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Tuesday 3 February 2004

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des débats
(Hansard)**

Mardi 3 février 2004

**Standing committee on
general government**

Health Information
Protection Act, 2003

**Comité permanent des
affaires gouvernementales**

Loi de 2003 sur la protection
des renseignements sur la santé

Chair: Jean-Marc Lalonde
Clerk: Tonia Grannum

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON
GENERAL GOVERNMENT**

**COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES**

Tuesday 3 February 2004

Mardi 3 février 2004

The committee met at 1352 in Algoma's Water Tower Inn, Sault Ste Marie.

**HEALTH INFORMATION
PROTECTION ACT, 2003**

**LOI DE 2003 SUR LA PROTECTION
DES RENSEIGNEMENTS SUR LA SANTÉ**

Consideration of Bill 31, An Act to enact and amend various Acts with respect to the protection of health information / Projet de loi 31, Loi édictant et modifiant diverses lois en ce qui a trait à la protection des renseignements sur la santé.

The Chair (Mr Jean-Marc Lalonde): I call this hearing to order. First of all I want to apologize for being late. We're having a heavy snowstorm in Toronto, so there was a delay in leaving Toronto. We are about 25 minutes later than the schedule is showing.

**ALGOMA COMMUNITY CARE
ACCESS CENTRE**

The Chair: I call immediately the Algoma Community Care Access Centre, if you want to come forward, please. Welcome to the standing committee on general government. We are here to hear your concerns or if you have any comments to make on Bill 31. Everything will be recorded. The way we proceed is that you have 20 minutes to do a presentation. If you take the whole 20 minutes, then we won't have any time for a question period. If you take 15 minutes, the remaining time will be divided amongst the three parties. I believe the last time that we had a hearing, last week, the last question was asked by Mrs Witmer, so the NDP will be the first one to ask a question after your presentation. Thank you for taking the time to come and visit us.

Ms Mary Tasz: Good afternoon. Thank you, Mr Chair and standing committee members, for providing me with the opportunity to appear before the committee today. My name is Mary Tasz. I'm a manager of therapy services with the Algoma Community Care Access Centre. Accompanying me is Rhonda Chennette, manager of client services.

The Algoma Community Care Access Centre is a statutory corporation under the Community Care Access Corporations Act, 2001, and provides services under the Long-Term Care Act, 1994, and the Health Insurance

Act. As you are aware, the access centre boards and executive director are appointed through the Lieutenant Governor in Council. The Algoma Community Care Access Centre receives 100% of our operating funding from the Ministry of Health and Long-Term Care.

The access centre has offices in Sault Ste Marie, Elliot Lake, Blind River and Hornepayne. We cover an area of 48,737 square kilometres and a population of 118,567 people. Our organization in the last year serviced 6,305 individuals.

In Algoma, people of all ages in homes, schools, long-term-care facilities and places of work may access health, support and information services. These services are based on client needs and are provided on a visitation basis. Referrals may be received from individuals, families, friends, physicians and community agencies. The Algoma Community Care Access Centre offers many services, including case management, placement coordination, nursing, different types of therapy and personal support. Many of these services are offered by in-house staff, and contracts for professional services are often utilized in the district. Our organization is sensitive to the privacy and confidentiality of the individuals we service, and most of our professional staff are members of colleges that set regulations and standards of practice that speak to the release of information, sharing of information, confidentiality and record keeping. Further, these colleges currently have disciplinary measures in place for breach of the regulations and standards.

Bill 31 is important to all Ontarians, because privacy is fundamental to our free and democratic society. Our access centre interacts with many parts of the health care system, including long-term care facilities, hospitals, school boards, community service agencies and other health service providers. Our care coordinators are responsible to assist individuals with understanding the health care system and in facilitating service coordination with in-house staff and external providers and sharing information with many health care providers.

PIPEDA has been the legislation that we have been adopting, because it became law on January 1, 2004. As an organization, we have adopted the 10 principles. PIPEDA speaks to the transfer of information, but Bill 31 takes the legislation into the health system and clearly identifies the health care providers who should hold the information.

The Algoma Community Care Access Centre supports the personal Health Information Protection Act, 2003, as

does the Ontario Association of Community Care Access Centres. Bill 31 provides a common set of rules and clear boundaries, which is vitally important to health organizations as we move to implement this legislation. This bill services two groups of individuals.

Organizations like ours that collect, utilize and disclose information for a variety of reasons: Section 36, permitted uses, recognizes the importance of using health information for service planning, monitoring, evaluation, education, risk management and quality improvement. Most importantly, however, Ontarians who access care will be ensured privacy of their personal information.

Section 14 of this act is welcomed by health care staff, as it permits the health information custodian to keep a record of personal health information in an individual's home with the individual's consent. This is especially important with multiple care providers entering the home environment. This bill is a positive step toward safeguarding personal health information and, again, the privacy of Ontarians.

As a community organization, Bill 31 makes it mandatory that we comply with this legislation. Although it is hoped that the individual knew that he could access his personal health information, this legislation will ensure that each individual knows that it is his right to see this information and to even change it or amend it if he disagrees. There is a process in place for complaints that is clear, and this will ensure that the individual is heard and that the organization is accountable. This bill ensures that personal information remains private, confidential and secure. It provides a clear framework that governs the disclosure of personal health information, as well as how and why it is collected and what it will be used for.

There is a concern about the limited consent or lock-box provision in this act. If there is a circle of care around an individual and that individual chooses to withhold consent for disclosure of information, then the delivery of appropriate health care could be jeopardized. This has further implications in that critical information could be blocked and information required for long-term-care facilities could result in inappropriate placement and treatment of the individual because it is impossible to be able to identify the individual's needs without all of the information.

This act also speaks to implied consent, explicit consent and informed consent. Wherever possible, explicit consent or informed consent is preferred, and gives individuals greater control and confidence in the control of their personal health information. This act also allows for individuals to withdraw consent, whether the consent is implied or expressed. Using the concept of the circle of care and implied consent, it can be explained to an individual that personal health information will be used only as it is required.

This act will ensure that individuals will be informed about their rights to privacy and will have control of who has their information. Individuals will be informed about the use and disclosure of their information at the first opportunity, and organizations will document the use and

disclosure of all information. A health information custodian will be responsible for ensuring that the records of individuals are retained, transferred and disposed of in a secure manner, which should provide further assurance of the privacy of an individual's information.

1400

Bill 31 talks about the creation of a secure health data institute. In health planning and research, this will ensure that the release of information and analysis of information will not have any identifying information. I'm not clear about where that will go in terms of long-term research.

We believe that the key to successful implementation of this act is education. The consumers and providers both require education to understand the rights and responsibilities of this act. The Ontario Association of Community Care Access Centres did provide us with a privacy tool kit that is based on the Canadian Standards Association's principles, in anticipation of the requirements of PIPEDA. This gives us a framework in which to comply with the federal legislation. This, however, will need to be modified to ensure compliance with the Personal Health Information Protection Act.

A common set of rules and guidelines is imperative to planning with all health care organizations in ensuring that there are consistent policies in place, access to personal information and the right to challenge compliance with privacy principles. Training of all the organizations so we interpret this act in a similar manner is vital to consistency amongst health care providers.

In conclusion, we are very concerned about the July 1, 2004, implementation date, especially in light of the area that we cover and recognition that we will require the tools and knowledge to implement this legislation and educate each staff member and those we have contracts with.

We would like to thank the standing committee for taking the time to travel to Sault Ste Marie and for your consideration. Each of us has the best interests of the individuals we serve, and we would like to see this legislation introduced.

The Chair: Thank you very much. Just before we proceed with the question period, I want to inform the audience that instant translation is available at the back. Also, you may address the group in the language of your choice. We all have the equipment.

We have 10 minutes left, which will be divided among the three parties. I am going to start with MPP Shelley Martel.

Ms Shelley Martel (Nickel Belt): Thank you for being here. I wanted to deal with your last point first: your concern about the implementation date. If you had it your way, what would be a more preferable implementation date that would allow you to do the training you need to do in order that your staff can comply?

Ms Tasz: I'm going to make a guesstimate and say six months after the act is proclaimed.

Ms Martel: Do you have any idea of what training costs might be for your organization as you try and

comply with the law and make sure not only yourselves as staff but also some of those you work with and are under contract with you also understand what their responsibilities are?

Ms Tasz: I think the training costs are going to be in terms of the time our staff have to take to come to the sessions and the time it takes me away from my job as a manager of therapy. I'm not sure what the actual cost would be.

Ms Martel: Do you think the kit that was already prepared by the association might be able to be modified and cut down some of those costs?

Ms Tasz: I think that's the plan of the association.

Ms Martel: You talked about consent, and one of the things you didn't mention, which the Ontario association referred to last week, had to do with express consent and how that would impact on fundraising. We've certainly heard that concern from the hospital sector, but we also heard it from the association in the context of the community-based organizations that the CCAC works with and how they would be impacted in their fundraising efforts if they were not able to go back to some of those very patients for whom they provide care, whether it be Meals on Wheels, support etc.

Do you have any sense in terms of the clientele you work with, the community-based organizations you would be associated with, if consent for fundraising purposes had to be express versus implied? What do you think that would do to their ability to raise money?

Ms Tasz: To the other organizations? Because we don't raise—

Ms Martel: No, exactly. But I'm thinking of community-based organizations like Meals on Wheels, for example.

Ms Tasz: I think express consent is important, but I don't think I want to get into that. The Group Health Centre does a lot of fundraising, and I think Elizabeth will speak to that. I think people already are giving consent so that fundraising can occur, and I don't think information is being given out unless they're given permission for that.

The Chair: The government side.

Mr David Oraziotti (Sault Ste Marie): Thank you, Ms Tasz, for your presentation this afternoon.

I'd like to highlight for the committee the size and area of jurisdiction that you're responsible for and the number of clients that you serve. Do you see any implications, in terms of this legislation being implemented, that would make it more difficult to deal with Bill 31 and the protection of information, given the various offices and size of the jurisdiction you're responsible for managing?

Ms Tasz: No, I don't. We cover a huge area, but all staff report to the central area. They would be trained the same way. We would have to get to our contract people—that's the difficulty—and make sure that they understand. Part of our travel is to go out to those areas regularly.

Mr Oraziotti: OK. If I could just follow up with one other question: On page 5 of your presentation, you refer

to "limited consent or 'lockbox'" and implications that may prevent information from getting to appropriate health care providers. Do you have any suggestions on what we might be able to do with the bill in regard to streamlining that, or suggestions that may make that concern less of an issue for groups like yourself?

Ms Tasz: I would hope that the circle of care may cover that off, may be a support system.

Mr Oraziotti: Do you see it as a major concern in terms of the legislation?

Ms Tasz: From my end, I don't think it's a major concern, but we're speaking from a smaller community where we have a lot of information that you may not have in Toronto or other areas.

Mr Oraziotti: OK. Thank you.

Mrs Maria Van Bommel (Lambton-Kent-Middlesex): I thank you very much for being here today. I certainly appreciate hearing from the grass roots and the people who actually do the on-the-ground delivery of health care.

When you talk about a circle of care, could you explain to us who is involved in providing that circle of care in the work that you do here?

Ms Tasz: From the access centre perspective, it would start with the care coordinator, and it could be a nurse, a physiotherapist, a doctor, a patient—there are different therapy groups involved with one person providing services in their home. So that would be their circle of care: family members.

Mrs Van Bommel: Thank you.

The Chair: Now we go to the official opposition.

Mr Jim Flaherty (Whitby-Ajax): Thank you for the presentation today.

I take it, under the bill, that the Algoma Community Care Access Centre would be a personal health information holder, a health information custodian under the bill. I have a couple of concerns. One is about the disclosure of personal health information in the hands of health information custodians such as the Algoma Community Care Access Centre. In section 36 of the bill, it says that your organization could, as a custodian, use that identified health information, a person's personal health information, for all kinds of purposes—for risk management, for error management, for activities to improve the quality of care, for educating agents to provide health care, for the purpose of a proceeding—and that you could pass that personal health information on to agents of the organization for those purposes.

Don't you have some concern about the breadth of those permissive uses of individual health care information without the consent of the individual?

Ms Tasz: The individual does consent per release.

Mr Flaherty: I'm sorry?

Ms Tasz: The individual would consent.

Mr Flaherty: That's my concern. It appears from the bill that the individual would not be required to consent to that. Subsection 36(1) gives a health information custodian the power to use this personal health information about an individual without consent. That's my concern.

I think we all value the privacy of our personal health information. I'm wondering whether, in your view, it's necessary to go that far to give custodians of personal health information that range of uses without express consent.

1410

Ms Tasz: I think what I want to go back to is that we have regulated professions within the access centre. As an organization, we do get consent before we release information. I think I hear what you're saying, but we still have to get permission before we can release that information. My understanding of the concept of the circle of care is it would only be released if required, if it was going to help that person, if it was necessary for treatment.

Mr Flaherty: How do you handle the issue now?

Ms Tasz: From one person to another? To talk to one person and to a different group? Is that what you're asking?

Mr Flaherty: Yes. What do you do with personal health information now, forgetting about this bill for a minute?

Ms Tasz: We get a person's consent to release that information.

Mr Flaherty: Thanks.

The Chair: Any more questions from the opposition?

Mr Jerry J. Ouellette (Oshawa): I have a question: Have you done any analysis to determine the cost to implement and, more importantly, the cost for storage of the records? Maintaining the security of records has been brought up in the past by various health providers—it's going to be very costly and currently is. Have you looked at any of those figures and determined the impact on your access centre?

Ms Tasz: No, I haven't.

Mr Ouellette: Any ideas on what that cost is going to be and how it's going to outlay?

Ms Tasz: No idea.

Mr Ouellette: OK. Thanks very much.

The Chair: The PA to the minister has a question.

Mr Peter Fonseca (Mississauga East): I'd like to thank the Algonquin Community Care Access Centre for presenting today. Your understanding and support of the bill is very thorough. One thing that was brought up was the lockbox. What happens now if an individual refuses to give you that information—refuses to allow you to see information?

Ms Tasz: The individual has the right to give us the information or not give us the information.

Mr Fonseca: In a case now where you feel you may need that information, what's done?

Ms Tasz: You go back to the individual and explain why—again, it's information, it's knowledge, it's teaching—and again ask for consent.

Mr Fonseca: In terms of personal health information, do you need all information? What information do you use presently?

Ms Tasz: We only need the information that's required for the service that's being brought in. That's the information that's used.

The Chair: Time is running out. We thank you for your presentation. Again, congratulations on the work you've been doing.

SAULT AREA HOSPITAL

The Chair: The next group will be the Sault Area Hospital, and will be presented by Manu Malkani, chief executive officer and president of the hospital.

Welcome, bienvenue. Once again, you have 20 minutes, which could be shared among the parties in the question period after, if you don't take the whole 20 minutes. You can start now.

Mr Manu Malkani: Good afternoon, Mr Chairman and members of the committee. My name is Manu Malkani. I'm president and chief executive officer of the Sault Area Hospital, here in Sault Ste Marie. My colleagues with me today are Johanne Messier-Mann, who has many hats at the hospital, including that of our chief privacy officer; Mary Lou Kennedy, who is our manager of health records; and Brady Irwin, who is our vice-president of public affairs. On behalf of all of us, I welcome you to Algoma district and thank you for giving us the opportunity to share some of our views.

By way of background, Sault Area Hospital is a recent amalgamation of two separate hospitals. Although we are corporately a new entity, just a couple of years old, we have been working together for the last 10 or 12 years with two boards but a single administration and amalgamated operations and so on. Our combined hospitals total 364 beds and cover a wide range of services, from acute care to long-term care. We employ over 1,700 staff. We have 350 volunteers, 120 physicians, 28 dentists and three midwives at the hospital. We also have a budget of about \$130 million. So we are a fairly large operation in that way.

We are a member of the Ministry of Health and Long-Term Care's rural network number 9, which links us with our partners in Wawa and Hornepayne. We provide a wide range of primary, secondary and tertiary care services to people not just in Sault Ste Marie but across Algoma district. We serve a total population of about 120,000 people scattered around an area of about 50,000 square kilometres.

The significance of all this is that we're a district referral hospital. Many of our patients come from long distances—three or four hours' drive and more one way—and after getting care here they eventually go back to their home communities for continuing care. We also refer patients from Sault Ste Marie to other regional centres in Sudbury, London, Toronto and elsewhere. Given our geography and the fact that so many other providers are involved, the efficient flow of information between us and other providers, both here in Sault Ste Marie and elsewhere in Ontario, is that much more key to good patient care.

We have always viewed patient privacy and confidentiality as very important matters. As some evidence of that, we have attached to our brief, copies of some of our current policies on patient confidentiality and privacy. That's just to give you a sense of the degree of rigour we have brought to bear on this task over the years.

As far as Bill 31 is concerned, we certainly endorse the proposed legislation. There are, however, three or four areas where we have some recommendations for your consideration. These are fundraising, research, correction of personal health information, the so-called lockbox provision and the quality of care committees.

As an overall comment with respect to patient information, we believe that the current direction of the health system to create integrated electronic medical records is in the best interests of patient care. While the proposed legislation does not appear to limit or constrain this, we do recommend that in crafting the regulations which will eventually support this legislation, special attention is given to enable the linking of records from different providers into an integrated patient record, secured of course with appropriate safeguards to prevent unwanted access.

As far as fundraising is concerned, the biggest financial impact of Bill 31 for hospitals will potentially be in the area of fundraising. If the act is passed as currently written, it will result in significant loss of revenues.

The requirement that hospitals seek express consent from individuals will pose considerable challenges, and we believe this is inconsistent with the privacy expectations of patients. I say that based on our experience of having received virtually no complaints about privacy and sharing information in this regard. Getting express consent is not practical and will take time away from patient care on the part of people who have to seek that consent.

Given that fundraising is a legitimate activity of hospitals and their foundations, Sault Area Hospital cannot support this provision of Bill 31. We recommend that at a minimum, hospitals be allowed to share with their foundations and fundraising staff non-health personal information such as name, title, address and phone number.

As an added measure of control of their information by patients, we do support providing them with a variety of non-patient-specific opting out provisions—information through posters and signs and so on, making them aware of what information we would share and how we would use it and giving them the choice of opting out, of directing us not to do that.

On the subject of research, we request that the definition of “research” in the legislation be narrowed so it very clearly excludes studies of an administrative or quality improvement nature. We don't feel it is necessary or appropriate to submit these to the research ethics board for approval first.

1420

With respect to access to and correction of personal health information, we note that subsection 53(10) requires that following correction, inaccurate entries be deleted from the record without any connecting link.

While we support the provisions to correct inaccuracies, we suggest that the link to the original inaccurate information be maintained. There are cases, for example, where the staff treating the patient may arrive at a diagnosis that eventually turns out to be inaccurate and is changed, but the treatment that was based on that is still a legitimate part of the record, and we think it should stay as part of the chart. We believe, as I say, that it would be important to retain all of this as part of the record even after the correction is made.

We are also concerned about provisions, set out in clauses 36(1)(a), 37(1)(a) and 48(1)(d), whereby patients may limit the use and disclosure of their personal health information to other care providers. We believe these sections put the patient at increased risk of inappropriate treatment and adverse consequences to their care, as well as potentially some additional risk to providers. We believe as well that such provisions will be very impractical and very costly to implement.

With respect to the Quality of Care Information Protection Act, it is unclear whether the protection provided applies only to one committee, ie the quality-of-care committee, or to any other committees of a similar role in the hospital where individuals carry out these sorts of responsibilities. The latter interpretation is necessary, given that there are many committees in the hospital. In our hospital, for instance, every one of seven programs has its own quality management committee, and there are others at the board level as well. So while we support the spirit and the intent, we hope it can be clarified that the same safeguards apply to as many quality-of-care committees as may be in place.

In summary, Sault Area Hospital supports the spirit of Bill 31 and commends the government for moving on this very important initiative. We believe our recommendations will serve to support and strengthen the legislation while protecting the interests of patient care.

Finally, we ask that sufficient consideration be given by government to the implementation of this legislation, particularly the cost of incorporating the new requirements and training of hospital staff. Sufficient time and resources must be provided so that the implementation of this legislation does not detract from the provision of care. Thank you very much.

The Chair: We have nine minutes left, which will be split among the three parties. I'll go to the government side, and Mr Leal.

Mr Jeff Leal (Peterborough): How much money does your foundation raise for Sault Area Hospital activities?

Mr Malkani: Through our normal fundraising activities every year we raise about \$800,000 to \$900,000.

Mr Leal: And you'd be concerned, just to follow up, that this legislation may put a crimp in your ability to raise that on a continuing basis?

Mr Malkani: I'm going to answer that in two parts, if I may. The portion we raise every year that comes directly out of new patient solicitations is about 5%, roughly \$40,000 to \$50,000 on an annual basis. Fundraising is

largely dependent on building a relationship with the donor, and what we raise in the first year is just a starting point for subsequent years. So I can't really give you a clear estimate as to what that will materialize to over the life of the relationship.

Mr Leal: I guess once you make the connection, there's the possibility of giving a second, third, fourth or fifth time.

Mr Malkani: Exactly.

The Chair: I have a question from Mr Rinaldi.

Mr Lou Rinaldi (Northumberland): In your conclusion, knowing the size and scope of the service area you cover with the two hospitals, you hinted that there are going to be some costs in the time frame as well, obviously, based on your geography and your position. Do you have any idea what some of those costs might be and what time frame you think would be adequate?

Mr Malkani: The costs are really in two parts. One is the training and orientation of the 1,700 staff and all of the physicians and so on on the new provisions. That would probably take three to four months to do—six months at the outside—and from a cost point of view, I would say \$20,000 to \$30,000. So it's not extraordinary in that sense.

The bigger and more difficult part of the costs to estimate are the system-related changes we would have to make. I unfortunately don't have an estimate for you on that. I can tell you now that we just do not have the capacity to comply with the lockbox provisions as stated in the act now. It would require a complete overhaul of the system, which would be at least in the hundreds of thousands of dollars, if not more, and from a time implementation horizon point of view would be at least a year or more.

Ms Kathleen O. Wynne (Don Valley West): Just a quick question about the correction clause. Are you suggesting, then, that both pieces of information should just stay in the record?

Mr Malkani: Yes.

Ms Wynne: OK.

Mr Malkani: Obviously the corrected information should be clearly identified, but the old information should stay as well.

The Chair: Now the official opposition.

Mr Flaherty: Thank you for your presentation, sir. My questions are not specifically directed to the hospital but more generally to the bill, and you may or may not be able to assist.

The scheme of the bill creates something called health information custodians, which are defined in section 3. These are people and institutions that are allowed to collect personal health information. Do you think it's appropriate for a politician to have access to the personal health information of an individual in Ontario?

Mr Malkani: Depending on the purpose of gathering that information.

Mr Flaherty: Well, this bill says that the minister may. The Minister of Health and Long-Term Care is defined as a health care custodian, and more than that,

the ministry is. So all the government employees in the Ministry of Health will be included as health information custodians.

It goes further. By regulation, they'll be able—"they" being the government—to prescribe classes of person. That won't be in here; this will be done by regulation under the bill. My concern is pretty fundamental about the individual's right to the privacy of their own individual health records. I heard what you said about fundraising and so on, and I understand that as a concern. But I go again to the right-of-access section of the bill, which is section 49, and again I see in clause 49(1)(d) that the government will have regulatory power to prescribe a class or classes of health information custodians with respect to which the individual will not have the right of access. So this bill says to individuals that the government, by regulation, is going to be able to deny you access to your own individual health record. Do you think that's appropriate?

Mr Malkani: I didn't read in here—and I might well have missed it—that the individual would not have the right to access that same information. I did recognize the piece about the government having the right to access some of it.

Again, I didn't see any difference between what this bill provides government and what the current Public Hospitals Act that has been in place for many, many years provides. Again, the intent has been to provide information for cancer research and public health research and that sort of thing.

Mr Flaherty: I don't, and I'm sure you don't, have a problem with de-identified information being used for such purposes. The difficulty here is that we're dealing with identified health information—your file, my file about our health information—and the government being able to say that I can't see it or you can't see it, and being able to do that by regulation, not openly in the Ontario Legislature. Anyway, enough; I'll let my colleague get a question in.

The Chair: You have about one minute left.

Mr Ouellette: Being a border community, the legislation has no ability to stop you from gaining information outside of the jurisdiction. So even if, for patient care, individuals were referred out of the province, do you see yourself as gaining information outside of the province as a method of fundraising? More importantly, you've already stated, and other groups have stated, that the fundraising costs could be as much as half a billion dollars to the industry as a whole throughout the province. Do you see other border towns, such as Sault, Michigan, capturing some of those funds by being able to lobby those individuals to gain funds that would normally go to Ontario hospitals?

Mr Malkani: I personally don't think that's much of a concern. The short answer is no.

1430

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I want to start with the fundraising as well. Could you tell me how you undertake fundraising now through the foundation?

Mr Malkani: We do share with our foundation staff now the same pieces of information I've identified: name, address, phone number. The foundation, long after the discharge, follows up with patients. As part of the relationship-building process we have several communiqués that we send out several times during the year. We invite these potential donors and actual donors back to the hospital for a variety of events to meet the people and visit the programs through that relationship. We have a variety of fundraising initiatives. Some of them are things like a car draw, those kinds of things, and various other programs: galas and so on.

Ms Martel: You said you raise about \$800,000 to \$900,000 annually. Can you give the committee an idea of what that would be in terms of individual donors versus a corporation?

Mr Malkani: I can give you that roughly. It's about 12,000 to 14,000 individual donors. Is that right, Johanne?

Ms Johanne Messier-Mann: Yes.

Mr Malkani: That does not include what we get through bequests and so on.

Ms Martel: You had said you'd like to be able to share information with people about their ability not to participate in funding by essentially posting signs in the hospital, which is one option. Another option that has been raised with us is that foundations would still be allowed to solicit directly by mail, but include in the letter an opt-out option. Would you be agreeable to that as a way to do it?

Mr Malkani: Very much so.

Ms Martel: Because you're already mailing to individuals anyway, so it's not an added or extra cost for you.

Mr Malkani: Yes, that's correct.

Ms Martel: Let me go to the provisions that are called the lockbox provisions. As you can understand, this has been a point of controversy among competing groups. One of the points that has been raised is that the lockbox provisions can essentially be overridden in the case of emergencies or where someone is incapable of making decisions through another in section 37, and that that should then relieve the concerns of health care providers and institutions to be able to provide health care, for example, if someone comes in an emergency situation or if someone comes in with a mental illness and is not capable of making decisions themselves.

Obviously you don't agree with that and you have some additional concerns, so I'd appreciate if you could tell the committee why you don't think that provision covers your concerns but has to go further in terms of essentially not allowing people to block some of their own personal information.

Mr Malkani: That provision deals only with cases where the individual is not able to give consent, for whatever reason. Our concern is with what we anticipate will be the larger number of cases where the individual is able to give consent but withholds it, but the information is relevant to the provision of care.

Ms Martel: You wouldn't normally be seeing that in an emergency situation, though.

Mr Malkani: Not necessarily.

Ms Martel: OK.

Mr Malkani: Johanne, would you care to add some specifics to that?

Ms Messier-Mann: Yes, as a previous nurse—for instance, under lockbox provisions now, people could choose to divulge information to a certain group and not to another group. As the circle of care—and all, as professionals, are bound by their colleges—we are abiding by confidentiality and require that information, both for the safety of the patient and also the safety of the caregivers who are involved in that case. Also, from a technical perspective it would be very difficult to route the information so that this group can find out and that group can't find out. So it's from both a patient safety perspective and a care provider perspective, and we all know that's a big issue in health care these days.

Ms Martel: So essentially the answer is not to allow individuals to do that. That is, as I see it, the only answer here to resolve this particular problem.

Ms Messier-Mann: We feel the answer is the circle of care. The people who are providing care to the patient need access to the relevant information to provide quality care.

The Chair: I believe Mr Fonseca has a question on behalf of the minister. You have 15 seconds.

Mr Fonseca: In regard to the fundraising, as an option at admission can the hospital ask something like, "Can the hospital keep in touch with you after your service and seek your ongoing support?" Would that be a viable option to this fundraising issue?

Mr Malkani: To the extent that the question would have to be put on an individual basis, it is essentially getting express consent. That's the logistical difficulty that we see.

Mr Fonseca: The example that I just gave you, would that be something, at admission?

Mr Malkani: That could work. We do have a few questions we put to patients at the point of admission. That could be another question that we put to them. That would be another one of the opting-out provisions.

The Chair: Your time is up. Thank you for giving us a chance to come to the Soo. We wish we had time to pay a visit to your hospital.

GROUP HEALTH CENTRE

The Chair: The next group is the Group Health Centre. Welcome to the hearings. Could you give us your name and your position.

Ms Elizabeth Bodnar: Good afternoon. My name is Elizabeth Bodnar. I am the chief privacy officer at the Group Health Centre, and I'm accompanied by Tamara Shewciw, who is our senior manager of information technology. We are here today on behalf of David Murray, our president and CEO, who wanted to be here. However, Ministry of Health representatives are visiting

the centre today, so that's where Dave is at this very moment.

The Group Health Centre is an ambulatory care facility in Sault Ste Marie. I would like to begin my comments by thanking you for travelling here to the Soo to hear our comments and concerns regarding this new bill and reassuring you that we have much to offer in terms of experience and expertise surrounding this topic, particularly as it relates to electronic medical records, or EMR as it's affectionately known.

For those of you who are not familiar with the Group Health Centre, it is the health care partnership of the Sault Ste Marie and District Group Health Association, which is a not-for-profit corporation that owns the physical facility, equipment and furnishings and hires all the non-physician staff, and the Algoma District Medical Group, which is an independent partnership of 64 physicians, including 37 primary care providers and a wide range of specialists.

The GHA, group health association, and the ADMG, Algoma District Medical Group, are interdependent entities that jointly operate the Group Health Centre through a joint management committee. As Ontario's largest and longest-established membership-based health organization, the Group Health Centre has been providing care to patients in Sault Ste Marie and the Algoma district for 40 years.

In 1997, we implemented an electronic medical records system that is the largest primary care based EMR in the country. This is a fully functional, comprehensive patient health information system. We have also funded the development of extensive security systems to ensure the privacy, confidentiality and security of our patient information. We have created policies and procedures to guide us in ensuring that the health information we collect is guarded with the utmost security, confidentiality and privacy. We are pleased to see that many of our policies and procedures reflect the principles that are outlined in this bill.

While we were implementing our EMR, we worked with our vendor on technical innovations that included restricted access to categories, such as psychiatry or counselling; an extra lock that can be placed on charts at the request of our patients; access logging, which allows us to see who has been in which chart and when; and handcuffing of users so they can only see what they require to see in order to do their work, which is provide patient care.

Of course, in this field of security, privacy and confidentiality, you are never done, so refinements to our systems are ongoing. Interestingly enough, two years ago, we explored with our vendor a process of information release based on patient consent, akin to the lockbox. This is proving to be extremely complex and expensive. Our seven years of practical experience with the EMR have provided us with knowledge and expertise, and it was best described recently by Michael Decter, recently appointed chair of Canada's new Health Council when he visited the centre in November and

said, "What Group Health Centre is doing with EMR others are still dreaming about."

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Our EMR is interfaced with existing practice management applications that provide ordering and receiving of diagnostic tests, automated faxing, prescription writing, sign-offs and so on. This fully functioning, integrated EMR, accessed by all GHC health care providers simultaneously, provides a truly collaborative medical practice. It allows for appropriate acute care for patients with complex chronic illnesses when the primary provider is not available.

The EMR gave us a tool to effectively manage chronic diseases and improve the quality of life of our patients. We have, with the hospital and the CCAC, been able to reduce hospital readmission rates for congestive heart failure patients by 58%. We have 2,717 adults with diabetes who receive enhanced diabetic management and the largest community anti-coagulation clinic in Canada, soon to reach almost 700 patients. These are all made possible by our EMR.

Bill 31's schedule B acknowledges the need for exception to express consent for health care teams who are sharing health information for the purposes of providing health care or assisting in providing health care, which is the basis of our chronic disease management program that produces the aforementioned results. It is reassuring that the McGuinty government supports the GHC philosophy of health professionals sharing information, leading to improved patient care and safety while giving the patients the right to control their personal health information.

This bill also specifically states, "for research conducted by the custodian," as a permitted use, to be performed in accordance with a research plan approved by a research ethics board. We are satisfied that we already conform with this requirement at the Group Health Centre.

We commend you for drafting a provincial bill that serves the needs of the health care sector better than PIPEDA, the federal act, as it was too general and commercially focused, leading to confusion and lack of clarity about how, and in some cases even if, it applied to health care. PIPEDA is also difficult to interpret when applied to research.

In closing, we want to ensure that as Bill 31 is being examined, and although we anticipate minor changes and additions, we feel strongly that privacy law as it relates to health care should not impede coordinated care and there should be a direct reference to the circle of care and the sharing of health information in teams, as that is what the Group Health Centre's model of excellence is based on.

Thank you for your time and attention. If you have questions, we will both answer.

The Chair: We have 11 minutes left, which will be divided among the three groups. I am going to start with the official opposition.

Mr Ouellette: Thanks very much for your presentation. It appears from the sound of it that you are ready

to go, so the time frame as found within the bill would be acceptable. Most of the other groups have indicated that that time frame would not be acceptable. So you don't have a problem with the time frame?

Ms Bodnar: We were prepared to go with PIPEDA January 1. We are implementing training programs. We had a launch in November with our staff day, but we agree that it would probably be six months to get everyone trained.

Mr Ouellette: So the time frame for implementation should be longer than what's considered here.

Ms Bodnar: I think so. Six months.

Mr Ouellette: Also, regarding the impact, I think your words were that it proved to be very expensive for you. Do you have any ideas on what the costs would be to health care as a whole in this area to implement this?

Ms Tamara Shewciw: Health care for us?

Mr Ouellette: For yourselves.

Ms Shewciw: Actually, when we looked at PIPEDA, we went through what was required for PIPEDA and did a threat-and-risk assessment and so on. It was just under \$1 million for us, which is a lot for an organization our size.

With this new bill, there's a lot of implied consents, and so on, that will help that, so I can see the costs coming down. But there's still a cost in terms of training and systems work, in terms of redoing with our vendors some of the things that work in there now to make sure that they comply with this legislation.

Mr Ouellette: OK. Thank you.

Mr Flaherty: Congratulations on running a successful group practice in Ontario, which we hope to see a lot more of. Does your group health association do any psychological testing or assessments?

Ms Bodnar: We have a psychiatry department and a counselling department, yes.

Mr Flaherty: Can you think of any reason for saying that a patient—this is what this bill says—will not have right of access to the raw data from standardized psychological tests or assessments? It's in section 49 of the bill.

Ms Shewciw: And your question is?

Mr Flaherty: My question is, if I have psychological testing, or my child does, at your clinic, why shouldn't I or my child have the right to see the test results?

Ms Shewciw: I know that within the college—it's shown in legislation as well—if the physician or the practitioner feels it would be detrimental and could cause you harm, then they do not have to show it.

Mr Flaherty: Then they have to say no, and then I can go to court and get an order that they produce the record. But that's not what this bill says. This bill says that I will not have the right to raw data from standardized psychological tests or assessments. It says that an individual has a right to access to certain personal health information, but not to a record that contains—and that's one of the listed items.

Quite frankly, I've seen this in draft legislation before and I've never understood it. Why are we giving this

special privilege to psychological testing, as opposed to ordinary medical and health care information? It must be some lobbying by somebody that gets this into this bill. I'd like to see it taken out, because I don't understand how a government should be saying to any family in Ontario that they should not have the right to access. I raise it with you because I know you run a big operation and you have that kind of information.

The Chair: Ms Martel.

Ms Martel: I'm interested in your lockbox provisions. You said an extra lock can be placed on charts at the request of patients. So essentially, your patients now have the opportunity to determine which information they want disclosed or not. Am I correct?

Ms Shewciw: Yes and no. At the very beginning, back in 1997, it was akin to an office having a special cabinet where they would put patients' files. So you had a medical records department and then there were some—you know, the movie star who comes to your clinic: "I don't want my chart in with all the other charts," so you put it into a special spot. What we did was to copy that in the program, in the software, to do exactly that. So what happens is that if this person comes forward and says, "I'd like my chart locked," there is a key put on the chart. Any time anyone has access to the chart, they have to go and get the key. Then we know so-and-so is trying to get into this movie star's chart. Is that reasonable or not? In the circle of care now, you have a user ID, you have a password and so on. You're providing care, so you have access to the chart. It just gives it an extra lock, and a key has to be provided to open up that chart.

Ms Martel: At what point can that be opened if the patient has expressly said they want their information to be locked?

Ms Shewciw: With the locked chart it's a little different from the lockbox. With the lockbox, you're saying, "I don't want this information passed along." In this case, what the patient is saying is, "Can you please lock it? I just want to know that there's this additional security on my chart that not just anybody can get in; I'll know specifically who's getting in because they have to ask for that key to open that chart."

We were exploring the lockbox as well. It gets very complex. I sat down with a vendor—this was two years ago—and it was actually to see if we can pass on information to the hospital; it was like, "Let's pass it on." Because our circle of care is such that it is the Group Health Centre, when you roster with us you are getting this circle of care. So it's providers, ancillary providers and so on. But now this is extending past our circle of care. So the patient can either say, "Yes, I consent to that," or not.

We started looking at it; the theory is great, and that's what we were looking at. Two years ago we said, "We need this." But when you start looking at the logistics, "Don't pass my information along to that physician—everybody else can see it—and only for that type of visit and only from those dates," how do you start setting that

up? Even though they've now said, "I don't want physician X to see it because he's my neighbour," or "I don't care for him; don't show him my chart," how do you know who the next physician will be to have access to that? Are you always having to inform patients that these are all the new physicians who now can access the chart or might be accessing the chart? It just becomes a real logistical nightmare to try to get that set up in the system.

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Ms Martel: So over and above any concerns about care and the provision of care, the practical reality of trying to implement that provision—

Ms Shewciw: It's going to be really tough. One of the ways that we were looking is even to just say that it's all or nothing. Either you lock your chart, so the locked chart and the lockbox become one—"I'm locking my chart; I don't want anybody to see it unless they have consent from me at that time"—or ahead of time, say, "I consent to these people to see that information." Then it's an all or nothing, not piecemeal: "I only want my progress notes and not my consult letters," or whatever. It's all or nothing. But then what happens is the patient has to—and they have to have some responsibility here too. If you want your chart locked, when you present yourself down at the hospital and there's nobody to open the chart—we're not a 24/7 operation. So if you go at night, who is going to unlock your chart?

The Chair: Time is up. The government side.

Mr Leal: Back to Elizabeth. Being new to provincial politics, I guess at the end of the day you want Bill 31 to be the best piece of legislation that's ever been put forward to the people of Ontario.

Consistently through submissions that we've received there's been a lot of comment about the federal legislation, PIPEDA. I guess "shortfalls" would be a way to describe it. Could you just describe to me some of these shortfalls you see in PIPEDA that you think we should make sure don't occur in Bill 31?

Ms Bodnar: I think, in looking at PIPEDA—and my comments describe the confusion that I know lots of hospitals felt: "Does it apply to us; doesn't it?" It specifically applied if you did fundraising, and PIPEDA was very specific about research: Everything needed a consent.

In our organizations and in the very nature of health care and the way that we see health care being provided in this province and in the country, we are all looking to improve care. I think Mr Malkani spoke to the fact that quality improvement is a big part of what we do. So in order to apply PIPEDA in the health care environment—it just wasn't specific enough. We felt that it was too confusing to apply.

When you're talking personal health information, as this bill does, there's an understanding that in the circle of care there's an implied consent by patients, particularly in our environment where there are many different disciplines, that if they become patients of the Group Health Centre, they are aware that once their physician

sees them and refers them to a physio, that physio will be putting information into their chart that goes back to the physician. It's a comprehensive chart. It's more manageable in health care. I think PIPEDA was just too commercially based, not focused enough.

Ms Shewciw: The whole issue of implied consent—with this, it's implied consent: "Yes, I'm presenting my information to the practitioner and I am consenting that he will pass it on to the appropriate people, not that any time he makes a fax he has to get my consent or any time he passes on a consult he'll have to get my consent." It just would make health care stop.

Mr Leal: Thanks for your response.

Mr Oraziotti: Thank you very much for the presentation. We're certainly fortunate in our community to have a facility like the Group Health Centre, which was recognized by the Romanow commission. It's certainly strongly supported by our party as a model of health care delivery.

I'll get to the point here: How do doctors at the facility feel about this proposed legislation, and how much of what is already being done at the Group Health Centre is consistent with the proposed bill?

Ms Bodnar: We had our physicians who are on our EMR user committee—the EMR user committee was started even prior to our implementation of EMR. We are partners—the association and the Algoma District Medical Group—in everything that we do. They reviewed the bill, along with us, and they are in agreement with the comments that we have provided to you. They believe in the team approach to care; that's why they practise in the environment that they do. Tamara works much closer with the physicians on the EMR user committee, but we definitely have had them review the bill. They are supportive, and their comments are reflected in what I presented today.

The Chair: Thank you. A job well done. Keep up the good work. Once again, thank you for coming.

Mr Fonseca: Thank you very much to the Group Health Centre for being so proactive.

I do want to call up some Ministry of Health and Long-Term Care staff to address some of the concerns that Mr Flaherty brought up. They could shed light on those.

The Chair: Do you want to clarify some of the questions that Mr Flaherty had before we proceed with the next group?

Ms Carol Appathurai: Yes. I'm Carol Appathurai. I'm the acting director of the health information, privacy and sciences branch. With me is Fannie Dimitriadis, legal counsel with the ministry.

I'd be happy to answer any questions.

Mr Flaherty: The question I raised with the last group about psychological test data: Why does an individual not have the right of access in this bill to that data?

Ms Appathurai: I have to confess to asking that same question myself. This was raised with us and requested to us by the psychologists and, I believe, the psychiatrists as

well. What they're saying there is that you have, of course, the right to the results of your tests, but you do not have a right to look at how the various parts of your tests were analyzed and evaluated, because that will impact on the results the next time you take the test. So yes, you do absolutely have access to the results of the tests, but not the to detail of how it was measured and evaluated. What marks you got in each section, how those sections are marked—you don't have access to that.

Mr Flaherty: With respect, that's not what the section says. The section says "raw data from standardized psychological tests or assessments." If anyone has any familiarity, as I do, with psychological testing, having spent a good deal of my life in court and looking at psychological testing, it's drawing things and there are all manner of psychological tests. The raw data is not the interpretative information; the raw data is the test itself as performed by the patient. It's very interesting that we have a professional association being patronizing to the people of Ontario. But this raw data has nothing to do with assessment. It is the actual test data. I hope there's a better reason for it being in the bill than that given to you by them.

Ms Appathurai: It may be their differing understanding of the reading of "raw data." I think, in their understanding, raw data refers to the test as it is evaluated and the comments in each section. We can certainly go back to the psychologists and get clarification on that.

Mr Flaherty: I do appreciate that.

My other, broader, concern, which I haven't had an opportunity to raise here, is the exclusion of quality of care information, in clause 49(1)(a), from the patient's right of access. What on earth is the justification for saying to a patient, a citizen of Ontario, that the Legislature is going to tell you that you do not have the right to your identified health information that relates to quality of care?

Ms Appathurai: Quality of care information is specific information, and I'll give you a little context. What happens in a hospital when there is an incident or a near miss is that a quality of care committee, which is composed of various professionals within the organization, gets together to look at, to discuss, to analyze the incident or near miss and determine how it can be avoided in the future and what needs to be put in place in terms of procedures at the system level or even at the individual level to ensure that this incident does not occur again.

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Those discussions are quality of care information, and you will note in schedule B of this legislation, the Quality of Care Information Protection Act, that protection is given to quality of care information only if the facts of the incident are in the patient's file to which the patient does have access. What the patient doesn't have access to are the opinions and discussions on that incident.

Mr Flaherty: We could debate that a bit in terms of the breadth of the definition on page 86 of the bill in schedule B, but in that definition there is also clause (c), which says, "satisfies the criteria for quality of care

information specified by the regulations." So here we have a regulatory power which is going to be given to the government to define what quality of care information is. What on earth does that have to do with what you just described?

Ms Appathurai: That is meant to be quite privacy protective. What we don't want is various hospitals springing up quality of care committees and protecting information that should not be protected. So through the regulation, what we will be able to do is develop criteria—and of course you know there's an open regulation-making process—that clearly define and constrain what information will be protected.

Mr Flaherty: That's not the way this is—

The Chair: I think we've gone far enough. I should have asked for unanimous consent before I got you to come to the table. The next time, I'll do that. I have to apologize. But again, could you give us some clarification of "raw data," what it really means? That's what you said a little while ago, that the former minister said. Thank you.

CHILDREN'S AID SOCIETY OF ALGOMA

The Chair: The next group is the Children's Aid Society of Algoma, central district. Welcome to the standing committee on general government public hearing on Bill 31. Could we have your name and your position?

Ms Trina Colizza: My name is Trina Colizza, and I am representing the Children's Aid Society of Algoma. I am here with Tracy Willoughby, who is the director of services from the children's aid society. We are here on behalf of Jim Baraniuk, who was unable to attend, as he is in Thunder Bay today.

Tracy's responsibilities as the director of services are to oversee the core protection services for the district of Algoma, which in our case extends from Hornepayne down to the border of Sudbury-Manitoulin, which is around the area of Spanish. Tracy oversees all of the protection, from the commencement of the first face-to-face visit to the time the family file is closed, as well as the legal components with our in-house counsel.

My responsibilities as the manager of resources are to oversee the prevention services that are in place prior to children coming into care and then the residential component of the children's aid society, which essentially manages the children in foster care, the foster care system itself, the adoption probation and the finalization of the adoption services.

We would like to say at the outset that we have only had the opportunity to have a preliminary review of this document. We are part of a large organization that will be speaking formally on this, but what we'd like to do today is present a few of the themes that we have researched over the last number of days. So we apologize for not being more proficient in the actual piece of legislation as it stands right now.

Ms Tracy Willoughby: Several coroner's inquests which occurred in 1997 and 1998 examined the deaths of children receiving services from children's aid societies across Ontario. These inquests resulted in recommendations directed to more open sharing of information by professionals, including those involved in health care, and by persons in the community with children's aid societies, as well as by CASs with professionals and individuals in the community. The inquests heard repeatedly how there were legal safeguards that protected confidentiality, sometimes at the expense of the safety, protection and best interests of children.

OACAS, our professional association, which represents 51 child welfare agencies across the province, supports the development of legislation that regulates the collection, use and dissemination of personal health information. As you are aware, children's aid societies must be able to access health information readily to properly fulfill our mandate of protecting vulnerable children. Furthermore, children's aid societies may need to access and/or disclose personal health information for specific purposes related to their statutory functions in protecting children.

We are submitting two inquest reports that will outline recommendations from two coroner's inquests for your consideration.

We do wish to draw to your attention part VIII of the Child and Family Services Act, which contains specifics regarding privacy of children's records and family records, and also to highlight that this part within the Child and Family Services Act has never been proclaimed. This section includes important matters of privacy, including access to records, provision for disclosure of records, consent to gathering and release of information related to service delivery to children, protection from liability, and codes of procedure for service providers. We suggest that this part of the Child and Family Services Act should be reviewed, updated as necessary and proclaimed so that the privacy of sensitive information about children and families can be protected. We have also included in our submissions part VIII of the CFSA.

Ms Colizza: The record requirements of children's aid societies are extremely complex and contain blended types of information, only some of which is personal health information. The process of separating personal health information from other forms of personal information, as proposed by the draft Personal Health Information Protection Act, could be complicated by the fact that personal health information is broadly defined as, among other things, identifying information that "relates to the physical or mental health of the individual." As a result, CASs could end up applying different rules to various parts of their files. Simply put, this would create an administrative labyrinth and produce unnecessary work within a resource system that is already overtaxed. We have brought a copy of the ministry standards and guidelines which we are required to strictly adhere to from the initial point of contact to file closure. We hope

this will provide you with a context of our responsibilities as set out by our ministry.

A CAS would be subject to the general limitations prescribed in the draft privacy act, which would represent additional encumbrances for the CAS in the course of discharging its child protection mandate. This would cause difficulties for a CAS in the course of carrying out its responsibilities as a statutory parent on behalf of children in care, which include the obligations to assess and then meet the medical, dental, psychological and psychiatric needs of such children, including the provision of examinations, assessments and recommended treatment in a timely fashion, and the recording of all such examinations, assessments and treatments.

Under the new disclosure obligations, it would appear that a child under the age of 16 years and in the care of a children's aid society whose personal health information records were in the possession of a health information custodian would have the authority to consent or withhold consent to the disclosure of his or her own records to a third party if he or she has the requisite capacity, regardless of the position being taken by the children's aid society. Under these new rules, there would be a presumption that the child had such capacity regardless of age. This could cause difficulties for a CAS that was of the view that such disclosure would be detrimental to the child or to some third party.

Under the provisions of the draft act, a CAS would be required to destroy or delete a record of personal information or to de-identify it after the purpose for which the information was collected has been fulfilled unless the CAS could bring itself within the exception that it "reasonably requires the record for purposes related to its operation." Given the fact that CASs are institutional litigants who often rely upon historical documents and records to defend lawsuits and to initiate protection proceedings on the basis of past parenting history, it would be highly prejudicial for CASs to be bound by these personal information record destruction requirements.

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Ms Willoughby: In summary, we wish to acknowledge that we have had the opportunity to conduct only a preliminary review of this legislation. OACAS will be submitting a written response pertaining to agencies governed by the CFSA in Ontario.

One area generating discussion in child welfare that we would like to briefly highlight is as follows: that at the very least CASs be exempt from the application of the draft Privacy of Personal Information Act, 2002, until such time as CASs are covered by either updated or proclaimed amendments to part VIII of the CFSA or additional CAS-focused amendments to the draft, and that, further, the task be prioritized to eliminate service barriers that are required to ensure the safety of children.

In the final analysis, any framework for the collection, use, disclosure, retention and disposal of personal information must facilitate and support information sharing for the purpose of protecting children and ensuring their

best interests and well-being. It would be of concern to the field if any proposed legislation in this area served to impede information flow or compromise the mandated investigative function of child protection workers.

The Chair: We have nine minutes left. I think it's time for—is it the NDP? OK. Shelley Martel.

Ms Martel: Thank you for being here today. I wanted to focus on page 3. I have questions for both paragraphs, but let me deal with the disclosure obligations. I'm not sure that I understand the concern with respect to the disclosure obligations of allowing someone under 16 to be making choices or providing consent regardless of their age. What's your specific concern?

Ms Colizza: For the children who are in care of the society, it is important for us to be able to find an appropriate placement for them in terms of their residential placement, and also in terms of the counselling and services that they are required to have. What we would be concerned about is, if there were an assessment and the child did not wish to disclose the contents of that assessment to us, that that might impede the treatment or the appropriate residential placement for that specific child.

Ms Martel: So the concern is not so much that there might be a lesser right for a child in care.

Ms Colizza: No.

Ms Martel: That's what I thought you were going to answer. OK. So it's a concern that information that would be relevant to ongoing treatment might not be disclosed.

Ms Colizza: Right.

Ms Martel: OK.

If I go to the paragraph just above that, where you're talking about concerns that it would make it more difficult for CAS to discharge its child protection mandate, can you give us some examples, or an example, of what the reference is there?

Ms Colizza: I think this particular paragraph would refer to the children in care, whereas oftentimes children come into the care of the society without our having much information related to their background. In order for us to ensure that there hasn't been neglect or a serious health concern—perhaps they have never seen a physician—or medical or psychiatric assessments that we're not aware of, then we would not be able to, perhaps even in court, discuss our protection position to ensure that those children are maintained in care and receive the appropriate services they need. Does that answer—

Ms Martel: It's the limitations, when you're talking about the general limitations. Maybe I just haven't read this carefully enough. I thought that most health information custodians would have to disclose to CAS, and perhaps that needs to be highlighted in the legislation. That would deal with your concern then.

Ms Willoughby: Yes. I think it needs to be clearly outlined. What we are finding currently with other legislation is that community service providers may often hide behind legislation to protect or withhold information in their own records. So I would certainly support a clear

definition and guidelines to the access and disclosure of records.

The Chair: Now the government side.

Mr Fonseca: I'd like to thank the Children's Aid Society of Algoma for their presentation. Currently, are the adolescents in your care given the opportunity to consent to the release of their health information?

Ms Colizza: We are required at this point in time—we do ask all our children over the age of 12 to consent to the release of information, or the sharing of information as well.

Mr Fonseca: So that practice is already in place?

Ms Colizza: Yes.

Ms Willoughby: That practice is also outlined in section 8. So proclaiming section 8 would legislate the disclosure and transmittal of those records as well.

Ms Wynne: So it's only section 8 that you want to take precedence over this bill? It's section 8 that you're concerned about? Are there other parts of the Child and Family Services Act?

Ms Willoughby: To our understanding in reviewing material from OACAS, that is certainly one of the more important issues that comes across, and how to have those two pieces of legislation work together. But yes, we would be supporting the proclamation of section 8.

Ms Wynne: When is that submission going to come to the committee? Is it going to come soon?

Ms Willoughby: To my understanding, OACAS is just finalizing their submissions, so that should be coming from them very soon.

Ms Wynne: Just in terms of the timing, it's important that we get it so it can be analyzed and it can become part of the discussion when we go through the clause-by-clause.

Ms Willoughby: Yes.

The Chair: Mr Ouellette.

Mr Ouellette: Thanks very much for your presentation.

We've heard from other groups that there's been a substantial amount of cost to train individuals to make sure that their operations are going to be able to handle the bill, should it pass. Have you looked at training costs for your operations? It's more than just medical that you take care of. How would that impact your agency, for example?

Ms Willoughby: Right now we don't have a cost calculated. However, children's aid societies in Ontario are governed by a funding framework, and certainly that funding framework would not provide us funding at this time for a particular position to disseminate information or disclose records. That will be one area of concern for all CASs in the province.

Mr Ouellette: How do you anticipate handling it if you do not receive an exemption, as you've asked for? How is that going to impact you, or how are you going to be able to move on with the information?

Ms Willoughby: On the funding?

Mr Ouellette: Yes.

Ms Willoughby: That would then be up to each agency to take out of their baseline dollars and to remove child protection workers to facilitate this.

Mr Ouellette: Being that a lot of the youth you handle are placed in different areas, do you find that there may be difficulties in placing—would you have any draft amendments? Do you figure the Ontario group is going to bring those forward?

Ms Willoughby: Yes.

Mr Ouellette: I think those are all the questions I have.

The Chair: Thank you for your presentation, and keep up the good work you're doing for the future of our kids.

1520

ALGOMA HEALTH UNIT

The Chair: The next group is the Algoma Health Unit. On behalf of the standing committee on general government, I want to welcome you to this public hearing. You have 20 minutes. You can take the whole 20 minutes or leave us some time for a question period. Could you give us your names, and positions.

Dr Allan Northan: I'm Allan Northan. I'm the medical officer of health for the Algoma Health Unit.

Mr Jeff Holmes: Jeff Holmes, business administrator.

Dr Allan Northan: I'll just say a few quick words. Jeff is our business administrator and deals with a lot of our information issues. He'll make most of the presentation. We will leave you some time for questions.

There are two major areas that we are going to look at. You've probably heard both of them in your travels around the province and here today—at least the second one. As a municipal-provincial organization we're covered by MFIPPA at this time and it's worked well for us in terms of most of the issues that come forward with PHIPA, so adding another piece of legislation is something that we're concerned about dealing with.

Related somewhat to that is that there will be administrative costs related to setting PHIPA up. We don't mind that if that happens, but we don't want to take those costs away from service. I guess we would ask if there is money to support any of the costs of implementing PHIPA if we do have that come forward.

From here, I'll let Jeff make the presentation around those two points.

Mr Holmes: We'll just give you a few comments on where our perspective is coming from—our position and our rationale on this presentation to Bill 31.

The Algoma District Health Unit serves approximately 20 municipalities across the district. Essentially, we have four service streams: public health protection, disease prevention, individual health promotion, and we're also a sponsor for a variety of community health programs, some including mental health and addiction services and infant development services.

The primary act that we are governed by is the HPPA, the Health Protection and Promotion Act. It has a series of mandates and guidelines that outline the standards that we are required to meet with respect to the service streams.

As Dr Northan has already mentioned, as a result of our alignment with municipalities, a fair number of the provincial health units are actually part of municipal government. We are covered under MFIPPA. Our service structure basically has personal health information, but then we have a lot information that one would conclude the public has a right to as well. So we have this two-pronged approach as to how we manage our information.

Our position in terms of private information is that we rely heavily on the legislation to protect personal health information. We classify a lot of our clients as vulnerable: clients of young age; clients in vulnerable situations, whether financially, educationally, the social environments they have been raised in, mental health issues, addiction issues. A lot of these clients come to us as they feel that we have this protection and privacy safety net surrounding our services. Some of the things they come forward with would be extremely embarrassing if that information came out in an inappropriate manner. So we use that to give that credibility to those people. As a result of that, our policies, procedures and practices are designed to ensure the safety net that we offer these vulnerable clients.

In our humble opinion, MFIPPA has worked well. It supports the public right to information, but it also requires us to look at the privacy rights of the individual client and the family. This is a constant that we are always debating: Is the public right to this information greater than the individual's privacy?

Essentially, in five words or less, we recognize that this legislation applies to a lot of other health care institutions and there are other issues that you've heard a lot about today and, I'm sure, elsewhere. We believe, and this is in discussions with the Toronto public health board as well as other health boards, that we would be excluded from this legislation because of the requirements under MFIPPA.

Our greatest concern is having two legislative acts governing how we manage our personal information. If there were any requirement to take new principles in this proposed legislation into consideration, we would suggest that you enhance the protection of individual privacy. Part II of MFIPPA may be a good way: taking some of the principles that smarter minds than mine will probably resolve and incorporating them in part II of MFIPPA. From our point of view, that would be a more efficient way of dealing with some of the designs around the legislation.

Again, in our opinion, MFIPPA has served the agency well in the use and disclosure of information. In our opinion, we believe MFIPPA deems the disclosure of personal information as an invasion of personal privacy, and that's why we choose to approach our business from that point of view. Again, as I said earlier, it's important to provide that safety net for our vulnerable clients. To date, we have no evidence that MFIPPA is not working well. Again, there's a concern that a second statutory requirement would only affect part of what we do, so we would still have a requirement to run part of our business

under MFIPPA and part of our business under the provisions in Bill 31. We would see this as adding additional complexity to what we do already, and it definitely adds new costs.

Most of our programs have very little funding support. The management of personal health information—we have virtually no automation in terms of our health records. Most of it is manually kept. Most of it is in multiple locations in multiple files, depending on the program. We have spent considerable time and resources pulling this information together in a way that allows us to manage it a lot more efficiently. We've also spent a fair amount of time understanding the various demands for information that we receive literally on a daily basis. We are often intermediaries in cases where there are custody battles, child protection issues, requests for information from a public access point of view. CAS and other agencies are constantly requesting information. The legal community—we're constantly dealing with subpoenas and things like that.

As a result, all that has to be filtered through our MFIPPA practices to ensure that the public right to this information or another agency's right to this information is governed accordingly versus the rights of the individual. These are the additional costs we're talking about: that process, those practices, understanding what our legal responsibilities are toward the agency; the duty to report versus the duty to protect the individual requires a knowledge management effort in the agency, and it requires considerable advice from the legal community from time to time, which adds to costs. Again, that's why we believe this new legislation, if added on top of MFIPPA, would just increase that cost burden.

To conclude, we feel we should be exempt from this new legislation. In terms of the quality of care information, we really have no comments on that part of the legislation. All of this is respectfully submitted, and we thank you for your attention.

The Chair: Thank you. We have nine minutes left, which is going to be divided among the three parties. Any questions from the government side?

Ms Wynne: I have, thank you. I'm thinking about the federal legislation, PIPEDA. Will you not be required to comply with that?

Mr Holmes: No. What we're looking at are commercial activities or our cost for services. Any fees we charge are purely a cost-recovery method, and very little of what we do is subject to any type of financial transaction. So from that point of view, we really don't see any requirement for us to comply.

Ms Wynne: So you won't be asked to make any changes under that?

Mr Holmes: That's our basic opinion at this point in time. We haven't received any great direction from head office yet on this, but that's our position at this time.

Ms Wynne: OK. Thank you.

Mr Fonseca: I'd like to thank the Algoma Health Unit. Thinking about SARS and with everybody's eyes on public health units, do you have some information for

this committee in terms of the flow of information within the health system to support public health and how that would work?

1530

Dr Northan: It's very difficult. I guess if you get a lot of cases, people can get lost in the numbers, but if something is starting out, whether it's SARS or whether it's one or two cases of meningococcal meningitis or whatever, we're aware of the situations, because those have to be reported to us as public health units. Then it's that whole thing about do we report to the public to warn them about some risk that they might have and how do we protect the individual?

I always wrestle with this as the media call me and say, "We hear we've got an 18-year-old teenager. Can you tell us what's going on?" I can't talk about somebody's personal situation, yet I do have a duty to, in whatever way, warn the community if there is a risk that might be in front of them. So that gets difficult.

If you go into something more complicated like SARS, if we've got cases arriving every day and we try to comment, "We've got two new cases today, three new cases," they say, "Are they from such and such a school, because my child goes there?" Do we say, "Yes, they are from that school," or "No, they're not"? Pretty soon you start to define who the people are. What right do they have to know about those cases and their personal misfortune versus what right do they have to know that to protect themselves? That's a difficult one to deal with. I'm not sure if this legislation helps us or hinders us with that.

If it really restricts us from saying too much, I guess then maybe the public is put at risk. I think we can probably get around that balance, but we have to be careful, because it's possible, with the kind of legislation that's coming forward, somebody could say, "By the information you released to the media to warn the community about a risk, you've exposed my personal health information. Therefore I am taking action against you." I'm not quite sure how that would work out.

The Chair: Now Mr Flaherty.

Mr Flaherty: Thanks very much for the presentation and for your obvious sensitivity to the rights of individuals in this province as opposed to the rights of the government to have a look at what goes on in our private lives.

In what way do you think the—all these acronyms; governments live on acronyms. There are no bonuses, so we hand out acronyms.

"MFIPPA, part II, 'protection of individual privacy' be 'enhanced' if required to accommodate the new principles introduced in Bill 31." Could you elaborate on how it could be enhanced?

Mr Holmes: I think it's more of a process that we would recommend you follow. We're really not versed well enough to suggest any enhancements. The whole point of that was that if smarter minds than mine said, "There's a handful of new practices and principles that we think are good for the citizens of the province," we

would suggest that you park them in that section of the legislation as opposed to creating a new act that requires a whole new effort on our part to understand it and implement it.

Mr Flaherty: One of the challenges with this proposed legislation that's in front of us, this bill, is that it begins from the wrong principle, in my view. The principle ought to be that the owner of personal health information is the individual and that, as you have set out here, "MFIPPA deems the disclosure of personal information an invasion of personal privacy," and the exceptions ought to be holders of that information handing it out to other people, and so on, rather than the main thrust of the bill, which is what we see here.

I don't see an adequate concern for the rights of the individual. I see a great deal of concern for the rights of the bureaucracy, for the rights of record-holders, for the convenience of people working in the health care system, all of whom we respect because it's challenging. But I don't see the respect for the individual, saying, "Those records are your property. They don't belong to this hospital or this clinic or this social service agency. They belong to you."

I admire you for the emphasis on the invasion of personal privacy. I'd commend to the parliamentary assistant and the people from the Ministry of Health that it should be in this bill that people have an absolute right to privacy of their individual health records, except for very closely defined circumstances, and that violation of that right is an invasion of their personal privacy, giving them a cause of action against those people who do it.

The Chair: Now Ms Martel.

Ms Martel: I want to go back to PHIPA, because this is not clear to me. I guess your own association has not given you instructions about whether you have to comply. You don't know if you're specifically exempt from the federal legislation.

Mr Holmes: I've not received any opinions.

Ms Martel: OK. The call on us today, which would be to exempt public health units from this particular legislation and continue to work with municipal legislation—is that the position of the Association of Local Public Health Agencies and the directors of health?

Dr Northan: No, it's just our opinion coming forward as the Algoma Health Unit. I can't really speak for the rest of the province. You've perhaps heard presentations from others, and I'm not sure if you got the same response or if you're getting a mixed bag on that.

Ms Martel: Actually we haven't heard from any other public health units. That's why I was wondering if this was going to be a consensus.

Do you make requests for personal health information? You certainly said near the end that you receive daily requests, and you listed a number of sources. On the flip side, do you do that? If so, are the provisions under which you make requests for information also outlined in the Municipal Freedom of Information and Protection of Privacy Act?

Dr Northan: I'm trying to think. I know we get a lot of requests from people for information we have about

them, but I can't recollect—Jeff, you handle our information—that we've actually asked in reverse.

Ms Martel: So from your perspective, as you look at the bill, you feel quite confident that any of the requirements around protecting people's personal health information can be met under the current requirements? You've not had complaints, there has not been disclosure, there's no track record which would indicate otherwise; in fact, the track record is that you've been very good at doing what you're supposed to do under that act to protect people's information, is that correct?

Dr Northan: It has worked for us. Because MFIPPA applies to us and probably not to a lot of the other stakeholders that have come forward today, we've had something in place. When we ask for the exemption, it's because of that. Perhaps others don't have that other piece of legislation to act on. It has served us well to this point.

Ms Martel: Can you give us an estimate—I apologize for this, because maybe you haven't thought enough about it. You were talking about the duplication in costs. Do you have a sense of what that might mean for your own organization trying to deal with the requirements listed in Bill 31?

Mr Holmes: I would think, in the years I've been involved, it could be up to \$30,000, \$40,000 or \$50,000 so far, on an annual budget of about \$10 million. So it's enough to make a dent, and there are some programs where we have zero room to move. There is no money for training, and there is certainly no money for legal opinions. Any time we burst out of the budget, we have to make special requests to get additional funding in all these types of things. A lot of the programs are really tight.

Dr Northan: It's certainly an invisible cost, in the sense that if we have to train staff—and most of the \$30,000 is to take staff and make sure they understand the legislation and how to work with it—that doesn't seem like extra cost because we do it out of our existing budget. But what it does is steal service from the client. These staff would be using those hours to deliver service, but now they're doing this. If this is important enough—and we don't argue that it might not be—then we would ask that those costs be looked at so we don't reduce service to the client.

The Chair: Thank you for taking the time to come and meet with us today.

1540

ALGOMA WEST ACADEMY OF MEDICINE

The Chair: The next group is Algoma West Academy of Medicine. On the behalf of the committee, thank you for coming. Your name is?

Dr Tim Best: Dr Tim Best.

The Chair: You're the president of the Algoma West Academy of Medicine?

Dr Best: Yes, sir.

The Chair: You have 20 minutes to make a presentation. If you don't take the whole 20 minutes, there will be time for questions by the three parties.

Dr Best: Thank you, Mr Chairman and committee members. As stated, my name is Tim Best. I'm a plastic surgeon here in Sault Ste Marie, Ontario, and president of the Algoma West Academy of Medicine, which is the group of physicians practising in this part of Ontario. I'm their elected representative.

I'd like to begin by expressing my thanks to the government for introducing the two acts that comprise Bill 31 and for the opportunity to offer to you my comments today.

This privacy legislation for the health care sector in Ontario, the Health Information Protection Act, and the statutory protections for quality assurance of information, the Quality of Care Information Protection Act, I believe, are long overdue and very welcome by the medical profession. It is a positive step forward.

The confusion created by the federal privacy law, PIPEDA, remains in my opinion largely unresolved. An example of this is that it appears under the federal legislation that physicians are subject to the provisions of that law for their office work but not for their hospital work. As physicians, we feel that a uniform set of rules that applies throughout the health care system is required and that a set of rules compatible with the day-to-day realities of practice should be introduced in this province. We see Bill 31 as fulfilling that.

Another specific provision of HIPA that I'd like to highlight is the issue of patient consent. The federal act calls for express consent, possibly written, for every new use or release of personal information. We feel that this is quite impractical. The HIPA allocation for implied consent based upon reasonable patient knowledge seems to be much more appropriate. I believe that under HIPA my patients would have clear control over their personal health information but that information that I need to provide good medical care would not be blocked by unnecessary bureaucracy and red tape.

The only caution I have in that regard is that I think most physicians are concerned about the notion of the lockbox provision, allowing patients to admit information or to withhold information, although I do appreciate that the flagging of such omissions in the chart at least would advise physicians when information is being withheld even though they wouldn't know what it is. I believe that part of the act should be monitored closely and perhaps at the three-year review a mandatory review of that portion be undertaken.

I also think that the introduction of the data institute to identify patient information before it goes to the government for planning purposes is a very worthwhile initiative. I believe this important step forward should be monitored with a view to expansion into health care research. A privacy tool could be used in the future to reduce the amount and movement of identifiable patient information within the system. In particular, in some areas of research, patients are not necessarily aware of

the uses being made of their personal information, and the de-identification manoeuvre could facilitate valuable study without the movement of patient-identifiable data.

A major criticism I have of Bill 31 is a concern about the extensive regulation-making powers found in the bill. They are so wide-ranging that they allow the government to change virtually any aspect of this law by regulation. I believe this is contrary to the traditional division of legislative and regulatory authority and represents an intrusion of the government's executive powers into the lawful powers of the Legislature. Not only does it create the power to completely undermine the content of the act; it undermines the democratic process of the Legislature. I recommend that this committee review the proposed regulation-making powers closely, with a view to significantly curtailing them.

Implementing HIPA will pose fairly substantial challenges for the health sector. I recommend that the government develop a formal process to coordinate implementation of strategies that involve the privacy commissioner and stakeholders, including physicians. I fear that if the government doesn't do so, the confusion that has been characteristic of the federal legislation may spill over into provincial activities.

HIPA is a long and complex bill, and the government should accept the responsibility for public education. The onus for public awareness cannot be placed upon physicians and other health care providers but should remain with the government.

In closing, I'd like to reiterate my support for the principles established in Bill 31, and I'd like to thank the government for introducing it so early in their mandate.

Certainly Algoma West Academy of Medicine lends their support to the specific comments that have been offered recently by the Ontario Medical Association with respect to line-by-line analysis. I urge you to move forward with the passage of proclamation of this legislation at the earliest possible date. Thank you very much for the opportunity to address you today.

The Chair: Thank you very much. We have 12 minutes, which will be divided among the three parties. The next one is the official opposition.

Mr Flaherty: Thank you, Dr Best, for your presentation, particularly with respect to the curtailing of regulatory powers. If I had a lot of time, I'd go through every section of the bill and pick out the regulatory powers. But there is, in my view, the bad habit that has grown up in governments over a long period of time of throwing in at the end of sections a broad regulatory power. You read through a section and it sounds all right, and then you get to the end of it. I say this as someone who has chaired legislation and regulations in committee of cabinet for a long time and used to have a lot to say about those kinds of sections.

If you look, for example, at the section that defines, "This part does not apply to a record that contains"—we're talking about access to records of personal health information on page 42 of the bill, section 49—the last part of it says, "Personal health information of the pre-

scribed type in the custody or under the control of a prescribed class or classes of health information custodians.” Then you go back, and of course you find that “prescribed,” as defined early on in the bill, “means prescribed by the regulations made under this act.” There are lots of examples of that in the bill.

I take it, from listening to your presentation, that what physicians want is certainty and efficiency in terms of privacy of information, access to information, disclosure of information. Is that fair?

Dr Best: Yes, I think that’s a pretty fair analysis. I think also as a general principle that, as medicine is a self-regulating profession, we are concerned when there is a significant bill that affects us that is not directly under legislative control and that would fall under regulatory control. I think the three-year introduction period addressed with this bill is sufficient time that it could be reviewed at the legislative level, and that’s where it should be reviewed.

Mr Flaherty: Can you see any reason for the Minister of Health to have access to identified health information?

Dr Best: I’d have to spend more time to think about that. It’s certainly possible. My initial response is yes. In certain health care emergencies, that may be necessary—I’m thinking in the public health arena—but I’d really like to withhold definitive comment till I have more time to think about that.

Mr Flaherty: Am I finished?

The Chair: No, you’ve still got 15 or 18 seconds.

Mr Flaherty: My experience has been that individuals very much prize the privacy of their health records and have great faith in their physicians as the key protectors of that health information, which is why I wonder about the broad definition of “personal health information” and “health information custodians” in this bill, including the Minister of Health and the people who work at the Ministry of Health, of whom there are countless thousands, as I’m sure you know. Has it been your experience with your patients that they highly value the privacy of their health information?

Dr Best: Absolutely. Whether we’re dealing with governments or insurance companies or health care providers, I think, sidestepping that slightly, the provisions for the implied consent in terms of physicians’ practices are a very positive step and should move forward, partially based upon the faith and trust that the profession so far has been able to uphold with patients as the guardians of that information, and therefore has been able to work for them, maintaining that privacy within implied consent.

1550

The Chair: Ms Martel.

Ms Martel: Thank you for coming today. Do you feel this legislation is going to create an excessive burden on yourself personally in your own practice, both financial and administrative? Also, do you have any concerns with respect to the offence provisions if one is guilty of disclosure?

Dr Best: As stated in my address, I think the first and most important thing the government needs to do with

the passage of such legislation is to take the responsibility to educate people. I don’t believe it is correct or desirable for me or my office staff to have the responsibility of educating people on the ins and outs of the legislation as it affects their private information. I believe it’s our responsibility to enact it but not to educate about it.

Sorry, the second part of your question?

Ms Martel: Can I be a bit more specific? You’ll have certain obligations; all physicians would and all specialists who have a practice would, essentially having someone as an agent. You would have to take the time to explain to your patients, if they wanted access to their information or if they wanted to make corrections, how they’d do that. Are those kinds of things going to be too much of a burden for you? I ask this because a presentation that we heard last week suggested that for family doctors it would be so onerous that many wouldn’t enter the profession any more. I’m really trying to get a handle on what the significant obligations are that would be so overwhelming that someone might make that actual choice. In terms of the group you’re representing—you talked about your speciality, and I don’t know what other broad categories of specialists or physicians you represent—is that the prevailing view?

Dr Best: I represent all of the physicians in the region. Certainly, any additional paperwork is not welcome. Again, what I would really stress is that I do not think it should be the responsibility of my office staff or myself to do that educational component; it should remain the government’s and the Ministry of Health’s obligation to do so. If a patient comes to my office and asks for a change in information, or what have you, under the provisions of the act, then obviously it’s my responsibility to carry it out. I really understand the spirit that if in addition to our duties so far we had to add in the educational component in order to advise patients—it often takes me more time to go through an informed consent than it does to explain the surgery to the patient at the current time. So an additional burden of information is certainly not welcome.

Ms Martel: But you wouldn’t want the government to be having a list of your patients in order to do that. So how would that work on a practical level? I’m being conscious of what you’re saying, but if under this legislation you have an obligation to tell your patients what the mechanism is to do A, B and C if they want information, you’re not going to want the government to do that public education, because that would mean the government having to have access to your patient records in order to fulfill that.

Dr Best: Not necessarily. I don’t know that it would be obligatory for the government to know the particulars of the patients’ issues in order to educate them. I would think that if a patient in my office had concerns about access to their records, or what have you, I would like to have the ability to just refer them to the local Ministry of Health office and they could find out their options from there.

The Chair: Now we'll go to the government side.

Mrs Van Bommel: Thank you very much for coming today. I want to go back to the regulation-making powers issue that you have concerns about. In the environment we live in today, we have rapid change in the way we collect, process and store data. Do you have any concerns that by entrenching everything in legislation we wouldn't be able to react quickly to changes we would need to do that we could do if we were working with regulations instead?

Dr Best: I think that going too far one way or the other has its problems. I think the current version, where virtually everything is at the regulatory level, is incorrect, and I think going in the opposite direction where everything is at the legislative level is also incorrect.

My suggestion would be that before the final proof of this is put out, a very careful review of it be done with parties such as the Ontario Hospital Association and the Ontario Medical Association to determine which are the most irritating factors to have at the regulatory level and which they would prefer to have at the legislative level. I agree with you that if it's all at the legislative level, then it's a prescription for a very slow—

Mrs Van Bommel: For inflexibility.

Dr Best: Yes.

Mrs Van Bommel: Are there any particular areas that you feel should be entrenched in legislation? Can you tell us the types of things you have concerns about in terms of being regulated and that you don't want to do, one way or the other? What types of things are you looking for?

Dr Best: Yes. An example would be the provisions that I alluded to earlier in my presentation about implied consent. Those issues are so fundamental to the effective working of day-to-day medicine that that should be protected at the legislative level because—referring to Ms Martel—if I had to have explicit consent for absolutely everything that I do involving patients, which is what the federal legislation suggests, it would at least quadruple the amount of paperwork and slow down the process incredibly to the point where I think it would cost a lot more for this government to provide health care than it does now. I'd see a lot fewer patients per day, and shortages we have in this region would go up dramatically. There has to be a very careful balance between the two, but I think there also has to be a respect for the fundamental principles being entrenched in legislation.

The Chair: We have 75 seconds left, and we have two persons left to ask questions.

Mr Oraziotti: Thank you, Dr Best, for being here today, and thank you for your presentation. I appreciate your support of our government's proposed legislation. I asked a question earlier of Elizabeth Bodnar of the Group Health Centre, and her response with respect to the doctors' support at the Group Health Centre was also very supportive of this type of legislation moving forward.

You did mention specifically section 71 with respect to the proposed regulatory powers of this bill, and that

those should be narrowed or reduced. Section 72 proposes public consultation before any regulatory changes are made. Do you feel that's adequate to address the concern of regulatory powers within this legislation?

Dr Best: No, I don't think that's adequate. I would like to see a more formal process where, again, the representative parties, the OHA and the OMA, would have a more direct input. I'm a little bit suspicious that just a public consultation may leave the door open for consultation and then change taking place regardless.

Mr Oraziotti: OK. Thanks for your input.

The Chair: Thank you, Dr Best, for your presentation and for taking the time to come and give us your position.

This concludes our group and individual presentations, but first I am going to ask, is there any other business?

Mr Fonseca: Yes, Mr Chair. I'd like to ask the standing committee—this is for tomorrow's hearings in Kingston—if the Canadian Blood Services could present for 40 to 60 minutes. They would do that at the end of the session tomorrow.

The Chair: I would need unanimous consent on that.

Ms Martel: Mr Chair, may I just ask a question? Their presentation would be 40 to 60 minutes long?

Mr Fonseca: Yes.

Ms Martel: Why would we allow that when we haven't allowed that for any other organization?

The Chair: That's why we need unanimous consent.

Interjection.

Ms Martel: But we've been pretty clear to everyone who has presented that if they are an individual, they get 15 minutes; if they are an organization, they get 20. Those are the rules that everybody else has lived by, and frankly, I think that rule should apply to this organization as well.

1600

Mr Rinaldi: I tend to disagree. If anybody else had asked for any exemptions, I think we would have assessed it. Nobody has asked. These folks have asked, and if they have some specific concerns, we certainly have the time. One of the comments was that we had lots of time to spare. While we're on the road—I mean, what I heard here today has made my trip to Sault Ste Marie worthwhile. If any agencies have those concerns—

Mr Flaherty: Especially the last one.

Mr Rinaldi: All of them, very much so. I think if people out there want to speak to us, that's what we're there for.

The Chair: This is why we need unanimous consent, though, because the procedure was 20 minutes per group.

Ms Wynne: I don't know what the procedure has been in the past. Has this happened before? Is it something that other groups have asked for in the past? I just don't have enough experience to know.

The Chair: It did happen before, yes.

Ms Wynne: It has happened before? OK. And groups have been given extra time?

The Chair: That is right.

Ms Wynne: I was never given extra time, so I wouldn't know.

Interjection: Did you ever ask?

Ms Wynne: Sure.

The Chair: So at the present time, are they scheduled to appear in front of the committee?

Mr Fonseca: They are scheduled to appear tomorrow. I believe they are first on our list for tomorrow—is that correct?—and they would move to the last position if we so deemed. That's where we wanted them to present.

The Chair: What is the position of the parties?

Mr Ouellette: Mr Chair, we've had situations in the past where what groups tried to do was amalgamate presentations so that they could extend their time. There have been attempts in other groups where they've said, "Well, we can't show up, but we'd like this group to present."

The decision at that time said that, no, only one presenter was allowed the set time for groups or individuals. I think once you start breaking from that, it opens the door because, had they known this option was available, other groups would be saying that they would like more time as well. The difficulty is, when you start a precedent that changes through the course of the hearings, other groups may not be supportive and they'll come forward and say, "Well, wait a sec. Why did you do it for them and not for us?"

The Chair: As I said, I've seen it happen in the last eight years. What is the position of the group at the present time? Do we stick to the 20 minutes per presentation?

Mr Fonseca: Mr Chair, I just heard from the Ministry of Health—I guess they've contacted the Ministry of Health—and they do have some elaborate concerns and issues that they want to discuss about the bill that will take more than the allotted 20 minutes.

Ms Martel: I appreciate what you're trying to say, but I think the committee needs to bear something else in mind. This is the fourth draft bill of this legislation. There were three consultation papers done as well. So it's not like there hasn't been ample opportunity for organizations to go around the block with the ministry on this on a number of occasions.

If the group has some specific concerns that they want to raise with the ministry that take them over the 20 minutes, I'm sure the ministry staff, who have been dealing with a number of these groups, would be

prepared to do that. But I really don't think we should be moving down the road where we set by motion what the timetable is, and because one group now has decided they can't say what they have to say in 20 minutes, they're asking for an extension. I suspect there would be other groups—and I see another presenter from a group of faith communities in Toronto who, had they known they could have asked for unanimous consent to extend their time, would have done that.

If this were really controversial legislation and if we hadn't been at this before, I might say yes, but this is the fourth draft bill. I'm finding it hard to imagine what else could come out that hasn't come out in the three previous drafts.

Mr Fonseca: I'd like to call the vote on this.

The Chair: Take a vote on it?

Interjection: There's supposed to be unanimous consent.

Ms Martel: You don't have my consent, if that's what you're looking for.

The Chair: According to the clerk, we can proceed with a vote. Would you move the motion.

Mr Fonseca: I move the motion that we allow the Canadian Blood Services to present for 40 to 60 minutes tomorrow in Kingston.

The Chair: That presentation will be done at the end of the hearing?

Mr Fonseca: Correct.

Mr Rinaldi: I would request a recorded vote.

The Chair: We should ask if there are any questions prior to voting. Any questions?

Mr Rinaldi: Just a recorded vote.

Ayes

Dhillon, Fonseca, Leal, Rinaldi, Van Bommel, Wynne.

Nays

Flaherty, Martel, Ouellette.

The Chair: The motion is carried.

Thank you very much to all the groups that have taken time to come and make a presentation.

The committee adjourned at 1606.

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Mr Peter Fonseca (Mississauga East / -Est L)

Ms Shelley Martel (Nickel Belt ND)

Also taking part / Autres participants et participantes

Mr David Oraziotti (Sault Ste Marie L)

Ms Carol Appathurai, acting director, health information and sciences branch,
Ministry of Health and Long-Term Care

Clerk / Greffière

Ms Tonia Grannum

Staff / Personnel

Ms Margaret Drent, research officer,
Research and Information Services

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