Third Session - Thirty-Sixth Legislature

of the

# Legislative Assembly of Manitoba

# DEBATES
# and
# PROCEEDINGS

## Official Report
## (Hansard)

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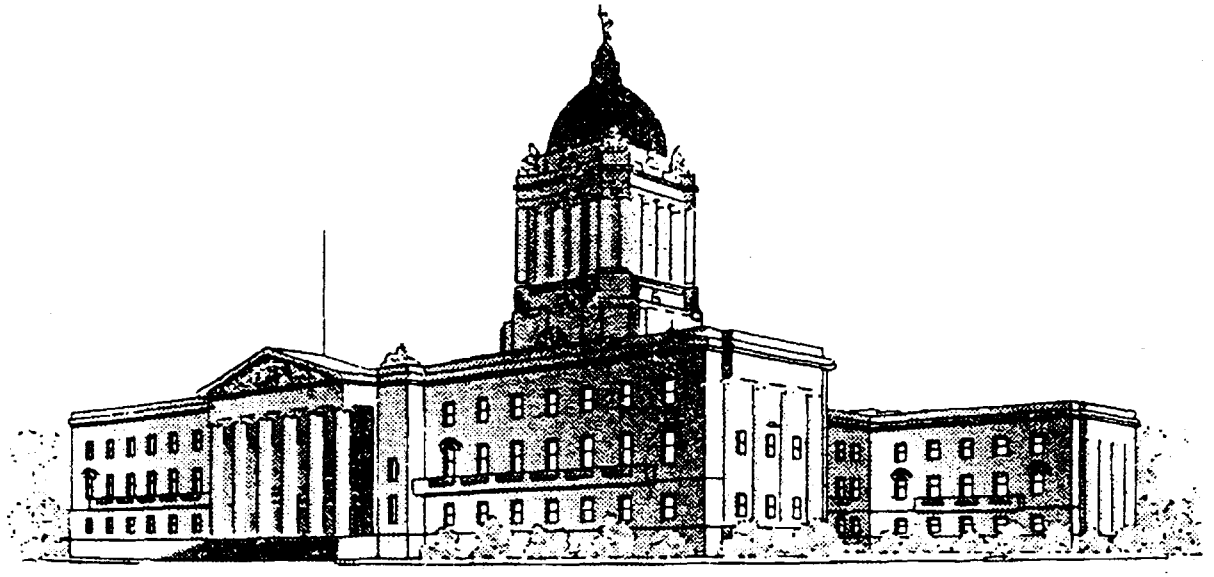

Vol. XLVII No. 42A - 10 a.m., Thursday, May 8, 1997

**MANITOBA LEGISLATIVE ASSEMBLY**
**Thirty-Sixth Legislature**

| Member | Constituency | Political Affiliation |
|---|---|---|
| ASHTON, Steve | Thompson | N.D.P. |
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| CERILLI, Marianne | Radisson | N.D.P. |
| CHOMIAK, Dave | Kildonan | N.D.P. |
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| GAUDRY, Neil | St. Boniface | Lib. |
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| HELWER, Edward | Gimli | P.C. |
| HICKES, George | Point Douglas | N.D.P. |
| JENNISSEN, Gerard | Flin Flon | N.D.P. |
| KOWALSKI, Gary | The Maples | Lib. |
| LAMOUREUX, Kevin | Inkster | Lib. |
| LATHLIN, Oscar | The Pas | N.D.P. |
| LAURENDEAU, Marcel | St. Norbert | P.C. |
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| Vacant | Portage la Prairie | |

# LEGISLATIVE ASSEMBLY OF MANITOBA

## Thursday, May 8, 1997

**The House met at 10 a. m.**

*PRAYERS*

## ORDERS OF THE DAY

**Hon. James McCrae (Government House Leader):** Madam Speaker, would you be so kind as to call the bills as listed on page 4 of today's Order Paper, namely Bills 26, 27 and 28; and after that Bill 7 which is on page 2 of the Order Paper, Bill 23 which is on page 4; and should there be time remaining after that, the bills in order as listed on the Order Paper.

## SECOND READINGS

### Bill 26–The Corporations Amendment Act

**Hon. Mike Radcliffe (Minister of Consumer and Corporate Affairs):** Madam Speaker, I move, seconded by the Minister of Government Services (Mr. Pitura), that Bill 26, The Corporations Amendment Act; Loi modifiant la Loi sur la corporations, be now read a second time and be referred to a committee of this House.

**Motion presented.**

**Mr. Radcliffe:** Madam Speaker, I will be very brief with preliminary remarks on this. It is referring to Section 16 of The Corporations Act and basically what we are doing, it applies to foreign trusts and loans and local trust and loan corporations that are operating in Manitoba. In fact, we are very proud that we have a wonderful trust and loan company, Investors Trust, that operates out of Manitoba and is a wonderful employer of the good people of Manitoba and performs a very excellent service in the mutual market in Manitoba, a mutual corporation.

Investors for the last number of years has been functioning at the federal standards and levels of regulation, and, in fact, what we are adopting now is the federal regulations to make them more harmonious and consistent with regulation across Canada. The federal government and all other provinces do not permit foreign trusts and loans to set up branches in Canada or respective provinces. Permitting branching raises various concerns. The solvency of the branch office depends on the solvency of the overall company, and so what we are doing is adopting the federal restrictions, the federal regulations–

**Mr. Steve Ashton (Thompson):** Are you sure about that?

**Mr. Radcliffe:** Ah, indeed, I am sure. [interjection] There will be no Bre-X in Manitoba, I can assure the–now I know the honourable member for Thompson is very concerned about that because, of course, he comes from a mining background, and I can say with great empathy that there is no dust on the member for Thompson, Madam Speaker.

**Mr. Ashton:** Well, I would not go that far.

**Mr. Radcliffe:** Well, indeed.

**Mr. Ashton:** Certainly no gold dust.

**Mr. Radcliffe:** No gold dust on the member for Thompson.

So, Madam Speaker, I would heartily recommend this bill to the attention and perspicacity of honourable members in this–[interjection] You liked that one? It is early in the morning–of the members of the Chamber. Thank you.

**Mr. Ashton:** I move, seconded by the honourable member for Dauphin (Mr. Struthers), that debate be adjourned.

**Motion agreed to.**

### Bill 27–The Public Schools Amendment Act

**Hon. Linda McIntosh (Minister of Education and Training):** Madam Speaker, I move, seconded by the Minister of Industry, Trade and Tourism (Mr. Downey),

that Bill 27, The Public Schools Amendment Act, Loi modifiant la Loi sur les écoles publiques, be now read a second time and be referred to a committee of this House.

**Motion presented.**

**Mrs. McIntosh:** Bill 27, The Public Schools Amendment Act, being tabled today, presents a number of changes to The Public Schools Act. These changes affect the terms of school trustees, the assignment of principal's duties to the superintendent in the case of the South Winnipeg Technical Centre, school divisions' and districts' flexibility in dealing with their bus fleets, financial provisions that no longer apply, the compulsory school age and the age at which the right to attend school at no cost terminates. I will speak very briefly to each of these in turn.

The first change concerns subsection 25(6) which sets the length of school board terms at either two or three years and allows for alternating school board elections or those in which trustees run for election at the same time. Some school boards want to schedule their elections to coincide with municipal elections. Not only would this measure save costs, but it might also ensure a larger voter turnout. Trustees would then serve a three-year instead of a two-year term. To make the new schedule work, a transitional one-year term would be required, and for this reason this section is being repealed and a statement substituted that would allow the Minister of Education to approve the increase or decrease in the term of office of trustees in response to a written request by a school board. This will make it easier for school boards to have elections run simultaneously rather than midterm of what is commonly known as the three-year term.

Subsection 52(2) is amended by adding the name of South Winnipeg Technical Centre to the list of school districts who can assign the duties of the principal to the superintendent. The governing board of South Winnipeg Technical Centre has requested this amendment so it can alter the centre's administrative system. The board believes the amendment will enable it to operate more efficiently and effectively as a vocational training institution.

The repeal of subsection 174(2)–this subsection requires the minister to authorize the disposal of school buses. At present, school buses are purchased by the Department of Education and Training and allocated to school divisions who then become responsible for their maintenance. The department however remains the owner. As of July 1, 1997, the ownership of school buses will be turned over to school divisions and districts to give them greater flexibility in managing school bus fleets, a move that necessitates allowing them to sell older buses, purchase new ones, or otherwise use the proceeds of the sale.

The repeal of financial provisions contained in Sections 186.1(1) through and including 186.2(4) which were enacted to limit the amount of taxation levied by school divisions for their special requirement in 1993-94, '94-95, these sections were limited to those years. They no longer apply; hence, they are no longer necessary. They were specific to those two academic years.

The repeal of subsection 258(2) pertaining to compulsory school age and the substitution of this new definition which clarifies some confusion over the existing definition, the new definition will be more clear and will read this way: A child who is seven years of age or older on December 31 in a year is deemed to be of compulsory school age at the beginning of the fall term of that year.

* (1010)

As well, the repeal of Section 259 will speak about the age at which school is completed. It pertains to the right to attend school to an age three years beyond the age of the majority. In some divisions, they were never sure whether that meant when a person became 21 or finished being 21. This will clarify the intent. The wording is improved and it says: The substitution will clarify the age beyond which students will no longer have the legal right to attend school at no cost. The amendment reads this way: In accordance with this act, a person who is six years of age or older on December 31 in a year has the right to attend school from the beginning of the fall term of that year until (a) the last day of June in the year in which the person becomes 21 years of age or (b) the day the person receives a graduation diploma as defined in the regulations, whichever comes first.

That should help with any confusion in the field.

Subsection 259(2) authorizes the minister to make regulations defining graduation diploma for the purpose of the preceding clause. Because of the need to keep wording consistent and because of the change in wording, we will have some consequential changes in The Public Schools Act essentially repealing Sections 17 and 18 of The Public Schools Amendment Act 1996 c.51.

In short, then, Madam Speaker, each of these changes has come about either as a request from the field or to clarify the original intent. The one that we particularly need to have passed this session to assist school boards is enabling trustees to apply to the minister to change their two-year term to three-year term or to a one-year term to enable them to have that consistency of all trustees being elected in the same year. This, they say, not only would enable them to work for improving costs but also where they are thinking of changing the number of trustees on their board or downsizing their board, they need to have people coming in at the same time.

Madam Speaker, with those few brief comments, I thank you for the opportunity to speak to this bill and conclude my remarks for now.

**Mr. Steve Ashton (Thompson):** I move, seconded by the member for Crescentwood (Mr. Sale), that debate be adjourned.

**Motion agreed to.**

## Bill 28–The Emergency Measures Amendment and Consequential Amendments Act

**Hon. Frank Pitura (Minister of Government Services):** I move, seconded by the Minister of Urban Affairs and Housing (Mr. Reimer), that Bill 28, The Emergency Measures Amendment and Consequential Amendments Act (Loi modifiant la Loi sur les mesures d'urgence et modifications corrélatives), be now read a second time and be referred to a committee of this House.

**Motion presented.**

**Mr. Pitura:** Madam Speaker, I have a few short remarks in regard to this amending legislation. The legislation in itself takes into account the fact of amalgamating the disaster financial assistance board, as it was previously known, and the Emergency Measures Organization. Both of these now are encased under one section or one branch of the department now known as the Manitoba Emergency Management Organization.

I think what it reflects is the fact that, as we all know, disasters often hit us in this province and in fact we are in the middle of one right now, but what it does do is recognize the fact that because of the fact that disasters may strike at any time, whether they be flood or whether they be a tornado or whether they be environmental, that every part of this province needs to go through a preparation in the event of any of these disasters striking their communities. So this legislation now enables the Manitoba Emergency Management Organization to work with communities not only in responding to disasters but also in terms of preparation and planning in the event of a disaster occurring.

I think that over the last couple of years we have seen what a positive result occurs when you have a lot of local communities involved in preparing for eventual disasters. It shows that the communities, once they are organized and ready to respond to a disaster, whether it be local or regional or even provincial in nature, have that ability to organize very quickly, respond, have people in place in various areas to respond to the disasters.

So it really makes a lot of sense for the amalgamation of these two bodies to be put together to address this new scenario with emergency management. The act also brings into correlation with these amendments all other acts of the Manitoba Legislature that may be affected as a result of this legislation.

One other important aspect of this act is that it does set up for the first time in Manitoba the Disaster Appeal Board. The Disaster Appeal Board is put into place to hear appeals from claimants with regard to not being satisfied with their particular claim, and I think that is a most important part of this act with regard to the changes. This board will have the power, once they hear an appeal from the claimant, of either confirming the appeal, burying the appeal or setting aside the appeal with respect to each claimant. The decision of

this board, Madam Speaker, will be the final decision. That is with regard to appeals to disaster assistance.

One other thing that the act does address is with respect to penalties, with regard to either environmental disasters or natural disasters, that for offences under the act the amount of the fine has been doubled to $10,000 or a year in jail or both depending on the particular offence. Basically, this part of the act was brought into this format to line up and correlate with other provinces who have similar offence penalties.

I think it is important to have this in the act in the event that what can happen in a natural disaster or in an environmental disaster is that for those persons who would choose not to respect the wishes of the local Emergency Management Organization, there is this particular legislation in place so that other lives will not be put in jeopardy as a result of one person disregarding the wishes of the Emergency Management Organization. So I think it is important from that standpoint to be there.

I would also like to share with the House as well that probably in the history of Emergency Measures and now the Emergency Management Organization there was never a need to use that section of the act, but it is there in the event that it needs to be used.

So with those few remarks, Madam Speaker, I am prepared to bring this bill further along in the House.

**Mr. Tim Sale (Crescentwood):** Madam Speaker, I move, seconded by the member for Dauphin (Mr. Struthers), that debate be adjourned.

* (1020)

**Motion agreed to.**

## DEBATE ON SECOND READINGS

### Bill 7–The Midwifery and Consequential Amendments Act

**Madam Speaker:** To resume second reading debate on Bill 7 (The Midwifery and Consequential Amendments Act; Loi sur les sages-femmes et modifications corrélatives), on the proposed motion of the honourable Minister of Health (Mr. Praznik), standing in the name of the honourable member for Transcona (Mr. Reid).

Is there leave to permit the bill to remain standing? [agreed]

**Mr. Tim Sale (Crescentwood):** Madam Speaker, I am very pleased to rise and speak in regard to this bill which I believe in the main is a good piece of legislation and has tribute to the many members of the community who put years and years of work into framing appropriate regulations and legislation, conceptual approaches to the licensing of midwifery in Manitoba.

I know many of the people involved and have known them for a great number of years, since at least the end or the last years of the 1970s. So I am glad to see that the province is finally moving on this issue.

From biblical times, women have played an important central and healing role in the delivery of health care of all kinds and particularly at the time of the delivery of children. There are numbers of biblical stories involving wise women, women healers who attend at critical times in people's lives, and the practice of midwifery dates from the dawn of recorded history in which women recognized that there were particular gifts and skills that they could share with each other at the time of birth.

From those earliest times, birth has been both a natural and a risky process. The vast majority of births are normal in the sense that they follow a pretty predictable path, but there are always those births which turn out to have an element of risk associated with them and the ability to predict that risk, while it has grown vastly over the last 20 years in particular, is nonetheless an imperfect ability and will always remain so I believe. So there will always be an element of risk associated with the process of human birth.

In the 1800s, surgeons like Lister, Pasteur and others recognized that one of the serious problems associated with human health was the whole question of infection, and they began to recognize the causes of infection and the possible ways in which it could be minimized or prevented. That was the birth essentially then of the

public health movement in England in particular, in France and in other developed nations, followed swiftly by the developing nations of the western world.

Very quickly, Madam Speaker, tremendous improvements in human health were noted as it became clear to people that clean water, well-ventilated dwelling places, the reduction of overcrowding and the practices particularly around childbirth relating to the use of sterilized or at least as scrupulously cleaned materials as possible would increase greatly the chances of the newborn child surviving and the chances of the mother in recovering from any injury or simply from the normal process of childbirth.

Madam Speaker, up to the mid-1800s, virtually all births were attended by women and not by men. In the developments of the medical profession in the mid-1800s and on to the beginning of this century, medicine progressed very quickly in its understanding and the level of its training of doctors. At the same time, it also became a very political movement in all parts of the developed world. Colleges of physicians and surgeons sought to take over responsibility for and control of virtually all human health-related events.

So what happened during that period of history was that the wise women, the women healers, the women midwives were slowly but very effectively marginalized from their role, which historically they had developed and cherished and nurtured and done a great service to countless women in performing. It is a matter of historical record that the so-called witches that were burned during the Inquisition and later in the Salem witch trials were very often the wise women of the communities. They were the healers, they were the women who were able to provide wisdom and guidance in difficult issues of human health, human reproductive care.

Very often, Madam Speaker, the midwife was one of the victims of the purges of those times. Unfortunately during the 1800s and early-1900s in the quest, in the laudable and legitimate quest for improving human health care, doctors displaced healers who were predominantly women. In the early part of this century and certainly accelerating into the present day, virtually all jurisdictions, with the exception of Canada and the United States, moved away from the complete dominance of the care of women at childbirth on the part of the medical profession and recognized that the continuing practice of midwifery was beneficial and could be brought to the same high standards of clinical practice that obstetrical medicine had attained over the many years of its development.

So in some countries, particularly in countries like Britain and some other countries of the British Commonwealth, the practice of midwifery never entirely disappeared. It was in retreat for many years, as doctors insisted that the only safe way to give birth was in a clinical setting under the direction of a trained obstetrician-gynecologist, and so a tug of war ensued between the traditional practice and profession of midwifery and the relatively newer practices under colleges of physicians and surgeons in the area of either family practice or gynecology and obstetrics.

Madam Speaker, in Manitoba this struggle is not yet over, and in so many ways we are a backwater in this particular issue in the developed world. I was privileged to be the director of the Social Planning Council from 1976 to 1985 in this city, and from 1978-79 to about 1983 the council was host to the organization that was called the Community Task Force on Maternal and Child Health. The task force was headed by a nurse with a great deal of high risk nursing experience, particularly neonatal nursing, Norma Buchan, and had at various times as many as 125 community volunteers involved in its 10 or 12 working groups. It published over 20 volumes of research and recommendations to the community in all areas of maternal and child health, human sexuality, reproductive law, reproductive choice, and many other aspects of this complex field.

There were many members of the College of Physicians and Surgeons involved in this task force, as well as lay members of the community. I remember one particular confrontation between Isabel Auld, whom many of the members of the House will know as the former chancellor of the University of Manitoba and a staunch community defender of the role of women in all aspects of life and a person of great tenacity and wisdom. She and I went to visit the head of Obstetrics and Gynecology, whose name I will not put on the record but a very well-known and well-respected clinician, who said words that were

approximately, the last thing we need in the medical profession is a bunch of do-gooders running around trying to tell us how to help babies get delivered safely in hospitals where they belong.

* (1030)

He apparently did not know that he was speaking to Isabel Auld who was then the chancellor of the University of Manitoba, and she walked down the hall to the office of the then head of the Faculty of Medicine at the University of Manitoba, Dr. Arnold Naimark, who was subsequently president of the University of Manitoba, and she said, Arnold, you really must do something about Dr. so-and-so, and Dr. Naimark said, it is all right, Isabel, he is just my unguided missile; we will deal with him. Unfortunately, Dr. Naimark may have overestimated his power because that particular doctor remained in charge of Obstetrics and Gynecology at the College for a great number of years following that encounter.

The maternal and child health task force found, among other things, that the rate of newborn deaths, the neonatal death rate, was approximately twice to three times in the inner city what it was in the suburbs, that is was four to five times in the North what it was in Manitoba's south, in its more affluent areas. In other words, as is the case with virtually all other health-related issues, outcomes of pregnancy were very much tied to family income, family wealth. That is true for heart disease; it is true for cancer; it is true for virtually all illnesses, that, unfortunately, illness and poverty are companions, close companions in too many cases.

That maternal and child health task force recommended in 1981-82, among other things, that this province move aggressively to develop midwifery on behalf of the women of Manitoba and particularly in rural and remote communities. However, Madam Speaker, unfortunately, the professional lobby in the community was successful in defeating the initiatives to move in this direction and remained successful, indeed, until the introduction of this bill some 16 years later.

Madam Speaker, as late as three years ago, the Faculty of Medicine was still strongly committed to the notion that every birth should take place in a community hospital, that there should be no such things as births outside of at least community-level hospital care, and their preference, very clearly stated, was that all births take place in a tertiary care setting. If they had their way three years ago, we would have centralized all births in Manitoba at St. Boniface and Health Sciences Centre.

Now, Madam Speaker, the centralization of births in high-risk settings such as neonatal intensive care units can be very, very narrowly defended on very slim statistical grounds based on birth outcomes. The difficulty is that virtually all of us would agree that birth is not simply a clinical, medical event. It is a profound human mystery, a profound human event in which the needs of mother and child are also complemented by the needs of the family and the needs of the community to welcome and integrate the newborn child.

Madam Speaker, I ask you to consider what happens in a northern community today in which we still medivac virtually all women from remote communities to have their babies in Thompson or in Winnipeg, sometimes in other communities, but more often in Thompson or in Winnipeg. Given medical preoccupation with risk minimization, this often means still today that women are taken from their communities as much as two months before they give birth and certainly four weeks before they give birth. They are put in unfamiliar urban settings. They are not sick. They are not at risk in any particular way. They are simply boarded in the city, taken away from their communities, taken away from their other children if they have them, taken away from their partners and forced to give birth in an urban setting which may be marginally clinically safer–if it is indeed, but if there is an additional safety margin, it is marginal according to statistics–but a vastly inferior social and community setting.

Throughout history, humans have made choices in which they have been willing to measure risk and assume a level of risk that seems to them to be prudent and reasonable in return for some other possibilities that they could not otherwise enjoy. Over and over and over again, women have said that they would prefer, if their health is reasonable and the pregnancy appears to be one that is normal–over and over again women have indicated their preference is to give birth either in their

own homes, or at least in their own communities, attended by competent medical care. Competent medical care has historically always included midwifery.

This bill makes possible finally in Manitoba the development of the practice of midwifery. Why has it taken until 1997 to do what other provinces in Canada–some six other provinces–have done for some time now? Why if we were committed to this, why if the previous ministers of Health, Mr. Orchard or Mr. McCrae, were committed to the notion of midwifery, did we not combine with Ontario so that we would now be in a position, as Ontario is, to have graduates of the programs that were launched in 1991 to train midwives? We have not even got a curriculum developed yet.

We are still at the point where we are going to set up in the next year the college that is going to govern the whole process of training. Why are we waiting till after the turn of the century to have midwives available to the women of northern Manitoba or to the women of urban Manitoba?

Why are we not now supporting our nurses, many of whom, Madam Speaker, have midwifery training in other countries and cultures, very high quality training? Why are we not supporting them to very quickly increase their competence or refresh their competence, using resources in other provinces, so that we can begin to offer this service in a timely and speedy manner? Women have waited too long, too long to be able to be attended at the time of delivery by a competent midwife of their choosing in a setting that recognizes whatever level of risk they have as a pregnant woman and whatever levels of choice seem reasonable under those circumstances.

Why are we still absorbing the enormous–and they are enormous–costs of medivacking women from northern communities and accommodating them in Winnipeg or Thompson over periods as long as several months instead of investing some of those resources in bringing our existing midwives in Manitoba into the active practice of midwifery today? Why has it taken this government nine years to finally get to the point, not of actually allowing midwives to practise, but beginning to talk about how we would get them in place? Finally with this act, we will have a legal framework. But will there be one midwife practising? No, Madam Speaker, there will not, because we do not have the college yet, we do not have a curriculum, we do not have a faculty, we do not have a training program. So far as we on this side of the House can determine, it will be a number of years before those final developments take place.

In the meantime, what have we got? We have a College of Physicians and Surgeons that is unfortunately still in opposition, still trying to exercise their control over this vital field, still trying to make it uneconomic for the Province of Manitoba, because they would like to remain in clinical control of the process of birth and delivery. They would like to limit admitting privileges of midwives to hospitals. They would like to determine how those midwives will actually function in practice. They are still not prepared to do what their colleagues in England, New Zealand, Australia, Alberta, Quebec, Ontario have all agreed to do, Madam Speaker, and that is to fully recognize the competency and training of midwives to attend at births, to be the physician surrogate in effect, to be the person in charge of the clinical process, able to prescribe, able to intervene, able to call on resources without having to first clear whatever they do with a physician.

* (1040)

So, Madam Speaker, we support this piece of legislation. It is long overdue, but we call on the government to use the measures that are at its control to ensure that we are not waiting another three or four years before midwives become able to be present in the numbers and in the locations in which they are required to make this truly an insurable service under medicare. There is no sense saying, as this act does, that midwifery is an insurable service if there are no midwives to provide the service. There is no sense at all suggesting that this act is going to suddenly make something possible, because it is not.

We have many, many remote communities served ably by nurses, but many of those nurses are not able immediately to deliver babies except in an emergency condition. I should say without being derogatory to the medical profession, of our three children, the first one

was delivered by a nurse in St. Boniface Hospital because the doctor did not get there in time. My wife, who is also a nurse, has often said that it was the most professional and best delivery of the three that she had. The other two in which our doctor made it, one, by the thickness of a human hair, and one, with adequate time, were not nearly so well handled in her view as a nurse who had assisted in a number of deliveries herself.

So, Madam Speaker, while we welcome the act, we call on the government to work with Ontario, Alberta, and Quebec to ensure that Manitoba nurses who wish to become licensed as midwives can speedily upgrade any credentialing that they need to upgrade–in some cases it will be minor, in some cases more extensive–so that we can quickly have on hand in Manitoba in a number of locations this very valuable, time-honoured, traditional and appropriate service. I hope the government will not only act to pass this legislation but that they will take action to implement the legislation in a much more speedy manner than they have prepared the legislation which took them almost as long as their entire mandate in government has been to finally bring forward.

With those remarks, Madam Speaker, I thank you for the opportunity to address this bill.

**Mr. Doug Martindale (Burrows):** It is interesting to have to speak on a bill and on a subject of which I know very little. It is always a challenge, but maybe this is a greater challenge than normal. Having never had the opportunity to give birth to a baby, I can only speak secondhand as to what these experiences are really like.

However, I do remember very well when our son, Nathan, was born at Eatonia Union Hospital in November 1977. He had the good fortune to be born in a small rural hospital that had lots of staff and very few patients. He was very slow in being born. I think my wife, Carol, was in labour for about 12 hours. Because there were many staff there, they took very good care of her and gave her back rubs, which she appreciated very much since she was experiencing quite a bit of back pain.

Our daughter, Tanissa, was born, in 1988, at Grace Hospital, and unlike Nathan, Tanissa came in a big hurry. We have always said that if there had been a train on the CP main line, Tanissa would have been born in the parking lot or the lobby. In fact, the obstetrician who attended was telling my wife not to push because he was not ready, he did not have his gloves on, and Tanissa was already bursting to come into this world. So she was the impatient one.

Maybe that is kind of symbolic of the differences in the personality of our two children. Nathan is kind of laid back. Maybe that reflects the fact that he took 12 hours in the birthing process. Tanissa is the one who was in a hurry being born and she is the teenager who is still in a hurry, the more aggressive one.

It is not that long ago that birthing was normally done at home or in homes. Some of my colleagues here in the Legislature, one of them was telling me that she was born in a hospital, but all of her brothers and sisters were born at home. This, of course, was considered normal. My father is one of 10 children, and probably all of them were born at home. My wife's great grandmother was a midwife in a rural area around Gronlid, Saskatchewan. Probably her parents' generation were all born at home. I have a friend in Winnipeg who is 60 years old. She was born on a farm near Fraserwood, Manitoba. At the time, her father was away, and her mother gave birth to Lillian during the night, and at six o'clock in the morning, her mother had to get up and milk cows. There was no other choice. She had to. There was no one else to do it.

Today with Bill 7, The Midwifery and Consequential Amendments Act, we are really going back to the traditional and historical way of giving birth at home with a midwife present, and this recognizes that pregnancy is a state of health, not disease, and that childbirth is a normal process. I think that is the way it should be. Unfortunately, that has not been true for most people born in our generation or in recent generations, especially in cities and urban communities where the births almost always took place in hospitals, and there really was not the alternative. So the good thing about this legislation is that now women have a choice. They can choose to go to a hospital, or they can choose to give birth at home with a midwife present.

The other positive thing is that we do not any longer see pregnancy as a disease, but as a normal state of health, and that childbirth, as well, is a normal process.

I think it is appropriate to recognize that this legislation has been a long time in coming. Many people, many women, have been working very hard to lobby government, to lobby others to see that this comes about. I think it was just yesterday I was listening briefly to Peter Gzowski, on Morningside. He was talking about birthing centres in Ontario. A group of women began lobbying the provincial government there, I believe, in 1979. Finally, in 1992, under the Bob Rae NDP government, legislation was passed allowing for birthing centres. So it took a very long time of lobbying for this to come about.

Regrettably, the current Harris Conservative government has cancelled the birthing centres, so they will not be going ahead. Of course, they gave a rationale for it, but one of the reasons for having birthing centres is that they are a much cheaper way of delivering the same service than in the hospital, and whoever he was interviewing was pointing out that hospitals have a very high overhead. Of course, you cannot get any lower overhead, I guess, than having a birth in a home. The only cost would be the salary and the time of the midwife.

(Mr. Peter Dyck, Acting Speaker, in the Chair)

With The Midwifery Act, we are going back to a traditional and historical way of giving birth at home with a midwife present, and it is a recognition that that is a normal process and a normal thing to do.

* (1050)

I have had a chance to browse through the act, and I cannot refer to specific sections, but in looking at the principles of the bill, it would seem to me that there are many parallels here with many other pieces of legislation. Probably if we were to look at other acts in the Department of Health, such as the College of Physicians and Surgeons, and this is probably true of the dental college and other professional colleges, there are probably many parallels here whereby they are set up under an act of the Legislature. There are standards for practice. There is a complaints committee, an inquiry committee, the right to appeal to the courts, and there are regulations and by-laws.

So I think it is obvious that a fair amount, probably a considerable amount of thought and preparation went into this act and that these matters were all thought through very carefully by the Minister of Health (Mr. Praznik) and his staff, hopefully with input and consultation from the people in the community who want to be midwives and who have banded together to lobby the government, and, hopefully, their concerns were taken into account in this legislation.

(Mr. Gerry McAlpine, Acting Speaker, in the Chair)

I believe that this bill incorporates many of the things that are recommended in a very interesting paper which I have in front of me which is called Report and Recommendations of the Working Group on Midwifery to the Minister of Health, February 1993, distributed by the Women's Health branch, Healthy Public Policy programs division in Winnipeg.

They recommend that midwives be recognized in the midwifery legislation as primary health care providers, and I am sure that in the legislation they are recognized as primary health care providers. That really gives them professional status, and that is important because it means that along with professional status, there will be standards of training and accreditation and, hopefully, continuing education so that they can keep up with their skills and learn new things and that, then, when people turn to a midwife, they are turning to somebody who is a qualified practitioner.

This report that I am quoting from recommends a College of Midwives of Manitoba, and the bill reflects that. There will be a council. That was recommended and that is in the bill. They recommend a complaints process, and that, too, is in the bill. There is an appeal process recommended, and that, as well, is in the bill, and a discipline committee.

All of these things are very important. We, as MLAs, occasionally get complaints from our constituents, and sometimes we are only dealing with–[interjection] Oh, I think all of us get complaints from our constituents, and sometimes we are able to deal with those complaints directly, and that is appropriate. Other times, we refer people to other organizations and bodies that are much more appropriate. For example, we might refer somebody to the Ombudsman, or we might refer somebody to the Children's Advocate.

Right now, some members of this Chamber are involved in a very interesting process. We are part of a committee that the member for Pembina (Mr. Dyck) is chairing. We are travelling to Thompson, and we are hearing presentations on video conferencing from Dauphin and Brandon, and we are also having public hearings in the committee rooms in the Legislative Building.

We are examining the Children's Advocate legislation with a view to–hopefully, the minister will bring in amendments to that section of The Child and Family Services Act. Especially with Child and Family Services complaints, in many cases it is not appropriate for MLAs to get involved in the details of the situation, because many times matters can only be dealt with by the courts. So it is inappropriate for us as MLAs to get involved. However, it is appropriate to ask someone else to investigate, such as the Children's Advocate.

Similarly with midwifery: If there is a professional association, if there is a college and we receive a complaint, then we can tell people what their rights are under this act, and they can lodge a complaint and it will be investigated. There is a hearing process and there is an appeal process, and hopefully that would be an appropriate way to refer constituents if they had concerns in this area.

I think one of the important aspects of this legislation is that it gives a more important role for women to play in the health profession. In the past men were exclusively doctors, and women had to fight first of all for the right to be doctors. Ever since, there has been a segregation of roles and responsibilities which fortunately has started to change in recent times so that in many medical faculties the majority of students are now women. Historically the majority of nurses have been women and that is starting to change very slowly, but there has always been kind of a tension between doctors, who in many cases were men, and nurses, who in many cases were women. Women have been fighting to get more responsibility and to carry out more functions. So there has been a disagreement between the medical profession or people within the medical profession, some saying, no, doctors should only do these things and nurses should only do these things. That is starting to change so that now the government has set up centres where nurses are the practitioners, and I think that elevates the status of nurses and gives them more importance, gives them more functions that they can do. In many cases, that is very appropriate.

In many cases, people seek the counsel of a doctor or the advice of a doctor for things that are not always medical problems. I know that in Chicago there is a medical clinic that was set up that in addition to having doctors and nurses on the staff had a counsellor on the staff. When people became aware that the counsellor was there, in many cases they asked if they could go to the counsellor rather than to the doctor, and that certainly saves taxpayers and government thousands of dollars. Potentially, you could save millions of dollars if people sought the most appropriate kind of care, and I think the midwifery legislation is a good example where people have a choice and the choice is less expensive.

I remember talking to the doctor who delivered our son Nathan in Eatonia, Saskatchewan. She said that many of her patients, especially seniors, came to her for advice as if she was a counsellor, and they did not really have any presenting medical condition. She was smart enough to recognize that, and she would ask them, well, what is your real problem? Why did you really come to see me? She said that for most seniors the main problem was loneliness.

So, you know, we have many examples of how the medical profession is being used inappropriately, and we do need to look for alternatives not because they are cheaper but because there are more appropriate alternatives. I think the midwifery legislation is a good example because it accommodates both. Yes, it does save money, but it is a more appropriate way to deliver a service, in fact a service that in many cases is identical whether it is delivered in the hospital or delivered in a home.

According to the research that I have in front of me, Manitoba actually lags behind other provinces on the provision of legalized midwifery services. Quebec, Ontario, British Columbia, Alberta, Saskatchewan, Nova Scotia are all in various stages of bringing midwives into the health care system as full, legal and valued professionals and offering a greater choice to women.

In 1991, Ontario became the first province to offer a bachelor's program in midwifery and to integrate midwifery education, services, and regulation into its health care and post-secondary education systems. Under the legislation passed by the NDP government, midwifery became a regulated health profession under the Regulated Health Professions Act which enabled midwives to care for women whose pregnancies and births were uncomplicated. A College of Midwives was also formed to register midwives and oversee standards of practice. The demand for midwife services in Ontario now is so high that midwives are turning away four women for every one they can accept.

I would like to add a concern here that I hope does not happen with a new college of midwifery as so often happens with other colleges, and that is the issue of accreditation. Frequently, we run into constituents who have professional training in other countries including doctors, dentists and many, many different kinds of professions. They come to Canada and they find out that their accreditation is not worth anything, that they cannot get accredited in Canada to practise the same profession here. Well, they can, but in many cases they have to go through an extremely rigorous and expensive process to do so. For example, I met a woman who was a recent immigrant to Canada from Czechoslovakia. She was trained there as a dentist, and she wanted to practise dentistry in Canada. Well, she had to pass exams by dental colleges in Canada. In fact, I think the exams took place in Ottawa, so she had to travel to Ottawa. She had to pay I think it was $10,000 for exam fees, and she had to provide her own patients.

* (1100)

So really what we see is that colleges become gatekeepers. They decide who is going to get in, and they decide how many are going to get in. Of course, it is to their advantage not to let in too many because then, of course, salaries would go down. I mean, they will argue–and I have certainly had this discussion with my dentist who is the registrar of the college of dentistry in Manitoba, that they should allow more people from other countries to be accredited and practise in Canada, and he always argues that it is a matter of standards, that their standards and training are not the equivalent in their home country as to what they are in Canada.

I think we do need to be more accommodating. We do need to make it easier to become accredited in Canada. This is a very important issue in the entire immigrant community. I know that my colleague the member for Broadway (Mr. Santos) has brought this up many times in the Legislature. He has often put resolutions on the Order Paper on the issue of accreditation. He gives speeches in the community about it. Many, many people approach him and approach our colleagues in this caucus about the issue of accreditation. They have talents that they cannot use, and they want to use these talents.

Just to use another example, the doctor that I mentioned who delivered our son Nathan, Dr. Nowinska, she was trained as a doctor in Poland. When she came to Winnipeg, she worked in the hospital in support staff because she could not get a job as a doctor. Now, I am not sure what she did to become accredited in Canada, but I know that in Saskatchewan she was able to practise her medical profession. But we are really wasting people's talents, abilities, training and lengthy years of education if we do not allow them to become accredited and practise in Canada.

We hope that if people have had training as midwives in other countries and they come to Canada, that the college will see fit to have them accredited to practise that here as well.

In 1992, Alberta introduced legislation to define the practice of midwifery and to establish standards and regulations to make it possible for midwives to practise openly. New regulations were introduced in 1994 to allow midwives to care for pregnant women at home through labour, delivery and after birth. Midwives were also given the legal ability to send women to the hospital, order lab tests and prescribe designated drugs. In 1993, B.C. announced an independent college of midwives to regulate the profession. In 1991, Health Minister Don Orchard established the Manitoba Working Group on Midwifery which recommended that regulated midwifery be introduced as an insured health service in Manitoba. An executive summary is attached.

In 1994, Health Minister Jim McCrae appointed the Midwifery Implementation Council following a commitment in the Speech from the Throne to begin implementation of the working group's recommendations. The council's mandate was to make recommendations on legislation, education, practice, equity and access issues surrounding implementation of midwifery as an insured health care service and autonomous profession in Manitoba.

The council reported to the minister with recommendations for legislation to legalize and regulate midwifery services in Manitoba and specific ideas to be incorporated in the legislation. Generally speaking, these recommendations were built into the legislation, and community groups are pleased with the result from the first glance at the bill.

It will be very interesting to hear these groups and individuals speak at the committee stage of the bill. I have not personally talked to any of them for three or four years, so I am looking forward to hearing their views on this bill and to see if they have any recommendations for amendments. Certainly, we will give careful consideration to those amendments and, if we think that those amendments are good ones, we will either encourage the government to put them forward, and if the government indicates that they are not going to, then we may bring forth amendments at the committee stage. So I look forward to hearing the presentations on the committee stage of Bill 7.

This bill establishes the College of Midwives of Manitoba. It creates the governing structure for the profession of midwifery, and it makes midwifery an insured health service, although this is only through an Order-in-Council determination like chiropractic or optometric services.

We have seen quite an erosion of insured health services in Manitoba and in other places in Canada, so it is good to see something new being added as an insured service. In fact, insured services is an extremely serious issue in Canada, because what we are moving to is a two-tier health system whereby some services are insured, and therefore they are available to all Canadians. Other services are not insured, and people have to either buy private health insurance or, if they are lucky enough, their employer has health insurance; if not, they are out of luck.

The most frequent complaints that we get as MLAs has to do with drugs and drugs that are not on the insured prescription drug list or have been dropped from the list. Frequently people will say, well, my doctor prescribed this drug, it is not on the insured list, so I cannot buy it unless I pay for it myself, it is becoming extremely expensive or it is too expensive to do that. Of course, we know that there are reasons for that. One of the reasons is that the Conservative federal government extended drug patent legislation to 20 years. The Liberal government ranted and raved against that legislation when they were in opposition. They have recently reviewed it, and there are some recommendations coming out of that, but it does not look like they are going to change the length of drug patent legislation.

This is actually one of the reasons why health care costs are going up so quickly in Canada, is the cost of prescribed drugs. We are not really surprised that the patent legislation will not be changed, given that multinational drug companies make large donations to political parties that have considerable influence, especially in Ottawa, because we are talking about federal legislation. In fact, they hire former cabinet ministers to be their spokespeople. We, as MLAs, get their mailings all the time, pretty, glossy, expensive mailings. I am sure they are mailing to every MLA and every member of Parliament in Canada. If you are like me, you throw their glossy expensive mailings in the garbage. It does not do them any good with me, but it certainly moves people in Ottawa.

In fact, we have a member of Parliament from Winnipeg who is on the committee reviewing the legislation. He wrote a letter to the drug companies asking for donations, hardly an impartial chair of a committee reviewing drug patent legislation.

But I think Canadians know what is happening. Canadians know that the cost of drugs is going up, that some of them are not being insured, they know why it is going up and hopefully they will express their opinions during the federal election, let the government know that health care and health care costs are an extremely important issue to them, and we do not want

to change. What we have is a good system in Canada, of medicare, where we have the universal, accessible and affordable system which costs less to deliver than other systems, like in the United States, and covers everyone, does not exclude people.

Under this act, The Midwifery and Consequential Amendments Act, a midwife is considered to be a primary health care provider with a specified scope of practice which includes some minor surgical and invasive procedures and some prescribing and diagnostic ability.

There is some vagueness in the definitions around the area of what is a normal birth, what is the process for registration and exactly who will qualify as a midwife, i.e., the traditional versus nurse-midwife question, which I am not familiar with but which I hope someone else will expand on in their speech, but some of this will be decided by the College. The former Minister of Health endorsed the position that both traditional and nurse-midwives should be guaranteed a place in the system.

Public representation is guaranteed on the governing council of the college, and the college is required to hold public meetings. The major area of concern in this section is that the transitional council will be appointed by Order-in-Council and is very much under the control of the minister. Of course, this happens quite often, and, of course, it is always a concern when the government has total discretion in who they are going to appoint because we know that they usually appoint friends of government, political cronies and people who donate to campaigns, people who are active in the party.

* (1110)

There are times when they appoint people who have no connections. I know that a friend of mine, who is the wife of a United Church minister, was appointed by this government to a position, and it came as a complete surprise. As far as I know, she has no political connections to the party in office, and so it was a good example of an impartial appointment. It just happened that the member of the Legislature for the area was a member of her church and probably recommended her as a good person who would serve on a committee. That is the kind of appointment that we like to see.

However, the members of the Midwifery Implementation Committee have been given the strong impression that they will be the appointed members which would be acceptable to us and the community.

We have concerns about access to services, especially in rural and northern areas, and support for educational opportunities to train midwives which are not expected until a couple of years after the bill is passed. This will be especially important to aboriginal midwives, many of whom have been practising quietly for years, but who should now be recognized and paid for the work they do.

In addition, giving the government's record on de-insuring services, we should raise concerns about the fact that midwifery is only insured through Order-in-Council. Further, there is no specific monetary commitment for this service in the 1997 budget. There has been quite broad consultation on the contents of this bill and the papers leading up to its introduction which is positive for this government.

We have sent copies of the bill to a number of groups and individuals for comment, such as the Women's Health Clinic, Manitoba Friends of the Midwives, the Women's Institute and the Manitoba Action Committee on the Status of Women, and, hopefully, they will come and present briefs at the committee stage of this bill.

There will be concerns from doctors who have already submitted an Op Ed piece about the need to keep doctors in the forefront of childbirth. There is also an ongoing question of the role of traditional lay midwives versus nurse-midwives. These issues will be sorted out by the College.

We in this party have always emphasized community health care, and the member for Crescentwood (Mr. Sale) spoke about that at some length, and we generally support the bill, but we need to be assured that our questions are dealt with about the implementation, access to midwifery, education and services and insurance coverage guarantees. We will continue to monitor the comments and reactions of community groups, although so far the major concern that has been

raised is simply how long it will take to get the bill passed and put into operation.

My guess is that it could be two or three years, because it will take time to appoint the interim council and to do all the things that are necessary before the bill is proclaimed. While people will think that that is too long and they may be right, it would not be unusual for new and complicated pieces of legislation to take several years before they are proclaimed.

Thank you, Mr. Acting Speaker.

**Mr. Stan Struthers (Dauphin):** I am pleased to be able to stand today in the House and talk, a little bit anyway, about Bill 7, The Midwifery and Consequential Amendments Act.

I want to begin by indicating that this is an issue of great importance to many of the constituents in the Dauphin constituency and that I have been approached by several groups and individuals to put forth some of their thoughts, some of their feelings having to do with midwifery, and, in particular, specifically to the bill today that we are talking about in the Legislature this morning.

It is my hope, and I have no reason to believe this will not happen, but it is my hope that this legislation will be passed once it has gone through the normal legislative procedure, once we have heard from groups and from individuals during the public hearing stage of the passage of this legislation. Between second and third readings, people will have a chance to tell the government and those of us in opposition what they think about this legislation and I would hope some good, positive suggestions that the government will listen to and eventually incorporate into this legislation.

My hope also is that since there is a lot of interest in this issue in the constituency that I represent, it is my hope that the government may see fit actually to come out and make an effort to talk to groups and women in the Dauphin constituency and certainly anywhere in the Parkland where they can get some information, some ideas, some feedback and some input on this legislation that we are debating here today.

Once the legislation is passed, hopefully incorporating changes that will be suggested between now and the time that this bill is actually voted upon in the House, I would hope that it would not take very long for the government to implement a plan for midwifery, because I think it is important. I think when you look at the amount of time that midwifery and home births have been taking place and compare that to the amount of time that we have been discussing the possibility of making midwifery a regulated profession, that you will see that the amount of time throughout humankind history that we have spent with midwives and home births is gargantuan compared to the relatively short time that we have been talking about regulating the profession.

(Mr. Peter Dyck, Acting Speaker, in the Chair)

Midwifery is not a new thing. Midwifery has taken place throughout the centuries. Home births have taken place throughout the centuries. As a matter of fact, I am sure we all have stories of births that have taken place not within hospitals, not within homes, but in a whole variety of different places, where people have actually given birth in places that you would not normally expect it.

My colleague from Swan River just said that they take place in fields, and those of us who are rural members have all heard of stories that have taken place where people, let us say for example in harvest time, have been out working in the fields, having to get done the chore of taking off the crop, not a lot of time in a busy day to take off into the hospital and spend a lot of time in the local community hospital. I think every family in rural Manitoba has got their story of mom or grandma or somebody giving birth in some pretty peculiar positions.

I know a friend of mine who I had gone to school with was born in such an event during harvest in the half-ton on the way to the hospital in the little town where I lived in Saskatchewan. Mr. Acting Speaker, this friend of mine grew up to live a very normal, healthy life. This friend of mine at the same time, though, was not born into the same kind of circumstances which I was. I was born in the Swan Valley hospital back in 1959, but he grew up to be just as normal as I did, if either one of us can be considered normal.

I look at some of the expressions around the House from a couple of people, and I will admit that some days I am more normal than others, but I would suggest, too, that the fellow who was born in the cab of the half-ton with just his mom and his dad is just as normal as I would be. Whether that is normal or not, I will leave that for you to debate and discuss if you have nothing better to debate and discuss, I would add.

But the point is midwifery has been with us and home births have been with us for many years. They have provided women and families in society with yet another choice, another option, an option that they can choose that is safe, an option that is full of supports, that sometimes we just may not think about really very quickly when you have become accustomed to having births take place in a hospital.

* (1120)

I want to point out that the debate over establishing midwifery as a regulated profession has been ongoing for some period of time. My understanding is that things really got serious about establishing midwifery as a profession in 1987 when consultations began and included the Manitoba Advisory Council on the Status of Women. Now, the Council on the Status of Women has seen this as a very important issue. I must add that they are joined in this sentiment by our very own Parkland Status of Women who are located in the community of Dauphin and serve the Parkland area, and it has been taken up by women's groups because it is a very important issue with women.

Mr. Acting Speaker, I have received many letters and phone calls, many inquiries having to do with home birth and having to do with midwifery from the folks who work with and at the Parkland Status of Women in Dauphin. They, of course, are not the only group that have approached me on this issue and indicated the importance with which we should be treating this issue here in the Legislature, and also their support for legislation that would provide the legislative structure for the profession of midwifery.

After 1987, the next step was the Report and Recommendations of the Working Group on Midwifery. Now, this Working Group on Midwifery reported to the Minister of Health, and that report to the Minister of Health was put forth in February of 1993 and had many recommendations that I think the present government should very closely scrutinize, should analyze and should eventually, I think, incorporate into whatever the final look of this bill would be once we finally vote on it here in the legislature.

I understand and I give credit to the government that many of the recommendations that were put forward by the Working Group on Midwifery have been included in the legislation that we are debating today, and I fully give the government credit for that.

I think that it is very prudent on their part to accept the advice of people who are actually, can we say, experts in this field. I know that many of the MLAs in today's House are interested in midwifery. They have varying degrees of knowledge when it comes to midwifery and the advantages of providing that choice for women and families who give birth. But as MLAs, we do not have the kind of experience, perhaps, and knowledge that would suggest that we could go ahead on our own and build legislation that will be of use to midwives and to women and families in Manitoba.

So it is very prudent on our behalf to consider very carefully the recommendations on this subject, the recommendations of the Working Group on Midwifery. Not only that, but we need to look broader than just the recommendations of the working group. We need to consult any source and all sources that can provide some good positive suggestions and some ways to improve the legislation that we are debating here today in the House.

Any government has that responsibility. I would expect that this government would take every opportunity that it can from any source that is available to it, to get advice and to make its legislation even better.

Now, the very first recommendation that the Working Group on Midwifery put forth was that midwifery be implemented as a regulated profession in Manitoba. That is what this legislation is setting out to do. Again, I applaud the government in its first step to provide some kind of recognition and status to a profession that has been with us throughout the centuries.

Another one of the recommendations that the Working Group on Midwifery put forth was in the whole area of the practice of midwifery. There are several, actually there are seven recommendations that the working group puts forth in the area of practice of midwifery. I would like to highlight several of them, because I think they warrant a lot of thought on our behalf as legislators.

The first one that I would like to highlight is the recommendation the working group makes that says that midwifery services be available in a variety of settings in accordance with the principles outlined in the philosophy of care and the scope of practice documents. Now, it is my understanding that once this legislation becomes law, a midwife would be considered a primary health provider. The midwife would be given the responsibilities of a health care provider and the advantages and the privileges that go along with that. It is also my understanding that a midwife would be considered a primary health care provider within a specified area and with a specified scope of practice.

Now, it is important, I think, that midwifery services be available in a variety of settings. I think the key there is variety of settings. As other speakers before me have mentioned, and I touched upon a couple of minutes ago, births have taken place in a number of different settings with a number of different circumstances attached to those settings.

Now I think that it is important that we recognize that the services of a midwife can be made available in a wide variety of settings to provide that kind of comfort and that kind of security to the woman and the child at birth time.

I think it is important in this particular recommendation to note as well that in rural and remote areas, the ability of midwifery to be available in a variety of different settings is very important. I know from my experience as a teacher in northern Manitoba that the settings available to people when it comes to giving birth can really be varied, more so than if you lived in, say, the city of Winnipeg or in some of our larger centres in rural Manitoba. The availability of choice is constricted in northern Manitoba because of a number of factors, sparseness of population, geography. The great distances that people in the North travel to go anywhere is something that we may not experience in other parts of the province. So that presents some very specific challenges to women and to families who are involved in the birthing process.

* (1130)

Another recommendation that is made by the Working Group on Midwifery states that midwifery be available to all Manitoba women as an insured service. The key here, I think, is that it be available to all women. Now, if it is not available to all women, then I would suggest that is an unfair situation for whatever reason. I do not believe anyone is going to go out there and say that some women have that option and some women do not. You may have a situation in parts of the province that are more remote than others where that option may not exist, unless we decide as legislators that that is a principle that we can accept, and that it is a principle that we as legislators are going to enforce. We are going to make sure that women in the North, that women in Tadoule Lake or Shamattawa or any of our northern communities, will have the option of home birth with the attendance of a midwife to–

**An Honourable Member:** That would be fair.

**Mr. Struthers:** That would be fair, as the Minister of Agriculture (Mr. Enns) so correctly points out. That would be the fair thing to do, and that is what I am hoping will be reflected in the final legislation when we vote on this later on in this session. We must, as legislators, ensure that all women have access to the service of a midwife, and that all women have the choice of whether they give birth to their child in their home or whether they give birth to a child in a hospital setting. The key is that women and families should always have the ability to decide, and it is more than just having the ability to decide where to give birth, but those facilities, those services have to be in place. We as legislators, I think, have a responsibility to ensure that those services be made available to all women, no matter where the families and the women happen to live.

Another recommendation that the Working Group on Midwifery put forth was that midwives be granted

hospital privileges in accordance with their scope of practice. That to me, at least to me, seems to make sense, because it draws upon another level of security for the woman and the child and for the family that is involved in giving birth. I think it makes sense in this situation, as in any other situations, to draw upon all possible resources to ensure the safety of the child and the mother and to also raise the level of comfort for the support group that naturally, I would hope in most cases, attends with the mother and the child during the birthing process.

It is my hope, Mr. Acting Speaker, that any woman giving birth has a support group around her–family, friends. It is my hope that happens, but I do understand that is not always the case. It is my hope that the kind of legislation that we are talking about here in the House makes it absolutely more comfortable, easier for the birthing process to take place, and also not just the birthing process itself, the act of giving birth, but that after the child has been born that there is a support system in place for both that child and the child's mother.

Another recommendation that was made by the working group was that there be an ongoing assessment of pregnant women who wish to have a home birth. Whether the birth takes place in the home or whether the birth takes place in the hospital, whatever the woman and the family choose as the place of birth, it seems to me to be important that a lot of preparation work be done beforehand. It also is my experience, in speaking with women in the Dauphin area who have experienced home birth–and I am thinking in particular of one woman who gave birth to five children in the comforts of her home and who recommends that to anyone else who may be thinking of giving birth to their children at home.

I have been informed by both the woman who is the mother of these five children and the midwife who attended each of these that a lot of preparation time was spent between the mother, the midwife and the whole family as the family grew. It was not just a case of the mother going into labour at home and frantically phoning up her friend who is the midwife. There was a lot of time spent in the leadup to the actual birth in which the midwife and the family discussed all possible angles when it comes to birthing at home.

An environment was set in the home well before the actual event took place, a very caring environment, a very stable environment and an environment in which the level of comfort for all involved was set very high. What that led to according to the woman who is the mother of these children, what that led to according to her, was a total feeling of ease when it came time to actually give birth and that the whole process was made much easier because of the amount of work that went in before the actual birth took place.

Another recommendation that was put forth by the working group stated that midwives conducting home births are responsible for having well-maintained equipment. I think this just makes common sense. I think if it was I who was giving birth, I would want that assurance. I understand that unless science really moves along very quickly over the next several decades that I will never have to go through that–

**An Honourable Member:** I am sure it can be arranged.

**Mr. Struthers:** It may be. You never want to doubt what modern science can do. I will not hold my breath on my giving birth, but if I was in that situation, I would hope, and I would expect, that there would be some standards that would need to be met, whether I was in the hospital or whether I was in my home, whether I was with a doctor or a nurse or a midwife.

The other recommendation that I would point to is that a home birth registry would be established and that the reason for this was to collect data in Manitoba that is relevant for future policy development. I think that is an education aspect of the recommendations in this working group that I think should be taken very seriously.

Speaking of education, the working group also made several I think very astute recommendations in an area that they entitled midwifery education. Some of these include that there be multiple routes of entry into midwifery education. One of the things that they talked about was setting up a four-year baccalaureate degree in midwifery and that if you are a midwife and you want to access this education, several routes be available to a midwife who eventually wants to gain this baccalaureate degree. The reason that I think it is

important to have several routes of entry is that there are many people out there right now who have the midwifery skills that are necessary, and their skills can be drawn upon by people at the university level or at the college that the legislation sets up. I think those people have skills that can be drawn upon and then passed on to a next generation of midwives who will be practising in our province.

* (1140)

I think it is also important, the next recommendation that I thought was key, is that individuals have opportunity to challenge courses offered in the program for advanced credit. Now, talking to people in my part of the world who have some experience in the area of midwifery, they do have a lot of knowledge and skills that they have gained through their experiences that I think they should be given credit for instead of being put into a course where they have to repeat all of the skills that they have already gained. I think they should be getting credit for it.

I have no doubt that the midwives that I have talked to can challenge some of the courses that would be offered and do very well at it and in that way can gain the degree that they would like to eventually obtain. I think this is very important, too, for the remote and rural areas of our province where midwives have been practising for a number of years. Instead of having them come into the city and take courses, they should be getting credit for the experience that they have gained already in the field of midwifery.

It is also a recommendation that clinical experience be acquired in the variety of settings in which a midwife is expected to practise. That, too, I think is an important recommendation of this working group. Again, I think the government has to recognize the experience already gained by people in the midwifery field in our province.

Another recommendation in the area of education is that faculty in the midwifery education program be predominantly comprised of practicing midwives. Again, I think it is important that we recognize the experience of midwives already in this province and that this recommendation on behalf of the working group does exactly that. It would be something that I would hope the government would take seriously.

Another recommendation that the midwifery working group came up with was that all faculty in the midwifery program responsible for teaching theoretical or clinical components have equal participation in the design, implementation and ongoing evaluation of the curriculum. I think this makes very good sense. As a school teacher and school principal, it was often quite frustrating to receive curriculum that I did not think fit in to the real world out there. Down in the trenches, teaching students, curriculum came across at times as being a little bit out to lunch. I really wondered sometimes when I was a schoolteacher about whether the department or the minister had consulted with any teachers out in the workforce to say, will this curriculum work, is this what is needed, does this curriculum tap into the skills of the students that we need to tap into?

Sometimes I really doubted if that was the case. I would hope, when we do go ahead and we do set up midwifery as a regulated profession, that every effort is made to tap into those real skills that midwives have, that can be used to improve our programs and can be used as a transfer to another generation of midwives who will follow in the years to come.

So again, I hope that we learn from our experiences in other professions. I hope that we do not make the same kind of mistakes that we have made in certain other professions. I hope that we can tap into the skills that are out there in the collection of midwives that we do have in the province now.

(Mr. Gerry McAlpine, Acting Speaker, in the Chair)

The midwifery working group also, I think, very astutely recommended that the educational program be sensitive to the historical underrepresentation by certain groups and post-secondary institutions owing to socioeconomic, cultural, and language barriers. When I first read that recommendation, it dawned on me that one historical underrepresentation in birthing was women. I think we could look over a period of the last several decades and see that the so-called expert on the scene was usually a man, usually a doctor. A nurse

may have been there, but the person calling the shots was the doctor.

In many cases, the opinion or the suggestions of the woman herself who was giving birth did not count too highly. The advice offered by a nurse, who was predominantly female, may have been taken into consideration but oftentimes was not. So I think the first historical underrepresentation that needs to be dealt with is the underrepresentation of women in the area of birthing.

I think that the other part of that recommendation that is significant is the socioeconomic, cultural and language barriers that we come across in Canadian society today. I think we have to do everything we can as legislators to make it possible for midwives to offer the services to all of the groups that have been historically underrepresented in our society. I think this allows this government the opportunity to address some of those historical underrepresentations.

Another recommendation was the proactive outreach strategies be implemented to raise awareness of the program within specific communities and to encourage participation in the program. I think we can all think of times when we have seen a good program, and we have wondered why there has not been the participation in that program that we would like to see. I think we have to, as legislators, take every opportunity to brag about our good programs. I think we have to take opportunities to make the programs available to people of our province, and that is the recommendation that this working group made and I think made very astutely.

Another recommendation, I think, that has some merit that should be considered by the government is the recommendation that states appropriate financial assistance be offered to facilitate the participation of individuals for whom cost is a barrier to education. Well, myself, along with other members, have indicated in this House the financial barriers that students face going into any university or college program.

Coming from rural Manitoba, I am particularly interested in the costs associated with the students that graduate from any of the schools in my constituency because not only do they have to pay the usual high costs of universities such as tuition and books and all that, but when you come from a remote or a rural setting, you end up paying for room and board on top of all the usual costs of university. I am very interested in working with others, and my colleague the MLA for Swan River (Ms. Wowchuk) is quite often talking in terms of Distance Education for her community. I think there are a lot of very positive approaches that we can take to bring education to rural and northern and remote areas of our province.

* (1150)

That is something that I think should be taken into consideration when we look to embark on a program for midwifery. It does not make any sense to simply ask people in our province who are interested in the services of midwifery to endure the same kinds of barriers that we put our university bound students through and our college-bound students through. I think what our goal should be as legislators is to make it as easy as possible for people to gain some of the skills and the knowledge that is associated with midwifery and then go out into our communities and provide that invaluable service to women and to families in the area of childbirthing. It does not make any sense to me to make it more difficult by throwing up more barriers, and the No. 1 barrier that has come across my desk, as an MLA, is always the financial barrier.

Another recommendation that the working group put forth was that the delivery of the program utilize appropriate Distance Education technologies and techniques. Now given today's technology, there are some exciting possibilities in the area of Distance Education and not just in the area of high school, or university, or college courses, but I think there is an absolutely wide variety of different ways that we can incorporate Distance Education technologies to help people gain the education and the knowledge and the skills that are necessary for people to become midwives and then take that service and provide it for folks in different parts of our province.

Mr. Acting Speaker, I see that my time is quickly running out. I just want to thank the House for allowing me a short time to put some of my thoughts on record on Bill 7. I look forward to hearing the

discussions that will take place in the public hearings section of the process of this legislation. Thank you very much.

**Mr. Jim Maloway (Elmwood):** I am pleased to rise today to speak on Bill 23, and Mr. Acting Speaker, this Bill 23 is the Manitoba Public Insurance Corporation Amendment Act. At the outset, I wanted to make a few comments on the minister's–

**The Acting Speaker (Mr. McAlpine):** Order, please. For the information of the honourable member for Elmwood, we are debating Bill 7.

It has been previously agreed that this matter will continue to stand in the name of the honourable member for Transcona (Mr. Reid). Agreed? [agreed]

**Bill 23–The Manitoba Public Insurance Corporation Amendment Act**

**The Acting Speaker (Mr. McAlpine):** To resume second reading debate on Bill 23 (The Manitoba Public Insurance Corporation Amendment Act; Loi modifiant la Loi sur la Société d'assurance publique du Manitoba), standing in the name of the member for Transcona (Mr. Reid).

Is it agreed that this should remain standing? [agreed]

**Mr. Jim Maloway (Elmwood):** As indicated, I am pleased today to speak to Bill 23, The Manitoba Public Insurance Corporation Amendment Act, and at the outset I wanted to make a few comments on the minister's address to the same bill on April 25 in which the minister, at great length, took time to talk about the great achievements of the former minister in his role as minister in charge of MPIC for the last eight years, and I want to take exception to the comments of the minister because, Mr. Acting Speaker, those were not a glorious eight years that the minister portrays in his address of this bill.

Let me go on to explain why that is not the case. This government came to power eight years ago, and it came to power partly on an issue that the previous governments had run a deficit in one particular year with Autopac. At that time that was a record deficit, but, Mr. Acting Speaker, in the government's attempt to manipulate the auto insurance rates around election time, around the last election time, this government managed to run the largest deficit the corporation has ever seen in 20 years, and this is supposed to be an example of good Tory management.

This government came to power. The Deputy Premier, and I remember it well, day after day used to ask questions about what he saw as incompetent government. Every question he asked had those buzzwords, those code words, "incompetent government," and, you know, that is coming back to haunt this government because as time goes by I think people are seeing far more clearly that it is in fact this government that is incompetent. This government over there, Mr. Acting Speaker, are the mismanagers of this economy and this province.

So it is quite convenient that after eight years this minister be replaced with another minister, because what better way, Mr. Acting Speaker, than to cover your tracks, to cover the tracks of the mismanagement that went on over that period. We saw the largest single loss in Autopac's history under the previous minister, the minister that the current minister gives an A rating to for his performance. In fact, the corporation lost $58 million during that–

**An Honourable Member:** How much?

**Mr. Maloway:** –$58 million during that period of the election, and this government conveniently hides when that question is raised. As a matter of fact, their defence, their only defence, is that the rates, whether they be inadequate or not, are vetted through the Public Utilities Board. That is just a convenient way of hiding. This government put the rate-making process and required that it go through the Public Utilities Board. But the public have to understand it is this government that appoints this Public Utilities Board. Mr. Acting Speaker, this is a political board, this is a political board of Tories. This is a political board of Tories who do what they are told, and they knew, they knew, in the run up to the election campaign that it was politically astute to keep the rates down to get the government through its political problems.

So I find the minister's comments somewhat interesting. For a minister who when he was House

leader back in 1988 and used to chase our group of 12 members around on relevancy questions on bills, you know, I must say you only have to read his comments to see how what goes around comes around, because if anyone had been listening to his comments the other day, his four pages of comments on this bill, they could have made dozens of relevancy interventions on this particular bill. This is exactly what this minister used to do when he first took over government back in 1988. So there is a case where this minister does not follow his own standards.

Mr. Acting Speaker, there are several other elements to this bill that we have to deal with here, and there is a whole range of issues. I guess we just have to look at where this government is going with this corporation to see that its current appointment of board chairman is none other than Bernard Thiessen, who is a Tory bagman–

**The Acting Speaker (Mr. McAlpine):** Order, please.

As previously agreed, this matter will continue to stand in the name of the honourable member for Transcona (Mr. Reid), and when it is again before the House, the honourable member for Elmwood (Mr. Maloway) will have 34 minutes remaining.

The hour being 12 noon, as previously agreed, I am leaving the Chair with the understanding that the House will resume at 1:30 p.m.

# LEGISLATIVE ASSEMBLY OF MANITOBA

Thursday, May 8, 1997

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