Title: Friday, October 15, 2004 HIA Review Committee
Date: 04/10/15
Time: 9:13 a.m.
[Mr. Jacobs in the chair]

The Chair: Good morning, ladies and gentlemen. We will call the committee to order. I apologize for being a few minutes late this morning. My plane was a little bit late, and I had to take care of some housekeeping things before we could get started here. So I appreciate your patience.

I want to welcome you all here this morning for what should be the final meeting of this committee. Thomas, you should be crying, not cheering.

For the record this morning I will ask that we state our names and go around the table, and maybe we could start with Mr. Broda.

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

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

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

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

The Chair: Welcome again, everyone. Certainly I want to express appreciation to the committee and to the technical team and support team for your perseverance and the extra work and hard work you've done in providing this committee with background information. I think the committee has done a great job in coming as far as we have and given the time frame we had and the time period in which we had to cover the information. So if we get carried away later today and forget to do that, please accept my personal appreciation and thanks for your service and assistance to this committee in what I think is an important work.

You should have received meeting materials on Wednesday, October 13, and there's only one issue shown on today's agenda for our consideration, which is the final draft. There will be some comments by the technical team on some aspects of the draft. Of course, there are a couple of questions which were not resolved which we will also provide some more information about, and I'm sure there will be some more discussion.

I notice that we are not scheduling a luncheon today. Apparently, we did not prepare lunch in the optimistic view that we would be finished our work. If we are not finished our work, of course we can come back after lunch, but we would have to have lunch on our own. Not impossible, but we can do it.

Mr. MacDonald: Mr. Chairman, perhaps since we are in the constituency of Edmonton-Centre, it would be the hon. Member Laurie Blakeman's turn to buy us lunch if we have to work till then. Since we're here in Edmonton-Centre, I think it's appropriate. She must know all the restaurants; right?

Ms Blakeman: Usually I bring a bag lunch. It's with me right now.

The Chair: Well, we'll give the hon. Member for Edmonton-Centre some time to think about that. We'll see how things go this morning.

Was that a motion, Mr. MacDonald, to put that on the agenda?

Mr. MacDonald: No.

The Chair: Having a look at the agenda, are there any additions or comments? Could I, then, have a motion to adopt the agenda? Mr. Goudreau, thank you very much. All in favour, please show your hand. Opposed? Carried.

All right. Did I miss anything?

You all should have received a copy of a letter from the Hon. Heather Forsyth, Solicitor General, and one joint letter from the vice-president of the Consumers' Association of Canada and the CEO of the Pharmacists Association of Alberta. These letters were received this week and are provided for information purposes only.

Okay. Anything else?

Evelyn, are you going to start with the document itself and tell us about some of the things that you've done with that?

Ms Swanson: Yes. Thank you. Everyone should have a copy of the draft report. It has been formatted for this meeting, and the staff in the Legislative Assembly Office did take the draft materials and put them into the format. So I thought what we might do today is first maybe have some discussion around the format, any comments that you have about the format. I think it looks quite clear, but we'll want to hear from you about that.

Since the last meeting we did do some rewording of some of the recommendations based on your discussion, and I'll want to run through those quickly with you. We have now got a mandate, an introduction section, and some acknowledgments. If you have any comments on those, they would be welcome as well. The consultation process has been described and is very much as you saw it last time. We've added a section called Review Process, which brings in a new recommendation 1 coming out of your last meeting. The body of the report has had very few changes in it, primarily to correct typing errors and that sort of thing. Appendices A, B, and C have been added to the document since you saw it last.

Running through these items in order, the first would be the question around format. The recommendations are now highlighted in the document. We have some nice clean pages with lots of white space on the side to help readers get through the document. Do you have any comments about the format?

9:20

The Chair: Well, that means everyone likes the format? Very good.

Ms Swanson: Okay. Great.

So I will move on now just to review not all the recommendations but only the recommendations that have been reworded or developed since the last meeting, the first one being recommendation 1. The committee wanted to have an overriding recommendation about the creation of a committee of the Legislature in 2005 that would deal with some matters that could not be handled within the time frame available to this committee. So that is recommendation 1 now.

1. A committee of the Legislature should be established early in 2005 to complete a focused review of several matters, including:
   - the scope of the Health Information Act, specifically related to the possible addition of privately funded health professionals, organizations with the primary purpose of providing health services that are not currently within scope, health clinics within post-secondary educational institutions and a new category of entity with a limited defined mandate to receive identifiable information for statistical analysis and research.

This part brings in a couple of points that you considered at the last meeting, being the inclusion of the health clinics at the universities and other postsecondary institutions as well as the request from CIHI and the Health Quality Council.

The second bullet reads "the purposes," so another matter that the committee of the Legislature would include in their deliberations would be

- the purposes for which, and the rules governing what health information can be collected, used and disclosed in relation to any additional entities recommended for inclusion under the Health Information Act.

The next matter would be

- consideration of whether amendments to the Health Information Act are required to address the intent to harmonize rules in the pan-Canadian health information privacy and confidentiality framework.

The fourth point:

- consideration of the need for more clear and transparent rules for the electronic health record.

This was added from the last meeting. And

- the powers of the Information and Privacy Commissioner in overseeing the administration of the Health Information Act.

So those are the main points that a committee would look at in the next round.

The Chair: So does that reflect the views of the committee on your recommendation that a committee be struck early in the new year to look at the items that have been listed and mentioned? Anything been missed?

Dr. Pannu: Mr. Chairman, I want to express my agreement with that part of the first recommendation that called for the establishment of a committee early in 2005. But I must note again my serious reservation and inability to support this amendment because of the fact that there's no reference here to – the committee made a decision, as a matter of fact, at our last meeting not to have the matter of the potential impact of the USA PATRIOT Act included for consideration by this committee.

The Chair: So noted.

Anything else? Okay.

It looks okay, Evelyn.

Ms Swanson: Thank you. There was a very minor amendment to recommendation 3 now that the committee has accepted it. It just says that "the definition of 'custodian' should be changed to reference s. 17(1)(a) of the Regional Health Authorities Act."

Recommendation 5 has a substantive addition to it in that it includes reference to the "health clinics whose primary purpose is health service provision within post-secondary educational institutions." So the full recommendation does incorporate that idea now.

Recommendations 11, 12, and 13 deal with health service provider information, and we would leave those for confirmation at the end of the meeting after your discussion on those topics.

Recommendation 18 now reads that "a committee of the Legislature established early in 2005 should consider the need for more clear and transparent rules for the electronic health record." This was a change from a proposal initially that Alberta Health and Wellness should do this review, but it's now in the committee of the Legislature section.

No changes on the next page, but there are a number of recommendations on page iv, recommendations 31 and 32 and 34. These are all related to the matter of disclosures to the police.

I believe that recommendation 31 is as it was typed and approved by the committee word for word. This is the one that says, "The Act should . . . mandate disclosure, without consent, to police services" of a series of pieces of health information. Any concerns about that one? No?

Recommendation 32 has been amended. The recommendation now reads:

> The Act should be amended to mandate disclosure of limited health information without consent to police services where a custodian has reasonable grounds to suspect a prescription reveals or tends to reveal that an offence has been committed or is being attempted, including the individual's name, address, date of birth, personal health number, the drug, dosage, prescriber's name and address, a copy of the prescription, and any other health information contained on the prescription.

The two changes were to mandate disclosure and to provide the information without consent.

Recommendation 34 simply clarifies that the information could be disclosed without consent, and this is the recommendation around

> the disclosure of health information, without consent, by Alberta Health and Wellness or other custodians to police services where there is reason to believe that an individual has committed fraud in obtaining Alberta health care insurance coverage, health services or health benefits from the publicly funded health system.

If that one is okay, then we'll move on to recommendations 38, 39, 40, and 41. These recommendations have not been changed from the previous draft, but I think that our time ran out before we got back to them. These are all recommendations around research. I will just read them through, and if the committee can indicate their agreement, that would be useful.

> 38. A committee of the Legislature established early in 2005 should consider a new category of entity under the Act with a limited defined mandate to receive identifiable information for statistical analysis and research.

This accommodates the Health Quality Council of Alberta and CIHI.

Recommendation 39: "The term 'ethics committee' should be changed to 'research ethics board'." This would be consistent with the common language used in the province and outside the province.

> 40. The Information and Privacy Commissioner should be authorized to publish ethics committee research approvals on a website with an explanatory note that the research has not necessarily been conducted and that health information has not necessarily been disclosed.
>
> 41. No changes should be made to ethics committee duties, composition or number; consent requirements and surrogates; requests for clarification or the requirement to consider the least amount of information and highest level of anonymity for the research purpose.

So these, I believe, reflect discussion from about two meetings ago, but we didn't actually go over the specific wording last time.

9:30

The Chair: Thank you, Evelyn. I think that's well understood by the committee.

I guess that if there are questions or comments, certainly we would be happy to receive those.

Dr. Pannu: Mr. Chairman, I'd like to address some matters related to recommendation 27, so if we'll turn to that, please.

The Chair: What page is that on?

Dr. Pannu: That's on page 3, I think, in the sixth draft.

The Chair: Are you referring to the executive summary, Dr. Pannu?

Dr. Pannu: Yes. You're right. I'm sorry. I'm referring to the executive summary.

The Chair: It's on page 26.

Dr. Pannu: Right. Yeah. Thank you.

The Chair: Was it number 27 that you wanted? Which recommendation, again, Dr. Pannu, did you want?

Dr. Pannu: Mr. Chairman, I'm just trying to make sure that the numbers in the executive summary and in the body of the report are referring to the same matter. I'm just trying to double-check. I think it's the same; isn't it?

Mr. Chairman, my feeling is that we need to tighten and clarify the language a bit with a couple of the bullets there. The first bullet, I think, deals with "health departments of provincial, territorial and federal governments for health services provided to persons under their jurisdiction." I'm proposing an amendment striking out the words "for health services provided to persons under their jurisdiction" and substituting "for determining eligibility to receive a health service or a health-related service or benefit and to provide for payment to persons under their jurisdiction." It simply clarifies the intent, I believe, of the amendment and tightens it. I will repeat if necessary.

The Chair: Yes, please.

Dr. Pannu: I propose that the first bullet of recommendation 27 be amended by striking out the words "for health services provided to persons under their jurisdiction" and substituting those words with the following words: "for determining eligibility to receive a health service or a health-related service or benefit and to provide for payment to persons under their jurisdiction." It specifies the purposes of disclosure a little more clearly, I think.

The Chair: I have a question from Mr. Lukaszuk before we proceed.

Mr. Lukaszuk: Mr. Chairman, often when health information is shared between one jurisdiction and another, it is in situations where there is an emergency. An Albertan has an emergency in another jurisdiction, and doctors in that jurisdiction require his charts from his home clinic to find out what kind of service they can provide him with. Eligibility for payment is the last thing that they worry about. What they need primarily is the health record of that individual so that they can give him the appropriate medical care and save his life. Payments are something that we worry about months later. Is he only willing now to allow sharing of eligibility for payment information? Shouldn't precedent be given to saving the person's life and not worrying about who pays whom when and how and why?

The Chair: Thank you.

Mr. Snelgrove: Mr. Chairman, I'm wondering if Dr. Pannu's suggestions aren't covered under the second and third bullets. The second bullet just about mirrors what he suggested, and the third one talks about payment.

Dr. Pannu: There seems to be an overlap there; you're right.

Mr. Snelgrove: There may be two issues. What your point was, I think, is in the second one. The first one is Mr. Lukaszuk's.

Dr. Pannu: "For health services provided to persons under their jurisdiction." I think my intent is to not leave the first reference a bit too vague. The second bullet to some extent specifies some of the purposes.

I think that Mr. Lukaszuk's point is one that I would like to address. I think that it's a valid point you make there that it's not so much the eligibility, that it's receiving service, but I think that the two are related. The information that will be requested, say, by a physician or a hospital in Ottawa for me if I happen to be there and am in need of service would be two kinds of information: eligibility for receiving service and, secondly, information related to health matters for receiving that service.

I think the amendment that I proposed does leave out a reference to information needed to provide the service – you know, health-related information – and that could be added to it to clarify. My amendment may then read: for determining eligibility to receive a health service or medical information needed to receive a health-related service.

The Chair: Okay. I've got a couple of comments. Linda from the technical team, you'd like to comment on this.

Ms Miller: Please. The intent of the first bullet is really reflective of the situation retroactively. This is after the fact, when respective jurisdictions ask information about the health services that were provided in that jurisdiction to their own residents to do policy analysis and the like. So that was the intent of the first bullet, therefore differing from the second bullet. I just wanted to make that point clear.

The Chair: Thank you very much.
Mr. Lukaszuk?

Mr. Lukaszuk: No. I withdraw my comment.

The Chair: Okay. Thank you.
Dr. Pannu, did you want to respond to that?

Dr. Pannu: I think that was my concern, that there's too broad a provision here for having access to the information and use of the information under the first bullet. As you say, it's post. It's after the treatment has been received.

Ms Miller: Yes.

Dr. Pannu: So the point, then, is: what are the purposes for which that information can be disclosed?

Ms Miller: A point of clarification. This is about individuals from other jurisdictions, so it's disclosing information about, as an example, a Saskatchewan resident that happened to obtain health services in the province of Alberta. After the fact, usually annually, records are sent back to the home jurisdiction to indicate to the province of Saskatchewan: these kinds of services were delivered for your residents over this period of time. That's the intent.

Dr. Pannu: Mr. Chairman, in light of this explanation – thank you, Linda, for that – I withdraw that amendment.

The Chair: All right.

Dr. Pannu: I have a second one, a small one, and that deals with the third bullet there, which is on the next page, page 27: "Third parties for payment purposes." The only amendment that I'm seeking to make to it is to add the word "only" at the end of the statement: third parties for payment purposes only. So the amended bullet would read: "Third parties for payment purposes only." I think, again, it clarifies it, specifies the purpose, and limits it if that's the intent.

The Chair: Linda, do you have a comment?

Ms Miller: No. That would be fine.

9:40

Ms Inions: It would be fine. I would just remind you of the way the act is structured. It says: information cannot be collected, used, or disclosed except as allowed in the act. So everything you're writing here is an exception. It goes without saying that if you say that it's for payment purposes, it would be payment purposes only, because of the whole way the act is set up. Keeping that in mind, it may be confusing to put an "only" in that provision and not in others. It goes without saying that it would be "only."

The Chair: Okay. Thank you, Ms Inions. To me that clarifies it suitably. Dr. Pannu, are you okay with that, or do you still want the amendment?

Dr. Pannu: I would like to have the word "only" added.

The Chair: In light of what Ms Inions has said, why would we want to put the word "only" in when the intent is that it's already inferred by the act?

Dr. Pannu: It's consistent with the intent of the act. We're simply clarifying that. Third parties are involved here. It's not other health providers or people within the health circle, as it's called. It's third parties involved here, and that's why I thought it important to emphasize that.

The Chair: It seems to me that it's an unnecessary amendment given the explanation that we've had, but, you know, it's in the committee's hands. Any other questions or comments from the committee?

Dr. Pannu wants to leave his motion to amend, as has been explained, by adding the word "only" to the third bullet. Any questions? [interjection] I hear the question called. I don't think we had a request for a recorded vote. All in favour of the motion by show of hands? Opposed? The motion is lost. Okay. Thank you.

All right. Seeing no other questions, Evelyn, can we proceed? We were on number 40. Did we finish?

Ms Miller: Mr. Chair, can we just have a point of clarification?

The Chair: Okay.

Ms Miller: In terms of the first bullet are we leaving it as it's stated then?

The Chair: Yes. Dr. Pannu withdrew his first amendment.

Ms Miller: Did he? Okay. I'm sorry; I did not hear that.

The Chair: Evelyn, go ahead.

Ms Swanson: Moving on then. I think we've dealt with 38 to 41, and we're now going to move to the next page, which is recommendation 51, in the executive summary. This was a decision of the committee from the last meeting: "The Duty to Comply with Order provisions of the Act should not be amended." That was the last change to the recommendations that we had. So unless there are other comments about the recommendations, I'll move on.

The Chair: I don't see any hands, so proceed.

Ms Swanson: Okay. Then there is a table of contents that's been added and will be finalized after this meeting to insert all the page numbers. The mandate of the committee appears on page 1, and an introduction to the committee's report appears on pages 2 and 3. It is fairly similar to what was in the consultation guide and reflects the committee's terms of reference. Page 4 includes some acknowledgments to the technical support team and the administrative support team. The consultation process, on page 5, is very much as it appeared in the last version.

On page 6 we've created a section called the Review Process, which indicates that the committee was not able to review all of the matters within the time frame that was available because the pan-Canadian health privacy framework was not yet available for review and also because there were some issues that required additional research and consultations. Then it indicates your recommendation about establishing another committee of the Legislature in 2005. So that is a new section.

Other than that, the body of the report is very similar to what you saw last time. It's all been reformatted. We have made some corrections here and there, but they're relatively minor.

The Chair: Okay. Inasmuch as the executive summary will probably be a page that's read by many people, I trust the committee is comfortable with the executive summary. Are there any other questions on the format or the changes that we made last time, which have now been reflected in the copy of the draft you have this morning?

Mr. Goudreau: Mr. Chairman, in terms of facilitating the review of the executive summary and recognizing the fact that certain individuals, like municipalities, for instance, might be just interested in recommendation 6, whether or not we should have a little reference there to what page in the report that's in, a little bit more detail.

The Chair: Sort of a quiet reference.

Mr. Goudreau: Maybe some of the background information just at the end of the actual recommendation.

The Chair: I think that's a good idea.

Mr. Goudreau: "See page 22" or whatever.

The Chair: Mrs. Sawchuk, would you like to comment about that?

Mrs. Sawchuk: Actually, Mr. Chairman, that's a great idea. You'll notice that in the body along the left-hand column we've done that now. We've actually put in the numbers that refer to the consultation guide questions, and that is very similar.

Mr. Goudreau: It's the reverse.

Mrs. Sawchuk: Exactly. It's just referring the committee's recommendations to the body of the document.

We can do that. No problem.

Mr. Goudreau: Yeah, it's quite simple.

The Chair: Okay. Good idea. Thank you, Mr. Goudreau.

Any other suggestions or comments before we proceed?

Okay. Evelyn, what is our next step here?

Ms Swanson: Well, unless anyone has any comments or concerns about appendices A, B, and C, which list the names of all the groups

and individuals who submitted to the committee and those who presented to the committee and the list of consultation questions, then I think we're probably ready at this stage to move on to a discussion of health service provider information and some of the material that Linda has prepared.

The Chair: Okay. I think the committee's ready to go there, so let's go. Ms Miller, Linda.

Ms Miller: Yeah, "Linda" is fine.

I believe the two outstanding issues that we need to discuss now are regarding the scope of the act with respect to protection of provider information, access to provider information, and also the request by the committee to consider the inclusion of access to provider information for research purposes. Based on a request that we received last time in terms of scenarios and in terms of what happens today, we've prepared four scenarios for the committee, and we'd like to spend a little bit of time to go through them. I hope that everybody has a copy.

The Chair: Is that the one with scenario 1, scenario 2?

Ms Miller: Yes.

The Chair: Okay. Have all committee members located that document?

Do we have extra copies?

Ms Miller: We do.

The Chair: All right. Has everyone found it? [interjections] I mean, I understand this. I'm usually lost myself.

It's really important that we get the documents. I think everyone has a copy now, Linda.

9:50

Ms Miller: Okay. Thank you. The first two scenarios are our attempt to describe what happens today with the current provisions under the act, to try to explain that situation first. The first scenario talks about when the department contracts with what we call a noncustodian organization – it could be an organization or an individual – for some analysis work for us, usually for policy support, and below we're disclosing to that noncustodian company nonidentifying patient information. So what happens today is that the department in this case contracts with that particular individual or organization for the disclosure of individual-level data. By using the term "individual-level," I'm not meaning identifiable, but it's still at the individual level. You just can't identify the persons themselves.

Based on the contract obligations that we have, that the organization or the individual signs, there are certain protections that that particular organization needs to abide by. Typically, those provisions reflect that the department contractually retains control of the disclosed data. The noncustodian may use the individual data to create the analytical reports as we've required them. The reports do not contain individually identifying information; however, they need access to the individual-level information to produce the reports.

Then the noncustodian is required, according to contractual obligations, to return or destroy the individual-level patient and provider information as per the instructions in the agreement. Most often they need both the individual-level data from a patient and a provider perspective to develop this report. Then what happens is that the reports are used by the department in planning and resource allocation for the health system management and policy development.

If permitted by the agreement established between the department and this particular organization or individual, the reports, which are in nonidentifiable form, can be used by the noncustodian for public, academic, commercial, or marketing purposes.

So that happens today, and we have instances where that has occurred since the enactment. What this current situation achieves, we believe, is a good balance between the disclosure of information in nonidentifiable form and the protection of the individual patient and the provider. It also permits noncustodians to access and use nonidentifiable health information to do research, to conduct data analysis for public and academic purposes, and for commercial and marketing purposes. It also permits custodians, including the department in this case, as an example, and the private-sector stakeholders to take advantage of data and trend analysis conducted by noncustodians.

So that's the situation that typically occurs today, and we have agreements in place with organizations of this nature.

Scenario 2 is also a current state with the current provisions.

The Chair: Ms Miller, perhaps there are some questions on that scenario.

Ms Miller: Sorry. I apologize. Are there questions at this point?

The Chair: Is any of that information collected with permission from the providers? How do you handle collection with or without permission?

Ms Miller: The information that we're accessing for this purpose is already collected as part of the provision of health services in the system. So this is information that is submitted perhaps under the billing requirements that the physicians have to receive payment or that the regions provide.

The Chair: But it is nonidentifiable information exclusively.

Ms Miller: When it's collected, it is identifiable. However, when it's released to this noncustodian organization, it is not identifiable. We anonymize it ourselves internally, within the department, before we release it to whoever that organization or individual is.

The Chair: Okay. Any other questions?

Scenario 2.

Ms Miller: Scenario 2 is also a situation that occurs today more for what we call research purposes, and we have many requests on this on an ongoing basis for release of what we also refer to as nonidentifiable, aggregate information.

In these cases what we call a noncustodian or a researcher approaches a custodian – in this case I'll use the example of the department – requesting the disclosure of individually identifying patient and health service provider information for research purposes. If it is determined that the research objectives may be met with nonidentifiable, aggregate information, the department agrees to match and aggregate the information prior to disclosure. This is an obligation that's built into the act for all custodians to abide by.

It is the duty of all custodians, notwithstanding the ethics approval, that every request for access to identifiable information has to be assessed in terms of need to know, least amount, and highest level of anonymity. That's the burden of being a custodian within the controlled arena. So based on the request, it is then the job of the

custodian to assess this request and see if the objectives of the request can indeed be met with this preferred option; that is, respecting the privacy of the individuals for which the information is being requested.

The next step – and I've covered this. The researcher requires or feels they require individually identifying patient and health service provider information to likely match against data they may already have in their possession. The research project is reviewed, as I've commented, by the ethics board; however, as commented, before disclosing, the custodian is bound to assess this in terms of the three fundamental principles of the act.

Working with the researcher and based on a privacy impact assessment that's accepted by the Privacy Commissioner's office, the custodian will match the identifiable health information with the researcher's data, but before disclosing the data to the researcher, the data is aggregated. The researcher analyzes the data and publishes the findings in a nonidentifiable and statistical format. The researcher then is permitted to use the findings for public, health system improvement in this example, for academic, and even for private purposes as long as it is analyzed and published in nonidentifiable, statistical form. So that happens today frequently.

The impact: we believe that this ability to disclose information in this manner permits custodians to data match information at the identifiable level in order to create a more comprehensive database for researchers. Disclosure is only permitted in nonidentifying and aggregate form to prevent unauthorized data matching and to protect privacy. We believe that that balances researchers' desire to access more comprehensive information at an individual level with patient and provider privacy, and it permits the researcher to use the research findings in a nonidentifiable form for a whole variety of purposes.

So the point here is that when we do get bona fide research requests into the department, the department as a custodian is required to assess that request and if possible meet those objectives through the release of data in nonidentifiable form. The department in this case takes on the burden of matching that data for the researcher and then disclosing it to the researcher in nonidentifiable form, and they're still able to achieve their particular objective.

The Chair: We have a question.

Mr. Lougheed: In point 1 the researcher requires the individually identifying data to match against data he already has. Can you clarify that a little bit more? What kind of data does he already have in his possession, and where would he have gotten it?

Ms Miller: I'll turn it over to Wendy. We just used it as an example.

Ms Robillard: There are a couple of things. The researcher may be approaching more than one custodian and linking data between custodian organizations, information that the department may not have but another custodian might. They want to link that to information that we have. So no one custodian holds all of the information.

The other thing that happens frequently is that researchers have a target population that they may already have identified, and they want additional information but only about that population, not about the general population. So they provide that level of information and then match against that.

Ms Miller: For example, they could have data from a pharmacy organization or from a particular health authority that the department has not got in its possession or custody or control.

Mr. Lougheed: So if I understand this correctly, then, perhaps they may have from a drug company a specific volume of drug that has been sold in a province or region or something. They would have that kind of information from a drug company, and they would want to match that against the geriatric patients in a health authority or something. Is that the kind of thing?

Ms Miller: That's entirely possible.

10:00

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. I'm looking at the options that you're giving us here, and all the scenarios and all the options that we have clearly entail both nonidentifying patient and health service provider information or identifying patient and health service provider information. But what we're trying to focus on over here in amending section 37 is identifying service provider information and not patient information. Why are you linking those two? Those two are separable.

Ms Miller: I don't believe they are. Typically most research requests or policy analyst types of requests require both because you need to understand what has happened from a provider ordering perspective in terms of on what type of population. So to understand the relationship, you need to have it linked at the individual provider and the individual patient level.

However, to link that, as I've commented before, the organization that's doing the matching has to do it at the identifiable level. But what the department then does in this case, as would be required with any custodian named under the act, is that data, once linked, is anonymized and then released subsequent to that step.

Mr. Lukaszuk: I'm not convinced that you're giving me the whole picture over here. You're anticipating what the researcher will ask for, that he will ask you for patient and service provider information, but that's not necessarily the true scenario.

What will happen if we amend section 37 allowing, now, researchers or others to access identifiable service provider information and not request patient information? That data is separated. You can merge it or separate it at will. You don't have to release both. You can release only one.

Ms Miller: If there's not a prohibition against releasing both, then you can acquire both I guess was my statement.

Mr. Lukaszuk: But the act clearly prohibits you from releasing identifying patient information. If we were to amend section 37 and allow you to release identifiable service provider information and yet prohibit you from releasing patient information, you could comply with that request, couldn't you?

Ms Robillard: We already have authority to disclose the patient information even for research purposes at an individually identifiable level. That's already in the act.

Mr. Lukaszuk: So if section 37 were to be amended and the protection of service provider information was removed, hypothetically, and any entity – not only researchers but any entity – were to approach you, then, and ask you for data on service provider information, you could release that without compromising patient identity; couldn't you?

Ms Miller: Under 37? Yes, I believe so. Yes.

Mr. Lukaszuk: Thank you.

So all the options you have over here which link service provider information with patient information are not the only options available if section 37 were to be amended?

Ms Miller: Could you restate that, please?

Mr. Lukaszuk: Sure. If we were to amend section 37 in such a manner that it would allow release of service provider information and yet protect patient information, there are more possible options than the ones you gave us here on this piece of paper, because all of your options over here imply that service provider information and patient information have to be released together as an aggregate.

Ms Miller: Just to be clear, it's permitted today in the current provisions to release patient information for research purposes. What is not permitted today in the act is to release for research purposes the provider information. We are requesting that that change be made because we believe that as long as the necessary steps are put into place, it is appropriate that information on providers be released for the research purposes which I'm trying to outline with the same provisions and protections that the patient data has today.

The Chair: Okay. Any other questions? Do you want to proceed with the others? Oh, sorry. Ms Blakeman.

Ms Blakeman: For clarification. I guess this is following on Mr. Lukaszuk's question. Is it possible, then, to be releasing health service provider information without also releasing information on individuals?

Ms Miller: In a nonidentifiable form? No.

Ms Blakeman: Nonidentifying individual information.

Ms Miller: As I tried to explain last time in the blackboard exercise, you're really talking about the same information in that regard. What the provider's practices are is the health service information of a particular patient. It's one and the same. It's how you link it in terms of identifying it with a provider or identifying it with a patient.

Ms Blakeman: This is at the crux of what we're trying to figure out here. If you release that health service provider information, are you accidentally or knowingly or unknowingly releasing any identifying individual information? It sounds like you are, because it's basically the same information.

Ms Miller: It would be individual but not identifying individual information.

Dr. Pannu: Are you stating what the current situation is?

Ms Miller: Yes. Well, I'm stating today that the current situation is that we can release patient information, with the proper protections, for research purposes, identifiable and nonidentifiable. What I'm requesting the committee to consider is that we also recommend the amendment of the legislation so that we can release provider information for research purposes with the same protections that we currently afford patient information. Today we can't even do that, and that has proven to be a limitation for the department. There's no question about that.

Mr. Lukaszuk: Going back to Ms Blakeman's question, because I'm not getting an answer. Are you telling me that if we were to amend the protection of service provider information, you would not be able to release identifiable service provider information without releasing identifiable patient information? Are you telling me that those are so intrinsically connected that they cannot be separated?

Ms Miller: No, I'm not trying to tell you that.

Mr. Lukaszuk: Okay. Because that's what your three-line column was implying.

Ms Miller: It's individual but not necessarily identifiable. It would be individual, so you would know that individual X received such-and-such services by such-and-such provider, but you wouldn't know that it was Linda Miller, as an example.

Mr. Lukaszuk: Well, every time a doctor provides a service, obviously there is a recipient of that service, unless he's doing it on himself. So if you provide service provider information, by implication obviously there is a recipient, but that's not identifiable. There's just a human being out there who has received that service. So implying to us that releasing information about a doctor and his procedure in some form also releases information about a patient is a moot point because obviously there is a patient, but there is no name attached to it or no identity attached to it. It's just a recipient of a service.

Ms Miller: I'm going to let Heather respond to that point.

The Chair: You mean Holly?

Ms Miller: Holly. Sorry.

Ms Gray: It feels that way at the office too.

I think Mr. Lukaszuk's point is correct. If section 37 were changed, depending on what the scope is – and I'm not sure I'm clear on what the change would be – you could disclose individually identifying health service provider information potentially to any person for any purpose.

The thing I think we have to keep in mind, then, is that once that information is out there, there's no restriction on how it can be used because it has been disclosed to any person for any purpose, which means it can be disclosed back to someone who has obtained individually identifying patient information, and that information I believe can potentially be data matched. So, in effect, you might disclose more information about the patient than was originally disclosed on the left hand with the information that was disclosed without restriction on the right hand, and because there's no restriction on the right hand, it can be brought around and I think there's a potential that it might be data matched.

10:10

The Chair: Okay. I have Mr. Broda, and then we'll go back to Mr. Lukaszuk.

Mr. Broda: Thank you, Chair. Yeah, I've got problems with this one as well. I'm not quite getting it. I've always said that the Health Information Act is to protect the individual patient's rights. With the workplace information, I'm not saying that it maybe shouldn't be available somewhere, but I don't know if it fits in this particular act to begin with.

I'm going back to one of the sheets that was presented.

The former Federal Privacy Commissioner issued a decision under PIPEDA after complaints were filed, that physician prescribing

> information is work product and not personal information. As a result, the information is not protected under PIPEDA.

I've had several physicians call me, and I've asked them the question why they are opposed. "Well, it's the AMA saying that we want to protect it." Also, a comment coming to me from one or two of them that phoned was saying: we get bombarded by pharmaceutical companies trying to promote a product. I said: there's a simple solution; just put a no-soliciting sign on your door if that is a problem. But I never got a clear answer why they would want to protect their own prescribing habits or whatever it may be.

It's workplace information, and, heaven forbid, I'd hate to see information on a patient which is never requested of the patient. Yes, it may be linked in that it's male gender, female gender, or how many females, how many males, how many children would get it or whatever, but it's the prescribing methods of that physician. So what are we protecting workplace information for? That's the question.

The Chair: Ms Miller, do you want to respond to that?

Ms Miller: I'm well aware of the federal Privacy Commissioner's, and my perspective is that whether you classify it as professional information or personal, it is my opinion that that's not the substantive issue. The issue is about privacy protection. The principle of privacy really is the right to be free from intrusion and interruption, the right of any individual to determine when and how and to what extent they share information about themselves with others.

In this case we're talking about providers; I'm well aware of that. I've expressed concern in terms of the fact that if you as a committee were to recommend that this protection be removed completely from the Health Information Act, there is no other privacy protection in legislation today in the province of Alberta for providers. That would I believe be a significant concern to providers. Providers are the people that collect the information for us in the first place. There's a significant risk, in my opinion, should that occur. There will be an impact in terms of what the providers are willing to share for the system, on behalf of the system, so that it can support proper trending and analysis.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. In reference to your last response about potential data matching and creating a bigger picture out of smaller pieces, if section 37 were somehow amended allowing a release of service provider identifiable information to one entity and now another entity has obtained patient identifiable information, how can this match occur when the body who obtains service provider identifiable information has no access and by no means can release that piece of information that pertains to patient identifiable information? Those two can never get together under the auspices of this act.

Now, the body who obtained the service provider identifiable information can give it to the one who has obtained the patient information, but that one can already have it anyhow because that one is within the circle of the controlled arena. So that's fine; they can have it anyhow. But the one from the controlled arena cannot release it outside to the body who has obtained service provider information, so there can never be that match that would jeopardize patient information.

Ms Miller: I believe it is possible.

Mr. Lukaszuk: Tell me how.

Ms Gray: I think the distinction between those two pieces of information is that one is obtained under a strict set of rules under the research provisions or as a custodian or the exceptions to custodians, which are protected by all the various safeguards that are put in, but if you remove section 37, there are no safeguards on that information. It's out there for public consumption, so it can be used however. I certainly can't foresee all of the ways that that information might be used, but data matching is one possibility. There are currently protections in place in the act that prohibit data matching unless it's strictly controlled, and the privacy of those people is protected even after the data matching.

The Chair: On this point briefly, Mr. Lukaszuk, and then Ms Blakeman.

Mr. Lukaszuk: Thank you. To restate the obvious, I appreciate that, but those two entities cannot match their information because the ones who have the critical piece that's patient identifiable are within the controlled arena, and they cannot release it any further. The one who has the service provider identifiable information, even though he would desire to have that information so he can match it, can't get his hands on it. So, yes, in theory if those two were to get together and data match, that would be dangerous, but they can't.

Ms Miller: There are instances, Mr. Lukaszuk, where identifiable patient information is disclosed outside of the controlled arena. There are instances where for bona fide research purposes, where there's been ethics approval, where the research question can only be answered by disclosing identifiable patient information, usually very large volumes of information are available outside of the controlled arena.

Ms Blakeman: I'm trying to go backwards in the information. Part of what we're looking at here is that if we remove section 37, then there's no control over the health service provider information. In other provinces – just refresh my memory, if I could prevail upon you – they do not have the kinds of protection that we're offering currently in the act, but most of them do specifically prohibit the use of health service provider information for marketing or commercial purposes. Am I correct in remembering that?

Ms Miller: There are a variety of either statutes or policies that have been adopted by the various jurisdictions. We have not done an exhaustive review of every jurisdiction, but we certainly have a good set of examples. There certainly are a variety of mechanisms by these other jurisdictions ranging from legislation all the way to a policy intent by a particular college or professional association. So it does range considerably across the jurisdictions.

Ms Blakeman: Thank you.

Dr. Pannu: Mr. Chairman, the point that Mr. Lukaszuk was pursuing is an important one, and I think the answer that we have gotten – and we got a categorical reply to that – is that identifiable patient information in large volumes does go out to noncustodians. The risk lies in that: that that information is out there. Then you have the service provider information out there, too, and the matching of the two then becomes more than just a theoretical possibility.

Furthermore, we need an exhaustive review, that Linda just suggested our technical team has not been able to provide us with, of the various ways in which these arrangements in different provinces protect or do not protect what part of service provider information or patient information. In the absence of that kind of

exhaustive review available to us, I think it would be, in my view, far too risky to take the next step and think about either radically amending the current section 37 or simply taking it out of the act.

10:20

As I argued I think last week as well, for the sake of protecting privacy of ourselves – this is what this act is about – we need to engage in an exhaustive review of information, which has not been done yet, and have that available to us and at the table before we make a decision. So I'm willing to move, Mr. Chairman, that this matter be deferred to the spring 2005 committee, at which time I would expect and hope that the technical resource people will provide to us that exhaustive review. We need it; we need that review.

The Chair: Dr. Pannu, before I accept your motion, I would like to continue with this discussion a little while longer. We have other members who want to ask questions. You know, it seems like we have gone into scenarios 3 and 4, but I was going to give Ms Miller an opportunity to also go over those scenarios. So would you mind if we just held that for a few minutes?

Dr. Pannu: That's fine.

The Chair: Okay.

Mr. Snelgrove, you haven't been in on this one, so I'll take you and then Mr. Lukaszuk.

Mr. Snelgrove: Well, unfortunately, Mr. Chairman, it seems like the more we talk about this, the more confused I get. I want to move this back from the concept we're talking about as to whether it's the pharmaceuticals trying to be very helpful and thus determining trends or whether it's the doctors trying to protect what they consider to be their professional code stuff.

I have to go back to how we treat everyone. I have a hotel business. I can't release information about who stayed in that hotel. I mean, certainly in some cases that could be touchy, but by and large absolutely nothing about that has to do with – we have to get them to agree to even say as much as: yes, he's a frequent traveller here. We can only develop trends. We can keep certain information about the travelling public but certainly nothing identifiable. That's how we're obligated to treat everybody.

For us to think, though, that some company, any company, has the greater good of our health care in mind, to come in and kind of ride shotgun on the doctors and give us that information is I think a stretch. If the Department of Health and Wellness and the minister say, "We need to know what's going on in X clinic in Calgary because we have concerns, and we are going to contract a company to investigate that, and we are going to allow them to collect the information we need to get to the bottom of this perceived or apparent failing of whatever kind in the system," I think the general public in Alberta would expect the minister and the department to be the people that decide at what level a doctor's information, the information between the doctor and the patient, is used or collected.

I think they would probably feel more comfortable if there were a specific parameter, much like the parameter around the research information that says: yes, you can collect it for these conditions at this time; other than that, you can collect nonidentifiable information. I don't think you need to treat a doctor any differently than anyone else. I know that in our business we can't release information that is as generic as where they stay.

So I'm having trouble with this. Yeah, we want to get the balance there, but I'm not sure that we're not putting too much weight on what might be motives or what might not be motives from both or three sides in this argument. Until there is a general or a close to general agreement with this pan-Canadian framework that says that this is the information we need as a health community to best provide these services, I don't believe that a piecemeal approach to this, province to province, works. I think we need to be very, very careful about what decision we're making based on whose point of view outside of the pan-Canadian framework and outside of the departments saying: this is the information we really need to know that our doctors are doing the job for us.

I wish it were 12 o'clock and we could ring the bell.

The Chair: The committee can ring the bell whenever it likes, Mr. Snelgrove. Thank you very much for your comments. We could pursue some interesting directions from those comments, but perhaps we should go to Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. I'm a little concerned with the last answer I got to my question, based on which Dr. Pannu formulated his motion, because what the answer is implying is that we are releasing a great deal of identifiable information to research entities. I imagine that we release that information to research entities that have passed the ethical scrutiny of their research and that they have signed some contracts with Alberta Health that they will not disclose the information any further and not use it for any other purposes.

What you're implying is that those individuals who are now in this controlled arena are susceptible to or possibly could release that information further to those who have obtained service provider identifiable information and allow for data matching. If they are as ethical and as compliant with the contracts that they sign currently with Alberta Health, which I'm certain they are, again this match could never happen.

Ms Gray: Sorry. That is not the impression I meant to give. The point I was trying to make – and maybe I can make it in a little bit more lay terms – is that I think we've not been able to see all the consequences that might come from removing the protections in section 37. So, in effect, it's not that a third party or noncustodian would suddenly have access to information that the researcher has. Clearly, the researcher came in and said, "We want a certain amount of identifying information," and we give it to them on that basis, but now that health service provider information is not protected, it can be combined as sort of free information, for lack of a better word, with the identifying information we have, and there's a potential that we have now disclosed more patient information to the researcher.

So there's a concern that when you remove one protection in one part of the act, it may have consequences in other parts of the act of broadening the scope of information that is available. I'm not sure we've explored all the consequences of what that might mean.

Mr. Lukaszuk: Mr. Chairman, "may." Give me one example – give me one; I'll buy your argument if you give me one – where someone can obtain service provider identifiable information and that's all he's allowed to obtain. Where in God's world is he going to get patient identifiable information so he can match it?

Ms Gray: It's not necessarily the person, the noncustodian, who doesn't have it. It's everybody, which includes custodians. So now removing a protection in one part of the act not only affects third parties, but it also affects custodians. Custodians now have greater access to that information, so they're able to do more with it. If you are a person, a researcher, who normally said, "I have a research project where I want information about, you know, 15- to 19-year-old females and the flu virus," you could go in and get a group of

information related to that. Now because health service provider information is also available, you might be able to take that information, data match it with the other information you've got, and suddenly you have a broader scope.

Now, maybe the answer is: that's okay. I'm just not sure that all those consequences have been explored. That was the only point that I was trying to make.

10:30

The Chair: Okay. On this point, Linda.

Ms Miller: I think that, bottom line, what we're requesting – this is a very complicated issue. It has large ramifications. We have not had the time to look at all of the options that have been presented to the committee in terms of the removal of this access to provider information. We require considerably more time to look at all of those implications in terms of the other provisions in the act, because it is a significant change to the current act and how it's been drafted, and that is our fundamental concern.

The Chair: All right. It's time for a break, but I'm going to take the two final speakers that we have. Then I would suggest that we take a break and sort of collect our thinking here.

Mr. Snelgrove: Just a point to Mr. Lukaszuk. For large cities or even centres probably bigger than 2,000 or 3,000 people, I believe that he's absolutely right. It would be just about impossible to connect the dots. But in the part of the world where I am, there are many small towns where a doctor visits once a week or once every two weeks. An example could be – and this is only hypothetical – that if it were noted that in the village of Dewberry a 40- to 50-year-old male received a drug for HIV/AIDS, that would be whittled down immediately to probably three people. That's all there are in that community between those ages. Now, that would be a stretch, and that is absolutely, completely hypothetical, but for smaller groups and more extreme treatment, if that information were out, I can tell you that probably by the end of the day in a small community you would know who it was.

The Chair: Okay. Thank you.
Mr. Broda.

Mr. Broda: Thank you, Chair. Just referring back to the chart of last week, the three-column one, basically workplace information is what we're talking about here because the personal information isn't allowed under that situation.

I liked Mr. Snelgrove's analogy about the hotel. Prior to FOIP even coming into place, when I was in the real estate business, with my workplace information, if they wanted to find out about me personally, I'd be happy if a researcher wanted to see how I performed. Certainly even back before FOIP came in, I knew that ethically it would not be sound to let out information on who bought a house – people find that out – for how much or what the payments are, how much down payment they had. That would never be disclosed.

As an individual why would I be afraid? I'd be very happy if somebody did some research and said: Dave Broda was a good realtor; he did X number of sales per year. Sorry; I know that it's a different analogy, but I'm going back to that workplace information. I'm saying that if everything else is protected, why as a provider should I be opposed to my workplace information being available?

Ms Miller: I think that's why we're suggesting that the committee look at the enablement of access to provider information for research purposes. The concern is that it follow the same protections under that proviso as it does for patient information, that it's appropriately released.

If it's removed completely from the act, any of that information is open. I mean, there's no protection, and we have no legislative authority to either grant or refuse disclosure. That's fundamentally the question of the day.

The Chair: Okay. I propose that we take a 15-minute break and reconvene at 10 minutes to 11.

Dr. Pannu: Mr. Chairman, will my motion come up then?

The Chair: Oh, we could certainly look at the motion. We'll be back. I don't think that we're quite ready yet for the motion, Dr. Pannu.

[The committee adjourned from 10:34 a.m. to 10:51 a.m.]

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

Prior to our brief adjournment, Dr. Pannu had raised the issue of the motion that he wanted to make, so I'm going to take that motion at this point if Dr. Pannu is still interested in making that motion. I think that in all fairness I have to deal with that.

Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. Karen, you have the wording of the motion with you?

Mrs. Sawchuk: Mr. Chairman, this was a bit of our confusion. It was to defer the discussions relating to . . .

Dr. Pannu: Section 37.

The Chair: Would that be recommendations 11 and 12 and 13?

Dr. Pannu: Right. Yeah, those three recommendations. I think that's right.

The Chair: I'd sooner refer to the recommendations than the section of the act, Dr. Pannu.

Ms Miller: If I could help or try to. Recommendation 11 is intended to be the recommendation with respect to provider protection in terms of inclusion in the act, while recommendation 12 is around the research provision: to enable access to provider information for research purposes. So those are the differences between the two recommendations.

Recommendation 13 is simply a housekeeping issue in terms of being able to include a business title. In our view, that piece is simply housekeeping and is straightforward.

The Chair: So did you want to include just 11 and 12?

Dr. Pannu: Yeah, 11 and 12.

The Chair: All right. Dr. Pannu's motion is to

> defer decisions on recommendations 11 and 12 to the committee that we recommended be struck in early 2005.

Is that correct, Dr. Pannu?

Dr. Pannu: Yes.

The Chair: Are there questions or comments on the motion? Ms Blakeman, did you have a comment?

Ms Blakeman: No. I made no indication that I had a comment.

The Chair: All right. Ready for the question? Okay. All in favour of the motion, please raise your hand. It looks like it's unanimous. I see no opposition, so those two items are deferred.

Recommendation 13. Do you want to just quickly go through 13, Linda or Wendy or Evelyn, if it's housekeeping.

Ms Swanson: Recommendation 13 on page ii of the Executive Summary states that the

> business title and professional registration number should be included in the definition of health service provider information and disclosure should be authorized to any person for any purpose without consent, subject to existing exceptions in s. 37(2).

The Chair: Are you okay with that one, committee? Okay.

Are there any other items on the agenda today under Other Business that anyone would like to discuss?

All right. This report will be tabled with the Clerk on Monday, October 18. Is that correct?

Mrs. Sawchuk: Yes, Mr. Chairman.

The Chair: Okay. And at that time copies will be provided to all MLAs.

Dr. Pannu: Mr. Chairman, as I indicated at the beginning of this morning's proceedings when we were talking about recommendation 1, I won't be able to support that recommendation and the report. I will be informing you in writing this afternoon of my reasons, that I'll be outlining, for not being able to support it.

The Chair: All right. Very good.

Ms Blakeman: Is there a motion coming to support the report as it has now been presented to us?

The Chair: I would appreciate that.

Ms Blakeman: Well, you're not going to get it from me. I'll let someone else move it, and I'd like a recorded vote, please.

Mr. Snelgrove: Mr. Chairman, I'd be happy to move that

> we forward the report as presented.

The Chair: Okay. Discussion? Questions?

A recorded vote has been requested, so I will have to call the roll. If there are no questions, I will call the roll on the motion.

Mr. Broda: Agreed.

Mr. Lukaszuk: Agreed.

Mr. Goudreau: Agreed.

Mr. Snelgrove: Agreed.

Mr. Lougheed: Agreed.

Dr. Pannu: Opposed.

Mr. MacDonald: Opposed.

Ms Blakeman: Opposed to the report. Thank you.

The Chair: Carried. Okay.

Any other questions on in what format it is going to the Clerk on the 18th? All MLAs will receive copies at that time.

Okay. I think we're basically finished, so again may I extend my sincere thanks to all members of the committee, the support team, and all staff and security and everyone who has helped us out.

Mr. Broda, sorry I missed you earlier.

Mr. Broda: Before we adjourn, I'd like to thank you personally as the chair. I think you did a really good job chairing the committee, and I think it should be recorded that we really appreciate it.

The Chair: Thank you very much, Mr. Broda. I won't call for a motion – I'm not sure it would pass – but I certainly appreciate those comments.

Ms Miller: On behalf of the technical team I'd like to express our appreciation for having the honour to work with you. We have enjoyed it, and we hope that we will meet you again on the committee of 2005.

The Chair: Thank you.

Anyone else?

Dr. Pannu: Mr. Chairman, I want to thank the technical team for their hard work. They really carried a huge burden to do the research, to do the background work so that we could engage in some fruitful debate. All of us have worked hard on it, but the technical team in particular, I think, deserves our plaudit for the work that they have done.

The Chair: Thank you very much.

Ms Blakeman: I'll add to that by expressing my appreciation for their patience and their good humour. It just carried us through a lot. Thank you.

The Chair: Ms Sorensen, Rhonda, would you like to indicate to the committee how we're going to release this and the procedure from here?

Ms Sorensen: Yes. On Monday a news release will be going out after the report is tabled with the Clerk, and it will direct people to the web site, where the report will also be on-line.

The Chair: Okay. Thanks again to everyone, and I would entertain a motion to adjourn. Mr. Lukaszuk. Thank you very much. All in favour? Opposed? It's carried. We are adjourned.

[The committee adjourned at 10:59 a.m.]