISSUES

[12] I begin with a brief overview of the procedural and factual background followed by determinations on the following main issues:

a. The potential limitations on an award of compensation;
    - the arguments of the MOH against retroactive compensation and compensation for injury to dignity; and
    - how the *Code* defines a "party" for the purpose of eligibility for compensation.

b. Compensation award:
    - the reasons why Courtyard is the best evidence for determining remedy, including retroactive compensation;
    - the reasons for finding that the Durber report is not the appropriate methodology for determining remedy;
    - the reasons for awarding $7500.00 in compensation for injury to dignity;
    - interest and timing of payments;

c. Orders to promote compliance with the *Code*.

PROCEDURAL BACKGROUND

[13] The hearing of this matter took approximately 50 days over several months in 2016 and 2017. Evidence on all issues, including remedy, was presented by both parties during the hearing. The hearing was not bifurcated; however, given the long history of negotiations between the parties, a decision on the remedial issues was deferred to give them an opportunity to negotiate a resolution. In the Interim Decision, the parties were advised that the Tribunal would reconvene to deal with the remedial issues at the request

of either party. The Tribunal received a request to reconvene from the AOM on November 8, 2018.

[14] In the Interim Decision, the Tribunal found that there was enough evidence to establish a breach of the *Code* after, but not before, the parties negotiated the 2005 funding agreement which ran from April 1, 2005 to March 31, 2008. Considering these findings, the parties filed written submissions with a view to tailoring their positions on remedy to the findings on liability. Oral submissions were heard on May 26, 2019 during which the AOM provided the Tribunal with a series of charts which set out several possible methods for calculating retroactive compensation.

FACTUAL BACKGROUND AND FINDINGS ON LIABILITY

[15] The complete factual background and findings on liability are set out in the Interim Decision and need not be repeated in this Decision. I have made every effort to ensure consistency in this Decision with the Interim Decision and to repeat only the evidence and findings necessary to explain the remedial decision.

Compensation Principles Established by the Parties

[16] Midwifery was recognized as a regulated health profession in 1993. Midwives are primary health care providers and specialists in low-risk maternity and newborn care. They work as independent contractors and negotiate with the MOH through the AOM.

[17] In 1993 the parties defined the terms “fair and appropriate” compensation and established principles and a methodology for ensuring that midwives were paid based on objective criteria and appropriate comparators. These principles embodied the history of midwives as sex-segregated workers moving into the formal health care system and taking on work which was historically associated with male-dominated family physicians and obstetricians.

[18] One of the fundamental principles of the AOM, which was adopted by the parties in 1993, was that compensation for midwives would reflect the overlapping scope of

practice they share with senior nurses and family physicians. Midwifery is not a subset of nursing and midwives do no work under the supervision of a physician. They are as autonomous and responsible as physicians for the services they provide within their scope of practice. Nurse practitioners were regulated in 1998. As I indicated in the Interim Decision, the AOM has long taken the position that nurse practitioners working in CHC's replaced the senior nurses with whom they were compared in 1993.

[19] Before the first agreement came about in 1993, the parties worked together with a compensation specialist using objective criteria to evaluate midwives against various possible comparators. Using the joint compensation study ("Morton") to inform rather than determine their negotiations, the parties settled on positioning midwives between senior nurses and family physicians working as employees in CHC's. Since 1993, the Courtyard review is the only other joint compensation study the parties have participated in.

[20] The importance of the parties having adopted an evidence-based methodology for setting compensation for midwives cannot be overstated: it made visible the overlap in SERW, among other factors, between midwives, nurses, physicians, and the other health care professionals. It also exposed the stereotypes about women's work which suppressed the compensation of midwives during the pre-regulation period and which operate to align midwifery more closely with other female-dominated professions like nursing. The maintenance of a physician comparator is what keeps midwives from slipping back into a place where the objective evaluation of their SERW is at risk of being replaced by stereotypic attitudes about women's work.

Individual Compensation vs. Program Funding

[21] One of the complexities in this case is that the AOM negotiates "funding agreements" with the MOH which address issues beyond the fees paid to individual midwives. Midwives work in practice groups and some work as partners in the practice. They are not paid a salary nor are they paid based on the individual clinical services they provide. Midwives are paid a fee per "course of care" which equates to a range of services

provided by a midwife to a pregnant woman and newborn. It is based on 24-hour access to midwifery services.

[22] The funding agreements have several elements which cover the delivery of clinical and nonclinical services, expenses, liability insurance, benefits, grants for things like equipment for new midwives, office equipment, and leasehold improvements and supplements for the additional costs associated with rural and remote practices. Midwife practice groups can also receive “caseload variables” which are fees for performing various non-clinical activities, such as taking part in hospital administration activities, spending additional time providing services to vulnerable populations or mentoring new registrants.

[23] The fee adjustment recommended by Courtyard, which I have adopted, is that part of the “course of care” fee which represents what midwives are paid for their services, including: a) an experience fee; b) an on-call fee; c) a retention incentive; and d) a secondary care fee which is payable when a second midwife attends as required by the model of care. The portion of the fee which is allocated to the practice group for operational expenses is not part of the adjustment recommended by Courtyard.

[24] The status of midwives as independent contractors and the complexities of the funding agreements they negotiate with the MOH make comparison with salaried nurses and physicians employed by CHC’s somewhat challenging. Many of the funding elements relate to expenses which would normally be covered for midwives if they worked in an employment model.

The 2005 and 2008 Contract Negotiations

[25] The negotiations between the parties have resulted in several funding agreements. The first agreement was achieved in 1993 and was followed by agreements which took effect in 1999, 2005, 2008, 2013 and, 2017. The agreement effective April 1, 2008 was concluded in part based on a commitment that the parties would engage in the first non-binding compensation study since 1993 (Courtyard).

[26] The 2005 agreement, which ran from April 1, 2005 to March 31, 2008, marked the emergence of the parties from years of compensation restraint. The AOM achieved significant increases to individual compensation levels and other important improvements in funding and program delivery. The negotiations leading up to the 2005 agreement were informed by a report commissioned by the AOM by the Hay Group in 2003, which was updated with input from the MOH in 2004 (the "2004 Hay Report"). The 2004 Hay Report incorporated the Morton report, validated the ongoing relevance of comparison with CHC senior nurses and physicians and positioned midwives between CHC physicians and nurse practitioners.

[27] As preparations began for the next round of negotiations leading to the 2008 contract, the AOM concluded that the compensation decisions the MOH was making with respect to themselves and their comparators were gradually pushing midwives out of alignment from the benchmarks achieved in 1993 and 2005. The AOM urged the MOH to address their concern that midwives were falling behind their comparators. In 2009, the parties achieved a new funding agreement which was intended to be in effect for three years commencing retroactively on April 1, 2008. Among other improvements, the parties agreed to an increase to base compensation rates of 2% per year (6% in total) and an increase in benefits from 18% to 20% as well as the joint compensation review.

The Courtyard Compensation Review

[28] The parties signed a Memorandum of Understanding on May 7, 2009, which addressed a number of important issues: the terms of funding for AOM projects; the formation of the Joint Midwifery Advisory Committee (JMAC) which was intended to supplement major negotiations and resolve disputes between the parties; the scope and details of the compensation review; and a commitment to renegotiate no later than September 30, 2010.

[29] The Courtyard compensation review took place from June to October 2010, with the full cooperation of both parties. The MOH and AOM had an equal number of representatives on the steering committee that supported the study including the

President of the AOM and the Manager of the OMP. The steering committee endorsed CHC nurse practitioners and physicians as appropriate comparators. The extent of the misalignment between midwives and their comparators was revealed by the review. At the end of the process, the Courtyard consultants recommended an adjustment which was intended to realign midwives, between CHC nurse practitioners and physicians, particularly after physicians received a significant increase in base compensation levels leading up to the study.

Imposition of Compensation Restraint and the 2013 Agreement

[30] The parties had agreed in 2008 that although Courtyard would be non-binding, it would inform the next round of negotiations. When Courtyard was released, the MOH had concerns about the methodology and recommendations, but chose not to extend the review or conduct another study to address those issues. Instead, the MOH imposed a policy of compensation restraint on the negotiations. The policy was derived from legislation which had come into effect in March 2010, several months before the Courtyard review took place, and which did not explicitly apply to independent contractors. Neither the AOM nor the Courtyard consultants were advised that compensation restraint would be applied to the negotiations commencing in the fall of 2010. The MOH also unilaterally rejected CHC physicians as an appropriate comparator for midwives.

[31] The AOM strongly advocated for the implementation of the Courtyard report, promoting the recommendation as a pay equity adjustment for midwives. The AOM explicitly rejected the option of filing an application with the Tribunal in August 2011, in favour of other strategies to convince the MOH to implement Courtyard. The 2008 agreement was extended beyond its expiry date of March 31, 2011, and finally in 2013, the AOM filed this Application and signed a new agreement.

Gradual Loss of the Benchmarks by the MOH

[32] The remedy I have ordered to reinstate the compensation benchmarks arises from the findings in the Interim Decision that the MOH was gradually losing touch with the

meaning of the principles and processes which had previously informed its negotiations with the AOM.

[33] It is important to note that while the AOM argued in this proceeding that CHC physicians are the primary comparator for midwives and that compensation for midwives should be set as a proportion of physician salaries, the Tribunal did not find that to be the basis of the benchmarks or the parties' agreements. Midwives were positioned between physicians and senior nurses and later compared to nurse practitioners when they achieved regulation. I accept that the AOM has negotiated based on achieving what it views to be an appropriate relativity with CHC physicians, but the evidence is clear that there was never an agreement that CHC physicians were the primary comparators.

[34] The MOH placed less and less emphasis on the benchmarks, eventually repudiating the principle of comparison with physicians altogether. Notably, the MOH does not take the same position with respect to comparison with nurses, which is precisely why sex-segregated workers require an evidence-based methodology for establishing the value of their work. It bears repeating from the Interim Decision that the position of the MOH in this proceeding is inconsistent with its promotion of midwives as equally competent providers of low-risk maternity care, along with family physicians and obstetricians.

[35] It is true that the AOM did not prepare for the 2008 negotiations based exclusively on the benchmarks. The AOM relied in part on another study undertaken for the AOM by Hay Group in 2007, which considered a wide range of public and private sector workers. It is also true that the MOH had not completely abandoned the benchmarks by this time. Witnesses for the MOH testified that in the preparations for the 2008 negotiations, the MOH considered increases received by other health care providers in a variety of settings including the original comparators. The MOH also considered the maturity of the midwifery profession in Ontario, compensation paid to midwives in other jurisdictions and the fact that midwives had received significant increases as a result of the 2005 negotiations.

[36] While I would not describe this as a strictly linear progression, it is apparent that by the time of the 2008 negotiation, the benchmarks were taking on less relevance in the compensation practices of the MOH. Consequently, the MOH did not recognize the relevance of the increases it was paying to physicians to the compensation it paid to midwives. It did not scrutinize how increases to physicians (or nurse practitioners) resulted in a shifting alignment between midwives and their comparators and did not attempt to validate whether midwives remained fairly compensated despite changes in the compensation of their comparators. For the most part, the effect of the shifting alignment between midwives and their original comparators was revealed over time, as is illustrated by the fact that the AOM considered but rejected the idea of filing an application with the Tribunal in August 2011.

[37] As a result, the AOM had to bargain and make trade-offs in the 2008 negotiations to secure a commitment from the MOH to a non-binding compensation study. The study was completed, but contrary to the 2008 agreement, it did not inform the positions taken by the MOH in the negotiations leading to the next contract. The loss of the benchmarks also prevented the MOH from fully appreciating the significance of the findings and recommendations made by Courtyard: an independent consultant, working in collaboration with both parties, using the parties' original funding principles as a guide, found that a group of sex-segregated workers required an increase of 20% to bring their compensation up to a fair and appropriate level.

The Application and the Report of Paul Durber

[38] When this Application was filed on November 27, 2013, the AOM included a job evaluation study which it commissioned for this proceeding. The study purports to demonstrate what midwives would have earned since 1993, based on the application of the New Zealand "Equitable Job Evaluation Factor Plan: Working Towards Gender Equality" (the "New Zealand methodology"). The consultant, Paul Durber, found that based on this methodology, midwives should have had their earnings adjusted based on changes from year to year in their SERW and their proportional relationship with CHC

family physicians. By 2013, for example, Durber found that the proportionate relationship between midwives and CHC physicians was 91%.

[39] The AOM initially sought compensation based on this report back to 1994 and then adjusted that request to 1997. In its submissions following the Interim Decision, the AOM indicated that it was seeking pay equity adjustments based on the Durber report back to 2005. For several reasons, which are set out later in this Decision, I have chosen the recommendations of Courtyard rather than Durber, to reinstate the benchmarks and to remedy lost income.

Conclusion

[40] This remedial Decision addresses the events after the parties achieved the 2005 agreement. As the MOH attempted various strategies to address concerns about physician shortages, aligning physicians in different models, and a significant economic downturn, it lost touch with the impact of its decisions on the benchmarks for setting compensation for midwives. The parties were on the right track to resolving the issues giving rise to this Application when they agreed to a compensation study as part of the 2008 agreement.

[41] This case crystallized during the negotiations between the parties after the release of the Courtyard's recommendations. To return midwives to the place they would have been but for the discrimination, is to bring the parties back to a state where they are working together to ensure that midwives are fairly and appropriately paid, using the benchmarks as their guide, and with the MOH adhering to its obligations under the *Code*. Implementation of the Courtyard report, combined with the orders made to promote compliance with the *Code*, brings the parties as close as possible to that state.

[42] I now turn to the remedies requested by the AOM and the various arguments raised by the MOH in response.

REMEDY REQUESTED

Request by AOM and Response by MOH

[43] To summarize, the AOM is seeking a wide range of remedies including but not limited to: compensation retroactive to 2005; compensation for injury to dignity; interest; and orders to promote compliance with the *Code* which would reform the compensation practices of the MOH and enhance the bargaining relationship between the parties.

[44] The MOH argues that any remedial order should be prospective in application on the basis that the Interim Decision represents a substantial change in the law. The MOH is also requesting that any remedial order identify with precision the required changes to the process for setting midwives' compensation. The MOH has also raised arguments that would bar or limit the entitlement of some midwives to compensation.

[45] I deal first with the arguments of the MOH.

POTENTIAL LIMITS ON A COMPENSATION AWARD

[46] The MOH has raised three issues that it argues would bar or limit the entitlement of some midwives to compensation:

a. There should be no order for retroactive compensation. All remedies should be prospective in application because the Interim Decision represents a substantial change in law in accordance with the Decision in "*Hislop*"*;*

b. There should be no order for injury to dignity, because of the public policy nature of the claim and the Decisions in "*Abbey*" and "*Mackin*"; and,

c. Compensation can only be awarded to parties, defined as any midwife who personally had a right to file an Application, but signed a consent authorizing the AOM to bring the Application on her behalf. This would exclude those midwives who were not practising within one year prior to the filing of the Application.

Retroactive Compensation: The *Hislop* Decision Does Not Apply

[47] There is no dispute that the Tribunal has authority to make both prospective and retroactive compensation awards. The MOH argues that the Tribunal should apply the decision of the Supreme Court of Canada in *Canada (Attorney General) v. Hislop,* 2007 SCC 10 ("*Hislop")*, and decline to order retroactive compensation in this case. The MOH argues that the Interim Decision represents a substantial change in the law and that the principles set out in *Hislop* weigh in favour of a purely prospective remedy.

[48] *Hislop* is a constitutional case which arose during a period of significant change in the law on same-sex equality rights. In *Hislop*, the Court dealt with the retroactive effect of striking down parts of the Canada Pension Plan legislation pursuant to section 52(1) of the *Constitution Act, 1982*. The decision addresses when a purely prospective remedy is appropriate to address a breach of the *Charter* in the context of other competing public interest issues.

[49] In *Hislop*, the Court found a breach of the *Charter,* but limited the retroactive effect of the remedy to 1999, based in part on a finding of reasonable and good faith reliance by the government on the state of law prior to that date. In 1999, the Supreme Court decided the case in *M. v. H.*, 1999 CanLII 686 (SCC) ("*M. v. H.")*, which marked a departure from previous Supreme Court decisions on the exclusion of same-sex partners from social benefits legislation. See, e.g., *Egan v. Canada*, 1995 CanLII 98 (SCC) ("*Egan*").

[50] The Court noted that in general, remedies are granted retroactively by courts "to the extent necessary to ensure that successful litigants will have the benefit of the ruling". However, "when the law changes through judicial intervention….it may be appropriate for the court to issue a prospective rather than a retroactive remedy": *Hislop* at para. 86. The Court canvassed various ways of defining a decision which represents a substantial change in the law, including one which makes a "clear break from the past" or gives context or expression to rights, principles or norms that were previously undefined: *Hislop*

at para. 99. The shift in the jurisprudence from *Egan* to *M. v. H.*, for example, represents a clear break from past Supreme Court decisions on same-sex equality rights.

[51] The Court also found that a substantial change in the law was necessary but not sufficient on its own to justify a purely prospective remedy. The Court set out several other factors to consider if a substantial change in law is found. Those factors include: reasonable or good faith reliance by governments on the previous state of the law; the fairness to the litigants of limiting the retroactivity of the remedy; and whether a retroactive remedy would unduly interfere with the constitutional role of legislatures and democratic governments in the allocation of public resources. See *Hislop* at para. 100.

[52] The *Hislop* principles have rarely been addressed by this Tribunal. In *Buklis v. Ontario (Community and Social Services)*, 2013 HRTO 918 ("*Buklis*"), the Tribunal discussed the applicability of *Hislop* in the context of a challenge to the Special Diet Allowance under Ontario's social assistance system. The Tribunal found that assuming *Hislop* applied to an adjudication under the *Code*, the Tribunal's decision did not constitute a change in the law and the balancing of the other factors set out in *Hislop* weighed in favour of a retroactive remedy.

The Arguments of the MOH

[53] The MOH argues that the Interim Decision involves a substantial change in the law which would justify a purely prospective remedy. The MOH has summarized the Tribunal's findings as imposing a proactive obligation on compensation-setters, to monitor compensation for sex-discrimination, by comparing a female predominant profession to a male comparator, not based on the gender predominance of the comparator group at the time of the comparison, but based on historic or stereotypic factors or comparisons that had been made earlier. In my view, that is an unduly narrow and compartmentalized description of the Tribunal's findings.

[54] The MOH argues that although a finding that the Interim Decision represents a substantial change in law is not determinative of the issues, the rest of the *Hislop* factors

weigh in favour of a purely prospective remedy in this case. The MOH argues that it relied, in good-faith, on the state of the law prior to the Interim Decision that compensation levels could be set by agreement with the AOM and otherwise in accordance with the governments' policies and priorities. The MOH also argued that to order retroactive compensation would unduly interfere with the priorities the government has established for the OMP.

[55] I have found that a) *Hislop* does not apply to the relationship between the parties; b) the Interim Decision did not create a substantial change in the law; and c) even if such a change occurred, the application of the other *Hislop* factors do not support a purely prospective remedy in this case.

Hislop Does Not Apply to the Relationship Between the Parties

[56] In my view, *Hislop* does not apply at all to this case. In *Hislop*, the Court was grappling with the effect of striking down legislation on entitlement to retroactive benefits under a complex, statutory, public benefits scheme in the context of emerging jurisprudence on same-sex equality rights. The AOM's claim, by contrast, invokes the government's role in setting compensation for contractors who deliver midwifery services exclusively within the OMP. While it is important to acknowledge the government's public policy role in establishing health care priorities generally and specifically its role in stewarding the OMP, *Hislop* does not apply to a claim for retroactive wage adjustments found to be owing to workers as a result of discrimination under the *Code*.

No Substantial Change in the Law

[57] The Interim Decision does not represent any change in the law: long-standing human rights principles were applied to the facts of this case which resulted in a finding of discrimination.

[58] The Tribunal found, on the totality of the evidence, that the AOM established adverse treatment connected to gender with respect to the compensation practices of the MOH. The Tribunal also found, on the totality of the evidence, that while the MOH gave

reasons for increasing physician compensation, it failed to adequately explain its methodology for setting compensation for midwives after the 2005 agreement. The agreement to conduct the Courtyard review put the MOH on a path to evaluating the ongoing fairness of the compensation paid to midwives considering the compensation increases paid to their comparators.

[59] The Tribunal explicitly rejected the notion that there was only one method by which the MOH could have maintained fair and appropriate compensation levels for midwives given the sex-segregated nature of their work. The Interim Decision did not establish any specific proactive obligation on compensation-setters as the MOH has argued above. Fundamentally, it is the obligation of the MOH to ensure that its practices do not contravene the *Code*. If the MOH takes no steps to monitor the compensation it pays to sex-segregated workers, it has no basis for explaining how it determined that gender was not a relevant factor in what those workers were paid.

[60] The Interim Decision describes the relationship between the work of midwives and work historically associated with men. The Interim Decision also describes the process by which the parties came to determine the appropriate comparators in 1993 and how midwives fell out of alignment with those comparators over time. As CHC physicians evolved toward female predominance and the gap in compensation between physicians and midwives widened, the MOH was at liberty to make changes to its compensation practices, so long as those changes did not result in discrimination against midwives as sex-segregated workers. Instead, the MOH chose to unilaterally withdraw from using physicians as comparators without establishing a new compensation methodology for midwives.

[61] The Tribunal also rejected the imposition of the statutory requirements under the *Pay Equity Act,* R.S.O. 1990, c. P.7, as amended, on the MOH either retroactively or prospectively. What the Tribunal found is that given the common underlying goals of the *Code* and the *Pay Equity Act*, the *Act* would be a useful resource in assisting the MOH in monitoring compensation levels for the negative effects of gender discrimination.

[62] There is nothing new about the Tribunal's Interim Decision which affirms that compensation-setters are ultimately responsible for ensuring that their practices comply with the *Code*. To the extent that any substantial change has occurred, it is in the MOH repudiating the principles and norms which historically governed the setting of compensation for midwives.

[63] Having found that the Interim Decision does not represent a substantial change in the law generally ends the inquiry. It also makes it difficult to hypothetically apply the other factors. However, even if I had concluded that there had been such a change, I would not rule out a retroactive remedy based on the other *Hislop* factors.

Reasonable or Good Faith Reliance on the Previous State of the Law

[64] The MOH argues that it reasonably relied on the existing law in determining that it could set the compensation of midwives through agreement with the AOM where possible, and by governmental policy decision where negotiations reached an impasse. This statement does not refer to the human rights law the MOH was relying on prior to the Interim Decision. The law before and after the Interim Decision is that compensation-setters are responsible for ensuring that their practices comply with the *Code*. In *Hislop*, the Supreme Court found that the government reasonably relied on the jurisprudence prior to *M. v. H*. There is no comparable shift in the law in this case. The MOH remains free to negotiate compensation with the AOM or set compensation unilaterally where they reach an impasse, so long as its actions comply with the *Code*.

[65] It was not the law in Ontario, prior to the Interim Decision, that compensation-setters could presume that gender is irrelevant to setting compensation for sex-segregated workers until such time as this Tribunal finds otherwise. To the extent that the MOH relied on the state of the law as established by the *Public Sector Compensation Restraint to Protect Public Services Act, 2010*, S.O. 2010 c.1, Sched. 24, that legislation contained a clear exemption for pay equity and human rights entitlements: See section 12 (3).

[66] I am not convinced by the arguments of the MOH that it relied in good faith or on a reasonable basis on principles of human rights law which have been altered in some way by the Interim Decision.

Fairness to Litigants

[67] In *Hislop*, the Court found that in seeking payment of arrears as far back as 1985, the claimants were overlooking the evolution in the jurisprudence of same-sex equality rights. This case is about the payment of compensation to midwives who deliver midwifery services. The Tribunal has found that the level of compensation paid to midwives was affected by gender discrimination. The Tribunal has not awarded more in retroactive compensation than was recommended by the compensation review in 2010. A purely prospective remedy would constitute a "hollow victory" and leave midwives without a remedy with respect to their compensation losses: See *Hislop* at para. 116.

Undue Interference with the Constitutional Role of the Legislature

[68] This case does not involve a challenge to legislation or a statutory public benefit scheme where complex public policy considerations go into determining eligibility and benefit levels. Accordingly, the concerns about the democratic role of governments in designing those schemes do not arise here. As I have indicated in the section on compensation for injury to dignity below, the general rule of qualified immunity does not apply to government in its role in setting compensation levels for workers. A retroactive remedy for lost income would not encroach on the legislative role of the government in the distribution of public resources.

Conclusions

[69] For those reasons, I find that *Hislop* does not apply, and assuming it does apply, I would not refuse to make a retroactive remedy based on the *Hislop* factors. I have concluded that the Tribunal should order retroactive compensation to midwives in accordance with the remedial principles developed under the *Code*.

Compensation for Injury to Dignity: The Decisions in *Abbey* and *Mackin* Do Not Apply

[70] The MOH argues that midwives should be precluded from receiving compensation for injury to dignity in accordance with the Tribunal's decision in *Abbey v. Ontario (Community and Social Services),* 2016 HRTO 787 ("*Abbey*"), application for judicial review dismissed, 2018 ONSC 1899 (Div. Ct.). The applicant in *Abbey* received benefits under a statutory public benefits scheme. The Tribunal found that the applicant was not eligible for compensation for injury to dignity because the policy directives she was challenging were derived from the legislative authority of the Director of the Ontario Disability Support Program ("ODSP") to determine eligibility and generally administer the provisions of the ODSP Act and Regulations.

[71] In *Abbey*, the Tribunal applied the decision in *Mackin v. New Brunswick (Minister of Finance)*, 2002 SCC 13 ("*Mackin*"), where the Court applied a general rule of public law to find that unless the government's conduct is clearly wrong, in bad faith or an abuse of power, courts will not award damages for the harm suffered as a result of the mere enactment or application of a law that is subsequently declared to be unconstitutional.

[72] The MOH argues that the situation before me is analogous to *Abbey.* The MOH argues that it was discharging a public duty and administered the OMP in good faith as a province-wide, publicly funded primary health care program for the benefit of Ontario residents seeking midwifery care. The budgetary and health priority planning decisions it made were exercises in public policy-making and in the allocation of scarce public resources among the many health care needs of the residents of Ontario. The MOH argues that it should not now be liable for compensation for injury to dignity, for the decisions it took in the public interest, even if such decisions are subsequently found to be discriminatory.

[73] I disagree with the MOH that qualified public law immunity applies in this case. There is no challenge to legislation, regulations or policies derived from legislation as was the case in *Abbey*. The AOM is not challenging the funding of the OMP in general, only

the level of compensation paid to midwives. I recognize the mixed public policy and employment context that is represented by this claim. The *Mackin* rule applies only to protect government from claims for compensation for harm flowing from legislative choices made in the good faith exercise of legislative authority and policies derived from legislation.

Only Parties Are Entitled to Compensation

[74] Although the reasoning is complicated, on a plain reading of the *Code*, midwives must establish that they are parties to the Application in order to qualify for compensation. The AOM is not a party to the Application. Only those midwives who gave their consent to the AOM to file on their behalf *and* were eligible to file their own application, are parties for the purpose of an award of compensation.

[75] It is clear from the language of section 45.2(1) that the Tribunal's powers to award compensation flow from determining that a party to the application has infringed a right of another party. The MOH is a party and an infringement has been found. The Tribunal may then direct the MOH to pay monetary compensation "*to the party whose right was infringed"*.

[76] This Application was commenced under section 34(5) which permits the AOM to file on behalf of another person:

> 34(5) A person or organization, other than the Commission, may apply on behalf of another person to the Tribunal for an order under section 45.2 if the other person,
>
> (a) would have been entitled to bring an application under subsection (1); and
>
> (b) consents to the application.

[77] The parties to an application under section 34(5) are the MOH and "the person on behalf of whom the application is made", namely, the midwives who signed consent forms. Section 34(5) does not create any substantive rights under the *Code.* It simply

permits another person or organization to bring an application on behalf of a person who would otherwise be entitled to bring the application themselves.

[78] Section 34(1), which is referenced in section 34(5), defines when a person may apply to the Tribunal for an order under the Tribunal's remedial powers in section 45.2. A person becomes eligible to file an application under section 34(1) if they meet the criteria set out in that section, or the Tribunal exercises its discretion to permit the person to file under section 34(1) where they meet the test for late applications in section 34(2):

> Application by person
>
> 34 (1) If a person believes that any of his or her rights under Part I have been infringed, the person may apply to the Tribunal for an order under section 45.2,
>
> (a) within one year after the incident to which the application relates; or
>
> (b) if there was a series of incidents, within one year after the last incident in the series.
>
> Late applications
>
> (2) A person may apply under subsection (1) after the expiry of the time limit under that subsection if the Tribunal is satisfied that the delay was incurred in good faith and no substantial prejudice will result to any person affected by the delay.

[79] Each individual midwife who has signed a consent form in this proceeding must be able to demonstrate that the Application was filed within one year of the last incident of discrimination she is alleged to have experienced. Failing that, a midwife would have to satisfy the Tribunal that the delay in filing was incurred in good faith and that no substantial prejudice will result to any person affected by the delay.

[80] The issue of the timeliness of the Application was dealt with by the Tribunal earlier in the proceeding. In a "bottom line" Decision, 2014 HRTO 1214, dated August 14, 2014, the Tribunal held that:

> I do not find that the Application as pleaded is untimely, and will not dismiss allegations which relate to events prior to November 27, 2012. In my view

> the events set out in the Application constitute a "series of incidents" within the meaning of subsection 34(1)(b) of the *Code*. This finding however, in no way limits any other arguments the respondent may seek to raise regarding the appropriate remedy that should be awarded if a violation of the *Code* is established by the applicant.

[81] The reasons for that Decision were then set out in Interim Decision, 2014 HRTO 1370, dated September 17, 2014. The Decision acknowledges that the Application was filed on behalf of registered midwives who were currently practising or *had previously practised* in Ontario. The Decision also cites the respondent's request that the Tribunal dismiss the Application as it related to midwives who ceased practising prior to November 27, 2012 (one year before the Application was filed).

[82] The Tribunal found that the entire Application was timely based on a series of incidents. The Tribunal also clarified the scope of that finding in the September 17, 2014 Interim Decision at paras. 56 and 57:

> 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.

[83] The Tribunal refused to dismiss any part of the claim for lack of timeliness to ensure a complete and proper analysis of the merits of the systemic, gender-based discrimination claims which were central to the Application. The Tribunal drew to the attention of the parties the possibility that even if the AOM was successful, not every midwife would be eligible for a remedy and deferred that question to a later stage in the proceeding.

[84] The MOH has requested that the Tribunal now address the question whether individual midwives are parties for the purpose of receiving an award of compensation. On my reading of the 2014 Interim Decision, I agree with the MOH that the Tribunal deferred questions of entitlement to compensation to a later stage in the proceeding.

[85] Clearly midwives who were practising within the year prior to November 27, 2013 and signed a consent form will be eligible for compensation for lost income and injury to dignity. I define “practising” as rendering services as a midwife and billing the MOH for those services or otherwise engaged in work, on behalf of their practice groups or the OMP generally, or midwives who would be practising but for a *Code*-related leave during that period. Midwives who left practice prior to November 27, 2012 would not meet the definition of a party and would not be eligible for compensation.

[86] The AOM directed me to its submission of June 10, 2014 which was before the member who decided the timeliness issue. In that submission, the AOM argued that midwives are compensated after they have provided the entire course of care which means that midwives who received compensation after that date have a timely claim. The AOM further argued that midwives who retired prior to November 27, 2012 continued to receive unequal retirement payments after that date, and that midwives who left but did not retire had unequal RRSP entitlements and were subject to an ongoing offer of employment on discriminatory terms even if they did not accept employment under the contract in force after November 27, 2012. The AOM also argued that midwives who ceased practice still suffered injury to dignity as a result of the systemic nature of the discrimination they suffered for years.

[87] The Tribunal has repeatedly held that experiencing the ongoing effects of an alleged infringement of the *Code* does not constitute a series of incidents. That is how I would describe the circumstances of those midwives who left practice prior to November 27, 2012 and were drawing on retirement funds, making RRSP deposits, billing for services which were rendered prior to that date and experiencing the effects of injury to dignity.

[88] The AOM argues in the alternative that midwives who ceased practice prior to November 27, 2012 can establish a good faith explanation for the delay and that there is no evidence of substantial prejudice to the MOH. The AOM argues that these midwives had been represented by the AOM and that the AOM pursued several avenues on their behalf, in good faith, to request that the MOH change its compensation practices. The AOM argues that this is consistent with sound public policy that encourages the settling of disputes internally, before pursuing litigation. The AOM also argues that it pursued internal recourse without ever asserting that it was giving up its *Code*-related claims on behalf of midwives.

[89] The Tribunal has consistently held that the pursuit of alternate redress for an alleged *Code* infringement, including internal processes and negotiations of the kind engaged in by the AOM with the MOH, does not stop the limitation period running under section 34(1). The Tribunal has also repeatedly held that to prove good faith, an applicant must demonstrate more than an absence of bad faith. The AOM considered, and then explicitly rejected, the filing of an application in August 2011. I find that the AOM cannot establish a good faith basis for the delay, having decided to forgo an application in favour of other possible avenues of redress.

[90] Given this finding, it is not necessary for me to consider the issue of substantial prejudice.

[91] Accordingly, midwives who were practising within the year prior to November 27, 2013 and signed a consent form will be eligible for compensation for lost income and injury to dignity. Practising is defined as rendering services as a midwife and billing the MOH for those services or otherwise engaged in work, on behalf of their practice groups or the OMP generally, or midwives who would be practising but for a *Code*-related leave during that period. Midwives who left practice prior to November 27, 2012, including those who billed the MOH for services completed prior to this date, would not meet the definition of a party and would not be eligible for compensation. The same principles apply to the award for compensation for injury to dignity.

Consent Forms

[92] Following the oral argument, the parties advised the Tribunal that they reached an agreement that individual midwives could file s. 34(5)(b) consent forms in this Application until August 8, 2019. After that date, the parties agreed that no further s. 34(5)(b) consents would be filed in this proceeding.

[93] Having concluded that individual midwives who meet the requirements set out above are entitled to retroactive compensation and compensation for injury to dignity, I now turn to the analysis of the quantum of those awards.

STATUTORY AUTHORITY AND REMEDIAL PRINCIPLES

Statutory Authority

[94] Section 45.2 of the *Code* states:

> Orders of the Tribunal: applications under s. 34
>
> (1) On an application under section 34, the Tribunal may make one or more of the following orders if the Tribunal determines that a party to the application has infringed a right under Part I of another party to the application:
>
> 1. An order directing the party who infringed the right to pay monetary compensation to the party whose right was infringed for loss arising out of the infringement, including compensation for injury to dignity, feelings and self-respect.
>
> 2. An order directing the party who infringed the right to make restitution to the party whose right was infringed, other than through monetary compensation, for loss arising out of the infringement, including restitution for injury to dignity, feelings and self-respect.
>
> 3. An order directing any party to the application to do anything that, in the opinion of the Tribunal, the party ought to do to promote compliance with this Act.
>
> Orders under par. 3 of subs. (1)
>
> (2) For greater certainty, an order under paragraph 3 of subsection (1),

(a) may direct a person to do anything with respect to future practices; and

(b) may be made even if no order under that paragraph was requested.

General Interpretive and Remedial Principles

[95] The interpretive principles set out in the Interim Decision beginning at para. 226 apply with equal force to determining a remedy for discrimination under the *Code*. The *Code* provides the Tribunal with broad remedial discretion to order remedies that are fair, effective and responsive to the circumstances of this case. The AOM makes the point, with which I agree, that redress for systemic discrimination requires systemic remedies. I agree with the AOM that the remedy should include orders which address the flaws and assumptions in the compensation practices of the MOH.

[96] The *Code* is remedial and not punitive. Orders of the Tribunal should provide individuals who have been discriminated against with access to fair and effective remedies tailored to the facts of the case in order to achieve this remedial purpose. See *Heintz v. Christian Horizons*, 2008 HRTO 22. In crafting an appropriate remedy, the Tribunal has often considered what will make the victim of discrimination "whole" or put them back, to the extent possible, in the position they would have been in but for the discrimination.

[97] There is no question that assessing the quantum of damages in this case has been difficult and time-consuming. However, in *Walden v. Canada (Social Development),* 2010 FC 1135*,* ("*Walden FC*") the Federal Court found that difficulty in assessing the quantum of damages is an insufficient reason to deny a remedy to complainants who have experienced discrimination. The Federal Court stated that the Tribunal: "has the duty to assess the lost income or wage loss on the material before it or refer the issue back to the parties to prepare better evidence on what the wage loss would have been but for the discriminatory practice". *(Walden FC,* at para. *67)*

[98] As the Supreme Court stated in *Moore v. British Columbia (Education),* 2012 SCC 61, the remedy must flow from the claim. In that case, the claim was made on behalf of

an individual who relied in part on evidence of a systemic nature to prove the individual claim. The Court found that the Tribunal had gone too far in ordering a range of systemic remedies and reinforced the importance of maintaining a focus on the individual nature of the complaint.

[99] This Application, by contrast, was brought on behalf of individuals but framed as a case of systemic discrimination. However, the remedy must still flow from the facts and the findings of discrimination. The losses experienced by individual midwives were not caused by the failure of the MOH to pay midwives an amount equivalent to what their *Pay Equity Act* entitlements might be if they had been employees since 1993 or the amount they might have been entitled to if the parties had agreed to the methodology set out in the Durber report. In the Interim Decision the Tribunal found that the losses arising from the discrimination were caused by a systemic failure on the part of the MOH to maintain its commitment to the benchmarks established in 1993 and maintained through the 2005 agreement.

Relevance of Statutory Pay Equity Decisions

[100] As the Tribunal stated in the Interim Decision, the provisions of the *Pay Equity Act* are not directly applicable to this Application. The MOH has also emphasized this point in describing how this case can be distinguished from the decisions of the Supreme Court in *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux,* 2018 SCC 17 *("Alliance")*, about the impact of amendments to pay equity legislation in Quebec, and *Centrale des syndicats du Québec v. Quebec (Attorney General),* 2018 SCC 18, ("*CSQ*"), about the impact of the lack of methodology for assessing statutory pay equity adjustments for employees in workplaces with predominantly male comparators. The AOM also cites *Ontario Nurses' Association v. Participating Nursing Homes*, 2019 ONSC 2168 with respect to this principle.

[101] There is clearly important guidance available in the long line of jurisprudence that has developed since the 1980's which establishes that women in female-dominated job classes face pervasive sex-discrimination with respect to their compensation. Those

cases, along with the *Pay Equity Act* in Ontario, also provide guidance on the proactive actions that are required on the part of employers to prevent and remedy sex-based pay inequity, including the maintenance of a male comparator or proxy. In *CSQ* the Supreme Court noted that: "women in workplaces without male comparators may suffer more acutely from the effects of pay inequity precisely because of the absence of men in their workplaces." (*CSQ* at para. 29).

[102] The MOH denies, contrary to the evidence of the history of this matter, that midwives ever had a male comparator, which has been disadvantageous to midwives in their negotiations with the MOH. Because of the circumstances of this case, I have directed the MOH to reinstate the benchmarks, including an appropriate physician comparator, to address the need for ongoing comparison with male work or proxies for male work in future compensation studies.

[103] The AOM also relies on statutory pay equity decisions for the argument that where pay discrimination has been identified, it must be remedied from the date the wage gap emerged through retroactive compensation. The AOM cites the Supreme Court of Canada decision in *Alliance* at para. 8 which stated: "Leaving wage inequities in place makes women 'the economy's ordained shock absorbers'". The AOM argues that if the Tribunal identifies pay inequity, midwives must be fully compensated otherwise this would give the MOH amnesty from their human rights obligations. See *Alliance* at paras. 36 – 37.

[104] It is also important to acknowledge that this statement was made by the Court in the context of a wage gap which was identified based on statutory requirements. In other words, once there is clear entitlement to a specific dollar amount, the complainant should receive full compensation. As is clear from the evidence in this case, there are several methods by which the MOH might have achieved compensation free of gender discrimination. In this case, I have identified the appropriate remedy for the wage gap based on the findings and recommendations of Courtyard.

[105] As the Tribunal stated in the Interim Decision at para. 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”. Recognizing the overlap between statutory pay equity and human rights principles, the remedial principles which have developed under the *Code* provide me with the necessary foundation to deliver a remedy that is appropriate in all the circumstances and addresses the systemic nature of the gender discrimination at issue in this case.

COMPENSATION

[106] In this section I address monetary compensation including retroactive compensation for lost income, compensation for injury to dignity, interest and the timing of the payments.

Reinstatement of the Benchmarks and Retroactive Compensation

Request by the AOM

[107] The AOM is seeking the following remedies related to compensation for lost income:

a. a compensation adjustment as of 2013 and retroactive compensation back to 2005, based on the Durber report, or an alternative assessment by the Tribunal;

b. the adjusted rate to continue subject to agreements the parties make through their negotiations; and

c. that the adjustments be made within four months from the date of the remedial decisions.

[108] The AOM requested an accounting process which would include the MOH locating and paying all midwives regardless of their status in this proceeding. This will not be necessary given the determination that only parties are entitled to compensation and the

parties to this proceeding have signed consents and are therefore known to the AOM and the MOH.

[109] I have ordered the MOH to implement the Courtyard recommendation, calculate the necessary adjustments flowing from the new adjusted rate as of April 1, 2011, and make the payments of retroactive compensation for lost income within six months of the date of this Decision. To the extent that there is a dispute between the records of a midwife and the records of the MOH, I have ordered that the parties resolve this dispute by engaging a third-party facilitator or working within an existing committee. Given that this is primarily a mathematical calculation, the parties should have no difficulty agreeing on an unbiased third party.

Reasons

[110] In addition to the general principles which inform remedial awards under the *Code*, there are principles which are specific to awards of compensation. It is well-established in human rights cases that the purpose of compensation for lost income is to restore an applicant, as far as it is reasonably possible, to the position they would have been in but for the discrimination. An award for lost wages extends over such period as is required to remedy the loss (*Piazza v. Airport Taxicab (Malton) Assn (1989)*, 1989 CanLII 4071 (ON CA).

[111] In *Fair v. Hamilton-Wentworth District School Board*, 2013 HRTO 440, upheld by 2016 ONCA 421 ("*Fair*"), the Tribunal applied this principle to award lost income for almost a ten-year period from the time the applicant's employment was terminated until she was reinstated. The Tribunal referenced the decision in *McKee v. Hayes-Dana Inc*., (1992) 12 CHRR D/79 (Ont. Bd. Inq.) in which the Board ordered lost wages and benefits for a period of eight years. In *Garrie v. Janus Joan Inc*., 2014 HRTO 272, ("*Garrie")*, the Tribunal ordered lost wages for a period of ten years. While awards of lost wages going back this far are not common, the issue in each case is how to restore the applicant to the place they would have been but for the discrimination.

[112] It is important to acknowledge that any assessment of lost income, even based on the best available evidence, will nevertheless be an estimate. The *Code* does not prescribe a process for establishing a specific level of compensation in a case such as this. Regardless of what level of precision is applied to calculating lost income, the first principle is that the benchmarks must be reset to recognize the systemic nature of the discrimination in the compensation practices of the MOH.

Choosing the Best Remedy Based on the Available Evidence

[113] In the Interim Decision, the Tribunal noted that the experts who testified in this proceeding provided valuable guidance on how the MOH could reform its compensation practices to address compensation issues for midwives and other sex-segregated workers. The focus in this Decision is on the evidence that will assist in determining the appropriate remedies that the Tribunal should order, which is different from the breadth of information and advice that a consultant would consider in taking on a role in reforming the compensation practices of the MOH.

[114] Despite the number of expert and non-expert witnesses, there is no compensation study which accounts for the many questions that have been generated throughout this proceeding about how midwives should be compensated. In *Walden et al. v. Canada (Social Development)*, 2008 CHRT 21 ("*Walden CHRT*"), the Canadian Human Rights Tribunal faced a similar situation. The Tribunal made a finding of liability, and then permitted further remedial evidence in a case involving nurses and doctors working as employees in the Canada Pension Plan program. In the liability decision, the Tribunal found discrimination based on the differences in how nurses and doctors were classified and compensated for doing substantially the same work. Doctors, the majority of whom were male, were classified with other doctors as medical advisors and paid accordingly. Nurses, the majority of whom were female, were classified, not with other nurses, but within an administrative services group which determined the level of compensation and benefits to which they were entitled. The Tribunal permitted additional evidence and indicated that it would need the assistance of a job evaluation expert to effectively

compare doctors and nurses before determining how to remedy the classification and compensation issues.

[115] In this case, the utility of a compensation study, with the safeguards inherent in a joint process, designed to address both the Tribunal's findings and the myriad issues raised by the parties about relevant comparators and compensation methodologies, was suggested to the parties at various points in the process. Both parties have urged the Tribunal to determine remedy on the evidence that was led at the hearing rather than present further evidence from a compensation expert to inform the remedial award. As an alternative, the AOM suggested a framework for an expedited compensation study which was considered but not imposed on the parties. An imposed joint study would not achieve the same benefits as a study entered into voluntarily by the parties working collaboratively toward the shared goal of establishing a credible methodology and findings.

[116] Both parties put facts and arguments to this Tribunal which were not put to the compensation experts when they produced the Morton, Hay and Courtyard reports. The MOH, for example, criticized Courtyard for not considering excess operational funds as income when that issue was never raised by the steering committee and those funds have never been treated by the parties as part of the income of midwives or in comparisons with CHC employees. In fact, this issue was never raised with Morton, Hay or Courtyard. The AOM argued that these funds accrue only to partners and are used to stabilize practices and cover unexpected expenses such as leaves of absence. I have considered the relationship between excess operational funds and the remedial award and determined that the issue should be left to the parties to address either through their negotiations on operational expenses or in future compensation studies.

[117] The AOM also criticized Courtyard for failing to apply a gender-based analysis that the AOM never raised before or after the study was completed. Courtyard validated the ongoing relevance of CHC physicians as comparators and therefore implicitly maintained the link to gender.

[118] During the merits hearing, the MOH called witnesses to explain the various increases given to physicians to address issues like recruitment and retention, or the disparity between the lowest paid, female-dominated CHC physicians and their counterparts working in other models. Some of these strategies turned out to be ineffective in addressing the problems they were intended to resolve. While the MOH explained the reasons for physician increases, it did not explain how it maintained the benchmarks in its negotiations with midwives, while it was increasing compensation paid to physicians.

[119] The MOH did not call an expert to validate how its seemingly reasonable explanations would be weighted in a compensation study comparing midwives and CHC physicians. MOH experts also agreed that a compensation study would be useful in the circumstances of this case. In a context where midwives have had their compensation set by comparison to CHC physicians, especially where that comparator is linked to the sex-segregated nature of their work, the MOH can only partly defend what it pays to midwives by explaining why it gave increases to CHC physicians. An expert would weigh those explanations and the impact of those decisions on the alignment between midwives and CHC physicians and validate, one way or the other, whether midwives remained appropriately paid despite increases paid to CHC physicians.

[120] It is the role of a compensation expert, not the Tribunal, to evaluate how differences in SERW, recruitment and retention, bargaining strength, and more specific factors like the retention of excess operational funds, benefits, grants, and the funding of liability insurance, should be incorporated into determining a specific compensation level for midwives. I am satisfied that the MOH has had ample opportunity to conduct a study of midwives' work and pay, either to inform its own practices or for the purpose of determining this remedial award. As a result, I have relied on Courtyard and not made any deduction from the recommendation for a 20% adjustment, to account for the explanations of the MOH as to why increases were made to compensation for CHC physicians in the period between the 2005 agreement and the Courtyard review in 2010.

Courtyard is the Best Evidence

[121] Courtyard is the second of two non-binding joint compensation studies undertaken by the parties, presumably in good faith, in order to develop the objective criteria necessary to evaluate the fairness of compensation paid to midwives. The Morton study led the parties a historic agreement which launched midwives into the formal health care system at pay levels which were objectively rational, fair, and appropriate.

[122] Courtyard illustrates how midwives gradually shifted out of alignment with their comparators after the 2005 agreement was achieved. Courtyard represents the best evidence of both the consequences of losing the benchmarks, and what compensation losses flow from reinstating them. While Courtyard recommended an "equity" adjustment of 20% for midwives at each of the six levels as of April 1, 2011, it is equally important that Courtyard reinstated the methodology of aligning midwives between their comparators and recommended regular negotiations going forward on that basis.

[123] The Interim Decision addresses the Courtyard report in detail. To summarize, the implementation of the Courtyard report represents the best remedy in this case for several specific reasons.

a) The Joint Nature of the Study

[124] The study proceeded with the full cooperation of the parties and an active steering group made up of equal numbers of representatives for the MOH and the AOM. As noted above, the President of the AOM and the Manager of the OMP participated as members of the steering group. Mr. Ronson, the lead consultant on Courtyard, testified in detail about the important role of the steering committee in developing the evaluation questions and framework for the study. He was also clear that as he was serving two clients and that it was critically important that the clients "had their fingerprints" on the study as early as possible in the process.

[125] Mr. Ronson described the steering group as responsive, constructive, and able to resolve any disagreements that arose through the course of the review. While the

recommendation for a 20% increase was a matter of informed judgment, it arose from the full participation of the parties in developing the framework for that recommendation. The Morton methodology was similarly a matter of "informed judgment", based on careful research and a collaborative joint process.

b) Courtyard Accounted for All of the Funding Midwives Receive

[126] Courtyard considered the full range of funding mechanisms for midwives and midwifery practices. The steering committee and the consultants made an appropriate distinction between what midwives earn and the portion of their fees which is allocated to midwifery practices for overhead expenses. This is consistent with the previous compensation studies and the history of the parties' negotiations, in attempting to achieve what Mr. Ronson called an "apples to apples" comparison between midwives and their comparators working in employment models. This includes adopting a formula for what would constitute a full-time work load for a midwife as compared to a CHC employee. In the end, Courtyard recommended a 20% adjustment to the four components of the fees that midwives earn for their services, the maintenance of benefits at current levels, and no further increases to other funding mechanisms.

c) Courtyard Incorporated Morton and Hay 2004

[127] Courtyard clearly incorporated the Morton and Hay reports and the long-standing principles which informed the parties negotiations since 1993. As the Tribunal stated at para. 192 of the Interim Decision, one of Courtyard's key findings was that the compensation principles established in the Morton report "…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".

[128] The report validates the comparison with nurse practitioners and repeats the methodology of finding an equitable relative positioning between midwives and their comparators. It also considers the ongoing role of obstetricians in low-risk maternity care, consistent with Morton. As a result, Courtyard represents the best evidence of what the

alignment would be between midwives and their comparators based on the continuation of the previous methodologies, negotiated through a joint compensation process. It also resets compensation at the appropriate level *before* the application of compensation restraint.

d) The Jurisdictional Comparisons

[129] Courtyard includes a jurisdictional scan which revealed only two provinces where midwives work in comparable models. At the time of the review, Alberta had 65 midwives while British Columbia had 145 compared to 480 midwives working in Ontario. The relevance of a jurisdictional scan will change over time with the maturity of midwifery models in other parts of Canada. In 2010, Courtyard placed the appropriate emphasis on comparing midwives to other primary health care providers in the same economic market, as compared to other jurisdictions, a principle the parties also agreed on in 1993.

d) The History of Midwifery in Ontario

[130] The AOM provided both the steering group and the Courtyard consultants with a thorough review of the history of midwifery in Ontario which is critical to understanding how midwives came to be compared with CHC senior nurses and physicians. This history played an important role in Courtyard's findings.

e) The Promotion of Courtyard as a Pay Equity Adjustment

[131] Although the review was non-binding on both parties, when the report was complete, the AOM did not argue that the adjustment should have been higher, or that Mr. Ronson had failed to properly evaluate how midwives compared with CHC nurse practitioners and physicians. While this is not determinative, I cannot ignore that the AOM vigorously and publicly stated that the MOH should adopt Courtyard as a pay equity adjustment. More than two years prior to the filing of this Application, the AOM explicitly chose to take measures other than file an application to convince the MOH to implement Courtyard.

f) The Timing of the Report

[132] And finally, the timing of Courtyard is important. It was conducted after the MOH had a given a series of increases to physicians, aligned CHC physicians with their comparators in other models and consolidated some incentives into their base compensation. While an argument can be made that midwives were not entitled to incentives for medical services they did not provide, that argument evaporated when the incentives were consolidated into the base compensation of physicians, regardless of whether they provided those services. Courtyard was also conducted just three years prior to the filing of this Application which makes it more contemporaneous than other reports with the events leading to the impasse in the parties' negotiations.

No Reduction for the Perceived Deficiencies in the Courtyard Report

[133] I do not agree that the perceived deficiencies raised by the MOH render the Courtyard report unreliable for my purposes. The parties have expressed a need for clarity and finality in the calculation of lost wages, and they were given an opportunity to provide additional evidence or commission other studies or negotiate a remedy between them. In my view, implementing Courtyard will give the parties a clear basis for expeditiously calculating the award and bringing finality to this dispute.

[134] Contrary to the objections of the MOH, Courtyard did consider all the elements which go into funding individual midwives and midwifery practices, including benefits, malpractice insurance, and the various grants, supplements and reimbursements they receive to pay their expenses. Courtyard then correctly concluded that some of those funding elements would need to be "backed out", as Mr. Ronson put it, in order to arrive at an accurate comparison with other health care practitioners working in models who also receive benefits and have their expenses covered by their employer.

[135] The comparators used in the report were based on the findings from previous reports as well as conversations with the stakeholders interviewed throughout the project. It is not accurate to say that Courtyard improperly relied on nurse practitioners as a comparator. At the time of the Morton report nurse practitioners had not achieved

regulation. The principle the parties adopted at the time was that midwives should be compared to senior nurses working in CHC's. The Hay Report of 2004 validated that nurse practitioners, the most senior nurses working in CHC's at that time, were the appropriate nurse comparator.

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

[137] Most of the concerns raised by the MOH relate to the jurisdictional comparisons. The comparisons were limited in any event by the different practice models in other provinces and the small number of midwives practicing in those models as compared to Ontario. The primary comparators the parties agreed on for the Courtyard study were CHC physicians and nurse practitioners.

[138] Mr. Ronson acknowledged that he did not add in 20% benefits for Ontario midwives or "back out" 20% for Alberta midwives in his calculations. He testified on re-examination that this issue had no impact on his overall recommendation for a 20% adjustment. Even adding in the 20% benefit, some midwives in Ontario would still be earning less than Alberta midwives. Only at the highest level would Ontario midwives exceed Alberta midwives.

[139] Mr. Ronson was also cross-examined on the fact that Alberta and BC midwives are responsible for a $1000.00 to $2000.00 co-payment for their insurance coverage. Mr.

Ronson conceded that he should have taken the co-payment into account in comparisons with Alberta and BC but again, this is relevant only to comparison with a small number of midwives in other jurisdictions and it constitutes a differential of $1000.00 or $2,000.00. Courtyard accounted for liability insurance for midwives and their comparators.

[140] As I indicated earlier, Courtyard was criticized by the MOH during the merits hearing for failing to account for excess operational funds. This issue was never raised with Mr. Ronson who "backed out" operational expenses from the total course of care fee in order to make an appropriate comparison with CHC employees who have their operational expenses covered by their employer. The steering committee was fully aware of this and had ample opportunity to raise this if it was a concern.

[141] The Courtyard review was an iterative process and the MOH had every opportunity to participate through the steering committee and review of draft reports. Mr. Ronson testified that he responded to the points raised by the MOH after its review of the draft report and that the input of the MOH made the report stronger. He was asked, for example, whether he had considered the educational differences between the professions and the length of training required. Mr. Ronson responded that he had taken that into account, and that he was struck by the significance of the clinical training midwives received. Mr. Ronson testified that the comments of the MOH did not change the overall recommendations. I am not prepared to speculate about the impact of the perceived deficiencies in the report which were never put to Courtyard by the steering group or repaired by the MOH when it had the opportunity to do so.

No Reduction for the Explanations of the MOH or a Failure to Mitigate

[142] As I indicated previously, I have made no deduction to the Courtyard recommendation to account for the position of the MOH that midwives and physicians are paid differently because of occupational differences. No one disputes that midwives and physicians are different. What is disputed is the value the MOH attaches to those differences for compensation purposes.

[143] I have also determined that it is not possible to speculate on the agreement the AOM and the MOH might have reached, especially what midwives would have been prepared to settle for, if MOH had interpreted Courtyard through the lens of its obligations under the *Code*. There is no duty to mitigate losses in an ongoing employment or contractual relationship by accepting an offer during contract negotiations that is less than the receiving party feels entitled too. The cases cited by the MOH on the duty to mitigate involved terminations or resignations.

No Reduction for Compensation Restraint

[144] After Courtyard, CHC physicians had their compensation reduced because of compensation restraint. I do not consider it necessary to do the same for midwives for that period. Midwives received no increases when the 2008 contract was extended on March 31, 2011, and therefore, have already done their part for compensation restraint.

No Adjustment Prior to April 1, 2011

[145] Although the loss of the benchmarks evolved over time after the parties reached an agreement in 2005, I have not ordered compensation back to the commencement of the 2005 or 2008 agreements. There was no finding of discrimination in relation to the 2005 agreement and no evidence that the AOM viewed the 2005 agreement as discriminatory. Between 2005 and 2008 the MOH was making compensation decisions with respect to CHC physician and nurse practitioners which the AOM raised in the negotiations leading to the 2008 agreement. I am satisfied that the best evidence of the income loss experienced by midwives resulting from this period is the analysis done by Courtyard. The Courtyard report, and the charts provided by the AOM during the May 2019 oral submissions, demonstrate that there was a significant change in the base salary of CHC physicians in 2010. In addition, the only condition placed on the 2008 agreement was that the parties would engage in a joint compensation study to inform the next round of negotiations. Courtyard was completed but did not inform the negotiations as the MOH had committed to in the 2008 agreement. The implementation of the report will also remedy that issue.

[146] Given this decision that the evidence does not support an adjustment prior to April 1, 2011, I have not found it necessary to address the comments by the Tribunal in the 2014 Interim Decision about the possible application of the doctrines of estoppel and laches.

The Durber report

[147] Until the Application was filed, the AOM endorsed the implementation of Courtyard as a pay equity adjustment. The AOM now argues that the Durber report represents the best evidence for establishing a new level of compensation for midwives as of 2013, and retroactive compensation back to 2005.

[148] The introduction of the Durber report, which applies the New Zealand methodology, has been a contentious issue in this Application. Midwives are not employees and the compensation practices of the MOH are not governed by the *Pay Equity Act* in Ontario. There was no legal basis, prior to this matter being determined by the Tribunal, to impose a pay equity job evaluation model as part of the parties' negotiations. The parties agreed in 1993 on their own benchmarks, some of which overlap with pay equity and job evaluation principles. Their negotiations have been informed, rather than determined, by these benchmarks. The findings in the Interim Decision were based on the extent to which the MOH had lost touch with the benchmarks and not a failure to apply a specific pay equity methodology throughout the history of the parties' negotiations.

[149] The AOM argues that the Durber report is the cornerstone of assessing compensation in this case because of the gender-based analysis and pay equity principles it applies. However, the Durber report was not part of the factual history leading up to the filing of the Application and it does not reflect the findings of the Tribunal in the Interim Decision. The Tribunal did not find that it was discriminatory for the parties to have settled contracts from 1993 to 2005 based on their own compensation benchmarks. The recommendations in the Durber report are expressed in terms of the proportional

relationship with CHC physicians, not relative positioning between the two primary comparators.

[150] The proportional relationship identified by Durber for 2013 would translate into a pay equity adjustment to midwives' compensation of 91% of the maximum rate of CHC physicians. While this is consistent with the standard of adjusting the job rate in pay equity cases, and may become the standard under a new compensation study, it is not consistent with the facts of this case, the previous compensation studies and the agreements of the parties that the highest paid midwife would be positioned below the lowest paid CHC physician.

[151] The Durber report also concludes that midwives should have received compensation increases based on changes in their SERW during long periods of time when their comparators were not receiving increases at all. The Tribunal did not find that it was discriminatory to fail to provide increases to midwives during these periods of compensation restraint.

[152] The parties' negotiations were informed, not determined by compensation experts. The Durber report does not account for the various benefits that midwives derive from being independent contractors in a controlled market where demand constantly outstrips supply. I also cannot rely on the report from 2005 forward, without accounting for the fact that the recommendations beginning in 2005 build on the analysis which started in 1993.

[153] As the Tribunal in the Interim Decision, midwives are entitled to a remedy, but not one which would retroactively impose new legal requirements and a new compensation methodology onto the parties' past negotiations. The remedy must flow from the facts of the case, including the negotiations between the parties and the reports which informed, or in the case of Courtyard, ceased to inform, those negotiations up to 2013.

[154] This is not to suggest that pay equity job evaluation methodologies are irrelevant to how the parties should be evaluating compensation levels for midwives going forward. The parties have been directed to participate in joint, collaborative studies which are

gender-sensitive and incorporate pay equity principles among other compensation methodologies.

Other Possible Approaches

[155] The MOH did not make submissions on what the appropriate level of compensation should be. It does not support the implementation of Courtyard, but it also did not undertake a different study to validate its impressions of Courtyard.

[156] I have considered resetting the parties' benchmarks by way of several other methods, including: as they were under the 1993 or 2005 agreement; in accordance with the recommendation made by Hay Group in 2004; and, the alignment exercise conducted by the MOH to bring CHC physicians in line with physicians practising in other models. The AOM provided calculations based on the implementation of each of these methodologies back to 2005. Having considered those various methodologies, I have concluded that the recommendations from Courtyard provide the best evidence available for remedying the Tribunal's findings of discrimination. This also avoids the Tribunal setting an arbitrary rate for midwives' compensation levels as of 2013. The adjusted rate for 2013 will flow from the 2011 adjustment.

Conclusion

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

Compensation for Injury to Dignity, Feelings and Self-Respect

The AOM's Request

[158] The AOM is seeking the sum of $7,500.00 per year for each midwife calculated based on the number of years each midwife provided services from 2005. The AOM is seeking $15,000 per year where a midwife is not awarded retroactive compensation.

[159] The MOH argues that an award for compensation for injury to dignity of $5000.00 per midwife would be appropriate to recognize the harm done by the violation of the *Code*. The MOH argues that the quantum should be proportionate to the nature of the discrimination found. Given that a discriminatory termination of employment merits an award of $10,000.00 to $20,000.00, the MOH argues that an award of $5000.00 per midwife is enough to meet the purposes of the *Code* in these circumstances.

[160] As I indicated previously, only parties to the Application are eligible for compensation for injury to dignity.

Reasons

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

[162] The guiding principles governing an award of compensation for injury to dignity, were set out in this Tribunal's decision in *Arunachalam v. Best Buy Canada*, 2010 HRTO 1880. The Tribunal identified the objective seriousness of the conduct and the effect on the particular applicant as the primary elements for determining the appropriate level of compensation.

[163] The considerations identified in *Sanford v. Koop* 2005 HRTO 53 as being relevant to the applicant's experience in response to the discrimination include (at para. 34): the experience of humiliation, victimization and hurt feelings; loss of self-respect, dignity, self-

esteem, and confidence; the vulnerability of the applicant, and the seriousness, frequency, and duration of the offensive treatment. The Divisional Court in *ADGA Group Consultants Inc. v. Lane*, 2008 CanLII 39605 (ON SCDC) also has recognized the Tribunal's authority to award compensation for the loss of the right to be free from discrimination and the experience of victimization.

[164] It is also well-established that the Tribunal's remedial powers are not punitive in nature. See *McCreary v. 407994 Ontario*, 2010 HRTO 2369. The purpose of considering the objective seriousness of the respondent's conduct is not to impose a punitive sanction on the respondent, but rather to include it as a factor in determining the appropriate compensatory award to be made to an applicant.

[165] In *Newfoundland (Treasury Board) v. N.A.P.E.*, 2004 SCC 66 at para.49 ("*NAPE*") the Supreme Court of Canada commented on the important relationship between work and dignity. The AOM argues that these observations, that a person's employment is an essential component of his or her sense of identity, self-worth, and emotional well being, are particularly salient for midwives, many of whom testified about the strong correlation between their work and their identities.

[166] The Tribunal has routinely made awards of compensation for injury to dignity to individual applicants in the context of employment cases where allegations of sex discrimination have been upheld. Many of those cases involve allegations of sexual harassment and assault which have attracted awards of more than $40,000. Others involving terminations range from $10,000 to $20,000.

[167] In *Garrie*, the Tribunal found that an employer had paid a woman with a developmental disability, discriminatory wages of less than minimum wage over a period of ten years. The Tribunal awarded the applicant lost income as well as $25,000.00 in compensation for injury to dignity. The Tribunal found that the respondent's conduct amounted to an objectively serious violation of the *Code*. For more than ten years, the respondent paid the applicant less than other workers solely because of her disability. The Tribunal also found that the failure to pay the applicant her entitlement to at least

minimum wage, undermined her self-respect as a human being and caused her serious emotional difficulties. As a person with a developmental disability the applicant was vulnerable to being exploited and discriminated against by employers. While this case involved a finding of discrimination in compensation over a significant number of years, the applicant's circumstances are not analogous to what midwives have experienced in their compensation negotiations with the MOH.

[168] In *Garrie*, the Tribunal cited the decision of *C.S.W.U. Local 1611 v. SELI Canada and others (No.8)*, 2008 BCHRT 436. This was the only previously decided human rights case that involved an award of damages as a result of an employer's discriminatory pay scheme. In that case, the BCHRT found that the respondent's practice of bringing temporary foreign workers from Latin America and Europe to work on its projects in Canada, paying the Latin American workers lower wages and providing them with less favourable housing, meal, and expense arrangements than European workers, was discriminatory. The Tribunal in *Garrie* commented that the payment of $10,000.00 to each complainant was too low and would likely fall on the higher end of the spectrum of cases decided under the *Code*. Again, while I agree that with the Tribunal that $10,000.00 is too low in these circumstances, these facts are not analogous with the experience of midwives in their compensation negotiations with the MOH.

[169] There are no cases from this Tribunal which are comparable to this case, where hundreds of applicants have successfully proven allegations of gender discrimination in compensation levels over a period of several years.

[170] At the federal level, the Tribunal in another *Walden* decision (2009 CHRT 16), awarded $6000.00 in "pain and suffering" damages pursuant to section 53(2)(e) of the *Canadian Human Rights Act*, R.S.C. 1985, c. H-6, as amended, to each of the individual complainants who testified about the impact of their employer's long-standing, discriminatory classification and pay. The Tribunal's decision not to award damages to all complainants based on the testimony of the representative complainants was overturned by the Federal Court in *Canadian Human Rights Commission v. Canada (Attorney*

General), 2010 FC 1135. The Federal Court did not comment on the quantum of damages awarded by the Tribunal.

[171] The AOM called five representative applicants to testify in support of its request for damages for injury to dignity. The representative applicants came from a variety of backgrounds and their experiences as midwives varied based on the amount of time they had been practising, their involvement in the AOM, their family status and practice location. Four of the five representative applicants were partners in midwifery practice groups. One applicant had worked as an associate but had ceased practising as a midwife.

[172] They testified about, among other things: the strong connection between their identities and their work as midwives; the caring dilemma they experienced in deciding whether or not to leverage their services for the pay they felt they were entitled to; the harm to their dignity and self-respect that the MOH no longer acknowledged their connection with the work of physicians; their sense of embarrassment that they were working so hard with such onerous on-call responsibilities for so little money; the lack of respect they felt when they compared the steps the MOH was taking to ensure fair compensation for CHC physicians with the AOM's negotiations on behalf of midwives; and how their dignity was further undermined by the failure of the MOH to take their concerns about gender discrimination seriously and having to push a complaint forward to the Tribunal.

[173] In addition to the subjective experiences of the representative midwives, there is an objective seriousness associated with the failure of the MOH, over a prolonged period, to proactively monitor the compensation of midwives or investigate their concerns about inequity in their compensation. Their vulnerability is exacerbated by the fact that the MOH is their exclusive funder.

[174] The AOM's request for $7500.00 per year for every year since 2005 could amount to $105,000.00 for a midwife who has participated in the OMP since 2005. At a rate of $15,000.00 per year for those not awarded retroactive compensation for lost income, that

would amount to $210,000.00. I agree with the MOH, and the cases it has cited, that these amounts are far in excess of the amounts awarded in other cases of sex discrimination in relation to employment. I also agree with the MOH that if I were to award double the compensation for injury to dignity to midwives who were not eligible for retroactive compensation for lost income, that would amount to a disguised retroactive salary increase rather than compensation for injury to dignity.

[175] Midwives are not paid on an annual basis, and the evidence demonstrated that there is wide variability among midwives in the number of courses of care discharged each year. In addition, the length of time that a midwife has been subject to the compensation practices of the MOH is only one factor in determining the appropriate level of compensation. There is no principled basis for calculating their compensation for injury to dignity on an annual basis.

[176] There are some similarities between this case and the 2009 *Walden* decision. On the one hand, ten years have passed since that decision was made; on the other, the nurses in the 2009 *Walden* decision were found to be doing the same core work as the doctors in the CPP program without recognition of their professional status as nurses. Having considered the appropriate criteria, the range of awards given by the Tribunal in other cases and the testimony of the representative applicants, I find that $7500.00 per party is an appropriate award of compensation for the violation of the inherent right to be free from discrimination and for injury to dignity. In determining that amount, I have considered the substantial number of midwives who would be eligible for this award which does not in any way trivialize or diminish respect for the *Code* or effectively create a licence to discriminate.

Interest

[177] Midwives who are eligible for compensation, including compensation for injury to dignity, are entitled to interest on those sums calculated in accordance with sections 128 and 129 of the *Courts of Justice Act*, R.S.O. 1990, c. 43.

[178] Prejudgment interest will be paid up to the date of this Decision. The Application was commenced in November 2013, in the 4th quarter. Accordingly, the prejudgment interest rate of 1.3% applies.

[179] Postjudgment interest will be paid on any outstanding compensation after the expiry of the six-month implementation period. This Decision is being released in the first quarter of 2020. Accordingly, the postjudgment interest rate of 3% applies.

[180] Interest on compensation for lost income runs from the mid-point of the award which will vary for each eligible midwife.

Timing of the Payments

[181] Payment for compensation for lost income is to be made within six months of this Decision. Payment for compensation for injury to dignity is to be made within 90 days of this Decision.

REMEDIES TO PROMOTE COMPLIANCE WITH THE *CODE*

The Request of the Parties

[182] The AOM is seeking a broad range of remedies to promote compliance with the *Code,* several of which are well considered and grounded in the evidence and findings of the Tribunal.

[183] The MOH has argued in favour of certainty as to its obligations and pointed out that some of the prospective remedies sought by the AOM are generally worded and imprecise.

Reasons

[184] Pursuant to s. 45.2(1) 3 of the *Code*, the Tribunal has the power to make an order directing any party to do anything that, in the opinion of the Tribunal, the party ought to do to promote compliance with the *Code*. Pursuant to s. 45.2(2) of the *Code*, this power

extends to future practices and may be exercised even if no order under s. 45.2(1) 3 was requested. In *Giguere v. Popeye Restaurant,* 2008 HRTO 2, at para. 91, the Tribunal found that any order under this section "should be reflective of the facts in the case, should be remedial, not punitive and should focus on ensuring that the key objects of the *Code*, to eradicate discrimination and to ensure future compliance, are achieved in the particular circumstances".

[185] While individual compensation plays an important role in remedying the losses associated with discrimination, this is a case that requires systemic remedies to bring the compensation practices of the MOH with respect to midwives into alignment with its human rights obligations. The remedies must be tailored to the facts of the case. The orders should be clear and capable of enforcement, likely to be effective in promoting compliance with the *Code* and should not result in the Tribunal taking on the role of policy-maker or arbiter of the parties' ongoing disputes.

[186] Given the systemic nature of this case, and particularly the fact that the MOH denies the relevance of gender to setting compensation for midwives as an almost exclusively female profession, compliance remedies are required to reset the compensation negotiations between the parties. I am not bound by the AOM's requests, although, as I indicated in the Interim Decision, the entire list is worthy of consideration by the MOH as it reforms its compensation practices. However, some of those requests would take the Tribunal well beyond its role. I have chosen to impose compliance orders that are capable of precision and enforcement.

Joint and Regular Collaborative Compensation Studies

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

[188] Midwives have been disadvantaged by the failure of the MOH to recognize the role of gender in their compensation, the overlapping scope of practice they share with physicians and the reasons for maintaining a physician comparator. The requirement for a compensation expert with pay equity expertise arises in part from these findings in the Interim Decision. The loss of the benchmarks is attributable in part, to the long periods of time that the parties have gone without an updated joint compensation study.

[189] The parties are ordered to participate in a new joint study, which will cover the period from 2014 to 2020, and will serve as a baseline for reinstating the benchmarks. After the first compensation study is completed, it will be updated prior to each new round of negotiations. I have set out below, the minimum requirements for the study (and the updates), subject to the parties agreeing on an alternative approach:

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

b. The study will be conducted by a compensation expert, agreed upon by the parties, who is experienced in pay equity, pay equity job evaluation methodologies and gender-based analysis. The compensation expert is not restricted to applying any specific compensation methodology;

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

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

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

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

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

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

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

Adoption of a Gender-Based Analysis for Compensation Policies

[190] The AOM has requested that the Tribunal order the MOH to reform its compensation practices to address compensation for midwives and other sex-segregated workers. I agree that there a basis in the evidence for making this order with respect to midwives but not other sex-segregated workers.

[191] I did not hear evidence about the compensation practices of the MOH with respect to other sex-segregated workers. The evidence in this case established that the MOH did not recognize the relationship between gender and compensation paid to midwives or the necessity to consider the effects of its policies and practices on midwives as sex-segregated workers. I heard limited evidence about midwives working in other models, some of which were developed during the hearing of this matter and others which are currently in development. To the extent that there are other midwives working as independent contractors outside of the OMP, this order will extend to the compensation practices of the MOH with respect to those midwives. I see no principled reason for excluding them given the broad remedial powers of the Tribunal and the relevance of gender to setting their compensation. However, I do not have enough evidence about midwives working in employment models to extend this direction to their compensation processes.

[192] The MOH is ordered to work with an expert, either internal or external to government, to implement a gender-based analysis (“GBA”) which will assess the gender impacts of the policies and practices associated with compensating midwives working as independent contractors and compensated by the MOH. The expert will choose the appropriate GBA model. I am satisfied that this is something the MOH ought to do to promote compliance with the *Code* and align its practices with its obligations under the

Code. This work is to be completed within six months of this Decision. When the work is completed, the MOH will deliver a summary of the analysis to the AOM.

Training

[193] I have declined to make an order for training. To the extent that there are any deficiencies in the knowledge of current MOH staff who deal with compensation for midwives, the orders for a joint study and GBA will address that issue.

2013 and 2017 agreements

[194] The parties reached a funding agreement in 2013, at the time the AOM filed its human rights Application. This agreement was in effect from April 1, 2013 until March 31, 2017. At time of the final hearing, the parties were in the process of finalizing their 2017 agreement which was reached without prejudice to this proceeding. This agreement is in effect for the period April 1, 2017 to March 31, 2020. Both agreements were reached without prejudice to the AOM pursuing this Application before the Tribunal.

[195] The implementation of the Courtyard recommendation will result in a new adjusted rate as of 2011. The 2013 and 2017 contracts will have to be adjusted based on that rate and the percentage increases achieved in those contracts will also need to be adjusted.

[196] The AOM has also requested an order that the MOH negotiate in good faith any further adjustments that may be necessary as revealed by the new joint compensation study. I cannot direct the MOH to negotiate in good faith, but the new study will inform all outstanding negotiations between the parties with respect to the 2013 and 2017 contracts that were deferred pending the outcome of this Decision.

Ongoing Negotiations and Binding Arbitration

[197] The AOM is seeking orders from the Tribunal to enhance the fairness of its negotiations with the MOH. Specifically, the AOM is seeking an order that the MOH collaborate with the AOM to set up and follow an equitable compensation bargaining

structure for midwives, like the process in place with the Ontario Medical Association which negotiates with the MOH over physician compensation, including for CHC physicians. The AOM requests that this include a process of binding arbitration as the MOH committed to the OMA in 2012 bargaining agreement.

[198] I agree with the AOM that to the extent that power imbalances in bargaining are linked to gender, they must be corrected. The Tribunal's role in remedying discrimination and making orders to promote compliance with the *Code* does not extend to redefining the bargaining relationship between with the parties. As I indicated previously, the parties negotiate over myriad issues other than the compensation levels paid to individual midwives. I have addressed the imbalance in their negotiations which relates to compensation by reinstating the benchmarks and imposing the requirement of ongoing compensation studies to inform those negotiations.

[199] In addition, neither party provided me with legal arguments on the Tribunal's jurisdiction to order binding arbitration. I doubt the Tribunal has such authority even considering its broad remedial powers and the decision of the *Supreme Court of Canada in Royal Oak Mines Inc. v. Canada (Labour Relations Board)* 1996 CanLII 220 (SCC) ("*Royal Oak*"). Even if the Tribunal had such authority, the imposition of binding arbitration is an extraordinary remedy, applied only in exceptional circumstances, which runs against the principle of free collective bargaining. As Justice Lamar observed in *Royal Oak*, even in the labour context, it will normally be patently unreasonable to impose such an invasive remedial order. The context for the order in *Royal Oak* was indeed extraordinary: by the time the order for binding arbitration was made, nine workers had been murdered as a result of the conflict.

[200] I would urge the parties to consider the benefits of binding arbitration, especially given how they have each expressed concern about the intransigence of the other; however, I would not order such an extraordinary remedy in these circumstances.

Reference to the Ontario Human Rights Commission

[201] The AOM has requested that the Tribunal refer this matter to the Ontario Human Rights Commission pursuant to section 45.4(1) of the *Code*. The purpose of the referral would be to address the issue of guidelines for compensation-setters under the *Code* with respect to compensation paid to sex-segregated workers.

[202] In my view, this is unnecessary. The Commission will receive a copy of the Decision and will then determine whether to undertake this kind of broad policy initiative based on the experiences of Ontario midwives. The orders in this Decision are based on the facts of this case.

Monitoring/Oversight Order

[203] The AOM has requested that the Tribunal remain seized to monitor and ensure ongoing compliance with the Tribunal's orders and directions. The AOM has also requested that an external Monitor be appointed with appropriate human rights and pay equity expertise to ensure that the Tribunal's orders are carried out.

[204] It is not necessary for the Tribunal to monitor the development and implementation of the compensation study or GBA. I have directed that the parties engage a facilitator to resolve any disputes that arise in that respect. If an alleged breach of the *Code* arises in relation to the implementation of the study, or the negotiations following that study, I would have no jurisdiction to determine those issues in any event. The parties will need to address future alleged acts of discrimination within the context of their negotiations, in binding arbitration should they so choose, or a new application to the Tribunal.

ORDERS

[205] The Tribunal makes the following Orders:

a. Within six months of the date of this Decision, the MOH will:

   - implement the 20% adjustment to the four components of the course of care fee as recommended by Courtyard;

- calculate the necessary adjustments flowing from the new adjusted rate as of April 1, 2011, including the recalculation of the percentage increases from the 2013 and 2017 contracts;

- pay retroactive compensation to midwives who meet the definition of a party; and

- adjust the four components of the course of care fee for all midwives delivering services through the OMP as of the date of this Decision based on the implementation of Courtyard and the recalculation of the 2013 and 2017 contracts.

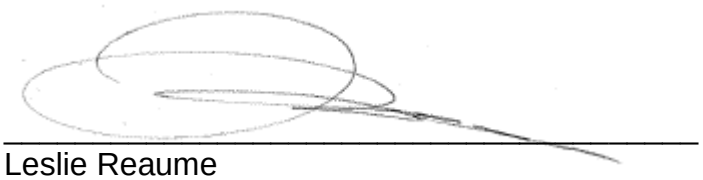
b. To the extent that there is a dispute between the records of a midwife and the records of the MOH, the parties are directed to engage a third-party facilitator or work within an existing committee to resolve the dispute. The costs of a facilitator will be paid equally by both parties;

c. The MOH will pay the sum of $7500.00 as compensation for injury to dignity, feelings, and self-respect, to each midwife who meets the definition of a party, within 90 days of this Decision;

d. Interest will be paid in accordance with paragraphs 177 through 180; and

e. The MOH will implement the orders to promote compliance with the *Code* as set out in paragraphs 187 to 189 (joint study) and paragraphs 190 to 192 (GBA of compensation policies).

Dated at Toronto, this 19th day of February 2020.



Leslie Reaume
Vice-chair

I resigned my appointment as a Vice-chair of the Tribunal effective July 27, 2019. I agreed to remain seized of this matter pursuant to section 4.3 of the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, to complete this Decision.