Title: Monday, September 13, 2004 HIA Review Committee
Date: 04/09/13
Time: 9:04 a.m.
[Mr. Jacobs in the chair]

The Chair: Good morning, everyone. I certainly want to welcome you to our committee meeting today, and I appreciate your attendance very much.

I assume that you've all received the meeting materials, which should have been delivered on Wednesday, September 8. We will be hearing five oral presentations today starting at – what? – 10:20 this morning. We'll hear two this morning and three this afternoon. We'll be breaking for lunch as usual around noon, and lunch will be available in our room.

You'll notice today that Heather Veale is not here, and I'm going to ask Wendy Robillard to speak to this item before we proceed. Wendy.

Ms Robillard: Thank you. Heather is away on medical leave for the next number of weeks, so I don't expect her to join us back at this table. Alberta Justice will be appointing another lawyer to take Heather's place, but that's not happened yet. I expect to hear further on that later this week.

The Chair: Thank you, Wendy.

I think at this point I will ask everyone around the table to introduce themselves for the record, and then we'll move into the agenda. Let's go to the committee members first and then come back. Okay?

[The following members introduced themselves: Ms Blakeman, Mr. Jacobs, Mr. MacDonald, Dr. Pannu, and Mr. Snelgrove]

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Ms Sorensen: Rhonda Sorensen, communications co-ordinator with the Clerk's office.

[The following departmental support staff introduced themselves: Ms Gallant, Ms Miller, Ms Robillard, and Ms Swanson]

The Chair: Thank you, everyone, and welcome again.

You have a copy of the agenda. Are there any questions or additions or comments on the agenda that's been proposed for today's meeting?

Mrs. Sawchuk: Mr. Chairman, if I could. Under item 4(a) and (b) for 4(a) you have yet another updated submissions list, which was just circulated this morning. So it's to replace the one that was in your meeting package.

Also, we do have a package of written responses to questions from the August 12 meeting, and that is included in the handouts this morning.

Under item 5, Summaries of Submissions. Originally it was shown as 66 to 68. They've now been brought current, up to and including the last submission, which was 72.

The Chair: Thank you.

Yes, Ms Blakeman.

Ms Blakeman: I don't know where to put this, so I'm seeking advice from the chairperson. I'm wondering if we're going to have any additional briefing from a secondary source on the harmonization project. We've had very thorough briefings from Catarina Versaevel but only briefing from that one source. I'm assuming that the committee will be discussing whether or not to jump on board with this harmonization at some point, and I'm a little concerned that all of our information is coming from one source. Is there an additional briefing coming from anywhere else at this point? That's a fairly big project to go with just one briefing on it.

The Chair: Thank you for the question.

Linda or Wendy, do you have a comment on that question?

Ms Miller: I'm not sure where a second source of briefing would come from. Catarina is leading this initiative nationally and certainly is the one, in our opinion, most informed about what is happening in that regard. I'm not certain what other perspective you would like to gain at this point in time.

Ms Blakeman: I don't know, because I don't know what the other perspectives would be at this point; I've only had one perspective. This is not offering any criticism on her presentation, because it's been astonishing. I am looking forward and thinking, hmm, 10 years in the future. When somebody says, "Uh huh, and you made that decision based on briefings through one source of information; did you?" I'd have to say: "Yes. I didn't talk to anybody else." So that's my question.

Ms Miller: A further comment. As part of the national pan-Canadian framework development Catarina Versaevel has conducted a number of consultation sessions with key stakeholders in Alberta, often similar stakeholders that are providing submissions to the committee and/or oral presentations. Those results of that consultation process will be discussed and brought forward to this committee. The next meeting is our anticipated timeline. That may assist you in gaining some other perspectives from those stakeholders that we have engaged with as part of that process.

9:10

The Chair: Thank you.

It seems to me that the information that has been presented by Catarina has been balanced and in depth. I think she's represented a pretty good point of view; however, I understand your question. At this point I guess I would welcome comments from other committee members.

Mr. Snelgrove: I agree with Ms Blakeman. It's not that the presentation hasn't been thorough and balanced, but it has been one person presenting. Even if we were to go to another provincial body that may be involved in the same kind of process as we are or that has done consultation, maybe we will be able to see as we get that information where there is a little red flag or a little white flag or something in there. I agree, and I understand the difficulty of the question because we don't know who to ask, but we know we should probably ask.

Ms Blakeman: Yeah. I think there's a question of due diligence.

The Chair: Thank you.

Anyone else want to comment? Well, I suggest that you allow us to take the question under advisement and discuss it with our staff and see what we can do.

Ms Blakeman: Thank you very much, Mr. Chairman.

The Chair: All right.

Any other questions arising out of the agenda? If not, I do need a motion to adopt the agenda as we have it. Thank you. All in favour, please say aye. Opposed? Good.

Karen, should we take those responses to questions at this point?

Mrs. Sawchuk: We should have a motion for approval of the minutes, Mr. Chairman, first.

The Chair: Oh, sorry. Yeah, the minutes.

Okay. August 12, the minutes. You have them. Do we have any questions arising? Corrections?

Ms Gallant: I was just wondering: on page 21 of the August 12 minutes under 4(c) – and perhaps Wendy can clarify this – it says, "Ms Robillard advised that the regional health authorities were responding to only one." Was that as well as municipalities? A number of those responses were municipalities.

Ms Robillard: Yes. It was not the regional health authorities.

Ms Gallant: Right. So I think that's a correction to the minutes. We should replace "regional health authorities" with "municipalities."

The Chair: Thank you very much.

Ms Gallant: You're welcome.

Dr. Pannu: Mr. Chairman, again on page 21. In one place my name has been modified, the spelling of it. Since these are official records, this should be corrected.

The Chair: Okay. Very good. I can only see the one place. Where's the other one?

Dr. Pannu: One place.

The Chair: Okay. Yeah. All right. So noted. Can we make that correction? Our apologies.

Any other suggestions, corrections, updates? If not, I would accept the motion to adopt the minutes. Dr. Pannu. Thank you very much. All in favour, please say aye. Opposed, please say no. So adopted.

Before we go to Administrative Issues, do we have any other items there, Karen or Corinne, that we need to cover?

Mrs. Sawchuk: I don't believe so, Mr. Chairman. As I mentioned, the most current – bad English – the most updated version of the submissions list is in the handouts this morning, and it's just for members' information. The responses to the questions are all in one package unless the members have some questions on that that Wendy or one of the other staff from Health and Wellness could respond to.

The Chair: Okay. Thank you, Karen.

So on the responses to committee questions from August 12, 2004, are there questions from the committee members who asked those questions? Do you want time to study those a little more carefully? Okay.

Do you have any additional comments, Wendy?

Ms Robillard: I would just make a couple of comments. The responses to committee questions include the meeting of August 24 and 25 questions as well. There are two questions, I believe, which are outstanding. One which had been assigned to Alberta Justice has not been completed yet. The other was a question about disclosures to police, and I did contact the Solicitor General's and Attorney General's departments but have not received a response to date.

The Chair: Thank you, Wendy.

All right. Seeing no further questions on that, Wendy, shall we move to the updated submissions? I think we have 66, 68. Is there one other one also?

Ms Robillard: Yes, there are a couple of others and a few supplementals as well.

The Chair: Okay. So just for clarification, has everyone got those? With the amount of people we have, it presents a challenge to find everything. I have found mine. I assume everybody else has found theirs.

Wendy.

Ms Robillard: Okay. Submission 66 was received from the Canadian Institutes of Health Research. They spoke to a number of questions. In terms of an individual's right to access their own information, they recommend that

> Part 2 of HIA be amended so as to exempt from the access provisions personal health information that a researcher uses solely for research purposes in accordance with appropriate conditions and approvals.

In terms of disclosure, "Are the elements of consent appropriate?" or "Should consent be allowed to be provided verbally?" they recommend that

> Alberta's HIA and/or its related policy documents allow, in exceptional circumstances where a researcher is collecting personal health information directly from an individual, for consent to be obtained orally if written or electronic consent would be culturally unacceptable in given circumstances or would be inappropriate for other good reasons. This exception would be consistent with Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans.

In response to the question "Should the HIA be amended to include stronger provisions to protect the confidentiality of genetic information?" they "support a definition of personal health information which includes genetic information." They recommend that

> there should not be a separate/exceptional legislative vehicle to govern genetic information but rather that genetic information should be viewed as a component of personal health information.

That is in line with the pan-Canadian framework, and CIHR was a part of that consultation as well.

In terms of the research provisions in the act, they support the view that

> the custodian-researcher agreement should stipulate . . . that the researcher will not contact individuals to recruit them in a research study unless the data custodian has first obtained prior consent by the individuals allowing contact for such purposes. However, [they] recommend that the HIA recognize exceptional circumstances where the data custodian may nonetheless authorize contact by the researcher in situations where it would be impracticable or inappropriate for the data custodian to obtain prior consent.

Further, they state that they recommend that

> HIA and/or its supporting policies reference the work done by CIHR with the health research community in identifying factors to consider when determining whether consent is inappropriate or impracticable in given circumstances.

The Chair: Were there any questions on submission 66? Okay.

Ms Robillard: Submission 68, Rabbi Ari Drelich. The rabbi indicated that

> he was not able to visit all the Jewish patients because he did not have the list of all patients which would allow him to see if there were any patients who for one reason or another did not make it on to the specific Jewish list.

So in regard to disclosure he recommends that

> the legislation . . . be fine-tuned to indeed protect the privacy rights of all Albertans, while at the same time allowing a controlled group of responsible individuals to have the necessary information to fully provide for their constituents.

The Chair: We will be receiving an oral presentation from this gentleman; will we not?

Ms Robillard: I believe tomorrow.

The Chair: Okay.
Yes, Dr. Pannu.

Dr. Pannu: Mr. Chairman, will we be receiving an oral presentation from CIHR, as well, either today or tomorrow? This afternoon; is it?

9:20

Ms Robillard: No, CIHR is not presenting this afternoon. It's CIHI, which is a different organization.

Dr. Pannu: CIHR is not?

Ms Robillard: I don't believe so.

Dr. Pannu: And who is? You said something similar?

Ms Robillard: The Canadian Institute for Health Information is presenting.

Dr. Pannu: Right. CIHI. Okay.

The Chair: Perhaps at this point I should just welcome to the committee Mr. Lougheed and Ms Kryczka, who were not here for introductions. So we acknowledge your presence and thank you.
Yes. Go ahead, Wendy.

Ms Robillard: Submission 69 was received from the Alberta Occupational Health Nurses Association, and they have responded to questions around purposes, definitions, and scope.

In terms of personal health information contained in an employee file and whether that should be part of the scope of the act, they respond "yes." They indicate that FOIP rules are currently applied to this information, and it's somewhat cumbersome.

> Access under HIA could become simpler for patients, and provide protection for providers who are releasing information. Other pieces of federal and provincial privacy legislation have not dealt effectively with health information.

In terms of the scope, whether it should be extended to WCB, they indicate "no." They state that

> this could lead to the WCB having access to non-occupational medical information. Currently the WCB is entitled to information pertaining to an occupational injury; however, without proper segregation of health information, potential improper disclosure of personal non-occupational health information could occur.

The Chair: Seeing no questions, let's proceed.

Ms Robillard: Submission 70 was received from the Alberta Urban Municipalities Association. They responded to the question regarding ambulance services, and they indicate that yes, ambulance services should be included in the scope of the act.

> They collect and use health/medical information and medical services are increasingly being extended to ambulances to relieve medical institutions of long waiting times. The AUMA Board of Directors also supports the empowerment of the Police in a similar fashion.

Ms Kryczka: I think it's a really important point that they say that they also support "the empowerment of the Police in a similar fashion." That connects us with the presentations that we had last time.

Ms Robillard: Yes. In fact, we'll be contacting them to clarify, because what the ambulance services piece asked is if ambulances should be included in the scope of the act. I think that's fairly clear. I'm not sure if they meant that police should be covered by the act or that registration information should be made available to them. So I'll follow up with them because their submission was not clear on that point, and I think it would be worth clarifying what they intended to say.

The Chair: Thank you, Ms Kryczka.
Other questions? Okay, let's go with 71.

Ms Robillard: Submission 71 is the Alberta Health Facilities Review Committee, and their submission dealt with the definition issue. The committee suggests that

> the definitions of "diagnostic, treatment and care information" and "health information" should be amended to document any significant observations in relation to a patient's condition and any report of unusual occurrence in respect of the patient. There may also be an added value in adding a definition of what constitutes thorough information in the rules for collection of information. Incident reports should be defined as being part of the patient's health information records.

So their submission is dealing with the recording of information in facilities.

The Chair: May we also at this point welcome Mr. Lukaszuk to the committee this morning. Thomas.

Mr. Lukaszuk: Good morning, Mr. Chairman.

The Chair: We're doing submissions now, Thomas. You should have a handout in your packet. We're ready to go with 1(a).

Ms Robillard: Submission 1(a) is a supplemental submission received from IMS Health. They are going to be doing an oral presentation this morning, so I assume that they will speak to both their submission and their supplemental. However, primarily they were agreeing with an appropriate amendment to define "other information" and say that it would "achieve the result of resolving the unintended problems created by section 37(2)(a)," which is around disclosure of health service provider information.

The Chair: Seeing no questions, we should proceed.

Ms Robillard: Submission 43(a). This is a supplemental submission from the Canadian Association of Chain Drug Stores, and their supplemental is also dealing with definitions and modification of definitions. So their supplementary submission "is in support of

amendments, similar to those proposed by AHW, to section 37 of HIA should [their] earlier submissions be rejected and section 37 remains in HIA." Their earlier submission was to remove the health service provider information. "If the provisions on health services provider information remain in HIA, a definition of the term is necessary to minimize the negative impact of the provision on patient safety initiatives." They submit that

> "other information" should be defined so as to make it clear that the section only restricts disclosures that would reveal information about health services providers that is protected under HIA, with the exception of information that is publicly available.

The Chair: Number 72.

Ms Robillard: Submission 72 is by the Canadian Blood Services, and I included some introductory comments. I thought they would help scope what Canadian Blood Services does. The mandate is in the first paragraph.

In the second paragraph they talk about their process for testing blood and for following up where blood products are used so that they can trace back, if they have to, for reasons of disease or other medical concerns.

CBS has specifically spoken to a number of sections in the act. In terms of the definitions, in the event that the committee were to consider including CBS within the scope of the definition of "custodian," they request "the opportunity to have further consultations with the Committee and/or its advisors on the unique circumstances of CBS." Although they're an integral part of the health care system, they differ from other players in that they do not as part of their core activities "provide direct patient care."

In terms of amending the scope of the act to include the government of Alberta, local public bodies, or other entities, they recommend "a change in the purpose and scope of the HIA such that it acknowledges public health as a legitimate use of health information against which the privacy of that information is balanced."

In terms of collection and specifically indirect collection they note that

> it is important that the HIA include all circumstances for indirect collection that a reasonable person would consider appropriate. The HIA currently does not specifically include an exception authorizing indirect collection of personal health information for public health purposes.

They recommend that "the HIA be amended to specifically authorize indirect collection" for that purpose.

In terms of "Are the purposes as currently listed in the Act appropriate?" they recommend that "public health purposes broader than 'public health surveillance' be authorized" under the act. By way of example, they use

> personal health information for lookback and traceback investigations; for purposes of delivering, monitoring and evaluating the operation, sufficiency and safety of the blood supply system; and for research and planning that relates to the operation, sufficiency and safety of the blood supply system.

In terms of disclosure, "Are the discretionary disclosures without consent . . . reasonable and appropriate?" they note that the current disclosure provisions require that "danger be 'imminent.'" They feel that "this sets a very high threshold before disclosure without consent is permitted." They also note that "HIA does not address those circumstances in which consent cannot be obtained as efforts to locate the individual have failed but disclosure is required for a legitimate public health purpose."

In terms of duties and obligations they raise an "issue that needs to be addressed at both national and provincial levels" in relation to privacy impact assessments and whether the provincial Privacy Commissioner should oversee, guide, and audit each PIA.

> Provincial oversight of national databases or repositories of personal health information without clear and consistent jurisdictional rules could potentially result in an undue administrative burden for national organizations such as CBS that implement personal information practices and technologies across our operations and that may be subject to privacy legislation in numerous provincial jurisdictions. Further inconsistency may result, as each Privacy Commissioner may render different assessments which may be grounded in slight variations in the provincial legislation.

The Chair: Are there any questions on those submissions?

9:30

Ms Kryczka: Again, I'm sure everyone noticed it, but I think it's really important: the access to information for research purposes. We've had that come up. It's one of the questions, anyway; right? It's come up again in particular with this organization, so it's very interesting.

The Chair: Thank you, Ms Kryczka.

Wendy, I think the deadline for submissions has closed, although we could still possibly receive a couple or three or four, whatever. I believe you have now done the analysis on all the ones that you have received. Is that correct?

Ms Robillard: We've summarized all of the submissions that we received to date. Yes.

The Chair: Okay.

We do have a little bit of time now until the next presentation. I understand that the presentation that was scheduled for 11:05 from IMS is ready to go at this point. If the committee desires to change the agenda to allow them to make their presentation now instead of at 11:05, we could proceed.

Dr. Pannu: So moved, Mr. Chairman.

The Chair: Okay. Thank you very much, Dr. Pannu. All agreed?

Hon. Members: Agreed.

The Chair: Any opposed?

Okay. I propose a five-minute break while IMS sets up, and then we will take their presentation. Thank you very much.

[The committee adjourned from 9:32 a.m. to 9:38 a.m.]

The Chair: I'd like to call the meeting back to order.

First of all I'd like to acknowledge and welcome the presence of Mr. Dave Broda. Welcome, David. I think everyone else has been acknowledged.

I'm certainly pleased this morning to welcome Ms Brenda Drinkwalter, vice-president of corporate affairs; Mr. Brian Carter, director of corporate affairs; Ms Anita Fineberg, legal counsel; and Mr. David Jones, legal counsel representative for IMS Health Canada.

They have agreed to move their presentation up this morning. I would just like to make the committee aware of an offer they have made to us, that they would be willing to also talk about the question that was raised by Ms Blakeman this morning relative to another viewpoint on the pan-Canadian work because I think some of them

have had some experience there. So following the presentation and questions, if the committee so desires, they would certainly be happy to make some comments on their perspective on the pan-Canadian network.

David, are you spokesman this morning?

Mr. Jones: Mr. Carter's going to start, actually.

The Chair: Okay. Before he starts, I'm going to go around the table and ask all the members to introduce themselves. Then we will start with Brian.

[The following members introduced themselves: Ms Blakeman, Mr. Broda, Mr. Jacobs, Ms Kryczka, Mr. Lougheed, Mr. Lukaszuk, Mr. MacDonald, Dr. Pannu, and Mr. Snelgrove]

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Ms Sorensen: Rhonda Sorensen, communications co-ordinator with the Clerk's office.

[The following departmental support staff introduced themselves: Ms Gallant, Ms Miller, Ms Robillard, and Ms Swanson]

The Chair: Thank you very much. Now we'll do the test to see if everyone got everybody's name; right?

Brian, we would invite you to commence your presentation.

Mr. Carter: All right. Thank you very much. Good morning, everyone. Thank you, Chairman Jacobs and Vice-Chair Kryczka and members of the special select committee and staff, for taking the time to have this discussion with us this morning. As mentioned, my name is Brian Carter, and myself and David Jones will speak on behalf of IMS Health. I'll take a couple of minutes to introduce my colleagues so you have a better appreciation for their background in the subject matter with regard to health information.

David Jones is with de Villars Jones in Edmonton. He's our legal counsel in Alberta. He's a senior lawyer, a former professor, an expert in administrative law, and the author of a textbook on the subject. He has extensive experience in privacy law and in matters going back to, for example, the original implementation of FOIP.

Brenda Drinkwalter is our senior vice-president for corporate affairs. She has a background in pharmaceuticals in Canada, has been in the industry for over 30 years, was a former regulator with Health Canada, represented Canada's generic drug industry for many years, and currently, in addition to her other responsibilities with IMS Health, is the global privacy co-ordinator for IMS world-wide.

Ms Anita Fineberg is our chief privacy officer and counsel to IMS. She has a lot of experience in both privacy and in health law and health policy, having worked for the Privacy Commissioner's office in the province of Ontario and also having come from the Ontario ministry of health, dealing with all privacy issues including FOIP and Smart Systems for Health, which is an equivalent initiative similar to Alberta Wellnet, and in developing Ontario's legislation on health information privacy.

As for myself, I'm a practising licensed pharmacist in Alberta and have been for 24 years. I am an Alberta graduate with a bachelor of science in pharmacy and also an MBA from the U of A. I have extensive experience in community pharmacy practice, in hospital pharmacy practice, in pharmaceutical sales, and up until recently was a drug store owner here in Edmonton. I'm also a former assistant registrar with the Alberta Pharmaceutical Association, now known as the Alberta College of Pharmacists. When the old association split into the College of Pharmacists and into the Pharmacists Association of Alberta, I was also a founding board member of the new pharmacy association and the organization's first president and past president. I've focused much of my career on health information, and I've been with IMS Health for the last seven and a half years, and I work out of Edmonton.

I'll talk for just a few minutes. One of the things that I would like to do is go over a scenario, which we've provided you a copy of. I'll also mention that you should have three handouts in addition to the scenario. There's an example of the types of information about a health service provider that are possibly captured by the Health Information Act but which do not fall within any of the 19 defined categories of health services provider information. That's for your reference.

Also, what we've done is provided you with another handout that provides the definition of health services provider information and itemizes the 19 specific categories and makes it easy for you to determine which ones fall into the categories of eight health service information provider information items that can be released without consent, compared to the other 11 that have a consent requirement on them.

So after I talk for a few more minutes, I'll ask Mr. Jones to talk in more detail with you about our proposed amendment for the Health Information Act. Our presentation will focus specifically on one aspect of the Health Information Act that several organizations, including IMS, have identified as being particularly problematic, that being the inclusion of the health services provider information in the act and how the current rules for health services provider information prevent the necessary flow of information throughout the health system.

9:45

Since the Health Information Act was enacted, the need for health information to inform and sustain our health care system has grown and changed abundantly. For example, if you look at initiatives around the electronic health record, there needs to be a normal flow of information throughout the system. This information is required for the increasingly important area of patient safety and, for example, to help patients make informed choices about their health provider.

We have provided you with copies of the written brief, which is very extensive but which we will not walk you through today. We will, however, discuss a scenario that's included in your brief, and it's a scenario that commonly occurs in Alberta today. It helps to exemplify some of the very real and practical problems, in this case in a drug store, with the flow of information.

Before I talk about the scenario, I'll just mention that with regard to health services provider information, one of the original recommendations that we had made in our written submission was that health services provider information be removed from the Health Information Act as we and many others believe that it doesn't belong in legislation whose primary purpose is protecting the health information of patients. There are many good reasons why health services provider information should not be included in the act. These are outlined in our written submission and in the submissions of others. In addition to the benefits of having visibility to this information, which include, for example, managing the health system, controlling costs, and improving quality, we would ask the question: what legitimate reason would there be for a health services provider wanting to keep information regarding their professional practice secret?

If health services provider information remains in the act after

your process is concluded, then we would like to suggest an amendment, that you will find in our supplemental submission, which Mr. Jones will talk about and for which we believe there is a lot of support from a variety of stakeholders.

If I can just draw your attention to the scenario that we've handed out to you. I won't read it out word for word. In this case we have an elderly lady, Mrs. Jones, who goes into her local pharmacy and makes a request of her pharmacist. As a practising pharmacist I can tell you that I've been in this situation many times. The request is very simple and straightforward, and it's one that occurs on numerous occasions over the years, and that is that Mrs. Jones asks her pharmacist to provide a printout of all prescriptions that she has received in the past year so that she can use this to submit along with her income tax return as a record of her medication expenses.

Normally, a prescription receipt contains information that identifies the prescriber of the medication. In this case the pharmacist, under the current Health Information Act and under the Privacy Commissioner's ruling on this point, would require a doctor's consent before that name can be released along with the other information about the prescription that Mrs. Jones got. In this scenario the pharmacist then would have to notify Mrs. Jones that he has to contact several different physicians who wrote prescriptions for her over the previous year to obtain their consent to release their name on the prescription receipt. Because he's had many similar requests in the past while, he asks her to perhaps come back next week and he may have that done.

She also leaves a new prescription with the pharmacist, and this prescription is for a narcotic painkiller. It happens to be a drug that's covered by the triplicate prescription program, which means that the pharmacist would normally be expected to transmit by mail a hard copy of that prescription to the College of Physicians and Surgeons of Alberta, who are noncustodians under the act. So the pharmacist, in filling this prescription and in sending a copy of it to the college of physicians, would be offside, having failed to gain consent from the prescribing physician that that information goes forward, in this case to a noncustodian, without their consent even though the patient might be fine with it.

Also, when processing their claim through Alberta Blue Cross under the drug plan for seniors, the pharmacist would have to gain consent from the prescribing physician before sending that claim forward as well for payment.

So the point we want to make is that neither the pharmacist in this case or Mrs. Jones would face this type of situation if they lived in any other province in Canada. With long waiting lists and escalating health care costs, we feel that every effort must be made to remove unnecessary legislative barriers to the proper flow of information to improve the efficiency in our health care system.

The government of Alberta decided to protect information about health services providers, including doctors, nurses, pharmacists, et cetera, under the Health Information Act without publicly stating a clear and legitimate justification for doing so, as recommended by the provincial Steering Committee on the Health Information Protection Act back in June 1998. Based on the Privacy Commissioner's interpretation of language in the Health Information Act, in his March 2003 ruling the health services provider's name is protected information if it reveals other information about the health services provider. The other information can be broadly interpreted to mean any other information about the health services provider.

So at a time when the electronic health record is being developed in Alberta to enable and streamline the sharing of information, the Health Information Act provides unprecedented protection to virtually any or all information about a health services provider, even information of a professional practice nature, and this presents roadblocks to the normal flow of information throughout the system. IMS asks the select special committee to consider changes necessary to prevent this type of scenario that we just discussed from playing out in Alberta's pharmacies.

I'll now turn it over to Mr. Jones to walk you through our proposed amendment for how this problem can be very simply and elegantly fixed.

Mr. Jones: Thank you. The starting point is to realize that there are three different, mutually exclusive categories of health information under the act. There's diagnostic treatment and care information, which has its own set of rules; there's registration information, which has its own set of rules. Both of those relate to patients. There's health services provider information, which relates not to patients but to the service providers: the doctors, the nurses, the pharmacists, and so on.

The act generally requires consent for the disclosure of health information. For the first two categories it requires the patient's consent, but for the third category it requires the provider's consent. The three silos of information, that structural fact, is absolutely critical to the problems that Brian has discussed. When the pharmacist wants to disclose to Mrs. Jones the names of the providers of the services to her, he needs the provider's consent. Of course, Mrs. Jones can't go and get it because she doesn't know the providers, because she's asking for the providers. So you have a catch-22 in many cases and a lot of additional paperwork. The first key is that health services provider information, HSPI in the lingo, requires the consent of the doctor or the provider.

The regulation of health services provider information is unique to Alberta. No other Canadian jurisdiction does it. There are 19 categories of HSPI. I passed out the definition from the act, and I've slightly annotated it because it makes it a lot easier to read and understand than from the act itself. There are 19 categories, and of the 19 categories eight, the underlined ones, can theoretically be disclosed without the provider's consent, what has been called business card information: the name, the business mailing address, electronic address, business telephone number, et cetera, the type of health services provider and so on, the profession, the job classification of the employer, the municipality in which the health services provider's practice is located. But the other 11 of the 19 categories require the consent of the provider for disclosure.

So there are 19 categories in all. It's not all information about providers that's regulated by the act, or at least we wouldn't have thought so. There are only 19 categories, of which eight are permitted to be disclosed without consent, but 11 require consent to be disclosed. There might be an issue as to whether the 11 are right, whether somebody's disciplinary record should be a protected area. Remember that the requirement to get the provider's consent allows the provider to keep it secret.

The opposite side of the coin of consent is secrecy. Who makes that decision? The provider, because it's the provider's consent that's required. So the provider can keep it secret. That's why Brian asked the question that I think is fundamental to this: precisely what legitimate reason would a provider have for keeping information about their professional work or any of these items secret? That's the bottom-line question.

9:55

The particular difficulty is in section 37(2)(a), which is on the second page of the handout. In section 37 the opening words start from the premise that the custodian may disclose eight categories of business card information for which consent is not required, may disclose those to any person for any purpose "without the consent of

the individual who is the subject of the information." That's without the consent of the provider.

So you would initially think that you could say that Dr. Smith is going to give a lecture on diabetes tonight. What's objectionable about that? You would think that maybe you could talk about: Dr. Smith is old and will be retiring soon, so you might want to think about getting a younger doctor if you're all of our ages and we're going to live forever and we want a doctor who's going to be around when we're old. Or that Dr. Smith speaks fluent French and you're francophone and are having some difficulty understanding medical things in English or whatever language you want. Unfortunately, though, you couldn't say that because none of those things – giving a lecture on diabetes, speaking French, being elderly and maybe going to retire soon – is one of the 19 categories. It's not one of the eight that are permitted, and it's not one of the 11 that's protected.

But 37(2)(a) says that you can disclose the eight that are permitted unless the disclosure of any of those eight that are permitted "would reveal other information about the health services provider." Our commissioner has interpreted "other information" to be any other information of any nature and kind about the provider, not just the other 11 categories that are protected. Functionally you would have said: "We only regulate 19 categories: eight permitted, 11 not permitted. We'll let you disclose the eight, no consent required, provided that you don't reveal any of the 11 that are protected." That would be functionally elegant. It would still raise questions as to whether the 11 are right, but that's a different issue. Our commissioner didn't interpret it that way. Our commissioner said that "other information" means other information. It means any other information.

So if you then look at the third sheet that you have, under the commissioner's interpretation of "other information," which isn't defined in the act, a custodian would not be able to make any of those statements, would not be able to say that a health services provider has been an expert witness 50 times, is old and is going to be retiring soon, that you might want to think about getting somebody younger, who speaks French, is going to give a lecture on diabetes tonight.

And there are some ridiculous ones. You couldn't say that Dr. MacDonald doesn't have any grey hair or that Dr. Blakeman doesn't have any grey hair either. You couldn't make comments about colours. You couldn't make comment about whether they're related to somebody. You can't make any comment whatever tied to the name or any of the eight that are able to be disclosed.

In our main submission, which tells you a great deal of information about what IMS does and about why it's helpful to have identifiable information about providers, on page 53 there are three suggested solutions to the problem. I'll just summarize what they are.

The first is: abolish the concept of health services provider information; take it out of the act. It doesn't exist anywhere else in Canada, and the previous committee, between the previous version of the act and the act that came into effect, said that the act should not include health services provider information as a concept unless a clear and strong rationale has been given for doing that. No such rationale has ever been given. So the first question is: why do we have HSPI? That takes you back to Brian's question: what legitimate reason would a provider have for protecting any information about them?

Secondly, since the act came into effect, we have the federal PIPEDA and we have the provincial PIPA. Why do we need to protect providers in the health sector differently than we protect providers in my sector, perhaps, or any other sector? We don't protect my work product information, as a matter of fact.

So the first solution is just amend, repeal HSPI. Get rid of the concept. It serves no useful purpose, but it allows providers to control, to maintain secret certain information that inevitably is going to be needed in the system way beyond my clients.

You've heard from the Pharmacists Association. You're going to hear this afternoon from the College of Pharmacists. You've heard from quite a few other people, and we know that there are problems with the triplicate prescription program. Different people disagree as to how they could be solved. We know that there are problems with the pharmacy information network, with Wellnet, with the wait list registry, and the list goes on and on and on. So the question is: do you try and solve each one and try and anticipate every one that might be there, or do you say that this concept doesn't have legs? So that's the first submission.

The second submission is that if you're going to retain the concept of health services provider information in the act, then repeal 37(2)(a). Just repeal it outright. Section 37(2) as a concept says that you can release eight permitted categories without consent. You need consent to release the other 11, and 37(2)(b) says that there's protection if the disclosure is going to harm somebody. No objection to the harm being there. That's (b). So the second suggestion is just get rid of 37(2)(a).

The third suggestion was to change the "or" to "and" between 37(2)(a) and (b).

The fourth suggestion is in our supplemental material that was just handed out to you earlier today and referred to, and it follows up on a suggestion – it's a small one – that Alberta Health and Wellness made that it may be necessary to make a definition of "other information" for the purposes of section 37(2)(a). At the bottom of the sheet with the section on it, I've added some particular words to say that for the purposes of subsection 2(a) other information means health services provider information described in the 11 protected categories and some of the other items which are actually excluded from the eight permitted ones.

So it would have the effect of making it clear that 37(2) is to allow the disclosure of eight permitted ones without consent to any person for any purpose, but it protects 11, and 37(2)(a) protects the sideways or tangential revelation revealing all those 11. But it's not intended to protect any statement whatever or any information whatever about the health services provider, because they're not protected. There are only 19 categories protected in the first place.

I think our time is up, Mr. Chairman.

The Chair: It's not quite up, but we would like to have some time for questions, Mr. Jones. So thank you and Mr. Carter for your presentations, and we do have a question already.

Mr. Lukaszuk: Thank you for that presentation. I did have the opportunity to read through most of your rather voluminous written presentation. Prior to this meeting I had given section 37 of the act some consideration, and I concluded that the only reasons that one may bring forward to justify the existence of that section in the act would include one of, if not all of, these factors: that it improves the safety of the patient in the system or it improves the efficacy of treatment that the physicians provide or it somehow enhances the economics of the system under the medicare system, the publicly funded system, and lastly that it prevents any potential jeopardizing of a practitioner's ability to practise the art of health care. I had a difficult time finding any correlation to any one of those four by linking that section to any potential adverse outcomes that may come in those four categories.

10:05

I do know for a fact that the argument for preserving section 37 in

the act by the proponents of that section would be that it protects the physicians from what they would term to be some predatorial activities of pharmaceutical companies that may choose to approach cohorts of physicians based on their prescribing patterns and target them for marketing purposes.

Now, one part of your report that grabbed my interest is on page 42 of your written submission, which I realize is just a little caption, a minuscule caption of what's happening in the health care system but perhaps depicts a prescribing pattern of one particular medication which would be of interest to the public. The government perhaps would even allow to enhance the safety of patients if that information were readily available, and that would have to be in the absence of section 37. Could you walk us, perhaps, through that graph, figure 13 on page 42, and explain what it depicts? And if section 37 was not in the act, what would we be able to do about this situation as described?

Mr. Jones: Before I ask Mr. Carter to do that, could I just respond to a couple of things you've said. The section that you're referring to could be repealing the concept of HSPI, which is found in 110 or 37, but the issue is the consent requirement, I think.

Secondly, you refer to drug marketing practices. We could have a long discussion about that. Today probably isn't the time to do that because the need to access information is much broader than IMS, and also doctors are very well able not to be targeted. They just have to say that they won't see drug reps, but that's a separate issue.

Under 37(2)(a) "other information" means any other information of any nature and kind. It means that a custodian practically can never disclose to anybody the name of a prescriber or provider at all for any purpose, and 37(2)(a) says that you can do that to any person for any purpose, and it's that internal inconsistency that's the problem.

Mr. Carter is the expert on what page 42 tells you, but you would not be able to do this if the commissioner's interpretation of "other information" being any other information isn't changed.

Mr. Carter: Okay. What figure 13 depicts is an example of groupings of prescribers in Alberta into quartiles. So each of the blue bars in the graph represents one quartile of all prescriptions in the year 2003 in the province for a drug that contains the active ingredient oxycodone. Oxycodone is an opioid, so it's a strong narcotic medication. It's used to treat pain, and it has a high potential for addiction and also for abuse. Many of you have probably heard of the drug called OxyContin, which is one brand of this particular drug that's extremely popular, and its use has increased in Canada over the past several years by some thousand per cent to the extent that it has become a problem as a street drug otherwise known as hillbilly heroin. Health Canada has recently gone to all pharmacies in Atlantic Canada and required them to report to Health Canada all prescriptions dispensed for the last six months for this drug, including identifiable patients and identifiable prescribers.

It so happens that Alberta has the highest per capita number of doses of oxycodone containing products out of any province in the entire country. That fact is something that IMS knows about because we track the prescription market. It's not a very well-known fact, and I think one would argue that this information can be extremely important from a patient safety perspective and for a variety of other reasons.

If you look at the graph, if you look at the first bar, the Q1 bar, what that indicates is that in that group you have 68 physicians who prescribe an average of 852 prescriptions per year for a drug containing oxycodone, and those 68 physicians are prescribing one-quarter of all prescriptions in the province. So you have 2 per cent of the physicians prescribing 25 per cent of the drugs. If you look at the second quartile, you have 181 physicians that prescribe the next 25 per cent. So, in essence, you have about 240 doctors prescribing half of all prescriptions containing oxycodone in the province.

Now, that doesn't make any commentary on whether or not that's appropriate. It just simply says that this is an interesting fact. If one wanted to do something more elaborate with regard to improving the quality of prescribing for this drug that we know has a high potential for addiction and abuse, you only really need to look at the first group or two groups of 240 or so physicians to put in place some type of an educational intervention and you'll have an extremely efficient effort in improving the quality of prescribing without, for example, having to re-educate some 6,000 doctors in the province, many of whom don't even prescribe the drug in the first place.

So it's just an example of if you're capturing this type of information and reporting on it, it helps to identify potential problems and emerging problems for virtually any drug or class of drug in Alberta or in Canada.

The Chair: Thank you for the question and the answer. May I ask that in the future questions and answers be a little bit shorter.

Ms Blakeman. After that preamble, yeah.

Ms Blakeman: Oh, yeah, put it in place now. Thanks.

The Chair: Only because we only have about six, seven minutes left and there are other members wanting to question.

Ms Blakeman: Thank you. I'll speak quickly then. I have a request of staff and a question, and then I have a second question, so please put me back on the list.

I'm wondering if the support staff can get us a copy of tax returns and this kind of health information that they are in fact seeking when they ask. I'm just following through on the scenario that's given to us here, that she was required to provide the doctor's name in order to get the income tax rebate or whatever she's seeking there. I just want to know what kind of information income tax requires around those medical rebates, if you can get that, and as well a copy of the hospital admitting form and what kind of information they're requesting from people as they check into a hospital.

My question. In your hit parade here under section 1(1)(o), "health services provider information," you have identified the eight categories of information that can be released without consent. Out of the remaining 11, or perhaps all of the 11, which of the 11 do you really need to conduct your business and why? Why do you need to know the gender or the date of birth?

Mr. Jones: We don't need to know any of that. Some other people may want to know some of that, but I think, Ms Blakeman, the relevant question is: look at (xi). Why would (xi), "restrictions that apply to the health services provider's right to provide health services in Alberta" – why should a custodian not be able to say that to anybody for any purpose? Why does the provider have the right to keep secret their restrictions on their right to provide services in Alberta? From our point of view, we don't need any of the 11 at all. I think other people may say that they think some of the 11 aren't right, but our issue is simply the phrase "other information" in section 37(2)(a).

Ms Blakeman: Okay. So you don't need and wouldn't use any of the other bits of information if it was available to you. This is less your concern than the phrase "other information."

Mr. Jones: Our issue is focused right on the meaning of "other information" in 37(2)(a).

Ms Blakeman: Same question. What other information do you require, then, from these health service providers, and why do you need it?

Mr. Jones: We don't require any information from them. It's information about them, to start with.

Ms Blakeman: Fine. Information about them.

Mr. Jones: By the way, there's no information at all about an identifiable patient that's disclosed to IMS. They have no identifiable patient information. It's simply some information about providers, and some of the information is not about the providers at all. It's about the actual form of the prescription that was filled, because very often it's a generic filling rather than a proprietary filling. It's the form it came in, whether it was a pill, a capsule, an injection, et cetera, whether it's a refill or a new prescription, how it was paid for, which isn't information about the provider at all.

10:15

The commissioner said that what we're getting inferentially – we actually aren't getting any information disclosed to us; it's what we're able to infer from what is given to us, which is the name and the postal code of the provider. We are able to infer the prescribing pattern of the doctor. Well, the prescribing pattern isn't one of the 19 that are protected, nor is the colour of their hair, nor that they speak French or English or anything else.

The Chair: Thank you for the questions and the answer. We do have two other committee members who want to question.

Mr. MacDonald.

Mr. MacDonald: Thank you, Mr. Chairman. I, too, will be brief. My questions are like this. You stated that you track prescription patterns. When is the information you collect made available to the public free of charge? My second question would be: do you exchange information on a routine basis with any police forces or any law enforcement agencies across the country?

Thank you.

Mr. Carter: Maybe I'll try to answer the first part of your question. Then I'll ask probably Anita to answer the second part. I'll just give you an example of making information available to the public free of charge. Let's use the example of researchers, who arguably would fit into the public. IMS has a policy of providing information to researchers to support academic research at no charge, so that means that at any point in time and many times a week we get requests from researchers for prescription information that can help support some of their research activities, again nothing that identifies patients but that may identify, for example, prescribing patterns of physicians.

I'll give you one small example. We're working right now with a researcher at the University of Calgary. He's a medical doctor. He has an interest in psychotherapeutics, so treating people for depression, that sort of thing. He's busy looking at patterns of prescriptions around the province and how they vary by regional health authority and looking to try to explain some of the reasons for those differences. So we currently are working with him to provide him with information mapped out by a regional health authority on the differences for a long list of drugs including, for example, major tranquilizers, antidepressants, and that sort of thing. So that would be but one small example.

The Chair: The second part.

Ms Fineberg: To answer Mr. MacDonald's second question, IMS has a code that describes our practices with respect to how we deal with this type of information. Consistent with that, with respect to disclosures to the police, should we be served with a warrant or a subpoena that requires us to turn that information over, we would certainly comply with that. To date I can tell you that we have not been approached by any law enforcement agency requesting any information from us.

Mr. Jones: Again, I would repeat, there's no patient identifiable information at all at issue.

The Chair: I see some confusion on this. Mr. Lougheed, did you have a question?

Mr. Lougheed: Are you going to clear up the confusion first?

The Chair: Okay. Is everybody okay with the answers? I guess I misread the committee. I'm sorry.

Mr. Lougheed.

Mr. Lougheed: Thanks. I don't know whether I don't understand something here or whether this sort of example, this Lara Jones example, is sort of frivolous and simple just because you're trying to make a point. Is all the information that is sought from the pharmacist not something that you would have already? I haven't looked at a prescription lately to answer this question myself, but wouldn't she have all that information if she'd just bothered to save the slips over the past year? [interjection]

Mr. Jones: Actually, that form, Ms Blakeman, breaches the act.

Ms Blakeman: There's no doctor on that.

Mr. Jones: Oh, there's no doctor on that. If you got the one that has the doctor, it would breach the act.

You would have to keep a copy of your prescription because the pharmacist cannot legally give you as a patient, even on the label of your medication, the name of the doctor because that's disclosing the doctor's name and other information about the doctor without the doctor's consent, and the doctor hasn't consented. The patient might have, but the doctor hasn't.

In a certain sense it's a frivolous example, and it's an example of a case where I think everybody in this room would say that it shouldn't be like that, but the act drives you to that.

Mr. Lougheed: I see your point.

The Chair: Our next group is here. If the committee is agreeable and if IMS are agreeable, we could come back after 11 o'clock for further discussion. It seems like there are some more questions here. Would that be agreeable to the committee? Is it agreeable to IMS? We may also at that point have time to talk about the pan-Canadian.

I think Mr. Lukaszuk has a burning question, so we'll take that one, and then we will adjourn until . . . Oh, you have a question also?

Ms Kryczka: I thought you had me down. I'm sorry.

The Chair: Sorry. Okay. Mr. Lukaszuk, could we go to Ms Kryczka and then to you?

Mr. Lukaszuk: Of course.

The Chair: Okay. Ms Kryczka.

Ms Kryczka: I'm sorry. I assumed that you had me on your list.

The Chair: You sent me confusing signals. I'm sorry.

Ms Kryczka: Okay. Well, my understanding is that you provided us with alternative solutions, the first one being to repeal the concept is what I heard, the first priority.

Mr. Jones: Yes.

Ms Kryczka: Would providers accept that?

Mr. Jones: I don't know. I think some providers would.

Ms Kryczka: That was one of my two questions. Can I just ask my second question? I just throw this out: why is Alberta the only province that has HSPI? Why are we different? We like to be different in other ways, but why do we have this?

Mr. Jones: If I can answer your two questions. I don't know what providers would say. I know that there are three or four who have submitted submissions to you who have said, "Keep the concept," but not one of them has provided a rationale for keeping it. No, not one. Secondly, I think you need to tax every one of those with: so what legitimate reason is there for your members or you as a provider to want to keep all information about you private, secret?

Secondly, why is Alberta different? I'm an Albertan. My children are fifth generation Albertans. I don't know why we're different. But the committee that looked at it between the two versions of the bill said that there needed to be a strong, clear rationale given for its inclusion. It's never been given. I would suggest, with the greatest respect, that it shouldn't be in the act.

Ms Kryczka: So it goes back to the legislation and whoever was on the committee and made that decision.

The Chair: I guess so.

Ms Kryczka: That would be a question I would have: was there any rationale at that time for making that decision?

The Chair: Yeah. I think it's a fair question, and we will try to address it later.

Ms Kryczka: Thank you.

The Chair: Mr. Lukaszuk, final question.

Mr. Lukaszuk: Thank you. Just briefly. Prior to having been elected, I dealt with matters of health, and routinely my offices would ask clients to provide us with a copy of an Alberta health care statement of benefits paid. It's a list printed off by Alberta Health listing the patient and then a whole slew of physicians that the patient has supposedly seen over the last seven years. Also, we have been obtaining statements from drug stores listing all the medications that they have been prescribed. Indeed, those did not include the physicians, but the Alberta statement of benefits paid includes the patient, the doctor, and the date and time of visit. In your opinion, would that form then be in breach of section 37 of the act?

Mr. Jones: Yes, it would be. Indeed, that illustrates the point that a patient, under the act as it's written, doesn't even have the right to access the name of their providers. So that's a problem in hospitals. If you want to get your chart from the hospital, the hospital is going to have to white out every name of every provider all the way through.

Mr. Lukaszuk: So the issuance of that form by our own department of health is ultra vires to that section of the act?

Mr. Jones: In my opinion, yes.

The Chair: Sorry to keep contradicting myself.
Mr. Snelgrove.

Mr. Snelgrove: This isn't to them, Mr. Chairman. It's quite simply that their position is probably one of the most crystal clear of all the presenters we're going to get, so I would have to question why they would need to reappear. I mean, the individual things, anecdotal stuff, we can go on, but we understand, I think, exactly what they're saying, and if we're going to have them come back . . .

10:25

The Chair: The only rationale we would have is if the committee wants to talk about the pan-Canadian from their point of view. They have offered to offer another point of view on the pan-Canadian question, which was raised earlier this morning. So that would be the rationale, Mr. Snelgrove, to allow them to come back, but I'm in the hands of the committee.

Ms Blakeman, you had another comment.

Ms Blakeman: Well, no. I have additional questions for these wonderful people who are appearing before us. This is part of my concern about the rush of this committee. I have some unanswered questions, and I'd like to be able to ask them and get them answered. I have real concerns if the committee is just going to move on, then.

The Chair: Okay. Anyone else on whether or not they should be allowed to come back? Dr. Pannu.

Dr. Pannu: Mr. Chairman, I would like to see them come back, and they are willing to come back. Certainly, the committee would benefit from a further exchange of views with them.

The Chair: We do need to go to the next group, for whom we're already five minutes late. So we will, I guess, ask you to come back and answer any other questions and also, hopefully, make some comments on the pan-Canadian aspect of the discussion.

Mr. Jones: Thank you, Mr. Chairman. My clients, who are based in Toronto, Ms Drinkwalter and Ms Fineberg, are here all day in any event. We're here. If we can be of assistance to understand some of the difficult issues, we're delighted to help.

The Chair: Thank you, Mr. Jones. We will take a brief adjournment to set up and will reconvene as quickly as possible.

[The committee adjourned from 10:27 a.m. to 10:31 a.m.]

The Chair: We will call the committee back to order.

We're very pleased to welcome Mr. Mike Higgins, executive director, and Mr. Brent Windwick, legal counsel, for the health boards of Alberta. Welcome, gentlemen, and thank you for taking

time to present to the committee this morning. I'm going to give the committee members an opportunity to identify themselves for your benefit.

[The following members introduced themselves: Ms Blakeman, Mr. Broda, Mr. Jacobs, Mr. Lougheed, Mr. Lukaszuk, Dr. Pannu, and Mr. Snelgrove]

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Ms Sorensen: Rhonda Sorensen, communications co-ordinator with the Clerk's office.

[The following departmental support staff introduced themselves: Ms Miller, Ms Robillard, and Ms Swanson]

The Chair: Thank you.

All right. The time is yours, gentlemen, to make your presentation, and hopefully we'll reserve some time for questions. Go ahead.

Mr. Higgins: Mr. Chair, committee members, thank you very much for giving us this opportunity to make oral presentation to you. My name is Mike Higgins. As was pointed out, I'm executive director of the Provincial Health Authorities of Alberta, and I'm appearing before you on behalf of the health boards of Alberta, comprised of the chairs of the nine health regions and the Alberta Cancer Board.

I want to first of all express regrets that Jean Graham, chair of the health boards of Alberta, was unable to be with us this morning. So I pass along her personal regrets to the committee.

I would also take this opportunity to introduce Mr. Brent Windwick. Mr. Windwick has been retained by us to provide counsel and advice in the preparation of our submission to the committee. Mr. Windwick will be speaking to some of the content in our report a little bit later on.

So first of all I want to thank you for providing us this opportunity for oral presentation on behalf of the health boards of Alberta, representing the nine health regional boards and the Alberta Cancer Board.

A written response to the committee's request for input was submitted on August 13, 2004. The written submission addressed the consensus views of Alberta's health authorities regarding the structure, interpretation, and application of the Health Information Act. The report outlined the perspective of the health authorities on a variety of subjects including the scope of application of the act; administration and operational challenges; harmonization with other privacy legislation; collection, use, disclosure, and retention of patient information; consent; and risk and liability. Individual health authorities may have elected to provide the committee with individual responses highlighting or adding emphasis to particular issues, but this submission on behalf of the health boards of Alberta does represent the consensus views of all health authorities.

Subsequent to our submission of August 13 a debate unfolded before the committee that attracted media attention over the question of access to patient information by police authorities. This development prompted the health boards of Alberta to prepare a supplementary submission elaborating on the health authority perspective related to that matter. This supplementary report was provided to the committee on September 9, 2004, and I hope you all have received copies of that.

So with that by way of introduction and background, Mr. Chair, with your permission I would like to invite Mr. Windwick to provide you with an overview, a verbal summary of the key points in our submission, after which we would be pleased to respond to your questions.

The Chair: Thank you.

Go ahead.

Mr. Windwick: Thank you, Mr. Chair. I will simply work through the original submission of August 13 and try to highlight the key points in that submission – Mr. Higgins and I agreed that it made sense to do that – and then perhaps after doing that, move on to the supplemental submission subject to the committee's views about this. I'll actually give you a page number as I go through as well, so you can see what I'm referring to as I summarize what the health boards of Alberta consider to be the key points of response.

First of all, on pages 1 and 2 of the submission we deal with scope of application of the Health Information Act. The bottom line on this, I think, from the health boards' perspective is that a model or a paradigm in which the Health Information Act regulates organizations that have as their primary function the provision of health services really makes the most sense from an operational point of view and from a regulatory point of view. Expanding it more broadly will, you know, certainly catch more kinds of health information or situations in which health information is collected like, for example, in schools. However, I think once one extends the scope of application of the act beyond organizations whose primary function is the provision of health services, you run into a lot of potential problems and complications.

So from the health boards' perspective the preferable course is to set up a model in which, for example, private surgical facilities, private clinics, privately paid-for services provided by clinics that also provide publicly insured services – health information collected by all of these bodies would come under the ambit of the Health Information Act. So that is an expansion in scope compared to the act as it currently is constituted. But other organizations whose primary purpose is not the provision of health services would continue to operate under their own governing legislation and be regulated in that fashion and, through effective harmonization of the different pieces of Alberta legislation, essentially achieve the same objective of broad coverage.

On pages 2 to 4 we deal with administrative and operational challenges. I should emphasize that this section expresses the health boards' views, really, more on implementation and application of the act than on the actual legislation itself. The other thing I want to emphasize is that the health boards feel that the Privacy Commissioner, the regulatory oversight, is appropriate and is necessary and is being effectively done; however, there are some significant challenges that health boards face in trying to deal with the administrative and operational application of HIA. There have been a couple of examples referenced on page 3 of the submission.

I'm not sure that any of these comments necessarily require legislative amendment to deal with them, but the intent in putting this in the submission was to permit the committee to have a perspective on the practical application of HIA that would be usefully borne in mind in considering legislative amendment.

On pages 4 and 5 the submission deals with "harmonization with other privacy legislation inside and outside of Alberta." This is pretty straightforward. Really, I think the key from the health boards' perspective is that one has to look at all of the dimensions of harmonization that are really necessary to make this work.

On pages 5 and 6 the submission deals with collection, use, disclosure, and retention, and this initial submission dealt very briefly and succinctly with disclosure to law enforcement agencies.

Obviously, the health boards have a supplementary submission that deals with that in more depth, and we'll come back to that in a bit.

The other key points under collection, use, disclosure, and retention were support for adding an exception to disclosure for the triplicate prescription program, as the consultation guide recommended. A feeling that retention rules right now are inconsistent and scattered all over the place: I think there's a pretty strong consensus of view that it would be better if there was some consistency about this, not necessarily through an amendment to the Health Information Act itself but through a regulation to the Health Information Act that would deal with retention. It would provide some consistent guidance for health boards, and it would essentially put all of the rules in one place.

10:40

On page 6 of the submission we deal with consent. The health boards' view about consent is that the existing model is "an effective model" and that from an operational perspective it is more useful for health authorities to have "an express consent with specific exceptions model" with kind of limited discretion built in as opposed to an implied consent model, in which there's a lot more judgment required of front-line providers about how consent is to be obtained and whether consent has been obtained.

Also on page 6 the submission deals with risk and liability. I think the key point that health boards want to make on this subject is that it is relatively straightforward for health boards, health authorities to control the activities of their employees, but it is more difficult for health boards to both know and to directly control the activities of parties with whom they contract. The suggestions that are made in the submission are effectively to take a close look at sections 60 and 62 of the act, which effectively make custodians guarantors of the actions of affiliates. While affiliates who are employees and under employment control of health boards are – I mean, it's a practical matter to exert that control.

The same is not necessarily true – we submit that it is impractical and unreasonable to extend this rationale to independent contractors. While the act does provide some legal protection to custodians – that is, immunity from civil lawsuit for good-faith actions – similar legal protection does not apply to penalties imposed by the Privacy Commissioner. So the health boards would look for a recommendation that would essentially shift accountability to some degree to the actual holders of the information – that is, the contractors in situations where these are independent parties – as opposed to having the custodian essentially strictly accountable for the way that these contractors deal with their information.

So that in a nutshell is the main submission made on behalf of the health boards. Do you have anything that you want to add to that, Mike?

Mr. Higgins: I don't think so. We can respond to questions.

Mr. Windwick: We could respond to questions on this before we move to the supplemental submission or move to the supplementary submission.

The Chair: Would you just cover the supplemental as briefly as possible, and then we'll take questions? There may be questions on the supplemental as well. I think that there will be.

Mr. Windwick: The health boards tried to make a very concise submission on the issue of disclosure to police services without consent. Basically, what we wanted to point out was, firstly, the variety of ways that the police are already able to access information under the legislation as it currently exists and under other legislation. The first page of the supplementary submission addresses a number of these ways. I should also say that different health regions are engaged in ongoing consultation processes with law enforcement services to smooth out any administrative wrinkles that may arise from the processes that are currently in place for law enforcement services to get access to information.

I spoke to the information/privacy co-ordinator in Calgary this morning and got a bit of a sense of a protocol that they're currently developing with the Calgary Police Service, which really would allow law enforcement to participate actively in every step of a consultation process. So if you think about these ways in which police can access information right now for purposes of investigations of an offence involving a life-threatening injury to the patient or where there is danger to third parties or if it is in the patient's best interests, essentially this protocol has at its root a principle that if a police officer is willing to assert that the situation meets the criteria that would allow these exceptions to be used, the health authority would accept that good-faith submission and would disclose the information.

The practical consequence is, I guess, two things. One, there are a lot of different ways that the police can access information right now. The other point is that from the health boards' perspective it's not entirely clear what the real impediment is that the police are experiencing right now. I think that if it was strongly demonstrated that there is a very real impediment to police being able to get search warrants to get information, for example, that's something that health boards would take seriously and would be prepared to enter into discussions to try to resolve.

But I'm not sure that that impression is really the impression of the health boards. Indeed, I understand that there was an inventory not too long ago of police/hospital interaction, that was I think commissioned by Alberta Health and Wellness, that involved a number of health regions to try to identify significant problems with those interactions, and my understanding is that that inventory really did not turn up significant problems or difficulties that the police were experiencing.

So I think that probably expresses it as well as I need to at the moment. The health boards believe that subject to, you know, strongly demonstrable evidence to the contrary, the existing model works – works for health boards, works for police – and strikes a reasonable and practical balance between the interests of police services in investigating crimes and the protection of individual privacy rights.

The Chair: Thank you very much for the presentations. We do have questions, so we will start with Mr. Snelgrove.

Mr. Snelgrove: I'm really surprised. There has to be a disconnect between what the average person and the hospital would be thinking when it looks like you're trying to protect someone who may come to the hospital with a wound from an accident or from a crime, a bullet wound in the leg, that may not be life threatening to them, and that it wouldn't be in the best interests of the entire province to phone the police on the spot rather than try and protect them if they suggest: "No, I'm not hurt that bad. Don't tell anybody that I'm here, so I can get patched up and get out on the road again." Maybe I'm just naive, but I just don't understand why the health boards wouldn't be saying right up front, "The best thing we can do is have a policeman in the hospital on Friday nights so we catch the guys coming in the door," rather than try and protect them through some kind of bureaucratic paper we put up in front of them. I'm just surprised.

The Chair: Thank you for the question. An answer?

Mr. Higgins: Mr. Chair, I would only comment in principle. First of all, I think it's important to understand that health authorities have a very serious obligation to protect the interests of the public and of individuals from the public who enter their facilities. They are also obligated to protect the privacy of the health information that they are charged with housing. Health authorities are in a position of having to exercise judgment and strike a balance between the public interest in a particular incident and the broader public interest associated with the requirement to protect health information.

In achieving those balances, I think that, as Mr. Windwick has pointed out, health authorities have established elaborate policies in compliance with existing legislation, have been able to indicate that they have achieved success in working effectively and successfully with police authorities in addressing their concerns. Beyond that, we're really lacking in evidence of circumstances where individuals' safety may be impinged or brought into question through the actions of a health authority in withholding information.

Mr. Windwick has pointed out in his comments that there are many avenues available to police authorities to gain access to information and to expedite those processes, and they avail themselves of those things. Health regions are in a co-operative stance when it comes to dealing with matters of this type.

10:50

The Chair: Thank you.

Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. Mr. Chairman, if Mr. Snelgrove believes that he is being naive, put me in the same category, because what I have just heard from the health boards of Alberta reconfirms to me that what the police departments were telling us over here was indeed true. If this is the reasoning that is being applied and if this is the test for releasing information that is being applied every time a police department accesses your hospital or any other facility to obtain information, then I can see exactly why they're having a hard time obtaining information.

With all due respect, I think you need to be reminded that you are public servants and that the greater good of Albertans is what needs to be looked at primarily. Why would you ever want to put yourself in a position where your front-line workers will be making the determination of what is and what isn't good for Albertans, of what is and what isn't a life-threatening situation that should or shouldn't be revealed to police? Why not allow the police to obtain the registration information and let those who are competent in the field, the judges, make the decision whether a warrant or a subpoena should be issued?

The Chair: Thank you, Thomas.

Who wants to take that one again?

Mr. Windwick: I'll try to respond to this. I'm not sure that we're really at cross-purposes here. I think that health boards acknowledge the importance of police being able to do appropriate investigations, and I think we're not just talking about a policy decision of health boards here. We're also talking about established legal principle about the extent to which police are given access to information and the circumstances under which police are given access to information.

I don't want to get into quoting from judges and so forth, but there are clear indications from judges who have looked closely at these things in cases decided by the Supreme Court of Canada that there really does need to be a separation between the investigative function of police, which is the police responsibility, and the protection of the confidentiality of health information, which is the responsibility of health care providers and organizations that collect that information. The question is, really, how to fit the two together.

I express my own view here, but I think that the health boards would probably agree that – I've just lost my thought here. Let me just rewind, and I'll come back to it. I'm sorry; I've just completely lost my train of thought here. Let me just suggest that the health boards – sorry; may I just take a minute? Twenty years of doing this, and it's never happened to me before. I had such an important thought to communicate to Mr. Lukaszuk that it's completely frozen my mind.

The Chair: Would you like us to go with another question and then come back to that when you get that thought back, Brent?

Mr. Windwick: Maybe if I could ask Mr. Lukaszuk to just ask me the question again, I'm sure it will cue my answer.

The Chair: He may if he'll do it very, very briefly, like in one sentence.

Mr. Lukaszuk: Well, what you're telling me in your answer is that you're hoping that a protocol is developed and based on existing decisions from the Supreme Court. You're putting a lot of faith in your front-line workers that they can interpret case law and on a case-by-case basis be able to either provide or not provide information to police.

What I'm saying to you is: why not provide non patient identifiable information, simply registration information, to police and let those who are truly competent in interpreting case law, being the judges, make the determination whether they will issue a subpoena or a warrant and allow, then, further access to information for purposes of investigation? Why would you put one of your doctors or nurses or other health care providers in the position of having to interpret case law and make that determination? That's not where their expertise lies. They are healers, not investigators and not judges.

Mr. Windwick: Okay. Thanks. You've actually now reminded me of my answer, so I really appreciate it. I think we're actually on the same page in terms of the need for having some sort of consistent rules that require front-line providers to exercise as little discretion as possible. The question is: how do you go about that? Do you simply present them with a judgment question in each case about when a policeman comes in and says, "Give me all of the information about all of the patients that you've had in your emergency department in the last week"? Well, I mean, that's probably not something that a provider is going to want to do, but if there is a general rule that registration information has to be provided, then the provider is going to be wondering: "Well, exactly what kind of information am I supposed to be providing? How far back am I supposed to be providing it?" How much of this is the police service sort of fishing around without a clear idea of what it is they're investigating?

I think that what the health boards really want is certainty and consistency, and the argument that we would make is that the existing regime provides that certainty and consistency. If the police services are saying, "We actually are losing the ability to get search warrants and get evidence in the timely fashion that we need to get them," then that's a different matter, and then the question is: what information is it that they're not getting? Then the question is: how

narrow a window of information could they be given in order to resolve that problem, and how can you go about it?

The Chair: Briefly on this point, Thomas.

Mr. Lukaszuk: Thank you. Just on that point. Your presentation is actually very timely, because running around my riding this morning is an individual who may or may not have a bullet wound from last night. I can assure you that Edmonton Police Service would love to go to one of your emergencies in Edmonton and ask: have you over the last 24 hours checked on any person who may have had a bullet wound? Now, if it wasn't life threatening, your officials would not release that information to the police.

Mr. Windwick: That is correct. To be clear and to make sure that we're talking about the same thing here, there is a level of disclosure that would allow a health region or a hospital to, say, identify whether John Smith was a patient in the hospital in the last 24 hours. Then there's a level of communication, you know: is there anybody here that has a bullet wound? Then there's a level of communication: is there anyone here who may have committed a particular crime?

I think that the key from the health boards' perspective is that there needs to be clear, demonstrable evidence that the police are being impeded in getting the information they need. I mean, we're talking about the ability to get the information that you're talking about through other means. If there is a clear, demonstrable need, then what is the minimal amount of information that is needed to respond to that? I'm not sure that either of those things have really been adequately addressed. I must confess that I haven't looked at the police service's submission, and maybe you are convinced by what they say, that there are situations that haven't been properly addressed, but from the health boards' perspective they haven't seen that kind of clear, demonstrable evidence that these kinds of situations can't be resolved by means other than amending the legislation.

The Chair: Thank you very much.

We do have several other people who want to question, so I'm going to ask for brevity on both sides.

Ms Kryczka: Well, probably all I'm going to do is give you my insight on what my previous colleagues have already expressed. I was just sitting here thinking of other instances in my life separate from health. I can tell you of the CBE in Calgary versus something else I've been working on, and it just seems to me that there's some territorialism. That is what I've been hearing. I mean, who is right? Who is wrong? I don't think that's really the point. The point is: why wouldn't you work together, not just for the individual, say, that you have in your emergency in your hospital that you're addressing but for society out there?

I think that there may have been a few bad instances where a policeman came in and, you know, badgered the staff. I could see that sort of thing happening, because they're doing their duty and then your staff is doing their duty. So whether you have one example or 10 from the police, it seems to me that in the future there has to be some discussion and, yes, some consistent rules. Who works with the police in emergency? Is it the doctors? Is it some other front-line worker? Is it someone who registers them? I don't know. What is appropriate information? I think it should be more an attitude of partnerships.

Going back to the example that I was giving you in Calgary, I find that it's very – you know, you can talk idealistically. You need to work together, but to change patterns of operating and behaviour is really hard to do in reality. That's the only thing I really want to add here.

11:00

The Chair: Any comment to that, Mike or Brent?

Mr. Higgins: Mr. Chair, I would only comment, I think, that the vein or the spirit of what you're suggesting in your observations is absolutely aligned with where the health authorities are at. I think that we have a track record of working effectively with police authorities to ensure that the appropriate balance is struck between their needs to protect the public's safety in the instance of situations like we've heard about versus the obligation on the part of health authorities to protect the privacy of patient information. In our submission health authorities are suggesting that we are very motivated to work co-operatively with police authorities to resolve these matters.

The Chair: Thank you.

Dr. Pannu, followed by Ms Blakeman.

Dr. Pannu: Thank you, Mr. Chairman. I want to start by thanking the health boards of Alberta for their brief, for their presentation here this morning. I'm quite impressed with the argument that the health boards make with respect to the expansion of the scope of it, et alia, to include all primary health care providers, regardless of whether they are private or public. That's I think an important point that's made in the brief, and I welcome that input on behalf of the health boards of Alberta.

I also want to thank the health boards for doing due diligence on the supplementary submission that you made to the select committee September 9.

Mr. Chairman, I just want to draw attention to the fact that I had requested information in our meeting of August 24 from the Solicitor General's department with respect to whether they have any data which would substantiate or corroborate some of the concerns that were expressed by the two police associations, the Edmonton police association and the Calgary police association, when they appeared before us. We don't have that information available at this time.

I'm grateful to the boards for drawing our attention to a recent assessment that has been done by the boards to assess the nature of the interaction between law enforcement bodies, such as police services, and the hospital authorities and the regional health authorities. If the information in this supplementary submission is correct – and I have no reason to question it – the assessment that's available to the health regions shows that there isn't a substantial problem.

In my questions to the Edmonton Police Service spokesperson here on August 24, again I tried to draw out information which would persuade me and the committee that there is, in fact, a substantial problem there in that regard. Six or seven cases were presented to us in written form, only two of which occurred over the last three years, the years during which HIA has been in place. The other four or five had occurred prior to HIA.

So the point is that HIA implementation has, in my judgment, not exacerbated whatever problems the police – and the police do face challenges. Doing investigative work is not easy. It's an obligation of the police to do that work, and they try to do the best that they can. The issue before the committee is whether or not HIA makes their work more difficult than has normally been the case. That evidence certainly was not available to me, was not presented in a persuasive form by the Edmonton Police Service.

The Calgary Police Service in an oral presentation drew attention to several cases that have occurred over the last three years, during the time the HIA has been in place, but what we need to do in order to assess the validity of that evidence is to go back and look at a comparable number of years prior to the HIA and see whether or not the problems that the police had when HIA was not there were any less serious during that time. Unless we have that information, we'll be simply allowing ourselves to be guided by hearsay evidence.

I think these are serious matters of civil rights, rights enshrined in law which protect our privacy, and hospitals and regional health authorities have fiduciary obligations. They have to respect the safety, the rights, the health of the people who walk through the door. They're not legally free to simply share the information that they have with anybody.

The Chair: Your question.

Dr. Pannu: Unless we are persuaded, Mr. Chairman, that HIA has caused special problems, unique problems, for the police services, I think the position that is taken by the health boards is a strong one, is a good one, and I certainly welcome this submission.

The Chair: All right. Do you have any response to that, Mr. Higgins or Mr. Windwick?

Mr. Higgins: I don't know that I can add anything to it except to reiterate that health boards of Alberta believe the current legislative regime is adequate and that we're prepared to work co-operatively with police authorities to resolve any procedural problems.

The Chair: Thank you.

Ms Blakeman.

Ms Blakeman: Thank you. We keep revisiting this same issue, and what's occurring to me is that we're not dealing with the problem. I'm wondering if, in the opinion of the health boards of Alberta, it would be helpful, if it would provide clarity to have legislation developed which directed front-line staff to contact the police when they see something that is obviously connected to criminal activity.

For example, we have recent legislation in Ontario. I'm not going to get the name right, but it's something about gunshot reporting legislation, in which it clearly directs front-line staff that if someone comes into the hospital, as Mr. Lukaszuk mentioned in a circumstance he just brought up this morning, with a gunshot wound and it isn't hunting season – he's not in there in his camouflage, and his rifle is not sitting in his truck – then the front-line staff would go: hmm, time to call the police.

Would it not be more helpful if we dealt directly with the problem, which is the staff's inability to contact the police when they see something that they believe is clearly connected to criminal activity? Would that be helpful?

Mr. Higgins: I can only surmise, based on my understanding of the principles, that the health authorities have based their submission on that.

First of all, I think they would be concerned about placing front-line staff in an ambiguous situation, the principle there. So to the extent that an intervention could clarify that, that's fine. My question in response would be: in legislating specific instances or circumstances, it leaves open to question whether or not a circumstance that presents in the emergency department, for instance, in fact falls into those guidelines. So it does open the door for staff interpretation.

The other thing is: how many of these circumstances can be legitimately identified proactively in a legislative framework? What about those instances that fall outside of the prescribed sets of circumstances that may be alluded to in legislation such as you're contemplating?

11:10

The Chair: A question on this point, Ms Blakeman, or a statement?

Ms Blakeman: A supplemental. I think there are three circumstances – gunshots, knifings, and severe beatings – where I think you'd be hard-pressed to come up with a household, domestic reason why any of those three would appear in your emergency wards, so I think legislation can be developed that's fairly specific. I'm hearing that if it's specific enough and it doesn't put the front-line worker in a position of having to determine a number of factors here, it would be helpful to you to have that.

Mr. Higgins: Yeah, and one of our principal concerns is that front-line staff not be placed in an ambiguous situation where they're having to express judgment on matters which they're not qualified to express judgment on.

The Chair: Thank you.

Mr. MacDonald, did you have a question for the committee?

Mr. MacDonald: Thank you, Mr. Chairman. I would like to express my gratitude for your time this morning. My questions are centred around section 64 and section 66 of the act.

In your remarks you were talking about contractors that provide health services. We all know that this government is intent on increasing the use of private, for-profit operators in the delivery of our health care system. When each health board or regional health authority has a contract, are there separate privacy impact assessments or is there one privacy impact assessment that's given to the commissioner and then the commissioner okays that and the contracting out can proceed? That's my first question.

My second question is: how many agreements are there now to work with information managers? We have the power in section 66 to enter into these agreements, to work with an information manager. How many agreements currently are in force in Alberta?

Mr. Windwick: Subject to what Mike has to say, I'm not sure that we have the answer to either of those questions. People who are here from the Privacy Commissioner can probably address the PIA question. My inclination is that there's probably one PIA that would deal with both the custodian and whoever the custodian contracts with.

As for the number of agreements with information managers, that's not information that I'm aware of. Are you, Mike?

Mr. Higgins: No. I'm sorry. I don't have that specific information at hand.

Mr. MacDonald: A supplementary.

The Chair: On this point, Mr. MacDonald? We are rapidly running out of time on this.

Mr. MacDonald: Yes. Certainly, Mr. Chairman, the definition of custodian in the act is quite broad, a very wide-ranging definition, but if you could provide that information in writing, not only to me but to all members of the committee through the clerk, I would be very grateful.

The Chair: So noted.

Dr. Pannu, did you have a brief question? Not a statement but a question.

Dr. Pannu: This is a different question.

The Chair: Okay.

Dr. Pannu: The question relates to the implied consent issue. In your brief you have serious objections to going down that route. You also draw attention to the fact that therefore you see a problem in the harmonization between HIA and PIPEDA. Would you like to elaborate on that, why it is that the implied consent model is inappropriate, and is that the reason why you find PIPEDA and HIA, as it currently exists, at opposite ends of the issue?

Mr. Windwick: I think it's a legitimate issue that by maintaining the existing consent model expressed with exceptions in HIA, there may be a problem with harmonization or substantial similarity with PIPEDA, and that's not really addressed here. I think we acknowledge that.

The practical issue for health regions, as we've been speaking about today, is one of certainty for front-line workers on how you deal with these consent issues. It's the consensus view of the health regions that the best way to give that kind of clarity and consistency to front-line workers is to have a rule with very specific exceptions and to say to them that unless the situation fits within one of these specific exceptions, you've got to follow the rule, and the rule is the express consent rule.

I think the concern is similar to the concern that's been expressed here with respect to disclosure to law enforcement agencies, that the more ambiguous or the more judgment involved – you know, when is express consent needed? When is implied consent enough? – the more difficult practically it is for providers to use the act. So that's really the basis of the submission.

The Chair: Thank you very much, Mr. Windwick and Mr. Higgins, for appearing before the committee. We appreciate the information you have provided for us and the clarity you've provided. So thank you, on behalf of the committee, again for your efforts to enlighten us on this important subject.

To the committee, we will now take a brief break and reconvene in five minutes with IMS for a couple more questions and comments from them on the pan-Canadian work. Okay? So adjourned for five.

[The committee adjourned from 11:16 a.m. to 11:23 a.m.]

The Chair: I would ask that the committee reconvene. We are pleased to have IMS back again. We have approximately 30 or 35 minutes left until lunch. I have at least two speakers on the list from the earlier presentation this morning who have additional questions for IMS. We also have an offer from IMS to talk about the framework, which I think would be an interesting perspective for us to hear, so I want to save some time for that. I think that 15, 20 minutes would be the minimum.

So I would just ask the committee members who have questions to give us questions, not statements, and brevity from all concerned, and we can probably get as much information as possible. I'm going to start with Ms Blakeman. I think she was on the list earlier, before we even got through the last round. So Ms Blakeman, followed by Ms Kryczka.

Ms Blakeman: Thank you. Can I just confirm that we do have the staff seeking the original discussions around health services providers and the reasoning that went on behind why the committee made that recommendation? Ms Kryczka brought it up earlier, and I just want to make sure that staff are in fact pursuing that on behalf of the committee.

Ms Miller: Just to clarify, I think there were three things that we were being asked to follow up on: the reasoning behind the current drafting of the legislation in terms of health provider information and the rationale for its protection. The second item was the need to get the tax form and specifically the piece around the health provider information that the tax form requires. The third point was a hospital admitting form. We can get some samples of them, but clearly they vary considerably, depending on which hospital and which region you're working with.

Ms Blakeman: Okay. You got it. Great. Thank you.

So my question to these fine people from IMS. You've put a lot – a lot – of effort, a lot of time, a lot of energy into your submission. It is by far the largest submission we have. It's an inch thick; it's got to be seven pounds. You've brought people out from eastern Canada to talk to us today. [interjection] Yeah, pound for pound, boy, you've got it. You really are trying to tell us something, and I'm not getting what you're trying to tell me.

You don't want the other 11 out of the health services provider information, section 1(1)(o). With my earlier question you didn't particularly want the other information when I asked you what specifically you wanted changed or allowed to be given to you under the – and I've got quotation marks here – "other information." You didn't have anything specifically.

So for all of the weight and depth and breadth and personal appearance of what you're trying to tell, what do you want and why? What information about health service providers does IMS want that they obviously are not getting now? What information do you want and why?

Mr. Carter: Information about the prescriptions that physicians prescribe is the other information specifically.

There are a huge number of reasons for the why, but essentially what we do is we monitor the prescription drug market, and then we report on what's happening so that those that need to know what is happening and should be deciding what should be happening can do their job, whether it be from a policy perspective or some other perspective. Short answer.

Ms Blakeman: Okay. Can you expand with some detail about the prescribing information from the doctors, please? What exactly are you looking for? If I have to rewrite this legislation and put something in that says, "Give these people this, this, and this," what is it that you need?

Mr. Carter: I think that really all we're asking is that the definition of other information be narrowed to mean only the data elements that are meant to be protected under the HIA, which would by exclusion mean that it wouldn't include anything else, including information about the drugs they prescribe. So the easiest solution is just simply to narrow down the definition of other information to mean those other data elements that are intended to be protected. Whether they're the right data elements or not, we're not getting into a lengthy discussion about that, and certainly none of those data elements other than the prescriber's name is of any interest for what we do.

Ms Blakeman: Help me. If I'm . . .

The Chair: The committee will have an opportunity to debate this, discuss this issue.

Ms Blakeman: I still don't know what they're looking for. If they want me to change things on their behalf and add something in here to be specific, you've got to tell me what you want, and what I'm getting is what they don't need.

Mr. Jones: No. I've been trying to tell you very clearly, Ms Blakeman, what we want. We want some clarification in the act. There are only 19 categories of information about health services providers that are regulated under the act. Any other information that doesn't fit within those 19 isn't governed by the act. So the language a person speaks, the colour of their hair, whether they're going to give a lecture – I gave some examples, but there is an infinite array of other information about providers that is not caught in the 19 categories that are in the act.

What we want is clarification around how 37(2), particularly (a), works. First of all, the act only regulates, recognizes, deals with 19 categories, nothing else. Of those 19, eight would appear to be permitted to be disclosed to any person for any purpose without consent to the provider and 11 require consent. Section 37(2) says: unless the disclosure of the eight which appear to be unregulated, appear to be permitted without consent "would reveal other information." The commissioner has interpreted "other information" to mean any other information, any information on the list that I gave of examples or any of the other infinite amount.

What we're asking for is that the concept under the act of having 19 categories, eight permitted and 11 restricted – that the "other information" be defined to refer to those other 11. Otherwise, the effect of the commissioner's ruling is: this is the doctors' secrecy act.

11:30

The Chair: Thank you, Mr. Jones. It seems to me that if there are further questions on this subject, maybe an individual could contact a member of your committee and discuss it further.

Ms Kryczka: Well, maybe my questions and the clarifications I'm going to ask for will follow. One of my questions on the two things was: who is IMS? Then I got busy reading your presentation, and I was wondering who funds you. Then I see that, well, you're world-wide and are a principal provider of information, statistical research, and analysis to the health sector, tracking patterns of disease and treatment, health outcomes, and prescriptions for and sales of pharmaceutical products, and that you have assisted governments, et cetera, and pharmaceutical communities. So I would say that you're research focused, and perhaps with this and where you're coming from, I just wonder if there isn't a roadblock for you to fulfill your world-wide mandate. I'm just wondering this.

I also, though, feel that what you're saying is that there are some roadblocks not just to the health system overall but to the role of the pharmacist, the community pharmacist, in the system. I know from presentations we've had to the health standing policy committee that, you know, the expanded role of the pharmacist in the health care system I think is embraced, but there are some complications there too. We're asking them to use their time a little differently, so any additional work that they have to do, paperwork for instance, poses – it's like a lawyer. You know, use of your billing time; your time means so much. Are you concerned about efficiency of the health care system nationally, provincially? Is that where you're coming from here?

I guess I just want a little more information in response to what I've just said. That would give me more information about where you're coming from.

The Chair: Okay. Thank you.
Go ahead.

Mr. Carter: The short answer to your question regarding efficiency of the health system would be yes. And if you use the example of the electronic health record and new integrated models of care, where the pharmacist among other health service providers has a critical role to play, the proper flow of information throughout the system is required in order to make it efficient and work well. In this case, having rules that many would view to be unnecessary around health service provider information actually prohibits that proper flow of information.

Ms Kryczka: Yeah, I could see that. I was just wanting to clarify that.

The Chair: Thank you.
Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. A question for Mr. Jones. The supplemental submission that's before us, which is September 10, I think clarifies exactly what changes you're seeking in the act. If the amendments that you are proposing here were to be given serious consideration by the committee, would that address the primary concern that you have brought to us today?

Mr. Jones: Yes, it would.

Dr. Pannu: That, now, is the clear definition of "other information" and that "other information" be defined to refer to those 11 of the 19 items that cannot be disclosed without consent.

Mr. Jones: Yes.

Dr. Pannu: Okay. That's one I just wanted to seek clarification on. Thank you.

The Chair: Thank you very much.

Dr. Pannu: My second question, related to it, is the IMS – I think Ms Kryczka asked that kind of question – which is a private organization. It collects this information, I presume, and then it provides it at a cost, for a price. Does it sell it to users, be they governments, research organizations, pharmaceutical companies, or others?

Mr. Carter: Yes. That's correct.

Dr. Pannu: And since the organization represents private interests in that sense – I think it would be fair to say that it does – to what extent would the changes that you are seeking in the act put public interest against the private interests that the IMS certainly is rightfully pursuing?

Mr. Jones: I don't think that it would. I think that the problem that particularly manifests itself in IMS's interest manifests itself across the whole system. You will hear later today from the College of Pharmacists, and they will tell you that it's causing them exactly the

same problem. You heard from the Pharmacists Association in August about the same thing.

The issue, I think, isn't so much: is IMS a private organization? Rather, it is: is there any reason why the information should be kept secret in any event, regardless of who is the recipient? Section 37(2) says that you may disclose those eight to "any person for any purpose."

The Chair: Okay. Thank you.

Dr. Pannu: Just half a second – half a minute, I mean. The reason I raised this question – I think we are trying to go on record on this as a committee. I read a review in the *Globe and Mail Review of Books* over the weekend, a book towards the end of that little flyer in the *Globe and Mail*. There's a scathing critique by highly respected medical doctors in the U.S. of the pharmaceutical manufacturing companies and how they exploit the patent law in order to not only market drugs that have been discovered, have been on the books for many years under new names but also to mislead physicians on this and influence them. So I wondered if IMS works in concert with pharmaceutical manufacturers in some way which might assist them in doing this work that's been criticized so harshly in this book.

Mr. Jones: I read that as well; I was interested in that. I think, Dr. Pannu, you have to distinguish the use of the information from the disclosure of it. Section 37(2) deals with disclosure, and we could spend some time talking about how IMS does disclose and whom it discloses it to and how it's used and so on, but that is a different issue from disclosure by a custodian to a noncustodian.

Secondly, the disclosure of that information and the use of that information is much faster than to IMS. You know, if that's the issue that one wants to target, then one ought to target that. The *Globe and Mail* article really is for the federal government to deal with because it's licensing and patenting of drugs.

The Chair: Let's move on. Thank you.

Mr. Lukaszuk.

Mr. Lukaszuk: Mr. Chairman, I'll withdraw my question.

The Chair: Thank you.

Mr. MacDonald.

Mr. MacDonald: Yes. I have a question, please. How many competitors are there in your field in this country or in North America that are also collecting this information? Or do you have a monopoly?

Ms Fineberg: In Canada we're probably the prime supplier and collector of this type of information. There are a number of smaller companies in Canada, but they don't have the capacity that we have. Certainly, in the United States and in the European countries in which we operate and in Latin America, we do have several other competitors. But one of the things that we're able to do because we operate on a global basis, a world-wide basis is to basically illustrate comparisons between drug utilization not only between Alberta and the rest of Canada, for example, but Canada and around the world. So when you're talking about looking at things that we speak to in our brief such as patient safety and cost containment and health system reform, we can provide a snapshot of what's happening in different jurisdictions to figure out who may be doing it better, who's doing it worse, what we can learn from them.

Mr. MacDonald: Thanks.

11:40

The Chair: Thank you very much.

Ms Fineberg and Ms Drinkwalter, I don't know which one of you, or both, is going to enlighten us on the pan-Canadian framework.

Ms Drinkwalter: Ms Fineberg is going to enlighten us.

The Chair: All right. We have about 20 minutes left. I realize that's a short time for a very important subject, but could you give us your perspective on that for the benefit of the committee, please?

Ms Fineberg: Thank you. I'll come to this from the perspective of a stakeholder who has been involved in the consultations on the pan-Canadian draft framework on health information.

Before I get into a little more detail, let me say that IMS has effectively sat at the stakeholder table in many contexts around the country in the development of either health information legislation or privacy legislation more generally. You've heard folks speak to the health information protection acts: HIPA in Alberta, HIP in B.C. You've heard folks speak to PIPEDA, the federal government legislation. We've been around all those tables and sort of have a sense of what's been happening and the trends in the area over the past few years.

You've also heard individuals who have either written submissions or appeared before the committee make reference to concerns they have about harmonization. Mr. Higgins mentioned that in his brief for the health boards as the previous presenter here. That highlights what from our perspective the framework is all about, this need for harmonization across the country. It's really fair to say that – I'm not even sure that a patchwork is the best way to describe it; I think alphabet soup might be a better term. You've got federal laws, you've got provincial laws, you've got health information laws, you've got business-oriented laws, you've got codes of ethics for your health practitioners, you've got hospital bylaws, and you've got guidelines, so it's very, very difficult.

There are two pieces to that pie. Not only is it difficult for custodians or trustees, like your boards or your hospitals or your doctors, to know what rules to follow in any one context, but as a patient wearing your patient hat with the rules respecting your information, because those rules are going to impact on your treatment and health – and we'll talk a bit about that – you want to know that there is symmetry between and among those rules across the country. So I think it's important to look at what the drivers are for this framework and to put on our little patient hat and think: okay; how is this going to benefit us at the end of the day?

You've heard Catarina speak to things like the impetus between the electronic health record and what that's going to do across the country and how that's going to improve health care and everything like that, but there are other drivers. If you look at the consultation document for the framework – at least the one that we got, because we're in Ontario and the ministry of health in Ontario sent it to us – it spoke to a number of other initiatives that are happening at a federal level and on a provincial level. All of these initiatives in addition to the electronic health record require information and similar rules across the country.

For example, the framework document in the background speaks to things like renewal: health information renewal, health services renewal. It speaks to examples like the example we referred to in our brief, the Canadian health protection act, and that is the manufacturers' responsibilities as it relates to health; for example, pharmaceutical manufacturers' responsibilities for the safety of their drug all

through the system, not just before the approval but postmarketing surveillance and testing it as people take it over time.

The point is that those initiatives have to happen on a national basis. So if I'm in Alberta and I say, "Well, this is a very good thing," we want to be able to track drug interactions. We want to know, for example, what the reporting rates are here in Alberta as compared to Nova Scotia or Newfoundland. You've got to have the same information available across the board. So that's, again, another driver for the framework.

The framework basically says to stakeholders: help us identify what they call the core provisions are to be. Those are the provisions where they have to be the same and mean the same thing across the country. Then we've got what are called ancillary provisions. These are things that aren't necessary for the EHR to work across the country, not necessary for these health renewal projects to work across the country, but it may be that the provinces may want to do something in these areas, you know, where their health system is particularly unique.

One thing, I think, that's very interesting – and this is a link that I see as a stakeholder involved in the process between the framework and the issues that you're considering in the HIA review – is the issue, for example, of provider information. The framework makes it quite clear – recall that it's only in draft form at the moment for consultation – that what we are talking about in the pan-Canadian context is making sure that the rules with respect to patient information are the ones that accord across the board.

So they are not going to regulate nor do they suggest regulating anything to do with provider information, because they've made an assessment with respect to looking at the EHR, the legislative renewal on health systems reform. They've looked at, I'm sure, in the context of the Mazankowski health system review out here and, you know, Romanow and all the other litany of them that speak to accountability and transparency – I think that at the federal level when they drafted the document, there's a recognition that we need information across the country, that all provinces need the same kinds of information across the country in order that we can get these things working.

So at this stage it's stakeholder consultation in the various provinces and federally, and then my understanding processwise is that there will be a report back, as Catarina mentioned, to the deputies in December of this year whether or not the framework as we draft it in response to the consultations will be accepted or rejected. I think that from then on we have a very complicated process because, as she mentioned, the objective in all of this in addition to making sure we have the necessary information harmonized for use across the country to achieve all those good objectives of accountability and transparency that we speak to – part of it is to leave the regulation of personal health information to the provinces.

So PIPEDA, the federal legislation, which has a commercial focus to it, will not intrude, and you'll have the flexibility of rules that are designed for health. But currently, the way the situation is, the federal rules do apply to certain transactions in provincial health systems, including those in Alberta, those dealing with disclosures of health information by physicians in private practice, pharmacists, and private labs. So that's a challenge currently, and that's one of the objectives that the framework harmonization is designed to remedy so that when it comes time for the federal government to review the federal law, much like you're doing here with your HIA provincial law – the federal PIPEDA law comes up for review in '06-07 – the provinces want to be able to say to Industry Canada, who is responsible for the federal law, that the provinces do have their act together and they do have legislation that meets the substantially similar test to PIPEDA.

11:50

The goal is that the framework core provisions will appear somewhere in provincial law, and the anticipation is that if the provinces have dealt with those core provisions, then the provincial law will meet that substantially similar designation so that it can apply to health information in the province as opposed to what the current situation is and the federal law applying to those situations of pharmacists, physicians, and labs in the province.

Different provinces are conducting their stakeholder consultations differently. I understand there have been some meetings here that Catarina has conducted with stakeholders, and I know that on the federal level and in some provinces they are doing mail-in. I think that from a stakeholder perspective it's important. For IMS and for other groups that operate across the country, I think it's important, but as a health information company we know how important it is to be able to measure.

That's why I was really interested in listening to the discussion earlier and the issues that Dr. Pannu raised with respect to the challenges that the police associations have maintained that they have in getting necessary information from hospitals. The issue was getting evidence to support the claims. What are the reports? What are the situations? Is there a difference after the HIA has come into effect? I think that illustrates much of what we've been saying in our brief, in the framework issues, and that is that you need information to be able to practise evidence-based medicine in this country.

Every report that you look at and all the recommendations for reform suggest that we need information. If you ask, you know, how many surgeries are conducted in this area, in this region or whatever, in a province in this week, many of the provinces don't even know that. You guys may be much better informed in Alberta, but I know that the other day the question was put to the health minister in Ontario, and Minister Smitherman couldn't respond.

So I think that as a starting point to improve the efficacy of the system, to get some controls on costs, deal with all these patient safety issues that are clearly becoming the responsibility of both the federal government and the provincial government, I think the framework is really important. I think it's important to note that, as I said, the scope is patient information, and from that perspective the current Alberta legislation is not in sync.

The Chair: Do we have any questions? Yes, Ms Kryczka.

Ms Kryczka: Yeah. Well, thank you very much for that information because it's really been in a nutshell, and it helps me – I'll speak for myself only here – to understand more what PIPEDA's goals are and what our task is within PIPEDA.

On the last sentence you said, I totally agreed with you, but I just made some notes. For IMS your goal, I guess, and PIPEDA's is to improve the efficiency of the system. You said something else and then to get some controls on costs and something about the transparency of information.

Ms Fineberg: Well, I think that basically if you look at the recommendations that have come out of all the health system reviews, Mazankowski and Romanow and everything, they all identify the fact that the health system is lacking in information, and information is necessary to achieve some of those objectives.

With respect to cost containment, we don't know what drugs work to keep people out of hospital more effectively than other drugs. Efficacy, efficiency in the system, patient safety: there are a lot of health system initiatives that we're talking about that need information, and I think that's really the point. The point is that if you have a legislative system that potentially covers up that information – you

know, the suggestion, as we've made here in Alberta, of the challenges dealing with health services provider information – you're not going to get there.

Ms Kryczka: I totally agree with what you're saying. I hate to say that in Alberta we don't have the same incentive to correct these problems: well, we'll just, you know, put more money into the system. If we were in a different financial scenario, I think we might be more motivated. Just a comment.

The Chair: Thank you.
Mr. Broda.

Mr. Broda: Thank you, Chair. Thank you for your presentation. Not all provinces have the Health Information Act in place; correct?

Ms Fineberg: That's correct.

Mr. Broda: Now, I know that provinces have the jurisdiction, but when we look at the pan-Canadian, when we look at the federal one, what's your perception? Do you see that Health Canada is going to come up with an act that will tie all of these and use the good parts of all of the legislation that's coming through provinces, or are they going to say: "Here is ours. Now you adapt to it"?

Ms Fineberg: No. The objective of the framework project is not for there to be new federal legislation that the federal government will develop. The objective, as I understand it, is that these common core principles be developed that the provinces across the country can accept. Then it will be the responsibility of the provinces in their own legislation, if they have no legislation, because some don't, to develop legislation that accords with those commonly accepted provisions. They may have to modify or amend their legislation to sync it up with those provisions in the framework, or they may have to do very little. But, ultimately, the objective is to get national consensus on the appropriate core provisions, and then it's the provinces that will bring those into their own legislative House.

The Chair: A supplementary, Mr. Broda.

Mr. Broda: You wanted to comment first, please?

Mr. Jones: If I could. The reason for that is that the federal PIPEDA legislation now currently applies to parts of the health sector, the commercial part, so all of our private office doctors, all private-based pharmacists, all labs, and so on. For it not to apply there, there would have to be substantially similar provincial legislation governing that health sector. HIA, in my view, isn't. The framework might be, and it's the iteration of that framework and that consensus that would then perhaps allow either a federal order saying that the provincial law is substantially similar or perhaps an amendment to PIPEDA. That's going to take a little while in the process, but that's the ultimate goal.

Mr. Broda: A further supplementary question. When we look at other provinces, we're talking about information flowing back and forth. With every province having specific – and we have computers within our own industry that cannot talk to each other. Is that going to tie in? If I want information as to what's happening in Ontario in a specific sector of the health system, if I would like to know what they're doing in comparison to ours, will that information be able to be tied in that way?

Ms Fineberg: Well, I suppose that ultimately in the future it will be. Let's talk about a couple of different things and be clear here. I mean, one of the reasons why across Canada it's important to have the same rules is from the patient perspective. Okay? I'll take an example that I'm sort of familiar with, you know, Ottawa-Hull. You've got two different provinces there, but it is not unusual for individuals to see physicians on both sides of the provincial borders. It's the same thing in Manitoba and Ontario. So you want to make sure that, you know, the rules that apply to your information on both sides work.

12:00

To answer your questions about, I guess, how provinces are doing in their health system, obviously they're not going to disclose patient identifiable data or whatever, but I would imagine, again, that if we had a common set of criteria and standards, then you could compare. At the end of the day, currently Alberta is fortunate in the sense of being able to pour in more money, but Ontario, for example, has to be more efficient. If you look at the core provisions, at least from my perspective, I think there are some things they should fix up, which is why they're consulting, but I think they've got it right. As I said, the core provisions deal with the patient information.

What's kind of interesting, coming back to Alberta, given that they don't deal with health services provider information, it's my view that you can look at our recommendations for either the elimination of the concept or the definition of "other information" and everything, and any of the recommendations that we've made to resolve the health services provider information issue will make you in sync with the framework perspective on the issue.

The Chair: Thank you.
Ms Blakeman.

Ms Blakeman: Thank you very much. At one point toward the end of your presentation you said that Alberta was very out of sync. Now, I take it that part of that – aside from private providers not being covered under our health information, does the most of being out of sync have to do with Alberta being more restrictive of health information?

Ms Fineberg: Are you directing the question to me?

Ms Blakeman: Yes, I am.

Ms Fineberg: I said that you were out of sync. I meant it in the context of providing rules that give privacy rights to health services providers. As Mr. Jones has indicated, you're the only province that does that. We discussed that, I think, earlier and posed questions as to why.

I think it's kind of interesting, if you link up the questions, as to the genesis of that in the legislation. That was obviously a number of years ago, and the world and the health system has certainly changed since then. You look at the framework, you look at health system reform, you look at the trend that we all talk about and speak to, and we want to know what's happening. Mr. Broda said: well, will I be able to see what's happening in another province? You speak to transparency, and you speak to accountability. I guess that from my perspective, if that's the direction you want to go, then I think it would be important for the province to be on the same page with respect to having health services provider information available.

I know we're all hungry, but I'll just finish up.

To answer a question from one of the members earlier that I'm not sure we answered, we've been following the submissions here with

respect to the views of health services providers having their professional practice information available, and I certainly do recall that Barry Cavanaugh from the Pharmacists Association when he was here with Mr. Windwick, who made a previous appearance, stated that from a pharmacist's perspective, that was clearly something they were very supportive of as far as having their information available.

The Chair: Thank you.

Mr. Lougheed: I'd just ask for some clarification, probably from the department people. A comment was made earlier, something about gleaning information about things that happen in different health authorities, for example. Does the minister not have a lot of access to all that information right now? Say there was a study throughout the province and it was found that one region was doing more of one kind of operation than another region, that it was out of sync with the rest of the province. That information is available to the minister right now. He'd know that there are more gallbladder operations in Calgary than in Edmonton, if that were the case. Is that true now?

Ms Miller: That information is available. I think the comment was made that we couldn't tell the minister the number of surgeries that were performed last week. Our data, the currency of it, depends on which data you're talking about, but we certainly have that information historically and can compare regions amongst themselves and across the country. It is historical in nature; it can be up to 18 months before we have the complete year in on particular data such as in-patient data, as a matter of instance. It does depend on which data you're talking about.

Mr. Carter: Just a brief comment. When you're talking about the drug utilization information, for example, the answer is that currently in Alberta, through Alberta Blue Cross for the seniors' drug program and for human resources, they track approximately 50 per cent of the prescriptions that are dispensed in any given year. If you look at the number of people that that represents, it represents about 20 per cent of the population.

So is this information available on drug utilization around the province? The answer to the question is really no, because you're missing 50 per cent of the scripts and 80 per cent of the population which is not currently being tracked by Alberta Health.

The Chair: Thank you.

I have three more questions, so I would ask for brevity. Ms Kryczka.

Ms Kryczka: Well, I guess at the end of the day, at the end of this exercise, assuming we have an approved efficient system with transparency information – you know, I've talked to a few people about this committee work that I'm doing now. Where I catch their attention – and I hope I'm not misleading them when I'm saying: if you were to be injured or become sick in another province in Canada, there will be better access to information on your health records, et cetera.

What is the benefit to the average citizen? There are obviously these other reasons why we're doing this.

Ms Fineberg: If you're asking in the context, for example, of an electronic health record, the arguments are that it keeps much better track of the tests that you've had. One of the challenges is that folks at least report that they're constantly being sent to have the same tests repeated over and over again. There is also the challenge, when you go to a new physician, of making sure that all the records and information get over there on a timely basis.

I was having some tests in a hospital, and it took my family physician weeks to get them, and then they were sent by fax.

Ms Kryczka: But this is within the province of Ontario.

Ms Fineberg: This is merely within one province.

Ms Kryczka: We're a very mobile population.

Ms Fineberg: Yes.

Ms Kryczka: On vacation or if we go live somewhere else, is that going to improve the situation also?

Ms Fineberg: That's the objective.

Ms Kryczka: I'm just asking on behalf of the citizens.

Ms Fineberg: That's the objective. You know, people who unfortunately have spent time in the health system, whether it's within a province or travelling around, have indicated that there are many things that can be done with respect to having their information available sooner to make it easier for them.

I think the other thing that we will see that much of this is designed to deal with is choices about physicians and health care providers. If you look at what's happening now, it's extremely difficult as a regular citizen, as a patient, to find out whether or not your physician is one who likes to treat a certain illness by prescriptions as opposed to surgeries. That's the kind of thing that as a patient I would like to know. If I, unfortunately, have to go to an oncologist, I want to know what his or her approach to treatment is, and that information currently for Canadian patients, unlike patients in other jurisdictions around the world, is very difficult to come by.

12:10

I think that we're certainly all aware of the waiting-time initiatives. I mean, you can't open your paper these days without hearing somebody, whether it's provincial or federal, talk about waiting times and wait list registries. I notice that you've got the wait list registry here in Alberta up on the Alberta Health and Wellness site, but as we indicated, the structure of that registry we would suggest is perhaps a bit uncertain, based on the provisions of the Health Information Act dealing with health services provider information.

The Chair: Thank you.

Mr. Lukaszuk: I will be brief; I promise. I hate to stand between you, Mr. Chairman, and lunch.

You have indicated that the only accurate information on drug utilization that the minister in this province currently has is that of those who purchase drugs through one of our approved plans, so mainly those would be the holders of the medical services card, those being seniors and low-income Albertans, AISH recipients, Alberta Works recipients, individuals who are in one way or another holders of that card. I think it would be reasonable to assume that their pattern of drug utilization may not be reflective of that of the general population by virtue of being seniors and being on AISH, for example. Now, my question to you then is: am I correct in assuming that the picture that the minister is getting is far away from what the actual picture of drug utilization in this province is? Hence, he is basing many of his decisions on flawed information, incomplete information.

Then my supplemental is to Alberta Health. Would it not then be in your best interests to obtain information that is much more objective and much more reflective of what the actual picture out there is so that you can arrive at proper policies of drug utilization and health care efficacy?

The Chair: Who wants to take that one?

Mr. Carter: I'll answer the first part of the question. The answer is: yes, they're dealing with only partial information. It's very difficult from a drug policy perspective, if you have responsibility for establishing policy for drugs in the province, when you only have information regarding a portion of the utilization. It makes it very difficult.

Mr. Jones: I'd answer the second part by pointing out that with the private plans that Blue Cross administers, the minister can't legally get information from those because they breach section 37.

Mr. Lukaszuk: Does Alberta Health have a comment on this?

Ms Miller: Yes, we do. The answer provided by IMS is in part correct currently. However, as you know, PIN, which is the pharmaceutical information network, is a big cornerstone of our EHR initiative in Alberta, and once PIN as part of EHR becomes implemented across the province, that will include all prescriptions and dispensing information. But as it currently states, it's true that Alberta Health has incomplete drug information.

The Chair: Thank you.

I'm going to allow one final, brief question.

Dr. Pannu: Mr. Chairman, I'll strive to be brief.

The Chair: Thank you.

Dr. Pannu: The observation has been made – I think David Jones made it first, then reiterated by Ms Fineberg – that the Health Information Act of Alberta is unique among the provinces in providing legislative protection for health services provider information. No other province has this kind of provision, if I understand it. Now, my question is to the resource people here. As I recall the debate on this act, I think the act referred to the Information and Privacy Commissioner of the time, Bob Clark, who made a very lengthy report on this act. I think that that review by Bob Clark provides the rationale for including health services provider information into our act. My request is the following: could you dig up that information and make it available to the committee? I can't recall the exact reasons given, but there was an extensive set of reasons given by the then Information and Privacy Commissioner in favour of the inclusion of this section.

The Chair: That's a yes; right?

Ms Miller: Yes. It definitely is a yes.

The Chair: All right. Thank you very much.

Mr. Jones: Could I just ask? I presume that means on the public record. We've searched the public record and cannot find anything. There may be some private things. So the source of any information, whether public or private, would be very helpful to be identified, from our point of view.

The Chair: Sure. Okay. All right.

Ms Drinkwalter, Ms Fineberg, Mr. Jones, Mr. Carter on behalf of IMS, thank you very much. I know you've made extensive efforts to be here today, coming from as far away as Toronto. We appreciate your perspective and the information you've provided for us. Please, on behalf of the committee, accept our sincere gratitude and thanks for the presentation and the information you have given to us. Thank you very much.

Committee, we are adjourned until 1:10.

[The committee adjourned from 12:16 p.m. to 1:15 p.m.]

The Chair: Okay. We will call the committee to order.

Mr. Snelgrove: At 1:17?

The Chair: I'm sorry, Mr. Snelgrove. My watch says 1:15, actually.

Mr. Snelgrove: That's south time.

The Chair: Well, of course, it's southern Alberta time.

Ms Kryczka: Mine says 1:14, Chair.

The Chair: I'm okay with yours, then.

Well, thanks to the committee for being here so promptly and for calling the chairman to account. I appreciate that very much.

We are certainly pleased to welcome this afternoon Ms Glenda Yeates and Ms Joan Roch for the Canadian Institute for Health Information. I'm pleased that they would come and present to us this afternoon. I'm going to ask the committee members to introduce themselves for your benefit, and then we will allow you to proceed with your presentation.

[The following members introduced themselves: Ms Blakeman, Mr. Broda, Mr. Jacobs, Ms Kryczka, Mr. Lougheed, Mr. Lukaszuk, Mr. MacDonald, and Mr. Snelgrove]

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Ms Sorensen: Rhonda Sorensen, communications co-ordinator with the Clerk's office.

[The following departmental support staff introduced themselves: Ms Gallant, Ms Robillard, and Ms Swanson]

The Chair: Thank you very much.

Ladies, proceed.

Ms Yeates: Thank you very much, Mr. Chairman. As the relatively new, I have to say, president and chief executive officer of the Canadian Institute for Health Information, I want to thank your committee for the opportunity to appear before you today. Also, I have to say that as someone who was born and raised in Lethbridge – I don't know if that was on south time or not – it's always a pleasure to be invited back to my home province of Alberta.

With me today is Joan Roch, who is CIHI's long-serving chief privacy officer. Joan has a long history of focusing on privacy issues within the context of CIHI.

Today my intention is to begin with a brief description of the Canadian Institute for Health Information, which I will more than

likely shorten to CIHI more often than not because it's too many words otherwise, followed by some comments that are related specifically to the legislation that you're considering here, the Health Information Act.

Before I get to our specific recommendations – and I'm going to focus on two of the specific recommendations from the written proposal that we submitted to the committee – obviously, we'll be pleased to entertain questions about any of the points raised in our brief.

I thought it might be useful if I provided some background information on the Canadian Institute for Health Information. We are an independent, nonprofit, pan-Canadian company. We're governed by a strong, active 16-member board of directors. These members are nongovernment and government representatives, so a combination of some government deputy ministers and health administrators from across the country. For example, in the Alberta context Sheila Weatherill, the president and CEO of Capital health, is one of two members that represent the prairie region, and in the past I understand that Mary Gibson, the associate deputy of Alberta Health, has been on our board as well.

CIHI is 10 years old; we just celebrated our 10th anniversary. It was created by Canada's health ministers, who were interested in having a much better source of quality and reliable health data, and more and more we have found over the course of those 10 years that not only health ministries but health providers, regional health authorities, and members of the public are looking for reliable, timely information that they can trust.

We provide Canadians with what we think are essential statistics and analysis about both health issues and health care issues. Maybe some examples that would be of interest to you. The Alberta Health Quality Council 2003 report used CIHI information to examine survival rates following heart attacks. They also used CIHI information to look at per capita expenditures on health care. The Alberta Heart Institute, when they were planning the demand for cardiac rehabilitation services, used CIHI data.

So we're involved in a broad spectrum of health information. We co-ordinate and develop it on a national level looking at national health information standards so that when someone is comparing, whether it's a C-section or post-stroke survival rate in one jurisdiction to another, you can actually be confident that those things are measuring a similar event and that that is comparable information.

We develop and manage a large number of health databases and registries. We support the development of health indicators. Of all the myriad of health data out there what is it that's important? What are those kinds of indicators that, actually, we should keep an eye on and watch in the context of the health care system? We conduct some health system utilization studies and outcome studies, and we also support analysis that is conducted by other researchers.

I might just illustrate with a few concrete examples the kind of information we would have. Our largest data holding is called the discharge abstract database, or as I've learned in the number of weeks, it's internally called the DAD. This is a very large database from all hospitals across the country. It includes a coded summary of a person's stay in hospital: why they were admitted to hospital, what is the diagnosis code, what were the events that occurred there, what tests, what procedures, what surgeries, and what was the length of the hospital stay. So this data, when we look at it for quality, feed it back to hospitals, provides them with comparable reports so they can understand how their situation compares to similar-sized hospitals, for example. Is their length of stay, is their rate of admission for certain procedures similar to what you would find in comparable Canadian hospitals?

A specific example that is, perhaps, timely of some of the work that uses the discharge abstract database, we released last week a report, Giving Birth in Canada. Using data from this, we were able to focus on five indicators: C-sections, use of forceps deliveries, epidurals, episiotomies, postnatal admissions, and provide at a regional level, regions of 75,000 population, a sense of how they are doing on those procedures relative to others. So that kind of report, we think, is quite critical for assisting providers at the local level and decision-makers both in operating and planning health services.

A second kind of registry we operate is the Canadian organ replacement registry. This is the database that looks at trends in renal dialysis and organ transplantation, including patient survival rates. We run a national trauma registry, which looks at causes of hospitalization for trauma and which is used to help not only plan trauma services but also look at injury prevention programs. So, for example, we've done reports in the past on ATV accidents. We've done reports on minor hockey, on playground injuries. We produced a report on Ontario playground injuries admitted to trauma centres. That kind of analysis has given policy-makers a kind of insight into what's actually happening and whether they might target some policy levers in response.

We run the Canadian joint replacement registry. This is the database that has information on hip and knee replacements, looking at joint-replacement patients over time. The notion there is that over time we should get a very good sense of which prostheses, which pieces of equipment last longer than others, which procedures have better outcomes than others.

So that is the kind of studies we do. We do many others. We, I think, tabled with your committee some copies of some of our reports. We have many others here if you are interested.

I guess we would summarize by saying that we certainly work to provide health information that we believe is key for individual consumers – health care providers whether they're physicians, nurses, or others; health care administrators whether they're running a regional health authority or hospital; or funders as in provincial government departments – to give some good information for making decisions.

There are a couple of things that we think are critical to being able to make those kinds of information available and useful. I think one of the keys to our successes is that we've worked well with our stakeholders across the country, understanding what their priority needs are for health information. Information can be costly to collect. It can be costly to maintain. We need to be sure that we're seeking and maintaining the right kinds of information that decision-makers need.

1:25

The second one, and particularly relevant to your committee's work, is addressing the privacy, confidentiality, and security matters. It's fundamental to our business. CIHI, I'm pleased to say, takes privacy and data protection very seriously. We've had a privacy policy in place since 1996, and we have regularly reviewed that policy as the field has evolved to make sure that it is up to date.

We have a variety of privacy protection practices that are in place. For example, we have signed agreements with all of those who supply our data – so those would be individual hospitals in some jurisdictions, regional health authorities in others, and ministries, for example – about how we can use the data and how we can report it and analyze it.

We have high levels of both physical and technical security. They would certainly be above the industry standard. We do routine checks for vulnerabilities in terms of ensuring that both our technical and our physical security is very strong.

We limit access to the data within CIHI. Only a limited number

of analysts who need to work on the data have access to each of the data holdings, and those access rights are regularly reviewed. We have in place tools that even for those analysts who work on the data, we can and do mask specific data elements from analysts.

Our publications are based on controls that minimize the risk of reidentification; cell size, for example. Even if the data is nonidentifiable, if the numbers are too small, we will suppress the result so that there's no risk of identifying someone inadvertently.

We think that in the last 10 years we've worked very hard to earn the trust and respect of those who provide us with the data. We're proud of our work, we're proud of our privacy program, and we're proud that it's considered to be one of the best in the field.

Now, with that context about our organization, I'd like to turn my comments to the Alberta Health Information Act. The committee, as I mentioned, would have received our written submission, but I was intending to just highlight two of the points that I thought were most important to us. The first is an issue of transparency and how it relates to the role of organizations that are like CIHI that have been established basically for the purpose of gathering and analyzing health information.

As you know, we are an information manager under the current Alberta Health Information Act. We have a signed information manager agreement with Alberta Health and Wellness. Now, section 66 of the act defines an information manager as a body that does three things:

(a) processes, stores, retrieves or disposes of health information,
(b) in accordance with the regulations, strips, encodes or otherwise transforms individually identifying health information to create non-identifying health information, and
(c) provides information management or information technology services.

We certainly do all of those three things, but the definition really focuses on the information services role, and in our view it is not particularly transparent as to the breadth of our functions. So it's not that we in some ways don't fit in this category, but we certainly do things that go beyond, we think, what one might expect from that definition.

There's certainly general agreement in terms of the research and analysis role, things like Giving Birth in Canada. Those are very helpful tools, I think, and the research and analysis is part of the specific agreement that we have under the signed bilateral agreement with Alberta Health.

So there's a clear expectation that we will in fact produce the kind of reports, the kind of information for decision-making that we do. But I think what we are finding is that as we do this analysis that supports health system performance, quality, and efficiency, these are some of the functions that under your legislation are also used to describe the roles of custodians.

But we're not here today requesting that we be named custodians under the act. We are well aware that the reason that we are health information managers rather than custodians is that it would be inappropriate for us to be custodians. We cannot comply with all of the obligations of a custodian under the act. We are not able to provide, for example, individuals with access to information about themselves or their record. We're not a primary data collector; we're a secondary collector and get it, in turn, from regional health authorities or ministries.

So it does seem to us in a sense that there is a role in the current system for a middle category between the information manager, which describes in the act potentially, in some people's reading, a more narrow information services role but somewhat less than that of a custodian and that in the interests of openness and transparency it may be useful to recognize this kind of middle ground or middle category in the legislation. This role is performed by organizations such as CIHI that are specifically used or established to collect and use health information for the purposes of analysis and research.

So while we can function under the current arrangements and have been doing so – we have the kinds of agreements, we have good relationships with the privacy office here, with Alberta Health and Wellness – if there were an opportunity for the legislation to be more transparent to the role of organizations such as CIHI in relation to health information, to the source of the authority by which we have that information, we would support that.

We made a similar suggestion to the FPT committee and to the Ontario Legislature during their privacy deliberations, and we note that Ontario has chosen to proceed with this middle category, with this kind of interim, between-the-two designation under their newly enacted Ontario Personal Health Information Protection Act, that we understand is coming into effect in November.

CIHI believes that the amendments recognizing the disclosure of limited personal health information to designated entities such as CIHI would be for specific purposes, would provide the public with greater transparency than the current provisions of the act. So, again, it's not as if we aren't functioning, but we think that a third, a middle category between the two that currently exist might offer greater clarity in terms of the role.

My second and final point is related to the collection and disclosure of health information to patients from another province receiving services in Alberta. As mentioned earlier, we collect the discharged abstract database, a summary of the patient's hospital stay when they are discharged from hospital. That, again, has data such as the reason for admission, the procedures that were performed, the length of stay. One of the services that we provide to jurisdictions is to include the information on behalf of their residents who receive services in other provinces in their discharged abstract database.

If a resident of the Yukon received services from a hospital in British Columbia, CIHI would, with the consent of those two jurisdictions, simply copy the summary information about the Yukon resident from British Columbia's records and also include it back to the report for the Yukon. The process is efficient in terms of the work that the parties have to do. It minimizes the number of times that the data are manipulated and transferred, it reduces the risk of error, and it also reduces the sort of security risk that exists every time data are transferred. So, for example, Alberta would get this kind of service in that you would receive information on Alberta residents who are treated in Lloydminster. That would be part of the information that we would give back to the Alberta ministry.

Currently, however, we do not have the authority to make these disclosures to other jurisdictions on behalf of their residents who received services in Alberta. Instead, what we have to do is create a separate tape of the records, forward it to Alberta Health and Wellness, who then forward the tape to the jurisdiction. So the receiving jurisdiction must then take extra steps to reincorporate the data, essentially, that was missing from the original tape they received from CIHI. A number of the jurisdictions have complained to us about what they consider the inefficiency and the increased risks that they think that situation entails.

Data respecting health services that a jurisdiction's residents receive elsewhere is important for health policy and service planning decisions. You often want to know, if you live in a border community, how many of your residents are seeking service elsewhere, and if we change a pattern of service offerings in a border community, what might the impact be on people seeking services elsewhere?

It's probably particularly true for the smaller jurisdictions such as the territories. The Yukon, the N.W.T., and Nunavut tend to have many of their patients referred south for services, and for planning

purposes they very much would appreciate getting that information back in a timely way.

1:35

So for these reasons, as we mentioned in our submission – and I think it was also mentioned in the government's submission to the committee – it would be helpful to include specific and limited authorization for these disclosures in the revisions to the act to facilitate the important information transfer.

In summary, the value of research into and analysis about the health system we think is very widely recognized. We think CIHI is an important part of that landscape in terms of informing debate on health reform initiatives and to contribute to the quality and the effectiveness of the care that we provide in the system, and we see every intimation that demand for that kind of research and information is just going to increase.

We appreciate very much the balancing of privacy and access, and we commend the balance that is struck in the existing act. We are recommending two very specific changes that we believe may improve, on the one hand, the transparency of the act and, on the other, the efficiency and information flows.

I want to assure you, though, that under any circumstances CIHI will continue to work with Alberta Health and Wellness to serve the health information needs of both Alberta and Canada.

So thank you very much for the opportunity to appear, and I know Joan and I would be happy to take your questions.

The Chair: Thank you very much, Ms Yeates, for a very good presentation, and we do have a question already from Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. On your first point I'm not sure if we would want to change the act just for the sake of the act. Since you're functioning quite well as is, would any changes that you propose allow you to collect more accurate information or information at a lesser cost to the ministers? What net benefit would there be to the Alberta taxpayer or the ministry who seeks the information from you?

Ms Yeates: Well, in the first change that we proposed, it is a transparency concern. The issue simply is: we can continue to get the information now, we believe, but is there a sense that the public will think that somehow we or the province have not been as clear about the fact that we have that information? If that is not clear to the public – and we try to make it very clear where the information comes from – we think that that's in the changing and evolving privacy environment. Being clear with people about what you're doing with the information is a good part of the battle, essentially. So we think Canadians generally support having the information used for research and analysis, but they like to be clear.

On your second point, about cost, I would say that there is an additional cost the system bears from the inefficiency of not being able to transfer the data easily from one jurisdiction to another, although I wouldn't be able to quantify it, and I can't tell you that I think it would be massive.

The Chair: Supplementary, Mr. Lukaszuk.

Mr. Lukaszuk: On your first part of the answer I'm not hearing any concerns from Canadians, particularly Albertans. Are you hearing any concerns relevant to your methodology of collection and perceived lack of transparency in the act?

Ms Yeates: Joan is saying no. I think our concern is always that we want to be straightforward. We have the data. We want to be clear. We think it's a good idea for us to have the data and get it, but we are simply wanting to be clear and not to appear to be hiding anything. So that's the rationale.

Mr. Lukaszuk: Thank you.

Dr. Pannu: A question on the same general issue. You talked about this middle role between information manager on the one hand and custodian on the other. Would it be just specific to CIHI or research organizations that use that data, that have access to the health care?

Ms Yeates: I think there would be CIHI-like organizations that would fall into this category. I know that in Ontario, where they have created this category, they have named, I believe, at this point four organizations. CIHI is one. ICES, the Institute for Clinical Evaluative Sciences, is another. Cancer Care Ontario is a third and the Ontario Joint Replacement Registry. So there are four bodies in Ontario that have been named at this time. They may name others. So my assumption is that there may be in fact other organizations, like organizations, in Alberta. I wouldn't want to speculate as to what those might be, but I think we are not looking for an exclusive category.

Dr. Pannu: Transparency, then, would come from the mere fact that the organizations have been mentioned as recipients.

Ms Yeates: Yes. The legislative authority for giving an organization such as Cancer Care Ontario or CIHI data would be clear. So there would be no individual or organizational qualms about how that was flowing, and the fact that it's part of a legislative framework gives it a certain transparency.

Ms Blakeman: Under the section you did on data matching, can I just clarify that when you are relinking, or data linkage, is it personally identified information that's in there? Do you ever end up at the point where you can identify a name and an ailment? Does that reconnect it?

Ms Yeates: No. When we talk about identifiable – and I'll let Joan add to this – things like a six-digit postal code and a health services number would mean that it qualified as identifiable. We are very cautious even with things like that, that we are considering identifiable. So it's not at the name level.

Ms Blakeman: No. But you could easily get a name. If you had a postal code and a health care number, you'd have it.

Ms Yeates: Well, it's the reason why we don't, for example, link things. We have all of these special rules when there are identifiable data, which is why most of what we do is actually nonidentifiable. Our bilateral agreement requires us to come back to Alberta Health and Wellness for specific permission if we were to do a study on identifiable data, for example, which sometimes, if you're looking at follow-up from a procedure, can be something researchers are interested in looking at. We have to get specific approval for those projects.

Ms Blakeman: Okay. A supplemental. Mr. Lukaszuk asked if you were hearing that Canadians were having a problem. My question is: have you identified, have you experienced any problems so that you feel you need to see these changes? They are presented in a language that indicates that, well, if you're looking for something to

do, this would be an okay thing by us. That's what I'm picking up here, but it doesn't seem to be vital. You're not asking us to change it specifically for a certain reason.

Ms Yeates: I think that's right. Now that we have one jurisdiction, Ontario, that has created this middle category – and we support the creation of that middle category and did so with them – if you then have other jurisdictions that don't have that clarity, will there be an assumption that . . .

Ms Roch: We're hiding something.

Ms Yeates: Yes.

As the situation evolves, we are looking for much consistency across the country. Obviously, we think that eases Canadians' understanding of what might be the case, but we will not be the same. I'll use categories 1, 2, and 3. The names are different, but we are not the same as a category 1 under the Ontario legislation as yours. If someone thinks that we are, then they would say: why would you be giving this kind of data? So it's a consistency argument as one province has now gone ahead with this typology essentially, and when you read the narrowness of the definition in the legislation, you could see in future some confusion arising.

So, again, because you were looking at the act, we felt we would make the point at this time.

Ms Blakeman: Thank you.

The Chair: Mr. MacDonald.

Mr. MacDonald: Yes. Thank you, Mr. Chairman. Earlier you spoke about section 66 in the agreement you have with the department, the Minister of Alberta Health, in regard to your relationship as an information manager. With the agreement that's set up with the department, are there any fees, and if there are, how much are they?

Ms Yeates: We have two agreements, and I'll let Joan speak to this more specifically. We have an information manager agreement under the act, which is about the rules and making sure that we follow the legislation. We also have what's called a bilateral agreement, which is one of the ways CIHI is funded by its parties, and in that agreement there is a core funding plan that Alberta Health pays as do all other jurisdictions who sign up with CIHI. My recollection is that's in the neighbourhood of about $1.1 million. I could get you the figure, but there is a fee that is paid by all jurisdictions who are currently members of CIHI for the services of running actually 22 registries.

1:45

Mr. MacDonald: I would like to reverse this, Mr. Chairman. The government here routinely charges excessive fees to the opposition whenever we apply for information. Is there a fee barrier to you whenever you want access to information from Alberta Health that they may have that may interest you?

Ms Yeates: No.

Mr. MacDonald: No. So there's no fee?

Ms Yeates: No.

Mr. MacDonald: Thanks.

The Chair: Does that make you happy, Mr. MacDonald?

Mr. MacDonald: Uh . . .

The Chair: Never mind.

Mr. Lukaszuk: Let's see if I can squeeze something into the *Hansard* that I can use during the upcoming campaign.

You have named some other . . .

Mr. MacDonald: Point of order, please, Mr. Chairman.

The Chair: We'll deal with it after the question.

Mr. Lukaszuk: You have named some other institutions from Ontario that are like yours that you feel should qualify for that middle category. Would you also allow for-profit bodies that manage and collect health information to fall within that category?

Ms Yeates: I don't think I would speculate. I mean, it would depend on the criteria for the category. I've given you the four designated entities in the Ontario case, and they have a set of criteria. So if you felt that there were other bodies that would be part of that category, that would presumably be part of a political or a public debate here in this province.

Mr. Lukaszuk: Thank you.

The Chair: Mr. MacDonald, you were raising a point of order.

Mr. MacDonald: Yes, Mr. Chairman. Under *Standing Orders of the Legislative Assembly* 23(h), (i), or (j) I would ask the hon. member to withdraw that comment. I'm here as a Member of the Legislative Assembly to review this act. This has nothing to do with anyone's re-election efforts. I think that comment was inappropriate, and I would ask the hon. member to withdraw it, please.

Mr. Lukaszuk: Mr. Chairman, not having the benefit of the Blues, I have clearly stated: let's see if I can squeeze something into the *Hansard* that I can use for the purposes of the upcoming election, without identifying that any other member in this room has done so. But if this member feels culpable of having done so, he may choose to speak to that. I never identified him, nor have I ever made any allusions that he has done so.

The Chair: Any further comments, Mr. MacDonald?

Mr. MacDonald: No, other than that was in my opinion a direct shot at not only myself but other members on this side of the House, and it was totally unnecessary – totally unnecessary. This is an all-party committee, and the hon. member's partisanship should be left at the door.

Thank you.

The Chair: Does anyone else want to speak to this?

I will give it some consideration, Mr. MacDonald.

Let's see. Do we have another speaker? Oh, Mr. Snelgrove. Yes.

Mr. Snelgrove: One of the things that's been brought forward: as the Premiers and the minister are getting into negotiations in Ottawa, they're continually talking about a new kind of reporting structure. When you talk about what you're reporting, I guess you could report

more and more about expenditures or timeliness and stuff like that, but doesn't that kind of fall under what you're doing now?

Like, do you see your role in a more national – I don't want to say more national system because that probably isn't going to happen, but with the reporting structure that you're doing, have they talked to you about increasing it or expanding it or becoming the kind of central data thing? Where do you see this going?

Ms Yeates: Well, I think we see a tremendous appetite at all levels for more information. The health system spends 10 per cent of our economy, and as an industry it is very complicated, and it's not easy to determine when you're doing a good job, when you could be doing a better job.

I think that the demand for increasing data and increasing making sense of the data in terms of developing it into indicators and things that people can really grab hold of will be increasing. I would say that that's true from the RHA level. I think RHAs are very anxious to have data RHA by RHA. How are we doing in Lethbridge versus Red Deer? That's important, as well as: how are we doing in Alberta relative to British Columbia on certain measures? So I think there's an appetite from Canadians to know how we're doing.

Mr. Snelgrove: So do you see your organization as being kind of the lead on this information?

Ms Yeates: Well, if asked. You know, we think we've built a solid reputation of being able to provide, as I say, neutral quality data that informs, whether it's an individual cardiac surgeon trying to understand his or her outcomes in a given region or whether it's an RHA or whether it's a province or whether it's a Canadian citizen. We think we are well positioned to see that expand, and I have to say that it is a company that has grown as provinces and governments have come to us more and more often. We're currently building a drug database, for example, because there is a desire for better data across the country, for understanding what's happening. We are trying to position ourselves to be able to respond to the needs of our clients, essentially, which has been for more and more data. So when I look ahead, I certainly see the demand for increased data to be very strong given the importance of the sector in the economy.

Mr. Snelgrove: Mr. Chairman, if I could go just a little bit further. With an organization of this scale, then, it's still going to be necessary for the provinces to handle information about personal medical history, whereas you're dealing in the broad national picture with information relating to trends or accessibility, stuff like that. We're still going to need to run information access on a provincial level below that.

Ms Yeates: Yes. Whether you're paying physician claims or subsidizing drug claims and supporting that way, paying individual hospitals, there will still be that need for data. But that's the data that essentially feeds up into the system, and when we have standards and can say that we can compare that accurately, we can feed it back then to individual hospitals, to provinces, and make much more of it than they could do on their own.

Mr. Snelgrove: So filtering out personal information, letting broad-scope information go up is kind of where we have to . . .

Ms Yeates: Some of these databases come, in a sense, with individual information. It can't be just that you did, you know, 900 hips in Capital health region last year. You actually have to know in some cases which people got those hips, how they did relative to the other type of procedure. So it isn't enough just to have statistical data. To make the data useful, not in all cases – not when you're dealing with dollars and cents average per capita expenditures, for example – but in some cases you do have to have data that gets down to the individual level so that you can aggregate it and work from there.

The Chair: Thank you.

Ms Kryczka: Well, my comment is probably redundant, and I'm repeating what I think I said earlier today, but I'm really impressed by the number of submissions. I don't know if you went through the list of submissions that came in that have articulated that there is a need out there for health information for analysis and research purposes. I know that you mentioned, I believe, the Alberta Health Quality Council and others. It's just been a very repeated message.

It's just a comment.

The Chair: Thank you.

I would point out to the committee, Ms Yeates and Ms Roch, that there is some information up here. Do you want to comment on what kind of information that is if the committee members want to pick it up?

Ms Yeates: Certainly. Maybe I'll let Joan speak to the floor.

Ms Roch: Sure. We provided you with copies of the annual health care report that Glenda was referring to earlier, and this provides you with a really good synopsis of the kind of comparative analysis that we do on an annual basis.

We've also provided a copy of the latest release. This was just released yesterday. It's Giving Birth in Canada, and as Glenda was saying, there are a number of indicators in here, and there is regional information provided in the document.

We've also provided you with a copy of the flagship report which is put out by the Canadian Population Health Initiative, which, again, is a part of CIHI's organization.

Just to give you a good picture of the privacy program that we do have running at the organization, we've provided you with copies of the privacy principles that we function under and which are referenced in the information manager and bilateral agreements that we have with Alberta Health and Wellness.

Just to give you an overview of the kinds of inventories, data holdings, that we do have, we've provided you with the catalogue.

Thank you.

1:55

The Chair: Those are in the boxes if committee members want them.

Yes, Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. My question is tangential to the review itself, but the CIHI's role is an important one, I think. I've used this information over the years in our debates in the Legislature, and that information, available to all of us – you know, the minister, all of us – does a very good job.

But my question. You are the creation of the health ministers across Canada getting together, making a decision to set up this entity and then fund it. You suggested that $1.1 million, I guess, comes from Alberta. There's a mention . . .

Ms Yeates: I wouldn't want to be absolutely certain of the figure, but that's my recollection from reading the bilateral.

Dr. Pannu: Is there a flat fee that each province pays into your budget? Or how does it work? Where does all of the money come from? It's a big operation, obviously. It needs money.

Ms Yeates: Yes. We have several sources of funding. One of them is through these bilateral arrangements, which vary somewhat from province to province. In Ontario, for example, the fee is sort of hospital by hospital. They are not regionalized, as you know, so there, rather than one lump sum from the ministry, it would be by the hospital.

But it really depends on the volumes of records, so it's based on the data elements that we would collect. There's a calculation done about how big Alberta's share – it's not on a per capita, but it is sort of a per size of the workload basis essentially.

In addition to that, in the last couple of accords or arrangements nationally there have been dollars set aside as part of those to enhance the data. I think there are first ministers referred to in both of the last two documents, the need for additional information. Those were then backed up by substantial investments, called road map 1 and road map 2, from Health Canada.

There's the ongoing core funding that we get, either from hospitals or ministries of health, that is supplemented in some cases by fee for service essentially. If a ministry, a province, wants us to do an extra piece of work on home care data for the province, we generate revenue in that way.

So we do that, but also where there were big gaps in data, there have been some investments as part of those arrangements of first ministers.

The Chair: Thank you very much, Ms Yeates and Ms Roch, for a good presentation. We appreciate very much the time you have taken to come and enlighten us. So on behalf of the committee may I again offer our thanks and gratitude for a job well done. Thank you very much.

We will adjourn for a couple of minutes while we get the Workers' Compensation Board ready to go. Thank you.

[The committee adjourned from 1:58 p.m. to 2:05 p.m.]

The Chair: We will call the committee back to order and welcome the delegation from the Workers' Compensation Board. What I am going to do here since I'm not absolutely positive on names – Mr. Kerr is not here? Guy is not here?

Mr. Mah: That's right.

The Chair: Okay. Anyway, I'll let you three introduce yourselves. I'll ask the committee to introduce themselves, and then we'll let you introduce yourselves and proceed with your presentation.

[The following members introduced themselves: Ms Blakeman, Mr. Broda, Mr. Jacobs, Ms Kryczka, Mr. Lukaszuk, Mr. Lougheed, Dr. Pannu, and Mr. Snelgrove]

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Ms Sorensen: Rhonda Sorensen, communications co-ordinator with the Clerk's office.

[The following departmental support staff introduced themselves: Ms Gallant, Ms Inions, Ms Robillard, and Ms Swanson]

The Chair: Thank you.

Mr. Mah, go ahead. Please introduce your colleagues.

Mr. Mah: Certainly. My name is Doug Mah. I'm the secretary and general counsel of the WCB. This is Susan Morgenstern, the WCB's chief privacy officer, and on my left is Mr. Rene Huellstrung, who represents the WCB's Millard Health centre.

First of all, I'd like to thank you, Mr. Chairman and members of the committee, for inviting us to address you today. Our issue is the inclusion of the WCB under the Health Information Act. The first thing I'd like to do is provide you with a brief background about the WCB generally and also about the information and privacy environment at the WCB.

As most of you know, workers' compensation in Alberta is a mandatory disability insurance program with regard to workplaces, and it compensates injured workers by providing a range of benefits including wage replacement, health care, and vocational rehabilitation. Workers' compensation in Alberta covers more than 100,000 employers and 1 million workers, representing approximately 75 per cent of the workforce.

Workers' compensation is founded on five major principles, the first being that benefits are paid on a no-fault basis; secondly, that those who participate in the system are immune from lawsuits; thirdly, that the liability is collective in that all employers are responsible; fourthly, that the administration of the system is entrusted to a neutral agency; and fifthly, that agency has exclusive jurisdiction, meaning that the courts do not make the decisions but, rather, the WCB.

With regard to accountability, the WCB operates at arm's length from government, but there are a number of accountability mechanisms. Most notably, there is a minister who is responsible for the Workers' Compensation Board. He is legislatively empowered to prescribe and has prescribed performance measures for the WCB. In addition, the WCB must file an annual report, which is tabled in the Legislature, and must hold an annual general meeting which is open to the public.

The Auditor General is the auditor of the WCB, and the Lieutenant Governor in Council appoints the members of the Workers' Compensation Board's board of directors. In addition, as a FOIP organization the WCB is subject to the jurisdiction of the Information and Privacy Commissioner. It is also subject to the jurisdiction of the Ombudsman and the Human Rights and Citizenship Commission.

Now I'd like to give you an idea of the scope of the document and information management at the WCB, and I'll begin by talking about the number of claims that we handle. Using 2003 as an example, the WCB received over 150,000 new claims in that year, of which approximately 40,000 were lost-time claims, meaning that the person who was hurt missed time from work beyond the day of the accident. During the year the WCB administered approximately 223,000 active claims, so those were new claims plus claims that were already in inventory. The WCB would have handled in the area of 1.6 million claim documents, receiving over 230,000 pieces of mail, and issuing over 2 million pieces of mail itself.

The size of claim files varies. In some cases it may only be a handful of documents. Our largest files are over 6,500 pages long, but on average a claim file is about 130 to 150 pages. Of course, many of those documents contain not just personal information but also health information; that is, information about a worker's injuries, his or her health status, health care history, details regarding diagnosis, treatment, and so forth.

In 2003 as part of its regular business the WCB's access to information department completed 19,447 requests for information, which represents 3.3 million pages of disclosed documents to injured workers and employers as well as the Appeals Commission, law

firms, and insurance companies. The access to information department employs 21 full-time staff to produce and collate the documents, and every page is reviewed in order to apply the existing privacy and access legislation. Access to information's primary function is to deal with the production of documents for the appeals system and outside inquiries, but the WCB also has a FOIP office to help it administer that legislation.

In 2003 the FOIP office received 808 inquiries regarding FOIP issues and opened 115 files under the FOIP Act consisting mainly of requests for personal information as well as some correction requests and of course, inevitably, complaints. I think it's fair to say that in general the WCB's FOIP compliance has been good, and it enjoys a relatively good and constructive relationship with the Information and Privacy Commissioner's office.

Now, with regard to the specific environment in terms of access and privacy, the WCB is established by statute, and it draws its obligations regarding access and privacy from three sources: the Workers' Compensation Act, the FOIP Act, and policies created by the WCB's board of directors. Most of the committee members will be familiar with the FOIP Act but may be less familiar with the confidentiality and access provisions of the Workers' Compensation Act and the provisions that allow the WCB to gather information so that it may carry out its adjudicative responsibilities.

Section 36 of the Workers' Compensation Act gives the WCB entitlement to collect information from any person entitled to compensation, including information relative to that person's disability and the compensation that the WCB considers necessary. So the WCB is entitled to receive the information that the WCB considers necessary to discharge its adjudicative responsibilities in respect of an individual.

Section 147 is a key section, and it controls access to WCB documents for the purposes of review and appeal. So persons who go into the review and appeal process are entitled to copies of their information, or if it's not their information, if they are affected somehow by the decision, then they may be entitled to that information as well. In addition, section 147 places a duty of confidentiality on all WCB employees who come in contact with that information such that they are under a legal duty not to disclose it or to use it except in the course of their duties.

Section 34 is a section which allows the WCB to require physicians to make a report to the WCB regarding an injured worker and also to request from a treating hospital or another treating agency information regarding an injured worker. Since the WCB is a FOIP organization, it is fully regulated with regard to collection, use, and disclosure of personal information in the administration of the workers' compensation system.

It would be our position that FOIP together with the provisions of the Workers' Compensation Act do provide for a reasonable flow of personal information to those who are authorized or required to receive it. FOIP and the Workers' Compensation Act, working together, also provide an individual with the ability to access his or her own information in a reasonable manner to request corrections and to ask for a review of any information or privacy decision made by the WCB by the Information and Privacy Commissioner's office.

2:15

Also, the policy that was created by the WCB's board of directors provides that the WCB will protect an individual's privacy and stipulates that personal information may only be used for the purpose for which it was collected. Another part of that policy describes how the WCB may disclose information, and that is to individuals who are directly affected during a review or appeal of a decision. In addition, there are provisions in the policy that allow for disclosure to another Workers' Compensation Board in Canada where that worker's claim is being adjudicated in accordance with the interjurisdictional agreement or where that worker moves to the other jurisdiction.

Now, on page 5 of our submission at paragraph 17 there are enumerated some 10 common principles that underlie both FOIP and the Health Information Act. I do not propose to go over those 10 common principles, but it would be our submission that the existing legislation applicable to the WCB – that is, FOIP and the Workers' Compensation Act – already provide a specific legislative environment that supports all of these principles.

The core of our submission is that there is not a compelling public policy reason, given the existing legislative context, for the WCB to fall under the auspices of the HIA, but there are reasons that would, we suggest, argue against it. The first is that there would be a substantial additional administrative burden. I'm sure you've heard that before, but in our particular case we would be put in a position where in reviewing those 3.3 million pages every year, we would be required to apply two sets of rules, the HIA rules and the FOIP rules. Invariably, this would lead to additional complexity and delay, and ultimately the costs of the system would have to be borne by the employers of the province.

There may be concern expressed about the WCB's rehabilitation facility, the Millard centre. Mr. Huellstrung is here to answer any questions with regard to that, but let me say that Millard Health, as we call it, is not a separate entity. It was established pursuant to section 83 of the Workers' Compensation Act, and it is part of the WCB. So all of its operations, its practices, and its people are subject to the same legal duties and responsibilities and obligations as the rest of the WCB. So, in short, the Millard centre is also subject to FOIP and the Workers' Compensation Act.

I don't propose to say too much more other than to summarize our position by saying that in our view the WCB is already adequately regulated with regard to information and privacy practices. It falls under FOIP and the Workers' Compensation Act, and we have yet to see a compelling public policy reason why the WCB needs to be further covered under the Health Information Act. The three of us are here to respond to any questions that the committee members may have.

Thank you.

The Chair: Thank you very much, Mr. Mah.

I will open it to questions from the committee.

Ms Kryczka: I haven't had much time to really digest all that you're saying except what hit me – just two points. The information is so well protected, and I guess that would be comforting to the individuals. I say "I guess" because I don't want to get into a discussion where I might disagree. I've had constituents in my office over the years. Basically – I just throw this out – would there not be some value for that information to be available? We've listened to submissions regarding access of information for research purpose and analysis purpose for the whole health care system. This is just how it hit me as we went through it.

On page 4 you define personal information. I like definitions, but I notice here that personal information includes "information about a physical or mental disability." I would assume that a mental disability is very sensitive with individuals. It's a question mark.

Mr. Mah: Sure. There are two questions there, and I'll have a stab at both of them, and then Ms Morgenstern may want to supplement what I have to say.

Firstly, with regard to research happily I am also the chair of the WCB's research program, and in compliance with FOIP the WCB has assisted and, in fact, has sponsored academic research in the field of occupational medicine and rehabilitation. So there is access to WCB data on an aggregate basis. Again in compliance with FOIP when researchers do want access to our workers, we have a process whereby the proper consents can be put in place, and the researchers can have access to a population of workers for research purposes.

The second question relates to the question of physical and mental disability, and I guess the acid test for us in making disclosure is whether the information is relevant to the issue at hand. Employers, for example, will take part in the review and appeal system and will take issue with certain aspects of a claim. If the issue of mental disability, for example, is not germane to the issue that's being appealed, that information is not released to the employer. So there is a degree of review and discretion applied to each document.

Susan, did you want to add something?

Ms Morgenstern: The other thing that might make you feel more comfortable with it, I guess, is that when we do obtain psychology reports or psychiatric reports and the employer may ask for a copy of the claim file, what we do is that for purpose of review or appeal we would generally give them the introduction to that report as well as the summary, and then the sort of internal details, if you will, are not disclosed unless there's something in the end. Down the road when they're at the Appeals Commission, for example, if there is something that is, you know, extremely relevant to their position, then they might have access to it, but initially they certainly don't have access to that. We've really had no concern raised by employers in regard to that. They do understand that it is very sensitive, and we try to handle it in that manner.

Ms Kryczka: Good. Thank you.

Ms Blakeman: Thank you very much for coming before us and supplying us with this information. I'm wondering if you could, through the secretary of the committee, provide us with two samples: one, your medical form that would be filled out and, secondly, your general intake form. If I'm missing a regular form that you would regularly fill out in which you are collecting information of any kind from people, could you supply us with a sample of that, please?

Mr. Mah: Certainly.

Ms Blakeman: Secondly, one of your arguments, if I understand it, is that you already come under FOIP and follow all of those regulations to the best of your ability, ever improving of course, and therefore you don't need to fall under health information. My question is a two parter, first directed towards staff here from the office of the Privacy Commissioner. Is not FOIP covering information that is nonhealth information? Was that not the intention of that act when it was set up?

2:25

Ms Inions: Health information is carved out of FOIP, and FOIP initially did not apply to many of the jurisdictions that held health information; for example, information under the Hospitals Act, the Mental Health Act, and that sort of thing. That was carved out of FOIP, so it did not apply to that. Then when the HIA was proclaimed, health information was carved out of the personal information that's covered by FOIP.

Ms Blakeman: Okay. Then we have a situation here where WCB is acknowledging that it enthusiastically participates with all of the regulations required of them under FOIP, but in fact FOIP is not covering the personal health information of individuals. What is the WCB's concern, then, and justification for not protecting the personal health information of the million or so workers who you have now collected personal health information on? Why won't you protect their personal health information? FOIP does not, so health information must.

Ms Morgenstern: Well, actually, the FOIP Act does give a definition of personal information, and it does include health information in the definition of personal information under the FOIP Act.

Ms Inions: Perhaps I'll just expand. The term "health information" is a defined term under HIA, whereas personal information under FOIP includes information about health in the hands of government departments. So it's confusing because the term "health information" is a defined term under HIA and is carved out. That's not to say that the information about health is not also included under FOIP, that applies to government bodies such as WCB. It's confusing because of the legal term of art, if you call it that, the definition of health information under HIA. That doesn't mean that FOIP doesn't apply to the information about health that's held by WCB or in government departments. Then the FOIP rules do apply to that information, which is part of the definition of personal information. One of the categories of personal information under FOIP does include information about health held by government departments.

Ms Blakeman: That didn't help me. It seems to me that there's still a gap in protection here for an individual's personal health information as we have come to know it on this committee and what we're looking at. As I understand it, WCB is saying, "We don't want to be included under this Health Information Act and the requirements thereof; we feel that we're accommodating that under FOIP," which does have a clause about personal health information, but I don't think it's covering everything that I understand would be covered in here.

Mr. Mah: Let me try to take a stab at it.

Ms Blakeman: Okay. Thank you.

Mr Mah: I think it's fair to say that WCB considers all of the personal information in its possession, whether it's someone's address, telephone number, gender or whether it's specific health information such as details of injury, diagnosis, treatment, prognosis, accident history, pre-existing conditions, genetic conditions, what have you, to be personal information protected by FOIP and treats it as such. The rules that apply to a worker's address and telephone number are also the rules that apply to personal health information. To us it's all the same. We apply the same rules. So, in our view, there is no gap.

Ms Blakeman: Good answer.

The Chair: Mr. Lukaszuk, do you have a question?

Mr. Lukaszuk: I do. To segue from Ms Blakeman's question, the only difference between an injured party who is covered under the auspices of the Workers' Compensation Act and that of an injured party who is litigating under the tort system is the location of the

accident. If the accident happens at work during work hours as part of their duties, it's covered by the act. If it happens outside of work, let's say a car accident, then it's subject to civil remedies. When it happens outside of work and it's part of the tort system, the flow of information between the doctor, the insurance company, and the other caregivers flows under this act which is being reviewed right now. Now, if it happens at work and it's under the auspices of WCB, it flows only under FOIP and this act does not apply.

Give me one good reason why the flow of medical information should be different between the patient who had a car accident at an intersection in a private vehicle and the person who had a car accident at the very same intersection while at work in a company vehicle.

The Chair: On this point, yes, Wendy.

Ms Robillard: Yes. I'd just like to clarify a few points here. Regardless of where the accident occurred, whether it was work related or otherwise, the information is bound by the Health Information Act insofar as the individual is seen in a health facility: a regional health authority, a physician's office. So if a patient is seen in any of those places, the Health Information Act applies to that information.

When the physician needs to disclose information to WCB, the physician looks at two pieces of legislation. One is the Health Information Act, which authorizes him to disclose without the patient's consent where another act requires it, and then he goes to WCB legislation to look to see what their act requires in terms of disclosure. So the information flows to WCB from a health facility protected under the Health Information Act. Yes, that information does flow. Once it gets to WCB, then the FOIP rules apply in terms of how WCB uses and further discloses that information.

Mr. Lukaszuk: That would be correct. But what if that patient is obtaining medical services from the Millard or from some of the preferred clinics under contract with the Workers' Compensation Board which are not part of the publicly funded system and are exclusive to workers' compensation?

The Chair: Does someone want to answer that one?

Mr. Huellstrung: Mr. Mah explained earlier that as far as the Millard centre we are fully part of the WCB and would be subject to the same rules as any other provider or as any other person within the Workers' Compensation Board would be.

Mr. Lukaszuk: But not the same rules as the patient who had a car accident in his private vehicle going through the publicly paid system and the tort system.

Mr. Mah: I think Ms Robillard addressed that. When someone is injured, regardless of the circumstances that person will generally go see his or her own primary physician before anyone else. That primary physician in gathering the information and in disclosing the information is subject to the Health Information Act. The difference is that once the information is received by the WCB, the WCB then applies FOIP to the information in its possession with regard to managing that information and with regard to disclosing it.

Mr. Lukaszuk: And that's where the differences arise.

The Chair: Okay. Are we all clear on this issue then?
Next question.

Dr. Pannu: The Health Information Act, HIA, has section 37 in it which addresses the health services provider information issue. FOIP does not address that. When you're seeking exemption for WCB from HIA, you are thereby seeking exemption from this particular act, which isn't covered in any form by the FOIP legislation. It's an additional element of HIA, health services provider information.

The committee is at the moment considering what to do with that section. If that section is retained, its application would be denied to the health care system and other legitimate people who want access to the information with respect to the health services suppliers who work in Millard centre. So why would you not make that information available to the health care system from the Millard centre? Because if you seek the exemption, that's what de facto you're asking for.

2:35

Mr. Mah: Yeah. Section 37 has a couple of parts, but one part relates to disciplinary proceedings for a health professional body, and then the second part deals with disclosure that "is authorized or required by an enactment of Alberta or Canada"; therefore, another law or another piece of legislation. It would be our view with the Health Information Act that even though should it not apply to the WCB, that does not exempt the WCB from an obligation to deal with exactly these two matters.

I'll deal with the second one first. The FOIP Act does allow for disclosure of personal information if it's required by another enactment of the province or of Canada, so there's kind of a parallel provision. With regard to the proceedings before the disciplinary body of a profession, it probably won't surprise you that within the context of WCB claims some people sometimes have complaints about health care professionals, whether it's their own health care professional or some other. So the suggestion here is that the WCB would somehow prohibit or bar the flow of information to that body. Well, I can tell you that it's never happened. We deal routinely with complaints by injured workers and others against physicians to the College of Physicians and Surgeons.

It would be our position that the provisions of the Workers' Compensation Act that allow release of information to a person who's directly concerned would permit us and has permitted us – in fact, we've done it. We've provided that information fully to the college in co-operation with them for the purposes of an investigation and a disciplinary proceeding if it goes that far. So it's not an attempt by the WCB to exempt itself from certain legal obligations. All we're saying is that the legal obligations are already present in the existing legislation, and we're following it.

Dr. Pannu: There are two pieces of information . . .
Mr. Chairman, with your permission?

The Chair: Proceed.

Dr. Pannu: . . . that under section 37 – I think the committee had the benefit of having a presentation made to it in the morning session. There were 19 different items related to health service providers in terms of information, some of which required consent; there's a consent requirement before that information can be released. There are another 11 that don't require consent. The issue is one of consent or not consenting of doctors, nurses, physiotherapists. These are the people we're talking about here. Now, people who work in the Millard centre, be they doctors, nurses, physiotherapists, or others, in my view should be subject to the same requirements for information protection as well as disclosure as, you know, outside practitioners. Would you have any objection to it?

Mr. Mah: We agree with you.

Dr. Pannu: Then the only act that defines in legislative terms which pieces of information require consent and which don't before they can be disclosed is HIA. Seeking exemption from HIA would protect HIA from the legislative requirements that apply to other health care facilities; that's the point. So there's a problem there, in my view, that I'll leave you to address.

Mr. Mah: I think we would agree with you that those persons who are members of professions and who practise those professions in whole or in part at Millard centre are of course subject to the same obligations as any other professional who is a member of that particular group and that those persons are subject to investigation and discipline like any other. We would agree with you that information that is required to bring those matters to finality ought to be provided to the professional or disciplinary body to deal with. We say that that is already permitted under our existing legislation, the Workers' Compensation Act, and that there is no bar to that happening under the existing legislation.

The Chair: Thank you.

We are rapidly running out of time, but we will have time for one final question from Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. Mr. Mah, based on your submission, since the practitioners that practise within the closed circle of the WCB realm of caregivers already fulfill the criteria of the highest standard of protection of privacy, which I don't doubt, and since you assure us that the Workers' Compensation Board already shares and transmits and stores information subject to the highest standard attainable, which again I don't doubt, why object to being included in this act? You're already exerting those efforts anyhow. You're already making sure that information is not frivolously shared with entities that ought not to have access to it, and that flow of information is subject to strict rules. Why not fall within this act and be in unison with the rest of the health care providers in the province?

Mr. Mah: Well, it's our position that that would require the WCB to apply two slightly different sets of rules to the same documents, and our argument really is one of administrative convenience but coupled with our belief that there is no significant public policy risk going on here. So to answer your question, it's really the administrative burden. That's the primary reason, but behind that we don't see how society would benefit any greater by requiring the WCB to incur this additional administrative burden.

As we pointed out in our submission, the 10 underlying principles of FOIP and the Health Information Act seem to be very similar. Well, they are very similar, and the public policy objectives that the HIA is trying to promote we say are met within the existing legislation and the existing practices.

The Chair: Thank you.

Ms Blakeman, you are going to make a liar out of me. Go ahead.

Ms Blakeman: I'm sorry. My most sincere apologies.

Under your appendices attached you've got "Policy: 01-02 Part II," and a bunch of other ones, "Application 1: General." Partway down are your justifications to the question, "How does the WCB protect individuals' privacy?" This is page 1 of 3 of the part II application, issue date June 1, supersedes January 1. Are you with me?

Mr. Mah: Uh-huh.

Ms Blakeman: Okay. There's a bullet that says, "making reasonable efforts to ensure information used in decision-making is accurate." Could you either outline here in some detail what you do to ensure that that information is accurate, or could you provide it through the secretary to the committee in a detailed form?

Increasingly I'm starting to question. I think sometimes in the collection of information for whatever reason we may not in fact be holding accurate information on people. I've certainly had my fair share of WCB cases where their file was lost or information from their file was put in someone else's or someone else's file was put into theirs, and decisions were made based on that. So what are you doing now, currently, to ensure that the information used in the decision-making is accurate?

Mr. Mah: I'll give you a short answer now, and if more detail is required, then we'll provide it through the secretary.

There are a couple of things. Every incoming piece of information, every document is examined for relevancy, for legibility, and for accuracy. I'll give you a quick example. When a medical report comes in and it talks about a worker's right leg, if the adjudicator knows that it's the left leg that's injured, then that piece of information would go back to the doctor and correction would be requested.

Secondly, when we're in the process of making disclosure, whether for the purposes of review or appeal or for some other purpose, there is a hierarchy of review that each file, indeed each document, is subjected to. If we catch something – there's someone else's claim number that's on this record or there's aggregated claim information on this record – it's caught at that point, before it goes out, so the person who is receiving the information doesn't receive information that that person is not supposed to receive.

So those are two examples of how we try to exercise some quality control over accuracy.

2:45

The Chair: Thank you. And you will provide further information, Mr. Mah?

Mr. Mah: Certainly.

The Chair: Thank you.

Well, on behalf of the committee, Mr. Mah, Ms Morgenstern, and Mr. Huellstrung, thank you very much for presenting to us today, providing the information to the committee, taking up your time to do that. We appreciate it very much. Again, thank you for coming in and presenting to us today.

We will adjourn for 5 minutes and reconvene at 2:50.

[The committee adjourned from 2:46 p.m. to 2:52 p.m.]

The Chair: All right. Let's call the committee to order. We're certainly pleased today to welcome the Alberta College of Pharmacists. Mr. Greg Eberhart and Mr. William Shores are here representing them to give us information and answer questions.

Let's start on my right today and introduce the committee to the presenters.

[The following members introduced themselves: Ms Blakeman, Mr. Broda, Mr. Jacobs, Ms Kryczka, Mr. Lougheed, Mr. Lukaszuk, Mr. MacDonald, Dr. Pannu, and Mr. Snelgrove]

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

[The following departmental support staff introduced themselves: Ms Gallant, Ms Inions, Ms Robillard, and Ms Swanson]

Mr. Snelgrove: Mr. Chairman, before we start. You may think that Greg is just smarter than average. It's only because he grew up in Vermilion that he got a head start. You know, give him a break.

Mr. Eberhart: And I followed Lloyd.

The Chair: Thank you, Lloyd.

Mr. Eberhart: Thank you, Mr. Chairman, and committee members. This is an opportunity which our college has been looking forward to for approximately three years, I think ever since the advent of the Health Information Act and the many hours that we've expended in discussions with the department and other partners in trying to implement this legislation.

It's not my intent to expand on new concepts today but rather to readdress the concepts which we introduced through our written submission and to provide you the opportunity to ask questions of us to discuss maybe solutions to those issues.

Joining me today is Mr. Bill Shores, who is legal counsel to our college. I will be doing the presentation, and through the question period if there are questions of a legal nature that I can't answer, I may choose to defer them to Bill.

I'd first like to emphasize that the role of our college is to support and protect the public's health and well-being by regulating the conduct of pharmacists and protecting the integrity of the drug distribution system. For many years our former association, which then became the college, has recognized and has full appreciation for the rights of individuals to the privacy and confidentiality of their personal information, and those issues have been addressed through our code of ethics and practice standards in years past and continue to flourish today.

I remember back in the early 1990s, as a matter of fact, as we were deliberating new legislation for pharmacists, which was eventually proclaimed in 1995, it was one of our recommendations that all community pharmacies have a private or semiprivate counselling area. Unfortunately, government didn't see eye to eye with us at that time and would not support that concept because it was seen as an extra cost to the system. So I find it rather interesting how the tide has changed over the course of the past 10 years.

I'd like to address largely four points this afternoon. First of all, to observe that pharmacists are affected by multiple pieces of privacy legislation both provincially and federally. To that end, we believe that we need a single piece of privacy legislation that expands across and covers the needs of individuals through the entire health sector. It does not seem prudent to us at the practitioner level to have different pieces of legislation that apply to the public sector and another piece of legislation that applies to the private sector. So today in Alberta pharmacists must comply with the Health Information Act, they must comply with PIPA, and in considering PIPA, they must also consider the PIPEDA legislation at the federal level.

The Health Information Act has introduced significant administrative burden on pharmacists and on other health professionals, including issues surrounding the collection of consent. We recognize that this is a message that has been brought forward to you by regional health authorities and by other health professions. This burden has been reflected in both increased costs to regions, increased costs to individual health professionals who are responsible for implementing the legislation, but I'd also like to suggest to you that it's brought an increased burden in costs to the delivery of health care. That is to say, the issues and factors around consent are detracting from the ability of individuals to deliver care. They need to focus on complying with the privacy legislation as compared to spending their time focusing on the needs of the individuals that they're serving.

I'd like to use an example of consent to try and illustrate that. Pursuant to the Health Information Act if a spouse is to pick up a prescription for their partner or for their child, written consent is required. Okay? So if you were asked to go to the pharmacy to pick up a prescription for your spouse, if full compliance with the Health Information Act were to occur, written consent should exist at the pharmacy. Further to that, every time that a pharmacist discloses information to a noncustodian, it needs to be recorded, and that record needs to be maintained. So it's not a matter of recording that for the purposes of perpetuity, but each time an event occurs, a record of the information that's been disclosed needs to be recorded.

Now, if you can take something as simple as that and replicate that over the very many customers or patients that a pharmacist takes care of in a given day, I think that you can appreciate the magnitude of the paperwork and the extra diligence that needs to go into complying with the Health Information Act. I'm using just a very, very simple and minute example to demonstrate the complexity that can occur and the onus that exists when disclosure from a custodian to a noncustodian occurs.

When we talk about custodians versus noncustodians, it also becomes complex in that again because of the many different pieces of legislation, the Health Information Act only covers publicly funded services. Therefore, if a pharmacist is asked to disclose information to another health professional who is not covered under the Health Information Act, in the interest of providing care, the same parameters apply. It becomes very complicated, very time consuming, very resource intensive.

3:00

Secondly, we would like to address the broad protection granted to health services provider information. We recommend that section 37(2)(a) of the act be rescinded. Rather than protecting the disclosure of provider information, we would recommend that the legislation address the use of provider information. For example, as a college we support the disclosure of service provider identifiers for the purposes of education, practice enhancement, and accountability. However, we do not support the use of provider information for the purpose of detailing prescribers of specific drugs. Again, our focus as a college is on the public interest. Our focus is about quality pharmacist practice, patient safety, the responsible and effective use of resources. We believe that provider information does need to be disclosed for those purposes in many ways throughout the system and that the wording within the current legislation is an impediment to that.

The third issue that we'd like to address this afternoon is limitations within the current legislation that affect the ability of pharmacists to report to police criminal conduct in relation to drugs. I'd like to clarify that when we focus on this statement, we are not focusing on a pharmacist reporting a criminal activity, but rather we're focusing on a custodian being entitled to make disclosure of diagnostic treatment and care information and health service provider information without the requirement for a warrant, subpoena, or court order – and this is the important point – when the health information at issue is being used to perpetrate a crime.

An example that I would use to illustrate to you: when we come back to the appropriate use of drugs, the responsible use of drugs, the safety of individuals, and the sustainability of the health system, the fact is that under the current legislation double-doctoring, which is a criminal offence punishable by up to seven years imprisonment,

cannot be reported by a pharmacist. We do not believe that that's in the public's interest. We do not believe that that's the intent of the legislation, and we would strongly encourage an amendment to effect that.

In conclusion, I'd like to come back to my opening comment. Today health professionals, and in our case specifically pharmacists, are affected by a broad array of privacy legislation, privacy legislation that is unclear, privacy legislation that is often conflicting, privacy legislation which, while it had good intent, is actually creating many impediments and extra costs within the health system.

It's our recommendation that the committee consider two separate alternatives or one of two alternatives. On one hand, you may consider amendments to various sections of the act to again improve upon the clarity, to further define the intent of the legislation as first written, and to further consider the costs that are incurred by virtue of the excessive administration that the legislation has introduced.

Alternatively, our recommendation would be that the Health Information Act in and of itself be rescinded in lieu of something like PIPA, which addresses the privacy of individuals, but use PIPA to address both the private sector and the public sector. The health system needs to be considered as a unit. It needs to be considered as a whole, and it is inappropriate that health professionals, administrators, service providers through RHAs need to contend with multiple pieces of legislation to try and achieve the same end. We're faced with segmentation within the health sector and, again, a lot of confusion that comes from this.

With those comments I would welcome any questions.

The Chair: Thank you, Mr. Eberhart. We do have some questions. Ms Blakeman.

Ms Blakeman: Thank you. Three questions. If you're going to cut me off, then put me to the back of the line for whichever I don't get in there.

The Chair: If they're brief and short, we will be fine.

Ms Blakeman: You made a statement about the requirement to obtain consent detracting from health provision. I find your example of a spouse needing written permission to pick up a prescription a weak example, quite frankly. I think it's well within the realm of possibility that you can go and get the written consent – it's not that onerous – or have the person come down and get it themselves.

So I guess I'm looking for some other examples of where you feel the question of consent has detracted imminently and dangerously, I suppose, from actual health provision. I mean, in that case we were talking perhaps a delay of getting a prescription while somebody went home and got the written consent and came back, but I don't know that it was truly detracting from health provision.

Mr. Eberhart: I think you need to put it in context as to how frequently that happens, particularly with an aging population. We're not just dealing with a spouse. We're not just dealing with a child. We're dealing with an aging population where it is probably more common than not for an agent or some other individual who is participating in the care of the individual to pick up prescriptions, and when we need to deal with written consent in its specific form, there is a huge cost both in terms of time and space that is associated with that. You need to put it in context, and that's why I chose to use something that was very, very, very simple, because the simple is not as simple as it sounds at first blush.

Ms Blakeman: I'm sorry. I'm just not accepting that example as a good reason to disclose additional health information or change the act, but I'll move on to my next question.

You were talking about eliminating section 37(2)(a). I can't believe this, but I think I heard you contradict your honourable colleagues who presented earlier this morning. You seem to be saying that under your preference of the changes or elimination of that act you didn't feel that the very information that I think IMS was looking for would not be included in that. Did I hear you correctly?

Mr. Eberhart: We spoke to section 37(2)(a), and our position does differ from that of IMS. We do not believe that the recommendation of IMS goes further, and we would cite that we as a college have a different mandate and a different purpose and a different reason for our recommendations than IMS. IMS as an entity has, I would understand, very specific needs, and I cannot speak for them as to what those needs are.

Ms Blakeman: Okay. Thank you. I was just checking that I heard what I heard.

A final question. Would not the creation of stand-alone legislation dealing with the problem of the double-doctoring and the reporting of offences under the Criminal Code Controlled Drugs and Substances Act or narcotic control regulations or the Food and Drugs Act be a cleaner way of dealing with the problem rather than talking about limitations, opening up the act again to reveal more of people's personal information? If the problem is the ability of the pharmacist to alert the police to a crime under any of these acts, would it not be a more direct route to establish legislation that in fact empowered pharmacists to do that?

Mr. Eberhart: I guess my argument would be: why does one want to create more legislation when we already have too much legislation? I think the right thing to do is to take a look at the legislation that's been created and do the right things first rather than create more legislation.

Ms Blakeman: But that's releasing more of people's personal health information.

Mr. Eberhart: Under very specific circumstances. Again, we are not suggesting that pharmacists report crimes. We're not suggesting that they report the criminal offences. What we're suggesting is that when there are actions that are purporting to a criminal offence that are in progress that the pharmacists be able to disclose that information.

Ms Blakeman: Well, we're talking about the same thing, and I'm saying that they should be able under legislation created to be reporting that. They can't determine that it's criminal until it has gone through a court.

Mr. Shores: Maybe I can just address that. The concern is that pharmacists will receive pieces of information – we get frequent calls about this – for example, a prescription where an extra zero has been added on to the number of OxyContin, which is a narcotic, that the person's going to get. That prescription has registration information on it, it has health service provider information on it, and it has diagnostic, treatment, and care information. The pharmacist can reveal the extra zero to the police but nothing else on that because everything else is valid. So that's a concern.

You have to say to the police officer: I'm calling you to complain about somebody perpetrating a fraud on me. The police officer invariably says this: "Well, I'll come down and have a look at the

documents you've got," and the pharmacist says: "Well, I can tell you what. I can't give you the document because it would be in breach of the HIA." The police officer will invariably say one of two things – we've had a case of this – one, "If I come down there and you don't give me the information, I'll charge you with obstructing justice," improper but it occurs, or alternatively: "We don't have time to examine things where we have to go to a court to seek a warrant on the information you've given me."

3:10

The other problem is the double-doctoring scenario. The only person that can actually identify a double-doctoring scenario is a pharmacist because the pharmacist is the only one likely to find out, subject to the health information record or the EHR being complete, that one person is presenting prescriptions from two physicians. The pharmacist can't report either of those to the police because they contain registration, health service provider information, diagnostic treatment and care information.

What we're asking for is an amendment to the HIA that would allow a pharmacist in those circumstances to reveal the information that's being used to perpetrate the crime.

The Chair: Thank you.

Mr. Broda.

Mr. Broda: Yes. Thank you. On your example of a spouse picking up a prescription, let me give you another scenario, and you can tell me whether this would work or not. Assuming that I deal with a specific pharmacy and I have, say, a six-month supply of prescriptions I deposited at that pharmacy and they also have the ability for me to fill that prescription by me phoning in but I happen to be out in the bush, for example, and I phone my wife and say, "I phoned in that prescription, but I won't be home until later this evening, and it's crucial that I have it" – that may occur only once – what if the pharmacy refuses to because of no consent? Where does the patient sit in that situation?

Mr. Eberhart: Their health is at risk, and I guess that's really what we're suggesting, Mr. Broda, that the health care professional is placed in a dilemma in this situation.

I'll use something analogous to that where it's not uncommon for pharmacists to act in good faith. January, February, March of every year it's quite common for one or the other spouse to acquaint the pharmacy and say: can I have a duplicate copy of my prescription receipts because I need them for income tax purposes? Many times pharmacists have proceeded to provide those receipts in good faith. Unfortunately, sometimes those receipts might be sought for ulterior motives, divorce proceedings, or otherwise.

So we now find ourselves in a position where we have to advise our members that when an individual, Mr. Broda, comes to ask for receipts for his family, we can say: well, Mr. Broda, we can provide you your receipts, but we're going to have to have written consent from your wife to provide hers, and if you have any dependent children that may be adolescents and able to make decisions about their own health care, we're going to have to have their written consent too. These are practices that have gone on for decades in the traditional system, and I think you can appreciate what confusion that adds.

Mr. Shores: If the pharmacist is satisfied that there would be imminent harm, there's an exception for release, but it means the pharmacist has to do the analysis: is the loss of this drug to you over the next three weeks going to cause you harm immediately? So the pharmacist has to do the analysis.

The college is not asking that the requirement of consent be removed entirely. It just wants other ways of getting it; for example, verbal consent so you could phone in from the bush and say, "Look; can you give this to my wife?" or else an implied consent. Both concepts are contemplated by PIPA in the private sector.

The circumstance where you've been dealing with a family for 20 years. Again it's a question I often get from pharmacists. "I've known these people for 20 years; I've dealt with them for 20 years; these are circumstances I feel comfortable with."

Mr. Broda: I have one further question, Mr. Chair, if I may. The question is on the triplicate prescriptions that we've got. Wasn't the purpose of the triplicate prescription to identify those issues that you brought up, such as double-doctoring or possibly having a physician that prescribes a number of this specific drug which would be a narcotic? That's the only reason you would have a triplicate prescription. Would that not identify also that this physician may be doing more prescribing than any other physician in, say, a local area of that specific drug? Wouldn't that be an obligation on your part to basically identify it, without having consent of those individuals, to a police force?

Mr. Eberhart: As far as disclosing it to a police force, I don't think the legislation is specific to say that it's our obligation to provide that to the police force. The need of the pharmacist occurs well in advance of providing information into the triplicate prescription program. In other words, typically when a pharmacist needs or wishes to report something to the police, it's at the time that the issue is in progress. The triplicate prescription program is really something that is more reactive in nature than proactive and has a management responsibility associated with it. Our challenge under the current legislation is that it is ambiguous. Again I want to underline "ambiguous." We believe that there is jurisdiction, but it is ambiguous respecting our ability to require pharmacists to make submission to the triplicate program, and therefore amendment needs to occur to make it abundantly clear that that is reasonable.

Mr. Broda: Thank you.

The Chair: Thank you, Mr. Broda.

Mr. MacDonald.

Mr. MacDonald: Yes, Mr. Chairman. Thank you. In regard to section 37(2)(a) could you please update me? There is a case before the Court of Appeal, and there is a lot of procedural wrangling. Could you explain that further, please?

Mr. Eberhart: I'm going to defer the question to Mr. Shores because he's been dealing with this on our behalf.

Mr. Shores: In terms of that litigation we are an intervener; we're not the leading case. There was a dispute over which documents needed to be produced by the Information and Privacy Commissioner's office. I'm not going to get into the technicalities of it, but essentially the decision of the judge about what had to be disclosed is being appealed to the Court of Appeal, and when that's decided, then it'll come back to the Court of Queen's Bench to decide whether or not the decision of the Information and Privacy Commissioner is sustainable. We're not involved in that appeal. We're interveners in the action in front of the Court of Queen's Bench.

The Chair: Mr. Shores, is this case before the courts?

Mr. Shores: It is currently before the courts. I'm just advising of the current status of the courts. It's simply a case that will be before the courts, I would anticipate, for some considerable time.

Mr. MacDonald: Now, a follow-up to that. Is this an appeal under the act?

Mr. Shores: The application for judicial review to the Court of Queen's Bench is pursuant to the act. That's right. It's under the act.

Mr. MacDonald: Okay. Excellent. This, as it works its way through the process, could eventually at some point in the future, if this were not appealed, wind up before the Supreme Court.

Mr. Shores: Theoretically, yes.

Mr. MacDonald: Wow. Okay. Thanks.

Ms Kryczka: Well, first of all, I just want to clarify. I feel that for pharmacists today there is a real frustration. You said something about the changing tide in the last 10 years. I think a lot of it is with your good work with government in terms of the expanded role in the health care system for the pharmacists, which is more time consuming. Yeah, I wish they had little cubicles and they'd talk to you right out in the public. I think it's great that you get that information.

The basic compensation for pharmacists, just to quickly clarify here, is fee for service basically?

Mr. Eberhart: That's right.

Ms Kryczka: Okay. I worked for lawyers, a large law firm, a number of years ago. You know, lawyers also bill on fee for service, unless there's some other arrangement that has happened in the last number of years. So you think about the time that you are spending on your advice to your client, yet you also said, Greg, that pharmacists are now being affected by this broad array of privacy legislation. I wrote that down. I mean, I think most pharmacists must have a real balancing act with the time, you know: on the one hand, I have to give advice to people; we're going in the direction of wellness, blah, blah, blah, and I've got all this paperwork I have to fill out. Right? That's time consuming.

Mr. Eberhart: I think that's why we need to look to a logical solution that deals with reasonableness and meets the ends that we've been working with over the past 20 or 30 years.

We all understand. We're all involved in the discussion about accessibility and sustainability within the health system. It's not our college's role to get into the discussion around the economics of pharmacy. We are aware and we are concerned, based on feedback, that the time available to pharmacists to dedicate to the care, which they are taught and learned about and wish to deliver and need to deliver, is detracted and distracted by the complexities around some of the privacy legislation that we have to deal with.

3:20

Pharmacists are in a unique position as compared to many other health professions because we have to deal with the private sector, the public sector, both provincially and federally, and it really does not make any sense to have different pieces of legislation for different payment models. We need to deal with the health system as a whole so that information can flow between providers and we can deal with the continuity of care without the disruptions and the distractions of the complexities of multiple pieces of legislation.

Ms Kryczka: I guess I would like to make another point related to that. Government and society should be concerned about the increasing costs of drugs. To my mind, a very important role of the pharmacist is to help ensure, especially with seniors who get confused – I get confused about my prescription, you know.

Mr. Lougheed: You're a senior?

Ms Kryczka: Well, I'm not quite yet, but I can easily get confused also with the instructions around taking a prescription. So I guess what I'm trying to say is that again all of this is part of the picture.

The other comment that I want to make is that I believe that my colleague Ms Blakeman mentioned that IMS was contradictory to what you were saying. You said: cancel 37(2)(a). My notes say that repealing it was also one of the options. In fact, I have it recorded as the second option. So I just wanted to say that I hear you with the same solution.

Mr. Eberhart: You can look to amendment 37(2)(b), but we do not believe that that goes far enough. We believe that you should be looking at readdressing 37(2)(a) and repealing it. Again our interests are quite different from the interests of IMS. Our roles and so forth are quite different. So to hear a similar recommendation for different purposes probably sends a significant message.

The Chair: All right. Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. If you could clarify just a bit of a conflict, perhaps, that I'm noticing. I hear you saying that because of the fact that a significant proportion of drugs end up on the street and are being trafficked or there's double-doctoring of medications, you feel that pharmacists should have the ability to report to police situations where this may have arisen. I have no issue with that. I think you may be onto something good there. But at the same time you're advocating that, for instance, I be able to get a prescription filled that is not written to my name without the consent of the person to whose name that prescription was written.

Mr. Eberhart: Could you repeat that, Thomas? I'm sorry.

Mr. Lukaszuk: You're advocating that I be able to have a prescription filled without consent, even though the prescription may not have been written to my name. You're saying that I can go and get my wife's prescription filled or my daughter's without written consent.

Mr. Eberhart: What we indicated was that you would be able to pick up a prescription that was processed for another individual. We're not suggesting that you be able to have a prescription filled for somebody else.

Mr. Lukaszuk: And how would you know that I am the person who is authorized and who will actually deliver the prescription to the person who is supposed to receive it?

Mr. Eberhart: I think that there is an issue of professional judgment that comes into play. Again, the example that I've used is at the family level, where the pharmacist is very knowledgeable about the family relationship: the husband, the spouse, the child, the caregiver. I mean, we build relationships within our professional practices

where we deal with the people on a daily basis, a weekly basis, a monthly basis, and we understand and know what those relationships look like.

The way that a pharmacist would deal with that and as Mr. Shores has suggested: if consent is necessary, then the implied consent or the verbal consent in those situations is a reasonable solution. If you have an individual presenting themselves whom you don't know and you don't know who the patient is, as a professional you should be allowed to apply your judgment. In those situations it might be reasonable to request written consent. But we need and there is benefit to having the ability to apply that professional judgment for the different needs of different individuals under different circumstances. To have a blanket requirement that written consent is required in all situations is not a good use of a health professional's time. It does not provide any additional service to the patient. It does not add to the care and safety of the individual.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. I can see your reasoning, although other presenters and members of the medical profession tell us: "Please fix the act in such a manner that we don't have to make subjective decisions. Make it uniform. Don't have our front-line workers make decisions on what is and what isn't appropriate, what should or shouldn't be shared. Codify it." At the same time you're asking for subjectivity.

You know, if I were to go to Costco pharmacy or one of the larger suppliers and say, "I'm picking up a prescription for Mr. Smith," the odds are that there are three there waiting, and maybe I could end up with one of them.

Mr. Eberhart: Again, I think it comes back to the professional practice requirements of the pharmacist. There is a responsibility to exercise due diligence. I would use the examples that I've cited where you know the family, where you know the individuals who are caring for or supporting one another. It's quite a different circumstance when dealing with strangers. Yes, there are some large pharmacies, and I think the degree of diligence that has to be exercised in the situation that you've described is somewhat different from the first example that I used. You know, just like with lawyers it requires judgment.

The Chair: Thank you.

We have a couple more questions. Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. Before I ask a more substantive question, for information: what percentage of practising pharmacists, or active pharmacists, in Alberta would be working on salary for health boards or hospitals or such?

Mr. Eberhart: We have approximately 3,200 practising members, and there would be about 15 to 18 per cent of those who are working for regional health authorities.

Dr. Pannu: The need for asking for this information occurred to me because this morning we had the hospital boards association of Alberta come before us, and they had something to say about whether or not the current model of consent for disclosure that's embodied in the legislation is appropriate or whether it needs to be changed, particularly the issue of implied consent. They took a very clear position that the present model is the right model. You are arguing for abandoning the current model of consent that's built into this piece of legislation.

In view of the fact that you are arguing that we should treat the health system as one system – you are doing that when you are arguing for one piece of legislation rather than three different ones. Now we're hearing two very different arguments from two different segments of the one health care system: one from you to allow implied consent or verbal consent and one from the boards of hospitals or health authorities who are arguing against it. So that's one concern that I have, and I don't know how to reconcile it.

Mr. Eberhart: Could I maybe depict a difference? I think that what you may be observing is a difference in who is presenting. We are presenting on behalf of front-line health providers. The hospital boards are speaking on behalf of a much larger infrastructure and a larger entity.

We've already experienced that when you look at the time required to collect consent, collect informed written consent. Prior to amendment of section 59 of the current legislation, through the Alberta Wellnet project we observed differences in time ranging from a number of seconds – it seems to me 30 to 45 seconds – and going on to some situations where it was taking upwards of eight or nine minutes. That in and of itself says to me that the current situation is not appropriate because, practically, for those who are or were collecting informed consent, there is no standard expectation as to what it really means or what they need to do, and they're going about it in different ways.

3:30

If you use those examples and again bring it back to the physician's office, bring it to the pharmacy, bring it to any of the other front-line providers who may be working as sole proprietors, and contemplate what that means in terms of effectiveness and efficiency and what it adds to the safety and care of the individuals, I would suggest that it's a detractor. Using the same analogy that I've described to your colleagues, health professionals who care for individuals on a regular basis have relationships with those individuals, and by virtue of those individuals acquainting that health professional, they are seeking their participation in caring for them for a given reason. They are implying that they want their assistance and the application of their professional knowledge and the use of their professional services and so forth.

You know, I find it interesting that implied consent is something that seems to work under PIPA for the private sector. Implied consent works federally under PIPEDA. Why can it not work within the Health Information Act?

The Chair: Briefly, Dr. Pannu. We have several other questions, and we are rapidly beyond our time here, so briefly.

Dr. Pannu: The position of the boards was that in fact the private sector should be brought under HIA, so that answers one of your concerns.

Mr. Eberhart: That's one of the solutions. It leaves other questions, but it's a solution.

Dr. Pannu: Right.

The second part is the problem that, as you said, roughly five of your members are active pharmacists and now work for these boards, and boards are saying that the issue of consent should not be reopened. What happens to those members? I don't guess they are members of the college but certainly members of the Pharmacists Association. There's a problem there. Those people who have their independent practice or business, have pharmacy stores is the

category that you're talking about. I'm talking about the other 15 or 20 per cent.

Mr. Eberhart: We're really talking about all of those individuals who work for RHAs, are licensed by the college, and have a responsibility to comply with the standards of practice of the college just as anybody working in the community environment.

I think the difference that we run into, Dr. Pannu, is that when you come to that regional setting, when we deal with disclosure of information, often the disclosure is managed by somebody other than the health professional. So a hospital pharmacist, for example, somebody working for the region, does have jurisdiction to share information with a community-based pharmacist or they have jurisdiction to share information with another physician or whatever the case may be.

When it comes to disclosure of that information to a noncustodian, it's highly unlikely that the pharmacist in the regional health authority would be dealing with the issue. That would be dealt with through another level of administration someplace within the health authority. That opportunity doesn't exist within the community, because we're dealing with much smaller infrastructures, whether we speak of a pharmacy practice, medical practice, or whatever the case may be.

The Chair: Thank you.

Ms Blakeman, followed briefly by Mr. Snelgrove.

Ms Blakeman: Thank you. I'm just following up on something that I heard you say around Mr. Lukaszuk's question and your example of the written and nonwritten consent to pick up prescriptions. What I heard you saying was that if the pharmacist was very familiar with the family and knew everybody, would say: "Okay; fine. Pick it up without written consent." My question to you, then, is: how does the same pharmacist then deal with someone they're not familiar with? Do they then require the written consent?

Mr. Eberhart: Absolutely. That's the element of professional judgment that could be applied there. I think that's really what we're requesting: that there be the latitude provided for some discretion and to recognize that implied consent and verbal consent have a role within the system. Not everything can be written. People can be informed in other ways than having to describe their intent in writing. That is recognized in other pieces of legislation, including provincial legislation, that addresses the private sector.

The Chair: Thank you.

Mr. Snelgrove: Just an observation, Mr. Chairman. It's kind of ironic that right now in Canada we have all the provinces and Ottawa agreeing that we've had a system being run for the last several years that we can't possibly afford, and we've had representatives of these systems come in front of us and tell us that what we're doing is fine. The more paperwork, the better. The more inefficient we make this system, the happier we are. Then we wonder about someone who is actually living in it coming in and saying, "That doesn't work." It's why we're going where we're going. And we wonder why they're here. It's just that simple.

The Chair: Thank you very much. Good comments to close on. [interjection]

Oh, I'm sorry, Ms Kryczka.

Ms Kryczka: You said that 85 per cent, roughly, are practising in the community.

Mr. Eberhart: That's correct.

Ms Kryczka: I could be wrong, but I'm thinking that many of them probably own their own franchises, their own stores.

Mr. Eberhart: That 85 per cent would practise in one of about 830 pharmacies and maybe slightly less than 50 per cent of those would be individual owners.

Ms Kryczka: Well, I do come back to the economics because I've worked in the public sector in a school where, you know, it's important how you teach kids and how things go, but you have no idea of the economics of running a school system. Then you go over to the private sector, and the only way you're going to keep your job is if you balance your budget. So like Lloyd, I rest my case; right? Thank goodness you're here, because I think that a lot of the frustrations have to do with trying to provide wellness information, to do a good job, but at the same time you have the burden of paperwork, et cetera, that's expected, and at the same time you're trying to make a few bucks out of your business. You don't have to respond.

The Chair: Thanks for the comment.

Mr. Lougheed, did you have a question?

Mr. Lougheed: Could you give me any indication of the ratio or proportion of prescriptions or volume of drugs dispensed by the 15 per cent as opposed to the 85 per cent?

Mr. Eberhart: No, I really couldn't, Rob, because you find that in the regional setting the type of medications that are provided are substantively different. With the changes in the health system, for those individuals who are institutionalized, whether it be for acute care, tertiary care, or long-term care, the type of medications that they're on are much more acute. They're much more specialized. Therefore, they're often more expensive also. So I can't really give you a ratio, if it may be, from a volume perspective or from a cost perspective as to what that would look like.

We do have to understand that those in the community environment are typically dealing with the continuing care, where we're looking at trying to keep people well so that they are not rehospitalized, and that we have to make sure that we understand that as a value as compared to a cost. That's why things like EHR and the management of health information is so important, so that we can work together to achieve that end.

Mr. Chairman, if I could, just to put some things in context around cost, I've talked about cost from many different angles. A real example that was brought to my attention: I know one small independent pharmacy that has shared their concern with us. They've gone to the lengths of fulfilling the responsibilities that the act prescribes in ensuring that they have policies and procedures in place to deal with the legislation. So outside of the costs that I have inferred that occur in day-to-day practice, it costs them $20,000 plus just to develop the policies and procedures to comply with the legislation. That's one small independent practitioner. If you take that and multiply it across the health system, whether it be pharmacists, whether it be physicians, whoever, I think you get some appreciation as to the upfront implementation costs, let alone the ongoing costs that we work with.

The Chair: Thank you very much, Mr. Eberhart and Mr. Shores, for an excellent presentation and for stimulating a lot of discussion. On behalf of the committee I extend our gratitude and thanks to you for

coming today and representing to us. Thank you very much.

We will finish the agenda before we break.

Dr. Pannu: I have a question for Mr. Eberhart before he goes. You referred to about $20,000 cost. Is it a one-time cost?

Mr. Eberhart: That was a one-time cost for that independent pharmacy to develop the policies and procedures that were necessary to comply with the act.

Ms Kryczka: Just to develop it?

Mr. Eberhart: Just to develop it.

Dr. Pannu: Yeah. A one-time cost. Thank you.

Mr. Eberhart: That's not implementation. That is to develop, not to implement. So once we get into implementation, that goes on.

3:40

The Chair: All right. Members, you will all get a copy of *Hansard*, so you will get all this information. Presenters, you can access *Hansard* if you want to read questions and see what you say.

We have two or three items we need to deal with, committee. I will respond to the point of order after we deal with two other items first.

Ms Inions, would you like to explain these two documents to the committee and what they actually mean? Does the committee have copies of these already? Not yet. Okay.

Ms Inions: They're available for distribution.

The Chair: So you can present those, and then we'll distribute.

Ms Inions: Would you like me to proceed now?

The Chair: Yes, please.

Ms Inions: I am not sure which one you're getting first, but I'll start off with the CMAJ article. They're both together.

The Chair: Okay. I appreciate what you're up against. Maybe while we're handing those out, Wendy, you could just quickly introduce the committee to tomorrow morning's agenda because it's something that's pretty significant, and maybe they need to be given an upfront on that.

Ms Robillard: Yes. We are going to be providing the committee members with an updated copy of the preliminary summary analysis chart. So we've done a fair amount more work on that since it was last distributed to you, I believe, from our office last Tuesday. So we have documents to give to you this evening.

Tomorrow when we meet in the morning, we will start to go through those documents and look at analyses of the submissions to date by question, excluding the I think six or seven submissions that we received since Friday. They have not been included in that yet.

We have captured, sort of, for the people who have responded to the committee so far, what their views are in relation to the questions, so how many agree, disagree, et cetera. We will go through that tomorrow.

The Chair: Thank you, Wendy.

Are there questions?

Dr. Pannu: For Wendy. So your summary would cover the first 66 or so briefs. Is that it?

Ms Robillard: Yes, I believe up to brief 65 and 67. Did we get 68 in there? [interjection] So up to about 68. Yeah.

The Chair: Ms Inions, I think they all have been distributed now, so if you would like to explain those to the committee.

Ms Inions: Okay. Thank you. The first document I'll address is the one that starts with mandatory reporting of gunshot wounds. This is the cover page, and this is in response to the comment made by one of the presenters at the last session that recommended taking a look at some of the CMAJ, *Canadian Medical Association Journal*, articles. There are three articles in here. It's an initial comment by the Health Law Institute and their ethicist, response to it by the emergency physicians in Ontario, who are recommending mandatory gunshot legislation in Ontario, and then a rebuttal on the top from the ethicist. I was actually able to confirm with Brent that these are the articles that he had in mind this morning when he mentioned his comment in his presentation.

I would like to just make a quick comment that there is a lot of misinformation out there about the status of the Ontario legislation in regard to reporting gunshots. There is no legislation in Ontario currently that requires reporting of gunshot wounds. There was a bill – it's Bill 110 – introduced this spring by the minister of correctional services in Ontario, not the ministry of health, and that has just been introduced. That bill, so far as I know, is very supported by the emergency physicians in Ontario. It's not supported by the Ontario Medical Association as a whole or by the Canadian Medical Association. That's contradictory information to some of the news articles out there, so it's a bit of a source of confusion. So I just mention that that is the status of that legislation.

The second piece of information you have – I see that actually Health and I have really killed an extra tree here, I guess – begins with the triplicate prescription program annual report. There has been a lot of discussion about that program before the committee, and I provided further background information in regard to the questions asked. So a little different way of capturing the information.

Essentially, the College of Physicians and Surgeons prepares and updates a list. The medications that are on the list are available on the web site, and if you turn to the back page of that package, it gives you the detailed list of everything that's on that list now. It was on the list the day, actually, that you asked the question; I pulled it off the web site then. It is updated periodically as further drugs are identified that are being abused or misused. If you turn to the second-last page, it gives you a list of the categories of drugs in the program and provides further information in regard to the program, about the criteria and processes and that kind of thing.

Unless there are questions, that's all I have to say about that information.

The Chair: Thank you very much.

Are there questions?

Ms Inions: I would like to ask one further question of the committee.

The Chair: Certainly.

Ms Inions: Today I believe it was Dr. Pannu who asked the question about a document that had been signed by Mr. Robert Clark, the

former Privacy Commissioner, that related to health service provider information and the rationale for that information being included in HIA. I ran back to the office over lunch, took a quick look, and could not find anything that was responsive to your request. I just wonder if you could give a little more information about what you were thinking of when you made the request.

Dr. Pannu: Well, I'll go and ask my staff if they can help me with that, and if I get the information, I'll share it with you.

The Chair: Very good. Thank you.

To the point of order. Having never dealt with a point of order before, which will be obvious in a moment, I will just read you one paragraph here under the powers and responsibilities of the chair. The chair shall be responsible for maintaining order and decorum at committee meetings: Standing Order 62(2). He shall be responsible for ruling on points of order when raised, and decisions of the chair may be appealed to the committee. Of course, if someone wants to appeal it, there is a process here that we will follow. I won't read that to you unless you decide to appeal.

I do have the Blues, and I do have a copy of 23(h), (i), and (j). Just so that everyone knows exactly what the allegations were, 23(h) says, "makes allegations against another member"; 23(i) says, "imputes false or unavowed motives to another member"; and 23(j) says, "uses abusive or insulting language of a nature likely to create disorder." At the outset I don't think (j) applies in this case.

Going to the Blues, Mr. Lukaszuk said, "Let's see if I can squeeze something into the *Hansard* that I can use during the upcoming campaign." Then he went on with other comments. In my humble opinion, the only item here that might apply would be imputing "false or unavowed motives to another member." I don't think allegations were made against another member, according to the Blues, and I don't think that (j), "abusive or insulting language," applies.

I've always been reluctant to try to decide what the motives were of one person when they make a comment. It's difficult for me as a human being to decide that. I also think that sometimes as committee members we lead with long preambles, which we probably don't need to do when we're asking questions to presenters. Given the number of questions that need to be asked and want to be asked, it probably would be appropriate if sometimes our preambles weren't quite so long, because they could be misconstrued as thinking we're trying to do something which maybe we aren't.

So I would admit that there probably is a question here about imputing motives. I certainly don't want to say something which wasn't intended, but it seems to me there would be some suggestion that that was a possibility.

Mr. Lukaszuk, having said that, do you have anything you'd like to say?

Mr. Lukaszuk: Certainly, Mr. Chairman. Thank you. As you have identified the proper sections, each one of them requires that another member be the subject of a comment. Hence, a member would have to be identified. As you know, at no point have I identified any other member than myself. I said: why don't I say something that would further my cause? Notwithstanding this, since the Member for Edmonton-Gold Bar has voluntarily identified himself to be that member, I will apologize to him sincerely.

The Chair: Mr. MacDonald, is that acceptable?

Mr. MacDonald: Well, that's acceptable, and I thank you. I thank you both.

The Chair: Thank you very much.

So having resolved that issue, are there any other items or questions anyone would like to ask?

Have we forgotten anything, Karen? Oh, yes. Okay. I'm told you can leave your material here tonight if you want to. The doors will be locked, and it will be safe.

If someone will move adjournment, we'll be adjourned until tomorrow morning.

Ms Kryczka: I'll move the adjournment.

The Chair: Okay. Nine o'clock tomorrow morning. All agreed?

Hon. Members: Agreed.

The Chair: We are adjourned. Thank you very much.

[The committee adjourned at 3:50 p.m.]