

Feminized Privatization and Health Care Reform in an Era of Constrained Public Spending: The Case of Ontario Midwives¹

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Abstract: On September 24, 2018, the Human Rights Tribunal of Ontario ruled that the failure of the Ministry of Health and Long-Term Care to proactively monitor and regularly negotiate midwives' compensation rates constitutes discrimination. In addition to revealing a significant pay gap between midwives and professionals performing similar roles, this landmark decision provides a window into the gendered nature of the state's efforts to constrain public spending while seeking to provide high quality healthcare provision in an era of austerity. Taking this legal case as a starting point, this paper asks how, in an era characterized by constrained public spending and the simultaneous withdrawal and reconfiguration of collective responsibility, paid health care workers are absorbing costs of services integral to social reproduction. Adopting a feminist political economy approach, I draw on an expanded concept of privatization to explore how the government of Ontario's efforts to cast midwives as autonomous primary health practitioners, as a means of maintaining the conditions necessary for a sustainable process of social reproduction, interacts with large-scale efforts to limit public spending by reorganizing and reinforcing degrees of separation between public and private labour, sectors, and responsibility. Through my empirical analysis of the case, I identify two interconnected illustrations of privatization operating in Ontario's public health care system: midwives' treatment as independent contractors, and the expansion of midwives' legislated scope of practice simultaneous to the implementation of compensation restraint. I argue that the two connected illustrations increase the portion of unpaid tasks performed by feminized paid care workers providing services integral to social reproduction, revealing the gendered impacts of privatization. Lending close attention to the evolution of midwifery in Ontario, and particularly its professionalization and subsequent devaluation via privatization since the early 1990s, this paper reveals how the contradictory forces of privatization are integral to health care reform, an ongoing project in an era of fiscal constraint.

In 2013, the Association of Ontario Midwives (the Association) filed an application under the *Ontario Human Rights Code* (1962) arguing that the Ministry of Health and Long-Term Care (the Ministry) systematically devalues midwifery, as work performed primarily by and for women, and which plays a vital role in reproductive health care, through discriminatory compensation practices (AOM 2016; HRTO 2018). In light of this violation of midwives' right to equal treatment without discrimination on the basis of sex under the *Code*, the Association called for back pay and a raise to redress over two decades of gender-based pay discrimination. Five years later, in a ground-breaking victory, the Human Rights Tribunal of Ontario (the Tribunal)

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delivered an interim decision ruling that the Ministry's failure to proactively monitor and regularly negotiate midwives' compensation rates constitutes discrimination. While the Tribunal has not yet prescribed specific remedies, it has determined liability and called for the Association and the Ministry to meet and negotiate "appropriate and fair compensation levels for midwives now and into the future" (HRTO 2018, 8). In addition to revealing a significant pay gap between midwives and professionals performing similar roles, this landmark decision provides a window into the gendered nature of the state's efforts to constrain public spending while seeking to provide high quality health care provision in an era of austerity.

A persistent shortage of family physicians willing to provide obstetrical care in Ontario has positioned midwives as integral to the Ministry of Health and Long-Term Care's efforts to ensure access to reproductive health care while mitigating the unnecessary costs of having high-risk specialists, such as obstetricians, provide low-risk pregnancy care (Bourgeault 2006; AOM 2016; HRTO 2018). In this context, the government's level of financial support has proven inadequate and inequitable vis-à-vis that provided to physicians; though the Association has repeatedly called on the Ministry to address such discriminatory compensation practices in negotiations and public campaigns, the Ministry's continued disregard for these concerns as well as its long-term implementation of compensation restraint ultimately prompted the Association to file their complaint with the Tribunal.

Taking this legal case as a starting point, my paper asks whether, and if so, how, in an era characterized by constrained public spending and the simultaneous withdrawal and reconfiguration of collective responsibility (Vosko 2002), paid health care workers are absorbing costs of services integral to social reproduction. Adopting a feminist political economy approach, I draw on an expanded concept of privatization to explore how the government of Ontario's efforts to cast midwives as autonomous primary health practitioners, as a means of maintaining the conditions necessary for a sustainable process of social reproduction, interacts with large-scale efforts to limit public spending by reorganizing and reinforcing degrees of separation between public and private labour, sectors, and responsibility (see for e.g., Armstrong and Armstrong 2005; Fudge and Cossman 2002; Fraser 1989). Through my empirical analysis of the case, I identify two interconnected illustrations of privatization operating in Ontario's public health care system. The first illustration is midwives' treatment as independent contractors, a status that allows the Ministry to strategically evade employer responsibilities insofar as independent contractors are excluded from provincial employment and labour laws and protections. The second is the expansion of midwives' legislated scope of practice, or tasks that licensed midwives may perform legally, without ensuring adequate corresponding increases in pay, a practice that ultimately requires midwives to perform unpaid tasks and labour in their capacity as publicly paid health practitioners. Challenging the false neutrality of privatization as a policy strategy, I argue that the two connected illustrations also reveal the gendered impacts of privatization insofar as they create conditions where costs associated with social reproduction, in this case reproductive health care, are being offloaded onto feminized paid health care workers. In paying close attention to the evolution of midwifery in Ontario, and particularly its professionalization and subsequent devaluation via privatization since the early 1990s, this paper reveals how the contradictory forces of privatization are integral to health care reform, an ongoing project in an era of fiscal constraint.

This paper proceeds in three parts. Section one applies the expanded conceptualization of privatization from feminist political economy to health care reform, broadly, and the case of Ontario midwives specifically. This section identifies two illustrations of privatization offered by the case: the treatment of midwives as independent contractors and the expansion of midwives' scope of practice simultaneous to the implementation of compensation restraint. Together these illustrations reveal how midwives are absorbing costs associated with services integral to reproductive health care, with highly gendered effects. This section also attends to the counterpart of privatization—regulation—to illustrate how the professionalization and legislation of midwifery in the early 1990s created opportunities to devalue and exploit midwives' unique skills and model of practice through different forms of privatization. Section two traces the evolution of midwifery in Canadian health care systems, providing the social, political, and historical context for how midwives in Ontario came to be professionalized and regulated as publicly paid health care practitioners in the early 1990s. Section three turns to the case itself to identify and explore the perceivable illustrations of privatization in Ontario's public health care system and interrogate their gendered effects. This paper concludes by placing the Tribunal's interim decision, and particularly its call for more equitable negotiations between the Association and the Ministry, in the contemporary political context, where privatization remains a persistent policy approach in Ontario health care and continues to shape midwives' work arrangements in the aftermath of this ruling.

Feminist Political Economy of Health: A Framework for Thinking Through Health Care Reform and Privatization

The following analysis and findings are informed by feminist political economy (FPE), a dialectical, historical, and materialist theoretical and methodological approach, and is particularly shaped by those insights into the political economy of health and health care in Canada. A key contribution of this scholarship is how both the institutionalization and reform of Canadian single-payer health insurance model has been shaped by a complex combination of economic, political, and social forces and actors, and thus cannot be fully understood without close attention to historical struggles over the organization of social reproduction as well as the drive towards capitalist accumulation (Coburn 2001; Armstrong and Armstrong 2010). As such, this scholarship seeks to identify those factors contributing to, and the continued effects of, reform and "rationalization" of public health care in Canada. Beginning in the late 1980s and characterized as a necessary cost-saving measure meant to simultaneously improve the efficiency and quality of a publicly funded collective good, health care reform brought about the reduction of federal contributions to and oversight over provincial and territorial health insurance plans (Coburn 2001; Armstrong and Armstrong 2010). In response to this shift, occurring alongside the intensification of global capitalism (Coburn 2001), provincial governments have developed, on an ongoing basis, various strategies of reform that as a whole aim to reduce public funding for de-commodified essential services.

An expanded conceptualization of privatization, informed by FPE, is instructive in understanding the impacts of disparate, continuous, and often complex governance and policy strategies related to aspects of social reproduction in a neoliberal era, including health care. In analyzing the social construction of private/public distinctions over time and space, FPE

scholarship refutes characterizations of private and public sectors, spheres, and labour as dichotomous, singular, and naturally divided, noting significant historical variations and variability, particularly along class, race, and regional lines (Armstrong and Armstrong 2005). With the aim of politicizing forms of work cast as private and/or to belong in the domestic sphere, adherents to this approach conceive of what are often understood as the public and private spheres as mutually constitutive and dynamic sites of contestation. Privatization, as a broad policy approach, has served, in part, to reconstruct, depoliticize, and naturalize new and longstanding private/public distinctions in an era of constrained public spending.²

FPE scholarship on health care reform illustrates that the degree of separation between public and private health care has shifted significantly as certain aspects of provincial medicare systems have been subjected to privatization. In order to identify and challenge the gendered effects of privatization in health care, Armstrong et al. (2012) identify a number of interrelated forms this trend can take. Extending beyond conceptualizations that understand privatization as a straightforward process of eroding the public sector to expand the private, privatization can involve the embrace of private sector managerial practices in the delivery of publicly funded supports and services, leading to the reduction and casualization of women-dominated hospital workforces, the intensification of service provision in order to shorten patient stays, and the consequential increase of workload expectations for those remaining employees (Armstrong et al. 2012). In health care, it can also involve contracting out certain aspects of delivery—including cleaning, food preparation, and laundry in hospitals, health occupations where women predominate and racialized women are overrepresented—to for-profit firms, with the effect of eroding job security and wages for these formerly public health care service providers (Armstrong et al. 2012; see also Armstrong and Laxer 2006). Additionally, privatization of public health care can entail the offloading of costs and services associated with publicly funded health care supports and institutions onto unpaid private actors, including (often women) family members and patients themselves (Armstrong et al. 2012).

The case of Ontario midwives is, in a sense, a story of incorporation into the public sector; following decades of exclusion from the province's public health insurance program, midwifery was regulated as a legitimate and medically necessary profession in the early 1990s (an evolution that is described in section 2). Yet, paradoxically, this regulation of midwifery has contributed to privatization of certain costs associated with meeting a growing need for comprehensive maternity and intrapartum health care. In analyzing this case, I thereby draw on

² In the introduction to an edited collection on privatization and the law, Fudge and Cossman (2002: 20) show that privatization serves to renegotiate “the relationship between private and public spheres that characterized the Keynesian welfare state” through various interrelated strategies, including re-privatization, or the reconstitution of formerly public goods and services to private firms, non-profits, and the family, individualization of social issues, commodification of public goods and services, among others. Collectively, such strategies hinge on the naturalization of reconstituted public/private distinctions supported by “normative claims about the natural superiority of the market and the family” (Fudge and Cossman 2002, 22). This reinforcement of new and often longstanding divisions between the private and the public serves to depoliticize the domestic (including unpaid work of social reproduction performed in the domestic sphere as well as paid work supporting certain aspects of social reproduction in the paid workforce) and the economic as separate realms, casting them both as inappropriate sites for government intervention (Fraser 1989). And yet, in the neoliberal era, these “private” realms are nevertheless subject to different forms of regulation through mechanisms that encourage market discipline (Fudge and Cossman 2002).

the concept of privatization to address two connected illustrations of its functioning in Ontario's health care system: first, reflecting the embrace of private sector managerial practices in the delivery of publicly funded supports and services, in this instance through the guise of work organization, the treatment of midwives as independent contractors; and second, consistent with both the intensification of service provision and the offloading of costs and services to, in this case, relatively underpaid medical professionals, the expansion of midwives' scope of practice simultaneous to the long-term implementation of compensation restraint.

With regards to the first illustration, midwives' independent contractor status, while consistent with the treatment of other health care practitioners, including many physicians, excludes midwives from a number of labour and employment laws and policies, effectively legitimizing and reproducing their discriminatory treatment. This treatment is amplified by midwives' work arrangements, including their compensation model and caseload expectations and restrictions, as well as their model of practice, which does not align with the "entrepreneurial values" utilized strategically by other health practitioners cast as independent contractors. The independent contractor status creates the necessary conditions for the second illustration of privatization, that is, the simultaneous expansion of midwives' scope of practice—or expansion of tasks licensed midwives may perform legally—and the long-term implementation of wage freezes. This trend has created a situation where midwives have taken on more responsibility and are providing more services for the same rate of pay, without adequate cost of living or inflationary adjustments. Justified as a necessary measure to meet the "demand" for maternal health care, this second strategy—aimed at cost containment—thereby expands the amount of unpaid tasks midwives perform in their capacity as publicly paid health care professionals, work that is integral to processes of social reproduction. While related to the (re)privatization of certain public supports associated with social reproduction onto *unpaid* private actors and families, the expansion of unremunerated social reproductive work among the *paid* workforce brings about different renegotiation and reinforcement of private/public divisions; in this case, publicly paid workers are individually performing a growing amount of unpaid tasks within their paid employment relation. Lending close attention to the expansion of unpaid tasks among paid health professionals, my analysis reveals how privatization can increase the rate of exploitation among midwives; while the expansion of the unpaid portion of the workday does not produce surplus value, insofar as this work is "unproductive" in a Marxist sense, it helps create and reproduce necessary conditions for capitalist accumulation, similar to other aspects of social reproduction, often performed by underpaid or unpaid women. The treatment of midwives as independent contractors, and the expansion of midwives' scope of practice without corresponding increases in pay are therefore necessarily gendered insofar as they create conditions where feminized paid health workers are absorbing costs associated with services integral to reproductive health care.

My analysis of the case of midwifery also attends to what FPE scholarship has identified as a necessary counterpoint to privatization in a neoliberal era: regulation (Fudge and Cossman 2002), related in this case to the simultaneous withdrawal and reconfiguration of collective responsibility through the reorganization of the public sector. The reorganization of the public sector—and in particular, the regulation and professionalization of feminized health care practitioners—in order to constrain public spending is therefore a central focus. By the early 1990s, many provincial governments were taking steps to professionalize woman-dominated

health care occupations, such as nursing.³ Characterized by the Ministry of Health and Long-Term Care as a forward-thinking solution to address the growing issue of insufficient resources for social welfare and wellness through the provision of preventative, holistic, and low intervention approaches to health care, provided overwhelmingly by women, the expansion of publicly insured health professions was in the interest of reducing public spending on health care costs and eroding the dominance and bargaining power of physicians (Coburn et al. 1999). In this context, feminized health care practitioners strategically deployed arguments of cost-effectiveness in order to appeal to the state's interests in constraining public spending while expanding their recognized scope of practice and legitimizing their unique skills and approaches; physicians, on the other hand, saw this professionalization, and particularly the elevation of registered nurses scope of practice in medicine, as a tool to undercut their value and degrade their skills (Bourgeault and Angus 1999). Shortly after the professionalization of nursing, the Ontario government regulated midwives as primary health care practitioners, a process I outline in the next section. I argue that this approach to regulating midwifery via professionalization offered the Ministry a more affordable and publicly funded maternal and intrapartum care option; it also opened up space to further devalue and exploit midwives' unique skills and model of practice through different forms of privatization.

The Evolution of Midwifery

Midwifery was once the dominant form of maternal care in Canada, organized and provided by Indigenous midwives prior to and during colonization, and generally accepted for its necessary role in early settler colonial health care (Bourgeault 2006; Biggs 1983). Starting in the early 19th century, however, medical practitioners successfully lobbied governments to deny midwives professional licenses. Home births became stigmatized, and hospital births increased in an effort to legitimize physicians' scientific knowledge and privileged status in health care provision (Bourgeault 2006; Benoit, Carroll, and Westfall 2007). Settler colonial federal policy in post-confederacy Canada also strategically undermined Indigenous midwifery practices through the erosion of local and indigenous reproductive health care practices; this coincided with the establishment of residential schools, which, along with other violent colonial policies and practices, aimed to sever cultural, linguistic, and kinship ties among Indigenous communities (Benoit, Carroll, and Westfall 2007). In this context, a medical model that seeks positivist and biological explanations as well as standardized treatments for all illnesses and health issues; prioritizes highly specialized and mechanistic treatments of the body; focuses primarily on cure and diagnosis over prevention and long-term care; and reproduces medical physicians' authority and expertise came to dominate the Canadian health care system (Armstrong and Armstrong 2003). In the process, holistic, naturopathic, and/or culturally or socially informed approaches to health were discredited and marginalized, but not erased.

The dominance of this medical model was further reinforced in the mid-twentieth century when the provinces started developing plans to transfer costs associated with medical

³ This shift was supported, in part, by the *Canada Health Act* (1984), which replaced references to "doctors" with terms such as "medical practitioners," or "health care practitioners," effectively opening opportunities for provinces to legislate and then directly pay less highly valued health care workers (Armstrong and Armstrong 2003).

care to the public sector. The federal government passed the *Hospital Insurance and Diagnostic Services Act* in 1957, and thereby agreed to reimburse provinces and territories for about half of the costs incurred by inpatient hospital and diagnostic services provided under a universal provincial or territorial insurance scheme (Armstrong and Armstrong 2003). Shortly thereafter, Saskatchewan became the first province to propose a universal and compulsory medicare insurance plan, a proposal that physicians initially rejected. Having built a popular physician-sponsored non-profit prepayment plan, doctors in Saskatchewan had increased their profits and established significant control over the payment and delivery of health care services (Fuller 1999). As a result, the Saskatchewan College of Physicians and Surgeons (SCPS), supported by commercial insurance companies, the provincial business community, and the media, launched a 27-day strike, beginning the day Saskatchewan's CCF government's, led by Premier Tommy Douglas, plan came into effect in 1962 (Finkel 2012). To end the physicians' strike, and ensure the SCPS was on board with a universal and compulsory single-payer health insurance program, the CCF government had to make some compromises. These concessions included sustaining physicians' fee-for service model, rather than creating full-time salaried positions, and allowing for physician and private hospital authority over administration and delivery (Fuller 1999). As the first province to implement a publicly-funded and privately delivered medicare program, Saskatchewan's compromise served as the model going forward. While each province developed its own public health insurance program, physicians' autonomy was protected, as was their entrepreneurial sensibility within a publicly funded health care system. Meanwhile, those non-allopathic health practitioners providing health services unrecognized as medically necessary by governments were excluded from the single-payer public insurance programs.

By the 1980s, however, the landscape started to shift. With the passage of the 1984 *Canada Health Act*, the relationship between federal funding and federal oversight of the provinces' and territories' fulfilment of these principles was significantly eroded, and as a result provinces were granted significantly more autonomy as well as responsibility in organizing and funding their health insurance models (Armstrong and Armstrong 2003; Fuller 1999). It was during this time many family physicians started to abandon time-consuming and less profitable obstetrical care, resulting in a shortage of publicly-regulated pregnancy and postpartum care (Bourgeault 2006). In general, family physicians found they could make more money doing less complex and time consuming procedures under their fee-for-service compensation model; additionally, because a low-intervention birth cannot be scheduled, the on-call and irregular scheduling involved in obstetrics did not appeal to many physicians (Barrington 1985). Meanwhile, starting in the 1970s, there was a growing interest among nurses associations to professionalize nurse-midwives, who played an integral role in northern health care systems, into urban and rural health care systems in the south; this developed alongside a "rebirth" of lay midwifery on the Canadian west coast in the 1970s and 80s, as part of a broader women's health and home birth movement (Bourgeault 2006). In this context, a contingent of Ontario-based midwives, with considerable public support, lobbied for greater public recognition and integration into the health care system in the mid-1980s (Bourgeault 2006), coinciding with the Ontario government's 1982 review of health professions legislation, to which a coalition of midwives put forward multiple submissions calling for the regulation of midwifery (Bourgeault 2006). The review board was eventually convinced, and in 1985 the Ministry of Health called for the integration of midwives into Ontario's health care system, a move characterized as a

response to a growing demand for accessible, publicly funded comprehensive maternal and intrapartum care, but which also offered the Ministry a cost-effective alternative to high-risk specialists, such as obstetricians, providing relatively low-risk pregnancy care (Bourgeault 2006).

Regulation of Midwifery

Midwifery was first regulated as a profession in Ontario under the *Regulated Health Professions Act 1991*, which recognizes 23 other professions; midwifery is also governed by the *Midwifery Act 1991*, which recognizes midwives as autonomous primary caregivers and determines their scope of practice to include provision of care during a “normal” pregnancy, labour, and post-partum period (AOM 2013; AOM 2016). Once regulated, midwives’ representative body, the Association of Ontario Midwives, and the Ministry engaged in collaborative effort to set compensation rates as well as a framework determining midwives’ compensation model and caseload expectations—an effort that is integral to the Association’s case (AOM 2016; HRTO 2018). Compensation rates were set through joint compensation analysis, in which a compensation analyst conducted a “rough pay equity analysis” in 1993 (AOM 2013; HRTO 2018). This complex and technical approach essentially compared positions relative to midwifery, including high seniority nurses as well as physicians in community health care clinics—a historically and at the time male dominant profession (AOM 2016). Accounting for difference and similarity in skills, efforts, responsibilities, and working conditions, the Association drew on findings of the joint compensation analysis (the Morton report) and engaged in positional bargaining to determine together that midwives should receive approximately 90% of Community Health Care (CHC) physicians’ starting rate of compensation (HRTO 2018).⁴ This compensation agreement was incorporated into the 1993 Ontario Midwifery Framework, which both the Association and the Ministry continue to refer to in negotiations, and which describes midwives’ model of practice, compensation model (initially set as a salary), operating costs, and caseload expectations. Caseload expectations, which have not changed since 1994, describe midwives’ workloads: a full time midwife is expected to provide complete course of care throughout pregnancy, labour, and birth, and 6 weeks post-partum for 40 patients and their newborns, and serve as secondary caregivers for an additional 40 patients and their newborns (HRTO 2018). Education and training for midwives was also agreed upon at this time; licenced midwives must complete a 4 year specialist baccalaureate degree, followed by a year of postgraduate mentoring and practice, as well as ongoing upgrading of skills and further education over the course of a career, as required by “the extensive standards, guidelines and protocols of the College of Midwives of Ontario” (HRTO 2018, 15).

In light of these collaborative negotiations, the legislation of midwifery appeared to benefit patients, midwives, as well as the province. Most immediately, registered midwives in Ontario received a significant increase in compensation. Prior to being recognized as a profession, midwives working fulltime earned an average of \$20,000/year; once midwifery was incorporated into Ontario’s health care system, they were earning more than three times this

⁴ Notably, at this time, CHC physicians were underpaid relative to other physicians; their underpayment was eventually recognized and addressed after joining the Ontario Medical Association (OMA) in 2004 (HRTO 2018).

amount (HRTO 2018). Moreover, patients seeking comprehensive maternity care now had an alternative and publicly funded option in the context of the growing shortage of family physicians practicing obstetrics. And finally, the province benefitted from midwives' relatively low compensation rates; indeed, the Ministry made public statements during this time, referring to growing research demonstrating the improved health outcomes associated with midwifery, and described the lower costs associated with midwives' low intervention approach to maternity care (HRTO 2018).

Despite this initial collaborative process, however, the government's level of financial support has proven inadequate and inequitable vis-à-vis that provided to physicians, including midwives' established comparator, CHC physicians (AOM 2016). After decades characterized by wage freezes and a general unwillingness on behalf of the Ministry to negotiate regularly and equitably with the Association, independent reports prepared by pay equity experts for the Association revealed a 48% pay gap when comparing midwives to CHC physicians, accounting for differences and similarities in skills, effort, responsibility, and working conditions (Durber 2013; Mackenzie 2013). Additionally, the Association and the Ministry engaged in a joint compensation review in 2010 which recommended an immediate 20% increase in compensation—an amount intended to address the lack of regular negotiations as well as an effort to bring midwives closer to a fair compensation rate relative to CHC physicians (HRTO 2018). In 2013, when the Ministry continued to ignore these calls for equitable pay, citing financial pressures and arguing CHC physicians are no longer an appropriate comparator nor a male-dominant group, the Association filed an application under the *Human Rights Code* (1962), arguing that the Ministry systematically devalues midwifery as work performed primarily by and for women that plays a vital role in reproductive health care. This application, the supporting materials, and the Tribunal's interim decision provide insights into the Ministry's strategic use of privatization in the years following the professionalization of midwifery, illustrating how such efforts effectively devalue and intensify midwives' work as publicly paid professionals taking on a growing portion of costs associated with social reproduction.

The Case: Association of Ontario Midwives v. Ontario (Health and Long-Term Care)

In their application to the HRTO, the Association argued that from 1994 to the present the Ministry violated midwives' right to equal treatment without discrimination on the basis of sex under the *Human Rights Code*, and in particular under sections 3, 5, 9, 11 and 12.⁵ To make this

⁵ The following sections of the Code were cited by the Association and applied by the tribunal in their evaluation: Section 3, "Every person having legal capacity has a right to contract on equal terms without discrimination because of...sex..."; Section 5, "Every person has a right to equal treatment with respect to employment without discrimination because of sex"; Section 9, "No person shall infringe or do, directly or indirectly, anything that infringes a right under this Part"; Section 11, "A right of a person under Part I (Freedom from Discrimination) is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where, (a) the requirement, qualification or factor is reasonable and bona fide in the circumstances; or (b) it is declared in this Act, other than in section 17, that to discriminate because of such ground is not an infringement of a right"; and Section 12, which prohibits discrimination because of association, by providing: "a right under Part 1 [Freedom from Discrimination] is

argument, the Association contended that sex was and continues to be a factor in the adverse treatment that midwives have experienced. It therefore sought compensation adjustments dating back to 1997, when the expansion of midwives' supervisory roles and non-clinical responsibilities heightened their value in relation to CHC physicians, marking the emergence of a growing gap in compensation, a trend that persisted going forward (Durber 2013; AOM 2016).

The Association submitted their complaint to the Tribunal, and not to the provincial Pay Equity Commission, primarily because of midwives' independent contractor status. In Ontario all employers—including the Ministry of Health—are mandated, by the *Pay Equity Act (PEA)* (1988), to engage in a *proactive* approach to pay (in)equity; unlike a complaint-based approach, employers are required to identify and resist the mechanisms of gender discrimination that are likely impacting their employees. Moreover, in contrast with equal pay for equal work provisions that limit comparisons to employees who do the same work (and at the same organization), the *PEA* operates under the assumption that wage-based discrepancies between men and women can exist both within organizations and across industries and sectors, and therefore 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*. However, although the Ministry provides midwives' sole source of remuneration and they must work within fiscal constraints in order to provide their services, midwives' status as independent contractors excludes them from the *PEA* and enables the Ministry to skirt its pay equity responsibilities. Unlike the *PEA*, the *OHRC* defines employment more broadly and extends protections against unequal treatment on the basis of sex to independent contractors and subcontractors. As the Association argued, if an entity is found to be responsible for a claimant being treated unequally, they will be held liable under the *Code*; this is the case even if the entity is not the claimant's "direct" employer (AOM 2013; 2016).

A central and strategic argument in the Association's application, then, was that despite the existence of the *PEA*, and midwives' exclusion from it, the right to be free from sex-based discrimination in compensation, or pay equity, is a fundamental human right guaranteed by the *Code*, specifically citing section 5. From here the Association noted that the *Code* mandates (under sections 3 and 5) equal treatment in employment and freedom from discrimination in compensation; it expects that "obligation holders" will take preventative action to protect vulnerable groups from various forms of systemic discrimination.⁶ Unlike complaint-based approaches, "obligation holders" under human rights law are expected to prevent, identify, and eradicate the mechanisms of discrimination that are likely impacting their employees. The claimant bears responsibility for providing adequate proof of discrimination, but evidence of the obligation holder's *intention* to discriminate is not required (See Section 11 of the *Code*). The *Code* also upholds that "business as usual" often adversely impacts marginalized groups and there is no requirement to prove intention (HRTO 2018; referencing section 11 of the *Code*). As evidence of the Ministry's failure to protect vulnerable workers, then, the Association

infringed where the discrimination is because of relationship, association or dealings with a person or persons identified by a prohibited ground of discrimination" (Human Rights Code 1990; see also AOM 2013; HRTO 2018).

⁶ To make this point, the Association cited *McCormick v. Fasken Martineau Dumoulin LLP* (2014); *CN v. Canada* (Canadian Human Rights Commission), (*Action des Travaille des Femme*) [1987]) (AOM 2016a).

identified a number of mechanisms, including midwives' independent contractor status, the expansion of midwives' scope of practice, and the implementation of compensation restraint, which together serve to devalue midwives' work and offload costs of publicly funded health care onto paid health practitioners.

Independent Contractor Status

In their application to the Tribunal, the Association argued that midwives' status as independent contractors, while integral to their model of practice, is instrumental to the Ministry's evasion of certain employer responsibilities (AOM 2016). At the time of legislation, midwives were initially cast as dependent contractors; they were re-cast as independent contractors in 1999 when the Ministry and the Association revised midwives' principles of funding and replaced their salary compensation structure with a course of care model—a singular fee to cover all services provided to one patient over the course of a pregnancy and post-partum period (HRTO 2018). The ministry justifies this status in employment on the basis of midwives' compensation model, irregular schedules, and on-call hours—work and pay arrangements that are essential to midwifery's comprehensive, low-intervention, and low-cost model of care. Moreover, the Ministry also countered accusations of discriminatory treatment by noting that male dominant and highly valued health care professionals are also typically treated as independent contractors, a longstanding aspect of Canada's publicly funded privately delivered medicare system. The Association demonstrated, however, that the associated lack of protective measures, in combination with the constraints midwives are subjected to in their work and compensation, have created conditions where the ministry can evade its employer responsibilities while offloading public health care costs onto midwives. An illustration of the turn towards private sector managerial practices in the delivery of publicly funded supports and services (Armstrong et al. 2012), through the seemingly neutral approach to work organization, midwives' status as independent contractors exemplifies the gendered effects of privatization in health care.

Independent contractors are excluded from a range of provincial labour and employment laws and policies, including, in Ontario, the *Employment Standards Act*, the *Labour Relations Act*, and, as noted above, the *PEA*. As feminist political economy reveals, labour and employment laws and policies that centre the norm of the full-time permanent worker with regular hours, often inadvertently serve to legitimize the precariousness confronting workers' whose employment relations deviate from this standard; these exclusions can also encourage employers to rely more heavily on those in “non-standard” employment relationships to save on labour costs and evade employer responsibilities (Vosko 2010). These insights arguably apply to the case of midwifery where the Ministry has repeatedly dismissed the Association's calls for adjustments in pay to address discriminatory compensation practices on the grounds that the *PEA* does not apply to midwives as independent contractors (AOM 2016; HRTO 2018). Despite the initial collaborative pay equity process, the Ministry has proceeded to freeze compensation rates while simultaneously increasing funding for recruitment and training in order to expand the midwifery program (AOM 2016). As the Association argued, the Ministry's underpayment of midwives and avoidance of employer obligations to take preventative action to protect vulnerable groups from various forms of systemic discrimination has been excused as

a necessary step towards financing the expansion of midwifery to meet growing demand for low-risk maternity and intrapartum care (AOM 2016).

Cast as pseudo-entrepreneurs, midwives are not only denied protection under provincial labour and employment laws and policies, but their work arrangements and their model of practice do not align with the “entrepreneurial values” strategically utilized by other health practitioners cast as independent contractors. In this sense, midwives exist within what Vosko and Zukewich (2006) call a gendered “continuum of precarious self-employment,” where women are overrepresented in the most precarious forms of self-employment, including solo and/or part-time self-employment, and men are overrepresented in the least precarious categories, such as full-time employers. This gendered precariousness of self-employment is neutralized and concealed, however, by a “male entrepreneurial norm,” which assumes the entrepreneur “chooses risk, autonomy, and independence over stability and direct supervision” (Vosko and Zukewich 2006, 67). As such, this norm effectively obscures how the decision to take up self-employment is not necessarily a strategic and objective choice to pursue “entrepreneurial values” rather than waged employment, but can, in some cases, be shaped by certain gendered constraints, including a lack of access to secure waged employment, a pressure to balance paid work with unwaged social reproductive responsibilities, or, in the case of midwifery, a patient-centred model of care that does not fit within the standard employment relationship and also demands a degree of autonomy. Without attending to the material forces and social context shaping conditions of self-employment, the male entrepreneurial norm upholds the assumption that conditions of employment among the self-employed constitute a “private matter rather than public concern” (Vosko and Zukewich 2006, 89).

The Association has effectively challenged this entrepreneurial norm and its privatization of precarious self-employment by arguing that midwives’ “entrepreneurial” capacities are significantly limited by their employer, particularly in comparison to physicians also cast as independent contractors. Not only are midwives’ caseloads limited by governing legislation and preapproved by the Ministry, and their pay determined by a course of care model, but the ministry also controls the creation and assignment of midwives to practice groups, limiting midwives’ capacity to increase their incomes through entrepreneurial strategies significantly (AOM 2016). In this highly constrained yet autonomous position, the independent contractor status serves to blur and reorganize public/private distinctions insofar as midwives have been excluded from provincial labour and employment policies and protections but are simultaneously “constrained more like employees in their work and compensation” (AOM 2013). Meanwhile, physicians compensated by fee-for-service model are not constrained in the number of patients they can take on, or the amount of services they can bill for; as such they can run their private practices like a business, finding efficiencies and intensifying services to increase incomes (AOM 2013). Notably, the work arrangements constraining midwives’ entrepreneurial capacities, though overseen and approved of by the Ministry, are also in alignment with midwives’ principled resistance to economic incentives in the provision of maternal and intrapartum care (AOM 2013; 2016). Still, the contrast between midwives and physicians’ constraints and capabilities in self-employment reveals the gendered impacts of privatization; both midwives and physicians may exist as independent contractors, but physicians can strategically expand their income and midwives cannot. Existing in this liminal space between employee and entrepreneur, between public oversight and private

responsibility, midwives fill a necessary role in maternal and post-partum health care without commensurate increases in pay. As such, midwives' independent contractor status creates the conditions for a second illustration of privatization: the expansion of midwives' scope of practice simultaneous to the implementation of compensation restraint.

Expansion of scope of practice and implementation of compensation restraint

The Ministry's expansion of midwives' scope of practice simultaneous to the implementation of constraint legislation provides a second related illustration of how privatization in health care operates. As evidence of the Ministry's failure to take preventative action to protect vulnerable groups, the Association noted the continued expansion of midwives' scope of practice since regulation. The Association cited the College of Midwives of Ontario's expansion of legislated skills and tasks that licensed midwives may perform legally to include the treatment of post-partum hemorrhage (2003), the administering of different drugs to patients (including newborns) (2009), the communication of a pregnancy-related diagnosis to a patient (including newborns up to 6 weeks old) (2009), support for Caesarean sections as first surgical assistant (2009), specific treatments for neonatal resuscitation (2013), among many other changes (AOM 2016; Durber 2013). These changes were agreed to by both the Association and the Ministry, albeit for what appear to be very different reasons. On the one hand, the Association has shown it sought to increase the value of midwives' work and overcome barriers midwives experience in hospitals (AOM 2013; 2016). Contrary to the dominant belief that greater skills will translate into greater financial rewards, however, the expansion of midwives' scope of practice did not correspond to adequate increases in pay; moreover, though the College has recognized midwives' measurable and observable clinical skills, some physicians and hospitals have sought to limit their scope of practice in order to maintain some level of control over more clinical tasks, effectively reinforcing the socially accepted hierarchy of skills that serves to legitimize physicians' authority (AOM 2016; see also Armstrong 2013).

On the other hand, the Ministry has consistently promoted midwifery as a comparable alternative to family physicians providing obstetrics, due to midwives' relative cost-efficiency and physicians' practicing obstetrics continued scarcity, a comparison that necessitates a comparable scope of practice (AOM 2016; HRT0 2018). Consistent with intensification of service provision in an ongoing process of health care reform, the Tribunal's Vice-Chair summarized in the interim decision that since regulation midwives' "scope of practice been expanded to take advantage of their remarkable skill set and to respond to changing health care priorities, underserved communities and vulnerable patient populations" (HRT0 2018, 16). In failing to engage in regular and adequate negotiations, however, the Ministry failed to ensure midwives' expanded scope of practice is reflected in their compensation (Durber 2013; Mackenzie 2013); without corresponding increases in pay, the immediate and ongoing costs of this expansion of skills and services has been funded primarily by midwives through the performance of certain unpaid tasks. The long-term implementation of compensation restraint has amplified these effects.

The Association argued that the imposition of various forms of compensation restraint on midwives since 1994 illustrates how a seemingly neutral rule of general application can have adverse consequences linked to the gendered nature of midwives' work. For instance, between 1994 and 2005, midwives' pay was frozen; compensation rates for CHC physicians were also

frozen between 1992-2003 (HRTO 2018). Though the Ministry argued that this commitment to fiscal responsibility and the related application of compensation restraint is neutral, the Association has shown that after 2004, when CHC physicians successfully sought representation by Ontario Medical Association (OMA), the Ministry permitted regular increases to CHC physicians' and family physicians' compensation rates in order to address a chronic shortage of family physicians and incentivize medical students to take on these practices (AOM 2016a; HRTO 2018). The expansion of midwifery, on the other hand, took a very different approach. In 2000, the Ministry expanded its budget for midwifery program two-fold, but this new funding was put towards recruitment, training, and payment for new midwives as well as increased professional liability insurance premium expenses; no funding was budgeted for compensation increases (AOM 2016; HRTO 2018). As the Association 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 and intrapartum care, while "CHC physicians were not expected to similarly finance the expansion of the CHC Centres" (AOM 2016, 75).

The key issue, however, at least for the Tribunal's purposes, was the Ministry's response to a joint-compensation review in 2009, which called for 20% increase in compensation for midwives, described as a one-time "equity adjustment" (AOM 2016). The review affirmed the 1993 funding principles, including the comparison with CHC physicians, and attributed the persistent gap in compensation to the Ministry's disregard for these original funding principles and irregular engagement in negotiations with the Association (HRTO 2018). The Ministry unilaterally dismissed these findings (on the grounds that CHC physicians were no longer appropriate comparators) and notified the AOM it would apply restraint legislation in the next round of negotiations (HRTO 2018). The government's new *Public Sector Compensation Restraint to Protect Public Services Act* (2010) was only meant to cover "employees" and made exceptions for pay equity adjustments and human rights entitlements (AOM 2016). Revealing the connection between midwives' independent contractor status and the implementation of compensation restraint, this legislation also excluded employees represented by trade unions recognized by the *Labour Relations Act*; as noted above, midwives, as independent contractors, are denied a constitutional right to collective bargaining under the *LRA*. Though the Association argued that this piece of compensation restraint legislation should not apply to midwives as independent contractors, and noted that pay equity adjustments and human rights entitlements were to be excluded from such policies, the Ministry nevertheless froze midwives' citing their exclusion from the *Pay Equity Act* as independent contractors and noting that midwives' comparators, CHC physicians, were no longer a male-dominant profession (2018).

The Ministry argued that the implementation of the constraint legislation was a general and impartial policy approach applicable to all contractors, including physicians represented OMA as well as midwives (HRTO 2018). Such commitments to "fiscal responsibility" can serve, as Brodie (2008) has argued, to depoliticize collective social issues, such as gender-based pay discrimination, on the grounds that some members of a discriminated-against group have now gained access to highly valued and historically exclusionary spaces and occupations. Indeed, the Ministry deferred to this legitimizing practice when it claimed that CHC physicians are no longer male dominant and have increased their compensation rates through representation by the OMA, whose bargaining strength is presumed to be both apolitical and neutral. Challenging the false neutrality of this cost containment strategy, the Association countered that the Ministry's

application of austerity driven measures in fact deepen long-standing discriminatory compensation practices revealed in the 2009 joint-compensation review.

This long-term implementation of compensation restraint, combined with continued expansion of midwives' scope of practice, illustrates how the intensification of service provision can combine with the government's transferring of public costs and services onto private actors in the form of unpaid labour. In contrast to the offloading of certain public supports associated with social reproduction onto unpaid individuals and family, here a growing amount of unpaid tasks are taken on by publicly paid medical professionals cast as independent contractors, exemplifying the complex ways privatization can shift and reinforce private/public boundaries in an ongoing project of health care reform. While characterized as an objective and necessary cost containment strategy, compensation freezes serve to not only reproduce gendered polarization among health care professionals but also increase the portion of unpaid tasks performed by paid workers, such as midwives, whose skills and responsibilities, integral to reproductive health care, have been expanded on an ongoing basis.

The Decision

To determine discrimination, the Tribunal applied a three part test: the first step involves an evaluation of whether identification with a prohibited ground exists; in the case of midwifery, as a profession performed for women, by women, and in response to a women's health issue, all parties agreed this identification is clear (HRTO 2018). Second is the evaluation of adverse treatment or disadvantage (HRTO 2018). Though the Ministry disputed allegations of adverse treatment, the Tribunal conceded that the application of compensation restraint to "sex-segregated workers is clearly disadvantageous"; whether its application is itself gendered remained to be determined (HRTO 2018, 68). This leads the third factor for determining discrimination, which is the determination of whether or not there is a connection between the adverse treatment and the protected ground; while the Ministry argued that adverse treatment must be proved to be arbitrary or derived from stereotypes, the Association argued that "business as usual" often adversely impacts marginalized groups and there is no requirement to prove intention (cited in HRTO 2018, 69).

The Tribunal ruled that there is sufficient evidence to prove gender-based discrimination between 2005 and 2013, but not earlier. This decision is primarily informed by evidence of the Ministry's reference, or lack thereof, to the original funding principles agreed upon in 1993. Although midwives pay was frozen from 1994-2005, negotiations in 2005 incorporated both the 1993 Morton report as well as positional bargaining to reach an agreement that included pay increases between 20-29% over the course of three years (HRTO 2018). Though the Association argued that, after a decade of zero wage increases, this amount was insufficient and incommensurate to boosts in compensation applied to CHC physicians, the Tribunal found that "the imposition of wage freezes leading up to the 2005 agreement had an adverse impact on midwives, but there is insufficient evidence to connect that impact to gender" (HRTO 2018, 79)

The tribunal was convinced, however, that the Ministry unilaterally withdrew from the original funding principles established at regulation to proactively prevent discrimination when engaging in negotiations with the Association after 2005. Of particular importance was the Ministry's failure to take preventative action to protect vulnerable groups from various forms of systemic discrimination after a 2009 joint-compensation review identified the need for an

immediate one-time “equity adjustment” (HRTO 2018, 80); the Ministry’s implementation of compensation restraint in the wake of this review offered sufficient evidence, for the purposes of the Tribunal, of midwives’ adverse treatment being connected to the gender of this feminized profession (HRTO 2018, page 80). Thus, in its interim decision, the Tribunal suggested that seemingly neutral policies, characterized as fiscally responsible measures, can in fact be gendered, insofar as they compound the devaluation and exploitation of feminized occupations providing client-led care to feminized, and often otherwise marginalized, patients. The decision also dismissed the Ministry’s emphasis on “merit-based” factors, such as differences in skills, training, and responsibilities, contributing to the compensation differences between midwives and physicians; as the Tribunal’s Vice- Chair noted, it is difficult to accept the Ministry’s assertions that midwives and physicians are different considering that it “promotes family physicians and midwives as comparable obstetrical providers, equally competent to care for women with normal pregnancies” (81). Put differently, it is hard to reconcile the government’s contradictory interests in, on the one hand, expanding midwives’ scope of practice to promote midwifery as comparable to obstetrical providers to save on costs associated with social reproduction, and, on the other hand, refuting that similarity in order to contain midwives’ compensation rates. Illustrating the gendered implications of the reorganization and reinforcement of public/private divisions in an era of constrained public spending, the case of Ontario midwives reveals how contradictory processes of privatization can simultaneously intensify and devalue paid feminized work associated with social reproduction in the public sphere.

In the end, rather than prescribing remedies proposed by the Association, the Tribunal’s interim decision encouraged both parties to “return to a state of cooperation with the original funding principles as their guide” (HRTO 2018, 89). The Tribunal remains “seized” of the matter, and thus available for further interventions, offering the midwives’ a leverage in negotiations which have historically been characterized by significant imbalances in power. The ruling is thus a major victory for midwives as independent contractors, treated as pseudo-entrepreneurs, insofar as the Tribunal has looked beyond the “male entrepreneurial norm,” which serves to justify the individualization and depoliticization of conditions of employment among the self-employed, and acknowledged the need, potentially, for greater transparency and further interventions. However, the next round of negotiations between the Association and the Ministry will take place in a political climate characterized by increasing rather than receding austerity. While engaging in a “cooperative process” with the Ministry makes space for critical contestation and change, these negotiations will still ultimately be informed and shaped by longstanding structural relations of in this instance, principally gendered, power and inequality.

Conclusion

The 2018 interim decision is undoubtedly a major win for Ontario Midwives, but the Association’s negotiation process will take place in a political climate where the provincial government has promised massive cuts to public spending; in this context, the prospect of the further privatization of public health care is a very real threat. Indeed, in December 2018, just three months after the interim decision was delivered, the Ford government revoked current and future funding for the College of Midwives of Ontario, a regulatory body for over 900 registered midwives practicing in the province. Though the Ministry has provided operational

grants to the College since midwifery was first regulated in the province in 1994, going forward midwives' membership fees will provide the sole source of funding to the College, the operation of which is mandated by midwives' governing legislation. Exemplifying how the government can offload costs of ensuring high quality and sustainable delivery of publicly-funded health care onto practitioners, a move that has been characterized as an objective and responsible measure on behalf of a fiscally constrained government, the change will place a new financial burden on midwives already subject to relatively low rates of compensation. The defunding of the College is thus another clear illustration of privatization, where the line between public and private is being shifted and reinforced, both at the same time.

This paper has shown how the legal case involving Ontario midwives offers illustrations of how privatization operates in an era of constrained public spending. Midwives' treatment as independent contractors as well as the expansion of their scope of practice simultaneous to the implementation of compensation restraint serve to renegotiate boundaries between public and private sectors and labour, re-assigning certain aspects of their publicly funded services and thereby eroding midwives' compensation rates access to labour and employment protections while increasing the amount of unpaid tasks they perform on a regular basis. The case of midwifery thus reveals how health care reform, which started in the late 1980s with the accelerated rise of neoliberalism, is an ongoing project and that privatization is a key tool for ensuring the simultaneous withdrawal and re-configuration of collective responsibility in an era of constrained public spending.

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