COMPENSATION REVIEW OF MIDWIFERY

PREPARED ON BEHALF OF:

MINISTRY OF HEALTH AND LONG TERM CARE

ASSOCIATION OF ONTARIO MIDWIVES

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VERSION FINAL

COURTYARD GROUP

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Executive Summary

Article seven of the 2008 Memorandum of Understanding (MOU) between the Ministry of Health and Long Term Care (MoHLTC) and the Association of Ontario Midwives (AOM) specifically requires the organizations to jointly retain an independent third party to conduct a compensation review of midwifery services. In July 2010, Courtyard Group was engaged to conduct this review.

As directed by the MOU, a Steering Committee was convened to oversee project activities and provide direction to the consultants (refer to appendix A for a list of Steering Committee members). At the outset of the project a set of evaluation questions were defined and approved by the Steering Committee to guide the review.

Evaluation Questions

1. Does the current compensation model recognize adherence to best practice guidelines and the achievement of the Ministry's policy objectives?
2. Does the current compensation model reflect the current scope of work performed?
3. Does the current compensation model reflect the volume/complexity of work performed?
4. Does the current compensation model reflect the costs of doing work?
5. What is the value of benefits, or equivalent funding received by midwives?
6. Does the current compensation model reflect the experience and training of midwives?
7. Is the current compensation model comparable to other professions performing similar work?
8. What market trends should be taken into consideration? Have compensation increases remained aligned with economic growth in Ontario?

Section one of this document provides the context for the findings and recommendations within this report. This section is tremendously important as the history of the midwifery profession and the care provided has often been misunderstood.

Section three provides a summary of the status of midwifery across Canada, and provides some more in-depth information regarding the midwifery programs in Alberta and British Columbia.

Section four addresses each of the evaluation questions individually, and reflects the evidence gathered through interviews, data analysis and document reviews.

Section five summarizes the conclusions drawn from the evidence and the recommendations formulated by Courtyard Group.

1. Context and Background

1.1. Impetus for the Review

Article seven of the 2008 Memorandum of Understanding (MOU) between the Ministry of Health and Long Term Care (MoHLTC) and the Association of Ontario Midwives (AOM) specifically requires the organizations to jointly retain an independent third party to conduct a compensation review of midwifery services. In July 2010, Courtyard Group was engaged to conduct this review.

The MOU indicates that the resulting report is to suggest the appropriate total compensation for midwifery services (i.e. course of care fees, and all benefits or equivalent funding).

1.2. Overview of Midwifery Services in Ontario

The Midwifery Act, 1991 defines the midwifery scope of practice as:

> *"The assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provisions of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries."*[1]

As described in the Philosophy of Midwifery Care in Ontario, care provided by midwives "is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs".[2]

Prior to 1994, small numbers of unregulated midwives provided care to individuals that actively sought their services. As the demand for midwifery care (and maternal services in general) increased in Ontario the support and rationale for the formal regulation of midwives as healthcare professionals strengthened. The Ontario Midwifery Program was formally established in 1994, and is designed to[3]:

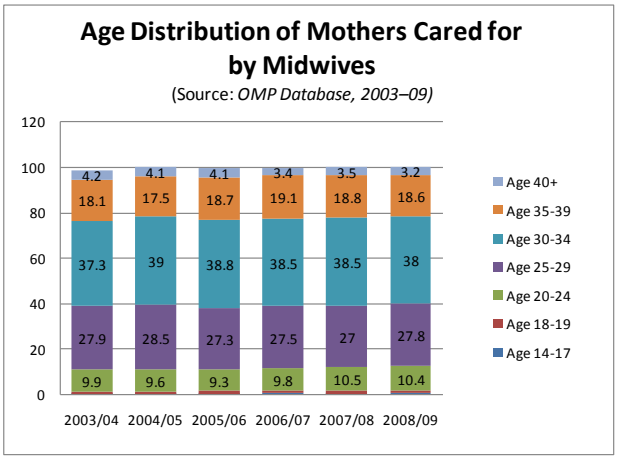
- Improve maternal and newborn outcomes;
- Provide maternity care through managed, community-based midwifery services;
- Provide equitable funding mechanisms that support the integration of midwifery services into the funded provincial healthcare system;
- Improve access to midwifery services across the province;
- Provide consumer involvement in the planning, delivery and evaluation of services;
- Ensure accountability for expenditure of public funds in accordance with Ontario's Transfer Payment Accountability Directive.

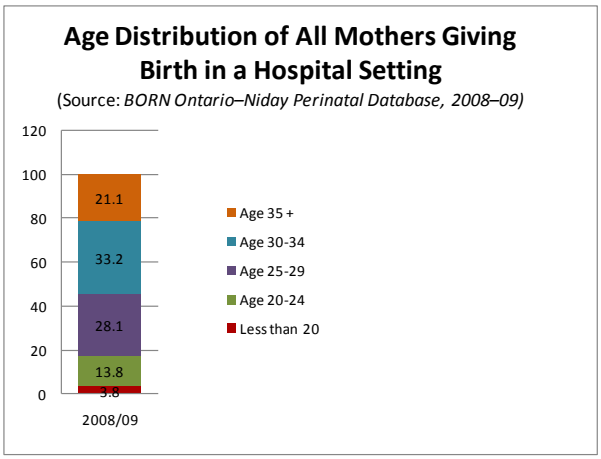
[1] College of Midwives of Ontario. Midwifery Scope of Practice. Midwifery Act, 1991.
[2] College of Midwives of Ontario. Philosophy of Midwifery Care in Ontario. January 1994.
[3] Memorandum of Understanding, Article 3, 2009.

The practice of midwifery is regulated by the College of Midwives of Ontario (CMO). The CMO is currently reviewing the midwifery practice model to introduce a greater degree of flexibility while still upholding the original practice principles. It is anticipated that the changes will better enable Midwives to respond to local needs, including those of special populations and the other professions and organizations involved in maternity care.

Midwives are organized into independent practices, and provide care at multiple locations which include their own clinic space (which may be situated in independent facilities, community health centres, or other locations), at the home of the client, or in hospital.

Midwives provide around the clock, on-call, primary care to women throughout pregnancy and to new mothers and their newborns for six-weeks following birth. Midwifery clients represent a broad spectrum of women that varies in terms of age, cultural background and ethnicity, socio-economic status and health status. Over two thirds of the clients cared for by midwives are first time users of midwifery services. The age of clients cared for by midwives has remained fairly consistent over the past six years. The average age of women cared for by midwives is slightly older compared to the provincial average for women giving birth in a hospital setting. In 2008/09 the proportion of women older than 30 years of age amongst midwifery clients was 59.8%, where as amongst all women giving birth in a hospital setting it was 54.3%.

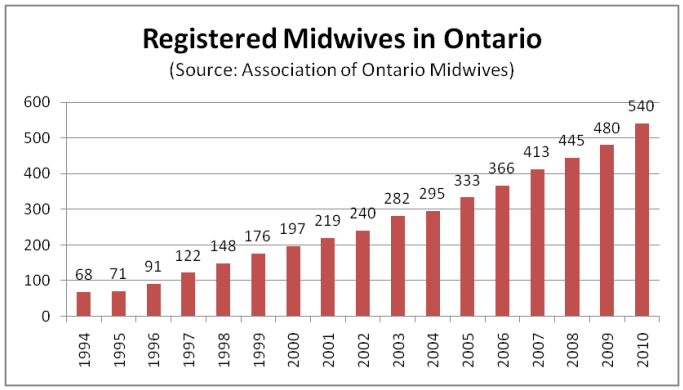




The majority of women are eligible for midwifery services, with a limited number of exceptions (e.g. women with serious medical conditions such as cardiac or renal disease). Midwives carry equipment and medication for labour and birth similar to that of a Level 1 hospital. In situations where the clinical status of the client requires knowledge or action that extends beyond the scope of practice of midwives, a consultation or transfer of care to a physician is arranged. The Indications for Mandatory Discussion, Consultation and Transfer of Care Guidelines, defined and published by the CMO, address how midwives deal with each type of clinical situation.

Typically, each client cared for by a midwife receives 14 prenatal appointments (including one home visit). During the intrapartum period the midwife manages the labour and delivery of the baby. Postnatal care extends over a six week period post-delivery. Typically, women receive three home and three clinic visits during this period. Midwives are on-call and available to their clients on a 24 by 7 basis.

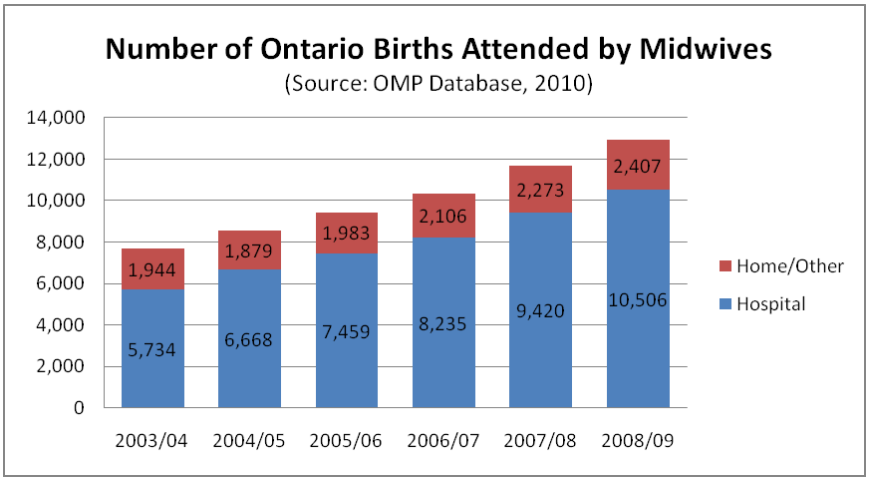
On average, the number of registered Midwives in Ontario has grown by 14% each year since 1994. In 2010 there were 540 registered Midwives. This number is expected to almost double within the next five years.



Since its creation in 1994, the profession has been focused on establishing a solid foundation for midwives within the existing health system. In the face of growing and unmet demand, the initial cohorts of midwives have worked to:

- Organize and operate the College of Midwives of Ontario
- Establish education programs and curriculum
- Provide practical training and mentoring for new midwifery graduates
- Educate the public and increase awareness of midwifery
- Organize the administration and operation of midwifery practices

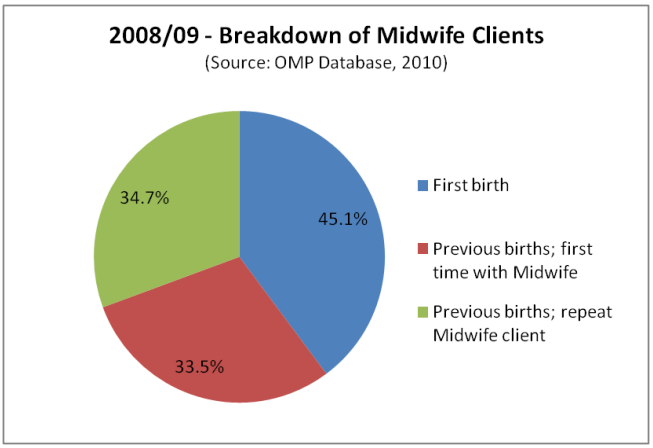
In 2009, midwives attended approximately 13,000 births, representing approximately 10% of all birth in Ontario[4]. A midwife was recorded as the primary care provider for 5874 hospital births in 2009/10[5]. Since 2003/04, the proportion of births taking place in the home has decreased by seven percent, although absolute numbers have increased steadily.

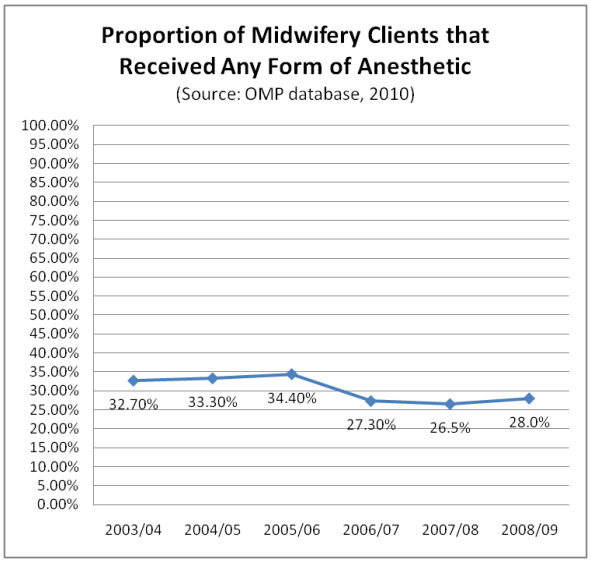


[4] College of Midwives of Ontario. The Facts about Home Birth in Ontario.
[5] Nidday database, 2010

The use of interventions amongst midwifery clients is often lower than the provincial average. For example, the proportion of women who had an epidural in a level 1 hospital in 2006/07 was 35.4%[6], whereas the proportion of midwifery clients was 17.1%[7] (in 2008/09 the proportion of midwifery clients using an epidural was 18.7%). The proportion of midwifery clients that used any form of anaethetic has decreased by nearly five percent since 2003/04[8]. C-section rates are also lower amongst midwifery clients. In 2006/07, the proportion of Caesarean births amongst women with low-risk pregnancies was 20%[9], where as the rate amongst midwifery clients was 15.3%[10]. Vacuum and/or forceps are used to assist in births which must be expedited due to maternal or fetal concerns. The proportion of births requiring forcepts or vaccum extractions is lower amongst midwifery clients compared to the provincial average. In 2006/07, 13.9%[11] of all low-risk pregnancies required forcepts and/or vacuum extractions, whereas only 6.7%[12] of midwifery clients required these interventions.

There is evidence that health outcomes for mothers and babies cared for by midwives are better than the provincial average, when comparing women of a similar risk profile. For example, breast feeding rates are much higher amongst midwifery clients. In 2006/07, the proportion of all women breastfeeding their babies at the time of discharge from hospital (i.e. one to three days post delivery) was only 59%[13]. For midwifery clients breastfeeding rates six weeks post delivery have been consistently been reported at 91% (2006/07 – 2008/09)[14]. The proportion of low birth weight babies amongst midwifery clients is also lower than the provincial average. In 2006/07 6.7%[15] of all babies born in Ontario weighed less than 2499g, whereas the proportion of all babies delivered by a midwife that weighed less than 2499g was only 3.0%[16].





[6] Niday database, 2006/07.
[7] Ontario Midwifery Program data, 2006/07.
[8] Ontario Midwifery Program data, 2008/09.
[9] Niday database, 2006/07.
[10] Ontario Midwifery Program data, 2006/07.
[11] Niday database, 2006/07.
[12] Ontario Midwifery Program data, 2006/07.
[13] Niday database, 2006/07.
[14] Ontario Midwifery Program data, 2008/09.
[15] Niday database, 2006/07.
[16] Ontario Midwifery Program data, 2006/07.

1.3. Overview of Midwifery Education

The accredited Midwifery Education Program (MEP) is provided through three Ontario universities: McMaster University, Laurentian University and Ryerson University. An International Midwifery Pre-Registration Program (IMPP) is also available through Ryerson University for midwives that have been trained internationally and wish to practice in Ontario.

The MEP receives funding from the Ministry of Training, Colleges and Universities for 90 midwifery students each year. The government invested $2.3 million to expand enrollment in the Midwifery Education Program from 60 to 80 positions starting in the Fall of 2007 with a further expansion of 10 seats the following year for a total of 90 positions. The IMPP graduates approximately 10 internationally trained midwives each year.

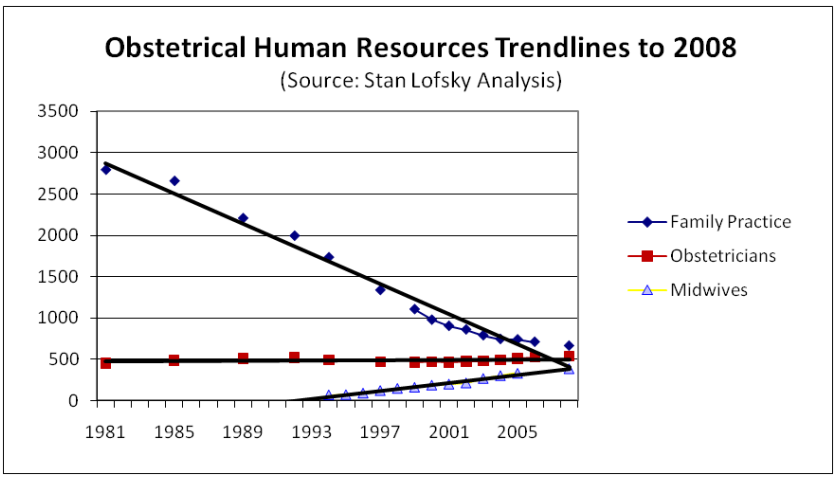
The MEP is a four year program which consists of a mix of health, social, and biological science courses and leads to a Bachelor of Health Sciences in Midwifery degree. Required courses include a foundation in anatomy and physiology, pharmacotherapy, biochemistry and reproductive physiology. During the final six terms of the program students participate in clinical placements; four terms are spent within a midwifery clinical practice and two terms are spent in inter-professional placements. During the practical component of the program, students are required to attend a minimum of 60 births, acting as primary caregiver for at least 40 births in home and hospital settings.

1.4. The Ontario Maternal Care Context

There are many care providers, beyond midwives, that are involved in the delivery of maternity and newborn care in Ontario. The majority of women receive prenatal care from an obstetrician. Other prenatal care providers include family physicians, midwives, and nurse practitioners. The proportion of family physicians that practice obstetrics has declined significantly in the last decade. Some of the factors that have influenced this decline include the perception that intrapartum care is too disruptive of personal life, and the community size within which the family physician practices (physicians are less likely to practice obstetrics in communities of less than 15,000 people)[17]. The scope and model of care provided by each of these provider groups varies. Likewise the frequency and duration of care also varies. It is of note that midwives are the only maternal care providers that are guaranteed to provide intrapartum care upon graduation and registration.

Maternity Care Provider	Number Practicing Obstetrics in Ontario (2008)[18]
Obstetricians	663
Family Physicians	538
Midwives	390

[17] Marshall Godwin, Geoffrey Hodgetts, Rachelle Seguin, Susan MacDonald. The Ontario Family Medicine Residents Cohort Study: factors affecting residents' decisions to practise obstetrics. CMAJ 2002;166(2):179-84.
[18] Stan Lofsky. Analysis of billing clinicians, 2009.



In 2009/10, 136,223 women gave birth in a hospital setting in Ontario[19]. Despite the fact that Family Physicians provided prenatal care for 27.3% of these women, they only attended 8.7% of the births.

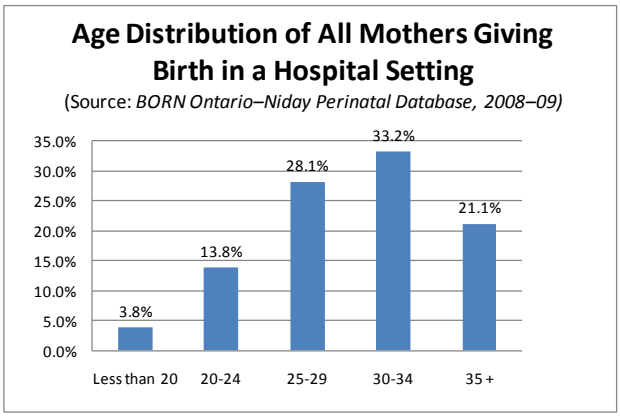
Attendant at Birth	Proportion of Women[20] (who gave birth in a hospital setting)	
	2006/07	**2009/10**
Obstetrician	86.2%	85.4%
Family Physician	8.5%	8.7%
Midwife	3.5%	4.3%
Nurse Practitioner	0.1%	0%
None	0%	0%
Other	1.7%	1.6%
Note: 0.1% of records were not recorded		

The table below illustrates the proportion of women (that delivered their babies in a hospital setting) that received care from these care providers. Note that some women may have received care from multiple provider types.

Provider of Prenatal Care	Proportion of Women[21] (who gave birth in a hospital setting)	
	2006/07	**2009/10**
Obstetrician	80.4%	76.4%
Family Physician	25.2%	27.3%
Midwife	5.4%	7.4%
Nurse Practitioner	5.6%	0.8%
None	1.7%	0.4%
Other	1.7%	1.0%
Note: 4.1% of records were not recorded		

[19] Niday Database, 2009/10/
[20] Niday Database, 2009/10 and 2006/07 data.
[21] Niday Database, 2009/10 and 2006/07 data.

In 2008/09, 136,300 women gave birth in an Ontario hospital. Of these women, 54.3% were over the age of 30. Approximately 45% of these women were having their first baby. The proportion of women with one or more pre-existing maternal health issues was 27.1%, which reflects an increase of 5% since 2006/07.



Several of the stakeholders interviewed through the course of this project noted the increasing complexity of pregnancies. This has been attributed to factors such as the increasing age of clients, pre-existing health conditions, use of reproductive technology and aids, and proportion of multiple births. All of these factors have contributed to the increased pressure on Ontario's perinatal system.

A desire to improve the quality of maternal care, the limited availability of maternity care resources, combined with the growing financial constraints within the healthcare system has motivated the Ministry to adopt policies and strategies that aim to reduce the provision of unnecessary procedures. For example, there is a focus on reducing the number of unnecessary c-sections.

1.5. Midwifery Compensation History

The initial midwifery compensation model was informed by the Morton Report[22] and the consensus of prominent stakeholders. The set of ideals that guided the development of the funding model include:

- The absence of fee-for-service or volume-based incentives, so as to encourage midwives to spend sufficient time with each client as needed and avoid rewards for the use of unnecessary interventions.
- Ensuring pay is equitable compared to other professions performing similar work.
- The use of cooperative and principle-based negotiation practices.

The Morton Report recommended that midwifery salaries should fall between primary care nurses and Community Health Centre (CHC) physicians (see 1994 salary ranges below).

CHC Physicians	Midwives	Senior Primary Care Nurses
$80,000 - $118,000	$55,000 - $77,000	$42,000 - $56,000

[22] Robert Morton and Associates. Compensation for Midwives in Ontario: Summary Report Prepared for the Midwifery Funding Work Group. July 1993.

In the first midwifery contract the course of care fee paid to each midwife for each client was based on an average case load of 40 courses of care per year, and the salary ranges defined in the Morton Report. This fee was meant to compensate midwives for all of their clinical work, including aspects such as on-call and secondary attendance at a birth. An additional $500 per course of care was allocated for operational costs. The contract also established 12 experience levels, with each level being paid an incremental $2000 per year.

This fee schedule remained constant for over 11 years. In 1999, the Ministry modified the midwifery contract in order to clarify the professional status of midwives in legal terms. Changes were made to recognize midwives as independent (versus dependant) contractors. No changes were made to the compensation levels.

In 2005 a thorough review was conducted and the Ministry agreed to allocate a set amount of funding towards increases to midwifery fees. A decision was made to distribute the money as increases to the course of care fees for each level of midwife, as well as 2% annual increases. However, midwives would not be eligible to move up experience levels over the course of the contract. Effectively, each midwife experienced a one-time increase to her compensation over the duration of the contract. To clarify what midwives were being compensated for and to simplify the administration of the funding within each practice, the course of care fees were broken down into several components (refer to section 1.6 for an explanation of the breakdown).

In 2008, another round of negotiations took place which resulted in modest increases to midwifery income levels (i.e. 2% annually). Changes were also made to recognize the increased costs of providing care in rural or remote areas.

The table below summarizes the key milestones and changes to midwifery compensation since 1994.

Date	Compensation Modification

1994	• First contract
	• Creation of Ontario Midwifery Program and the initial Transfer Payment Agency (TPA)
	• Established course of care funding to compensate midwives for the average time spent providing care
	• Target compensation based on Morton Report: $55K - $77K annually
	• 12 fee levels established
	  ○ Level 1: Slightly above primary care nurses
	  ○ Level 12: 90% of lowest level of pay for CHC family physicians
	• No annual increases were incorporated into the contract

1999	• Second contract • No increases to compensation • Definition of midwives as independent contractors (previously dependent)
2005	• Third negotiation • Hay Report commissioned to inform negotiations[23] • In the first year of the contract annual income levels increased between 20 and 29% (depending on the experience level of the midwife) with larger increases pertaining to the lower experience levels • Annual increases (between 1-2%) were realized for the remainder of the contract • Six fee levels established (from 12 step model)
2008	• Fourth contract

[23] Hay Group. Association of Ontario Midwives: Compensation Review. February 2004.

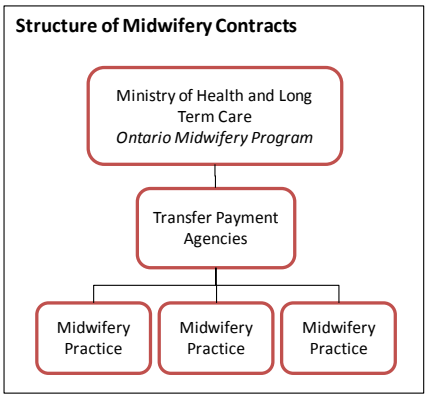
- Introduction of:
  - Experience Fee Rural/Remote supplements
  - Operational Fee Supplement for Small Rural or Remote Practices
- Introduction of incremental increases to course of care fees (2% annually)
- 2% increase (from 18% to 20%) to 'other expense' disbursements (i.e. benefits)
- Elimination of retention incentive for L1-5 Midwives

1.6. The Current Compensation Model

As of September 2010, the Ministry of Health and Long Term Care contracts with 17 TPAs across Ontario, which in turn distribute funding to 540[24] registered midwives working within 71 practices. The size of each practice ranges from one to 16 midwives.

The Ministry is responsible for approving the number of midwives that are eligible to work in each practice. The Ontario Midwifery Program also approves the maximum number of courses of care and caseload variables that each midwife/practice is eligible to bill. Proposals for expansions to this maximum (i.e. the creation of new midwife positions within practices) can be submitted to the Ministry of Health each year. TPAs receive funding annually based on the billings of the midwives in each practice.

Typically, midwifery practices operate under a partnership model. Funding from the TPA is issued to the partnership, which is then distributed as appropriate amongst its members.



The fee associated with each course of care varies depending on the experience level of the midwife. Currently there are six levels. Each course of care fee is comprised of seven components:

Allocated to midwives:

- Experience fee
- On-call fee
- Retention incentive (for level 6 midwives only)
- Secondary care fee (payable only when a midwife from the practice is present at the birth)
- Experience fee supplement (for qualifying rural and remote practices)

Allocated to midwifery practices:

- Operational fee
- Operational fee supplement (for qualifying small rural or remote practices)

Not all components of funding are received by individual midwives as direct compensation. The components of the course of care fee that are directly allocated to billing midwives include the experience fee, on-call fee, retention incentive, secondary care fee and experience fee supplement. The operational fee and operational fee supplement are directed to the practice as a partnership to cover overhead operating costs.

[24] August 2010, Association of Ontario Midwives

In addition to the course of care fees, midwives or practices may also receive:

Allocated to all midwives:

- Travel disbursements (directly allocated to all midwives as compensation for out-of-pocket expense)
- Other expense disbursements for the purchase of group benefits insurance for individual midwives (allocated to all practices based on the number of courses of care billed)

Allocated to qualifying midwives/practices:

- Professional development disbursements (reimbursed to midwives that submit receipts for costs incurred)(maximums apply)
- Second attendant disbursements (allocated to practices that receive College approval)
- New registrant equipment grants (allocated to new registrants)
- Office equipment grants (allocated to practices that are approved by the Ministry)
- Leasehold improvement grants (allocated to practices that are approved by the Ministry)
- Remote practice group grants (allocated to practices that are approved by the Ministry)

To compensate midwives for non-clinical activities and activities that require time above and beyond the expected norm, practices are able to bill for various caseload variables. The effort required for each caseload variable is calculated in terms of equivalent courses of care (ECCs). There are six types of caseload variables:

- **CV1 – Client Populations:** Compensates midwives for outreach and caring for special populations (e.g. teenage, Amish or low income women)
- **CV2 – Non-Clinical Activities:** Compensates midwives for time spent on non-clinical hospital and inter-professional work (e.g. hospital committee work)
- **CV3 – Time in Travel:** Compensates midwives for travel beyond the norm (i.e. 45 minutes of travel each way for six home visits including one intrapartum visit)
- **CV4 – Supervision:** Compensates midwives for supervising a Midwife as instructed by the College
- **CV5 – Mentoring:** Compensates midwives for mentoring a Midwife in her first year of practice
- **CV6 – Practice Development:** Compensates midwives when developing/expanding a practice caseload in a particularly challenging area, or creating a brand new practice

As previously mentioned, each practice must request approval from the Ministry for the number of caseload variables to be billed each year. The compensation model allows for the number of ECCs billed via caseload variables to be countered by a reduction in the number of clinical courses of care billed.

2. Review Methodology

This midwifery compensation review took place over a 14 week period, from July 27, to September 30, 2010. As directed by the MOU, a Steering Committee was convened to oversee project activities and provide direction to the consultants (refer to appendix A for a list of Steering Committee members). During the initial meeting of the Steering Committee, the project plan was confirmed and project governance structures were defined. Early on in the project, a set of evaluation questions were defined and approved by the Steering Committee to guide the review.

Evaluation Questions

1. Does the current compensation model reflect the current scope of work performed?
2. Does the current compensation model reflect the volume/complexity of work performed?
3. Does the current compensation model reflect the costs of doing work?
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7. Does the current compensation model recognize adherence to best practice guidelines and the achievement of the Ministry's policy objectives?
8. What market trends should be taken into consideration? Have compensation increases remained aligned with economic growth in Ontario?

The following project activities were conducted to inform the development of the final report:

- **Review of background documents** – Pre-existing reports (e.g. Morton Report, Hay Group Report) and documents were reviewed in order to understand the context for this review, as well as changes to compensation and scopes of practice that may potentially impact midwifery compensation levels.
- **Research on midwifery programs across Canada** – Published information related to the regulation and compensation of midwives in other Canadian jurisdictions was collated. Interviews were also conducted with officials in Alberta and British Columbia to understand the rationale for their respective compensation models and to identify learnings that may be relevant to Ontario.
- **Stakeholder interviews** – Interviews were conducted with a variety of stakeholder groups to understand the historical relevance of various aspects of the current funding model, as well as to gain insight into areas of funding that may require modification going forward.
- **Data analysis** – Data related to historical fee schedules and salaries (for midwives, nurse practitioners, family physicians and obstetricians) were analyzed. Health human resource data and data related to maternity services in Ontario (via the Better Outcomes Registry and Network database) were also analysed.
- **Steering Committee Meetings** – Periodic meetings were held with members of the Steering Committee to obtain feedback and guidance regarding the direction of the review.

3. Canadian Jurisdictional Review

Legislation to regulate midwives has been passed in most Canadian jurisdictions. The table below summarizes the status of midwifery programs across Canada.

	Year of Regulation	Number of Midwives	Primary Payers	Primary Funding Model	Service Delivery Model
British Columbia	1998	145 (2009)	BC Ministry of Health	Fee per course of care	Independent practices
Alberta	1998	65 (2009)	Alberta Health and Wellness	Fee per course of care	Independent practices within a managed program
Saskatchewan	2008	6 (2009)	• Regional Health Authorities • Private payers	• Salary • Private fees	Employees within regional health authority (RHA) affiliated programs/services
Manitoba	1997	40 (2009)	Regional Health Authorities	Salary	Employees within RHA affiliated programs/services
Ontario	1994	480 (2009)	Ontario Ministry of Health and Long Term care	Fee per course of care	Independent practices within a managed program
Quebec	1999	101 (2007)	Ministry of Health and Social Services	Contract	Delivered via Health and Social Service Centre affiliated programs/services
New Brunswick	2008	NA	Private payers	Private fees	NA
Nova Scotia	2009	7 (2009)	Health Authorities	Salary	Employees within three RHAs
PEI	NA	NA	Private payers	Private fees	NA
Newfoundland & Labrador	NA	NA	Private payers	Private fees	NA
North West	2005	3 (2009)	Health Authority	Salary	Employees within Health Authority
Nunavut	2008	NA	Private Payers	Private Fees Project funding	NA
Yukon	NA	NA	Private payers	Private fees	NA

Both Alberta and British Columbia have well established midwifery programs. Interviews were conducted with Ministry officials in these provinces to obtain more detail on their programs for comparative purposes. A high level summary of their respective compensation models is illustrated in the table below.

	British Columbia	Alberta	Ontario
Operational structure	Independent practice; no provincial control over practice location or size	Independent practice within a provincially managed program	Independent practice within a provincially managed program
Compensation model	Course of care fees (Five fee components per course of care)	Course of care fees (no segmentation of course of care fee)	Course of care fees (no segmentation of course of care fee)
Course of care fee	$3,042.19 (2009)	$4150 (2009)	$1,984 – Level 1 (2010)* $2564 – Level 6 (2010)
Income level	$97,410 (Avg. based on 2008/09 billing data)	$166,000 (2009/10 negotiated income level)	$81,713 – Level 1 (2010) $104,847 – Level 6 (2010)
Additional compensation for overhead (e.g. equipment, administration, etc.)	No	No	Yes • $744 per course of care (Operational Fee) • $80-$200 per course of care (Travel disbursements) • Grants (application/approval basis)
Malpractice insurance	Subsidized; Each midwife pays $2000/yr	Subsidized; Each midwife pays $1000/year	Subsidized; Ministry pays entire insurance premium for all midwives
Benefits coverage	No	No	Yes 20% of course of care fees
Maximum billable courses of care	60	40	40

* Note: Course of care fee comprised of Experience Fee, On-Call Fee, Retention Incentive, and Secondary Care Fee

British Columbia

In British Columbia, midwives are funded on a course of care basis. The Midwifery Program costs the Government approximately $17M per year, and there are approximately 160 active midwives. In 2007 the Ministry established a Master Memorandum of Understanding with midwives. Prior to this, contracts were held with each individual midwife.

Unlike in Ontario, midwives bill the government directly using the same automated billing system as physicians (Teleplan). In 2008/09, 144 midwives billed course of care fees totalling $14,026,981, indicating that the average annual income was approximately $97,410. Separate funding covers the costs of specialist referrals, or diagnostic tests ordered by Midwives.

The Ministry has made a conscious effort to maintain the simplicity of the Midwifery compensation model. Currently, there is no specific compensation for:

- On-call services
- Second attendants
- Travel fees

- Rural or remote practice
- Non-clinical and administrative activities
- Overhead costs (including rent, equipment, administrative support, etc.)
- Health benefits
- Professional development

Claims for each course of care are segmented into five parts. The compensation model is designed in a manner that compensates the most responsible care provider for each segment of care. Only one regulated health professional is permitted to bill for an individual segment of care. Thus, if a client moves during her pregnancy, or a physician conducts the delivery portion, then the billings for the entire course of care would not be submitted by one midwife. The total fees for each full course of care (as of April 1, 2009) are $3042.19. An individual midwife can bill for a maximum of 60 courses of care, annually. On average, each midwife delivers approximately 30 courses of care.

The majority of midwives practice in private practices in groups of four or more midwives, as advised by the College's approved model of care. Changes to the legal scope of practice within the last two years include the ability to initiate an induction without a physician order, the ability to assist a surgical c-section and the ability to perform a vacuum delivery. The education programs are continuing to adjust the curriculum to reflect the training required to develop the necessary competencies.

Unlike in Ontario, midwifery services are not organized as a managed Ministry program in British Columbia. Therefore, there are no restrictions to where midwives are allowed to establish their practice.

In response to the lack of competition in the insurance market, a Risk Management Program within the government underwrites midwifery practice, thus lowering the cost to midwives substantially. Currently, the Midwives Association of British Columbia collects $2000 per midwife annually, which is then submitted to the relevant area of the government.

Alberta

Government funding for the Alberta Midwifery Program was formally initiated in 2009/10, although discussions between Alberta Health and Wellness (AHW), Alberta Health Services (AHS), and the Alberta Association of Midwives (AAM), began in early 2008. Decisions regarding the administration and governance of midwifery services are still being finalized. Currently, the Association and AHW are operating under a Memorandum of Understanding.

Similarly to British Columbia (BC) and Ontario, funding is allocated on a course of care basis. However, unlike the BC model, fees for each complete course of care are not segmented based on portion of the prenatal, intrapartum, or postnatal care delivered. In principle, midwives receive the entire fee regardless of when the client came into care, or whether a transfer of care was required. With respect to transfers of care, midwives are encouraged to continue in a supportive role. The provision of primary care does not cease simply because responsibility for a certain aspect of care has been transferred to another clinician.

The course of care fee is not subdivided into components, as in Ontario, and it is intended to reflect both the experience of midwives as well as the administrative and operation aspects of their work. There are no additional fees or subsidies for:

- On-call services
- Second attendants

- Travel fees
- Non-clinical and administrative activities
- Overhead costs (including rent, equipment, administrative support, etc.)
- Health benefits
- Professional development

Malpractice insurance is subsidized by the government and purchased on behalf of the profession by AHW through HIROC. Each midwife is required to pay $1000 annually. The province is currently investigating if reduced insurance rates can be secured for midwives practicing part time.

There is no additional funding to support the mentorship of new registrants. However, to compensate the more experienced midwives for supporting a new registrant, some practices withhold a portion of the course of care fee from the new registrant and redistribute it to the mentors.

The maximum number of courses of care that each midwife is permitted to bill is 40. The Association plays a role similar to that of the Ontario Midwifery Program in that it manages the approval of new practices and the location practicing midwives.

Two midwives are expected to be present for each delivery. In the case where a second midwife is unable to attend, another clinician must be secured. This role is frequently played by a nurse, though practice varies geographically. The typical compensation for a non-midwife attending a delivery as a second attendant is approximately $350. Midwives are expected to pay the second attendant out of their course of care fees.

In the existing agreement, annual compensation for midwives is as follows:

- 2009/10 - $166,000
- 2010/11 - $176,000
- 2011/12 - $184,000

Alberta Health Services rationalized that midwifery compensation for clinical services delivered should mimic the compensation level of a nurse practitioner and that the compensation for overhead expenses should be similar to that of a family physician. The AAM provided data to help determine/validate the overhead costs of midwives, which was calculated to be 38% of the clinical compensation. That is to say, the 20011/12 compensation level could be broken down into $133,300 for clinical compensation plus $50,700 for overhead compensation.

Inter-professional care is starting to increase as some midwives are beginning to practice within Primary Care Networks (PCNs). AHS and the AAM have begun to develop funding agreements for midwives and PCNs that are operating under this ‘alternative’ model. In principle, the clinical compensation for these midwives will remain the same, but the overhead compensation may be reduced to reflect that supports that are available to the midwife through the PCN (e.g. office space, supplies, etc.).

4. Other Areas of Evaluation

The following sections address each of the evaluation questions that were assessed in the scope of this review.

4.1. Adherence to best practices & policy objectives

Evaluation Question:
Is the current compensation model aligned with the Ministry's policy objectives?

The table below outlines some of the Ministry's policy objectives (formal and informal) and describes aspects of the midwifery compensation model that demonstrate alignment with these goals.

Policy Objective	Alignment of Compensation Model
Reduce/minimize unnecessary interventions	• Course of care funding structure does not reward midwives based on the number/volume of interventions provided for each client
Provide care close to home	• Model of practice allows client to choose the location of her delivery (e.g. home or local hospital)
Ensure access for individuals in rural and/or remote areas	• Supplements and incentives are provided for midwives practicing in remote/rural areas
Optimize the use of health human resources	• Modifications to scope of practice have enabled midwives to assume full responsibility for primary maternity care • This improve patients' access to the 'right' provider at the 'right' time
Recruit and retain qualified health human resources	• Retention incentives have been put in place to ensure senior midwives continue to practice
Ensure access to 24 by 7 care	• Course of care fees require midwives to be on-call for clients on a 24 by 7 basis

In 2004 the Ministry defined a set of outcome and process related data elements that would enable the monitoring of health outcomes associated with the delivery of midwifery maternity care in Ontario. The dataset includes elements related to the demographics and health status of clients, the results of tests prescribed by best practice standards, as well as characteristics of the antepartum, intrapartum and postpartum care provided.

The release of funding through the TPAs is dependent on the practice's submission of the mandatory data set annually. An online data entry system allows for this data to be submitted electronically. In 2009, on-entry validation functionality was implemented to increase the quality of the data submitted. Algorithms embedded in the system help to identify data fields that are incomplete or inaccurate.

Periodic adjustments can be made to this data set to influence the work performed by Midwives. For example, data elements related to H1N1 screening have been implemented to ensure Midwives explicitly assess the potential existence of H1N1 infections. Compared to other professions, the direct linkage between compensation and adherence to practice guidelines is quite strong in Midwifery.

4.2. Scope of work performed

Evaluation Question:
Does the current compensation model reflect the current scope of work performed?

The work of Midwives can be broadly grouped into three categories:

1. Clinical care
2. Teaching, training and mentoring
3. Administration

Clinical Care

Midwives are autonomous providers of maternity primary care. They possess the skills and knowledge to provide the full spectrum of care required by a typical pregnant woman. Moreover, a woman with a normal pregnancy may receive the entirety of care required from a midwife, and may not see another type of obstetrical care provider throughout her term.

The legal scope of practice of midwifery is defined by the *Midwifery Act, 1991*, and the associated regulations. Ontario Midwives are permitted to perform ten controlled acts, four of which were recently approved via the Regulated Health Professions Statute Law Amendment Act, 2009. The amendments to the controlled acts include:

- Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks post-partum.
- Additional drugs available for prescription, designated in the regulations.
- Intubation beyond the larynx of a newborn.
- Putting an instrument, hand or finger beyond the anal verge.
- Taking blood from fathers and donors for the purpose of tests.

The implications of the changes to the controlled acts can be assessed in terms of the type of work performed by midwives, as well as the level of responsibility. The first three changes represent a shift in terms of the accountability of midwives, and reinforce the role of midwives as a primary care provider of maternity care. Midwives have long been capable of identifying and testing for common infections amongst pregnant women, although prior to this legislation they were not permitted to formally communicate a diagnosis based on the results of the tests – a function that would be expected of a primary care provider. Similarly – the ability to conduct routine screening tests on fathers reflects the expected role of a primary care provider.

The expansion of the medications now available for prescription also reflects an increase in the level of responsibility given to midwives. Previously midwives were required to refer a client to their family physician to receive some necessary prescriptions. This represented an inefficient use of healthcare resources.

The ability to intubate newborns represents a change both in terms of the type of work that midwives are able to perform, as well as the level of responsibility. The addition of this controlled act requires midwives to maintain an annual certification of competence. The level of responsibility associated with this controlled act is significant as *not* intubating a newborn in certain emergent situations may now have legal implications.

The table below compares the midwifery scope of practice with that of physicians and nurse practitioners. There are few acts relevant to maternity care that are available to physicians and not midwives. The significant areas of difference are in the extent to which each controlled act may be performed. Relevant activities that a competent physician is able to perform that a midwife is not include:

- Conducting surgical procedures including c-sections
- Prescribing and administering certain medications, including anaesthetics

With respect to maternity care, the nurse practitioner scope of practice is more limited than midwifery. The most significant difference is the inability for nurse practitioners to be the most responsible clinician in managing the labour of a pregnant woman. With respect to prescribing medications, nurse practitioners are unable to prescribe some of the medications (related to maternity care) such as oxytocin.

Controlled Acts of Comparator Professions		
Physicians	**Midwives**	**Nurse Practitioners**
Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis	Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks post-partum.	Communicate to a client or his/her representative a diagnosis made by the member, identifying, as the cause of a client's symptoms, a disease or disorder that can be identified from: • the client's health history; • the findings of a comprehensive health examination; or • the results of any laboratory tests or other tests and investigations that the member is authorized to order or perform.
Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.	Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area	Performing a prescribed procedure below the dermis or a mucous membrane
	Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking	
Administering a substance by injection or inhalation	Administering, by injection or inhalation, a substance designated in the regulations	Administer a drug by inhalation or injection that the member has prescribed
Putting an instrument, hand or finger, i) beyond the external ear canal, ii) beyond the point in the nasal passages where they normally narrow, iii) beyond the larynx, iv) beyond the opening of the urethra,	Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period	Putting an instrument, hand or finger i) beyond the external ear canal, ii) beyond the point in the nasal passages where they normally narrow, iii) beyond the larynx, iv) beyond the opening of the urethra, v) beyond the labia majora, vi) beyond the anal verge, or
	Inserting urinary catheters into women	
	Intubation beyond the larynx of a newborn	

v) beyond the labia majora, vi) beyond the anal verge, or vii) into an artificial opening into the body.	Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour and the post-partum period	vii) into an artificial opening into the body
Prescribing, dispensing, selling or compounding a drug	Prescribing drugs designated in the regulations	Prescribe a drug, or category of drug, as designated in the regulations
Managing labour or conducting the delivery of a baby	Managing labour and conducting spontaneous normal vaginal deliveries	NA
Applying or ordering the application of a prescribed form of energy	NA	Order the application of a form of energy prescribed by the regulations
Allergy challenge testing of a kind in which a positive result is a significant allergic response.	NA	NA
Setting or casting a fracture of a bone or a dislocation of a joint	NA	NA
Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust	NA	NA
Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses	NA	NA
Prescribing a hearing aid for a hearing impaired person	NA	NA
Treating an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning	NA	NA

A study conducted to inform the initial compensation model set in 1994 found that the average time spent on each course of care was 48 hours. It was recognized that the activities performed within the course of care would vary for each client, depending on her needs. Interviewees have acknowledged that the 'basket' of activities performed has changed somewhat since the inception of the profession. However, the flexibility of the current compensation model to allow for these shifts is viewed as beneficial.

The use of the course of care funding model and the organization of midwifery services as a provincially managed program have an impact on the manner in which some midwives practice. One of the implications of the funding model is it is difficult for midwives to organize funding for midwives working outside of the traditional midwifery practice setting. Funding for innovative inter-professional teams can be challenging.

The compensation models for other professions can indirectly impact the scope of practice of midwives. For example, the fee-for-service funding model can disincent obstetricians from supporting midwives as the primary care provider and detract from the midwives' ability to maintain responsibility for care when minor complications are identified.

There is variation in the work performed by midwives in hospital settings across the province due to varying hospital policies and local clinical leadership. In some hospitals, Medical Advisory Committees have been known to restrict the scope of practice of midwives within their organizations. Despite this fact, in many regions midwives have been able to integrate into the local maternity care team, and the hospital supports and supplements the care provided by the midwife. Midwives that actively practice in a hospital setting are increasingly participating in inter-professional team meetings, hospital committees, and other initiatives. However, it is unclear if they are being compensated by the hospital for this type of work on par with other professions performing similar work inside the hospital.

Teaching, Training and Mentoring

The profession has established a culture of 'see one, do one, teach one'. During the final years of the MEP, students spend time learning within a practice setting. Each full-time midwife that has been practicing for more than one year (and has no conditions on her professional practice) is able to take on up to three students per year. The vast majority of qualifying midwives participate as a preceptor. To compensate practices for the time spent teaching students, the Ministry of Training Colleges and Universities provides each practice with $500 per student per term (3-4 months). This fee has not changed since 1994. No additional funding is provided by the Ministry of Health.

Following graduation, new midwives are required to practice under the guidance and mentorship of an experienced midwife for one year. This requirement places a significant demand on the relatively small population of practicing midwives, as approximately 50 to 70 new midwives graduate from the MEP and IMPP each year (expected to increase to 80 to 100 graduates per year in 2011/12). This translates to nearly one midwife per practice in Ontario, per year.

Mentors are expected to be available for consultation whenever the new graduate is practicing. This can be time intensive during periods that the new graduate is on-call, as the mentor is essentially on-call as well. The College is in the process of defining the required mentoring activities more explicitly.

Practices receive compensation for the time spent mentoring new graduates through billable caseload variables (CV5). Midwives are permitted to bill between three and six equivalent courses of care for each midwife they mentor, based on criteria outlined in the fee schedule.

Administration

Since midwives work through independent practices, each is partly responsible for the administrative operations of the practice, which includes activities such as:

- Record keeping and submission of Ontario Midwifery Program forms/data
- Financial budgeting and tracking
- Practice management
- Student planning
- Scheduling of appointments
- Scheduling of caseloads
- Ordering and maintenance of supplies and equipment

- Rental or lease of office space
- Hiring and management of administrative staff
- Liaising with TPA re: annual budget
- Maintenance of hospital privileges
- Legislative compliance (e.g. PHIPA, OOHSA, Bill 168, CMO requirements, liability insurance requirements)

Some of these activities are conducted by midwives directly, whereas others are performed by administrative staff. Prior to the 2005 agreement, operational expenses were budgeted by practices and approved and funded on a line by line basis. The amount compensated for operational expenses has been estimated to be approximately $500 (per course of care). In the 2005 contract the Operational Fee was parsed out and set at $600 for the first year, $700 for 2006/07 and 2007/08/. Over the last three years, this fee has increased by approximately 2% annually. The current Operational Fee for 2010/11 is $744. A component of the Experience Fee is also intended to reflect the portion of this administrative work performed directly by midwives.

Currently, the main mechanism for ensuring that administrative reporting is maintained is the formal linkage to payment. Practices do not receive funding if the required data is not reported. Administrative requirements are also defined within the CMO's professional regulations.

It can be challenging for smaller practices to secure the necessary support staff to ensure these administrative activities are conducted in a thorough and proactive manner. Similarly, the complexity of larger practices also poses administrative challenges. Managing midwifery practice schedules to accommodate high volumes of clients as well as student placements requires a significant amount of dedicated resources.

Administrative activities performed by midwives that are considered 'above and beyond' the normal requirements are compensated through a billable caseload variable (CV2). These activities may include hospital committee work, provincial planning programs, or inter-professional committees. Each practice may apply to bill for a maximum of five CV2s per year. This was increased from three CV2s in the 2008/09 agreement.

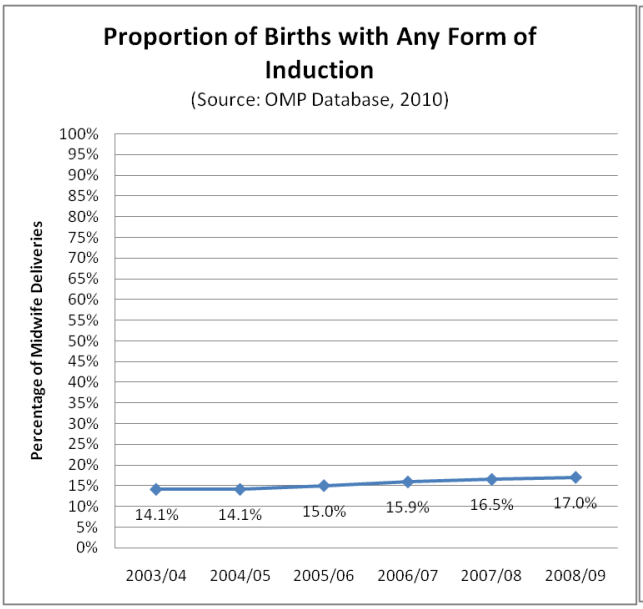
4.3. Volume/complexity of work performed

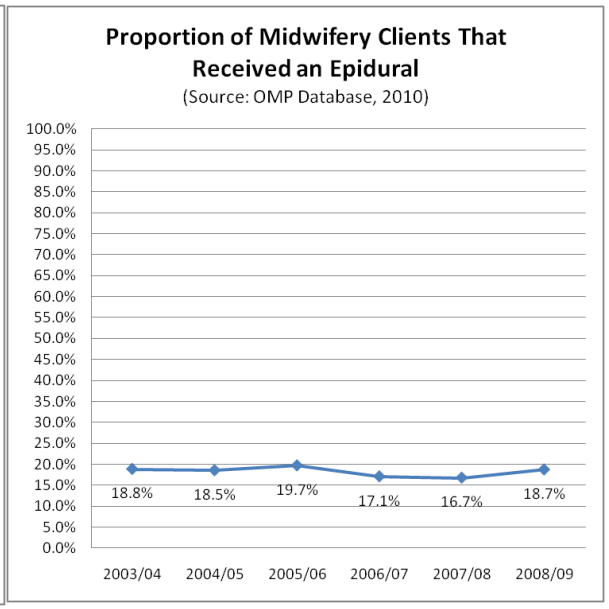
Evaluation Question:
Does the current compensation model reflect the volume/complexity of work performed?

Clinical Care

An interview with the College of Midwives of Ontario (CMO) indicated that there haven't been many major changes to the clinical practice of midwifery in the last five years (i.e. new applications of technology or modifications to best practices). However, there have been increases in the number of inductions amongst the clients cared for by midwives[25]. The use of epidurals has remained fairly constant since 2003/04.

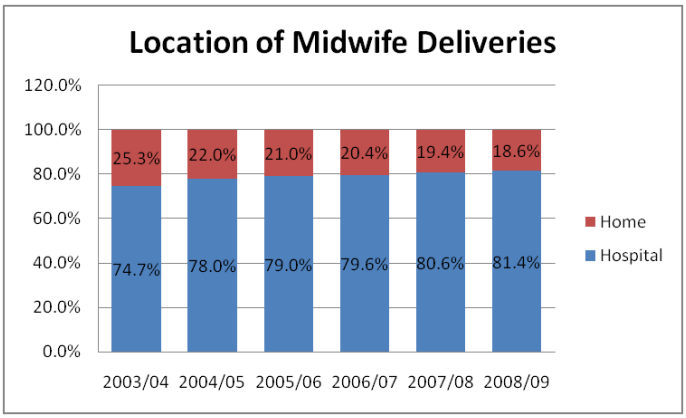
[25] MOHLTC MOR Data, 2003/04 – 2008/09





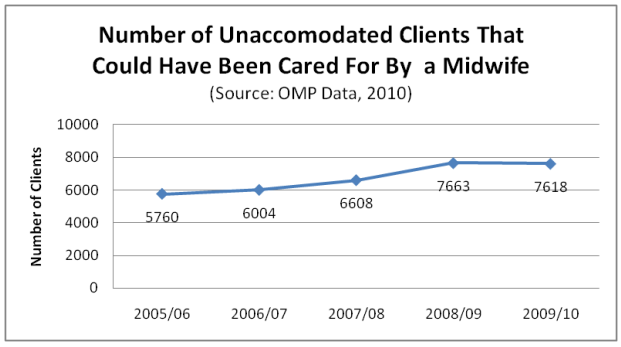
As the proportion of pregnant women in Ontario cared for by a midwife increases, it should be expected that the characteristics of midwifery clients will more closely reflect the provincial norm. The use of anaesthetics and induction techniques may increase towards the provincial average over time, although the rate of interventions amongst midwifery clients is likely to always remain lower than the provincial average as a result of the midwifery philosophy of care and intentional minimization of interventions.

Midwives are increasingly delivering babies in hospital settings (81.4% in 2008/09 compared to 74.7% in 2003/04[26]). The complexity of this work is significant as a result of the potential use of more complicated labour and pain management techniques (e.g. oxytocin and epidurals). The Ministry and the profession have strived to minimize unnecessary transfers of care and maximize the continued involvement of the midwife in cases where an obstetrician or specialist is also required. Anecdotally it has been noted that midwives have been increasingly more successful in maintaining primary care responsibilities for clients that require some form of augmentation or an epidural.



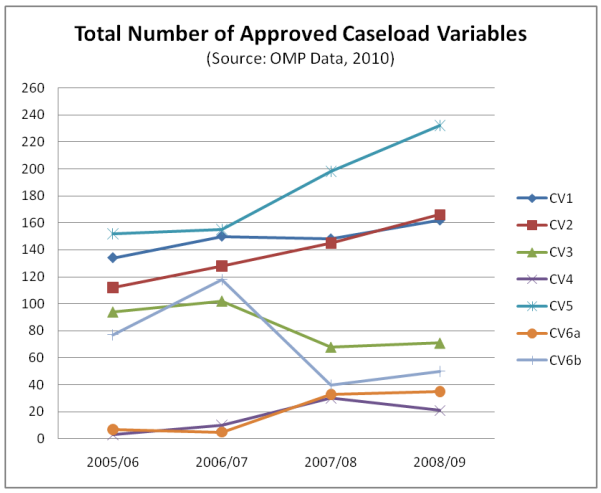
[26] MOHLTC, OMP data, 2003/04 to 2008/09

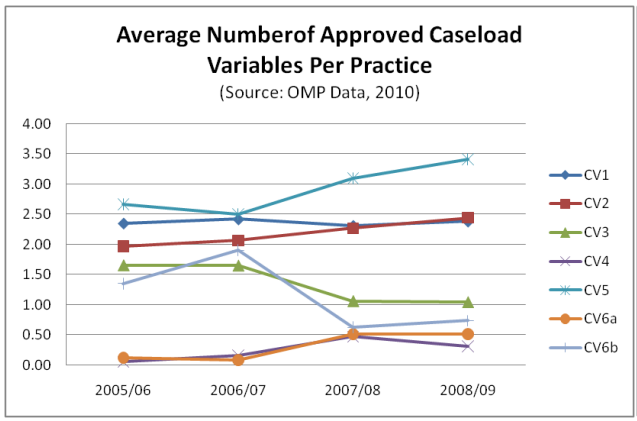
The demand for midwifery services is unmet in Ontario. The number of women that request midwifery care but are not accommodated continues to increase. The primary reason for non-accommodation is that the practice has already reached its maximum client capacity (capacity being determined by aspects such as the number of practicing midwives, and the caps hospitals place on the number of midwife attended births). Since 2005/06 there has been a steady increase in the number of women not accepted as the care they require is outside the midwifery scope of practice (35% increase from 2005/06 to 2009/10). However, this is a relatively small proportion of all the women that are not accommodated (i.e. four percent of all unaccommodated women in 2009/10).

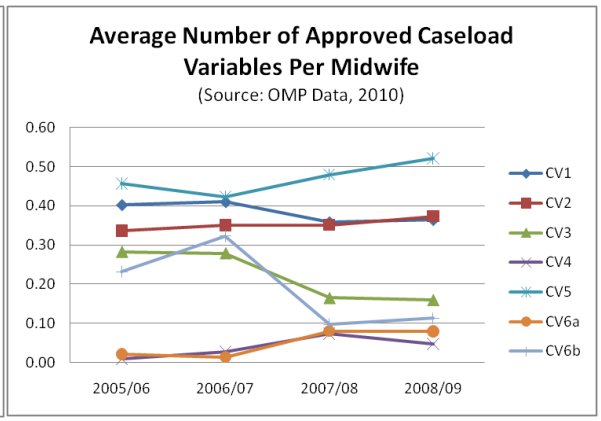


Non-Clinical Activities

Anecdotally, the non-clinical workload of the profession has been significant. As described in the overview of midwifery services in Ontario, the effort required to train the growing numbers of midwives, and establish the necessary regulatory supports has placed a strain on the relatively few numbers of midwives in the profession. An analysis of the approved number of caseload variables from 2004/05 to 2008/09 illustrates the increase in the number of midwives being mentored (CV5). It also reflects the absolute increase in the extent of non-clinical committee and project work (CV2) conducted, though the average amount per midwife has remained fairly constant.







4.4. Costs of doing work

Evaluation Question:
Does the current compensation model reflect the costs of doing work?

The table below illustrates the categories of costs associated with midwifery practice along with the aspects of the current compensation model, if any, that relate to each area. The table also illustrates how these aspects of compensation changed in the last negotiation.

Area of Cost incurrence	Relevant Aspects of Compensation Model	Analysis
Travel	• Travel disbursements based on service area type (per course of care) • CV3 – Time in travel (excessive travel)	• Travel disbursements did not increase in the 2008/09 negotiations; documentation requirements were streamlined • 6 Rates based on service area type - $80, $100, $120, $140, $160, $200 • CV3 maximums did not increase in the 2008/09 negotiations
Office/Practice overhead	• Course of Care Fee – Operational component • Grants (Office equipment, leasehold improvements, practice start up, other expenses) • CV6a – Caseload development • CV6b – New practice group	• Operational fee increases: 16.7% in 2006/07, 2.0% in 2008/09, 2.1% in 2009/10, 2.1% in 2010/11 • Average office equipment grants approved per practice: $8,738 (2007/08 – 64 practices), $14,017 (2008/09 – 68 practices), $14,641 (2009/10 – 71 practices) • Average leasehold improvement grants approved per practice: $5,076 (2007/08 – 64 practices), $4,216 (2008/09 – 68 practices), $3,358 (2009/10 – 71 practices) • CV6a maximums increased from four to 10 in the 2008/09 negotiations; CV6b maximums have remained the same

		• Minimal IT funding
Professional development	• AOM professional development subsidy	*Funding Received:* • AOM received funding to administer the Professional Development Program • $1000/midwife in 2008/09, $1500/midwife in 2009/10, $1500/midwife in 2010/11 (approximately half is used to reimburse midwives for costs incurred, the other half is used to develop programs available to all midwives) *Costs Incurred:* • Midwifery conferences cost approximately $500 - $1000 per conference • Requisite emergency skill re-certifications (e.g. NRP, ESW, ALARM) vary in cost ($40 - $600) • No midwifery masters program exists in Canada (international midwifery masters programs are available); Costs of relevant masters programs vary

Professional fees	• None	• Annual College Fees
		  • 1994 – 1997: $1035
		  • 1997 – present: $1535
		• Annual Association Fees
		  • 1994 – 2007: $2500
		  • 2007 – present: reduced in stages to $1600

Mentoring time	• CV5 – Mentoring	• Three to six per mentored midwife ($8000-$10,000 per midwife depending on experience level) • CV5 allocation per mentored midwife did not change in the 2008/09 negotiations
Non-clinical activities to improve care	• CV2 – Non-clinical activities	• Maximum of five per practice per year • Increase from maximum of three in 2008/09 negotiations

Other professions do not necessarily incur all of the same costs as midwives. It is also of note that not all professions receive the same type of compensation for the costs that they do incur. The table below summarizes the costs that comparator professions incur directly (i.e. they must pay some out of pocket monies), and the items for which they receive full or partial compensation.

	Midwives			Nurse Practitioner			CHC Family Physician*			Obstetrician		
	Incurred Directly	Compensated Directly	Compensated Indirectly	Incurred Directly	Compensated Directly	Compensated Indirectly	Incurred Directly	Compensated Directly	Compensated Indirectly	Incurred Directly	Compensated Directly	Compensated Indirectly
Office Overhead	Y	Y	N	N	N	N	N	N	N	Y	N	Y
Malpractice Insurance	N	N	Y	N	N	Y	N	N	Y	Y	N	Y
Travel	Y	Y	N	N	N	N	N	N	N	N	N	N
Professional Development	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N
Professional Fees	Y	N	N	Y	N	N	Y	N	N	Y	N	N
Formal Preceptoring	Y	Y	N	N	N	N	N	N	N	Y†	Y	N
Non-Clinical Activities	Y	Y	N	Y	Y	N	N	N	N	Y†	Y	N

Legend: Y=Yes, N=No
* Variable by CHC
† Relevant to obstetricians in academic hospitals; not relevant to obstetricians practicing in non-academic organizations

4.5. Value of benefits or equivalent funding

Evaluation Question:
What is the value of benefits, or equivalent funding received by Midwives?

In addition to the compensation that is directly attributable to the work performed by midwives, the Ministry provides funding for various programs, disbursements and grants that directly or indirectly address some of the costs incurred by midwives. Some of the benefits support the profession or practice as a whole as opposed to directly benefiting an individual midwife. Certain aspects of funding are channelled through the AOM, and others are provided directly to Midwives through their TPAs.

	Benefit	Analysis
Benefits to Midwives	AOM Benefits Program	• AOM received $1.5M in 2009/10 and 2010/11 to administer the Parental Leave program • Practices receive an amount equal to 20% of the course of care fee on behalf of each midwife (excluding the operational component) (see 2010 values in the tables below) • This funding is forwarded by the practice group to the AOM Benefits Trust that purchases Basic health coverage with these funds • Left-over funding is deposited in the member's RRSPs; this amount has declined in recent years as the cost of benefits has increased faster than the overall benefits envelope • The original concept was for the proportion of health benefits to RRSP as 75:25; currently the ratio is 85:15 due to the rising cost of health benefits

	Benefit	Analysis
Benefits to Profession/Practice	AOM Professional Development Program	• Discussed in section 4.4
	Travel disbursements	• Discussed in section 4.4
	Malpractice Liability Insurance Program	• Funding from the Ministry is allocated to the AOM for the purchase of malpractice insurance (via Healthcare Insurance Reciprocal of Canada) on behalf of its members • In 2010/11 – the Ministry paid $40,594.10 per midwife
	Second attendant disbursements	• Costs of College approved second attendants(that are in addition to those covered by the Secondary Care fee component) are covered by the Ministry for practices with caseloads of less than 160 courses of care
	Remote or small rural special second attendants disbursement	• Qualifying practices received $18,000 in 2009/10 • Approximately four practices qualified in 2009/10
	Grants	• Discussed in section 4.4
	AOM special projects funding	• $200,000 allocated to AOM annually in 2009/10 and 2010/11 for projects to improve outcomes in special populations, build capacity or achieve other objectives approved by the Ministry
	AOM Rural and Remote Practice Locums Program	• $110,000 allocated to AOM (2009/10 – 2010/11) • A portion of this funding covers the cost of administering this program

The following table illustrates the funding that is allocated to practices, and redirected to the AOM Benefits Trust, for the purchase of group benefits. All practices are eligible to receive this funding based on the number of courses of care each midwife bills.

2010/11 Benefits Allocation (per course of care)		
	Urban	**Rural/Remote**
Level 1	$397	$422
Level 2	$417	$447
Level 3	$438	$473
Level 4	$459	$494
Level 5	$481	$516
Level 6	$513	$548

As a source of comparison, the table below illustrates the types of benefits/disbursements that are provided for CHC Family Physicians, Family Health Teams, and Nurse Practitioners.

Profession	Description of Benefits
Obstetricians	• Malpractice insurance is subsidized by the government; physicians are required to pay approximately $5900 per year • On-call funding is not common and is variable depending on the hospital/community • OMA Priority Insurance Plan (OPIP) – Eligible to all physicians and their families in Ontario who work a minimum of 15 hours a week. The premium is $50/year. The remainder of the funds needed to cover the premium is paid by the OMA.

Family Health Team Physicians	• Professional development subsidy - $100 for each hour spent at approved continuing medical education conferences, seminars, etc.
	• Locum coverage (for Blended Salary Model physicians)
	  ○ Level 1 (1300-1474 roster size): $7,189.50
	  ○ Level 2 (1475-1649 roster size): $8,151.59
	  ○ Level 2 (1650 + roster size): $9,113.69
	• Lead physician payments for leadership duties (e.g. recruiting staff, organizing team)
	• Overhead expense subsidies for Blended Salary Model physicians, interdisciplinary healthcare providers and administrators within the practice (note: overhead is already included within the blended capitation or blended complement compensation models)
	• Office Practice Administration grant (for blended capitation and blended complement models)
	• Pregnancy/Parental Leave Benefit Program
	• IT funding – Allocations are based on the number of approved interdisciplinary health providers and administrative staff, and covers hardware, software and support. Non-physician costs are covered by MOHLTC. Physician related costs are covered by Ontario MD.
	• OMA Priority Insurance Plan (OPIP) – Eligible to all physicians and their families in Ontario who work a minimum of 15 hours a week. The premium is $50/year. The remainder of the funds needed to cover the premium is paid by the OMA.

Primary Care Nurse Practitioners	• Benefits program – equivalent to 20% of salary for nurse practitioners directly funded by the MOHTLC • Benefits (e.g. vacation, pension plan, professional development) for nurse practitioners employed/funded by hospitals or other organizations or means vary • Professional development fund through RNAO (max $1500 direct reimbursement per year)
CHC Physicians	• Funding equivalent to 25% of salaries is allocated to CHC operating budgets for the administration of physician benefits

4.6. Experience & training of midwives

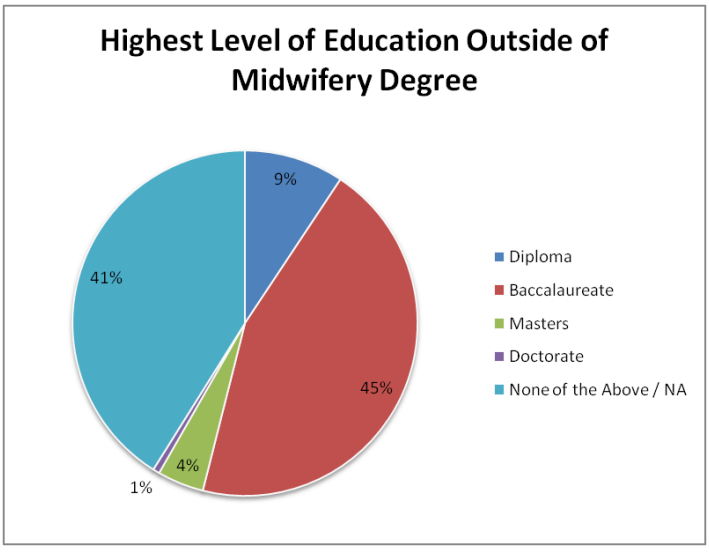
Evaluation Question:
Does the current compensation model reflect the experience and training of Midwives?

The curriculum of the Midwifery Education Program (MEP) has continually expanded to reflect the evolving role of Midwives in maternity care in Ontario. Additions to the clinical scope of practice within the *Midwifery Act* have also led to expansions in the type and content of courses provided. For example, recent additions to the prescribing authority of Midwives have been reflected in updates to the pharmacology related curriculum.

The MEP curriculum underwent a significant update in 2007 when the program was expanded to 90 students. The problem-based learning approach influenced the design of courses and the program incorporated more hands-on learning techniques (e.g. intensive labs and simulated learning exercises). An additional term of inter-professional and community placements was added to the third year.

Currently, the first year of professional practice is conducted under the supervision and mentorship of an experienced midwife. Once a midwife meets the new registrant requirements they are permitted to practice independently.

The characteristics and backgrounds of students have also evolved over time. At the inception of the MEP, there was a backlog of individuals awaiting registration. The majority of these students were formerly practicing as doulas or unregulated midwives, and required the formal education in order to practice in the regulated environment. Today, students applying to the program often have a previous undergraduate or graduate level degree, and the decision to enter the profession has been based on significant contemplation and consideration of multiple options. Of the 482 registered midwives in 2009, approximately half possess a baccalaureate, masters or doctorate degree in addition to their midwifery degree[27].



[27] Health Professions Database, 2009 submission

An analysis of the number of births attended by fourth year students in various clinical programs revealed that on average nursing students have attended one, medical undergraduate students have attended 22, family physician residents have attended 30, obstetrical residents have attended 500 and midwifery students have attended 83[28].

Aspect of Education Program	Midwives	Family Physician	Obstetrician	Nurse Practitioner
Minimum number of years of training (full time)	4 yrs (undergrad)	4 yrs (undergrad) 4 years (med program) 2 yrs (specialization)	4 yrs (undergrad) 4 yrs (med program) 5 yrs (specialization)	4 yrs (undergrad) 1 yr (graduate diploma)
Name of degree	Bachelor of Health Sciences, Midwifery	Doctor of Medicine, Family Medicine Specialty	Doctor of Medicine, Obstetrics & Gynecology Specialty	Bachelor of Science, Nursing PHCNP Certificate
Level of degree	Undergraduate	Post Graduate	Post Graduate	Post Graduate
Length of clinical placements	2.5 years	1 year clerkship* 2 years specialization*	1 year clerkship* 5 years specialization	~ 18 weeks*

*Note that NP and family physician clinical placements are not necessarily specific to obstetrical training

4.7. Comparisons to other professions

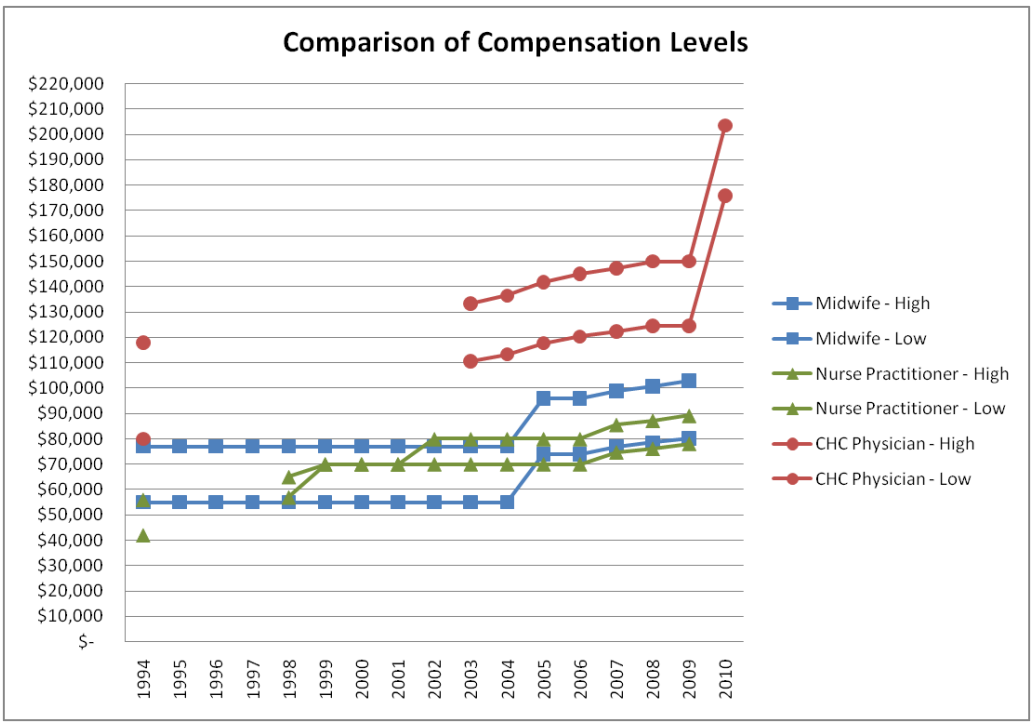
Evaluation Question:
Is the current compensation model comparable to other professions performing similar work?

Midwives are providers of primary maternity care. While there are aspects of their work that are similar to other professions, there is no comparator that fully aligns with midwifery. Based on the findings from previous reports as well as conversations with the stakeholders interviewed throughout this project, the following professions have been used as comparators in this report:

- Nurse Practitioners (Primary Care)
- Community Health Centre (CHC) Family Physicians
- Family Health Team(FHT) Family Physicians
- Obstetricians

The graph below illustrates the compensation levels available to midwives, primary health care nurse practitioners and CHC physicians (practicing in areas that are not underserviced). The 1994 salary levels for CHC physicians and Nurse Practitioners were derived from the Morton Report. For years where data was unavailable, the graph is left blank.

[28] Babies Can't Wait: Primary Health Care Obstetrics in Crisis. Report to the Ministry of Health and Long Term Care. July, 2006.

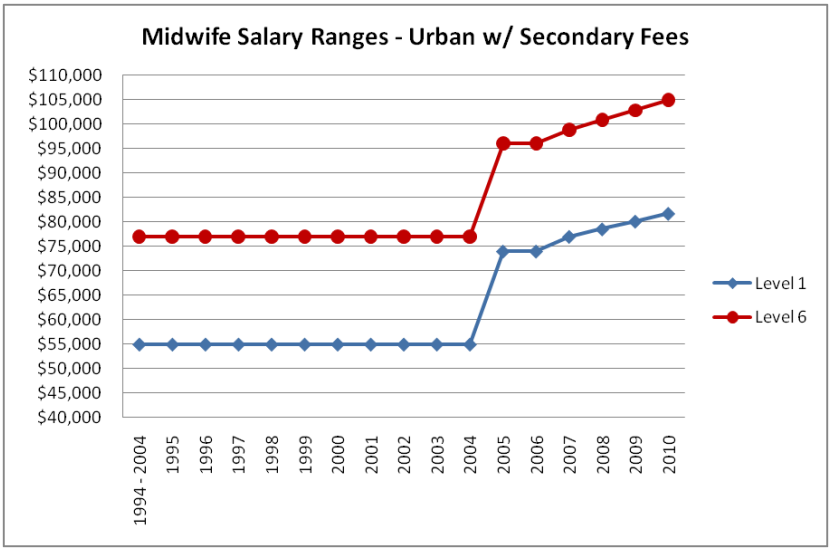


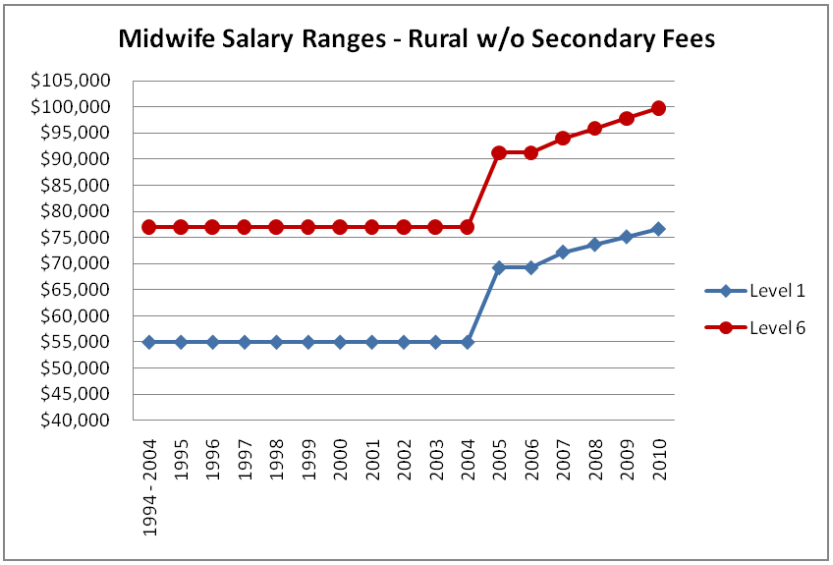
The table below further illustrates the current salary ranges of comparator professions.

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

Midwife Compensation

Midwifery salaries are dependent on the experience level of the midwife and the geographic location of the practice. Two scenarios have been used to create the salary graphs below. The first scenario reflects a midwife practicing in an urban setting, conducting 40 courses of care over the year and attending 36 births as the second attendant. The second scenario reflects a midwife practicing in a rural setting, conducting 40 courses of care over the year and not attending any births as a second attendant.



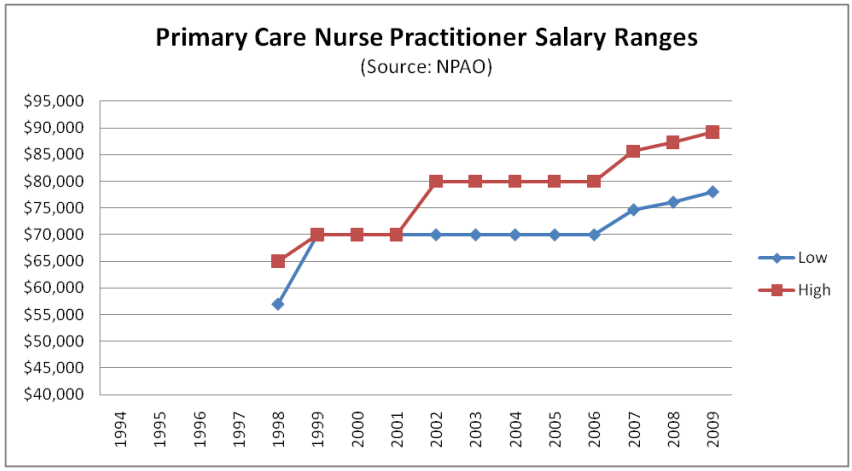


Nurse Practitioner Compensation

Legislation to regulate nurse practitioners was passed in 1998. Initially, nurse practitioner positions were primarily in CHCs. Ministry programs, such as the Underserviced Area Program (UAP), led to the creation of many new nurse practitioner positions. In 2007, the Minister announced a 6.7% compensation increase to all Ministry funded nurse practitioner positions. Subsequent increases were made to all primary health care funding models (1.9% in 2008, 2.25% in 2009).

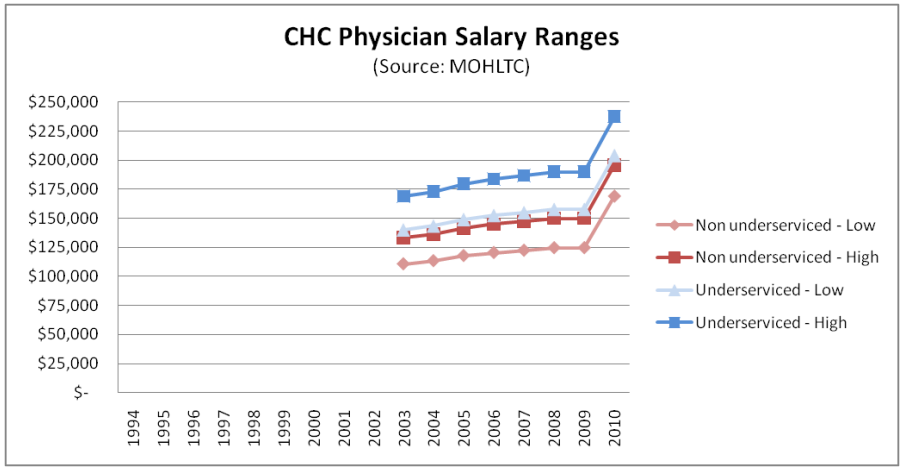
As of August, 2010, 1260 nurse practitioners were registered members of the Nurse Practitioner Association of Ontario. Of these, 876 are within the Primary Health Care specialization. The primary source of funding for primary healthcare nurse practitioners (PHCNPs) is through the Ministry. The majority of these positions are in primary care, community based practices (e.g. FHTs, CHCs, NP Led Clinics, etc.). Some PHCNP positions may also be funded by other ministries (MCYC, MCSS, Corrections), and provide a higher compensation. For the most part, the Nursing Secretariat has been successful in coordinating increases to compensation. Exceptions include new PHCNP positions which are being funded through LHIN initiatives at significantly higher rates (approximately $90,000 to $115,000). Compensation for nurse practitioners employed by hospitals is also known to be significantly higher (anecdotally between $90,000 and $120,000).

As a part of revised funding agreements, in the coming months any nurse practitioner who is self-employed or seconded but whose contract is funded by the Ministry of Health will have to become an employee. This will impact FHTs primarily.



CHC Physicians

The salary levels for CHC physicians are defined by the Ministry and funding is channelled through the LHINs for payment to CHCs. In addition to salaries, CHC physicians receive an additional $5454 annually for providing 24-by-7 coverage. LHINs also allocate an additional 25% of salaries in the CHC operating budgets for physician benefits. However, each CHC may vary in terms of how this additional funding is administered.



FHT Family Physicians

There are three main compensation models for family physicians practicing in Family Health Teams (FHTs):

- Blended capitation model (for Family Health Networks and Family Health Organizations)
- Blended complement model (for Rural and Northern Physician Group Agreements)
- Blended salary model

All of these models provide a capitated base payment for the provision of comprehensive care plus incentives, premiums and special payments for the provision of specific primary health care services. Income stabilization (IS) is also available for these physicians to develop their rosters prior to converting to the group-based blended capitation funding model. Physicians' opting for IS receive a guaranteed compensation rate for up to 12 consecutive months prior to commencement with the group.

Refer to Appendix E for a complete list of all payment incentives, bonuses and premiums offered to physicians within the FHN and FHO models. The list below highlights those that are of most relevance to those pphysicians practicing obstetrics:

- Prenatal Care Premium – additional –$2,000 for providing prenatal care to a minimum of 5 patients during first 28 weeks of gestation
- Labour & Delivery Premium – $5,000 payment for a threshold of 5 or more patients served for all Family Physicians including those in Patient Enrolment Models (PEMs). A physician receives a bonus after submitting valid claims for fee schedule codes P006A, P007A, P009A, P018A and P020A.

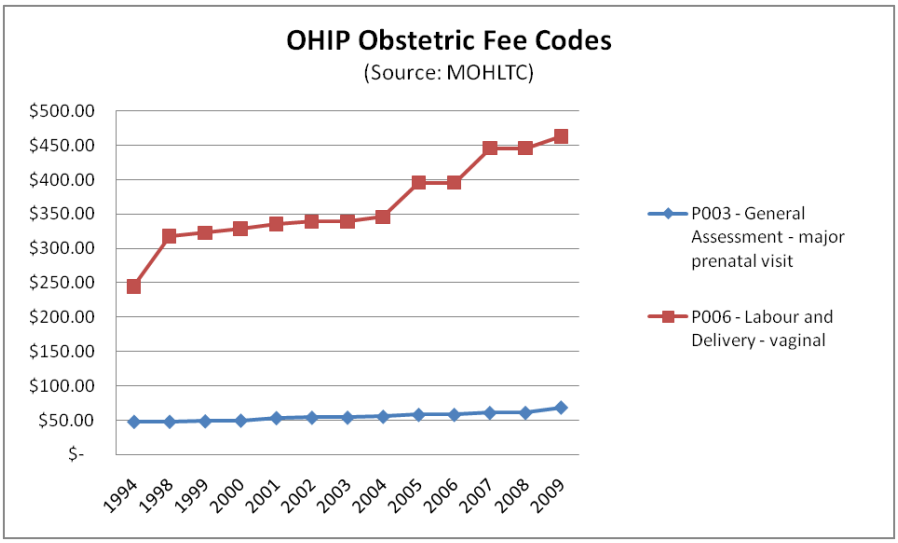
  An additional $3,000 eligible to PEM signatory physicians if a threshold of 23 or more patients are served and for submitting the above fee schedule codes. (Note: As of FY 2009/10, Labour & Delivery Premium replaced the Obstetrics premium.)
- Newborn Care Episodic Fee – incentive payment for up to eight well baby visits
- After Hours Premium – 20% of fee codes billed during after-hours period is paid to Family Health Team
- New Graduate-New Patient Fee – Income stabilization fee for each new patient enrolled (up to 300 patients per physician within the first year of practice); $100 for new patients under 65 yrs, $120 for new patients between 65 and 74 yrs, $180 for new patients older than 75 yrs
- Mother/Newborn New Patient Fee – Fee for enrolling unattached mother within two weeks of giving birth ($350)
- Unattached Multiple Newborn Fee – In the case of multiple births, $150 per additional newborn of an unattached mother
- Rural and Northern Physician Group Agreement – Premium of $5000 per year for practices with an OMA Rural Index of Ontario score of greater than or equal to 45; Each additional increment of five triggers an increase in payment by $1000

Obstetricians

The number and specificity of OMA OHIP fee codes related to obstetrics has increased since 1994. Two of the most commonly billed codes, which correspond with the type of care provided by midwives, are:

- P003 – Major prenatal general assessment
- P006 – Vaginal delivery

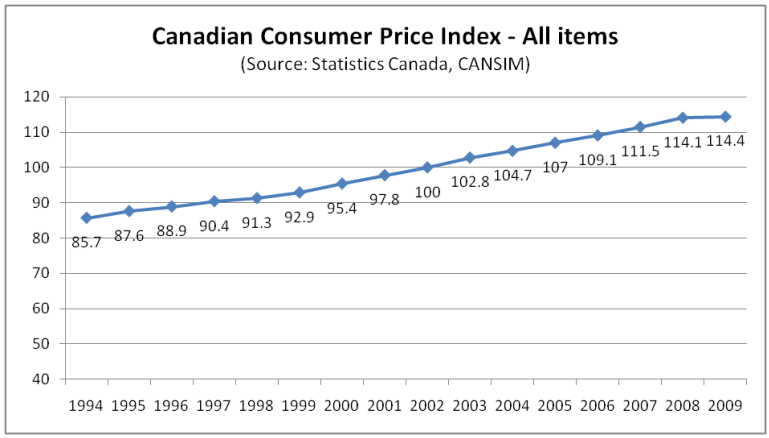
Between 1994 and 2009, the fee for P003 has increased by 43% and the fee for P006 has increased by 89%. In order to provide incentives for family physicians that deliver low volumes to remain in practice, those that deliver less than 25 babies per year are eligible for certain premium payments. For example, those that qualify are eligible to bill for twice the P006 rate if only one baby is delivered within a day. All physicians are also eligible for an additional 50% of P006 if the birth takes place after working hours (e.g. weekends), and an additional 75% if the birth takes place in the middle of the night.



4.8. Relevant market trends & alignment with economic growth

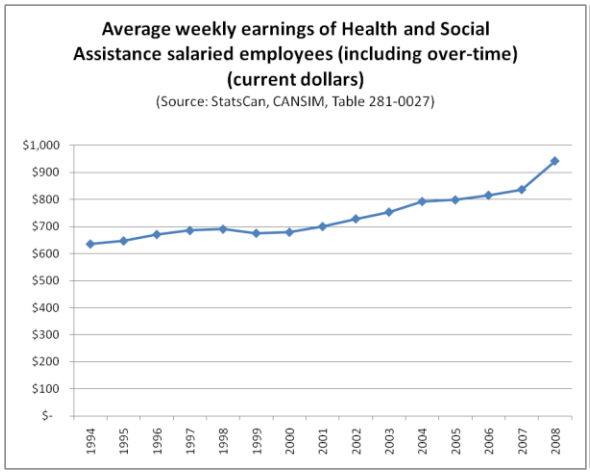
Evaluation Question:
What market trends should be taken into consideration? Have compensation increases remained aligned with economic growth in Ontario?

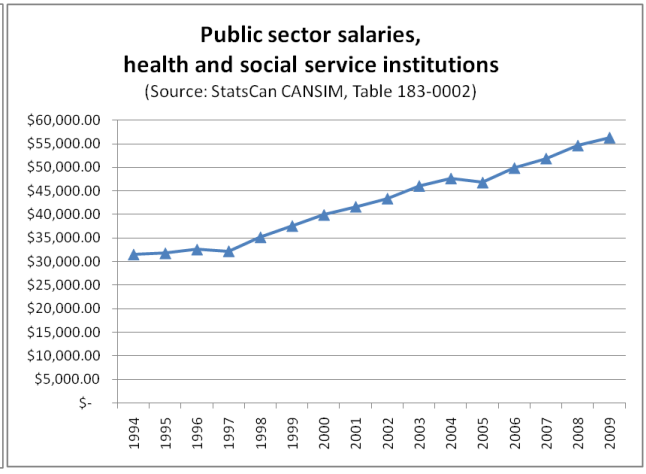
The consumer price index (CPI) measures changes through time in the price level of consumer goods and services purchased by households. The annual percentage change in a CPI is used as a measure of inflation and can be used to adjust for the effect of inflation on wages, salaries, pensions, etc. to show changes in real values. Between 1994 and 2009, CPI increased by 33.5% overall. The average annual increase was 1.8%. Between 1994 and 2008, midwifery salaries increased on average by 32.7% (refer to Appendix C – part 2). The average annual increase was 2.1%.



Other measures of relevant comparison are the average weekly earnings of individuals working within the health and social assistance industry (based on the North American Industry Classification System), and the annual salaries of public sector workers within health and social service institutions.

One of the graphs below reflects the weekly income of salaried employees, including any overtime income, calculated in current dollars. Between 1994 and 2008 income levels increased by 48%. The average annual increase was 2.9%. Annual public sector salaries of individuals working within health and social service institutions increased by 78.5% between 1994 and 2009. The average annual increase was 4.0%.





5. Findings and Recommendations

Based on the documentation reviewed and the information gathered through interviews and Steering Committee meetings, Courtyard Group has concluded the following:

The midwifery profession and maternity services in Ontario

1. Since first being regulated in 1994, midwifery has emerged as a mature, self-regulating healthcare profession that currently has over 500 members practicing in Ontario.

2. The profession has grown rapidly, placing pressures on members to assume extensive and intensive roles in teaching, mentoring and supervising of students and new graduates.

3. Enrolment in the midwifery education program, offered at three Ontario universities, was increased by 50% in 2007, but there is still significant unmet demand for midwifery services in Ontario. In 2009/10, over 7500 women requesting midwifery services and were denied service due to capacity limits.

4. Midwives are primary maternity and newborn care providers who deliver healthy babies safely and effectively and provide excellent pre- and post-birth care. They are trained and capable of supporting a significant majority of all pregnancies, often with no consultation of another healthcare provider such as an obstetrician. However, they are also trained to recognize high-risk situations and to consult and refer as appropriate.

5. In 2009, midwives attended approximately 13,000 births, representing approximately 10% of all birth in Ontario[29]. This number is constrained by the number of registered midwives, and other factors such as hospital determined caps to the number of midwife attended births. Approximately 50 to 70 new midwives graduate from the MEP and IMPP each year (expected to increase to 80 to 100 graduates per year in 2011/12 due to expansions to the programs). The current growth rate of the profession is the maximum it can achieve sustainably.

6. The scope of practice of midwifery was expanded in 2009. While not changing the essence of midwifery services, additional responsibilities were added to the scope of practice that require additional specialized education and on-going continuing education and certification.

7. The absolute number of home births continues to rise modestly, but most births supported by midwives now occur in hospital settings, in accordance with the preferences of expectant mothers. In 2008/09, 19% of births attended by midwives took place at home[30]. There have been shifting patterns of maternity care over time, as family physicians increasingly have exited from providing maternity care; a combination of midwives and obstetricians have filled the gap.

8. Midwives produce excellent care outcomes for both mothers and babies – with lower rates of Caesarean sections and higher rates of breastfeeding to cite just two examples.

9. The Ministry of Health and Long-Term Care has significant reporting requirements that must be met before a midwife is paid for a birth. This data is useful and reporting is supported by the profession, but it does represent a significant administrative burden to midwives that is not comparable to many other professions involved in obstetrical care. Reporting requirements entail a considerable amount of duplicative manual data entry.

[29] College of Midwives of Ontario. The Facts about Home Birth in Ontario.
[30] Ontario Midwifery Program database, 2008/09.

The Existing Compensation Model

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

2. Compensation for clinical practice consists of several elements: payment for a course of care that includes prenatal, intrapartum, and postnatal care; compensation for the burden of 24-by-7 on-call coverage; payment for attending a birth as a secondary midwife; compensation for the provision of care to clients in rural or remote areas; progress over time through six experience levels. These elements continue to be well supported and appear to be appropriate.

3. Several additional types of compensation are available to midwifery practices in recognition of overhead costs and non-clinical activities that midwives assume. All practices receive travel disbursements paid on a per course of care basis. Practices may also apply for and receive payment for "case-load variables" that recognize an increasing number of non-clinical activities assumed by midwives, as well as items such as excessive travel requirements, and the mentoring of new graduates in the first year of practice. They may also apply for a variety of grants for items such as office equipment and improvements.

4. Unlike Alberta and British Columbia, the Ontario Midwifery Program allocates funding for the purchase of group health benefits and malpractice insurance for practicing midwives.

5. The 1994 Morton report found that the income of a midwife should be somewhere above that of a primary care nurse and below that of a Community Health Centre family doctor, taking into account a variety of factors, including training, scope of practice, responsibility, overtime and other requirements. These comparators evolved slightly in 2004 based on the findings of the Hay Report, which replaced primary care nurses with nurse practitioners (a nursing category that was not in existence formally in 1993). We see no reason to change this positioning, and believe it has only been reinforced given the history and development of both the profession and maternal care in the province over the past 16 years.

Compensation Level

1. It is difficult to find exact comparators either in Ontario or elsewhere on which to base an assessment of the appropriate level of midwifery compensation. To some extent, comparisons are always "apples to oranges" as different professions and jurisdictions cover, or don't cover, particular expenses of the cost of practice, or provide direct or indirect compensation in different forms.

2. Looking at broad economic indicators, the income of midwives has roughly kept pace with increases in the Canadian Consumer Price Index (CPI) between 1994 and 2010; however, increases for midwives fell well below those of salaried health and social assistance employees as well as public sector salaries in health and social services over the same period.

3. Examining nurse practitioners as a comparator profession reveals that nurse practitioners at the bottom end of the compensation range are now paid the same as level 1 midwives; and in some practice settings such as hospitals they may be paid significantly more. At the top end of the range nurse practitioner pay may again exceed that of Level 6 midwives.

4. For family physicians working in Community Health Centres and in Family Health Teams, compensation is now well above that paid to midwives.

5. The two provinces with midwifery programs large enough to serve as comparators for Ontario's program are British Columbia and Alberta.

6. At face value it appears as though compensation for midwives in Alberta is close to double what it is in Ontario ($81,713 to $104,847 in Ontario compared to $176,000 in Alberta in 2010/11); however, compensation levels in Alberta are intended to cover all overhead costs that midwives are required to pay for out of pocket . In Ontario midwives receive supplemental disbursements and grants in addition to the compensation noted above to cover overhead costs. Overhead costs in Alberta are estimated to be 38% of income, therefore Ontario compensation levels should be compared to $127,536 in Alberta ($176,000 less 38%).

7. Compensation in British Columbia for midwives appears to be modestly higher than the current levels in Ontario ($97,410 in British Columbia compared to $78,540 to 100,776 in Ontario in 2008/09), although an "apples to apples" comparison is difficult since the British Columbia model subdivides each course of care into five phases with associated fees, and the volume of billable courses of care is not managed by the province. Furthermore, there is no specific compensation for overhead costs.

Negotiation History

1. Intermittent and irregular negotiations between the midwifery profession and the Ministry have hurt the compensation of midwives and contributed to need for this review. There were no true negotiations between 1994 and 2005 and no compensation increases. There was a new contract in 2005 and another in 2008 and there now appears to be a pattern established of regular negotiations. This is critical.

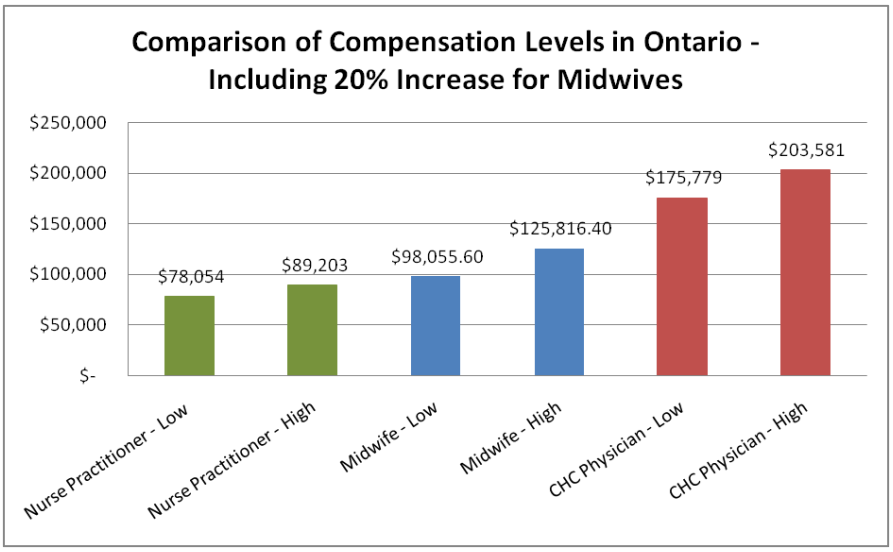
2. Delays on the Ministry's part in negotiating the 2008 contract led to it being settled just after the economic downturn and after the Ontario Medical Association and the Ontario Nurses Association settled multi-year contracts with the Ontario government with income increases averaging about 3% annually. The midwives settled for more modest increases and without any adjustment to reflect what they saw as historic inequities. Government is now signaling that it wants compensation freezes when public sector collective agreements are negotiated in the next few years. It has already imposed freezes on non-union employees in government and the broader public sector.

Recommendations

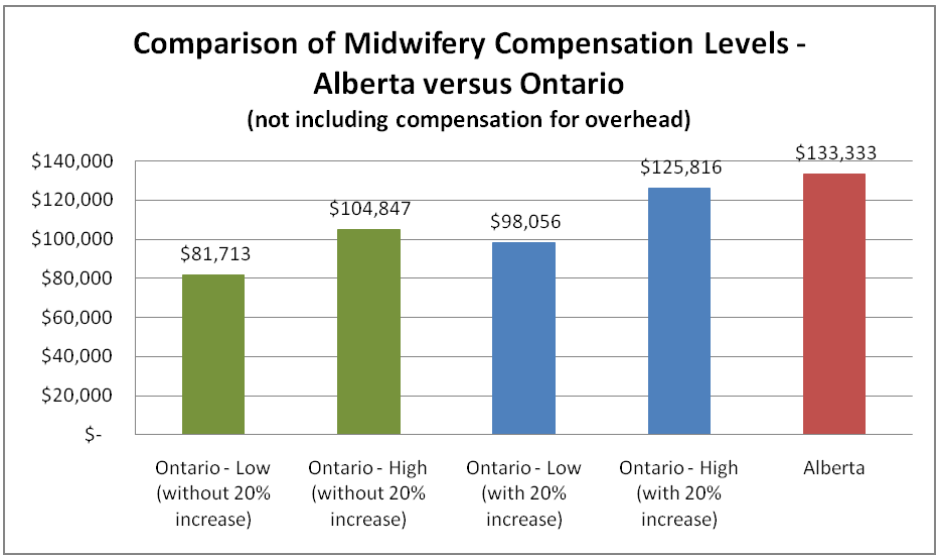
Following from the observations and conclusions outlined above, Courtyard recommends:

1. A one-time equity adjustment to midwifery compensation (i.e. experience fee, retention fee, secondary care fee, on-call fee) that would raise the income of midwives at each experience level by 20% effective April 1, 2011. This would restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians. While not completely consistent with the original Morton principles (which would push the upper limits of compensation for experience midwives even higher) we believe such an adjustment is fair in all the circumstances. Benefits allowances should remain at 20% of income, but will increase correspondingly.

   The table below illustrates compensation for midwives relative to nurse practitioners and CHC family physicians assuming the one-time equity adjustment of 20% is implemented effective April 1, 2011. Of note is that all three professions receive additional support for the provision of health and other benefits. In the case of overhead expenses, for nurse practitioners and CHC family physicians, these would typically be covered by the employer. In the case of midwives, they receive support for operating costs through the operational component of the course of care fee, as well as disbursements and grants (described in section 4.4). In order to provide an equitable comparison amongst the professions, both benefits and compensation for overhead costs have been excluded from the table below.



   The table below compares the proposed compensation level with the 2010/11 compensation level for midwives in Alberta. The Alberta compensation has been reduced by 38% to account for the embedded overhead fees, and to enable a comparison of compensation for clinical services only. With the proposed 20% increase Alberta compensation levels are 8% higher than the highest experience level in Ontario.



2. Regular negotiations on other elements of compensation and any annual changes in compensation should take place in 2011 and at regular intervals thereafter to avoid similar situations in the future. Changes in compensation will obviously reflect the pattern of wage settlements with other professions and the general economic climate.

3. Consideration for the introduction of a caseload variable (CV) for specialized clinical services. As with the existing CVs, the ability to bill for this new CV would be subject to prior Ministry approval. As part of our consultations for this review, we heard several examples where increased flexibility around payment for clinical services would benefit both midwives and the public. Some midwives are starting to develop specialized skills, such as the ability to turn breech babies, which lead to system-level efficiencies due to the avoidance of certain interventions (e.g. C-sections). Interdisciplinary care also needs to be encouraged and compensation models may need to be adjusted modestly. A new CV for specialized clinical services may allow this flexibility and support the on-going clinical development of the profession and its relationship with other maternal healthcare providers.

Appendix A: List of Steering Committee Members

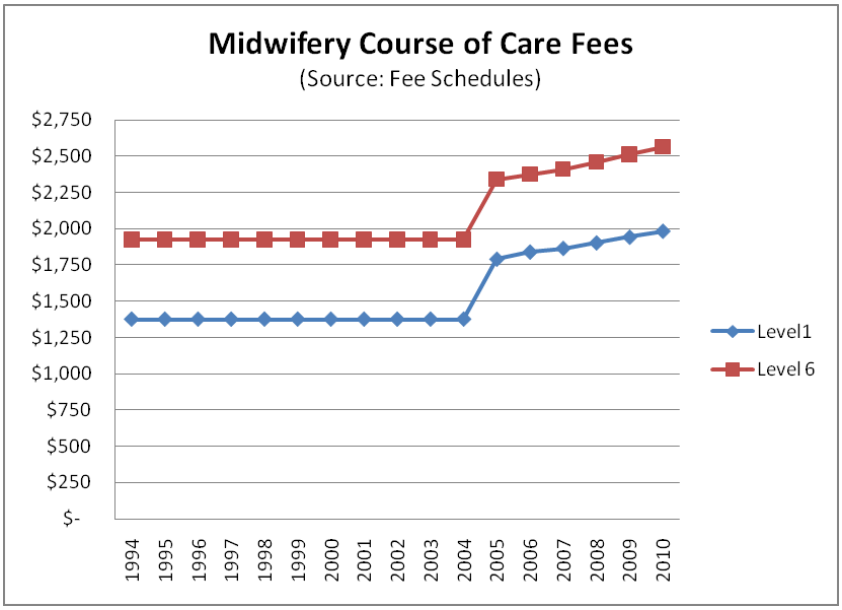
Name	Organization
Katrina Kilroy	Association of Ontario Midwives
Kelly Stadelbauer	Association of Ontario Midwives
Juana Berinstein	Association of Ontario Midwives
Seetha Raja	Ministry of Health and Long Term Care
Melanius Finney	Ministry of Health and Long Term Care
Arda Ilgazli	Ministry of Health and Long Term Care

Appendix B: List of Interviewees

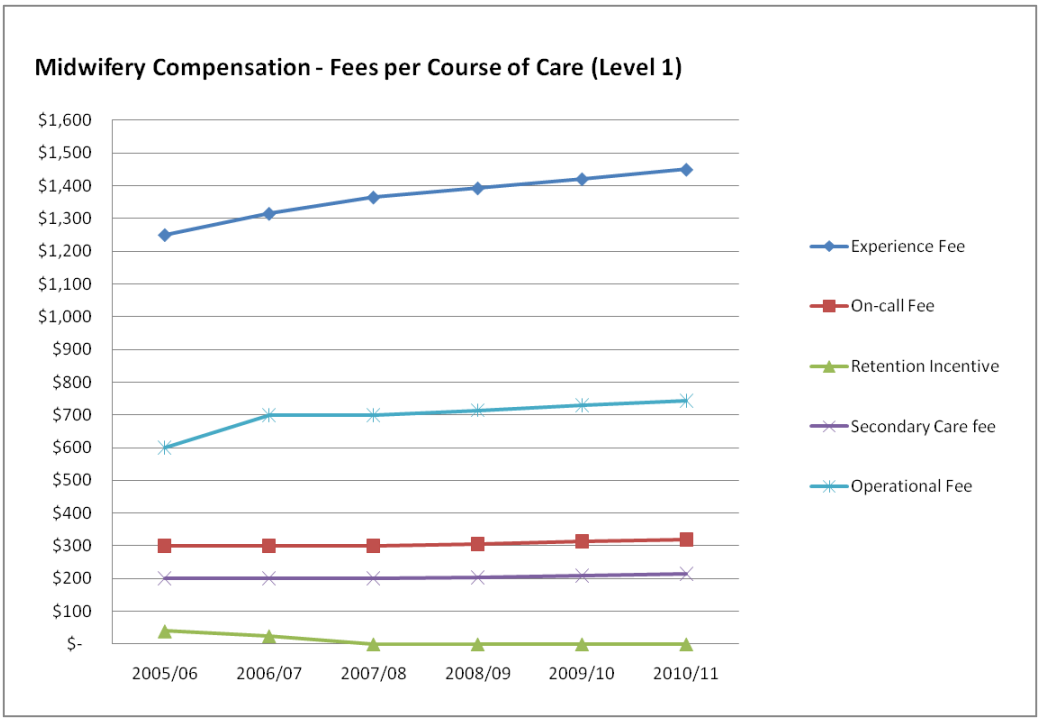
Name	Organization
Vicki Van Wagner	Ryerson Midwifery Education Program
Dr. Eileen Hutton	McMaster Midwifery Education Program
Wendy Katherine	Ministry of Health and Long Term Care
Dr. Charlotte Moore	Ministry of Health and Long Term Care
Katrina Kilroy	Association of Ontario Midwives
Kelly Stadelbauer	Association of Ontario Midwives
Juana Berinstein	Association of Ontario Midwives
Seetha Raja	Ministry of Health and Long Term Care
Melanius Finney	Ministry of Health and Long Term Care
Beverlee Sealey	British Columbia Ministry of Health
Robin Kilpatrick	College of Midwives of Ontario
Deborah Adams	College of Midwives of Ontario
Dr. Bill Mundle	Ontario Medical Association, Obstetrics
Jane Baker	Alberta Association of Midwives
Anita Paras	Alberta Health and Wellness
Joanna Pawlyshyn	Alberta Health Services

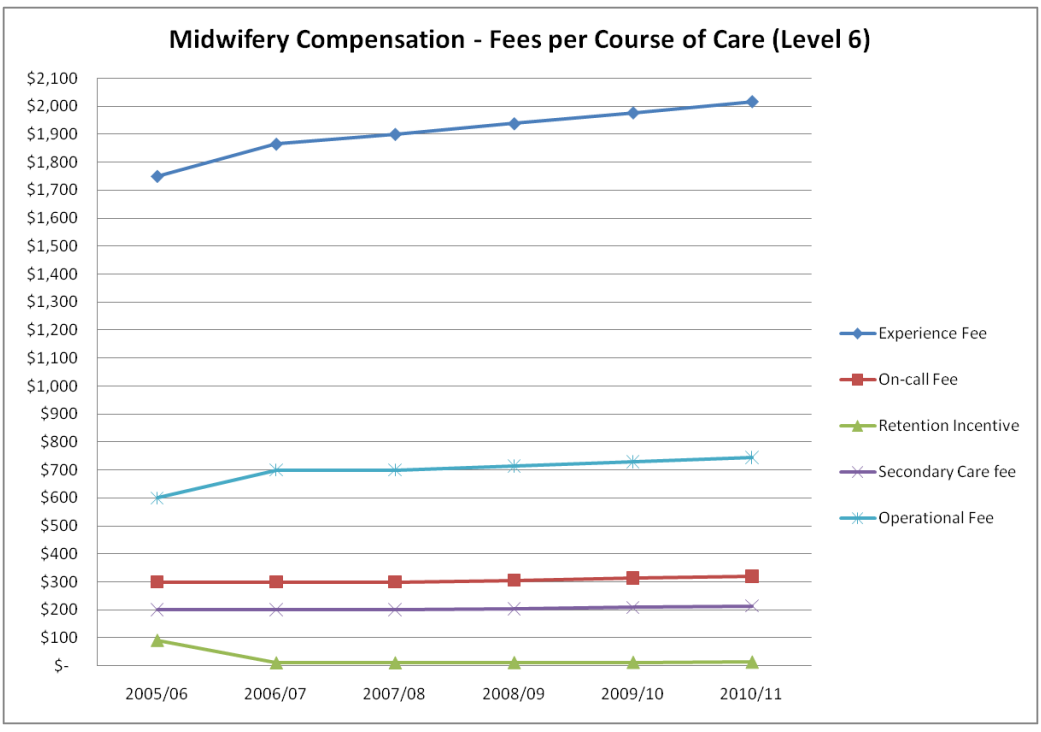
Appendix C: Income Analysis & Calculations

PART 1: Course of Care Fees – Analysis



Note: Course of care fee includes: experience fee, on-call fee, secondary care fee, retention incentive


Midwifery Compensation - Fees per Course of Care (Level 1)
$1,600
$1,500
$1,400
$1,300
$1,200
$1,100
$1,000
$900
$800
$700
$600
$500
$400
$300
$200
$100
$-
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
Experience Fee
On-call Fee
Retention Incentive
Secondary Care fee
Operational Fee


Midwifery Compensation - Fees per Course of Care (Level 6)
$2,100
$2,000
$1,900
$1,800
$1,700
$1,600
$1,500
$1,400
$1,300
$1,200
$1,100
$1,000
$900
$800
$700
$600
$500
$400
$300
$200
$100
$-
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
Experience Fee
On-call Fee
Retention Incentive
Secondary Care fee
Operational Fee

FEE SCHEDULE - 2005/06

	Experience Fee	On-call Fee	Retention Incentive	Secondary Care fee	Operational Fee	Rural/ Remote supplement
Level 1	$ 1,250	$ 300	$ 40	$ 200	$ 600	$ -
Level 2	$ 1,350	$ 300	$ 60	$ 200	$ 600	$ -
Level 3	$ 1,450	$ 300	$ 60	$ 200	$ 600	$ -
Level 4	$ 1,550	$ 300	$ 60	$ 200	$ 600	$ -
Level 5	$ 1,650	$ 300	$ 60	$ 200	$ 600	$ -
Level 6	$ 1,750	$ 300	$ 90	$ 200	$ 600	$ -

FEE SCHEDULE - 2007/08

	Experience Fee	On-call Fee	Retention Incentive	Secondary Care fee	Operational Fee	Rural/ Remote supplement
Level 1	$ 1,365	$ 300	$ -	$ 200	$ 700	$ -
Level 2	$ 1,460	$ 300	$ -	$ 200	$ 700	$ -
Level 3	$ 1,560	$ 300	$ -	$ 200	$ 700	$ -
Level 4	$ 1,660	$ 300	$ -	$ 200	$ 700	$ -
Level 5	$ 1,760	$ 300	$ -	$ 200	$ 700	$ -
Level 6	$ 1,900	$ 300	$ 10	$ 200	$ 700	$ -

FEE SCHEDULE - 2010/11

	Experience Fee	On-call Fee	Retention Incentive	Secondary Care fee	Operational Fee	Rural/ Remote supplement
Level 1	$ 1,450	$ 320	$ -	$ 214	$ 744	$ 125
Level 2	$ 1,551	$ 320	$ -	$ 214	$ 744	$ 150
Level 3	$ 1,657	$ 320	$ -	$ 214	$ 744	$ 175
Level 4	$ 1,763	$ 320	$ -	$ 214	$ 744	$ 175
Level 5	$ 1,869	$ 320	$ -	$ 214	$ 744	$ 175
Level 6	$ 2,017	$ 320	$ 13	$ 214	$ 744	$ 175

PART 2: Annual Income - Analysis

Scenario 1: Urban practice w/ 2 Midwives attending birth

Calculation

Annual Income = 40 (course of care) + 36 (secondary care fee)

Course of Care Fee = experience fee + on-call fee + retention incentive

	Annual Income Amount						
	1994 - 2004	2005	2006	2007	2008	2009	2010
Level 1	$ 55,000	$ 74,000	$ 74,000	$ 77,000	$ 78,540	$ 80,111	$ 81,713
Level 2	$ 61,000	$ 78,800	$ 78,800	$ 80,800	$ 82,416	$ 84,064	$ 85,746
Level 3	$ 65,000	$ 82,800	$ 82,800	$ 84,800	$ 86,496	$ 88,226	$ 89,990
Level 4	$ 69,000	$ 86,800	$ 86,800	$ 88,800	$ 90,576	$ 92,388	$ 94,235
Level 5	$ 73,000	$ 90,800	$ 90,800	$ 92,800	$ 94,656	$ 96,549	$ 98,480
Level 6	$ 77,000	$ 96,000	$ 96,000	$ 98,800	$ 100,776	$ 102,792	$ 104,847

	% Change						
	1994 - 2004	2005	2006	2007	2008	2009	2010
Level 1	0.0%	34.5%	0.0%	4.1%	2.0%	2.0%	2.0%
Level 2	0.0%	29.2%	0.0%	2.5%	2.0%	2.0%	2.0%
Level 3	0.0%	27.4%	0.0%	2.4%	2.0%	2.0%	2.0%
Level 4	0.0%	25.8%	0.0%	2.3%	2.0%	2.0%	2.0%
Level 5	0.0%	24.4%	0.0%	2.2%	2.0%	2.0%	2.0%
Level 6	0.0%	24.7%	0.0%	2.9%	2.0%	2.0%	2.0%

Scenario 2: Rural practice w/ 1 Midwife attending birth

Calculation

Annual Income = 40 (course of care fee)

Course of Care Fee = experience fee, on-call fee, retention incentive, rural/remote supplement

	Annual Income Amount						
	1994 - 2004	2005	2006	2007	2008	2009	2010
Level 1	$ 55,000	$ 69,200	$ 69,200	$ 72,200	$ 73,644	$ 75,117	$ 76,619
Level 2	$ 61,000	$ 74,000	$ 74,000	$ 76,000	$ 77,520	$ 79,070	$ 80,652
Level 3	$ 65,000	$ 78,000	$ 78,000	$ 80,000	$ 81,600	$ 83,232	$ 84,897
Level 4	$ 69,000	$ 82,000	$ 82,000	$ 84,000	$ 85,680	$ 87,394	$ 89,141
Level 5	$ 73,000	$ 86,000	$ 86,000	$ 88,000	$ 89,760	$ 91,555	$ 93,386
Level 6	$ 77,000	$ 91,200	$ 91,200	$ 94,000	$ 95,880	$ 97,798	$ 99,754

	% Change						
	1994 - 2004	2005	2006	2007	2008	2009	2010
Level 1	0.0%	25.8%	0.0%	4.3%	2.0%	2.0%	2.0%
Level 2	0.0%	21.3%	0.0%	2.7%	2.0%	2.0%	2.0%
Level 3	0.0%	20.0%	0.0%	2.6%	2.0%	2.0%	2.0%
Level 4	0.0%	18.8%	0.0%	2.4%	2.0%	2.0%	2.0%
Level 5	0.0%	17.8%	0.0%	2.3%	2.0%	2.0%	2.0%
Level 6	0.0%	18.4%	0.0%	3.1%	2.0%	2.0%	2.0%

Appendix D: Historical Income of Comparator Professions

	Nurse Practitioners	
	Low	High
1998	$ 57,000	$ 65,000
1999	$ 70,000	$ 70,000
2000	$ 70,000	$ 70,000
2001	$ 70,000	$ 70,000
2002	$ 70,000	$ 80,000
2003	$ 70,000	$ 80,000
2004	$ 70,000	$ 80,000
2005	$ 70,000	$ 80,000
2006	$ 70,000	$ 80,000
2007	$ 74,690	$ 85,630
2008	$ 76,109	$ 87,257
2009	$ 78,054	$ 89,203

Source: NPAO

	CHC Family Physician			
	Non underserviced		Underserviced	
	- Low	- High	- Low	- High
2003	$ 110,600	$ 133,245	$ 140,201	$ 168,905
2004	$ 113,259	$ 136,450	$ 143,573	$ 172,967
2005	$ 117,669	$ 141,763	$ 149,163	$ 179,702
2006	$ 120,351	$ 144,995	$ 152,564	$ 183,799
2007	$ 122,264	$ 147,299	$ 154,989	$ 186,720
2008	$ 124,460	$ 149,945	$ 157,771	$ 190,073
2009	$ 124,460	$ 149,945	$ 157,773	$ 190,074
2010	$ 175,779	$ 203,581	$ 212,121	$ 247,361

Note: Not including $5454/year fee for providing 24x7 coverage

Source: MOHLTC

	Obstetric OHIP Fees						
	Dollar Value						
	1994	1998	1999	2000	2001	2002	2003
P003 - General Assessment - major prenatal visit	$ 48.20	$ 48.20	$ 48.90	$ 49.85	$ 53.55	$ 54.10	$ 54.10
P006 - Labour and Delivery - vaginal	$244.70	$318.11	$322.70	$329.00	$335.60	$338.95	$338.95

	Obstetric OHIP Fees						
	Dollar Value						
	2004	2005	2006	2007	2008	2009	2010
P003 - General Assessment - major prenatal visit	$ 55.45	$ 58.20	$ 58.20	$ 61.00	$ 61.00	$ 68.75	$136.15
P006 - Labour and Delivery - vaginal	$345.75	$395.75	$395.75	$445.75	$445.75	$462.85	$916.45

Source: OMA - OHIP Fee Schedule

Appendix E: Family Health Network (FHN) and Family Health Organization (FHO) Incentive Payments

The below is a list of payment incentives, bonuses and premiums offered in the FHN and FHO models.

Capitation Based Payments:

- Blended Fee-For-Service (FFS) Payment
- Comprehensive Care Capitation Payment
- Long-Term Care Base Rate Payment
- Seniors Care Premium
- Core Service Hard Cap (for core services provided to non-enrolled patients)
- Complex Care Capitation Payment for services provided to complex vulnerable patients for the first year after a physician enrols a complex vulnerable patient

Preventive Care:

- Preventive Care Management Service Enhancement
- FOBT Distribution & Counselling Fee
- Cumulative Preventive Care Management Service Enhancement
- Targeted Medical Education Service Enhancement

Incentives:

- Diabetes Management Incentive
- Heart Failure Management Incentive
- Add-on Initial Smoking Cessation Fee
- Smoking Cessation Counselling Fee

Premiums:

- Premium for Primary Health Care of Patients with Serious Mental Illness
- After Hours Premium
- NP Special Premiums & After Hours

Special Payments:

- Obstetrical Deliveries
- Hospital Services
- Palliative Care
- Office Procedures
- Prenatal Care
- Home Visits (Other Than Palliative Care)
- Labour & Delivery
- Long-Term Care Premium

Rostering and Patient Fees:

- New Patient Fee
- New Graduate – New Patient Fee

- Per Patient Rostering Fee
- Newborn Care Episodic Fee
- Unattached Patient Fee
- Unattached Complex/Vulnerable Patient Fee
- Unattached Mother & New Patient Fee
- Unattached Multiple Newborn Fee
- FOBT Positive/Colon Cancer Increased Risk New Patient Fee

Other Payments:

- Rurality Gradient
- Office Practice Administration Grant
- Group Management Leadership Payment (GMLP)
- Telephone Health Advisory Service Payment