Title: Monday, September 27, 2004 HIA Review Committee
Date: 04/09/27
Time: 9:05 a.m.
[Mr. Jacobs in the chair]

The Chair: I would like to call the committee to order and welcome everyone here on this beautiful late September morning. As I drove in last night, I was amazed by the colours that exist in northern Alberta. You're way ahead of us in southern Alberta. I don't know if that's good or bad, but it's certainly beautiful up here. It's coming in southern Alberta, but you're ahead of us. So I get to watch it twice.

Mr. Broda: Do you have any trees?

The Chair: We do have trees, yeah. I would like to invite Dave Broda to accompany me next year on what I've been doing the last three days and get knocked off his horse four or five times by branches, and then he can ask me if there are any trees.

Mr. Lukaszuk: It's that same tree every time.

The Chair: Thomas, perhaps you should join us also. We'll talk about that later.

So just a couple of preliminary items as we move forward today. Meeting materials were sent via e-mail to members and staff on Wednesday, September 22, and Friday, September 24. If anyone has questions about materials that you should have received or if you don't have the materials or if you have a question, please raise it, because there is quite a bit of information. Is everybody okay? All right.

The minutes from August 24 were e-mailed, and the minutes from the August 25 meeting were distributed this morning.

There's only one agenda for today and tomorrow since the committee's focus will be on the issue analysis summary and policy options during these next two days of meetings. Additional items can be considered under Other Business, and there are some additional items which will be considered under Other Business.

We'd like to welcome Ms Holly Gray from Alberta Justice. Holly, would you hold up your hand? She is replacing Heather Veale, who of course is not available because of health reasons. So welcome, Holly.

Of course, as everyone knows, we'll be breaking for lunch around noon today.

Are there any questions on those items to this point?

Dr. Pannu: Mr. Chairman, I shared a copy of a letter that I received on the 24th.

The Chair: Yes, I have it. We'll consider it under Other.

Dr. Pannu: Then that will be about when?

The Chair: Well, that depends on the committee. We could be there in 10 minutes if you want to, but I suspect it will be this afternoon sometime, 3:30. That's a guess, Dr. Pannu.

It's important that the committee deal with the items that we're going to discuss today, because if we're going to stay on the time frame for a draft report to be in your hands prior to October 7, our staff need to have the discussions of today finalized. So these two meetings today and tomorrow are really the last two meetings we'll have to discuss what's going to be in the draft policy document, draft recommendations, and then, of course, that will be finalized. We will ask you to finalize that document on October 15.

My best guess for the item, Dr. Pannu, is later this afternoon. Okay?

I would now like to ask all members of the committee to please introduce themselves. We'll go first with the elected members, and then we'll go with the staff members.

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

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

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

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

The Chair: Thank you very much. Again, welcome, everyone, to today's meetings. You have the agenda of September 27, and we already said that the 28th would be the same basically.

Are there items to be added to the agenda, Karen? Did you tell me that we were adding?

Mrs. Sawchuk: Mr. Chairman, I believe that the agenda has to stay as is. All of the additional items that the committee may be dealing with today or tomorrow will have to go under Other Business because they weren't circulated to the members prior to the agenda being done. So what's on the agenda is the official record at this point. Anything else gets brought up under Other Business, and the record will be corrected at that time.

The Chair: Thank you, Karen.

So a resolution to approve the agenda? Mr. Lougheed. Thank you. All in favour, please raise your hand. Opposed?

Okay. For clarification today, we have had some misunderstandings on votes in the past, so I'm going to ask members today, if they want to ask for a recorded vote on a motion, to ask for that prior to the vote. Then those in favour and those opposed will be recorded. So for simplicity, if you want a recorded vote, would you please request that to the chair prior to the vote? It's no problem doing that, and it's perfectly acceptable, but that would be the process we would prefer to follow.

Okay. We've adopted the agenda, so the minutes of August 24. Is that the one you said you had . . .

Mrs. Sawchuk: Yes.

The Chair: Karen says that there's at least one amendment that needs to be added.

Mrs. Sawchuk: Mr. Chairman, on the header on each of the pages other than the first page it shows August 10. It's been corrected now to read August 24, but on the copy that the members have it does refer to August 10.

The Chair: Are there any other additions or corrections to the August 24 minutes?

Mr. Goudreau: Mr. Chairman, I'll move adoption of the minutes of the August 24 meeting.

The Chair: Thank you very much. All in favour, please raise your hand. Opposed? Okay.

Moving to August 25, any corrections or additions to those minutes? Seeing none, could I have a motion to adopt?

Mr. Broda: So moved.

The Chair: Okay. Thank you. All in favour? Opposed? Carried.

We will then move to item 4 on the agenda. Evelyn, are you going to start on this one?

Ms Swanson: Yes, I will.

The Chair: Okay. So, Evelyn, would you please explain to the committee the document we have in front of us called Health Information Act Review: Issue Priorities. If you want to start with other categories to give background, that's fine.

Ms Swanson: Okay.

The Chair: These are the recommendations of the staff as to how we might proceed, so we will certainly entertain discussion, but I would ask Evelyn to commence the discussion on these. Has everyone got these? This is called Health Information Act Review: Issue Priorities, and there are two pages, pages 1 and 2. I don't know what day you received it.

I still see people looking for this, so let's pause for a moment till we get everyone onside with this.

Did it come out with this?

Mrs. Sawchuk: It was on Friday, Mr. Chairman.

The Chair: It's in front of my page 13 of 13, and then there are two pages, 1 and 2, which are entitled Health Information Act Review: Issue Priorities. In other words, it's the recommendation of the staff for the priorities, which we asked them to do.

9:15

Dr. Pannu: Are there some spare copies, Mr. Chairman?

The Chair: Certainly. I've got four myself, so you're welcome to any of mine.

Do we now have in everyone's hands a copy of the document called Health Information Act Review: Issue Priorities, pages 1 and 2?

Evelyn, the floor is yours.

Ms Swanson: Thank you. At the last meeting of the committee the technical support group was asked to go away and to develop some priorities for discussion by the committee. We did do that and also attempted to identify some possible responses to many of the issues. What we've done in these two pages is to create about six categories of issue, and we've slotted all of the issues into one or the other of the categories.

The first category is Priority Issues for Committee Discussion. We would see these as being items that the committee would probably spend a good portion of the next two days discussing.

Then we've got Other Issues on Which Amendments Are Suggested. These would be items where we are suggesting some changes in response to stakeholder input. There are quite a number of them: there are eight of these items.

The third category would be Amendments Suggested to Address Housekeeping Issues. These are items that we've identified that are basically housekeeping.

The Chair: Evelyn, if I may. On Other Issues on Which Amendments Are Suggested, I'm just wondering if any committee members have questions or comments. Are you going to come back to that one, Evelyn?

Ms Swanson: I'm going to come back through all of them.

The Chair: I'm sorry. Proceed.

Ms Swanson: That's fine. I was just going to tell you what the categories are, and then we'll come back and identify the content of each category.

The Chair: Okay. Good.

Ms Swanson: Okay. Housekeeping issues, then, is the third category.

The fourth category we've suggested might be to defer to a future committee of the Legislature that might be convened early in 2005. These are issues on which there is need for additional research and background work and perhaps additional consultation.

The fifth category is Issues Suggested for Deferral for Further Research and Consultation (by Alberta Health and Wellness in Consultation with Stakeholders) Prior to Next Legislative Review.

So these are items on which we believe there is need for a considerable amount of background work with stakeholders. They tend to be somewhat technical issues that require a little bit more time to find solutions to, and they're also items that we think could wait a little bit.

The next category is items on which we have some analysis underway, and we would be intending to slot this one into one or the other categories over the course of the next two days.

Status Quo are the items that were suggested by stakeholders and their recommendations where, generally speaking, there were only one or two stakeholders who mentioned this item. They were often items where clarification of the current provisions was requested, and we would be able to provide that clarification without necessarily creating amendments to the legislation itself. So these would be the six or seven categories that we're proposing to slot all of the items under.

The Chair: Perhaps we should go back, then, and talk about each one.

Ms Swanson: Sure.

The Chair: Then there will probably be questions, I assume.

If you have a question, please let's deal with it when you have it as we go forward rather than waiting until we finish the category.

Ms Swanson: So under Priority Issues for Committee Discussion we've identified three major issues, but they're very large ones, the first being the scope of the act including its application to other government departments, local public bodies, other public bodies, health professionals and health service organizations, Alberta Blue Cross, Workers' Compensation Board, employee health information in employer records, and nonrecorded information. This scope question actually deals with the first series of questions in the consultation guide, and this was an explicit part of the terms of

reference for the committee, so we feel that it would be a priority.

The second item suggested as a priority is discussion around health services provider information. There we had a question about whether or not health services provider information should be included under the Health Information Act and whether or not that information should be available for research purposes and also some technical considerations.

The third item for discussion would be disclosures for police. There are other issues that would be subject to discussion as well, but we see most of the time likely being taken by these three big ones.

Okay. Moving on, then, to Other Issues on Which Amendments Are Suggested. The first one is that we would suggest that an amendment allow access to identifiable health services provider information for research purposes on the same basis as access to identifiable health information about individuals.

Second, a number of the respondents raised issues around vexatious or frivolous requests for access to information, and we suggest an amendment that would essentially stop the clock while those requests are being considered by the commissioner.

Third, we've identified very many suggestions for disclosures without consent to various parties for various reasons, and after reviewing them all, we're suggesting a number of amendments that would allow disclosure without consent including disclosures to collaborative or integrated programs; third parties for payment purposes; provincial, territorial or federal health departments about services provided to people under their jurisdiction; other Alberta government departments and the federal government for payment purposes and determination of eligibility for health benefits and services; the triplicate prescription program, that's operated by the College of Physicians and Surgeons; and a successor where a custodian remains a custodian but transfers records. This is a technical item that was suggested by the office of the Information and Privacy Commissioner.

9:25

The fourth item on which we are suggesting an amendment would be a number of changes related to research provision. The first is basically a housekeeping change where we would change the term "health research ethics committee" to "health research ethics board." The second was a suggestion from the office of the Information and Privacy Commissioner, who requested authority to publish ethics approvals for research. We're suggesting that that be allowed after custodians have decided whether or not to disclose the information.

The fifth one has to do with the requirement to note every time information is disclosed about an individual. We would propose to remove the requirement to note the purpose of that disclosure when the disclosure is through an electronic system with an automatic audit capability.

Sixth, we're suggesting an amendment to add a provision to allow for collection, use, and disclosure of a unique identifier for health service providers for authorization and authentication purposes.

The Chair: A question on this point.

Ms Blakeman: Actually, on 5. Do you want to go through the whole thing and go back to ask questions?

The Chair: All right. That's fine. Sure.

Ms Swanson: Number 7, we're suggesting that we use the existing regulation-making power to create a regulation respecting retention, disposal, and archival storage of records. This was suggested by a few of the stakeholders.

Number 8 is that we enable a next friend or guardian ad litem to exercise the rights of an individual under the act if the exercise of the right or power relates to the powers and duties of the next friend or guardian ad litem.

So these are all items on which we have identified some need for change and would propose change. At a later step we'll actually go through the rationale for making any changes. That's included in a chart called Issue Analysis Summary. So at this point we're not looking for agreement, necessarily, with any suggested recommendation; it's just that these are issues that we think should be given some attention.

The Chair: Before I take Ms Blakeman, I have a couple of questions, comments on process. You pointed out that what we're doing here is presenting to the committee the priority issues and other issues and how to deal with the categories. When we get through this discussion, we would ask for support by resolution from the committee that these be acceptable as priority and other category issues.

The other question I have, Evelyn, is related. Probably I should know this, but I'm sorry; I don't. We've got a category of priority issues, and then we've got a category of other issues. Are the other issues also included in the analysis charts?

Ms Swanson: That's right.

The Chair: They will be there. So I guess my question is: priority versus other?

Ms Swanson: It's more a matter of time management in a way, because we think on the priority issues the committee may want to allocate a little more time to discussion. On the priority issues we've also prepared a discussion paper to allow for the committee to have as much information as possible to make its recommendations.

The Chair: So it's basically, then, time allocation, and you will be providing to the committee more information on the priority issues.

Ms Swanson: That's right.

The Chair: And if the committee agrees to these recommendations, we will be saying that we're going to spend more time on Priority, and then if we do have time, we'll cover Other. But that will come out in your analysis paper also.

Ms Swanson: Yes. We would hope that you can cover all of the issues that have been identified, but some of them you might consider in a little bit less detail than the priority issues.

The Chair: Okay. Thank you very much.

Ms Blakeman: Did I hear you correctly, that there would be more in-depth discussion of the items under Other Issues on Which Amendments are Suggested?

Ms Swanson: That's right. We've provided a chart, and it gives the suggested response as well as the rationale, and we would go through each of those items individually.

Ms Blakeman: Okay. I'll hold my question until then. Thank you.

The Chair: So that's this chart here, page 13 of 13. That's the one we're referring to. I trust that everyone has a copy of that.

Okay. So you're deferring that question?

Ms Blakeman: Yeah.

The Chair: Okay.
Any other questions thus far on Evelyn's analysis?

Dr. Pannu: Under Priority Issues, Mr. Chairman, we have three issues there identified for us, which include other government departments, public bodies, health professionals under the first one, and then we have health services provider information and disclosures to police. These are matters that came before us either through written briefs or through oral presentations before the committee.

One issue that I hope the committee will address this afternoon when we go to Other is the PATRIOT Act and its ramifications for legislation. I would hope that we can identify it as priority issue 4.

The Chair: Well, I guess, Dr. Pannu, we probably need to wait for that discussion, and if the committee so decides . . .

Dr. Pannu: I just wanted to note it at this point in this section.

The Chair: Okay. Thank you.
Seeing no other questions, Evelyn, maybe we could proceed with Amendments Suggested to Address Housekeeping Issues.

Ms Swanson: Okay. In this area we've identified five amendments that were identified by Alberta Health but also in at least one case by another stakeholder. First of all, the definition of custodian. There is a reference in one of the definitions to the RHA Act, and the particular section referenced is not accurate, so we would just update that.

Item 2, the definition of health services provider information. We were suggesting that it include business title and professional registration number and that the act would authorize disclosure of both of these to any person for any purpose, subject to the exceptions that are listed in the act related to revealing other information about the provider or potential harm to the provider.

The third is to correct an oversight that occurred in the initial drafting of the legislation to allow for disclosure to First Nations police on the same basis as at present for other police services.

Fourth, we would propose to authorize professional bodies to retain health information used in an investigation or a hearing for 10 years for consistency with the Health Professions Act. Right now we have an inconsistency between what's allowed under the Health Professions Act and what's allowed under the Health Information Act, and we would just make them consistent.

Item 5 is to delete reference in regulation to the "Billing Practice Advisory Committee" and replace it with reference to a "committee of an organization referred to in section 18(4) of the Alberta Health Care Insurance Act." This committee is a custodian, and it's named in the regulation. Its name has changed, and rather than changing the regulation every time the name changes, we would reference the provision in the act.

So those five items are all housekeeping items.

The Chair: Are there questions on housekeeping? Comments?
Okay. Defer to a Future Committee category.

9:35

Ms Swanson: Yes. Under this category we would deal with the harmonization of the Health Information Act with the pan-Canadian health information privacy and confidentiality framework.

Second, we would deal with the inclusion of some additional privately funded health professionals under the Health Professions Act and organizations with a primary purpose of provision of health services, and in considering their inclusion under the Health Information Act, we would propose that the rules that should apply in these cases be reviewed as well.

Third, we are proposing that two of the items suggested by the Information and Privacy Commissioner to extend his powers be looked at in the next review, one of them being an extension of his powers to include audits and the ability to compel information for audits.

Fourth, an extension of his powers to enter into extraprovincial agreements respecting investigations.

So these are items that we are suggesting be deferred to a future committee of the Legislature.

The Chair: I have one question, Evelyn. Could you give some more background on 1, the harmonization of HIA with the pan-Canadian health information privacy framework? Has that one been delayed? We've been led to believe all along that we would sort of make these two compatible. So could one of you give some background on that?

Ms Robillard: Yes. I'll speak to this issue. When we originally set out with this review with a conclusion time sometime next year, that fit well in terms of the time frame with the pan-Canadian framework discussions. As we looked at changing the timelines for this committee, we were of the hope, I guess, that the pan-Canadian framework consultation process would have concluded and we would have largely the feedback that we needed to consider here.

When Catarina was last at this table to discuss this issue, she acknowledged that we've not heard from all of the stakeholders even within Alberta yet on the pan-Canadian framework. One of the primary groups that we've yet to hear from is the physician community, which is a significant community relative to this initiative. As well, other jurisdictions are still concluding their consultation process, so we are somewhat out of sync.

We are anticipating that the pan-Canadian framework review will have recommendations in light of that process sometime in early December. If we were to try and make recommendations based on what we think might come out of that review, we would be speculating to some extent, so it's problematic.

The Chair: Thank you.
Mr. MacDonald, did you have a question or a point?

Mr. MacDonald: Yes. I have a question for information purposes, please. Now, while the pan-Canadian framework develops on a basis across the country – and we have three health information acts at the provincial level – what legislation would have supremacy in a court of law? That framework is virtually redundant, correct?

Ms Robillard: That framework is not legislation; it is a framework.

Mr. MacDonald: Exactly. It's a framework.

Ms Robillard: Yes.

Mr. MacDonald: So essentially it means nothing in a court of law at the moment.

Ms Robillard: My understanding of that would be the expectation that the plan behind the framework is to develop rules that would be harmonized by each provincial jurisdiction within the legislation that was appropriate for them to do that in.

Mr. MacDonald: Thank you.

The Chair: Mr. Goudreau.

Mr. Goudreau: Thank you, Mr. Chairman. Under deferral to a future committee, 3 and 4, "extension of the Commissioner's powers to include audits" as well as "extension of Commissioner's powers to enter into extra-provincial agreements," I fail to understand why we would want to defer those two and not deal with them under this review.

The Chair: Okay. Thank you. Who wants to answer that question?

Ms Swanson: Our reason for suggesting deferral of these two items is that with respect to the audit and ability to compel information, the item hasn't been discussed with stakeholders. It would impact on stakeholder operations if audits are conducted, so we feel that that is an item that should be discussed, not to say that we are opposed to it, just that it is an item that should probably be subject to consultation.

With item 4, the commissioner's powers to enter into extraprovincial agreements, we would like some time to work with the commissioner's office to have a better understanding of what his needs are in relation to extraprovincial agreements and how information would be protected when it's being looked at by an external body. So it's really to do some additional research and consultation in support of the next committee's work.

The Chair: You look very pensive, Mr. Goudreau. Is that acceptable?

Mr. Goudreau: Well, it seems to me that the commissioner was here and identified certain issues, and we've identified those issues here. I suppose that with all of these we could carry on and do a lot more research and a lot more thinking about it. I think that somewhere along the line we need to make a decision, and it seems to me that those would be appropriate for this committee to decide on during this particular review.

The Chair: All right. Ms Kryczka on this point; otherwise, I have Mr. MacDonald.

Ms Kryczka: Yes, it's on this point. For me I would respect the recommendations of the staff who have worked on this. I guess that I feel that they have better knowledge of what needs to be done to move this forward in working with the commissioner's office. Like, it's one thing for him to come in here and report it and say what he'd like to have. I agree with the extraprovincial agreements, I agree with what he asked for, but I guess I respect the fact that they may need some additional time, as they've just said. If additional time means six months or whatever it is – sometime in '05, right? – you're going to have a committee struck to finish these in '05. So if the timing is all right, I'm okay with that.

The Chair: Okay. Thank you.

Did I not understand you to say also that we haven't heard from some stakeholders who may have an interest on this subject?

Ms Swanson: That's right. It wasn't specifically a question put to stakeholders.

The Chair: So how will we deal with that now?

Ms Swanson: A future committee would likely deal with that. It might put out this as a suggestion for follow-up. It would be up to the future committee as to how it would deal with it.

The Chair: Well, it seems to me that if we need other stakeholder consultation and they haven't had a fair chance on this one, it maybe would be justifiable, Mr. Goudreau, to extend that.

Mr. Goudreau: Yeah. I'm fine with that.

The Chair: Okay.

Mr. MacDonald, did you have an additional question?

Mr. MacDonald: Yes. Perhaps it is to be addressed to the officials from the commissioner's office. The discussion earlier in the spring in regard to the miscellaneous statutes act was that the commissioner was to have some sort of power under FOIP, or the access to information act, to have the authority to work with other jurisdictions. Now, I don't know how this works with the Health Information Act, but certainly the commissioner has indicated in correspondence to me that he's waiting for the Information and Privacy Commissioner in British Columbia to release his report on the outsourcing of health services and how this affects or does not affect British Columbians with the PATRIOT Act, which is the American legislation that has wide-sweeping powers and that has implications for citizens of British Columbia, and it certainly has implications for Albertans.

Now, the commissioner has said that he's waiting for this to happen in B.C. What sort of authority does the commissioner have now that would give him the authority to wait, or what sort of process works in that case? I was told that we could wait, that we could have patience and wait for the British Columbia commissioner to report on this issue, yet you're telling me that all this should be deferred. Can someone help me with that, please?

9:45

The Chair: Mr. MacDonald, I would say that we do have the letter from Dr. Pannu which we're going to discuss under Other today, which it seems to me does relate to your question somewhat.

Mr. MacDonald: You bet it does.

The Chair: Anyway, I don't know, but if someone from the commissioner's office wants to respond or comment, we would welcome that.

Ms Inions: Well, the difficulty in practice is that life has to go on and complaints have to be responded to, so the provincial commissioner continues to have to deal with issues because he doesn't have this authority in a duplicative way. The federal commissioner as well as the provincial commissioner would need to look at the same issue if a complaint came in. If there were the authority for the extraprovincial commissioner powers and delegations, then it could be handled by one commissioner. So it's the streamlining; it's, I guess, an economy; it's an efficiency in doing work that there's a legislative duty to do. You must go ahead and receive the complaint and address it and do what you need to do under the legislation.

I think the PATRIOT Act issue may be quite a separate type of issue, in that that report is forthcoming and will need to be responded to. That's a very specific kind of situation, when information is being compelled, in contrast to the ongoing work of the commissioner's office, where there's a duty to respond to a complaint and investigate and mediate, and many of these complaints

now, because HIA covers both private and public sectors, clearly will have implications for PIPEDA and the federal legislation.

So it certainly is very problematic to continue for a lengthy time without the clear authority to streamline that process.

The Chair: All right. I think we should move on here. We will be covering this again under Other as requested by Dr. Pannu.

Are we down to – which one? Issues Suggested for Deferral for Further Research. Okay. Could we start with that one, then?

Ms Swanson: Yes. The first item that we are suggesting be deferred for further work by the department with stakeholders is the matter of orphaned records. This was an issue raised by both the office of the Information and Privacy Commissioner and the College of Physicians and Surgeons, and they each had different suggested approaches to the issue. We think that there is need for further discussion with the stakeholders and in particular the custodians to try to find a solution that will be workable.

The second item has to do with disclosure of health information without consent to police to investigate fraud in the health system. This was an item that was suggested in the government of Alberta submission. Upon further investigation we feel that this is an area that does require some additional work before a specific amendment is proposed, so we would like some time to do that work.

The third item is custodian duties and obligations related to the electronic health record. This also was an item raised in the government of Alberta submission. Most of the people who responded to the questions around the electronic health record felt that it was somewhat premature to identify changes in the rules. Some thought the rules should stay the same, others thought some specific changes might be made, and still others said that it was still too early. So we would suggest that this item be deferred for further work as the electronic health record is evolving.

Dr. Pannu: Mr. Chairman.

The Chair: Certainly, Dr. Pannu.

Dr. Pannu: Evelyn, would you clarify? You said that some people want the rules to stay the same, others want changes. Who are these people? Would you clarify, please?

Ms Swanson: I would have to go back to our stakeholder summary to answer that question.

Dr. Pannu: Oh, I see. You mean the submissions.

Ms Swanson: That's right. But I think about half of them said that the rules should be much the same in principle regardless of whether the records were in paper or electronic form.

Dr. Pannu: Thank you. I've got the information.

Ms Swanson: Okay. Item 4 has to do with the retention period for notation of disclosures. This item was suggested by, I believe, one of the pharmacy-related groups. We need to do some additional work to determine what change might be appropriate for all the stakeholders who would be involved. There was one suggestion, but it would affect many custodians. There is a need for additional research on it.

The fifth item is one that was suggested by the government of Alberta submission as well. It has to do with the information manager provisions, the information management agreements, the application of these provisions to custodians who are also information managers, and the relationship to affiliates. These issues have all arisen around electronic health records, and there is room for additional background research and some time to do it before decisions are made about changes to the legislation.

Number 6, fees set out in the Health Information Act regulation, we would propose be deferred until the regulation review in 2005. That regulation has to be reviewed and repassed or amended by November 2005.

The Chair: Okay. We have a question. Mr. Goudreau.

Mr. Goudreau: Just maybe an additional comment. It doesn't really relate to sections 1 to 6 there under deferred issues, but at one of the first meetings I brought up the fact that there were some records that had been seized by the police, and those records were sort of in never-never land. In this case the custodian was being investigated for a murder, and I received a pile of phone calls from family members saying, "How can I access those records?" and "Where are those records?" and "Who has authority over those records?" Somehow I don't think that's been addressed, whether or not this should be part of orphaned records/seized records kind of thing, and it should be looked at. I don't know if it is in the act or not.

Ms Miller: I think that we would consider that issue under the orphaned records category. Surely, we recognize that a process needs to be established to accommodate that issue as well as other issues associated with orphaned records. The issue is: what is the appropriate mechanism? There are very differing opinions on what that is, so we need further investigation.

Mr. Goudreau: See, in this case they're not really orphaned records.

Ms Miller: Not technically, yeah.

Mr. Goudreau: They're records up in the air, and somebody needs to take over those records. It's certainly a matter of trying to figure out a process that doesn't allow people to suffer.

Thanks, Mr. Chairman.

The Chair: I think Mr. Goudreau raises an excellent point. Just for clarification here, you're recommending to the committee that they recommend that another committee be convened early in 2005 to discuss the items under that category, but this category is recommending that these items be considered prior to the next legislative review. So I assume that they would be included in the next legislative review, whenever that is, which probably is three, four years down the road.

The member raises the point that, you know, his people need some explanation now, not four years from now. So I don't know. Is there any way we could move it up into the previous category of items to be considered by a recommended committee early in 2005? Is that a possibility? That would probably be more acceptable to the member than the next review.

Mr. Goudreau, would that help?

Mr. Goudreau: Certainly, that would make more sense. At least it needs to be discussed, and it needs to be decided upon, I think, and the quicker the better.

9:55

Ms Miller: I think we certainly could see it moving forward. What we were looking at at this time was that we, as Alberta Health,

needed to do considerably more work. Presuming we can get through some process and agreement on what is the right way to handle orphaned records, certainly that could be put into the category of the next committee, for early '05.

Ms Kryczka: I just want to clarify that with each of these points we are going to be going into them in a little more depth.

Ms Miller: Yes.

Ms Kryczka: Thank you.

The Chair: In the analysis document, the three-column document, whatever it is, we will be discussing . . .

Ms Kryczka: That's where we will get more into this?

The Chair: Well, except for the ones that are being deferred. We won't get into those.

Ms Kryczka: Yeah. I guess I'm just wondering: this is all the information we really need at this time, to look at these two pages and agree that we're going to go forward on this basis? Then we'll get more information following.

The Chair: Yes. We're just talking . . .

Ms Kryczka: Otherwise, I have nothing to say then.

The Chair: We're talking about process here and recommended priorities and categories. When we get into the analysis, we will actually be talking about the recommendations, pros and cons, et cetera.

Ms Kryczka: So there'll be more in-depth discussion on all of this?

The Chair: Yes.

Ms Kryczka: Okay. Good.

Dr. Pannu: Mr. Chairman, just clarification. Linda has just agreed to move something from one category to the other. I just want to be sure exactly what's being moved from the next legislative review category back to the review to be undertaken in 2005. All of these six items will move up?

Ms Miller: My understanding is just the orphaned records content, number 1.

Dr. Pannu: Okay. The first one. All right.

The Chair: Comment, Linda?

Ms Miller: No. That's my understanding.

The Chair: I want to make sure that we're clear on the two stages we're talking about here. One is that early in 2005 the recommended committee deal with some of the items we haven't had time to deal with in this review. That is the recommendation that's being recommended to this committee. Okay? Then, of course, we would also expect that at some time in the next four or five years there will be another review of the Health Information Act.

I actually think the recommendation by the technical team to do a review early in 2005 is a good recommendation because it leaves us some room to deal with some of the items we won't have time to deal with. If that's the decision of the government, then certainly that would help this review.

I think, though, Evelyn and Wendy, that we probably should also include that the next review, in 2005, would have a limited scope. I don't see why they would need to review all the items this committee finalizes. Would that be your thinking?

Ms Robillard: Absolutely. The intention would be that that committee have limited scope and that this committee would deal with a large number of issues and end up resolving those ones.

The Chair: I'm certainly comfortable with that because I'm cognizant of the people who have presented and taken time to make submissions here. I think to the best of our ability we need to deal with the recommendations – at least some of the recommendations – they've made, and they perhaps can be comforted by knowing that others will be dealt with early in 2005.

All right. Did you want to finish up on those last two before we proceed, Evelyn?

Ms Swanson: Okay. The next category is Items on Which Additional Analysis is Underway. The Alberta Long Term Care Association made a suggestion about substitute decision-makers, and we're just doing a little bit of work on that and hope to have a suggested response by tomorrow.

Status quo items. As I mentioned earlier, these were often items that were raised by only one or two stakeholders, who made recommendations on particular items. A good many of them dealt with clarifications of existing provisions, and as we looked at these items, we often concluded that in our view the legislation was relatively clear and that we would be able to provide guidance by way of our policy manuals and interpretations back to the stakeholders so that they can work within the existing provisions.
So a number of them were strictly clarifications.

There were some other suggestions related to stakeholder accountability and some to increase authority to disclose without consent, others to decrease authority to disclose without consent, and we felt that on balance it was better not to move on any of those. We will go through each one of them in the chart, and you can take a look at the rationale that we had for our suggested response on each one and make your determination.

The Chair: Thank you, Evelyn.

If there are not questions on the last categories, I would like to suggest to the committee that we would like to adopt these priority and other category issues as a recommendation as identified by the technical team, that the committee would agree to these subject to the proviso that, first, Dr. Pannu has requested that under Other he wants to raise a point that he, I assume, is going to ask to be considered as a priority issue. So we would make your acceptance of these documents subject to that discussion under Other. Also, I think that under orphaned records the recommendation has been made that number 1 under issues for deferral for a future legislative review be moved up to the future committee to be convened early in 2005. [interjection] Yes, we will take you in a moment, Ms Blakeman. Those would be at this point the two provisos that we would be amending or adding to these pages 1 and 2. We would like at some point today to get these adopted by resolution with those provisos.

Ms Blakeman: I'm seeking advice or input from the technical

support that are here. There are two issues that are not specifically laid out in the lists and categories that you've given to us. May I presume that the accuracy of information and the issue of informed consent would be discussed as part of or perhaps across categories? I'm concerned that those two issues are not showing up, and I think they have come up a number of times in what people raised with us here in presentation, but they may not merit a category unto themselves because they cross all categories. Would I be fair in assuming that?

Ms Robillard: The issue on consent – informed, implied consent and all of those issues – is linked to the pan-Canadian framework, and as we go through the chart, we will address those questions as they come up and provide our suggested response and rationale. So, yes, we'll get into detail on that.

Ms Blakeman: The second one was the accuracy of the information and the implications that that has in a number of areas.

Ms Robillard: We never had a question of accuracy put before the committee to my knowledge or recollection.

Ms Blakeman: It was raised by people that presented to us in the context of: is the health information held accurate?

Ms Miller: To be honest, I don't recall it being specifically asked that way.

Ms Blakeman: It came under the Consumers' Association. I asked specifically about what the rate of error was, and she couldn't give it to me from theirs, but she gave it to me from another similar study at 40 per cent inaccurate.

Ms Miller: I do not recall that discussion. However, I'm not sure how legislation could address, fundamentally, the accuracy issue. I'm concerned with what the proposal was there in terms of how that could be achieved. Improving accuracy of information is an ongoing issue and probably always will be. It's about accurate input. It's reflective of the kind of system design that you build into a particular information system. It's about ensuring that the kind of data that you're asking to be collected works in sync with a provider's workflow. I mean, there are many, many factors that influence the accuracy of information. Legislation in that regard or legislative provisions: I'd struggle with that at this point.

Ms Blakeman: I wasn't seeking legislation.

10:05

Ms Robillard: If I can add to the question, there is a provision currently in the act which puts a duty on the custodian to ensure the accuracy of the health information that they have. It says, "Before using or disclosing health information that is in its custody or under its control, a custodian must make a reasonable effort to ensure that the information is accurate and complete." So that provision is in the legislation.

There's also a provision around correction and amendment. So if an individual identifies an error in their information, they have a process to ask a custodian to correct that and to seek the commissioner's review of that decision should there be difficulty. I'm not sure what beyond that you would like us to address.

Ms Blakeman: I think it'll come up in the context of discussion around scope.

The Chair: All right. Thank you.

Could I have a resolution? Is someone prepared to move adoption of the Health Information Act review issue priorities and categories subject to those amendments that have already been defined?

Mr. Broda: I'll make that motion.

The Chair: Okay. Thank you very much.

Dr. Pannu: Mr. Chairman, I think it's reasonable to ask the committee to approve the framework which is being proposed here with the exceptions that you have already outlined. However, we're dealing with a huge bulk of important information that is contained in all the briefs and discussions around this table. I would hope that this framework is interpreted with some degree of flexibility allowed in in case, as we examine some of these issues, some other items might come up that we're willing to include.

The Chair: I always hope that common sense would prevail, Dr. Pannu. So, you know, if there is an item that comes up that the committee feels should be included, I certainly would entertain that concept, yeah.

Okay. On Mr. Broda's motion that

> we adopt these two pages as the priority and other categories subject to the two provisos that were made,

namely Dr. Pannu's letter for discussion under Other and the orphaned records and also with the comment that's been made relative to discussion as we go forward that if there's an item that in the discussion comes out that it's felt by the committee needs to be added, that would be the committee's prerogative, all in favour, please raise your hand. Opposed? Carried. Unanimous. Wow.

I'm going to propose now that we break for a few minutes before we get into the hard stuff and that we reconvene at 10:30 sharp.

[The committee adjourned from 10:08 a.m. to 10:31 a.m.]

The Chair: All right. We will reconvene, call the committee back to order.

Evelyn, I will leave it to you for the order. I don't know; are we going to start with number 1? Incidentally, we are now on the Draft for Discussion: Health Information Act Three Year Review, Issue Analysis Summary, page 1 of 13. Is that the document that we're going to look at now?

Ms Swanson: We're going to use that as a backup.

The Chair: Okay.

Ms Swanson: What I thought we might do is start with the three priority issues, the first one being the scope of the act. There was a discussion paper handed out at the beginning of the meeting headed Question 3, Scope. Does everybody have that?

The Chair: Okay. Question 3. Everyone got that one? It's called Discussion Paper: Scope.

Ms Swanson: There is additional background in the issue analysis chart. My apologies for various pieces of paper, but we'll try and bring it together for you.

This discussion paper, question 3, actually is an overriding question that also relates to questions 4, 5, 7, 8, and 9. This is the question about whether the scope should

> be expanded to include other departments of the Government of Alberta, local public bodies as defined in FOIP, and to any other

entity that is not a custodian and that has health information about the health of an individual in its custody or under its control.

The Chair: A question, Evelyn. Are you on question 3 in the other document?

Ms Swanson: Yes. I'm on Question 3, Discussion Paper, and in your issue analysis summary it would be question 3.

The Chair: Thank you.

Ms Swanson: We retained the order of the items in the consultation guide. That's why they're out of sync with our priority issues. If it's okay with you, I will sort of run through the background and the analysis that we've done, because we just handed out the paper this morning, and then go into discussion, or you can raise questions as we go along.

So the background to this item is that the act currently applies to custodians of health information primarily in the publicly funded health sector. The current custodians include the minister and the Department of Alberta Health and Wellness, the RHAs, the Alberta Cancer Board, the Alberta Mental Health Board, hospitals and nursing homes that are not directly operated by the RHAs or the two boards. It also applies to health service providers paid under the Alberta health care insurance plan, and that includes physicians, chiropractors, dental surgeons, dental mechanics, opticians, optometrists, podiatrists, osteopaths, pharmacists and pharmacies regardless of how they are paid, and boards, agencies, committees, and other organizations that are listed in the regulations. So that's the current list of custodians.

Although it's not stated here, the information that's covered by HIA and held by these people relates only to the information related to a service that's paid for by the department.

The act also applies to affiliates of custodians, and these are people that are employees of custodians or agents or contractors, volunteers, and physicians paid by a custodian or physicians having privileges with a custodian. So those are the affiliates. The AADAC and PDD boards are excluded. Ambulance operators were also excluded.

Additional background. One of the reasons why we're looking at this now is that the provincial steering committee on the original HIA recommended in 1998 that the health information rules should apply to both the public and private sectors in order to create a level playing field and also to ensure that privacy is protected regardless of whether the custodian is a public- or private-sector entity. The government did not accept that recommendation in whole. They determined that the act should apply primarily to the publicly funded sector but did accept the notion that the matter should be reviewed by a committee of the Legislature after three years of experience under HIA. So that's where we are now.

The Health Information Act creates a controlled arena within which the custodians can share health information without consent for purposes listed in the act. It also includes privacy protections for individuals and health service providers respecting disclosure outside the arena and creates rights of access for the individual to the individual's own information. So it sets out the two parts. One is the protections for the individual and the access provisions for the individual to see his own information. The other side of it is setting out rules within this controlled arena within which custodians and affiliates can share information.

Also, in Alberta we have the FOIP Act, which protects personal information, the privacy of personal information held by public bodies. This act also creates rights of access by the individual to both general information and personal information. The personal information does include information about a person's health and health care when the information is not held by a custodian under HIA. This means that health information held by public bodies is subject to privacy protections and individual access rights under either HIA or FOIP. This is relevant to the discussion of scope because privacy protection is there regardless of whether your health information is in Alberta Health and Wellness or social services, HR and E. Regardless of where it is, there are privacy and access protections.

Since the Health Information Act was introduced, additional privacy legislation has been proclaimed for the private sector. PIPA, which is a provincial act, provides privacy protections for the individual's personal information, including protection for employees of private-sector organizations. So this starts to get at the private sector, where HIA and FOIP don't apply.

PIPEDA is the federal legislation for the private sector. It provides privacy protection for the individual's personal information, including information about health and health care. It creates rights of access to one's own personal information. This act also includes protections for employees of federally regulated organizations.

So that's background about the privacy legislation environment.

Now, on to what the consultation told us. We found a great deal of consensus that ambulance operators should be brought within the scope of HIA. There was also considerable support for bringing other health professions and health service organizations within the scope. So those are two categories.

But there was very little support for bringing some other potential bodies under HIA. There was little support for bringing Alberta government departments or local public bodies under. There was little support for bringing Alberta Blue Cross or the Workers' Compensation Board within the scope. The rationale is that individual health information held by these bodies is seen to be adequately protected now under the various pieces of privacy legislation, and individuals do have rights of access to their own health information.

10:40

There was considerable consensus that adequate privacy and access protections are in place for health information in employee records, so there was very little suggestion that health information in employee records should be brought under HIA.

In our analysis we are indicating that all entities that provide health services in Alberta or that hold health information about individuals are covered by one or more privacy acts, and Alberta Justice did provide us with a memo that outlines and compares the provisions in the four pieces of legislation and also a chart comparing PIPA, PIPEDA, HIA, and FOIP.

Then we go on to indicate that Alberta government departments and local public bodies, like the schools, fall under FOIP, so that's the relevant legislation. Health professionals in private practice and health service organizations that are privately funded fall under PIPA and/or PIPEDA. In light of the privacy protections and rights of individual access provided in these other statutes, the primary question for inclusion under HIA seems to be whether any additional health professions or health service organizations should be brought into the controlled arena and, if so, determining what rules should apply to their collection, use, and disclosure of health information within the arena.

Few health service organizations currently outside the scope and no health professions currently outside the scope of HIA participated in the consultation. Their views about inclusion are not known, and

their needs for health information from other custodians are not entirely clear. So the people who might be affected by coming in didn't respond.

The Chair: Could we take a question at this point, Evelyn?

Ms Swanson: Sure.

The Chair: Mr. MacDonald.

Mr. MacDonald: Yes. Thank you. Earlier you stated that there was considerable consensus that adequate privacy and access protections are in place through other legislation for health information in employee records. If we look at that definition – I think it's 1(1)(k) under the Health Information Act.

> "Health information" means any or all of the following:
>
> (i) diagnostic, treatment and care information;
>
> (ii) health services provider information;
>
> (iii) registration information.

Where would an alcohol or drug test as a pre-employment test fit in or not fit in? Is that considered health information, or is that under occupational health and safety? Where does that information fit into the scheme of things?

Ms Robillard: I believe we provided a response to this via Government Services, and I don't have that response in front of me, but it links back to who is doing the pre-employment test. Most employers are outside of the Health Information Act, so HIA does not apply to that information. Many of those employers are bound by PIPA and some by FOIP, so the provisions in those pieces of legislation would apply.

Mr. MacDonald: So a blood test or a urine sample would not in that case be considered health information.

Ms Robillard: If the organization who has that information is not within the scope of the act, HIA would not apply to it.

Mr. MacDonald: Thank you.

The Chair: Okay.

Ms Swanson: Okay. On the next page we have a series of recommendations that deal with questions 3, 4, 5, 7, 8, and 9, various questions about who should be within the scope of the act. Based on our analysis, our suggested response would be that we not bring other government departments or local public bodies within the scope of HIA because they're adequately covered by FOIP.

The Chair: Are there questions or comments on that recommendation?

Ms Blakeman: A reality check. Can I just be clear here? What we've got is that FOIP is provincial legislation which covers government and the MASH sector. Right? Municipalities, academic institutions, schools, and health. Correct? Okay. So FOIP covers information held by government or by that MASH sector.

PIPA has provincial jurisdiction and covers information held by the private sector and the NGO sector. Anybody else I've missed? Okay.

PIPEDA is covering information held by the federal domain and the provincial domain, also for people in the private sector or the NGO sector. Right?

Ms Swanson: I believe so.

Ms Robillard: Fundamentally, yes.

Ms Blakeman: Okay. Then Health Information does cover only health information under the province.

Ms Miller: As defined in the act currently.

Ms Blakeman: As defined in the act. Okay. Sorry. As we start saying, "Well, yeah, that's okay because it's covered somewhere else . . ." But is it covered in the same way? Does it have the same sort of protections? No. Those other acts are designed for other functions beyond strictly the holding of health information and the sharing of health information. Okay.

Thank you.

The Chair: Further to that, could you clarify again for my benefit what PIPEDA does? Private for some areas in provincial and federal?

Ms Miller: It's federal legislation that would apply for services typically described as those funded in the private sector. Where it overlaps or could potentially overlap into the public sector is that PIPEDA includes services provided by the physicians, the pharmacists, and labs that are privately owned. In HIA today those services that I just described, the overlap, are also caught in HIA services, so that's where the overlap occurs in current scope arrangements.

The Chair: Thank you.

Ms Blakeman: Thanks.

The Chair: So the rationale is that we don't need to bring these others under because they're already covered with some other privacy legislation such as FOIP, PIPEDA.

Ms Miller: That's correct; yes.

The Chair: Right.

Ms Miller: Pending, you know, the recommendation later on that the whole pan-Canadian framework discussion be tabled to be addressed as part of the activities of the next committee.

The Chair: Any other questions or comments on recommendation 1?

Which questions did you say again that we're addressing here?

Ms Swanson: Questions 3, 4, 5, 7, 8, and 9.

The Chair: So if we get through these recommendations, have we covered all the discussion on those six questions?

Ms Swanson: Pretty much. There is some additional background in the chart on some of these specific items. Maybe I should go back through those.

The Chair: Yeah. I think that would be helpful.

Ms Swanson: Okay.

The Chair: Because it seems to me that I read something that might be in addition to.

Ms Swanson: Okay. Question 3: I believe that in the chart, the issue analysis summary, I've pretty much covered that in the discussion paper.

10:50

Question 4 was specifically: "Should operators as defined in the Ambulance Services Act be included in the scope of the Act? If yes, what is the rationale?" Our suggested response, consistent with your conclusion at the last meeting, is to include ambulance services and ambulance operators within the scope of HIA, and the rationale is that there was consensus that ambulance services are an integral part of the health system as reflected by the government decision to transfer governance and funding to the RHAs in 2005. There was a lot of consensus that inclusion would improve information sharing and be a benefit to patients.

Question 5 was whether the scope of the act should be changed given the implementation of the Electronic Health Record, and if so, how, and what are the reasons? I will focus on the rationale on this one. Here we are suggesting that this be the focus of the next review of HIA through a committee of the Legislature established early in 2005. We think that this question does need some additional background. The rollout of the electronic health record to existing custodians province-wide is expected to take about three years. There is no demonstrated need for inclusion of additional custodians for purposes of the EHR immediately. However, inclusion of additional health service providers should be considered as soon as possible in order to ensure a complete assessment of the rules that should apply to the sharing of health information among these providers and existing custodians.

The Chair: A question, Evelyn. So consistency between the review recommended in early 2005 and the fact that some of these aren't going to roll out for three years: how will that future committee deal with that?

Ms Swanson: I think the committee would still need to spend some time talking with stakeholders about their inclusion, whether they should be included or not, and what rules should apply to their inclusion if they are included, so it will take some time to sort that out. Any legislative amendment takes a little bit of time to work through the system.

The Chair: Okay. Thank you.

Go ahead, Evelyn.

Ms Swanson: Question 7 is the next one that's relevant. "Should personal health information contained in employee health files be part of the scope" of HIA? If yes, what is the rationale? If not, what's the rationale?

So here we are suggesting the status quo, that health information in employee files not be brought under HIA. There was considerable consensus that there is adequate privacy and access protection in place through existing legislation including FOIP, PIPA, and PIPEDA. The health service providers would prefer not to deal with rules in multiple acts. They do want harmonization. But extension of HIA to health information in employee records would require all employers to deal with multiple acts. So on balance we're saying that the status quo is probably the place to be.

The Chair: Comments or questions from the committee on question 7?

Did you also say 8 had application here?

Ms Swanson: Yes, 8 has application as well. This is a question of whether the Workers' Compensation Board should be included in the scope. On this one as well we're recommending the status quo. Again there was considerable consensus that there's adequate privacy and access protection through the Workers' Compensation Act and through FOIP, which both regulate information practices of the WCB. In fact, a number of custodians – not just custodians but other stakeholders – raised a concern about potential loss of work or privacy if the Workers' Compensation Board becomes a custodian under HIA with access to additional health information without consent. So there was considerable consensus on that one as well.

Number 9 has to do with the question of the Alberta Blue Cross, whether it should be subject to HIA. Again we're recommending the status quo, and the reason is that again there was considerable consensus that privacy and access protections exist in other legislation and that they are adequate for Alberta Blue Cross insurance and benefit plans. The government-subsidized plans for seniors and individuals that are administered by Alberta Blue Cross on behalf of Alberta Health and Wellness are already under the scope of HIA. Alberta Blue Cross is an affiliate for the purpose of those plans. Other government-funded benefit plans administered by Alberta Blue Cross – for example, Alberta Human Resources and Employment – fall under FOIP, so Alberta Blue Cross there is bound by the rules under FOIP. And for its employer group plans and individual plans administered by Alberta Blue Cross, coverage is provided by PIPA and/or PIPEDA. So they are working with all four pieces of legislation now.

Our suggested response is that Alberta Blue Cross should be treated in the same way as other insurers to avoid an unfair advantage or disadvantage to any particular insurer. Insurers should not be custodians, because individual privacy and confidentiality would be reduced by allowing insurers access without consent in the controlled arena and because they are not health service providers. Insurance companies fall under PIPA and/or PIPEDA. The Insurance Act does not impact the ability of insurers to disclose personal information without consent, though it does allow for collection and use of personal information about those who are related parties without consent.

So when it comes to Alberta Blue Cross, we're suggesting the status quo. It is covered one way or another, and there's no need for information sharing there.

The Chair: Do we have questions or comments?

So going back to the discussion document recommendations, have we covered all those other items? Are there any questions or other comments that need to be made relative to the recommendations, Evelyn or Wendy or Linda? Anybody?

Ms Blakeman: So if we accept the work that has been done and put before us and the compilation of various people's and organizations' views on this, it seems to me that we are talking about expanding the scope only to include ambulance operators. That's the only group that we are specifically looking at changing and adding into the scope. All other possibilities to be added into the scope have either been deferred for other discussions or turned down. Am I reading this correctly?

Ms Swanson: That's right. We are suggesting that a next committee of the Legislature in 2005 look at the question of privately funded health professionals and privately funded health service organizations and, for that matter, any other health service organization out there to determine whether or not they should be brought within the scope of the Health Information Act primarily for purposes of

information sharing. The question would be: do they need information sharing in order to provide health services, to improve patient care, or to manage the health system? From a privacy perspective we feel that for the most part privacy is protected under FOIP, PIPEDA, or PIPA.

11:00

The Chair: We've covered quite a bit of ground here, so I want to make sure that the committee is okay with the recommendations.

Dr. Pannu, do you have a question?

Dr. Pannu: Mr. Chairman, you said: if the committee is okay with the recommendations. I wonder what information you're seeking from us.

The Chair: Okay. The recommendations have been made. These recommendations that I referred to have been basically covered in questions 4, 5, 7, 8, and 9. So my question was: are there any other points under the recommendations that weren't covered under the questions that we addressed or vice versa? I'm just giving the committee every opportunity to ask questions on the recommendations or the application of the recommendations to the questions that we addressed.

I have two questions. Ms Kryczka and then Ms Blakeman.

Ms Kryczka: Well, mine wasn't a question specifically. I just wanted to make the comment that I think that it's come a long way, but it's been captured from the first document, the long document that we had at our last meeting, where we were presented with more information. This is just another summary that I think is very concise and captures everything. I just commend the work that's been done.

Ms Blakeman: All we've had so far is a discussion of who to put into the scope or possibly gather into the scope, but there's been no discussion of who maybe should be taken out of the scope. I continue to have concerns that the Minister of Health and Wellness and cabinet colleagues of the Minister of Health and Wellness are privy to individually identifying health information without consent.

I've asked questions on the record about how many times the minister has requested information, and the answer is: none. But there is a request in the pipeline, I understand, and I still have concerns about why the minister as an individual needs to know individually identifying health information about people without consent and, further, that that information can be shared with other members of cabinet. I need to put that on the record. Nothing I have seen or read in the many times we have gathered here now and in the additional reading I have done justifies that information, that power.

The Chair: Thank you.

Does anyone wish to address that again? I acknowledge that Ms Blakeman has raised that issue before; I can remember that. We no doubt talked about it then.

Again to the point she makes, Linda.

Ms Miller: Yeah. I believe I tried to answer this question in the government submission.

If I could first speak to the part of section 46(1) which talks about how "the Minister or the Department may request another custodian to disclose individually identifying . . .," and it goes on. The department on behalf of the minister requires individually identifying information because it is our only way of linking information from one database to another, to be absolutely certain that you are linking the right information about the same person across the different databases. There is no single database that exists that captures it all across the whole continuum of health services.

So we receive it from the custodians, primarily the health authorities, in an individually identifying capacity for linkages. However, within the department very few people are provided access to identifiable information at an individual level. It is linked typically by very technical people that are technically proficient in systems development but probably have very little understanding of health service information.

It then is linked across the databases and posted in what we call a data warehouse where subsequent people, such as policy analysts and management people, access the information to determine a particular answer to a question posed by the minister or perhaps a member of the House, depending on whatever the question is, or some future strategic directions for the health system. Only under very rare – we have commented on one situation that is in the pipeline where we are asking or suggesting to the minister that he compel further identifying information. We do not have any information at this time whether the minister will actually agree to that request that is in the pipeline as we speak.

Ms Blakeman: My concern here is that it's without consent. What is the roadblock to having the minister or his designated representatives, such as staff in the department, go to the people that they need the information from and get consent? It causes me great concern when we have a minister of the Crown that gets access, unfettered essentially, without consent and the information is individually identifying. One modicum of protection for the individual would be the requirement that there is consent.

Ms Miller: My response to that would be that in the department's view it would be administratively overburdensome to do that. We are talking about linking millions and millions of records, depending on the particular question or analysis trending that is under review.

I mean, there are an uncountable number of questions that are asked within the department and/or of the department, which require linkage of, as I've said, millions of records in any given period of time. So to ask for consent for each of those questions under each of those circumstances, we'd be overburdened, without question. It would completely paralyze any analytical or strategic direction that the ministry could provide if we had to do that.

Ms Blakeman: But I thought that up to this point the minister had not requested individually identifying information, that that had not happened.

Ms Miller: For information that we don't currently have as identifying is the one in the pipeline.

Ms Blakeman: Oh, I see. But all the information you've already got, you can work with.

Ms Miller: We ask for it to be identifiable at the individual level for the reasons I've tried to outline. It is our only way, it's anybody's only way to link records from the acute care sector, say, to the home care sector, to the ambulatory care sector, to any other sector of the health care system. It's the only way with any degree of certainty that you're linking the right records across those continuum. It's absolutely imperative for obvious reasons, and to do that, you need to have the unique identifying information of a particular individual.

Ms Blakeman: Well, I'll just stay on record with my serious reservations on this. Thank you.

The Chair: All right.
Mr. Goudreau.

Mr. Goudreau: Thank you. Just to bring the committee up to date, the ambulance operators came to me in the last little while, and in rural Alberta, especially in my part of the world, they are often not the first responders to an accident or a call. Sometimes the fire truck or another rescue unit gets there first, and then they need or feel that they have to use a defibrillator or provide some health service. I think we need to look at that in future reviews. I don't want to add to this particular review, but I think it might be something to look at in the future.

The Chair: So a question, Mr. Goudreau. Are you saying that ambulance operators don't want to be included?

Mr. Goudreau: No. They want to be included, but they've also indicated to me that often they are not the first responders to a particular situation and that maybe others, including those that are trained with the fire department or in a rescue truck, should be included.

11:10

The Chair: Okay. I hear you.
Wendy or Evelyn or Linda, do you have any response to that?

Ms Robillard: I can provide a very preliminary response. Some of the first responders who may approach a scene and may in some cases provide some kind of a health service to sustain life aren't largely part of the health system and don't require ongoing information sharing. In fact, they probably in those cases don't even collect health information. They may act before they even know who the person is. The ambulances are on scene usually fairly quickly, and they are part of the health system. They do transport and share information back and forth with the hospital. So the requirement for the sharing of health information is different even if there is some provision of service by another department.

The Chair: Okay. Thank you.
Other comments or questions? Did you have additional comments on these recommendations?
Okay. Would your plan, technical team, be that we get resolutions to support these as we go forward rather than the whole document?

Ms Miller: Yes.

The Chair: Okay. So you would like us to get a resolution on the items, the questions that we have now covered?

Ms Miller: If possible.

The Chair: Okay. Before we do that, we have – were you going to make a motion, Dr. Pannu?

Dr. Pannu: Not quite. My question concerns question 6 in the table. "Should health services provider information be included within the scope of the Act? If not . . . provide the rationale." So you're suggesting status quo at the moment, I think.

Ms Swanson: We're going to discuss that item in some detail next, after we conclude this item, health service provider information, if that's okay.

Dr. Pannu: Okay. All right.

The Chair: So that question was – we're not covering that one yet under these recommendations, but in a way it is the scope. Yeah. Okay.
Any other?

Ms Inions: Could I ask a question?

The Chair: Sure. By all means.

Ms Inions: I'm not sure where the privately paid services fall. Is that something that you're saying falls under PIPEDA now, and your recommendation is to leave that information there? The information I'm talking about is the information that's not public sector, so it's not covered by HIA, and it's not FOIP, but it's a part that's taken out of PIPA, the provision of health services by private entities. Where does that go? Is that going under PIPEDA, and that's what you're recommending?

Ms Swanson: It is under PIPEDA right now, and it would stay there until such time as a decision is made about bringing some or all of those health service providers within the scope of HIA.

Ms Robillard: In 2005, so that would be part of the next committee that would be convened early in the new year to discuss that.

Ms Inions: Okay.

The Chair: What we've done to this point is covered the questions that are numbered 3, 4, 5, 7, 8, 9, and although there have been one or two reservations noted for the record, I'm going to ask for a motion to adopt the recommendations as have been explained to you and as have been given to us in the analysis document.
Okay. I have the motion. Mr. Lukaszuk, is it your intent to move that?

Mr. Lukaszuk: That's correct, Mr. Chairman.

The Chair: All right.
Did you have a question on the motion, Ms Blakeman?

Ms Blakeman: I was just going to suggest that the motion be as specific as possible along the lines of recommending that ambulance operators be included in the scope but that no other entity that requested it or considered it was going to be included, just so it's clear what we're doing here.

The Chair: Is that okay with you, Mr. Lukaszuk?

Mr. Lukaszuk: That's correct. My motion is that
> we adopt the recommendations as presented with the exception that ambulance operators be included in the scope.

The Chair: Any other questions?

Ms Swanson: Would you want to include in that motion something about recommendation 3, regarding privately funded health professionals and health service organizations, being considered in 2005 by a committee of the Legislature?

The Chair: That is stated; right? So I think the intent is to include it. Is that correct, Mr. Lukaszuk?

Mr. Lukaszuk: That is correct. That's already part of the record.

The Chair: So noted, that that is included; okay?

All in favour of the motion, please raise your hand. Opposed? Okay. So it's carried.

Evelyn, where are we going next?

Ms Swanson: Our next item is Health Service Provider Information. That's the next priority item, and there was a discussion paper handed out at the beginning of the meeting.

The Chair: So do we have a doc?

Ms Swanson: It's headed Question 6, Health Service Provider Information.

The Chair: So has everyone got this discussion paper, Health Service Provider Information, Question 6? All right. Proceed.

Ms Swanson: All right. Thank you. In your chart of the issue analysis I would point you to question 6, which is: "Should health services provider information be included within the scope of the Act? If not, kindly provide the rationale."

There are actually three issues that we've identified on this topic. The first is the topic of the discussion paper, which has to do with the inclusion of the information and the protections that are provided for the information. The second issue, which is not in this paper but is addressed in the chart, is the release of health service provider information for research purposes. The third is essentially a housekeeping item around the inclusion of business title and professional registration number. So we'll deal with these sort of in order.

The first is the question whether to retain the provisions, and we'll focus on the discussion paper if that's okay. By way of background, a number of questions were asked about the original rationale for including health service provider information under HIA. So we did go back and took a look at the documentation and spoke with Catarina Versaevel about it. Health service provider information was included under HIA to ensure transparency to health service providers about the ways information about them could be used and when it could be disclosed. So it started out as a transparency issue.

Alberta Health and Wellness and other custodians including pharmacies hold electronic data about the practice of physicians. In the case of Alberta Health and Wellness this is a by-product of billing information for physician services. In the case of pharmacies this is a by-product of filling a prescription and submitting it for payment. Physicians have concerns that the information be used appropriately by custodians and protected from unauthorized use and disclosure. Other than disclosure to professional bodies and disclosure of basic business card type of information the act permits disclosure to noncustodians only if it is authorized or required by an enactment of Alberta or Canada or if the provider consents to its disclosure.

The policy intent was to require that custodians obtain the provider's consent for disclosing identifiable health service provider information to noncustodians for use by noncustodians for a commercial purpose. The central issue is sale of identifiable information about the professional practice of one health professional by another custodian to a noncustodian for packaging and resale in identifiable form to third parties without consent.

More specifically, at present prescription information that includes the physician's name but excludes the patient name is sold by participating pharmacies without the physician's consent. The information is assembled about the drugs a physician prescribes and then sold to pharmaceutical companies. The pharmaceutical companies use the information to target physicians for information about their products in order to influence prescribing toward their own products.

Pharmacy-related stakeholders took the view that the current protections for health service provider information are too broad or inappropriate under HIA. Suggestions were made to remove health service provider information from the act or to change the provisions so protection would not be extended to practice information. Other stakeholders generally see the current provisions as appropriate.

11:20

Physicians are concerned about this practice, and in Alberta many have expressly denied consent to the use of their prescribing information in this way. However, the practice has continued.

In response to concerns the Information and Privacy Commissioner considered the matter and ruled that information revealing the treatment and prescribing practices of health professionals cannot be disclosed without the professionals' consent. The commissioner ordered pharmacists to cease selling that information to a third party. The third party has appealed the ruling, and the order is currently under review by the courts.

In Manitoba, where the ministry holds drug prescribing information in its databases, the ministry is prevented from disclosing the physician's name without consent. Manitoba provides aggregate information on drug utilization.

In Saskatchewan we understand that the Saskatchewan Pharmaceutical Association has agreed, at the request of the Saskatchewan Medical Association, not to disclose the information.

In Quebec the legislation respecting personal information in the private sector was amended in 2002 to specifically protect professional information.

The former federal Privacy Commissioner issued a decision under PIPEDA after complaints were filed that physician prescribing information is professional and not personal information. So the federal Privacy Commissioner took a different view, or they were looking at different things, but the decision was that prescribing information is not protected under PIPEDA, and the matter is now before the federal courts.

So our analysis then. The rationale provided by pharmacy-related stakeholders for eliminating protection against commercial use without consent includes inability to provide the physician's name to the physician's patient on a pharmacy record or on a tax receipt. This is not a reasonable interpretation of the provisions, and physicians are not seeking such a provision.

Suggestions were made that the practice pattern information sold without consent could be used for purposes of quality improvement and quality assurance. These functions are more properly performed within the health system through mechanisms established for this purpose, including the professional colleges and the quality assurance and quality improvement mechanisms established by RHAs and other custodians.

Suggestions were made that practice pattern information would assist the public in selecting a physician. Interpretation of practice information is extremely difficult even for experts, and such information is unlikely to facilitate patient choice of practitioner.

We've identified two options for consideration. One of them is that we maintain the status quo and if necessary clarify the protections for health service provider information, including professional work product information, against commercial use and disclosure for commercial use without the consent of the professional concerned. The impacts would include that the original policy intent of HIA

would be retained, that the sale of physician prescribing information by participating pharmacies would cease, and that pharmaceutical companies would be less able to target their products to specific physicians. In addition, pharmacies would lose some existing revenue and physician concerns will have been addressed.

The second option is to remove the protections for health service provider information. The impacts would be that the sale of physician prescribing information would continue; physicians would have more concerns about how the information in databases will be used and disclosed; removal of existing protections would not engender trust and positive working relationships between physicians and government on health reform initiatives like the electronic health record; trust between professionals will be undermined to the possible detriment of team approaches to improve the care of patients; and last, while FOIP would provide some protection in some circumstances and PIPA would provide some protection for some practitioners, there is no other legislation in Alberta that would effectively protect practice information from commercial use without consent.

So our recommendation is option 1, status quo, and, if necessary, clarify the protections for health service provider information, including professional work product information, against commercial use and disclosure for commercial use without consent.

The Chair: Thank you. This one, I expect, will create some discussion.

Mr. MacDonald, I have you on my list for first question.

Mr. MacDonald: Yes. Thank you, Mr. Chairman. Could you update us, please, on how much money potentially pharmacies could lose from their existing revenue stream?

Ms Swanson: I don't have information on that subject. I don't know.

Mr. MacDonald: Thank you.

The Chair: Yes, Mr. Broda.

Mr. Broda: Thank you, Chair. A question that I have here is that I just want to know, for one: who are we protecting here? Obviously, the physicians is what I see here.

In your analysis you have indicated here that

> suggestions were made that the practice pattern information sold without consent could be used for purposes of quality improvement and quality assurance. These functions are more properly performed within the health system through mechanisms established for this purpose.

Could you explain to me what mechanisms and how they get their information. Or did they hire somebody to do it? If you're hiring somebody to do it, you're already allowing it to happen. So could you answer that question?

Ms Swanson: The current mechanisms would include quality assurance programs, for example, that the regional health authorities have in place, quality improvement programs. The College of Physicians and Surgeons is the body that's established to govern the practice of medicine in the province and to monitor the practice of medicine in the province. They do have the triplicate prescription program, which looks at one aspect of prescribing. So there are some mechanisms there.

With respect to the particular information work is going on on the development of a pharmaceutical information network that ultimately, the intention is, will collect information on prescriptions prescribed and dispensed in Alberta. This system will have appropriate governance. There will be rules around who can access that information and rules about what it can be used for. The rules currently in HIA would apply to that information.

So although we don't have that information in total for Albertans now, the intention is that it will be in a database in the future. It would have governance through the health system and be subject to the rules under HIA.

The Chair: Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. Two questions were asked earlier. They are related. How much revenue is generated by and for pharmacies when they sell the information on prescription patterns? You said that there is no information available?

Ms Miller: We wouldn't be able to access that information. We're just aware that . . .

Dr. Pannu: Is it because it's considered proprietary information?

Ms Miller: I would assume so, yes. That's their revenue stream. You know, we would not have access to that information.

Dr. Pannu: Right. I just wanted that clarified, why that information is not available and won't be available.

I'm trying to assess the merit of the recommendation with respect to two questions: one, does it protect the information that should duly be protected and, second, whether or not providing that protection for physicians has any bearing on the drug costs, which are rapidly escalating within our health care system? Given that we're already concerned about how to control or slow down the growth in these costs, does commercialization of this information, which would be the result if the second option were adopted, have a negative impact on the ability of the health care system to try and slow down those costs on drugs?

11:30

Ms Miller: Certainly, understanding the costs of pharmaceuticals is a very significant concern for any government. In fact, there are organizations that do this work on our behalf, do analyses of prescribing patterns, but they're done on a basis of trending information. It's not identified at the individual practitioner level. An analysis could be, for example, that prescribing practices of physicians in Edmonton show a difference from prescribing practices of physicians in Calgary. That type of analytical work is very critical and important to the government, but the argument here is that that information and analysis can be done at the nonidentifiable level and presented in a manner that is supportive of the policy and strategic work for the health system.

Dr. Pannu: The second part of the question, I think, that I wanted some comment from you is on the ability of the pharmaceutical industry to target particular physicians when this personal information is available. How does it impact the general ability of the public health care system to control drug care costs? How does it lead to the escalation of costs, if you wish, if you allow targeting?

Ms Miller: I think there are those that believe it does. Do we have quantitative data to support that statement? Not that I'm aware of at this point in time, but there certainly are trends shown in other analysis work where there are different prescribing practices.

Whether that can be directly linked back to the marketing ability of a particular pharmaceutical salesman or not, I don't have the answer to that, but certainly there's a perception that it does. I know that the Alberta Medical Association is not happy with the current situation and, in fact, have written to a particular organization asking that that not occur because they're not giving the consent for that information to be released. However, the practice is still underway.

The Chair: Thank you.

Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. The analysis on this issue that was done by the department I find to be a little unusual because it focuses primarily on the adverse effects which may result from the commercial use of that information which already is in place. If, indeed, physicians in Alberta object to their prescribing pattern information being sold by pharmacies to pharmaceutical companies, I'm sure there is a mechanism under a different piece of legislation which we can use to curb that practice if it indeed causes hardship to the physicians.

I'm surprised to hear that in the first place because I know that most physicians welcome visits from pharmaceutical company representatives for (a) educational purposes and (b) the ability to have samples which they can then pass on to their patients. It's a bit of a value-added service that many physicians offer. Nonetheless, the department has focused on this profit capability as if it were a dirty word, and I don't see anything positive stemming from sharing that information or making that information available in this presentation.

Just off the top of my head I can think of many things. For instance, if one looks at the presentation, I believe by IMS Health, we find that the moment a triplicate prescription was introduced for certain drugs, the prescribing pattern of many physicians has suddenly changed simply because they did not want to partake in the triplicate prescription. They did not want to have the information of what and when they prescribed so transparent, so they started using other drugs that are similar but yet not covered by the triplicate prescription, and that concerns me.

I know, as Dr. Pannu has indicated, that not only in Alberta but in Canada we're desperately trying to curb the cost of prescription medications. At this point the only information the minister has available to him is the quantum and the variety of prescription that is being sold out there to those who are covered by the medical services card because those we know about. We pay for it, we know what we pay for, and perhaps we know even whom we pay for. But that is not a true reflection of the prescribing pattern in the province because the ones covered by the medical services card are those who are heavier users of prescriptions by virtue of the fact that many of them are AISH recipients or many of them are elderly or in the lower socioeconomic bracket, who statistically tend to be higher users of the health system.

So the information that the minister has before him right now, based on which he develops policy, is not a true reflection of prescribing patterns in this province, and that holds true for many other provinces. For that reason alone, if we are to develop an effective policy in Health on drug utilization and prescribing abilities and whatnot, we need to have that information transparent, and we won't have it until that information is released.

Lastly but perhaps most importantly, I think Albertans should have the right to know their physicians' prescribing patterns. Not only that, but what is the record of a given physician's practice? I don't see why that should be protected in any way. Some may choose not to read into that and visit physicians just at random, but some may choose to. I probably would be one of them. If I were to put my health in the hands of a given physician, I want to know something about his practice. I want to be able to avail myself of some records showing me what his success rates are, what kinds of medications he prescribes, and what kind of work he does. I don't think that's an unreasonable thing for Albertans to have, and I don't see any of that in this overview. I just see this commercialization as if it were such a horrible thing, and if it is, let's stop it under a different legislation. But to kibosh all that's positive that can come out of it simply to stop pharmaceutical companies from buying this formation to me is simply on the scale of positive versus negative. It doesn't wash.

The Chair: Who wants to tackle that one?

Ms Miller: There are many questions in there. I'm not sure where to begin. First and foremost, the department does not take the view that commercialization is a negative issue. There is significant concern on this issue that has been focused on the sale of prescribing information. The physicians of Alberta as represented by the Alberta Medical Association have grave concerns with the current practices underway. I believe they have written to the chair, and this may be the time to circulate the letter and maybe take some time to read the view of the Alberta Medical Association.

The Chair: Everyone does have a copy of that letter; do they not? It's in there someplace. We'll try to find that. Your point is that we should have a look at that letter; okay?

Ms Miller: Yes. This is a significant issue.

Dr. Pannu: Mr. Chairman, which letter are you referring to?

Mrs. Sawchuk: It was handed out this morning. It's in your information package.

11:40

Dr. Pannu: A letter from whom?

The Chair: It's from the Alberta Medical Association, addressed to the chair of this committee, which I have asked to be copied and distributed to all members of the committee.

Okay. Maybe we should let them have a moment to read that. It was just tabled this morning, so let's just pause for a moment while committee members read it.

Linda, now that the letter is available, do you want to continue to comment?

Ms Miller: Sure. I just wanted to point out that, obviously, there's some grave concern about the situation and the request as outlined by the Alberta Medical Association. This debate has been going on since HIA was first drafted.

Fundamentally, one of the issues that I believe the committee needs to consider is that the physician community and profile of the physicians in terms of the degree of information we have about physicians is far greater than probably any other provider group in the system. One of the reasons for that is, obviously, the billing practices and billing fees that are submitted to Alberta Health, and certainly the information out of that database, which is of great interest to a lot of people, is very fundamental and unusual relative to other provider groups. The need for the physicians to have assurance that this information will be carefully, carefully guarded is paramount to Alberta Health and Wellness and the minister

because we need that information in terms of what happens in their particular offices. The predominant number of health services in our health system still occur in physician clinics and the like. It's important information in terms of the completeness of our individual profiles.

In terms of the incompleteness of the data around drug information, that's true. Currently Alberta Health and Wellness has very limited data on that. Certainly, complete data would be very much a goal and is a goal of the minister, and that's why we have invested over the last number of years in the pharmacy information network.

We believe that within the three-year period and probably even within the next year's period that database will be considerably more complete because we're in the process as I speak of developing interfaces to pharmacy systems so that the data that a particular pharmacy adjudicates on a particular patient will be automatically sent to our PIN database. We believe that within a year, actually, we will have a substantively greater complete number of records of the number of drugs that are dispensed and prescribed in Alberta's health care system. So the issue will be dramatically improved within the year with the current legislative provisions.

I guess my argument here today in front of the committee is that to change for the reason of completeness of data around pharmacy – I believe we have mechanisms well underway to do that. To make the suggestions as proposed would cause considerable angst and concern in the system on a different front, and that would be around the use of that information for what is deemed by that provider group as inappropriate.

The Chair: Okay.

I have two more questions on my list. Mr. Broda.

Mr. Broda: Thank you, Chair. I believe Thomas has brought up my point, but I'd like to question again. What Thomas brought up is individuals that are not under an insurance plan and pay from their own pocket for prescriptions. Who tracks that? How do we do that?

Ms Miller: At this point in time it's by that pharmacy, but once we have the pharmacy information network rolled out and the system-to-system integration, as we call it, is in place – the goal is that that will be accomplished this year – that information would also be populated in the pharmacy database.

Mr. Broda: Thank you.

The Chair: Ms Blakeman.

Ms Blakeman: Thank you. As I look at this issue, I think what's important if we're considering removing protection is that there are a number of things we need to consider. When I go back and look at the purposes of the act, out of the seven sections that are listed for purposes, three of them deal specifically with the need to protect the privacy of individuals. Particularly I'll note section 2(c), "to prescribe rules for the collection, use and disclosure of health information, which are to be carried out in the most limited manner and with the highest degree of anonymity that is possible in the circumstances."

So do we enhance patient personal health information privacy if we remove protections? I don't think we do in this instance. Do we get better health care? I would argue that we don't. I think Mr. Lukaszuk will argue that we do, but I'll allow him that argument.

My concern is: looking at what we've seen in the past, which is that for groups like IMS, who has been here every day and is here again today monitoring the proceedings of the committee, I am not convinced that their use of this gives us a better health care system. So if I'm judging this by "do we enhance protection of patient information?" no. Do we get better health care out of this? I would say no.

A couple of the issues that Mr. Lukaszuk had raised were something about: well, there's nothing wrong with buying this information. But, in fact, information is not being bought from the person whose information it is. The information is coming from the doctors, but it's being purchased, if it's being purchased at all, from the pharmacist, not from the doctor.

11:50

I think as well, if I might rebut some of the other points raised by Mr. Lukaszuk, that keeping the protection in the act as it is now, in other words keeping the status quo, does not preclude in any way pharmaceutical companies from continuing to visit prescribing doctors to provide them with samples and to give them all the information in the world. They do that now, and they can continue to do that. So we don't gain anything, in that section anyway, by taking away the protection that exists now in the act.

I followed through on some of my questions from the original presentation from IMS around the little stories about the elderly woman who wasn't able to get her tax rebate and that. I, in fact, contacted Revenue Canada and asked for the information that they specifically require in order to process refunds around medical expenses, and the name of the prescribing physician is not required. So the little sample story that we were given is erroneous. It doesn't exist. It doesn't ever happen.

The lovely elderly woman could easily take whatever she did get from the pharmacy because the only name they're requiring under the expenses section, according to Revenue Canada, is the name of the person who actually got paid for the drugs, which would be the name of the pharmacy, not the name of the prescribing doctor. Okay? They want the name of the drug, of course, and a few other things but not the name of the doctor.

So the arguments that were put to us about why it was so important that IMS and others get access to the health provider information: so far none of them have played out.

I would argue that the idea of removing the protection that is in the act now does not accomplish protecting Albertans' individual health information, and it does not enhance the health care system. I would argue that it will cost us more because if we have physicians being able to be targeted specifically on their prescribing habits, they're targeted to sell not less expensive drugs, I would argue, but more expensive drugs. People get used to getting them, and they want those more expensive drugs, and that in turn costs our health care system more money. I really doubt that you're going to be having these people coming forward arguing that doctors should be prescribing the generic version of things. I'm sure it will be the newest designer drug.

So I don't think this enhances the system, I don't think it saves us any money, and I don't think it protects Albertans. I would argue that we take the recommendations and stay with the status quo.

Thank you.

The Chair: Okay. I do have three more speakers. We are approaching the lunch hour.

Linda, any response to that? I think probably we've covered most of it. Okay.

So, Mr. Macdonald, I have you on my list.

Mr. MacDonald: Yes. Thank you, Mr. Chairman. I have a question in regard to your information that you have provided.

Again, we have discussed in the past here – and I want to be brief – the ruling of the Information and Privacy Commissioner, the fact that the third party has appealed the ruling and that the order is now currently under review through section 82, I believe. So if we were to accept the option here, number 1, to maintain the status quo, what would be the implications of accepting that if the order by the commissioner were overturned in this judicial review?

The Chair: Is your question relative to the issue before the courts, Mr. MacDonald?

Mr. MacDonald: Well, this is not an issue, Mr. Chairman, before the courts. This is a judicial review of the commissioner's ruling, which is a separate matter, and I would appreciate some legal advice.

The Chair: All right.

Ms Gray: Sir, if the status quo were maintained and the commissioner's ruling were upheld, then the status quo would stay in place.

If the commissioner's ruling were overturned, I think the department would have to look at the reasons provided by the court and determine if further amendments to the act were required. If the intention of the provision was not upheld by the court, we may take the reasons from the court, determine if another amendment was required to implement that policy, and go forth.

If a change were made now, I expect the proceedings currently before the court would become moot because we would have a new provision that would have to be interpreted. That's sort of at the control of the parties, of which the government is not one.

Those are three potential outcomes.

Mr. MacDonald: Thanks. I found that very helpful. I appreciate it.

The Chair: All right. We do have two more. Obviously, we're not going to get to the vote on this one before lunch. I sense that we're not quite ready to vote yet, so I'm going to take anyone who wants to speak, ask them to be brief, and then we will adjourn for lunch.

Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. Some good comments by Ms Blakeman, but in my arguments I never argued that removing the protection of the service providers would enhance Albertans' privacy. That's not the goal of removal of that section. But one could equally argue that it wouldn't jeopardize Albertans' privacy either. It's a moot point on the enhancement or jeopardizing of Albertans' privacy of health information because what it addresses is the doctor's privacy and not the privacy of the recipients of the care. So I don't see any correlation there.

The next argument Ms Blakeman made was whether it would improve the provision of care, and I would continue to argue that it has the potential of improving the provision of care and not jeopardizing it, an example being that very recently in the province we launched a campaign: Do Bugs Need Drugs? We've been targeting all doctors, trying to convince them not to prescribe antibiotics as frequently as they currently do, because many of the conditions can resolve themselves either without antibiotics or with the use of different medications. It is a very expensive campaign, and we had to launch it against all doctors.

Now, if we were to know that there was only a certain segment of doctors who in our opinion overuse antibiotics, we would be able to target just that group alone, saving the ministry a great amount of money and educating only those doctors who need to be educated on that issue as opposed to preaching to those who are already converted. So does it have potential for improvement? I would argue yes. We could develop policy that is much better targeted and much more responsive to current trends than what we have right now.

The Chair: Okay. Thank you.

Linda, would you like to respond?

Ms Miller: I don't mean to get into an individual debate, although it appears that way; doesn't it?

I certainly hear your comment, and segmented targeting would be helpful. I believe we can still do that without allowing access to the individual level of information to the degree that we're talking about here today. There are still ways of anonymizing the data so that you can look at segments: certain kinds of practice patterns in certain communities as long as the community is defined large enough so that there isn't a readily available way of targeting that it is a particular provider.

So you can still achieve some of the goals that you were talking about with what we're proposing in the status quo arrangement. That would be my response to Mr. Lukaszuk's comment.

The Chair: Okay. Thank you.

Mr. Goudreau: Just very quickly, Mr. Chairman. Ms Blakeman talked about Revenue Canada and the need for information there. A few years ago my daughter required a fair amount of medical attention that forced us to travel from the far north to Edmonton, and when I did put my claim in as part of my expenses through Revenue Canada, it was quickly appealed. Under the appeal, then, I had to provide the following information: the dates, the time, the mileage, the meals that we were claiming, who the doctor was, the type of treatment that was required, the relationship of the child, whether it was a daughter or a son, those kinds of things, and then my portion of my cost on prescriptions as well as my total costs. That was required of me by Revenue Canada to justify my claim, so I did provide that. That's just to indicate that they wanted to know who the doctor was that had provided the services.

12:00

The Chair: Thank you.

It is a little bit past 12 o'clock. Lunch is here. I would suggest that we eat lunch and give people a few minutes to reflect on this question before we deal with it, so let's adjourn until 1 p.m. for lunch.

[The committee adjourned from 12:01 p.m. to 12:59 p.m.]

The Chair: Okay. I am going to call the committee to order. It is 1 o'clock, and we do have a majority.

We still have some more questions from the committee on question 6. Mr. Broda.

Mr. Broda: Thank you, Chair. I'd like a little clarification if I may. In my opening question I had asked, basically, who we were protecting. I guess that in looking at your document here, Discussion Paper, you indicated that the former Privacy Commissioner "issued a decision under PIPEDA after complaints were filed, that physician prescribing information is professional and not personal information." That's exactly what I'm saying. The personal protection is there. There is no personal information that is disclosed. It's only the prescribing information of the professional.

You indicate here that the matter is now before the federal courts. My understanding, that I've tried to get at here during the lunch

break, is that that has been withdrawn and that the Privacy Commissioner's statement has been upheld. It's been withdrawn from the federal courts. So it is professional not personal information. I'd like some clarification on that from whoever.

Ms Inions: It's my understanding that you're absolutely correct. That was Maheu, and they withdrew that application.

The thing to keep in mind is that PIPEDA has very different words and provisions than does the Health Information Act, and the specific type of information they were discussing in that federal finding was work product information. It was linked to a name, so under our legislation the name itself would be caught in the definition of health information but not necessarily protected because it could be one of the exceptions.

Mr. Broda: One further question I would have also, if I may, Chair, is on the Saskatchewan Pharmaceutical Association in your statement here. My understanding is that that's been disbanded and there are two associations now, and I'm not sure what they are. Is that correct?

Ms Miller: I'm not aware if it is.

Mr. Broda: Okay. That's what I heard, that the Saskatchewan Pharmaceutical Association has been disbanded and that there were two associations formed. I don't know what's happened with that one, so if we can clarify that one. Could you get me an answer for tomorrow, if possible?

Ms Miller: Certainly. We can follow up with that.

The Chair: Thank you.

Mr. Lougheed, do you have a question?

Mr. Lougheed: Yeah. We were talking a long time ago about section 37, and when I look at the information in the recommendations there about the status quo and changing things, I recollect some discussion about linking 2(a) and (b) and instead of having an "or" there at the end of (a), changing it to an "and." Somehow when I look at this recommendation and your discussion about it here, there doesn't seem to be reference to that, in my mind, and how that would address any of those issues that were brought forward. I think the AMA was one group that had talked about that, and I think, if I'm not mistaken, it might have been IMS, but I'm not sure. Do you remember?

The Chair: Okay. Who wants to respond? Anyone?

I recall the issue coming. I think that maybe one of the presenters raised that issue.

Ms Miller: We're struggling at the moment. We think that maybe that was in reference to another clause, but we're just clarifying our notes.

Mr. Lougheed: I know it was 37(2)(a) and (b).

Ms Miller: Okay. If you could just give us a moment.

Could we take that as a take-away? We will get back to the committee on that question tomorrow.

The Chair: Yes. Okay.

What I'm going to suggest here on this question 6 and the discussion guide that we've received on question 6: I'm going to ask the committee if they would consider tabling a decision on this one until tomorrow because we do have some questions that we need answers to and clarification on. Would that be agreeable to the committee? Would someone like to make a motion to that effect? Mr. Lukaszuk.

Mr. Lukaszuk: Yes, Mr. Chairman. It appears that some of the questions that Mr. Broda raised relevant to the facts or accuracy of what's been presented as facts by the department need to be clarified, and Mr. Lougheed raises a question of a technical amendment to the current legislation. I believe that before we vote, we should have that factual information, so I would move that we table the voting portion of this meeting until tomorrow.

1:05

The Chair: Thank you.

Any discussion on the motion?

Mr. Lougheed: I don't think that "technical" would be quite the right term.

The Chair: Okay.

All right. All in favour, please raise your hand. Opposed? Carried.

So given that, then, can we move on to another question?

Ms Robillard: Okay. The next question that we would like to draw your attention to is question 24. There are two discussion papers. The first one I'd like to speak to is entitled Disclosures to Police Services. There's nothing beyond that. It's a four-page document.

The Chair: Okay. Just hold on till we get that in our possession.

Dr. Pannu: When were they distributed?

Ms Robillard: It was distributed this morning.

The Chair: Did you say that there were two documents on this one, Wendy?

Ms Robillard: Yes, there are two documents. The first document I would like to speak to is entitled Disclosures to Police Services. Full stop. For anyone following along in the three-column chart as well, it is question 24, and the suggested response in the three-column chart was that a range of options would be developed for discussion and that a discussion paper would be provided at the table, which it has been.

The Chair: It's on page 8 of 13?

Ms Robillard: Page 8 of 13 is right.

The Chair: Okay.

Just to make sure, has everyone got the two papers on question 24? One is: Disclosures to Police Services. What's the other one?

Mrs. Sawchuk: Disclosures to Police Services Related to Prescription Drugs.

The Chair: So has everyone got those two?

Okay. Are you going to start with just police services?

Ms Robillard: Yes. That's where I'd like to start today if I could.

The Chair: Yes. The only question this one deals with is number 24?

Ms Robillard: Yes.

So the issue here – and I'll walk through the document since you've not had time to pay much attention to it yet – is that the police services are requesting broader access to health information. The following amendments have been proposed by the police, so these are all stakeholder requests. They are to authorize the disclosure of information to police seeking a warrant, subpoena or court order.

The specific wording attributed to the Lethbridge police services: "To authorize the disclosure of registration information and confirmation that the person was treated, when they were treated, the nature of injuries, and what treatment and procedures were carried out to police seeking a warrant, subpoena or court order." The Calgary Police Service: "To provide for the disclosure of health or registration information (i.e. location, name and admission date) to obtain warrants." The rationale they provide is that that level of information is necessary in order to obtain a warrant.

The second request is to authorize the disclosure of health information to a law enforcement agency for the purpose of assisting in the investigation of a criminal or provincial offence. Specifically, the Edmonton Police Service requested: "To provide for disclosure of registration information and health service provider information without consent for law enforcement purposes." Calgary requested: "To provide for the disclosure of patient information to a law enforcement agency for the purpose of assisting in the investigation of a criminal or provincial offence."

The rationale: The police are seeking authority to disclose health information, potentially including registration information, diagnostic treatment and care information, and health service provider information, for broad law enforcement purposes including obtaining warrants and satisfying their duties under the Criminal Code of Canada.

The next stakeholder request was "to encourage or mandate health care workers to notify the police with basic registration information when they treat a person whose injuries were caused in the commission of a crime." That was submitted by the Lethbridge Regional Police Service. The rationale was that that level of reporting is required to enable the police to meet their duty of detecting crime, establishing the identity of those involved in the commission of crime, bringing offenders to justice, et cetera.

The last request was "protecting the health care professional from any criminal or civil liability for the release of such information in good faith." I would just draw your attention to provision 105, which is immunity from suit, which is already provided for in the act.

The background. The act currently has several provisions that enable custodians to disclose registration information and individually identifying diagnostic treatment and care information to the police without the consent of the individual who is the subject of the information to comply with a subpoena, warrant, or order for investigating an offence involving a life-threatening personal injury to the individual, to avert or minimize an imminent danger to the health or safety of any person.

The police provided the example of missing person investigations and where there are concerns for the safety of health service providers to illustrate their need for additional information. Disclosures for both of those examples are currently enabled in the act.

There were no concerns raised in relation to the provisions that are already in the legislation, but the police have requested additional, quote, provisions to address other concerns.

Eleven of the 18 respondents, including the police, agreed with providing at least some discretionary authority in certain circumstances to disclose registration information to police. Stakeholders were not always clear nor was there agreement on the circumstances under which greater disclosure would be appropriate. Seven respondents recommended no change.

Many stakeholders were concerned that extending the provisions for disclosure to police without consent may discourage patients from seeking medical care or may result in individuals withholding information necessary to provide treatment and care. In both the written and oral presentations on this subject there was frequent reference to the term "registration information." Under the act registration information includes elements such as name, personal health number, gender, date of birth, home address, health service eligibility information, location information, and billing information.

However, the submissions and oral presentations indicate that the police are also seeking other types of health information such as facility location and admission discharge dates – there is some question whether, under the circumstances outlined by the police, location or admission information would constitute registration information – diagnostic treatment and care information, including where and when a person was treated; the nature of the injuries and what treatment and procedures were carried out; and health service provider information, specifically the name, address, and telephone number of the physician providing treatment, in order to determine where health records may be located or to identify another potential source of information.

Any expansion of mandatory or discretionary disclosure of health information to police could result in Charter challenges to the HIA under the right to privacy; for example, protection against unreasonable search and seizure. However, even though the legislation may be found to limit a guaranteed right, it can sometimes be saved under section 1 of the Charter, which states that all rights are subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

In order to survive the section 1 scrutiny, government must prove that the legislation meets the two-part Oakes test. The objective of the law must be of sufficient importance to justify limiting a Charter right, and the means chosen must be reasonable and demonstrably justified by showing that the law is rationally connected to the objective, uses the least drastic means to accomplish the objective; for example, it impairs the right no more than necessary to accomplish the objective and is proportionate. It must not have a disproportionately severe effect on the person to whom it applies.

Of the options that this paper outlines – and it outlines five options with no recommendations for the committee – the first one is to continue with the status quo. The impact of the status quo would be that the balance is on protecting individual privacy over access with discretion to disclose to police in circumstances of imminent danger, life-threatening injury, to comply with subpoenas and warrants, and when another enactment permits. Individuals continue to have appropriate access to medical services and to provide information to their physicians as necessary, custodians and/or affiliates continue to interpret the current authorities for disclosure to police, and the police continue to experience difficulties with accessing health information required to obtain a warrant.

1:15

The second option is limited disclosure of only registration information when the police are seeking a subpoena, warrant, or court order.

The impact would be that this would continue to protect diagnostic, treatment, and care information, which is seen to be the most

sensitive health information. However, such a provision would address some but not all of the concerns identified by the police. Any expansion of the authority to disclose health information to police could result in a Charter challenge, but under this option a Charter challenge is less likely to succeed than under options 3 and 4 because the disclosure is more limited.

Disclosure of registration information and limited disclosure of diagnostic, treatment, and care information and possibly health service provider information when it is reasonably suspected that a person seeking health services has been involved in some form of criminal activity. For example, disclosure could be limited to patient name, address, location in facility, and date of admittance.

The impact is that we have limited disclosure of diagnostic, treatment, and care information to enable continued protection of the individual's most sensitive information. It would meet the needs expressed by the police during the review process, the balance moves toward more access, it may still require interpretation of the provision by custodians and/or affiliates, and any expansion of the authority to disclose information to the police could result in Charter challenges to the act.

The fourth option is the introduction of very broad authority to disclose similar to section 40(1)(q) of FOIP.

> A public body may disclose . . . information . . .
> (q) to a public body or law enforcement agency in Canada to assist in an investigation
> (i) undertaken with a view to a law enforcement proceeding, or
> (ii) from which a law enforcement proceeding is likely to result.

That is the FOIP provision, so under HIA a similar provision would potentially enable the disclosure of registration information; diagnostic, treatment, and care information; and health service provider information.

The impact is that this broadens the ability to disclose to all health information, all types. It erodes the protection of individual privacy and enables the disclosure of diagnostic, treatment, and care information and again could result in a Charter challenge to the act.

The fifth option is stand-alone legislation requiring mandatory reporting of gunshots, stabbings, and severe beatings.

The impact is that this clearly imposes a duty on custodians and/or affiliates to report. Current provisions may already enable the disclosure of information in some of these specific situations, allowing the custodian to disclose registration information and individually identifying diagnostic, treatment, and care information to the police for the purpose of investigating offences, including life-threatening injuries to the person, and to any person if the custodian believes on reasonable grounds that the disclosure will avert or minimize an imminent danger to the health or safety of any person. This option may impede the individual's ability to access necessary health care, Alberta may become the first jurisdiction in Canada to require mandatory reporting, and any expansion of authority to disclose health information to police could result in Charter challenges to the act.

The Chair: Wendy, would you like to deal with this one before you move to the next discussion paper?

Ms Robillard: Please.

The Chair: All right.

Ms Blakeman: I had a question to the lawyers who are advising us. On the first page of this discussion paper, Disclosures to Police Services, about halfway down under Rationale the last sentence talks about "satisfying their duties under the Criminal Code of Canada." Now, my understanding is that there is nothing as currently exists that precludes any officer from fulfilling their duties under the Criminal Code of Canada. In other words, anything that they need in order to satisfy the Criminal Code is already available to them. So that statement actually doesn't need to be there, because anything they need to do to satisfy the Criminal Code they can already do.

Now, whether that's because they're in a life-threatening situation, if there's Criminal Code stuff to be done and it's life-threatening, they can do it now. If there's imminent danger, they can do it now. If there's diminished mental capacity, they can do it now. If it's under the Child Welfare Act, they can do it now. If it's under the Protection for Persons in Care Act, they can do it now. Even if it's under the Fatality Inquiries Act, they can do it now. So there's nothing actually that is impinging upon their ability to complete the Criminal Code. Am I correct in that? To the lawyers. Sorry.

Ms Gray: All of those exceptions that you enumerated are correct. Part of the difficulty I found in looking at the police submissions is that they weren't always completely clear on the circumstances in which they thought they were being impeded. They gave examples, but from a purely legal point of view I felt that there was not enough information in the submissions to determine whether there was an issue.

For example, there could be issues if it were found on further consultation with some of the municipal police that the HIA has put in place an impediment to exercising rights that they have under other enactments. Even though in a legal context we may find that one enactment is paramount to another, there may be a requirement for either clarification or we may find that it may only be a perceived impediment or we may in fact find that there is some impediment.

For example, one of the examples that was given in a submission was when they attend on a motor vehicle accident. The suggestion, which wasn't completely clear in the submission, was they would be able to gather certain kinds of information at the scene of the crime but for the fact that the person needed to go to the hospital. Once they got to the hospital, it created an impediment that normally wouldn't be there. But there was not enough information in the submission to determine that.

So in this section this is the rationale that was provided in the submissions, although from a purely legal point of view there is probably a need for some further consultation with the police to identify whether there are specific situations that may be causing a problem or whether it is a problem of interpretation or practice, which was apparent in some of the other submissions that the police made.

The Chair: Okay. Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. I strongly believe that in our deliberations on this particular part of the review we have to keep in mind who it is that we're trying to serve here as elected officials. I think section 1 of the Charter and the test attached to it give us pretty good guidance. It tells us that if any legislation infringes individuals' liberties and rights, the benefit from that infringement must be greater than the infringement and the adverse effect to that individual itself.

I am quite surprised, actually, hearing some arguments to the contrary from the members of the opposition because as I recall my social studies classes and my political science courses, it is entrenched in the root of liberalism that the greater of the society is more important than the greater of the individual. Yet I as a Conservative, who should be arguing that the greater of the individ-

ual is more important than that of the society, am arguing just the opposite. I strongly believe, Mr. Chairman, that the infringement on an individual's right, who in many cases would be an individual who is suspected of having been involved in a criminal activity, is not as abhorrent as the importance of protecting the society from that criminal element. I get continuously frustrated when I hear that because of Charter arguments or perhaps some interpretation of the Charter or fear of Charter challenges we are drafting legislation that indeed protects the criminal element more so than the victims in our society. I mentioned that in the last meeting.

Very recently in my very own riding there was a shootout, Mr. Chairman. There was an anticipation by police that there was out there an individual who may have gunshot wounds and chances are would have checked himself into a hospital. Now, even if the police were to know that for certain, they obviously cannot obtain a subpoena for every hospital in the province or in the capital region because to get a subpoena or a court order, they have to satisfy a judge or justice of the peace that they have reasonable and probable grounds on which to believe that a given individual has checked himself into a given facility. So (a) they have to have the name of the individual, (b) they have to know which facility.

1:25

I personally would see nothing wrong with this scenario, and I believe that most Albertans would see nothing wrong with this scenario where a police officer would show up at a variety of medical facilities, emergencies, and say: have you had anyone check into your facility within the last 24 hours with a bullet wound? I think any reasonable Albertan would say that that's the right thing to do. Whom are we trying to protect: Albertans or a person who checks himself in with a bullet wound or some other wound?

From a more practical perspective the motor vehicle accident situation is the most common one. It happens daily in Alberta on several occasions. Police arrive at the scene of an accident. Sure they can gather evidence from the scene of accidents such as skid marks and things of that nature, and they're sure that they know who the drivers were. Very often they will never know who the passengers were. They may not even know who the drivers were because all they know is who the registered owners of those vehicles are, but it may have been the wife or a friend driving the vehicle.

Those victims of the accident get picked up by an ambulance and rushed to emergency, and that's where they lose track of them. They can't ask them what happened for the purposes of investigating. They can't check whether any one of them has been impaired. They lose track of those individuals. Again, I think most Albertans and even most drivers for our own protection would want police to have that access and know who the individuals were so they can question them further and properly investigate a car accident.

So when we decide on this one, Mr. Chairman, I think we have to bear in mind who it is that we're trying to protect over here and is that infringement really so great. I would suggest that option 3 probably is the most reasonable one. Encouraging the Legislature to draft a stand-alone act would require us now to start identifying injuries that would fall within the scope of the act. Bullet wounds and beatings probably are the most common, but what happens to stabbings, and what happens to other injuries? You know, there could be an endless list to it. I think 3 gives us a fair balance where the greater of the society is protected at some level of infringement of liberties and rights of the individual who is a suspected individual.

The Chair: Thank you. Following your preamble I wouldn't have been surprised if you'd recommended option 5.

Mr. Lukaszuk: No.

The Chair: Thank you.

Anyone want to respond to Mr. Lukaszuk's points?

I have some more speakers.

Mr. Lougheed: A question that I'm wondering about. If somebody has got a stab wound and comes into the hospital and that stab wound has punctured his heart – I don't know anything about the medical side of it, but I'd assume that something like that would be a life-threatening injury – it's my understanding, then, that the police could obtain information about who that fellow is and so on quite quickly, like right now. That's disclosed to the police. That's correct?

Ms Robillard: The provision in the legislation under 35 is that a custodian may disclose individually identifying diagnostic, treatment, and care information without consent to a police service "for the purpose of investigating an offence involving a life-threatening personal injury to the individual. So the custodian can choose to disclose that information.

Mr. Lougheed: Some more questions along this line then. Can you give me some insight into how they'd make that decision?

Ms Robillard: How a custodian would decide? Well, presumably, I guess it would be up to the custodian to try and sort out why they thought the individual presented the way they did, whether there was an offence or not. It may be as well, as has been suggested, that the police may come looking for information about someone relative to a potential offence. So the custodian might know that there has been some kind of a situation that the police have been inquiring about, may see a patient and may make that determination. I'm not sure beyond that. I'm really trying to come up with some ideas.

Ms Miller: If I could, based on my experience in the health care system. Typically what custodians do is develop their own internal policies and procedures interpretation of the act. So some custodian organizations may indeed have done that. But, to be frank, what typically happens is that these kinds of situations often occur at midnight, when people are very busy, and it's often left up to the particular provider that is seeing that particular circumstance to make the judgment call.

What I did hear from some submissions is that that can be applied inconsistently. What would be helpful to them is some consistency and clarity in the rules. I did hear that argument from a number of presenters.

Mr. Lougheed: Could you clarify: helpful to whom?

Ms Miller: To the provider so that there's less interpretation possible. That would be seen as helpful. I do remember that comment from I believe a physician in the David Thompson health region.

Mr. Lougheed: So just to follow up then, is it your experience or can you give me some answer: somebody comes in and he's got a stab wound in his arm, no life-threatening injury, so it's unlikely then, because it's not life threatening, that it would ever be reported to the police; right?

Ms Miller: Really, I can't comment on that. I mean, I think it would vary considerably based on that particular provider's knowledge of the legislation, knowledge of their internal policies, and their own bias, I guess one would say.

Mr. Lougheed: Why do you say "knowledge of the legislation" when it seems like it's so discretionary?

Ms Miller: Because the legislation speaks to imminent danger. Your example was a knife wound to the arm. I'm assuming that wouldn't be – I suppose it could be if it severed an artery, but if it was a simple stab wound, it wouldn't be classified as imminent danger.

Mr. Lougheed: It seems to me that there's a whole lot of discretion there, even if it is close to life threatening.

Ms Gallant: Mr. Chairman, I just want to also maybe add to the provision that Wendy reviewed for you with regard to the fact that they have discretionary authority to disclose in a life-threatening circumstance but, again, if it's not contrary to the express wish of the individual. So if the individual has expressly requested that it not be disclosed, they are to consider that in their discretionary authority. Just so you don't lose sight of that second part of that provision; just so you're clear when you make your deliberations.

Thank you.

The Chair: I have to interject here, Mr. Lougheed. If I have a wound that was given to me in criminal activity, I would never want to disclose it. Never.

Ms Gallant: So as that individual says no to the physician – I guess that's what Linda is trying to articulate – they must then consider that in their consideration of whether to call the police or not. That's currently how it's written.

The Chair: Okay. Rob, are you through with this point, or did you have another question?

Mr. Lougheed: Not quite, but I like your thinking there, Mr. Chairman.

The Chair: Just a country boy through and through.

Mr. Lougheed: So just to help my understanding a little bit more, it's really unlikely that that person who has a stab wound to the arm would have any information passed on to the police because it's not life threatening, when in fact it may have been just a stroke of luck that the person stepped aside or got his arm in the road and it in fact missed a direct hit to his heart and hit his arm instead. So all the circumstances could have been exactly the same. It could have been the same kind of activity where in one case the surgeon may in his decision report it to the police and in the other situation he wouldn't, very unlikely that he would.

Ms Miller: Those scenarios that you have described are very possible.

Mr. Lougheed: Thank you.

1:35

The Chair: Mr. Lougheed, on a couple of occasions I have actually cut my arm accidentally through my own negligence, and frankly when I went to the doctor, I didn't care whom they disclosed to because I had nothing to hide. So they can tell whomever if they want.

Mr. Lougheed: Agreed.

The Chair: Thanks.

Ms Blakeman.

Ms Blakeman: Thank you. When I looked at this issue – and it's now come up a number of times in this committee – the first thing I did was remind myself of why I was here. We're not here reviewing the Police Act; we're here reviewing the Health Information Act. I go again to the purposes of the act, which are:

> (a) to establish strong and effective mechanisms to protect the privacy of individuals with respect to their health information and to protect the confidentiality of that information,
>
> (b) to enable health information to be shared and accessed, where appropriate, to provide health services and to manage the health system,

and the third,

> (c) to prescribe rules for the collection, use and disclosure of health information, which are to be carried out in the most limited manner and with the highest degree of anonymity that is possible in the circumstances.

So when we look at this proposal from the police services to expand how they are able to get information about individuals' personal health information and a fairly wide range of additional categories of information – for example, their physical location, their billing information, their immigration status, a number of other things that can be gleaned from the information that would be available under the registration information – which is the basis of what the police services are requesting, I think what I'm hearing is that there's a misunderstanding in some cases between whether the issue is the police trying to gather information on an individual or whether we're trying to deal with reporting criminal behaviour. Those seem to get interchanged in our discussion, and in fact they are two different things.

When we're talking about an individual presenting to the hospital with a knife wound in their arm or a severe beating or gunshot wounds, then we're talking about the ability of the health care providers to alert police that they believe that there has been suspicious activity or possible criminal activity. That, I have said before, should be dealt with by stand-alone legislation which empowers the people to report when they see that, and that clears up that problem.

Now, if we go back to the gather information section of this, once again we are not talking about police in a hurry. We are not talking about police with any time constraints on them when we discuss this. We've gone over and over: this is not police that are chasing somebody right now. This is police coming in, when they've got time, to get background information they can then take back and get a subpoena, a court order, or a warrant. They are not in a hurry.

If they were in a hurry, they already have the provisions to get the information, and it would not be withheld from them. So if somebody is bleeding on the floor, if they're chasing the guy in from the street – so imminent danger, life threatening – children are vulnerable people so children or anyone covered under the Protection for Persons in Care Act or even under the fatalities act: all of those situations are already covered.

We're not talking about anything imminent here, so why would we be giving away people's personal health information when the situation has no urgency to it? No urgency to it. Any situations that have urgency are dealt with, and there are provisions to deal with the provision of the information.

The second part of this is that there is an assumption that everybody is a criminal or that anyone that would present to the hospital with an injury is a criminal, and I don't think we can make that assumption. Certainly, if you're talking about criminals that are involved in life-threatening situations, criminals that are involved in

imminent danger, criminals that have perpetrated some sort of abuse on vulnerable people, once again you've already been able to deal with them under the existing provisions of the act. So that's not what we're talking about. There's no urgency, and any really bad guys have already been captured under some other provision that's already available here.

Mr. Lukaszuk kept making broad statements about how he knew that Albertans would be in favour of this. We don't know how Albertans feel about this. We have not surveyed them. We have not directly asked them this question. We have not sought this information from them. We don't know how they feel about this. We do know from the studies that were done by the office of the Privacy Commissioner how much the protection of their personal privacy means to them, and I think the figure we bandied about earlier was 68 per cent.

So we know that our job here today is to look at a review of the Health Information Act and the protection of people's personal health information. We know that there are two issues that keep coming up in this category: the police's ability to gather information versus the reporting of suspected criminal behaviour. We know that there's a solution to the reporting of criminal behaviour problem, so we're back on concentrating on gathering information. Any time the police seem to need to gather information that in any way has urgency attached to, it is already dealt with under the act. They're already able to get that information.

So when it's not urgent is what we're talking about. Essentially I'm being asked to say that, yes, police services across the province should be able on a nonurgent basis to get personal health information ranging from financial information, which is billing information essentially – where they are located, their home address, phone number – and any number of other things, and I do not find that sufficient grounds to erode any protection of an individual's personal health information. There's been a lot of obfuscation here. There have been a lot of hysterical stories, but I think that when you boil it down, there is not enough information here to erode the protection of people's individual privacy.

So I would vote strongly against this, and I would ask now that there be a recorded vote. Thank you.

The Chair: When we get to the vote, we will make a recorded vote. We are several speakers away from the vote. So noted. When we get to the vote, it is going to be recorded.

Ms Kryczka: Well, I guess I'd have to go back and read the document exactly to have a very long presentation here, and we're not in that position. I guess what I really heard the police saying is that if someone who had been involved in criminal activity was in the hospital, they wanted to feel that they would have co-operation when they arrived there. I suppose it could be a two-way situation. You know, like, they could be contacted by the hospital or by the custodian if they felt that this person had been involved in criminal activity. My memory is that it was more that when they do go to the hospital because they have good reason to believe that a person is there, there are degrees of lack of co-operation or some co-operation.

I'm not going to get involved in this philosophically. I thought that their request was very reasonable. We have a victims' assistance program that Justice has brought in and increased the dollars for funding, because quite obviously I think there are some laws where we almost bend over backwards to protect those who violate the law. I think this was a fairly straightforward request.

I understand that there have to be some guidelines drawn up or whatever, but we're not into the minimanaging of this act. We are talking on a different level. Actually, I was pleasantly surprised when my colleague suggested option 3, because I would agree with option 3 being a very good compromise.

The Chair: Okay. Thank you very much.

Mr. MacDonald.

Mr. MacDonald: Yes. Thank you, Mr. Chairman. I have some questions in regard to other jurisdictions. How do they balance this act, regardless of whether I'm in a gang fight or whether I'm in a duck blind and I have a gunshot wound and I go to receive treatment? How do those jurisdictions handle that? Are there any Canadian jurisdictions? I understand that there are. Who are they, and how do they handle this?

1:45

Ms Robillard: Noela, can you respond to this?

Ms Inions: Is this a set-up?

Ms Robillard: No. I thought you had some information.

Ms Inions: Yes. In regard to your question about whether there are Canadian jurisdictions that require reporting, there are no such jurisdictions. There is a bill that's been introduced in Ontario. It's only in first reading. It was introduced by the minister of correctional services, not the ministry of health. So that bill has been introduced but has not gone any further at this juncture. There is no mandatory reporting of gunshots, stab wounds, beatings, that sort of thing generally.

I need to qualify that with specific exceptions that have already been raised. For example, Protection for Persons in Care Act – there's required reporting under that legislation – and the Child Welfare legislation: those kinds of statutes do require specific instances to be reported. But the Criminal Code, for example, does not have a provision that requires reporting of criminal activity, so those are the other statutes. Usually where this kind of reporting comes about is the other statute governing the more specific activity.

You'd already asked what other jurisdictions are doing on this front, and most jurisdictions have some general exceptions like the imminent danger, pursuant to subpoena, and those kinds of things. But in Manitoba, for example, their statute, their health information act, allows specific information to be disclosed: the individual's name, that they are in fact a patient in a facility; secondly, is their general health status critical, poor, or fair; and thirdly, location of the individual in the facility. That is it.

We've kind of talked about registration information in a very general way. That's everything from PHNs to your home address. There's a long, long list of what is included in the definition of registration information under the Health Information Act. Those three categories are what can be disclosed in Manitoba, and as I understand the police, they're saying that they need more information sometimes to get a warrant. That seemed to be the most consistent gap for them. So it's not all this diagnostic, treatment, and care information necessarily; it's more information to get a warrant. Those three pieces of information are what's been working in Manitoba since 1997.

The new legislation in Ontario that's just been introduced, their new health information act, to come into force in November, has those three categories as well that can be disclosed. I think that may be a way of bridging the gap, but the registration information category itself is very broad.

These other two jurisdictions have kept that to three categories of registration information.

The Chair: Mr. MacDonald, do you have an additional question that covers your information?

Mr. MacDonald: No, other than I would make the statement that I would choose very carefully who I was to spend some time in a duck blind with.

The Chair: Thank you very much. Good advice.

Mr. Lougheed: In reading some other stuff we were given before and having heard it mentioned quite often here, I think maybe I know the answer, but I'd rather hear some of your opinions on it.

In 5, the stand-alone legislation regarding mandatory reporting of gunshots, stabbings, and beatings, and in lots of other places there's this comment that if people have some fear of this reporting, it may impede the individual's ability to access necessary health care. Can you give me any kind of insights into that thinking process that would go on? Do people heading for the hospital in these circumstances – they've been stabbed for some reason or another – evaluate "Should I or shouldn't I go?" based on: is this likely to be reported or not likely to be reported? Any insights?

Ms Miller: In the earlier part of my career I worked up in northern Alberta for about 10 years as a nurse, and I came across a number of incidents when I would believe that the particular person that had been injured could've looked to me or any other person as a suspicious incident, if you will. They were gravely concerned about being reported to the police for whatever reason. I'm not saying I agreed with them or disagreed with them, but it certainly did enter into their mind, and they were quite concerned with that.

Mr. Lougheed: So to clarify a little bit. The reason that they're concerned is what? Why would they be concerned? The police would find out something about a criminal activity they were involved in, or they'd find out about somebody they were trying to protect, or all of those?

Ms Miller: I believe all of the above. I have to admit that as a clinician I didn't pursue that line of questioning a great deal with them, but certainly I was led to believe all of the above.

Ms Inions: I'm afraid I'm going to go back to my nursing career as well. The trouble is that a lot of this is anecdotal; isn't it? How do you get hard evidence on these kinds of questions? The physicians believe very strongly that it affects people's decisions to come, you know, whether or not there was a reporting duty. I have been in a situation where the police wanted to see someone. They came in and asked to speak to him, and I asked him if he wanted to talk to the police. He literally jumped off the stretcher and ran out of that hospital. I've been in those situations.

It depends on where the individual is from. If you're dealing with a patient from South America or something, there's great fear of the police. They are not a trusted person. Sometimes it's because of their own culture. Often it's other issues. It's not the issue at hand where the fear arises, but it's other circumstances that person is in.

Keep in mind that the person who got stabbed is probably not the perpetrator. They're already a victim in their own way. That's sometimes why health information, once it's disclosed to the police, then is part of a court proceeding, perhaps, and that information is out there in the public realm. That, for example, was one of the issues at hand before the Supreme Court of Canada in R. versus Mills. That was a little 13-year-old girl who had charged someone with sexual assault, and as soon as her information was disclosed to the police, then it became part of a criminal proceeding and was out in front of that proceeding, and that was a huge, huge issue in that case.

So there are just a great variety of circumstances.

Mr. Lougheed: On that very example, isn't a 13 year old's name protected all over the place?

Ms Inions: Well, when there's enough information out there, the information is identifiable even if you don't have a name involved. In R. versus Mills, Mills was the accused. So her name was not disclosed in the name of the case, but certainly her information was at issue.

Mr. Lougheed: But how does this relate to the health provision?

Ms Inions: It doesn't relate so much to perhaps being compelled by the police. It wasn't in that instance. But she had received counselling and psychiatric care, and that was being used against her in the criminal proceeding to say that her evidence should not be believed.

The Chair: Thank you.

Mr. Lukaszuk, followed by Dr. Pannu.

Mr. Lukaszuk: Thank you. Mr. Chairman, the issue of urgency, whether the police are in hot pursuit or whether it's an urgent matter or not, in my sincere opinion is a red herring because if police are in hot pursuit and there is a life and death situation and there is a bona fide urgency, indeed they do have access to a larger scope of information than otherwise stated. However, criminals are not any less criminal just because they're not in a position of urgency or there is no imminent danger at this given point. Just because the person with wounds who checked into the hospital is not wielding a knife now at the nurses and the doctors doesn't make him any less criminal at any given time. The problem the police have is that when they approach the hospital and say, "Do you have this guy on your premises receiving medical care?" the hospital cannot release that information, whether he is being at any given time dangerous or not.

1:55

So the urgency really is a red herring because you can have an urgent situation where there is no imminent danger, or you can have a nonurgent situation where there is imminent danger. It doesn't matter. The police nonetheless still have to do their work and be able to speak with the individual.

Now, it doesn't have to be a criminal. In the situation of a car accident where victims are picked up by ambulance and need to be investigated, there is no imminent danger. There is no rush. Yet I think we would all agree that it is to our common benefit that the police speak with the drivers and the passengers, find out what happened, find out whether the drivers were under the influence of alcohol or any other substance. That's information that the police should be able to have. So urgency is a nonissue.

Now, the Member for Edmonton-Centre made the comment that we haven't polled Albertans. Well, I don't think we need to poll Albertans. I think Albertans elected us to make those decisions without having to poll them. I believe that most reasonable Albertans would agree that if there is a balance of protecting the public as opposed to an individual who could be suspected of criminal activity, it's to the benefit of the public, and they would agree with us.

This issue of cultural biases directed at police is an important one but not one that we should be taking into consideration in drafting

laws. I think, again, most of us would agree that in this province we have top-notch police enforcement. As a matter of fact, our police officers are training police officers throughout the world, in some of the areas from where those individuals who don't trust police come from. Now, are we going to start drafting our legislation based on certain individuals' cultural biases against police? I don't think we can do that. We have to assume that our police do their job the best that they know how and that they can, and if police indeed ever exceed their authority, then we have mechanisms to curtail that through courts and police commissions and others. So bias is something that we definitely should not be taking into consideration.

You know, Mr. Chairman, I just recently did a review of correctional facilities in Alberta, and I visited about 10 to 15 prison facilities. When I spoke with the inmates, I was surprised to learn that all of them were innocent. You would think that because of their perceptual bias that the police were unfair and got the wrong guy, we have just incarcerated about several thousand innocent people, yet we don't draft our criminal act based on that.

The Chair: Thank you.

Roseanne, on this point?

Ms Gallant: On this point. Thank you, Mr. Chairman. I just wanted to share with Mr. Lukaszuk that in fact we did poll Albertans in our survey of March 2003 survey that we provided to the committee. The question was asked: would they prefer to provide consent or not before health information is disclosed to law enforcement officers? Eighty-six per cent agreed that they would agree that their consent be required before their health information is disclosed to law enforcement officers.

Now, admittedly, we did not break down the question to say "health information as defined by the act," meaning diagnostic, treatment, and care information. So we could have asked, I suppose: would you mind if only your name, location, and status of condition be disclosed for purposes of obtaining a subpoena, warrant, or court order? However, it was asked.

So I do believe that Albertans would not be keen to have their diagnostic, treatment, and care information disclosed. However, as our commissioner has recommended, he would support a limited disclosure provision for registration information that is limited to those three categories.

So if that's helpful to the committee.

The Chair: Thank you.

Would the committee note that the chair certainly appreciates eloquence, but he also appreciates brevity.

Mr. Lougheed: Can you expand on that, please?

The Chair: Mr. Lougheed, I think that's self-explaining.

Not to inhibit anyone, except that I do appreciate brevity, and given the time and the amount of work that we have to do, if we could make our comments sometimes a little more succinct.

I hate to set you up with that, Dr. Pannu, but you are next.

Dr. Pannu: Mr. Chair, I am a bit concerned that just before my turn was to come, you thought it was necessary for you to preface what I have to say with what you said. But I'm always very respectful of the chair.

I've been listening carefully, Mr. Chairman, to the arguments for increasing powers of the police so that they could have information disclosed to them or for compelling health authorities or health providers to disclose information to police, but much of the discussion seems to be based on hypothetical scenarios: what if this happens or that happens? In the review of the briefs that were provided to us from that end of the table with respect to the legal impediment that HIA might have created for police forces, if I heard that opinion correctly, there's no clear evidence that that's happened. Whether increased impediment is perceived by the police, I think those of us sitting around the table who heard the police briefs will agree that, yes, there's that perception.

So in terms of this particular piece of legislation creating special impediments, in a legal sense I think the case still has to be made that that's the case, that that in fact has happened. If that case could be made convincingly enough, then I'd be inclined to look at some amendments that will remove that impediment.

The other source of evidence, other than hearsay, as I've said before, I think – and I'm going to repeat it – is to ask ourselves: what can we learn with respect to this issue from the experience of the last three years during which HIA has been in place? I've yet to get any information from any source – and I have requested that – that would demonstrate, that would demonstrably show that indeed HIA has created those impediments in practice if not in law. The examples that were brought before us and that we were asked to look at in the oral submissions of a variety of police forces and in their briefs don't seem to rely on evidence. They seem to emphasize their perception of what has happened. I think that to make changes in this legislation, which might bring even Charter challenges to the kind of changes that are being sought, without having in hand the kind of evidence that I'm asking for, have been looking for, I think would be not a very wise thing to do.

So I don't think there is a case here, based on evidence, based on legal analysis or on incidents where some violent individual rushed to a hospital and treated it as a nice refuge or that this act has permitted that over the last three years, that should cause us to take a second look and say that we need to tighten those loopholes.

I want to conclude by making some general comments on: what does the Charter do for us? You know, the Charter of Rights and Freedoms really compels all of us, including legislators, to recognize the limits of the powers that we have to create legislation that will take away or that will impinge on our fundamental freedoms and rights, in particular personal liberty.

2:05

The Charter of Rights and our laws do protect us from each other, from violence, from taking our privacy away, from invading our confidentiality, so one person to another, I think, is protected by that. But the Charter also protects us against excesses by governments, and governments, we do know, can make mistakes, and they do. It protects us from the strong arm of law and law enforcement agencies. It protects us against the very government that many of us sitting around the table always want to cut down and reduce, that doesn't think we need it. Yet we know that in our own experience, in our own lives, we have seen all kinds of governments erring on the side of breaching and assaulting our individual liberties and civil rights.

So that's how I see the Charter. It's not just to protect criminals; it's to protect all of us against unreasonable and excessive coercion. I mean, that's why, I guess, any law that we make can be subject to challenge by us. You know, we are here, presumably, to protect people, but people do turn around, take us to the highest court and tell us: you were wrong. So we should be humble and modest in recognizing that we can make wrong judgments. Therefore, we shouldn't see the Charter of Rights as if, say, it's a horse that we want to beat all the time. Its utility should be recognized.

So the advice that we're getting here, I think, is a very weighty

one, in my view. At this stage I think the first option I would like to choose is to not make changes, to track the information and see how HIA and its given provisions impact the ability of the police. When we are convinced over the next period of years that this in fact has happened and that we are smarter now in gathering information which will give us guidance, then we should perhaps change, but we shouldn't take lightly our duty to protect our own civil liberties and the civil liberties of the society and the rights that it stands for.

Thank you.

The Chair: Thank you.

Mr. Snelgrove, you haven't been in this debate yet, so please proceed.

Mr. Snelgrove: Well, I certainly appreciate the doctor's statements about protecting civil liberties. So much of the legislation that we see brought in is done under the premise of: well, if we just save one child. So we're all supposed to swallow, then, because that's going to save a child. We'll make laws. Then on the chance that we might infringe on some criminal's right, we wouldn't allow a hospital or obligate a hospital to phone and say: "Guess what? We just had a fellow with two pounds of cocaine rupture in his stomach." You know, he could destroy a thousand lives with this stuff, but we can't phone the police. Or "We just had a couple of people come in obviously full of bullet holes from some kind of gang shooting," and we can't get them off the streets before they kill an innocent child. We can't phone in and say, "Obviously, this is very reflective of an automobile accident; this person is obviously intoxicated," and we can't notify the police. He can go kill someone else.

I guess we all have to answer to whatever level we are or we want to. I don't believe that the FOIP questionnaire was really reflective of the situation. Most people presume themselves to be law-abiding, good citizens, and in those conditions none of their information would be released. But when you cross the line and involve yourself in criminal activity, then certainly you wouldn't want any of your information released if it may help convict you. In the way the question was put and if you put it in that context, then certainly most people would say: we don't want to do that.

But I have no problem voting to not only mandate but certainly allow health facilities to report criminal activity when it's in their obvious interests.

The Chair: Thank you.

We are now down to, in some cases, the second and third stab at this one, so may I again ask that we be brief with our second and third comments.

Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. Those were true words by Dr. Pannu. I would concur that the Charter is a wonderful tool, and it's something that we ought to cherish, but it only works when utilized properly. The Charter in itself has a really good guideline for us. Section 1 of the Charter tells us that every time you're making a law, make sure that the greater good to the society outweighs the potential harm to an individual.

As Ms Blakeman indicated, not everyone is a criminal, and we have to appreciate the fact that, indeed, there could be someone who shows up at a hospital with a wound that appears to be of a criminal nature yet was very innocent, and police may end up questioning that person even though he is a law-abiding citizen and has never been involved in any criminal activity. But that's where the test of section 1 of the Charter comes in: is the harm that we have now done to that individual greater than the potential protection that we could have provided to Albertans? I would argue that most Albertans would say no. I know that I personally wouldn't mind being questioned.

The questionnaire that was given, that Ms Blakeman seems to be hanging her hat on and pointing out right now, was a question that was not put in perspective of what we're doing right now. I am convinced that if you were to ask Albertans, "Would you object to having registration and some limited information provided to police officers when they believe or when the medical care provider believes that a patient was involved in a criminal activity?" most Albertans would say, "No, I would not object." That's not what the question asked. Hence, in this case, if the time is appropriate, Mr. Chairman, I would make a motion and move that we adopt option 3 as presented by the department.

The Chair: We'll accept the motion, but we have to finish our speaking list before we vote.

Ms Kryczka: Well, actually, what I was going to say briefly follows from Mr. Lukaszuk. I guess it's great to sit around and philosophize – I took philosophy courses many years ago – but, you know, we really have to deal with realities. Back on the work in progress, what the Edmonton Police Service recommended is I think pretty straightforward. You know, we've had a lot of examples here and, say, personal philosophies, but they just asked to provide for disclosure of registration information without consent for law enforcement investigations and also to provide for disclosure of health service provider information without consent for law enforcement proceedings.

The Lethbridge regional police just said that discretionary disclosure to police should be expanded to include the authority to disclose registration information to police seeking a warrant, subpoena, or court order. Also, it would just encourage or mandate health care workers to notify police with the same basic information when they treat a person whose injuries were caused in the commission of a crime. I mean, that's what they asked for, and I think it's been easy to digress from what they asked for.

The Chair: Okay. Thank you.

Mr. MacDonald, you have the last question today, and then we'll deal with the motion.

Mr. MacDonald: Thank you, Mr. Chairman. I will be brief, but I certainly would support option 2 and for this reason. If we require guns to be registered in this country, then gunshot wounds, in my view, should also be registered as well when the police are seeking a warrant, a subpoena, or a court order.

Thank you.

The Chair: Okay. Well, we do have a motion for option 3, so if it doesn't pass, we will go back to more options.

Mrs. Sawchuk: Ms Blakeman wanted to record the vote.

The Chair: That's absolutely right. We are going to do this so that it's recorded. I will call the roll. First of all, Mr. Lukaszuk, would you again state your motion and how it's going to be?

Mr. Lukaszuk: Thank you, Mr. Chairman. I move that
> the committee adopt recommendation 3 as it appears in the document entitled Discussion Paper: Disclosures to Police Services.

The Chair: Thank you.

Any questions?

2:15

Dr. Pannu: Just the language of the motion, Mr. Chairman. Is it "option" or is it "recommendation"?

The Chair: It is an option, but Mr. Lukaszuk, as I understand it, is moving that as the recommendation of the committee.

Mr. Lukaszuk: That is correct.

Mr. Lougheed: That would not preclude endorsing option 5 as well?

The Chair: Well, Mr. Lukaszuk, I'd let you respond. It's your motion. That's the stand-alone one.

Mr. Lukaszuk: Well, option 5 proposes that we recommend that stand-alone legislation requiring reporting be drafted. I'm not sure if it's within the scope of the committee even to make such a recommendation, because it doesn't relate to the Health Information Act.

I believe that all we can do is amend the Health Information Act, and in the future if any member of the Legislature chooses to bring forward a bill putting in place an act to further enhance the Health Information Act, then stand-alone legislation could be developed. But I'm not sure, Mr. Chairman, if we have the authority.

The Chair: I assume that we could recommend that as a committee if the committee so desired. Holly or Noela or Roseanne, any legal opinions here? Could the committee actually make this recommendation legally?

Ms Gray: I don't see why not.

The Chair: Okay. So it is an option.

Dr. Pannu: Mr. Chairman, option 5 has the merit of us protecting the health care system and the health care providers from having to do the job that they don't see themselves trained to do and yet addressing the problem.

I just want to say this. Whether it's a hospital or whether it's a doctor's office or whether it's a nurse that they're dealing with, when we go to these places, we assume that we have a relationship of trust. We may have questions about particular doctors for abusing their position or this and that, but in general I think that unless we all are convinced and are willing to recognize that you can't have a medical system unless there is that relationship of trust and that relationship of trust between the patient, the care receiver, and caregiver is something that we all want to protect for our own good, we won't get the kind of health care that we need.

The first four options put that relationship of trust in some degree of question. If we want to have a piece of legislation that requires reporting, you know, on some violent action that may be committed with people who end up somewhere, I think option 5 would be probably the best for that reason. All I wanted to do was restate my position.

The Chair: Thank you.

Mr. Lougheed did ask a question on 3 relative to 5. Otherwise, we have the motion for number 3. So we're going to deal with that one. If it does not pass, then we will obviously have to go and deal with another one. Mr. Lougheed, was your question answered?

Mr. Lougheed: Yes. We'll deal with 5 after the vote here then.

The Chair: Okay.

I'm just going to poll each committee member, and would you vote either yes, in favour of the motion, or no, opposed to the motion? Okay. Ms Blakeman, I'll start at your end.

Ms Blakeman: Opposed to the motion.

Mr. MacDonald: I am opposed to this motion.

Dr. Pannu: Opposed.

Mr. Lougheed: In favour.

Ms Kryczka: In favour of the motion.

Mr. Broda: In favour.

Mr. Lukaszuk: In favour.

Mr. Snelgrove: In favour.

The Chair: Okay. The motion is carried.

Ms Blakeman: I'd like to propose a second motion, and that is that the committee recommend that the government consider presenting stand-alone legislation requiring mandatory reporting of gunshots, stabbings, and severe beatings as outlined in option 5 in the discussion paper.

The Chair: Okay. I don't understand exactly what your intent is here, Ms Blakeman. Would you tell me again what you want to do? We accepted option 3, so now you want us to consider, beyond that, option 5?

Ms Blakeman: Yes, because it was clearly pointed out that the two do not preclude each other.

The Chair: Okay. So as a follow-up to 3, 5 would be an option?

Ms Blakeman: This isn't a follow-up to anything. This is requesting that the government look at separate legislation that requires health care workers to report . . .

The Chair: Would you state the motion again, please, Ms Blakeman?

Ms Blakeman: Be happy to, Mr. Chairman. I move that

> the committee recommend that the government consider presenting stand-alone legislation requiring mandatory reporting of gunshots, stabbings, and severe beatings.

Mr. Lougheed: I'll second it, Mr. Chairman.

The Chair: We don't need seconders.

Okay. So we have another motion. No one's asked for a recorded vote here.

Ms Blakeman: I'd like a recorded vote, please.

The Chair: All right.

Mr. Lukaszuk: Are we going to speak to that motion or not?

The Chair: Sure. Of course we will speak to the motion. I'm still struggling with the intent here, but we'll take some questions.

Mr. Lukaszuk: Well, I agree with you, Mr. Chairman. You know, if option 3 was not palatable to the Member for Edmonton-Centre and since option 3 has passed, adding option 5 not only reinforces option 3 but now provides much greater opportunity for law-enforcement agencies to obtain information from our health care providers, which I, personally, don't object to. So I will definitely vote in favour of that because now it makes option 3 that much stronger.

But if we were to accept the arguments that are now recorded from Dr. Pannu and Ms Blakeman, saying that we have to protect the sanctity of the relationship between the patient and the physician, all of the sudden now we will make it incumbent on the physician not only to provide information only when he's asked for it by a police officer but actually himself initiate the disclosure of the information. That bodes very well with me, so I definitely will support that motion.

The Chair: Thank you.

Anyone else?

Mr. Snelgrove: I just don't know how you pick and choose what criminal activity you're going to report. Number 3 says any activity involving criminal activity. Number 5 says gunshots, stabbings, severe beatings. Drunk driving, drug smuggling, and other things like that are every bit as dangerous, so I don't know why you'd want to limit the scope of what you're going to report. I think it's redundant.

The Chair: Would any technical staff like to comment here on the situation the committee now finds itself in? Nobody wants to tackle that?

Ms Miller: I'm certainly not going to give legal advice, because I'm no lawyer, but under option 3 as I read it the important clause there to be considered is "when it is reasonably suspected that a person seeking," and it goes on. Obviously, it's the provider that needs to make that judgment call of reasonableness in terms of suspicion that a person has been involved in some sort of criminal activity.

That differs from option 5 in that there's no interpretation there. Either you have a gunshot wound, a stabbing, or a severe beating or not. So that to me is the difference. That would be my attempt at trying to explain the differences between the two options.

The Chair: Okay. Thank you.

It just seemed to me that option 3 provided some balance in the discussion that I heard back and forth here for the last hour. I, personally, don't have serious problems with option 5, but I thought 3 was a good balance.

Yes, Mr. Broda.

Mr. Broda: Thank you, Chair. I think that the second motion by the opposite side was basically asking government to put in legislation, which I think with number 3 would be actually put right into our act. The other one is stand-alone, so I would support that motion.

The Chair: Okay.

Well, the question has been called, so we will again poll the committee, and it's either in favour of or opposed to – okay? – the motion by Ms Blakeman recommending option 5.

Did you have a question on process, Dr. Pannu?

Dr. Pannu: Yes.

The Chair: Okay.

Dr. Pannu: Mr. Chairman, this committee is reviewing the Health Information Act.

The Chair: Yeah.

Dr. Pannu: I think it's outside the scope of this review to make recommendations to the government on a separate piece of legislation. I think I won't be able to vote for it. I would like to have the right to abstain on the grounds that I don't see it within the purview of what this committee is charged to do.

2:25

The Chair: What are our rules on abstaining? Do we care if they abstain?

Mrs. Sawchuk: The vote will be recorded, Mr. Chairman.

The Chair: So you could just record that you abstain, Dr. Pannu.

All right. We'll be consistent again and start with . . .

Mrs. Sawchuk: I'm going to double-check that, Mr. Chairman.

The Chair: Okay. I'll go to the other side of the table to start.

Mr. Snelgrove: Opposed.

The Chair: Mr. Snelgrove is opposed.

Mr. Lukaszuk: I'll support that motion if the motion falls within the purview of this committee. Support.

The Chair: Well, the legal advice so far is that it does fall within the motion.

Mr. Lukaszuk: In that case, I'll support it.

Mr. Broda: Support it.

The Chair: Okay.

Ms Kryczka: The motion being number 5 choice?

The Chair: Yeah, that's right.

Ms Kryczka: I don't support it.

The Chair: Okay.

Mr. Lougheed: I support.

Dr. Pannu: Abstain.

The Chair: Sorry. Ms Kryczka, you support it; right?

Ms Kryczka: Are you looking at me? I do not support the motion.

The Chair: Okay. Sorry.

Mr. Lougheed, you were?

Mr. Lougheed: Support.

Dr. Pannu: I'm abstaining.

Mr. MacDonald: For the record I support Ms Blakeman's motion.

Ms Blakeman: I support the motion.

The Chair: Okay. I believe the motion carried. Is that correct?

Mrs. Sawchuk: Mr. Chairman, for the record I stand corrected. All members must vote.

The Chair: Okay.

Mrs. Sawchuk: So, Dr. Pannu, we're doing a recorded vote.

Dr. Pannu: Mr. Chairman, I raise the question of: is this for committees? I know what the procedure in the Legislature is.

The Chair: Dr. Pannu, we have a motion on the floor.

Dr. Pannu: That's why I sought your guidance, Mr. Chairman. Is this part of the terms of reference of the work of the committee? The answer was that it's not.

Ms Gray: As counsel for the department I am reluctant to absolutely confirm that it is within the terms of reference. That advice should probably come from counsel for Leg. Assembly. But it is possible to take a vote subject to that determination, I believe.

The Chair: Okay. Thank you very much.

Subject to that. If we determine later that we're beyond our scope here, Dr. Pannu, then we'll have to vote again, so could you vote one way or the other on that condition?

Dr. Pannu: I find it an untenable position, Mr. Chairman. Logically I don't find it tenable. I vote now, and then it's subject to something later? It makes no sense to me. Either I'm voting for or I'm voting not.

The Chair: All right. I propose that we take 15 minutes. In the meantime we'll try to clarify it. We'll reconvene at 2:45, and hopefully we'll proceed with the next item. So for 15 minutes we are adjourned.

[The committee adjourned from 2:28 p.m. to 2:42 p.m.]

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

When we broke, we had before us a question on whether the motion by Ms Blakeman that was before the committee was within the framework or purview, if you will, of this committee. One of our members asked for clarification on whether he could abstain or not. We suggested that if a member were here, they had to vote. So we now have with us Mrs. Kamuchik and Mr. Reynolds, who are going to offer to you their opinion on whether or not this motion is within the purview of this committee and the reasons one way or the other.

Mr. Reynolds, are you speaking to this?

Mr. Reynolds: Thank you very much, Mr. Jacobs. Yes. As Mr. Jacobs said, my name is Rob Reynolds. This is Louise Kamuchik, who is the Clerk Assistant and Clerk of Committees. I'm Senior Parliamentary Counsel with the Legislative Assembly.

I think you'll appreciate that we haven't had time for an extensive review of it. Nonetheless, the question as it was put to us, as Mr. Jacobs said, was whether this motion concerning stand-alone legislation requiring mandatory reporting of gunshots, stabbings, and severe beatings – it goes on, but that's the motion – could be made as a recommendation, as I understand it, as falling within the committee's mandate.

After just reviewing a few documents – and Louise and I have had a brief opportunity to confer on this – the short answer, which everyone appreciates from a lawyer, is: yes, it seems to be within the committee's mandate to consider the motion if it so wants to recommend it. The committee's mandate is set out in the motion, Government Motion 16, that says that

> a Select Special Health Information Act Review Committee of the Legislative Assembly of Alberta be appointed to review the Health Information Act as provided in section 109(1) of that act consisting of the following members . . .

Obviously, you know who you are.

But then section 109 of the act refers to a review and says:

> A special committee of the Legislative Assembly must begin a comprehensive . . .

I underline that word "comprehensive."

> . . . review of this Act within 3 years after the coming into force of this section and must submit to the Legislative Assembly, within one year after beginning the review, a report that includes the committee's recommended amendments.

"Includes the committee's recommended amendments." So it seems to suggest that the report could even go further if it so wished.

Now, of course, subsection (2) discusses to whom the review must be addressed or things that the committee must look at.

In any event, the short answer is that the committee has the jurisdiction to decide what its amendments are. You look at the document that created the committee – and I've done that – the motion and the act, and broadly speaking, it doesn't seem to be outside the scope of either of those.

Does that answer the question in any way, hopefully?

The Chair: I believe it does.

Are there any questions of Mr. Reynolds?

Ms Blakeman: I knew what I was doing.

The Chair: The interesting thing here is that the member who wanted to abstain has found the true way to abstain: don't come.

Anyway, thank you.

Mr. Reynolds: You're welcome. Good luck. Thank you very much.

The Chair: Thanks for coming down. We appreciate it. We might call you again.

Mr. Reynolds: Yes, yes.

The Chair: On this motion, Mr. Lukaszuk.

Mr. Lukaszuk: I'm just wondering, Mr. Chairman. In the spirit of fairness and to allow the member who brought this issue to question and who definitely showed through his speeches a definitive degree of interest in this matter, should we not postpone the vote until such time as he returns to this Chamber and allow him to vote?

Ms Blakeman: The vote has been taken.

The Chair: The vote has been taken, but I need to clarify, Ms Blakeman, to make sure that everyone understood the motion. We have received some clarification on the motion. Could I just read the motion as we now have it? I think it's consistent with what you moved, but for your information could we read this as it stands? If the committee is in agreement – I agree with you: we did vote. The member who didn't vote is not here.

Mrs. Sawchuk: Mr. Chairman, maybe if I could for the record just verify that the correct wording is on the record for the motion that was put forward by Ms Blakeman: that the Health Information Act Review Committee "recommend that the government consider presenting stand-alone legislation requiring mandatory reporting of gunshots, stabbings, and severe beatings." That was it.

The Chair: Okay. Is that what everyone thought we were voting on? Does anyone see a need to delay or postpone or wait? Okay.

You have a record of everybody?

Mrs. Sawchuk: I do, Mr. Chairman. Thank you.

The Chair: All right. Thank you very much for a very interesting – oh, I forgot the count. How many for and how many against?

Mrs. Sawchuk: Five for and two against.

The Chair: Okay. So it did carry.

All right. Wendy, where are we going now?

Ms Robillard: I'm almost afraid to say it.

The next discussion paper that we have is titled Disclosures to Police Services Related to Prescription Drugs. It's a two-page document.

The Chair: We are still on question 24.

Ms Robillard: The reason we're bringing forth another discussion paper is that this is a much narrower question than the previous one we addressed.

The Chair: Is this the one dealing with fraud, Wendy?

Ms Robillard: Yes, around prescriptions.

The Chair: So we are delaying that discussion. We're not? Okay. Very good.

Sorry. Proceed.

Ms Robillard: Okay. So the issue here is that the Alberta College of Pharmacists recommended authorizing disclosure without consent of individually identifying health information to police if the custodian has reasonable grounds for believing that the information reveals or tends to reveal that an offence under the Criminal Code, the Controlled Drugs and Substances Act, the Narcotic Control regulations, or the Food and Drugs Act has been committed or is being attempted.

The background. In their submissions some pharmacy-related stakeholders indicated that pharmacists can be aware of individuals who alter otherwise valid prescriptions in order to increase the amount of a prescribed drug to be dispensed or are aware of double doctoring. They indicate that there are no current provisions in the act to enable the disclosure of this information to the police.

Value Drug Mart recommended allowing custodians discretionary power to release health information to peace officers when the custodian suspects a criminal activity.

2:50

The Pharmacists Association of Alberta in their written submission supported keeping and not changing the current rules on the basis that the current requirements have proven to be practical, predictable, and consistent with the legislative intent. In their oral presentation the association supported that custodians in those circumstances should be authorized to disclose that information to either the College of Pharmacists or to the police where they have uncovered evidence of abuse.

If the pharmacist's intention is to report an activity that could cause imminent harm to any person, the current provisions in the act may already authorize the disclosure. As with other disclosures of health information without consent to the police, the challenge is finding the balance between appropriate access to health information and protection of privacy.

The College of Physicians and Surgeons of Alberta operates the triplicate prescription program as a means to partially address the issue. Physicians have not been consulted about this idea and would be affected by a change.

The first option: status quo. The impact: the balance remains on protecting privacy over access.

The second option: limited disclosure of registration information only. The impact: such a provision would not address or resolve the concerns as identified by the pharmacists in that they've identified a need for disclosure of information beyond registration information.

The third option: where the pharmacist has reasonable grounds for believing that the prescription reveals or tends to reveal that an offence has been committed or is being attempted, authorize the disclosure of limited health information including a copy of the prescription and limited registration information including the individual's name, date of birth, personal health number, and address. This would also include the name, address, and phone number of the prescribing physician. There could be some requirement to consult with either the College of Pharmacists or the College of Physicians and Surgeons of Alberta before disclosing the information to the police.

The impact: limited disclosure of health information enables continued protection of the majority of diagnostic treatment and care information. It would meet the needs expressed by the pharmacists during the review process. The balance moves toward more access without moving too far away from the protection of privacy for individuals, but there is risk of error in the pharmacist's assessment of the situation and potential harm to an innocent individual and physician. It would still require interpretation of the situation and the legal provision by pharmacists. Any expansion of the right to allow police further access could result in a Charter challenge to the legislation.

The Chair: Thank you, Wendy.

Ms Blakeman: Three questions. Am I picking up in the third bullet there that the pharmacists said one thing in a written submission and something slightly different in their oral submission?

Ms Robillard: The Pharmacists Association of Alberta in their written submission talked about keeping and not changing the rules, but when they were here and were asked specifically about that, they said in this little narrow piece that they didn't necessarily disagree that there should be a way to support this. However, generally to expand the provisions was not what they were requesting.

Ms Blakeman: Okay. The second question: is the interpretation too weak, then, under section 35(1)(m), which the pharmacists seem to be saying is the provision that would allow them to do what was needed here? What's the problem?

Ms Robillard: If one were concerned about a potential offence under the Criminal Code or one of those other pieces of legislation, section 35(1)(m), which is imminent harm, may not apply. It might not be broad enough to authorize that.

Ms Blakeman: Okay. So it's more concerned with medical rather than fraud, and that's the limitation under section 35.

Ms Robillard: Right. If the pharmacist was concerned about the individuals themselves and not the activity, section 35(1)(m) might allow that disclosure.

Ms Blakeman: Okay.

Which of the options best fits the requirements of section 2(c), which is "in the most limited manner and with the highest degree of anonymity"?

Ms Robillard: Those overriding principles could apply to any of these options, and those are overriding provisions in the legislation for all collection, use, and disclosure activities.

Mr. Snelgrove: Mr. Chairman, on question 24 I would like to move that

> we recommend option 3 as presented in the discussion paper.

The Chair: Okay. Mr. Snelgrove has moved that the committee recommend option 3, which is:

> where the pharmacist has reasonable grounds for believing the prescription reveals or tends to reveal that an offence has been committed or is being attempted, authorize disclosure of limited health information including a copy of the prescription and limited registration information including the individual's name, date of birth, [and so on and so forth].

You can read it.

Ms Blakeman: A recorded vote, please.

The Chair: Oh, yes. Okay. We want a recorded vote. So noted.

Any other comments or questions?

Dr. Pannu, we did discover that it is within the mandate of the committee to make that motion which Ms Blakeman made, so had you been here, you would have had to vote.

Okay. Any comments or questions on the motion as moved by Mr. Snelgrove? So either in favour or against, again starting with Ms Blakeman.

Ms Blakeman: Opposed to the motion.

Dr. Pannu: Opposed, Mr. Chairman.

Mr. Lougheed: Agreed.

Ms Kryczka: In favour of the motion.

Mr. Broda: Agreed.

Mr. Lukaszuk: In favour.

Mr. Snelgrove: Agreed.

Mr. Goudreau: Agreed.

The Chair: The motion is carried.

Okay. Where are we going next?

Ms Swanson: I think that at this stage we could move to the chart and start going through the other issues, if you would like, from 1 on through. Is that suitable?

The Chair: Okay. That's 13 pages?

Ms Swanson: That's right.

The Chair: Where were we going to start?

Ms Swanson: We thought we'd start with 1 now.

The Chair: Question 1?

Ms Swanson: Yes. Question 1 in the issue summary.

The Chair: Okay. Are there other discussion papers on this one? Is this all we have?

Ms Swanson: That's right.

The Chair: Everybody with us? It's the draft for discussion Health Information Act Three Year Review: Issue Analysis Summary.

I think we're okay, Evelyn, so go ahead.

Ms Swanson: Thank you. The first question was: "Are the purposes in the [Health Information Act] appropriate? If not, please explain why." Our suggested response on this one is to maintain the status quo. There was general consensus that the purposes in HIA are appropriate as they're written now.

There were a couple of suggestions, though, and we will mention them here. The AMA's suggestion to give primacy to the principle of least amount of information and highest degree of anonymity in a preamble is not consistent with the fundamental notion that the act must provide a balance between protection of the individual's privacy and access to health information where appropriate to provide health services and manage the health system. Privacy is already stated as the first of seven key purposes. So the reason for rejecting it is that the act is about balancing privacy and need for access.

Another point, that was suggested by the Canadian Blood Services, was that public health be added as a purpose because that's the activity that they are engaged in. On review we felt that there was no compelling reason to make this one of the fundamental purposes, because information for public health purposes has not been problematic to date.

3:00

The Chair: Okay. Do we have questions, comments on question 1, purposes?

Evelyn, how many of the presenters said that the purposes were okay versus they're not okay?

Ms Swanson: I believe that there were three that had some comments. There were a total of 11 comments; 11 stakeholders commented. The Consumers' Association feel that we should remove the first purpose because it's misleading and deceptive. The comment from the Alberta Medical Association was that we create

a preamble and give prominence to the highest degree of anonymity and least amount of information, and from the Canadian Blood Services, that we acknowledge public health as a legitimate use of health information. So three out of 11.

The Chair: Okay. Thank you.

Do we have any other questions or comments on question 1? I would like to do this by motion if the committee agrees with the recommendation to maintain status quo.

Dr. Pannu: On the issue of primacy to the principle of least amount of information, I presume that only information which is directly relevant to the diagnosis or treatment of the individual involved is what is meant by "least information," or what?

Ms Swanson: This is a principle that's incorporated in the act now, and the AMA believes that it's so important that it should come at the very beginning of the act in a preamble and make it pre-eminent. But it is an overriding principle that applies to every collection, use, and disclosure for whatever purpose. It must be taken into account by custodians.

Dr. Pannu: Mr. Chairman, my concern is with sort of leaving the question of not only what information is collected but what purposes it's used for. The Graydon report talks about the establishment of medical savings accounts, for example. Now, would this information then be available for that kind of purpose? That's my question, and that's why I felt that perhaps the principle enunciated by the AMA is worth the serious consideration of this committee, because I don't think that the Health Information Act should generate information and make it available for purposes with little to do with health but with schemes of private delivery.

Mr. MacDonald: Enhancing privatization.

Dr. Pannu: That's right. Enhancing privatization. That's my concern, my serious concern.

The Chair: Dr. Pannu, you're assuming a lot in your concerns.

Dr. Pannu: Mr. Chairman, the outright rejection of the suggestion made by the AMA raises questions, and I think I have a duty to raise those questions. How do you avoid assumptions when the statement here says that putting this principle in the preamble "is not consistent with the fundamental notion that the Act must provide a balance between protection of the individual's privacy and access to health information where appropriate to provide health services and manage the health system." Managing the health system is the one that rang alarm bells for me. There really is now a larger purpose being suggested here, implied, and if you call it assumption, yes.

The Chair: There's another word in there, and that word is "balance."

I think, Linda, you had a comment here. Did you?

Ms Miller: Yeah, I did at one point. I was concerned that Dr. Pannu was saying that we would remove the principle. We're just suggesting that the need to make it as part of the preamble is not necessary.

Dr. Pannu: No, no. Putting it in the preamble. I understood that.

Ms Miller: I just wanted that clarification.

The Chair: Okay. Anyone else?

Mr. Snelgrove: Do you want a motion, Mr. Chairman?

The Chair: I would like a motion.

Mr. Snelgrove: I move that

> we accept the suggested response and maintain the status quo with regard to question 1(a).

The Chair: Okay.

Ms Blakeman, you're going to ask for a recorded vote; right?

Ms Blakeman: You are correct.

The Chair: That's fine. We all like to have our names called, so it's no problem.

On the motion, any questions?

Okay. I'll start again with you, Ms Blakeman. In favour or against?

Ms Blakeman: Opposed.

Mr. MacDonald: Opposed. Thank you, Mr. Chairman.

Dr. Pannu: Opposed, Mr. Chairman, for the reasons I've given.

Mr. Lougheed: Support.

Ms Kryczka: In favour of the motion.

Mr. Broda: Support.

Mr. Lukaszuk: Support.

Mr. Snelgrove: Agree.

Mr. Goudreau: Agree.

The Chair: All right. I feel sorry for Leg. Counsel, who have to do this for 80 people in the Assembly, and they do it by memory. Well, I'm impressed.

All right. Where are we going next, Evelyn?

Ms Swanson: To 1(b). The question is, "Would the inclusion of the additional purposes be acceptable?"

The additional purposes in the consultation guide were about transparency and accountability.

Mr. Snelgrove: Mr. Chairman, we've voted to maintain the status quo, so could we move to question 2?

The Chair: So you're saying that we already covered 1(b)?

Mr. Snelgrove: Yes, we did.

The Chair: Is that what you're saying, Mr. Snelgrove?

Mr. Snelgrove: Yes.

The Chair: So I think everybody understands that.

Ms Swanson: Move on to question 2 then?

The Chair: Yes.

Ms Swanson: Okay.

Number 2 was a question about definitions: "Are there any definitions that should be modified? If so, kindly provide the rationale . . . and any suggested wording."

In this particular question there were a number of suggestions for definition changes that relate to substantive comment to questions later on in the list. In those cases we have deferred consideration of the definition to the substantive section rather than dealing with them out of context here. Examples would be the definition of custodian. We gathered that information in question 3.

Here we are recommending the status quo in terms of the actual legislation, but we would provide clarification of terms through guidelines as necessary. Most of these suggestions were unique to a particular stakeholder. There are only a couple of cases where a stakeholder has asked for clarification of the same definition. Many times this was for purposes of clarity, so we are suggesting that we do some work to provide some guidelines and policy interpretations.

The Chair: Could you give me an example of what that might be?

Ms Swanson: Okay. Would nonidentifying information be a good one?

Ms Miller: Manage the health care system was one. Security. These are terms that are frequently referred to in this whole arena.

The Chair: So in the guidelines you would just clarify those definitions?

Ms Miller: Yes.

The Chair: All right. Thank you.

I'd say that we've got a status quo recommendation here.

Mr. Broda: So moved.

The Chair: Okay. I do have a motion from Mr. Broda to move this.

Mr. Broda: To leave it status quo under item 2.

The Chair: Yes.

Does anyone want to speak to the motion? No? Okay.

All right. Seeing no one wanting to speak, did we have a motion for a recorded vote here? We don't, so we don't need to have it recorded. Okay.

All in favour of the motion on status quo for number 2, please raise your hand. Opposed? Carried. All right.

Ms Swanson: We've already dealt with questions 3 and 4 and 5.

The Chair: Right. Question 6 is tabled until tomorrow.

Ms Swanson: That's right. We'll deal with the other two parts of number 6 when we've dealt with the first part.

The Chair: All right.

Ms Swanson: Number 7 we've dealt with. Numbers 8 and 9 are dealt with. So that takes us to question 10.

This is: "Should the definition of health information be changed to include non-recorded information?" I believe that at the last meeting the committee agreed with the consensus of stakeholders that it should not be included in the scope of the act to any greater extent than it's already included. So status quo.

3:10

The Chair: Thank you.

Questions? Comments? Is anyone prepared to move this one?

Ms Robillard: I just have a question as to whether that decision was already made at a previous meeting.

The Chair: Well, I think it was. Did we not deal with that last time?

Ms Miller: I don't know that it was a formal motion.

The Chair: I think we need a formal motion.

Mr. Goudreau: Mr. Chairman, I'll make that motion then.

The Chair: Thank you, Mr. Goudreau.

So status quo on question 10 has been moved by Mr. Goudreau. Anyone on the motion? All in favour, raise your hand. Opposed? Carried.

Okay. Question 11.

Ms Robillard: Question 11 is: "Is the process for obtaining access to records appropriate?"

The suggested response is that we amend the act to authorize the commissioner to stop the clock on response time for processing a request until after the commissioner's decision about a custodian's request to disregard the individual's request for access. So it's when a custodian comes forward with a request to the commissioner to decide whether this is a vexatious request that the processing would stop in the interim.

Section 87 enables the custodian to seek the commissioner's approval to disregard access requests if "because of their repetitious or systematic nature, the requests would unreasonably interfere with the operations of the custodian or amount to an abuse of the right to make those requests," or if "one or more of the requests are frivolous or vexatious." However, current provisions do not address the need to stop the clock when an application is made to disregard a request. HIA requires a response within 30 days.

Based on FOIP experience, the process requires a written request to the OIPC to seek approval to disregard. The OIPC provides a copy to the applicant and an opportunity to make written representation in response. The custodian is provided a copy of the applicant's written response. Time elapsed prior to a decision can exceed the 30-day response time.

In the FOIP adjudication order 5 a judge provided comments in relation to an applicant's numerous requests to a local public body, indicating that it was the applicant who abused the system, finding the requests frivolous or vexatious. For that reason the judge concluded that the requests could have been disregarded as authorized by the act. The judge also expressed concerns about how lengthy the process was and concerns about staff time and cost to the custodian in addressing the requests. The issue was not identified until after the last FOIP review, so I don't believe it's gone forward to that legislation.

The options include status quo, in which case the custodian is obliged to continue processing the request while the request is being considered by the OIPC, and often the request will have been processed by the time there is a ruling, which is equivalent to no provision to disregard frivolous or vexatious requests. The second

option is to amend it to stop the clock when the custodian requests a ruling from the commissioner under section 87. This enables the custodian to cease processing until the commissioner can render a decision, enables the commissioner to address the custodian's concern, may delay the individual's right to access if the OIPC finds in their favour. So it could delay the amount of time before an individual could receive their information.

The Chair: Thank you, Wendy.

So two options are recommended here or are there for your consideration, options 1 and 2. Do we have comments or questions?

Dr. Pannu: Is there any restriction on how much time the OIPC can take? Are there any limits on that? Any of you?

Ms Gallant: I would have to double-check, but I believe that, no, we don't have a time frame within which the commissioner has to make a ruling back to the custodian. I don't believe there is a set time, but I'll double-check the act.

Dr. Pannu: The stop-the-clock recommendation would make sense provided that the applicant who went to the OIPC has some time limit guarantee that the complaint will be processed. I can see the reasonableness of the recommendation provided that there is also some assurance in law to the person who takes the matter to the OIPC. It's a question of balancing those considerations.

The Chair: Okay. Thank you.

Under the stop-the-clock option what would happen to vexatious or nonsensical requests?

Ms Robillard: In terms of the recommendation that we made to stop the clock?

The Chair: Yeah.

Ms Robillard: If an individual submitted what was considered by a custodian to be a vexatious, frivolous request, the custodian could refer that by letter to the commissioner, and that, according to the amendment we're proposing, would have the effect of stopping the clock, so they wouldn't have to continue processing the request until the commissioner ruled.

The Chair: Okay. Thank you.

Mr. Lukaszuk: Mr. Chairman, the act may not provide for a limit, but can you give us, based on track record, what usually the turnaround time is? You know, based on track record, that would give us that security.

Ms Inions: These particular situations are not common, so there isn't much of a track record. I think that's one of the reasons there's probably not a specific provision either. It's just a rare situation.

I expect that a lot of these processes would require notice to the parties, and then the parties can, you know, respond and that sort of thing. So there are many things that are out of the control of the commissioner as far as the time that would be required to render a decision. But I'll just double-check and see if there's something written into the act. It may be the kind of situation that it would be very difficult to ascribe any time frame to. There haven't been many of these kinds of decisions made.

The Chair: Does the committee want to delay this vote until we clarify the questions?

Dr. Pannu: I would so propose, Mr. Chairman.

Mr. MacDonald: Could you please tell me how many occasions there have been where requests have been determined to have been frivolous or vexatious to date? You said it was uncommon; right?

Ms Inions: It is. I can't tell you off the top of my head. You're asking the question of the FOIP legislation then, I take it, or are you asking just the HIA?

Mr. MacDonald: Well, you could say both. Like, there would be people in the Department of Energy that would argue that every time I submit an access to information request, it is frivolous or vexatious. This is a serious matter. I mean, access to information is to keep the government transparent. The Health Information Act, as I understand it, is to protect all health information from maybe prying eyes or prying hands. Who's to say? But if this is not a matter of great concern, I don't know why we're dealing with it, unless of course we expect in the future that we can use this to exclude cases.

The Chair: Well, that was one of the questions that was posed, Mr. MacDonald.

Ms Inions: I can certainly get you an answer as far as the number of times this has formally been asked of the commissioner, has come forward as an issue under FOIP and HIA. I can get you that information.

Mr. MacDonald: That would be terrific.

Who would determine if such a request were vexatious or frivolous?

Ms Inions: The commissioner.

Mr. MacDonald: Who would do that, you know, at the request of a custodian or whatever? I appreciate that.

The Chair: All right. Seeing that we have some questions here that we need information on, I suggest to the committee that we table this one until tomorrow. Is there agreement for that? Opposed? Okay. I see no opposition, so we will table 11 until tomorrow.

So are we going to 12 next?

Ms Robillard: Yes. Question 12: "Are the exceptions to the individual's right to access their own information (both mandatory and discretionary) appropriate?" The suggested response is status quo. The rationale: considerable consensus existing provisions are adequate. The Canadian Institutes of Health Research suggested that health information a researcher uses solely for research be exempt from the access provisions as proposed in Ontario's draft regulations. However, under HIA, this is already the case for noncustodian researchers. Access provisions apply only to health information used for research by custodians and/or their affiliates.

The Chair: So we have a status quo recommendation here. Does the committee have any questions or comments? Mr. Lukaszuk.

3:20

Mr. Lukaszuk: I'd like to make a motion
to accept the status quo on this question.

The Chair: Thank you. So moved.

Questions on the motion? Yes, Ms Blakeman.

Ms Blakeman: Just requesting a recorded vote, please.

The Chair: Yes. We'll start with you, Ms Blakeman. Are you in favour or against?

Ms Blakeman: Opposed.

Mr. MacDonald: Opposed.

Dr. Pannu: I'm opposed, Mr. Chairman.

Mr. Lougheed: Support.

Ms Kryczka: Support.

Mr. Broda: In favour.

Mr. Lukaszuk: Support.

Mr. Snelgrove: Agreed.

Mr. Goudreau: Agreed.

The Chair: Okay; it's carried.
Question 13.

Ms Robillard: Question 13 is relative to the amount of fees set out in the Health Information Act regulation, and the suggested response is to defer review of the fees to the regulation review scheduled for 2005.

The rationale. The regulation expires on November 30, 2005, unless repassed in its current or amended form. The matter of fees can be reviewed more fully prior to that date and any changes made at that time.

Ms Blakeman: Could I just get a reminder of how much the average access is costing people? I've got the figure $55 plus $5 a page photocopying in my head, and I'm not sure if that's accurate.

Ms Robillard: There's a $25 basic fee that can be applied to a request and then additional fees on top depending on the amount of records, type of records, amount of time it requires a custodian to sever, et cetera, et cetera.

Ms Blakeman: To my reading this is a difficult one because what we've heard is a number of the health care providers say: this is an onerous task for us to provide this information, and you're not allowing us to charge enough money. But if I look at the Consumers' Association, which is one of the few groups representing patients, or individuals, as compared to health care providers and commercial operations, they're indicating that people are finding that amount of money onerous.

I think that in the ones I've heard of – perhaps others have a different experience – particularly when they're trying to access records around long-term care and treatment options that have been put in place for aged parents, there are all kinds of things about supervision while you look at the records, and then you have to pay the nurse by the hour at 40 bucks a pop. That to my eye would start to get expensive. So I'm a little leery to have this passed on without a bit more discussion from the committee about where people are likely to come down on this one.

It seems imbalanced towards the care providers, but I'm sympathetic, having run a number of nonprofits, to how these constant requests to fulfill legislation suck money out of your organization and you're not providing service as a result. So this is a very difficult one.

The Chair: Well, Ms Blakeman, is your concern with the deferral of this question until next year? Is that the concern?

Ms Blakeman: Yeah. I'm a little concerned about it being deferred to a regulation review. Now, that's not a committee of the Legislative Assembly. It wouldn't come before the Assembly. It's done behind closed doors, and I don't even know who would be on the committee. So I'm just looking for a bit more discussion here about any anticipation of where this debate would go.

The Chair: All right. Are you on this point, Ms Kryczka? Is your comment on this point?

Ms Kryczka: Yes, I am. I'm flipping back to the work in progress because then you see the breakdown of the various differing responses, and I appreciate the summary in the document we've been working from today. But I understood initially that all we're looking at now is whether we defer this one or not; right? As recommended?

The Chair: Well, defer it to . . .

Ms Kryczka: I think it should be deferred because – sorry if I'm barreling ahead here – if you look at the different answers on the work in progress, there are many different reasons. So I think that there has to be some work done on this. I don't think that it's up to us to decide today what the committee's going to do or who's going to be on the committee, et cetera. That would be up to the minister of the day. I think we just are saying that it's okay to defer it because work needs to be done. That's my understanding.

The Chair: All right. Okay. That's what's being recommended.
Some concern has been expressed. Anyone on the technical team want to address the concern raised by Ms Blakeman?

Ms Miller: I think the concern that there needs to be more analysis done – the regulation review is scheduled, and there will be a thorough look at that in preparation for that review. As you saw with the responses by the various submitters, the rationale on either side of the argument varies considerably.

The Chair: Okay. So when the regulation review by this committee takes place, does what they do have to come to the Legislative Assembly?

Ms Miller: No, not necessarily.

The Chair: All right. I've got some more comments. Mr. Lukaszuk, then back to Ms Kryczka.

Mr. Lukaszuk: Thank you. I don't think that this committee should get into issues of micromanagement. We can set the policy and determine that, indeed, the fee should be not prohibitive but at the same time reasonably compensate the providers for the amount of work that they put into the provision or reflect the medium which is required. It could be X-ray films or whatever it is that they're providing. But I think that it would be unreasonable for us now to determine an exact dollar value of what it should be.

There are so many different media through which health information is provided. We're not strictly looking at photocopies. Those

could be radiograms. There could be X-ray pictures. There could be MRI pictures, printouts, and various electronic forms of transmission. For us right now to try to determine the dollar value, I don't think any one of us here at the table has the expertise to do so. So, perhaps, deferring it to a committee who actually has expertise and knowledge of the media and the costs involved would be a reasonable expectation of this committee.

The Chair: Thank you.
Ms Kryczka.

Ms Kryczka: What I was going to say has already been said.

Dr. Pannu: Mr. Chairman, there's a question before this committee: is the amount of fees set out in the Health Information Act regulation appropriate? So are we to say that it's inappropriate for this committee to answer that question? That's what it'll amount to if we simply say that some committee responsible for regulations, having nothing to do with the Legislature itself, will make the determination. I think that it will be inappropriate for us not to respond to this question fully and properly and here.

So to me the recommendation and the rationale and the suggested response are unacceptable because we represent the Legislature here. All we're saying is that we are abandoning our responsibility as a committee of the Legislature to do what the Legislature expects us to do.

The Chair: All right.

Mr. Snelgrove: No. What it's saying is that in fact they're going to be reviewed anyhow. No matter what we decide collectively here about it, that review will take place with regard to all government fees, and that's its timeline. So we can spend as much time as we like about it, but the simple fact is that that committee will be charged to review all regulatory expenses, and we might as well just let them do it.

The Chair: Okay. Thank you.

Mr. Lukaszuk: I'll withdraw unless the member opposite can satisfy me right now – I personally admit not to have the expertise, but I'm not sure if Dr. Pannu can right now tell me what would be a reasonable cost for a printout of an X-ray film. I have no idea. So I think that the best that this committee could do, being a committee that deals with a larger picture, is to set a guideline to be fair to both the provider and the recipient. But for us to actually start quantifying dollar values on matters that we have no understanding of whatsoever – and I'm assuming that Dr. Pannu does not have expertise in that area – would be simply unreasonable.

The Chair: Okay. Thank you.

Mr. MacDonald: Well, the first thing, Mr. Chairman, is that the whole issue of fees is listed in the act. For anyone to think, whether it's an X-ray or a photocopy or anything, that recovery of those fees should pay for the complete administration of the Health Information Act I think would be erroneous. One would only have to look at the wise words from Justice McMahon in another matter related to access to information fees in that they should not be seen as a barrier, essentially.

Certainly, if one is to compare, for instance, the photocopying charges that come from the Legislature Library, which are significantly less than a photocopy of a sheet of paper under this act – you know, this is one government department to another – these fees are excessive. They certainly are. I would like someone to point out to me, please, any time when less than 25 cents, the maximum allowable, has been charged in a request to have an item photocopied. If it is the maximum, why is it always the maximum?

3:30

Ms Miller: Alberta Health tends not to charge, but, you know, we're just one custodian of many.

The Chair: Could you adjust your mike a little bit, Linda?

Ms Miller: Sorry. I'm usually not that quiet.
Alberta Health does not charge for photocopying, but we are but one custodian named under the act.

Mr. MacDonald: Okay. I appreciate that.
Again, in conclusion, Mr. Chairman, I think we should look at the comparison to the federal government. The federal government charges $5 for a freedom of information request, and I think the Health Information Act should adopt a similar fee schedule.
Thank you.

The Chair: Okay. Well, the recommendation here is to defer the review of fees to the regulation review in 2005. That's the recommendation.

Ms Kryczka: I move that we defer.

The Chair: Okay. I do have a motion that
the recommendation to defer the review of fees be adopted.
I do have that motion.
Yes, tell me, Ms Blakeman.

Ms Blakeman: Could we have a recorded vote, please?

The Chair: Yes. I never would have guessed.

Ms Blakeman: No need to be snarky. It's a reasonable request.

The Chair: Any questions on the motion?
All right. We'll start on the other side of the table this time. Mr. Goudreau, in favour or against?

Mr. Goudreau: In favour.

Mr. Snelgrove: Agreed.

Mr. Lukaszuk: Yes, Mr. Chairman, definitely in favour.

Mr. Broda: Agreed.

Ms Kryczka: In favour.

Mr. Lougheed: Agreed.

Dr. Pannu: Opposed.

Mr. MacDonald: Opposed.

Ms Blakeman: Opposed.

The Chair: Thank you.

I propose that we try to get through 14, and then we'll move to Other Business today because we do have a break there before we move into part 3. So if we could finish 14, then we'll go to Other Business because we do have some items under Other. Then we would of course, following Other, be ready for adjournment until tomorrow morning at 9 o'clock. So 14, please, Wendy.

Ms Robillard: "How should the [Health Information Act] be amended to address the concept of custody or control of a custodian within the EHR?"

We have two separate suggested responses here. The first one is to defer the request for consideration of need for more clear and transparent rules for the EHR to Alberta Health and Wellness. The rationale is that there was not consensus among stakeholders about the need for changes or about what changes might be appropriate. As pointed out by one stakeholder, it is premature to consider changes to the concept of custody and control at this stage of EHR implementation.

Do you want me to move on to the second suggested response?

The Chair: Please.

Ms Robillard: Add a provision to allow for the collection, use, and disclosure of a unique identifier for health service providers for authorization and authentication purposes in the EHR. The rationale: although not directly related to the concept of custody and control in the EHR, a unique health service provider identifier is required at this time for continued EHR implementation to allow for authorization and authentication of those who access and enter records on the EHR.

The Chair: Okay. Thank you very much.

Do we have questions or comments? Again we have a defer and an add. Yes, Mr. Broda.

Mr. Broda: To accept the recommendation of deferring it for more clear and transparent rules under the EHR.

The Chair: So that is a motion to adopt that one?

Mr. Broda: Yes.

The Chair: What about the other one on add?

Mr. Broda: As well. Both.

The Chair: So I do have a motion from Mr. Broda to defer and to add as defined in the document. I see, Dr. Pannu, that you have a question.

Dr. Pannu: Yes, please, Mr. Chairman. Defer to when?

The Chair: Wendy, Linda, do you want to comment on when?

Dr. Pannu: It's a question of specifying it, Mr. Chairman.

The Chair: Sure. That's fine.

Ms Robillard: This is one of the issues that is suggested for deferral for further research and consultation by Alberta Health and Wellness in consultation with stakeholders prior to the next legislative review. So that would be the one some years out.

The Chair: So this will not be for consideration by the recommended committee early in 2005? This would be for the next review?

Ms Robillard: Yes.

Ms Miller: The rationale for that, again, is that this issue is still very new in terms of the electronic health record as is the concept of the electronic health record, and we need some added experience to help provide clarity to those terms and obviously, then, the necessary legislative provisions to enable that.

The Chair: Okay. How many stakeholders were in favour of deferring? You mentioned here one stakeholder. Was there more than one? [interjection] There was more than one? Okay.

Dr. Pannu: Who was that stakeholder?

Ms Swanson: Five of the 11 organizations supported no change in the act to the concept of custody or control. There were 11 organizations that commented, so half of them took the position there was no need for change right now.

Who were those? Three professional associations or colleges, one health authority, and one university.

Dr. Pannu: My next question: what happens in the meantime? Is there a sort of vacuum between now and three years when this may come up for review?

Ms Miller: It's status quo. We are working with the current definitions under custody and control in terms of the access rules to the electronic health record. Once a custodian is provided access to the EHR, they by definition have custody and control of the EHR because the EHR now does not belong to one of the custodians. It's a compilation of information from a number of the custodians that are participating in the EHR.

It is a new concept. It is something very new to the health system. We have set up legal frameworks and agreements to cover this particular issue, and our recommendation is that we need as a system to work through that and have more experience about it to see where there are areas which need improvement and/or change before we would feel comfortable making a recommendation at this time.

The Chair: Linda, could you comment again on how that review would tie into the next review of the act? Would those recommendations by Health, should they come forward, go forth to the next committee? How would that work?

Ms Miller: We anticipate the next comprehensive review of the health act would occur in approximately a three-year period, as the current legislation has drafted, so we believe the timing is solid in terms of that would give us a couple more years to work with the current concepts and the arrangements in terms of the development of the electronic health record and how the various participating custodians will be able to understand the implications of having access and therefore custody and control of the EHR. That added two years' experience gives solid experience that could feed into the next comprehensive review. Does that answers your question?

The Chair: Okay. Thank you.

Any other questions?

I would appreciate a motion one way or the other on this one. I'll take Ms Kryczka's.

Mr. Broda: I made the motion.

The Chair: Oh, you made the motion. Okay. Sorry, Dave. I remember now, yeah.

Okay. We do have a motion on this one from Mr. Broda which included

to defer and add as defined in the document.

A recorded vote also?

Ms Blakeman: No.

The Chair: It was not a request. Okay.

All right. So we'll just do a hand vote. All in favour, please hold up your hand. Opposed? Carried.

I've had a request for a five-minute break before we go into Other, so we will take a five-minute break, and then we'll proceed with Other, allowing the chairman time to get his papers together.

[The committee adjourned from 3:40 p.m. to 3:49 p.m.]

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

Under Other I know that we are going to discuss Dr. Pannu's request, but are there any questions from any of the committee on any of the documents that were tabled relative to the questions you asked to be clarified at the previous meetings? Those responses should have been on your desks this morning. Everybody okay with those? Have they all been addressed? Okay.

Are there any other items other than the one by Dr. Pannu that anyone wanted to table today? Therefore, I assume that this is the only item we have under Other.

Dr. Pannu.

Dr. Pannu: Thank you very much Mr. Chairman. I shared a copy of the letter from the office of the Information and Privacy Commissioner with you.

The Chair: Do all committee members have a copy of that letter?

Dr. Pannu: It's dated September 24, 2004, last Friday. The letter was signed by Cindy Walker Watson, assistant to the commissioner, and was addressed to me. The letter states as follows.

> Please be advised that David Loukidelis, Information & Privacy Commissioner of British Columbia, has delayed the release of his report on outsourcing and the PATRIOT Act to the end of October due to additional submissions received by his office. As a result of this delay, Commissioner Work will be unable to provide comment on the report until after this time, rather than at the end of September, as previously stated.
>
> The Commissioner will be in the Edmonton office next week.

The substance of the letter is that the commissioner won't be in a position to report to this committee in the next few days, which are the last few days of the current month.

The committee was certainly hoping to receive the advice of the commissioner based on his exchange of information with his counterpart in the province of B.C. Unfortunately, that report has now been delayed, so this committee, Mr. Chairman, must ask what we should be doing.

This morning, when I looked at the Health Information Act review issues and priorities proposals that were put before us, there were three matters that were given the highest priority. Those were: scope of the act, and we've been working on that today; health services provider information, the second major issue; and disclosure to police, another matter that we have paid regular attention to and had a good debate over.

I'm proposing, Mr. Chairman, that we put this very important matter of the impact of the USA PATRIOT Act on outsourcing and, therefore, on the privacy and confidentiality of the information of patients in our province – I think it's important that we deal with this matter on an urgent basis. As I look at the purposes of the act on page 12 of the Health Information Act, in addition to stating very clearly "to establish strong and effective mechanisms to protect the privacy of individuals with respect to their health information and to protect the confidentiality of that information," 2(f) states: "to establish strong and effective remedies for contraventions of this Act."

Contraventions of this act, I presume, would include unauthorized disclosure to parties of the information that's supposed to be kept confidential by individuals and institutions and groups that hold that information in trust. The USA PATRIOT Act, according to the information that has been supplied to us, will in fact compel not Canadian companies but American companies and their affiliates operating in Canada, who may be providing services through outsourcing – American intelligence services will have the power to compel those organizations, those companies, those agencies to disclose that information regardless of the provisions of our act.

That is a matter of major concern to many Albertans, certainly to lots of British Columbians. I understand that the Privacy Commissioner in British Columbia has received to the tune of about 500 briefs on this issue, so very, very widespread concern. It's a serious concern. I have been receiving some e-mails – I'm sure you've been getting copies of them – from a popular web site here, a web-based organization called vivelecanada.ca. That organization is also expressing concern about the impact that the USA PATRIOT Act would have on the ability of our current legislation to protect us from the disclosure of information that the act purports to protect on our behalf.

The fact that we do know that the USA PATRIOT Act can compel U.S.-based organizations or their affiliates, some of which may be operating here, to disclose information against our wish, against our legislation, raises serious concerns. So my proposal to you this morning, Mr. Chairman, was for me to have the opportunity to suggest to this committee that we put outsourcing and the USA PATRIOT Act as a fourth priority issue in our agenda and that we address this issue urgently and before we come to the completion and finalization of the report.

3:55

For that reason, Mr. Chairman, I have a motion that with your permission I would like to put before the committee for its consideration and see if the committee will take an opportunity to debate the motion and then make the decision that I think it should make, which is to in fact not proceed with the finalization of the report unless we have determined on our own now, in the absence of information which was going to be available to us from British Columbia by the end of this month but will not be, see what we can do ourselves as a committee in our recommendations.

The Chair: Are you prepared to read the motion, Dr. Pannu?

Dr. Pannu: Yes, please.

> Whereas the USA PATRIOT Act grants American law enforcement agencies special powers to violate privacy rights that could include accessing the personal health information of Albertans held by American companies or affiliates of American companies;
>
> Whereas Alberta's Information and Privacy Commissioner has informed me by way of a letter dated September 24, 2004, that he is unable to provide comment on this important matter until after the end of October;

> Be it resolved that the preparation of the final report and recommendations of the Health Information Act Review Committee be deferred until such time as Alberta's Information and Privacy Commissioner has provided the committee with comments on the extent to which the USA PATRIOT Act compromises the privacy of Albertans' personal health information.

The Chair: Dr. Pannu, given the length of that motion, I think everybody should have a copy of that motion.

Dr. Pannu: I have enough copies here, I think, Mr. Chairman.

The Chair: Mr. MacDonald, you raised your hand a few minutes ago. Did you want to speak to the motion, or do you have some comments prior to the motion?

Mr. MacDonald: My remarks, Mr. Chairman, could be speaking to the motion.

The Chair: All right. Go ahead, Mr. MacDonald.

Mr. MacDonald: Certainly I appreciate again the support of Dr. Pannu in this matter. It's a matter that I first raised at this Select Special Health Information Act Review Committee near the end of June. I appreciated Dr. Pannu's support at that time for my motion to have this committee urge our local Privacy Commissioner to review the implications of the PATRIOT Act on Albertans and their health information.

Certainly this is the second delay – this is not the first delay – that the B.C. Privacy Commissioner has had to make because of the large volume of submissions that he has received, but I, too, am very concerned as our provincial government proceeds to outsource even more health care procedures and tests to U.S.-linked service providers. Last year alone the public accounts of Alberta indicated that out-of-province health care totalled over $37 million, and that was up from $28 million in the previous fiscal year. This is a very important issue. It was raised during question period in the Legislative Assembly by a government member on May 5 of this year.

No one knows how our own federal government or the U.S. government are using their new powers under the expanded public security legislation. This is why I would urge people to support the motion that's before us this afternoon.

The PATRIOT Act in the United States, which was passed quickly into law in 45 days after the September 11, 2001, terrorist attacks, significantly increased the surveillance and investigative powers of law enforcement agencies in America. Section 215 of the act grants these agencies access to many records including medical records.

Now, when we look at what has happened in B.C. in the public interest, I think it is very important that we have a look at this and the implications in Alberta, considering how anxious we are to further privatize our health care delivery system. At this time I would like to express my gratitude to Dr. Pannu for again bringing this important matter before this committee, and I would urge members to vote in favour of the motion.

Thank you.

The Chair: Thank you, Mr. MacDonald.

Ms Kryczka: Well, I would just say, from the logistics, if this is the second delay and there have been 500 submissions – that's on the B.C. side, so there may be another delay – and then we would have our Information and Privacy Commissioner review that, who knows when he would get to us? If this committee, though, would decide in their deliberations that it is important enough and appropriate enough to put on our timeline, such as the two-page document that we reviewed this morning, the issue priorities, it would just seem reasonable to me that it would be deferred to a future committee of the Legislature to be convened early in 2005. That would be appropriate, looking at the logistics.

The Chair: Thank you.

Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. I find the request most unusual. First of all, perhaps a rhetorical statement. I wonder if either one of the two members have actually read the PATRIOT Act, and I'm wondering what section of the act it is that they're so concerned about.

Mr. MacDonald: Section 215.

Mr. Lukaszuk: As I look at the act – and I have read it – the preamble of the act says that it's passed by the Senate of the United States, and it says that it's "to deter and punish terrorist acts in the United States and around the world, to enhance law enforcement investigatory tools, and for other purposes." As I understand this act to be, it's an act designed whereby if the American government has reasonable and probable grounds to believe that a company is involved in subversive or terrorist activities, it is able to seize that company's records to determine whether indeed they are.

The Privacy Commissioner for Alberta, Mr. Frank Work, has clearly indicated that there's no need for him to carry on an investigation because British Columbia is doing it, and all privacy commissioners throughout Canada are working along with British Columbia and will make decisions based on whatever the outcome of that investigation will be, whenever it will be.

Now, what the two members are proposing is that in order to protect Albertans against the unlikely incident that the American government may find a company involved in subversive or terrorist activities, what we would literally have to do is shut down any activity, any economic or other trade activity, with the United States forthwith, right now. It could be a cattle rancher selling some beef or it could be an insurance company. Most of the insurance companies we have are American based. It could be the gas flowing through our pipes or the oil being pumped and sold to the United States. Any companies that do a cross-border business are subject to this particular law.

So, by extension, if we were to all of a sudden stop cross-border provision of medical services – and it's a trade that flows both ways – I imagine that those two members would also propose that we cease any economic activity with the United States because we are by de facto subject to this law, and I propose that that's ludicrous.

First of all, I would be dumbfounded to find that a medical office somewhere in the United States is involved in terrorist activities. If they are and if they can point out any, I would be interested to find out. Second of all, just because the American government has responded to the September 11 terrorist attacks by granting itself additional powers, only in the event that a company is found to be involved in subversive situations, it does not mean that now Canada and the rest of the world will cease trade with the United States. If that's their position, which abundantly appears to be so, why don't they say so?

4:05

The Chair: Okay. We are past 4 o'clock. We had agreed to adjourn at 4 o'clock. I'm happy to spend a few minutes on this, but I'm not

happy to spend the whole afternoon and the evening on it. So I would ask for brevity again, although my brevity comments have basically been ignored today.

Mr. MacDonald, you have another question or comment?

Mr. MacDonald: Yes, I do, and I will be brief, Mr. Chairman.

First off, for the hon. member's information, on March 5 of this year the Privacy Commissioner issued a news release stating that Alberta's personal information is not exposed to the PATRIOT Act, but this is not about the hon. Member for Edmonton-Strathcona and myself.

I would like to bring to his attention the *National Review of Medicine, Serving Canada's Most Dedicated Physicians*, and this issue is dated April 22, 2004. On the front page of this is an article – it's a serious issue, hon. member – "Government & Medicine: A 'Patriot Act' of treason?" It goes on to say that "BC's outsourcing plans could declare open season on health records for the FBI." Now, there's another quote here. It starts: "No private company has ever had access to insurance data on this scale before." And you want to ignore this?

I think you're wrong, and I think you're misinformed, and I would urge you again to support the motion as was suggested by Dr. Pannu this afternoon.

Thank you.

The Chair: Okay. Thank you, Mr. MacDonald.

Anyone else before I allow Dr. Pannu a couple of minutes to close debate? And this will be the close of debate. Anyone else want to speak to this?

Okay, Dr. Pannu. Briefly, quickly, you can close.

Dr. Pannu: Thank you, Mr. Chairman. I am somewhat surprised that the Member for Edmonton-Castle Downs should play down the seriousness of the issue in the way he has done.

I just want to read a few lines from the September 2004 open letter that the Information and Privacy Commissioner of Alberta, Mr. Work, released. He says this:

> There is currently a great deal of activity going on across the country with respect to the issue of the USA PATRIOT Act and implications for personal information of Canadians held by American companies or affiliates of American companies. The issue first surfaced in British Columbia with British Columbia's Information and Privacy Commissioner conducting an investigation into the dimensions of the issue. Like most of the other Commissioners in Canada, I am following Mr. Loukidelis' progress with great interest. The Information and Privacy Commissioners of Canada, myself included, have been consulted by Mr. Loukidelis and we have given him our input in terms of what issues we think his investigation should address and what the concerns are for us in our respective jurisdictions.

No point in reading the whole letter.

The Chair: All members have a copy of the letter.

Dr. Pannu: The point is made that the issues are important. They are so significant that information commissioners all across Canada are paying attention to it, while my friend across the way is making it into a laughing matter that we should stop trade with Canada. Is that what the information and privacy commissioners are all about? No, it's not. It's a very serious matter. It's a matter that deserves the most serious attention of this committee, and it shouldn't be dismissed or pooh-poohed in the way in which my colleague has done.

The Chair: On this point, Mr. Lukaszuk.

Mr. Lukaszuk: Very, very much on this point. First of all, Mr. Chairman, no one is making this a laughing matter. What really trivializes this matter is the misuse of such factual information and bringing it forward over here in such a trivial way.

But if you're going to read a letter into the record, Dr. Pannu, I suggest you read the whole darn thing, because if you read the last paragraph the commissioner says:

> Therefore, what I proposed to do is to continue to be in touch with Mr. Loukidelis, monitoring the progress in his investigation. When his report is released, I will review it closely, and my office will analyze it with an eye to determining its applicability to the situation in Alberta, namely, what the risks are with respect to the personal information of Albertans, and what remedies there might be. I will issue a formal statement of our findings in that regard.

I assume, Dr. Pannu, that you have already on your own conducted an investigation. You know what the outcome will be. You have determined that Albertans are in jeopardy, and you're trying to scare them when the commissioner tells us: sit and wait; when I find out what the outcome of the investigation is, I will let you know. Then we will reasonably act accordingly.

The Chair: All right. Thank you for reading the last part of the letter, Mr. Lukaszuk.

Mr. MacDonald, you ask on this point?

Mr. MacDonald: Yes, just a point of information to help the hon. member understand this issue more clearly. If he could read the information that was provided to this committee by Alberta Health dated August 12, the submission of August 12, 2004 – this is from, I believe, Alberta Health and Wellness authorities to this committee, and this is in regard to the question I raised on June 21, 2004 – I think it would be very helpful to the member to be able to understand this issue a little bit more clearly.

The Chair: Thank you.

All right. I am going to call the question.

Mr. MacDonald: A recorded vote, please.

The Chair: Okay, a recorded vote. Fine. We are not putting the whereases here.

Moved by Dr. Pannu:

> Be it resolved that the preparation of the final report and recommendation of the Health Information Act Review Committee be deferred until such time as Alberta's Information and Privacy Commissioner has provided the committee with comments on the extent to which the USA PATRIOT Act compromises the privacy of Albertans' personal health information.

So that is the motion.

Dr. Pannu: On a point of order, Mr. Chairman. Why are the whereases being excluded? Those are the reasons . . . [not recorded]

The Chair: So Dr. Pannu is okay.

Dr. Pannu: Thank you.

The Chair: The recorded vote will start. I'll ask the members individually to be either in favour or against, and we'll start with Ms Blakeman.

Ms Blakeman: In favour of the motion from Dr. Pannu.

Mr. MacDonald: I also, Mr. Chairman, am in favour of the motion.

Dr. Pannu: In favour.

Mr. Lougheed: Opposed.

Ms Kryczka: Opposed.

Mr. Broda: Opposed.

Mr. Lukaszuk: Opposed.

Mr. Snelgrove: Opposed.

Mr. Goudreau: Opposed.

The Chair: The motion is lost.
Motion to adjourn?

Hon. Members: Agreed.

The Chair: All in favour?

Hon. Members: Agreed.

The Chair: We are adjourned until tomorrow morning at 9 o'clock.

[The committee adjourned at 4:13 p.m.]