**Beyond Equal Treatment: Gendered Employment Norms and the Devaluation of Feminized Labour in Ontario’s Healthcare Industry**

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*Abstract*

In 2016, the Association of Ontario Midwives (AOM) brought the province’s Ministry of Health and Long-Term Care to the Ontario Human Rights Tribunal of Ontario (HRTO), calling for a significant pay raise after more than twenty years of gender-based discrimination. Independent reports prepared for the AOM show that comparing midwives and Community Health Care (CHC) physicians reveals a 48% pay gap (Durber 2013; Mackenzie 2013). In addition to this differential in pay, the AOM’s ongoing legal action speaks to how midwifery, a profession emblematic of gendered employment norms in healthcare, is devalued, and elucidates the contradictory role of the state when positioned as both employer and legislator. Moreover, this legal case illustrates the possibilities and limitations of Ontario’s existing *Pay Equity Act*—a comparator-oriented approach—when addressing gendered-based discrepancies in compensation within and across occupations and sectors. This paper first investigates how, in a province where pay equity is protected as a fundamental human right, and whereemployers, including the government itself, have pro-active obligations, legislated under the *PEA*, to redress systemic discrimination in compensation, a branch of its own ministry has been able to evade these very obligations. It then examines the *PEA*'s main mechanism of measuring value, job evaluation, and argues that this process, which necessitates the identification of a comparator, can inadvertently reproduce and intensify gendered disparities. Contending that a more effective job evaluation process would challenge the social valuation of skills that set wages within and across sectors, this paper call for more transformative approaches to gendered pay inequity.

In Ontario, Canada, those expecting to give birth without any anticipated complications have the option of choosing a physician or a midwife to provide primary care during and after pregnancy. Costs associated with both of these services are covered by the province’s medicare program. Since the occupation was regulated in Ontario in 1994, midwives have offered an increasingly popular publicly-funded maternity care alternative. Despite a chronic shortage of midwives available in the province, they help alleviate a larger shortage of family physicians willing to provide maternity and intrapartum care, and are integral to the Ministry of Health and Long-Term Care’s human resource plan to mitigate the unnecessary costs of having high risk specialists, like obstetricians, provide low risk maternity care (AOM 2016a).

Though midwives play a key part in Ontario’s health care system, their employment as primary care providers, in a profession dominated historically and to the present by women,[[1]](#footnote-1) is devalued. Indeed, in June 2016, the Association of Ontario Midwives (AOM) brought the province’s Ministry of Health and Long-Term Care to the Human Rights Tribunal of Ontario (HRTO), calling for a significant pay raise after more than twenty years of gender-based discrimination. Independent reports prepared for the AOM and presented as evidence in the HRTO hearings show that comparing midwives and Community Health Care (CHC) physicians, and accounting for differences in required skills, education, and knowledge, reveals a 48% pay gap (Durber 2013; Mackenzie 2013). In addition to this differential in pay, the AOM’s ongoing legal action speaks to how midwifery, a profession emblematic of gendered employment norms in healthcare, is devalued, and elucidates the contradictory role of the state when positioned as both employer and legislator. Moreover, as this paper will show, this legal case illustrates the possibilities and limitations of a comparator-oriented approach to addressing gendered-based discrepancies in compensation within and across occupations and sectors.

This conference paper explores how, and in what ways, midwives’ feminized health care work is devalued, with the broader goal of identifying the limitations of existing policy responses to prevailing inequalities. Particularly, I focus on Ontario’s *Pay Equity Act* (PEA) and how it measures value across occupations.[[2]](#footnote-2) Section one introduces the theoretical framework and analytical approach to the devaluation of feminized work that this paper adopts, building upon pre-existing scholarship. Section two then interrogates the relationship between midwives’ status, constructed by the MOHTLC (their ostensible employer), as independent contractors and their resultant exclusion from protective labour and employment policy measures as well as the *PEA*. In a province in which all employers are mandated, by existing pay equity legislation, to engage in a *proactive* approach to pay (in)equity, this section illustrates how a branch of government has been able to evade its pay equity responsibilities by distancing itself from its employment-related obligations. Considering what pay equity might look like if the scope of the *PEA* were broadened to include independent contractors, and thereby midwives, section three explores the possibilities and limitations of the comparator-oriented job evaluation method. Telling the story of how midwives, upon regulation in the early 90s, received a rough pay equity adjustment, this section first delineates how the MOHLTC was able to dismiss any subsequent pay equity responsibilities on account of midwives’ independent contractor status; this section then shows how, even if midwives were, hypothetically, covered by the *PEA*, this legislation’s reliance on the application of a job evaluation model that necessitates identification of comparators can in fact reproduce and intensify gendered disparities. By way of conclusion, I briefly consider how alternative approaches to gendered economic injustice in the labour market, such as raising the floor of minimum standards for all workers engaged in work for remuneration, regardless of occupation, industry, or the existence of a suitable comparator, could help bolster the effects of pay equity legislation and ensure more just forms of distribution across occupations and sectors.

**Section One: Feminist Analyses of Devaluation of Social Reproduction and the Centring of Gendered Employment Norms**

Midwifery is a woman-dominated occupation in health care, an industry where gendered occupational segmentation has been, historically and to the present, institutionalized and reinforced through public policy. While midwives are technically not covered by Ontario’s *PEA*, the AOM’s call for back pay as a result of a persistent gap in compensation relies on the assumption, put forward by pay equity as both a political strategy and legislative initiative, that wage-based discrepancies between men and women can exist both within organizations and across industries and sectors. For many decades now, pay equity has assumed that this systemic issue is linked to the historical undervaluation of “women’s work,” specifically the work of social reproduction.

Drawing on feminist political economy, I understand social reproduction to involve both the provision of daily needs (e.g. food, shelter, care, etc.), as well work that ensures intergenerational reproduction (e.g. developing and sustaining socially accepted standards of living, education, and health) (Luxton and Bezanson 2006, p. 3-4). Attention to social reproduction, through the lens of feminist political economy, is central to my theoretical framework for three main reasons. First, it reveals the link, often strategically hidden from view, between the production of goods and services, and the reproduction and sustenance of life. This link is particularly relevant to the case of the midwives, given their primary involvement in maternal and reproductive health and the overrepresentation of women, many of whom are presumed to have their own social reproductive responsibilities outside of work, in the profession. Second, the hierarchical structure in health care is deeply rooted and linked to the devaluation of social reproductive work in the home; the model of practice instituted in hospitals stresses intervention through surgery and drugs, or allopathic care provided by medical and surgical specialists. At the same time, the model of healthcare that dominates Canadian provinces’ public medicare systems simultaneously devalues daily, preventative, and non-allopathic forms of health care (Armstrong, Laxer, and Armstrong 2007). Thirdly, the costs of social reproduction informs the basis for standards of living, which in turn informs socially acceptable wage levels, and wage gaps, in the labour market (Picchio 1992).

Rejecting the ideological assumption that wages are determined by gender-blind and “objective” market forces, this paper posits that wages are shaped by the social relations of gender, class, and race embedded in production processes and mechanisms of distribution. Following pay equity analysts who highlight how gender intersects with class throughout all levels of society, including within the supposedly neutral capitalist market, I contend that the devaluation of feminized work serves to reinforce dominant employment norms and socioeconomic interests (Acker 1989, Steinburg 1991, Fudge and McDermott 1991, Kainer 2002). In Canada, as women’s labour force participation rate trends upwards,[[3]](#footnote-3) recent annual data show that, comparing year-round full-time employment earnings, women earn 74.2 cents for every dollar earned by men (Moyser 2017). Additionally, in that same category, women are more likely to be employed in a low-waged occupation than a high-waged occupation, while the opposite is true for their male comparators (Moyser 2017). Because wages are a cost of production, the simultaneous devaluation of, and increased demand for, women’s waged labour can be linked to an employers’ desire to increase surplus value gained through the production of goods and/or services (Kainer 2002); alternatively, this trend is also beneficial to certain employers, like branches of the state, which may be less concerned (ostensibly) with surplus value but still seek to limit public sector costs through the employment of devalued women workers (Bakker 2003; Armstrong and Laxer 2007). Moreover, the devaluation of skills associated with social reproduction, and women’s and particularly racialized women’s resulting disadvantaged position within and outside of the labour market, is beneficial to employers and also some workers who have a stake in maintaining organizational and social arrangements that advantage their gender, racial, and class interests (Kainer 2002).[[4]](#footnote-4) In the context of the health care industry, the authority of physicians, specialists, and surgeons, occupations where men form an above average proportion of workers in a sector largely dominated by women, is understood to be both “justified and required in order to ensure effective diagnosis, treatment and cure” (Armstrong, Laxer, and Armstrong 2007).[[5]](#footnote-5) This hierarchy, however, and its associated gaps in compensation, provides certain and disproportionate economic benefits to physicians, surgeons, and specialists, and cannot be disassociated from these workers’ material interests. Drawing on these theoretical insights, and with attention to this hierarchy that characterizes Ontario’s health care industry, this paper interrogates the fraught relationship between midwives and their single employer, the MOHLTC.

As a legislative initiative, pay equity aims to challenge the contemporary ideal of the abstract worker, a supposedly gender neutral and unencumbered individual without “obligations outside the workplace” (Acker 2012, p. 218). Despite the erosion of the male breadwinner/female caregiver gender contract, which prevailed as part of a class compromise during the height of the welfare state in post-WWII-era industrial capitalist countries (Acker 1988), and which primarily benefitted white blue-collar and male workers (Quadagno 1994), labour and employment policies often still assume an unburdened full-time, permanent worker with a single employer and regular working hours (also known as the standard employment relationship (SER); see Vosko 2010). This tendency upholds the long-standing structural and gendered separation of the workplace and the domestic space, casting activities integral to social reproduction as marginal to the paid labour market (Acker 2012); it also legitimizes the vulnerability of many workers engaged in employment that falls outside of this model (Fudge & Vosko 2001). Acknowledging the value of the work that women do within and outside of the paid labour market, and decentring the norms that disproportionately benefit the interests of already dominant workers, managers, and employers when measuring this value, is thus integral to rectifying wage-based differentials from a pay equity standpoint.

But deference to these employment norms is not always explicit or obvious. Even policies like pay equity, which attempt to better protect workers who deviate from a “male standard” can inadvertently reinforce it as the norm. As section three will show, the *PEA*’s reliance on a comparator-oriented method to measure value—job evaluation—not only reproduces existing occupational hierarchies, but can also intensify differences in compensation and other conditions of employment.

**Section Two: Midwives Tenuous Relationship with their Employer, the MOHLTC: Why Midwives are excluded from Ontario’s Proactive Pay Equity Model**

Ontario’s 1987 Pay Equity Act is proactive, which means that rather than putting the onus on workers to identify and complain about particular instances of wage discrimination, it asks employers to collaborate with workers to identify and resist the mechanisms of gender discrimination that exist within a given organization and span the labour market. In addition, unlike equal pay for equal work provisions that limit comparisons to employees who do the same work (and at the same organization), the *PEA* allows for comparisons across occupations and sectors and between workers who may not be engaged in exactly the *same* work but whose skills, efforts, responsibilities, and working conditions are *comparable*.

A proactive pay equity model that allows for comparisons across industries and sectors would be highly valuable for a group of workers like midwives; as a woman-dominated occupation providing patient-led maternal and reproductive health care, midwives 1) are already vulnerable and would benefit from the burden of responsibility being placed on their employer, the MOHLTC; and 2) are without male comparators in their occupation. However, because they are independent contractors, midwives are excluded from the *PEA,* enabling the Ministry to skirt its pay equity responsibilities, as well as its employer obligations under the *Employment Standards Act* and the *Labour Relations Act* (AOM 2016a).

Midwives’ fraught relationship to their employer reveals how the state, when serving as the employer and legislator, can deploy certain measures to limit public sector costs and, in the process, constrain workers’ compensation and collective rights (Panitch & Swartz 2003). Arguably, as the AOM’s case shows, the state’s ability to evade obligations as an employer, and their associated costs, is linked to existing legislation that can be wielded to serve the interests of employers. When Ontario midwives first entered into a contract with the Ministry in 1994, they did so as dependent contractors—self-directed in their “business operations” but dependent on one source of remuneration their services—and therefore eligible for rights protected by the *Labour Relations Act* (*LRA*) (AOM 2016a). Then, in 2000, the province modified its contract with Ontario midwives, casting them as independent contractors. No longer perceived as dependent contractors, or quasi employees, and cast rather as self-employed entrepreneurs, midwives’ independent contractor status strips them of their constitutional right to collective bargaining under the *LRA*. Midwives’ ability to demand fairer wages and better working conditions might be less constrained if their dependence on their single employer—the MOHLTC—was recognized. Yet their work arrangements as contractors—whether dependent or independent—also currently allow the Ministry to evade employer obligations governed by the *Employment Standards Act* (*ESA*), which sets out minimum conditions of employment in areas such as wages, working time, and vacations and leave.

Independent contractors’ exclusion from the *PEA,* the *LRA*, and the *ESA*, is indicative of narrow associations of self-employment with entrepreneurial motivations in labour and employment law and policy (Vosko and Zukewich 2006). In the healthcare industry, these associations run deep: when Canadian provinces first implemented compulsory, state-run medicare schemes in the 1960s, physicians, motivated to maintain the more lucrative fee-for-service compensation structure, opted to be cast as independent contractors (Finkel 2011). As explained in the AOM’s application to the HRTO, fee-for-service compensation structures continue to benefit physicians; unlike midwives, whose caseloads, partly as a consequence of the intensive nature of each individual case, are constrained and also pre-approved by the MOHLTC, physicians are “not constrained in the number of patients they can take on nor the kinds of service they can bill for” (AOM 2014, p. 45). Despite these financial constraints, the Government of Ontario can defend its characterization of midwives as contractors partly because of their on-call scheduling and irregular hours, arrangements that are, paradoxically, sanctioned and encouraged by the MOHLTC (AOM 2016a). Indeed, such work arrangements are central to midwives’ ability to provide patients with continuity of care outside institutionalized healthcare; they also enable them to serve individuals and communities whose reproductive experiences have, historically and to the present, been marginalized or highly regulated by government-funded institutions (National Aboriginal Council of Midwives 2016). Midwives’ independence, on-call scheduling, and irregular hours are thus essential to their practice. But that does not necessarily mean these workers are willing to exchange security for flexibility. As delineated in the AOM’s arguments during the HRTO proceedings, as well as in their submission to the province’s Gender Wage Gap Steering Committee (Ontario Midwives on Closing the Gender Pay Gap 2016), midwives’ ongoing complaints about pay inequity also involve a repeated request for adequate regulatory protection despite their classification as independent contractors.

After being cast as independent contractors in a 2000 devolution agreement, the AOM made its first request with the Community Health and Promotion Branch of the MOHLTC for an equitable compensation increase and back pay as a result of the government’s failure to make cost-of-living adjustments or adjust their pay in relation to comparable primary health practitioners, such as Community Health Care physicians (AOM 2016a). Then, after commissioning and submitting an independent compensation review revealing a significant pay gap between midwives and similar health care occupations where men (at the time) were overrepresented, and leading a successful public awareness campaign, the AOM was granted small compensation adjustment in 2005 (AOM 2016a). This was the first pay increase midwives received since their compensation rate was set in 1994, a process that involved a rough pay equity analysis that will be described in Section 3 (Durber 2013; AOM 2014; AOM 2016a). Consistent and adequate increases in compensation to address midwives’ equity concerns were delayed and denied, however, on the grounds of limited government resources (AOM 2014; AOM 2016a). A notable instance of this was in 2010, when the MOHLTC decided to apply compensation restraints covering only “employees” under the Liberal provincial government’s new *Public Sector Compensation Restraints Act* to freeze the midwives’ pay (AOM 2016a). Illustrating state’s willingness to openly view midwives as comparable to employees in circumstances where such treatment will lower public sector costs, the MOHLTC subjected midwives to this restraint legislation (AOM 2016a). Simultaneously, the employer refused to make an exception for the AOM’s request for pay equity adjustments, an exception that the legislation permitted, on the grounds that pay equity legislation does not apply to midwives as independent contractors (AOM 2016a).

Repeated yet unproductive attempts to encourage the MOHLTC to change its compensation practices led the AOM put increasing pressure on the MOHLTC’s through its designated internal avenues for negotiations. This same process had resulted in significant increases in compensation for CHC physicians, whose compensation is also set by the Community Health and Promotion Branch but are represented by the physician and male dominated Ontario Medical Association (OMA) in their bargaining processes (AOM 2014; AOM 2016a). For midwives, however, this drawn-out bargaining process was ineffectual and, eventually in 2013, the MOHLTC informed the AOM that it would no longer negotiate the midwifery contract (AOM 2016a). In a province where pay equity is protected as a fundamental human right, and whereemployers, including the government itself, have pro-active obligations, legislated under the *Pay Equity Act*, to redress systemic discrimination in compensation, a branch of its own ministry has been able to evade these very obligations. And yet, well-aware of the systemic discrimination still informing their compensation rates, Ontario midwives instructed the AOM to try a new approach: filing an application with the HRTO alleging that, in contravention of the *Human Rights Code* (*HRC*), the MOHLTC continually and systematically set a discriminatory compensation structure for midwives (AOM 2014). Unlike the *PEA,* which excludes midwives as independent contractors, the *HRC* defines employment more broadly and extends protections against unequal treatment on the basis of sex to independent contractors and subcontractors, employees who may not have a “direct employer,” in the traditional sense. The *PEA*, and specifically its reliance on job evaluation processes, is still central to this case however, which relies heavily on the existence of a comparator—namely, CHC physicians—to identify and rectify a persistent and significant gap in pay. The next section will explore the possibilities and limitations of job evaluation in this context.

**Section 3: *What if* Midwives were Covered by the PEA? The possibilities and Limitations of a Comparator-Oriented Policy Approach to Pay Equity**

In a pay equity policy framework, job evaluation is central to measuring value and identifying gendered pay inequities. Originally developed in the early twentieth century to allow managers and employers to legitimize occupational hierarchies and pay scales, and to uphold the distinction between managerial and non-managerial jobs (Evans and Nelson 1991), in historic and contemporary mainstream use, job evaluation is a highly politicized mechanism (Steinberg 1991). Pay equity policy has appropriated this process in a dual effort to reveal how accepted evaluation systems, while apparently technical, abstract, and without bias, actually centre dominant employment norms when measuring “sameness” or “difference,” while simultaneously challenging gendered occupational segregation (Kainer 1996). It is not always possible, however, to exercise feminist oversight of the job evaluation process to ensure gender, class, and race hierarchies that inform the wage setting process are identified and dismantled; even in cases where the collaborative job evaluation process is guided by effected workers, unions, and employers, implementation and subsequent wage adjustments often depends on the balance of power between and among workers, unions, and employers (Steinberg 1991).[[6]](#footnote-6) Additionally, the need for a comparable worker can serve to counteractively centre male workers and skills and work arrangements traditionally associated with men via implementation. For instance, for those occupations in close proximity to highly valued jobs, the pursuit and identification of a comparator can assist in securing better wages. Yet, for those workers who cannot locate a comparator, or for whom the comparator is similarly devalued, equal treatment reproduces the status quo (Acker 1989; Steinberg 1991; Vosko 2010). This section first outlines how, upon regulation in 1994, midwives received a one-time pay equity adjustment, after which the MOHLTC defended its continuous and intentional disregard for the AOM’s pay equity concerns as the result of midwives’ independent contractor status. Then, putting the independent contractor exclusion aside, hypothetically, I ask: if the *PEA* wereto apply to this female-dominated occupation, what would the possibilities and limitations of the comparator-oriented job evaluation method be? And does the comparator-oriented *PEA* address and challenge or reproduce and intensify gendered disparities in compensation?

 In Ontario, all private and public sector employers with more than 10 employees are required, by the *PEA*, to develop and implement a pay equity plan. The first step in this process is determining job classes and their gender predominance[[7]](#footnote-7); then, the value of a “female-job class,” is established by using a “gender-neutral comparison system based on skill, effort, responsibility, and working conditions” (Handman and Jensen 1999, p. 82).[[8]](#footnote-8) Once the female job class is evaluated, it is compared to a male job class of “equal or comparable value” (Handman and Jensen 1999 p. 82). If this comparison process reveals a gap in pay that cannot be accounted for by factors such as “seniority, merit, or a shortage of qualified recruits,” the employer is required to adjust compensation rates so that the women workers in question are paid the same amount as their male comparators (Handman and Jensen 1999, p. 82, 84).

Because job evaluation is traditionally based on a job-to-job wage comparison, it can be highly restrictive in female-predominant occupations, such as professions in health care like nursing and midwifery, where it is difficult to identify male comparators in the same organization. In light of this limitation, Ontario made two amendments to the *PEA* in 1993: one introducing the proportional value comparison method (which allows female and male job classes within the same organization to be compared even though the jobs are not perfectly matched), and the other introducing the proxy-comparison method, allowing for an organization, in a sector where women predominate and no male comparators exists, to find male comparators in an external organization (Pay Equity Task Force 2004).

These amendments were introduced around the same time that midwifery was being incorporated into Ontario’s public healthcare system. Before midwives’ employment structure was determined, and when the AOM and the MOHLTC were still considering community health centres (CHCs), birth centres, and hospitals as possible employers for midwives, a joint committee process involving the MOHLTC and the AOM determined midwives’ funding and compensation rates. Notably, midwives’ compensation rates were set through a blended approach that combines proportional value comparison and proxy-comparison to evaluate midwives’ and CHC physicians’ skills, efforts, responsibilities, and working conditions (AOM 2016a). At this time, 100% of midwives were women, while 75% of family physicians—a category that includes CHC physicians—were men (AOM 2014). Taking into account midwives entry-level competencies, this rough pay equity analysis set midwives compensation range slightly below their, at the time, male comparators’ starting rate of compensation, determining that midwives should receive approximately 90% of CHC physicians’ starting rate of compensation (AOM 2016a).

This collaborative determination of compensation, along with the agreement to provide annual cost of living increases, was incorporated into the Ontario Midwifery Program Framework, a document that both the AOM and the MOHLTC have referred to during the HRTO legal proceedings (See Overview Summary of AOM Witness Evidence, Appendix 2.) Additionally, expert reports by Durber (2013) and Mackenzie (2013) show that the findings of this 1994 rough pay equity analysis still stand: through a detailed pay equity analysis, which once again blends the proxy-comparison and proportional value comparison methods, Durber compared midwives’ required skills, efforts, responsibilities, and working conditions to CHC physicians in 2013, and found that midwives should earn 91% of CHC physicians’ pay (Durber 2013). And yet, although the skills, efforts, responsibilities, and working conditions associated with midwifery have increased considerably since 1994, and midwives’ comparators, CHC physicians have received substantial and continuous pay increases, midwives’ pay was frozen from 1993 to 2005, after which inadequate and irregular increases were provided that were incommensurate to the compensation provided to their comparators (Durber 2013; Mackenzie 2013).

 As explained in section 2, once the MOHLTC restructured midwives’ employment from salaried dependent contractors to independent contractors, a classification that provides for billable courses of care, caseload variables, disbursements, and grants, the government was able to justify its exclusion of midwives from pay equity entitlements insofar as independent contractors are excluded from *PEA* entitlements (AOM 2016a). Moreover, during negotiations with the AOM prior to 2013 and in its response to the AOM’s application to the HRTO, the MOHLTC has argued that it is inappropriate to compare and align midwives’ compensation arrangements with CHC physicians because midwives are contractors and physicians are salaried (AOM 2016a; Appendix 5). In other words, the comparative level of compensation as determined by the initial job evaluation process does not, from the MOHLTC’s perspective, still stand due to certain technicalities introduced by midwives’ independent contractor status. This treatment of job evaluation as a technical rather than political process conceals how government’s decisions around compensation are not neutral but motivated to serve dominant interests.

The MOHLTC’s argument the midwives are not comparable to CHC physicians because of their different employment arrangements relies on the notion of the similarly situated. Fay Faraday and Jan Borowy’s (2071) critique of recently proposed changes to the *ESA*’s provisions guaranteeing equal pay for equal work shows how this notion can significantly limit equal pay protection. For Faraday and Borowy, the *ESA*’s requirement that two workers being compared must perform “substantially the same kind of work” and that “their performance requires substantially the same skill, effort, and responsibility,” (*ESA* 2000) “enables or encourages employers to manipulate minor job duties or responsibilities to maintain unequal pay” (Faraday and Borowy 2017, p. 5). In the case of the midwives represented by the AOM, if the MOHLTC presumes that employment arrangements must be “substantially the same” in order to compare workers, and it has cast one group of employees as independent contractors, it will not be accountable for discrepancies in pay. However, as the AOM has pointed out, the notion of the similarly situated has not held the same weight for CHC physicians. Since 2004, CHC physicians have been recipients of “equitable compensation,” determined through the comparison and alignment of these salaried physicians with comparable but fee-for-service (i.e., independent contractor) primary health care physicians (AOM 2016a, Appendix 5).

Evidently, there is some other measure of similarity that is informing MOHLTC’s decisions around compensation. According to the AOM, the MOHLTC is more willing to compare the CHC physicians to fee-for-service physician because, in a sector largely dominated by women, men have historically formed an above average proportion in both occupations (AOM 2014; AOM 2016a). Additionally, although women’s representation in family medical practice is growing (as of 2016, approximately 45% of family physicians in Ontario are women (CIHI 2017), both CHC physicians and fee-for-service physicians continue to be centred in Ontario’s health care system where medicalized or “scientific” and allopathic interveners, such as physicians, have historically and to the present been awarded dominance (AOM 2014, AOM 2016a; see also Armstrong, Laxer, and Armstrong 2007). As a system developed by medical men, the Canadian public health care system has a long history of equating physician’s allopathic model of practice (which stresses use of surgery and drugs) with healing and devaluing the daily, preventative, and primary health care work that other, often women-dominated health care professions, such as nursing and midwifery, provide (Armstrong, Laxer, and Armstrong 2007). The occupational hierarchy in healthcare is, as a result, gendered, insofar as it aims to centre and protect those occupations where men have historically dominated; this hierarchy is also linked to the material/economic interests of physicians to prioritize diagnosis and treatment, areas where physicians typically dominate and specialize in, over preventative, allopathic, and daily care (Armstrong, Laxer, and Armstrong 2007; Finkel 2011). In their application to the HRTO, the AOM notes that this system is, in part, reproduced by the overrepresentation of physicians in the MOHLTC, and, as a result, compensation rates in health care are heavily informed by gendered assumptions about what constitutes skills and responsible work (AOM 2014, p. 22). Such gendered norms are starkly illustrated by the MOHLTC’s different approaches to the expansion of the Ontario Midwifery Program and the expansion of the CHC Centres: as the AOM has argued, the underpayment of midwifery work was deemed a necessary step by the Ministry to finance the expansion of the service to meet growing demand for low-risk maternity care, while “CHC physicians were not expected to similarly finance the expansion of the CHC Centres” (AOM 2016a, p. 75). In this instance, the Ministry’s “fiscal responsibility,” a supposedly gender-neutral practice, has had significantly different consequences for midwifery, as a “female-job class,” in comparison to CHC physicians.

The MOHLTC’s deference to the notion of the similarly situated, then, has allowed the Ministry to reinforce and uphold existing hierarchies in the health care industry. Faraday and Borowy (2017) argue that correcting such systemic discrimination in compensation for female job classes requires a proactive approach, as delineated in the *PEA,* requiring an employer show that a difference in compensation does not discriminate on the basis of sex. In their submission to the government of Ontario’s Gender Wage Gap Strategy Steering Committee, the AOM has suggested that broadening the scope of coverage under the *PEA* to include independent contractors would better protect feminized health care workers, such as midwives (AOM 2016c). However, would this amendment to the *PEA* adequately address the devaluation of feminized labour in healthcare? Does this legislation, and particularly its reliance on comparator-oriented methods of job evaluation, sufficiently question the objectivity of wage determination models and effectively transcend the limitations of the “similarly situated”?

The case of midwifery demonstrates that, under certain circumstances, job evaluation can effectively improve wages workers seeking pay equity. Indeed, when midwifery was first regulated and incorporated into Ontario’s medicare program in 1994, the rough pay equity analysis discussed above improved midwives’ wages significantly (AOM 2014). Prior to regulation, midwives practicing in the private sector and in an urban setting earned approximately $20,000 annually; after this collaborative pay equity analysis, which, looked to CHC physicians as comparators, midwives’ compensation rate was set at $55,000 to $77,000 per annum, approximately 90% of their comparators starting income in a fully serviced area (AOM 2014; AOM 2016a). Given the widening gap between midwives and CHC physicians compensation rates, which as of 2013 was about $94,800 (Mackenzie 2013), it is arguable that, if independent contractors were covered by the *PEA* and the MOHLTC was thereby required by legislation to maintain equitable pay, midwives’ earnings would be substantially higher. But it is also true that this ongoing comparative process would require relying on, and not necessarily challenging or transforming, the norms and value systems that have differently situated these workers in the first place.

Feminist political economist Leah F. Vosko’s analysis of how dominant interests are centred in regulatory responses to the precariousness experienced by part-time and temporary workers helps to illuminate some of the possible limitations of job evaluation and its use of the comparator. Vosko shows how policies that attempt to better protect workers whose employment arrangements deviate from the standard employment relationship (SER)—i.e. a full-time, permanent worker with regular working hours and a single employer—can in fact reinforce this employment relationship as the norm. Policies that subscribe to equal treatment on the basis of form of employment, and promote equivalency through the notion of the comparator not only require that a comparator exists, but are also often limited in their scope of coverage. As a result, only those workers in employment relationships closely “resembling the SER are assured of protections,” while those whose employment relationships that deviate from the SER are pushed further to the margins. (p. 101). In addition to instituting fewer and more limited protections for those forms of employment that deviate most obviously from the SER, such comparator-oriented policies could also counteractively motivate employers, who might want to evade their responsibility to ensure equal treatment on the basis of form of employment, to rely more heavily on these unprotected workers (Vosko 2010). Thus deference to the SER as fulcrum, even when comparisons aim to ensure non-discrimination, can inadvertently “reinforce a labour force structured in tiers based on form of employment, shaped by social relations of inequality” (Vosko 2010 p. 157).

While Vosko’s primary focus here is on form of employment, the critique of the comparator points to some of the possible limitations of job evaluation as a solution to gendered discrepancies in compensation across occupations and industries. If job evaluation views compensation rates to be an extension of the value systems upheld by capitalist society, this mechanism for measuring value can potentially draw attention to the worth of women’s work and challenge the gendered, classed, and racialized hierarchies that determine the compensation setting process under the guise of supposedly neutral measurements of merit and/or skill. If, however, job evaluation does not dismantle but utilizes, and in so doing normalizes, the dominant employment norms as modes of comparison, that mechanism will only serve to conceal the structural relations of power inherent to compensation rates, and the hierarchies that are often veiled by the fallacy that wages are set by unbiased and neutral forces of supply and demand. In this latter case, job evaluation will serve to ensure improvements for those who are within closer proximity to the dominant, while those who deviate more obviously from this norm, and are already undercompensated for their work, will continue to earn the same or less wages. This reproduces and reinforces existing gender, race, and class hierarchies within and across industries, such as health care, where proximity to “science-based” professional health occupations in hospitals (i.e, “direct” health occupations where men make up a higher than average proportion of workers) means better wages for women. Meanwhile, associations with “women’s work,” (i.e., supportive and non-allopathic health care occupations, where women, and especially racialized women are overrepresented) puts workers at greater risk of low wages and poverty.[[9]](#footnote-9)

 In addition to reinforcing the gender, class, and racial relations that inform the hierarchies of remuneration, job evaluation can also intensify occupational segmentation and its associated wage gaps. If job evaluation brings some workers, such as CHC physicians, closer to those already centred and valued in an occupation or industry, but not others, such as midwives but also CHC nurse practitioners, employers may be more motivated to rely on those devalued workers and to freeze compensation rates. According to the AOM, the MOHLTC has been motivated to keep midwives’ compensation rates down in order to fulfill growing demand for low-risk maternal care without increasing public sector spending (AOM 2014, AOM 2016a).

Following this logic, if *PEA* coverage is extended to midwives as independent contractors, it could be beneficial to this profession insofar as they can rely on a proxy-comparison job evaluation with CHC physicians. And yet, this policy’s reliance on the comparator could serve to further institutionalize low wages for those occupations that most clearly deviate, in terms of required skills and content, from those jobs located at the top of the occupational hierarchy. For instance, ancillary workers who provide “services” like laundry, food service, cleaning, clerical work, child-care, and home-support, many of whom were formerly employed directly by hospitals, are increasingly cast as independent and dependent contractors for cost-saving purposes (Armstrong and Laxer 2006); considering that comparators in these types of roles across industries also receive low wages, a comparator-oriented approach to equity for these workers would, hypothetically, not result in significant or adequate gains.

Though midwives in Ontario are still awaiting a ruling from the HRTO, the materials emerging from their case illustrates how broadening the scope of coverage under *PEA* would undoubtedly offer significant improvements for feminized health care workers, strategically cast as independent contractors. But it also shows how a more effective job evaluation process would challenge the social valuation of skills that set wages within and across sectors. Proceeding as a politicized process, it would aim to transform, rather than accept, these existing valuation systems as well as the gendered character of economic restructuring where federal and provincial states, under the façade of fiscal responsibility, disinvest from public services and goods through wage freezes and privatization (see Bakker 2003; Armstrong and Laxer 2006; Armstrong, Laxer, and Armstrong 2009).

**Conclusion**

This paper has argued that the *PEA*’s exclusion of independent contractors can allow employers, including the state, to skirt pay equity responsibilities in order to save on labour costs. Moreover, the reliance on the comparator to measure value and address gaps in compensation can benefit some workers, but reinforce low wages and precarious working conditions for others. If job evaluation, in a pay equity context, defers to the norms that evaluate skills and responsibilities according to the dominant interests of employers and certain workers, then the outcomes will only serve to reinforce the gendered occupation segmentation and its associated gaps in compensation. More money for workers whose occupations do not deviate significantly from those located at the top of the organizational or industrial hierarchy will not bring about broader social change. Where pay equity can be successful, however, is in its ability to illustrate the ways in which certain skills and work are systematically devalued across sectors in the labour market and within the private domestic sphere. As the case of the midwives helps to illustrate, resistance to pay inequity and gendered economic injustice can shed light on injustices currently accepted as status quo. What is also needed is collective action towards feminist redistribution strategies that first challenge the tiered hierarchies of wage determination, and then work to develop a comprehensive strategy to raise compensation rates for all workers regardless of their proximity to employment and occupational norms that are centred and highly valued.

Proactive pay equity and its job evaluation process is, of course, not a stand-alone policy solution. Economic inequality is a broader structural issue, and a more comprehensive approach is needed to effectively address wage discrimination experienced by workers in all sectors, not just a select few at the expense of the many. As some contemporary anti-poverty, feminist, and labour activists argue, raising the floor of minimum standards for all workers, regardless of occupation, industry, or the existence of a suitable comparator, is necessary in light of the detrimental effects of labour market restructuring. Amendments could include mandating paid emergency leave and sick days for all workers, regardless of their employment relationships, and a higher minimum wage (which, after years of campaigning led by community-organizing groups, is now being implemented by the Government of Ontario). These and other changes could institute fairer compensation rates and working conditions in low-wage occupations, where women and immigrants are overrepresented (Macdonald 2017), and where strategies like pay equity have been less effective (see Kainer (2002) on supermarket restructuring and gender equality, for example). A higher floor could provide a solid foundation for an expanded pay equity model that aims to institute a broader conception of value, expose the gender-biased assumptions about skill and work that determine wages and give shape to occupational hierarchies, and protect vulnerable workers from being pushed further to the peripheries of the labour market and its employment regulations.

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1. According to the AOM, as of 2016, all but one midwife practicing in Ontario identified as women (AOM 2016a). It is important to note that I understand women to include cis and trans women. However, this paper draws heavily on secondary sources, policies, and data that do not always indicate who is included in or excluded from this category. [↑](#footnote-ref-1)
2. This paper builds on the major research project I completed for my MA, which interrogated the relationship between the Ontario’s Pay Equity Act and economic restructuring contributing to the privatization of public health care jobs with high concentrations of women. [↑](#footnote-ref-2)
3. In 2015, 82% of women aged 25-54 participated in the labour market (Moyser 2017, no page number). [↑](#footnote-ref-3)
4. It must be noted that, in general, pay equity literature and the associated feminist advocacy for state interventions into systemic gendered inequality in the labour market has called for the erasure of difference among women for the sake of achieving tangible gains. This political strategy, however, is insufficient insofar as race also significantly influences waged-based inequities in the labour market (Cornish 2016),and that colonial and white-supremacist frameworks continue to differentiate between the value of women’s social reproductive labour along race lines (see Dua 1999, Bakare-Yusuf 1999, and Hill-Collins 2000). A strategy that acknowledges and challenges the fact that work done by white women is more highly valued that work done by racialized and immigrant women is absolutely necessary when addressing economic inequality. [↑](#footnote-ref-4)
5. The resulting inequality in power has been further instituted by the *Canada Health Act* (*CHA*), which has allowed for the private oversight of public health care provisioning and given doctors more power to determine what constitutes medically necessary, and therefore publicly funded, services. The *Act* has thereby served to justify and reinforce distinctions made in hospitals but also in subsequent health policy between those defined as “direct” health care worker and those seen as supportive or ancillary workers in health care (see Romanow 2002). [↑](#footnote-ref-5)
6. For instance, in Ontario, because existing legislation does not prevent an employer from conflating or replacing annual pay increases with annual pay equity adjustments, accessing the benefits offered by the legislation can require legal action led by a powerful union that can afford, “both politically and economically, to litigate (Handman and Jensen 1999 p. 86). [↑](#footnote-ref-6)
7. The legislation accounts for different measurements of gender predominance, and allows for gender stereotypes and historical incumbency to be taken into consideration in addition to a statistical threshold when determining “female-job classes” (p. 117-118; *PEA* 1988). [↑](#footnote-ref-7)
8. Further guidelines for this evaluation process are not provided; the development and implementation of job evaluation is overseen by each employer and, where a union exists, the employees’ union (Handman and Jensen 1999, p. 82). [↑](#footnote-ref-8)
9. According to the 2009 Statistics Canada Survey of Labour and Income Dynamics (SLID), comparing workers employed in hospitals nationally, women working in professional occupations in health (i.e., physicians, dentists, surgeons, and other direct health professionals, excluding nurses) earned an average of $33.35 per hour, while women working in assisting occupation in support of health services (i.e., dental assistants, care aides, orderlies, and personal assistants) earned an average of $20.46 per hour (*Health industry and occupation by sector* 2009; Armstrong, Laxer, and Armstrong 2007). Meanwhile, women working in “all other occupations” in hospitals—that is, a category that is not classified as a health occupation but includes those who work in ancillary occupations like cooking, cleaning, laundry, clerical work, child care, and home support—earned an average of $24.65 per hour (*Health industry and occupation by sector* 2009). Racialized women are overrepresented in this third grouping: 35 percent of visible minority women working in hospitals are located in “all other occupations” (i.e., ancillary), while only 10 percent of women working in hospitals who are not identified as a visible minority are in that same grouping (*Health industry and occupation by visible minority status* 2009). Similar wage discrepancies exist between men working in these same categories, but men make up a higher than average percentage of those working in professional health occupations: 29 percent of male health care and social assistant workers employed in hospitals in 2009 held professional health occupations, while only 10 percent of all women health care and social assistant workers were represented in the same category (*Health industry and occupation by sector* 2009). Visible minority women are significantly underrepresented in professional health occupations and make up less than 1 percent of all visible minority women who work in hospitals (*Health industry and occupation by visible minority status* 2009). [↑](#footnote-ref-9)