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Tuesday 30 March 2004

Mardi 30 mars 2004

Speaker
Honourable Alvin Curling

Clerk
Claude L. DesRosiers

Président
L'honorable Alvin Curling

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LEGISLATIVE ASSEMBLY OF ONTARIO

Tuesday 30 March 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

Mardi 30 mars 2004

The House met at 1845.

ORDERS OF THE DAY

HEALTH INFORMATION PROTECTION ACT, 2004

LOI DE 2004 SUR LA PROTECTION DES RENSEIGNEMENTS SUR LA SANTÉ

Mr Smitherman moved second reading of the following bill:

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

Hon George Smitherman (Minister of Health and Long-Term Care): I'm privileged today to have the opportunity to share my time with the member for Northumberland and the member for Mississauga East. It is my privilege to rise today to speak about Bill 31, the Health Information Protection Act, 2004.

Last week this House was united in grief. On this issue, I believe we have the opportunity to unite in common purpose. This bill is one on which there is broad agreement. It's a bill that builds on the work done by the previous government and it incorporates the work done by a unified and unanimous committee.

I think it's worth saying often that our government has taken a very different approach to the way committees work. On this one, we had a lot of stakeholder input before we brought the draft of the bill forward. Subsequent to that, as a result of the work that we took to committee and the work of the committee, we've been able to improve the bill further, and I think that's terrific.

The protection of personal health information is a vital part of our government's plan for positive change in health care. That's because this bill is anchored on the principle that patients are at the centre of their care. Patient-centred health care is the bedrock principle that guides the changes that we are making in health care. That is our transformation agenda.

We have a responsibility to ensure that people have the information, the resources and the opportunities to be informed and effective participants in their own health and well-being. We believe that patients must have the means to control how their personal information is used because, after all, it belongs to them. Bill 31 puts people in charge of their own health information.

The McGuinty government's plan for positive change aims to make health care into a true system. Let's face it, what we have today is really more of a collection of separate silos than a properly connected system. We have great institutions of the highest calibre of health professionals anywhere, state-of-the-art equipment and know-how, but there aren't the undeniable benefits that flow from co-operation and from having a common cause. Our government has made it a priority to tear down the walls between health care silos, walls that stand between the patient and the care they need.

Under Bill 31, health providers in the patient's circle of care will be able to share information and work as a team to make the best possible care decisions for that patient. It will enable us to harness the vast potential of health information technologies to deliver better quality and safer care. The protections in Bill 31 give people confidence that no matter where they receive care, their personal health information is safe and secure. Public trust is at the heart of this bill.

Public trust is an essential element to innovations, like the electronic health record that will enable us to transform health care. The electronic health record will bridge physical distances, penetrate silos and allow an unprecedented level of communication within health care. The benefits to patients are obvious. Their care will be more informed, more comprehensive and safer. This innovation will allow patients to make a seamless transition along a continuum of care. What we're really talking about, with the vision of an electronic health record, is the idea that no matter where you travel in our province, if you become ill and require the services at an emergency ward, that emergency ward ought to have all the information that pertains to your personal health history. That will save us costs around repetitive tests, but way more importantly it will ensure that our valued health care providers have all of the information available when it comes to my treatment and your treatment. I know that is an important priority. In simple terms, Bill 31 establishes rules for the collection, use and disclosure of personal health information. It will also provide individuals with a legislative right to access and correct their own personal health records.

1850

It's an important bill because health care information is important. Medical information is a vital component of proper, effective health care. A patient's medical history

is, for obvious reasons, crucial in assessing his or her current health, diagnosing illness or prescribing medication.

But personal medical information is also highly personal, perhaps the single most personal and sensitive type of information which exists about us. It is a fundamental part of our personal identity and our very essence as human beings. Simply asking questions or taking tests can raise extremely sensitive issues that we would not want known to employers, clients, colleagues or the public at large.

For reasons which are obvious to all of us, this type of information must be treated with the utmost care and complete respect. Patients must have the right to ask questions, take tests, receive treatment and take medication without fear that this information can in any way compromise their privacy, their dignity, their personal security or their economic well-being.

I'm a gay man. In my community, especially in the earliest days of the HIV and AIDS epidemic, people were very concerned. The government of the day then, led by a health minister—I believe it was Elinor Caplan—made sure that people in my community had access to anonymous testing. It is that kind of principle that we've brought to this bill, to make sure the decisions that are incorporated here in the form of legislation reflect the way a patient would want that dealt with.

Other provinces, as well as the federal government, have implemented health information privacy legislation, but Ontario still lacks clear and comprehensive rules about how medical information should be handled. This bill fills that void and, in doing so, it makes an important contribution to the overall improvement of our health care system.

The general principles which form the foundation of this bill are very easy to grasp. Putting these principles into practice is a complex task, involving difficult, technical and, in some cases, contentious issues. This invaluable and challenging task fell to the members who serve on the standing committee on general government. Their work over the past three months has been exemplary. It has helped us to strengthen, clarify and improve this bill. In fact, notwithstanding the fact that so much work had been done by the previous government and by stakeholder consultation in the interim, the standing committee carried over 100 motions to amend this bill. The speech says "to amend it"; I say "to improve it."

We have gained valuable assistance from the work of the members of that committee. I want to say to the members who serve on that committee, and particularly to committee Chair Jean-Marc Lalonde and Vice-Chair Vic Dhillon, that there's the spirit of non-partisan cooperation. The lack of rancour and the productivity evident in that committee's work is in large measure due to their skilful leadership. I think in large measure it's due to the fact that on an issue as important as this we can demonstrate to the public that no matter what divisions may be there for us in our partisan world, on a matter about people's personal health information, all sides, all parties in a government reflective of the representation in the Ontario Legislature, can come together.

The public also played an important role in bringing us to where we are today. The public consultations on Bill 31 demonstrated that Ontarians have strong views about these issues, as they should, and the input we received has significantly improved this legislation.

In a few moments my parliamentary assistant, the member from Mississauga East, will describe some of the key areas and improvements and changes that appear in the revised bill, but I'd like to take a moment to highlight a few amendments that resulted from the committee's discussions across the province.

Organizations and hospital foundations told us that requiring patients' express consent for fundraising would adversely affect their ability to raise vital dollars from the community. We listened to their concerns and we acted by agreeing to a balanced solution, one that protects the patient and does not hamper community fundraising. Only a patient's contact information can be disclosed for fundraising purposes, and hospitals can rely on implied consent rather than having to seek the express consent from every single patient. On this point, I'd really like to thank my colleague the member for Ottawa Centre. As an MPP, Richard Patten brings to his work the experiences of having been involved, working for a hospital and helping to raise funds for a hospital. We have made this amendment as an expression of good faith toward our hospitals, which provide so much support to Ontarians. We know that they can be trusted to deal with this most cherished information. Even the knowledge that one has sought treatment is personal information, and we are grateful for the commitments that Ontario's hospitals have made about the way this information will be handled.

The bill can only be effective if it can be effectively enforced. Bill 31 enhances the powers of the Information and Privacy Commissioner and ensures that the commissioner has the support and resources to carry out a strong oversight and enforcement role. The commissioner had concerns about the investigative powers of the Information and Privacy Commissioner. We worked with the commission and we addressed those concerns. When I appeared before the standing committee on general government in January of this year as they began to consider this bill, I said that on issues like privacy and confidentiality there is very little room for partisanship. This isn't an ideological issue, it's an issue where there exists broad agreement around basic principles, and I think we've demonstrated that.

Even though she's not with us right now, I really want to recognize the member for Kitchener-Waterloo. Elizabeth Witmer served as Ontario's health minister for some 40 months, and during that time she spent a considerable amount of effort in helping to develop what were the earliest pieces of this legislation. While the legislation she brought forward did not meet with the test of support from all quarters, it has enhanced the efforts that we are able to collectively applaud this evening.

Privacy protection was then the right thing to do, and it's certainly the right thing to do now. These protections are long overdue in Ontario. Let's make sure we get it right, but let's also make sure that we get it done. That's where we're headed.

I'd like to take a few moments to speak in fairly broad terms about what the bill does. Bill 31 would, for the first time ever in Ontario, provide broad legislative protections for the privacy, confidentiality and security of personal health information. Currently, there are no consistent rules covering what information can be collected and how that information can be used and disclosed. Existing laws that deal with health information apply in some health care settings and not in others. This legislation addresses those problems. This legislation begins to treat our health care system as a system, not just parts of it; all parts of it are covered here.

Essentially, Bill 31 gives people the right to have access to their records of personal health information and to require correction of these health records if the information is incomplete or inaccurate. It provides for oversight and enforcement of these rights, and for effective remedies if these rules are broken. The basic rule put forward by this bill is that a patient's consent is required before the patient's personal health information can be collected, used or disclosed. Without express consent, a patient's doctor would be prohibited from disclosing that patient's information for any purpose other than the provision of health care. Without express consent, that doctor, pharmacist or nurse would be prohibited from releasing information to insurance companies or employers. After all, it's not their information; that information belongs to the patient. Within the circle of health care, consent may be implied, unless the individual has expressly instructed otherwise, and in some cases, for example in an emergency, an individual's consent would not be required. Bill 31 also gives patients the right to be informed about how their information is being protected by practitioners and to access their medical records. I think I mentioned twice now that people will have the opportunity not just to access their medical records but to seek changes and corrections.

1900

We all know that any rule is only good if it's enforced. Bill 31 contains very firm but fair penalties for any breaches of the act, penalties which I believe are in appropriate proportion to protection and the need for protection. We said earlier that we firmly believe this is a patient's information. It belongs to a person and it is the most personal information. Therefore, we are providing for fines of $50,000 for individuals and $250,000 for organizations that might compromise an individual's information. Also, where the commissioner has made an order or where a person has been convicted of an offence under the act, a person affected may sue for damages. No other provincial health privacy legislation explicitly provides for this. I think it is the right thing to do. If their information has been shared improperly, patients will also have a right to be informed about how to make a complaint, and how to contact the Information and Privacy Commissioner if their concerns are not promptly addressed.

The federal legislation which came into force in January of this year does not address any of these issues. It deals with the transfer of personal information in the commercial/private sector within the province. It was developed to support electronic commerce. It wasn't developed with the health care system in mind. But our legislation was, first and foremost, developed with the health care system in mind and with the patient's use of the health care system foremost. It applies to doctors and other health care practitioners, hospitals, doctors, long-term-care facilities, health care clinics, laboratories, pharmacies, the Ministry of Health and Long-Term Care and other health-related organizations. It also applies to individuals and organizations outside the health care system, such as insurance companies, employers and schools, with respect to personal health information that they receive from health information custodians.

Let me speak briefly about one more issue which we were extremely sensitive to in drafting this legislation, and that is research. The reality is that the aggregate health information, without name attached, is an incredibly important tool that we utilize in planning for our health care system. So, clearly, patient information is vital to medical research. In most cases, researchers don't need to know the specific identities of individuals in their study. Most research is conducted with information that is completely anonymous. But researchers sometimes require identifiable information in order to link various pieces of data—for example, to study how a disease evolves or to determine the effectiveness of a particular treatment. Patient consent can sometimes be impossible due to the sheer size of the population studies. In these types of situations, researchers must gain approval from a research ethics board before any patient information is disclosed. I believe that these safeguards are adequate and that they would not compromise the vitally important medical research which we all depend upon and benefit from.

The bill before this House is strong. The bill before this House is effective. It would give Ontario the toughest rules and limits on how information is gathered and used. Indeed, I believe it represents the gold standard in health information protection in this country. Officials in my ministry tell me that they have been consulting broadly with other provinces that are depending upon the forward-thinking work that Ontario has been involved in.

This bill is central to our government's plan to change health care because our plan for health care is one which puts the patient first. This is a plan which is supported by the people of this province and which builds upon the health care traditions of our great nation. Patients must come first—not hospitals, not physicians, not pharmaceutical companies, not insurance companies and not the government.

At the end of the day, health care is about people delivering services to people. It is about patients. This

bill sets that out in a clear, balanced way to ensure that patients have a system which is accountable and transparent, a system which respects their rights, their dignity and their privacy. As I said earlier in my remarks, it's time for us to get this done. That opportunity is here today.

I look forward to a principled and thorough debate on this bill. I welcome the input of members on all sides of this chamber. By working together, we can produce legislation that we can all be proud of, legislation which provides a valuable, meaningful and long-overdue service to the people of Ontario. I believe that Bill 31, coming early in the life of a new government, does truly demonstrate the capacity that this legislative chamber has, and all of the members who are sent here to represent their ridings have, when we engage them and the legislative committee in a process that takes advantage of the time, expertise, knowledge and interest of the people who fill the 103 seats that are in this chamber.

I want to close with one personal note. There is a provision in the bill called a lockbox, and it's a provision that perhaps doesn't enjoy universal support, but a lockbox provides that any Ontarian who so wishes to put a square, a box, a lock, a circle around any of their information to prevent its disclosure is entitled to do so.

I think it's critically important, at the end of the day, that the involvement in our health care system of any individual is based on the principle of trust, and I think it's a principle that we must all support, that if any individual Ontarian has information in their health record that they do not want disclosed under any condition whatsoever, that is a right, an entitlement which I personally put into this bill.

I think it's critically important that we make sure that as we move forward, we recognize that if the patient comes first, if we have a health care system that is patient-centred, the patient, at the end of the day, has the right to determine how and when, and frankly, if their personal health information will ever or should ever be disclosed. There's a lockbox provision in this bill, and I'm particularly proud of it.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): On a point of order, Mr Speaker: I'm relatively new here and I'm looking for clarification. Is there not a requirement in our rules that there needs to be at least one member of the official opposition?

The Deputy Speaker (Mr Bruce Crozier): That's not a point of order. We have a quorum.

Further debate?

Mr Lou Rinaldi (Northumberland): I guess, first of all, I want to acknowledge the absence of the fellow from the opposition here tonight. I wonder how much they really care about health care in Ontario and how much it really means to them. But nevertheless, this is an important bill.

First of all, I want to congratulate the minister for taking such a bold step right off the bat as we form this government for the betterment of providing privacy to health care service in Ontario. I think this is a bold move, and I think what this means for the province of Ontario and Ontarians is it starts to establish a good footing as we move forward with health reform in this province.

I must not forget the minister's PA, who took the lead as we travelled across the province to hear from interested folks. Along with the PA, we had an all-party committee which I was happy to be part of. I also want to acknowledge the staff who did such a great job of putting this bill together as it moved forward.

I'm honoured. This is the first time in my tenure as the MPP for the riding of Northumberland-Quinte West to be part of a committee to deal with public input. It was really gratifying, as we travelled the province, for members from all three parties to hear concerns, the real concerns from the people of Ontario. There were individuals, there were professionals, there were groups, and they had one thing in common: They were very passionate about the way we deliver health care in the province of Ontario and the importance of respecting the privacy that people have. They all spoke, they all brought their concerns, and they were very well taken.

It was great to see that after the consultation process—I'll take a word out of the minister's comments that I had written down. We had roughly 150 amendments, but I think we need to remove the word "amendments" and replace it with the word "improvements," because there were truly improvements. The committee worked very diligently together to try to find the best solution on how we can protect the privacy of the people of Ontario but at the same time have the opportunities to deal with issues that could affect the health of all Ontarians and research and fundraising, as the minister eloquently put it together.

1910

I guess one of the things that we need to keep reiterating as we debate this bill is the importance—I think it's important, it's vital. People in Ontario have long been ignored when it comes to the privacy of health care. There was no proper process; it was done in a hodgepodge type of scenario. We tried to make the situation fit as best we could. That put professionals at risk, it put people's privacy at risk in Ontario, because there was no proper agenda to follow. I believe we set out the goal for real, positive change to protect privacy. That's what this is all about, because health is one of those things that is very important. I think we all have to respect and understand that.

As I said at the outset, as we travelled the province, we listened. I really believe that all of the concerns that were brought forward were legitimate and they really meant something to the people who brought them forward. I believe there were no hidden agendas and they were all real issues. We're going to create some legislation in the province of Ontario that, bar none, is going to lead Canada in the way we reform and protect the privacy of folks.

This legislation will definitely put some clear rules that professionals, governments and individuals will have to follow, and these will be consistent rules. The rules will be consistent right across the board that we will all

have to follow, and there will be substantial penalties if those rules are not followed. I'm sure that we, as politicians here in this House, and professionals in a trade, whether it's hospital doctors, pharmacists, all those caregivers, are all prepared to come to the table and help us deliver.

There are some existing laws that the federal government brought into play at the beginning of 2004. We heard loud and clear that they weren't the things we needed to hear. It dealt with some issues but, once again, it left the information sector for health care very fragmented. It dealt more with electronic commerce and it certainly did not cover the whole spectrum of privacy.

As I mentioned before, we are going to create some consistent rules, we're going to abide by those rules and we will have that legislation that would make it transparent so that when they're infringed on and they're not delivered properly we have some true recourse in order to deal with those situations.

The minister indicated that there will be stringent regulations that the custodians will have to keep that information and only divulge it as needed, as described by the rules and by legislation. Some of the organizations outside of the health sector that need that information—that information will only be divulged on a needed basis and without all that related information.

It was sort of a contentious issue as we travelled across the province that this bill might hinder the function of fundraising, which is a really big bonus for our health care providers and our hospitals. We live in a province where community involvement is critical to the way we deliver services. As new hospitals are built across the province, as health clinics are built across the province, without the help of those volunteers who raise numerous amounts of money to make sure their communities have the best possible health care—our intent was never to hinder those. So we put some clear guidelines on how we could still address those and yet not abuse the fact that the privacy of people's health records is protected, yet extend that arm that would allow those people to carry on the great work they do.

We would be able, as I said before, to disclose just the necessary information. This would not allow information to be divulged unnecessarily, so the only information that would be let out would deal with those issues. I believe we would all be well looked after.

One of the other issues that was quite clear as we travelled across the province was implementation. I believe that no one who made a presentation—I stand to be corrected—but the majority all supported what we were trying to do. They all felt very strongly about this new legislation. They all wanted it. But one of the concerns in some sectors was that it was fairly comprehensive and they wanted to make sure they got it right the first time, so they needed time to implement it.

The minister had set a very rigorous schedule that we would implement this legislation by July 1, 2004. But we heard over and over again that that would probably make it impossible for some delivery service agencies to accommodate it with their systems in place. Once again, they wanted to make sure they got it right. They felt very strongly that this was really important and they wanted to get it right the first time. Through the amendment process, our government and our committee certainly recognized that, and one of the amendments was to extend it to January 1, 2005.

Not only did those service delivery folks—whether it was doctors, pharmacists or hospitals—want to get it right, I think our government wants to get it right. I heard over and over again that all parties at one time or another made a great effort to bring legislation to deal with privacy. We finally put it all together, and I think this government recognizes as well that maybe that extra six months will make a great deal of difference on whether we get it right the first time or not. I certainly support that.

One of the things we talked about is that when we pass legislation we always tend to hear that governments of the day seem to have power or give the minister added powers. In this case, the privacy commissioner would be responsible for overseeing any mismanagement of the files, regardless of who had the files. The commissioner will have the sole right to respond to concerns and also to take the bold step to initiate an investigation where they feel that their privacy was infringed.

As we heard the minister mention, we have to make it worthwhile. We need folks to buy in, but at the same time we have to put some meat into the process. We have some penalties. We've heard sometimes that those penalties are harsh, and I am not suggesting they are not harsh in some cases. But I think this government has to lead by example. We have to make sure that people abide by these regulations. The fines that we recommended were $50,000 for individuals and $250,000 for organizations. That is a lot of money, but I believe the importance of this bill as we move forward, the impact on Ontarians as far as protecting their rights, their privacy—I believe that it's the right way to go.

I believe that this act is a very important part of our government. It's getting in step and getting in line with the rest of Canada as we try to provide a public health care system across the country. I believe the bill that we are debating here tonight is because of the fact that other provinces across Canada have the same legislation in place. We heard over and over again that we were lagging behind a little, but I believe what we are bringing forward with this bill is even better. We've learned from those other provinces across Canada.

Our staff did an awful lot of research. As ideas were brought forward from public input, we kept on asking, what does another province do? What does New Brunswick do? What does Alberta do? Every time we look into those things, we believed that as the bill goes ahead, we're a step ahead.

1920

I couldn't stress more the importance of privacy. I'm going to take a bold step and go outside this bill to see how privacy impacts on Ontario, even on other factors of

this great province. Under the former government there were some privacy breaches. I am quoting from the Toronto Star of January 11, 2000: "The Mike Harris government had no business releasing the private information to a pollster" of one of our banks.

The same comments were made by other media, and I'll quote. This relates so closely to what we're trying to do to protect privacy with health care. This is a quote from the Kitchener-Waterloo Record: "The Privatization Secretariat made a serious administrative error by supplying an Angus Reid executive with a list of the names, addresses, phone numbers and bank balances of every account holder."

The financial information that those people of Ontario had is just as important as health care records. We certainly don't want to go down that track. We need legislation to deal with these issues. We need to put closure to these things. I really believe we're going down the right track.

I will quote another one on the same issue: "The Ontario government committed a major breach of the privacy rights of tens of thousands of Ontario bank depositors." This was from the Globe and Mail.

So it's very, very important. We as a government, our leader, made it very clear that we need to be transparent when we put legislation in place.

We talk about dealing with issues behind closed doors. I'll tell you that one of the last kafuffles that then-Premier Harris tried to do in the last days that he served as leader of the government was to have an order in council, with maybe less than a handful of cabinet ministers, to give a health care break to major sports teams. We just cannot put up with those circumstances. So with dealing behind close doors, those privacy issues are just as important as we deal with the health care privacy legislation.

Just further on how we need to be transparent, to speak on what we believe in, when the Leader of the Opposition became Premier after Premier Harris resigned, somebody just opened the door so that he could take a post. A year later Mr Tilson, after being nice to the Premier, got a really plum job and nobody knew that. It was done behind closed doors. So we cannot act in a vacuum.

The same thing happened when the then government delivered a budget at an auto parts plant. We debated earlier this week about an interim supply motion; I believe it was yesterday. We had some very good debate across the House. I tell you, for a rookie like myself it's a real learning curve. Yet the government of the day, because they didn't come back to this House where business should be conducted, decided under special warrant to spend $36 billion without discussing it and debating it in this House. I tell you, that's not acceptable to the people.

Mr McMeekin: How much was that?

Mr Rinaldi: Well, I have $36 billion—billion, with a "b." I don't even know how many zeros there are in a billion, it's so big.

Mr Michael Gravelle (Thunder Bay-Superior North): Nine.

Mr Rinaldi: Nine? Thank you.

Let me just go back to the health care sector a little bit. I know this is diverging from the bill a little bit, but it's critical. We need to be upfront with this information. In 1995 in the province of Ontario, we had 60 underserviced communities. That's a lot of communities. Lo and behold, today we have 122 underserviced communities and we're short 569 family physicians.

I come from a rural part of Ontario, and one of the main industries in my community is growing senior citizens. They seem to migrate. That's our main industry. We have a very vibrant retirement community. Although we're only about two hours east of Toronto—most of those people come from the Toronto area—I hear over and over again, "I'm 80 years old and I've got to drive to my doctor in Markham."; "I've got to drive to my doctor in Scarborough." Yet, we've done nothing to alleviate those problems.

At the same time, we destroyed part of our health care system—or the previous government destroyed it. We saw during the SARS episode that we all experienced—it was sad situation, but it's reality. It happens to humans.

Mr Rosario Marchese (Trinity-Spadina): We're going to make it better now.

Mr Rinaldi: We are going to make it better.

We were short so many nurses that we ended up paying between $70 and $100 per hour for overtime nurses—just not acceptable.

We need to make sure that this bill goes through. I think we worked through it. With all due respect, it was a leaning experience for me to travel the province. It was also very, very interesting that all parties were able to agree on those amendments. So I look for speedy passage of this bill. It's an excellent opportunity.

The Deputy Speaker: The Chair recognizes the member for Mississauga East.

Mr Peter Fonseca (Mississauga East): I would like to thank Minister Smitherman and my colleague the member from Northumberland for doing such a fantastic job. I'd like to thank the committee members, Jean-Marc Lalonde from Glengarry-Prescott-Russell and our Vice-Chair from Brampton West-Mississauga, Vic Dhillon.

It's a great pleasure that I come here today to speak about a bill that the minister has so eloquently talked about. It really transcends all political ideologies and serves to protect and enhance health care for all Ontarians, a goal that I'm sure all of us, as Mr Marchese would say, want to happen here in this province.

Something special happened when we left Queen's Park Circle. As a new MPP and not having been on a committee, as we toured the province, the member from Kitchner-Waterloo, the member from Nickel Belt, we all came together, as the minister said, to work on this bill and to make it better, to better this bill. I believe it is a great bill for all Ontarians.

Bill 31, the Health Information Protection Act, 2004, will serve not only to protect the privacy of Ontarians'

personal health records, but will lay the foundation for future health care by addressing potential concerns of emerging technologies in health care, such as electronic health records. While Mr Smitherman outlined the legislation and spoke to the need and reasons for this bill, I'd like to focus on the details of the bill, as well as some of the amendments that have been made to it.

The bill is composed of two components, with the first being the Personal Health Information Protection Act, 2004. Right now, there's a lack of consistent rules in Ontario covering what health information can be collected and how that information can be used and disclosed. Existing laws dealing with health information apply in some health care settings, but not in others. With the advent of online technology and the increased flow of information in the health care system, the need for clear and consistent rules for the privacy and security of personal health information has become more critical than ever.

Before, when we used to get something like a diagnostic done, an X-ray, a CT scan, an MRI, we used to get it in film or in a folder. Today, what's happening is that all that information is being put on digital format, or electronic health, as the minister talked about. With one click, that information, as you know with your emails, can go to many different people. We have to make sure that is well protected. Simply put, public trust is the foundation of our health privacy legislation; it's about trust.

The Personal Health Information Protection Act would apply to the collection, use and disclosure of personal health information by health information custodians. These custodians include hospitals, doctors, other health care providers, as well as the Ministry of Health and Long-Term Care. The act allows health care providers to rely on an individual's implied consent to the collection, use and disclosure of the person's health information if it is needed for health care purposes, but patients must know how that information will be used. That's where the lockbox concept comes in, and this is so important about this bill. This is the right of people to state expressly when their personal information cannot be shared within the circle of health care. The lockbox ensures patients have greater control over the disclosure of their personal health information.

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It's sad to say, but many diseases and illnesses still have a stigma today. When we talk about mental health or HIV, it's the patient, the customer, the person who is receiving that health care who owns that information. If they want to lockbox it—if they want to put a square around it, as the minister said—if they don't want anybody else to see it, that is their prerogative. As well, the act enhances the powers of the Information and Privacy Commissioner to create a strong oversight mechanism. The commissioner will be responsible for overseeing the legislation and ensuring compliance with it.

Minister Smitherman has mentioned the need for people to be able to correct inaccurate personal health information. This act will ensure that Ontarians have access to their information and can correct it, when needed. The act enables them to complain to the Information and Privacy Commissioner should their request for access or correction be refused by the custodian of their information. What's more, where the commissioner has made an order or where someone has been convicted of an offence under the act, the person affected by the conduct that gave rise to the order or offence may sue for damages.

Suing for damages: The bill has stringent penalties put in. The minister has outlined those penalties. They are very severe. These penalties are fines of $50,000 for individuals and $250,000 for organizations convicted of an offence. This is to really reiterate where the minister is going. We are making health care in Ontario customer-focused, patient-focused. The individual is at the centre of the care.

Another aspect of the act is the creation of a secure health data institute, which would be at arm's length from the government. The institute's information practices and privacy protections would be approved by the Information and Privacy Commissioner. The institute would receive and analyze information required by the Ministry of Health and Long-Term Care for health system planning and management, knowing that this information is so important to creating a health care system, which we really don't have right now. We have health care, but we have many different silos that have not allowed a system to be created. That system is being created today, and this bill will help in the creation of that system. It would release such information to the ministry in de-identified form, or minimal identifiers could be released to the ministry in certain cases but only as approved by the Information and Privacy Commissioner.

The act provides rules for people who are not health information custodians. That includes, for example, insurers and employers who receive personal health information from a doctor or other custodian. Such people or organizations would be restricted as to the use and disclosure of personal health information. Patients must provide their express consent before such organizations or any organization outside that circle of care could be given the information. It is the right thing to do.

Research is critical to improving the health of Ontarians. Bill 31 provides flexibility in allowing research to happen while protecting that sensitive, personal information that we want to make sure stays protected and is used for the right reasons.

In most cases, research is conducted with anonymous information, but in some cases researchers do require identifiable information to link various pieces of data. In situations where consent cannot be obtained, the act says researchers must have the approval of a research ethics board before a health information custodian may disclose the information to the researcher.

As everybody in this House and those listening today can see, many checks and balances have been brought into this bill. An example of such an instance could be

the research on large populations of patients where the researcher has no contact with the patient and it would be difficult or prohibitive to seek consent of the patient regarding the use and disclosure of that information.

In the second component of Bill 31, which is the Quality of Care Information Protection Act, 2003, our government is well aware of the need for health care professionals to share information and hold open discussions that can lead to improved care and safety. This bill is not about handcuffing somebody and stopping us from receiving the best care; it's about trust, checks and balances, and making sure that it is patient-centred, and that they are getting the best care possible in the most secure manner.

Our government is well aware of the need that health care professionals have to share this information. That's why we drafted Bill 31 with protections for quality of care information in quality of care committees. This is particularly critical when a medical error occurs in a hospital or in a health care setting. Accidents and things do happen; mistakes happen. They have to be taken care of and you have to look at the root cause, what was the process, the procedure, and what took place. That information provided to the quality of care committee and the opinions of committee members would be shielded from disclosure in legal proceedings. This is to make sure they can have an open forum where they can discuss these quality issues that are taking place in health care, thus creating an open and free dialogue between health care professionals that would serve to enhance patient care and safety.

As has been reiterated by the minister and the member for Northumberland, this is about the patient. We are always focusing on the patient, not around the silos, not around all the providers, but always centred on the patient. If we continue to do that and go down that path, our health care system will be second to none. However, this protection must be balanced with the need for patients to know the facts surrounding their file. As a result of this, the protection of quality of care information has been limited so that it doesn't permit the shielding of facts relating to the incident itself. The protection ensures a careful balance between the need to promote quality care and the need to ensure accountability.

Some of the key amendments came out as we criss-crossed the province and listened to all the stakeholders—and I say this in a non-partisan way, with the member for Nickel Belt, the member for Kitchener-Waterloo and everybody participating to make this bill the strongest bill, to make it the best for all Ontarians.

Let me highlight some of those key amendments. First of all, as we've noted, health care stakeholders have been very supportive of our decision to move forward with health information privacy legislation. What was brought down by the federal government was really around e-commerce and did not focus on health care. This bill has brought health care as the main focus to it, and looked at, once again, making sure that the patient is at the centre.

However, it does not mean the bill has not been without its critics or that there have been no concerns around Bill 31. Having had the distinct pleasure of serving on the committee and looking at Bill 31, I, along with my fellow committee members, were able to hear from numerous groups and associations. The submissions they presented to the committee have helped us make several improvements to the bill from its original drafting, changes that helped make the bill before us today a better and more effective tool by which to protect Ontarians' privacy and ensure the continued provision of quality health care that has become the hallmark of our province.

I want to thank our stakeholders for their advice and valuable work on this initiative. Many stakeholders such as the Centre for Addiction and Mental Health expressed concern that the proposed July 1, 2004, time frame would not give them enough time to prepare for the legislation coming into force. The minister reiterated it and the member from Northumberland spoke about it. So what did we do? We moved that date. That was actually put through with a motion, and I will say from a motion from the opposition, that helped bring that forward. I believe it was the member for Kitchener-Waterloo. As we toured the province, this was a great experience. It was so non-partisan.

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The date has been moved to January 1, 2005, to ensure plenty of time to implement the legislation. While we recognize the need to implement this bill as quickly as possible, we also recognize the need to work with the various stakeholders to ensure that they are ready and able to comply with Bill 31. That is acting responsibly.

Another amendment is based on feedback from stakeholders such as the Information and Privacy Commissioner, the Ontario Hospital Association and the hospital foundations concerning the fundraising provisions in Bill 31. Much talk happened over this in regard to the fundraising. Provisions were made. The provisions have been expanded to permit health information custodians to use and disclose limited personal information about a patient for fundraising purposes where it has the implied consent of the patient. However, this information is limited to the patient's name and contact information only. You may be getting a call or receiving a letter from a foundation, but that is all the information they would have. They would be able to have your name and your contact information, and that would be it.

This change strikes a balance between the valuable work that the organizations like hospital foundations are doing in raising the much-needed money for the health care sector, and the right of the people to control how their information is collected, used and disclosed. This will ensure the transparency we need.

Another amendment is based on feedback from the health professionals' colleges that regulate Ontario's doctors and nurses and other health care professionals. This amendment extends the type of protections provided by the Quality of Care Information Protection Act to the college's quality assurance programs. This change will

help the colleges in their mandates to protect the public and it will ensure accountability. Furthermore, clarification was made to specify that nothing in Bill 31 will interfere with the regulatory activities of the colleges under the Regulated Health Professions Act, 1991. The College of Social Workers and Social Service Workers, or the board, under the Drugless Practitioners Act—this will ensure clarity.

Another amendment relates to the investigative powers of the Information and Privacy Commissioner. As they presented to us in committee, we listened and made sure that all the stakeholders had a say and were able to come back and were given their time. The right questions were asked. They were open-ended questions, questions toward always bettering this bill. This is a fantastic bill for all Ontarians that we all should be very proud of.

Another amendment was that we worked with the commission to address the commissioner's concerns, and the commissioner, in a very open dialogue with the minister, was able to feel that there was a partnership, working together on behalf of the patient—always focused on the patient. This is probably one of the proudest moments that the committee had, that our focus always centred on the patient, the 12 million Ontarians who get health services every day. That is our focus. If we don't lose sight of that focus, we will always be on the right track. These changes have given the commissioner the tools she needs and the clear direction needed to allow her to fulfill her duties.

Our government is proud of Bill 31 and we're pleased with this revised version of the bill. We're also pleased to have had the opportunity of working closely with our health care partners and with the Information and Privacy Commissioner. We look forward to continued work with our partners to ensure that Ontarians are the healthiest people in Canada. When we say that, sometimes we think of health care. Right now, many times, we have sick care. We want to make sure that we bring it to health care. Let's look at getting health care to the patient at the right time, at the right place, when they need it.

I look forward to continued work with our partners to ensure that Ontarians are the healthiest people. I am convinced that Bill 31 best serves Ontarians. It serves the needs of patients and health care providers by providing a clear picture, a consistent picture, one that has rules for collecting, using, storing and sharing personal health information. This bill provides clarity, direction, transparency and accountability, and these are all the things that Ontarians deserve from their government. We are committed to delivering them every day, 24 hours a day, seven days a week, 365 days a year. We are here to focus on 12 million people in this province so they get value for their dollar and they know that they can trust a government that is looking after their interests as the taxpayers of this province. Thank you.

The Deputy Speaker: Questions and comments?

Mr Garfield Dunlop (Simcoe North): It's a pleasure to be here this evening to make a few comments on Bill 31. I'm looking forward to the comments from my colleague the former Minister of Health, Elizabeth Witmer. I'm listening to the comments and questions and I'm listening to the debate, but I can tell you that my former minister, the Honourable Elizabeth Witmer at the time, introduced much of this bill. We will look forward to how much you want to amend this bill and how much you want to change it. That's how I'll decide whether or not I'll vote on it.

I do want to say at this time that I'm so pleased that Minister Witmer was elected as the member for Waterloo in the last election and she is now back as the critic for the health and long-term care ministry. She has so much to offer. I can tell you, for you members on the opposite side, it would really pay you to listen to a lot of the advice she gives, particularly to Minister Smitherman, because she has come through with a lot of very positive things for the health care field in the province of Ontario.

I've said this a number of times to Elizabeth, but I want to say again how much her expertise means to me. When I was elected in 1999, I came in as someone with a potential hospital redevelopment project in front of me in the city of Orillia. It had been going on for 14 or 15 years. You guys have all heard about the hospital expansions and redevelopments and what they mean to communities. I'll tell you, without Elizabeth Witmer, it would not have happened. She played a very, very important role in initially announcing the money. You know, guys, no matter what party you're from, you've got to be happy to see a new hospital in the province. Orillia Soldiers' Memorial Hospital has a fantastic new redevelopment program, and I say thank you to Elizabeth Witmer for doing that.

Mr Marchese: I just want to say for the record that New Democrats are going to support Bill 31. I say this because we are so unfairly criticized, because people on that side say that all New Democrats do is simply criticize and oppose, and it's not true. It is true that often we are very critical of the government and we do that as cogently as we can because that's our job. But there are times when the government will do things that we will agree with and, in this case, we are going to agree.

Unlike Bill 8, the bill called the Commitment to the Future of Medicare Act, which in my view competes with, seems to emulate or wants to exceed the totalitarian aspects of Bill 26, the same bill—and some of you rump folks don't know this. The Ontario Health Services Restructuring Commission—you remember, some of you old-timers, how we attacked Bill 26 for being one of the most totalitarian bills we had ever seen. We are saying Bill 8 competes with, seems to emulate or wants to exceed that totalitarian aspect of Bill 26. So with that bill we have strong disagreements. Our health critic, from Nickel Belt, has already made a case against it; we'll do so tomorrow night at around a quarter to 7. Please stay tuned. She will be speaking to this bill at approximately 9 o'clock, and by "she," I mean my colleague from Nickel Belt. So please tune in.

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Ms Laurel C. Broten (Etobicoke-Lakeshore): I feel I should start my comments by welcoming the viewers at home, as my colleague has across the way.

I'm very pleased to stand tonight and speak to Bill 31, An Act to enact and amend various acts with respect to the protection of health care information.

In the opportunities over the last several months to travel across the province and speak to Ontarians about what they want their government to do, the residents of the community of Etobicoke-Lakeshore, which I represent, and those across the province gave us some messages. Those messages were very loud and clear and are supported by our action in this legislation. They told us to put patients first, to put patients in charge of their medical records and put them in charge of their personal information. Bill 31 does just that. They also told us to acknowledge that there is only one patient traveling through a health care system that at times doesn't operate as a holistic system, where one arm doesn't speak to the other. The opportunities that are provided to us by Bill 31 to treat the health care system as the system it is, is a positive change and will be viewed as such by Ontarians.

They also want us to bring health care into the next century, to take advantage of technological advances that we've seen over the last number of years, so that information can travel with patients and we can ensure that the information needed by our medical practitioners, whether they are across the road or across the province, can be brought with them by patients. Bill 31 gives us an opportunity to move in that direction. It gives us an opportunity for the better management of patient information, which will allow for an improvement of the health care system. Ontarians said loud and clear when we had an opportunity to speak to them over the last number of months that that is what they wanted us to do. So it's a proud moment as we deal with Bill 31 here in the Legislature.

The Deputy Speaker: Questions or comments? The member has two minutes to respond.

Mr Fonseca: I must be feeling a circle of love here today which I have not experienced yet. But to see all the members—

Ms Shelley Martel (Nickel Belt): I didn't speak yet.

Mr Fonseca: The member for Nickel Belt—

The Deputy Speaker: The member for Mississauga East, I just wanted to tell you, don't let her intimidate you. You have the floor.

Mr Fonseca: I can say that everybody must be having a great evening and I can see that this bill is directed at all of us. It is non-partisan and patient-centred. It is making sure we get the best quality health care for everybody in Ontario. It is protecting those it should protect: the patient, the customer. It addresses so many issues that so many stakeholders and groups have been waiting for and longing to be addressed. We experienced that as we were able to travel throughout the province—to the north, to the west, to the east. As we did that, the stakeholders came forth. It wasn't about slamming the bill, it was about improving it. That's what we're feeling here. It's about improvement, it's about making health care work for all Ontarians. That is the focus. This bill will be seen as a shining star for all Ontarians. Mr. Speaker, like I said, I feel the love.

Mrs Elizabeth Witmer (Kitchener-Waterloo): I do appreciate the opportunity to join the debate on Bill 31, the Health Information Protection Act. I want to thank the Minister of Health for his kind comments earlier this evening.

This is a bill that has been a long time in the making. Our government recognized the need to put in place such a bill. We knew it was very important that we put in place a bill that was going to protect patient information, that was going to make sure that the use of that information was only done properly, in a way that it protected the individual, and people needed to know how and when that information was going to be disclosed. So we now have for the first time ever, upon the passage of this bill, a bill that will establish some very consistent and comprehensive rules and safeguards for the protection of that personal information.

I think the fact that this bill has taken so long to get to where we are today speaks to the fact that there is nothing more important in life than the protection of personal health information to individuals. In the development of this bill, and I think this is probably the third or fourth iteration of this bill, we continued to hear from individuals, professional associations, health providers and colleges about the concerns they had with the bill.

I think it's important that governments have worked to get it right, and I do want to express my appreciation at the outset to the minister and his staff. I think they have undertaken very comprehensive consultations with the stakeholders, and I think we're at a point where there is almost unanimous agreement on the bill. Obviously, any concerns that remain are around issues such as the lockbox, the implementation and the regulations. I hope that the minister and the ministry staff will continue to consult with all of the stakeholders in the province, as they have been doing, in order that people can be fully assured that when the bill finally becomes law on January 1, 2005, we've had the consultations that will make it the best bill it can possibly be.

I think this is an example of what we can do when we all work together. This is a very non-partisan bill. This bill is to protect people. It's to give people access to their own personal health information. It allows them to make changes if changes are necessary. So it is very patient-centred, and I'm glad we're finally where we are today.

It's a very technical bill, and although there was a lot of consultation—we had input from individuals, health professionals, health care providers and others—I think most of the general public would be unaware that this bill was even under discussion. So we're here today, and I think at the end of the day everyone is going to support this bill. Certainly it will be to the benefit of the people in Ontario because it will allow for the protection of their personal health information.

Having said that, I want to also draw the comparison between Bill 31, which I do believe got full consultation and full debate—and I do believe that the government was responsive to the concerns that were expressed, and appropriate changes were made. They certainly incorporated some of the amendments that the opposition parties introduced, and we're grateful for that. I hope that in the same way the government will see fit to make amendments to Bill 8, because regrettably on Bill 8, which of course is another health act, although there was consultation, there are still many, many concerns being expressed by health care providers who are going to be impacted by the provisions contained in Bill 8.

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There are some fundamental concerns about the issue of accountability. Accountability is the principle of Bill 8. I know the government often talks about Roy Romanow and what he said. He talks about accountability, and he talks about accountability going two ways. It goes to the government, to the minister, to the ministry and to the health providers. Regrettably, Bill 8 does not speak to mutual accountability. It doesn't hold the government accountable for their actions. It doesn't hold them accountable for making sure that people have access to health care services and programs in Ontario. All the accountability goes one way.

This issue of access to services is extremely important, and we heard that today. We've heard this government say that Bill 8 is going to eliminate two-tier health care. I would submit to you that Bill 8 isn't going to do that. Bill 31 doesn't do that either. We had with us here today the Meningitis Research Foundation of Canada. They talked about the need for all children in this province to have access to a vaccine which could prevent meningitis. I hope that this government will introduce this vaccine, because meningitis today is a vaccine-preventable disease.

The reason I mention that is because right now we have two-tier medicine in this province when it comes to the vaccine that is currently available to treat people and prevent them from getting meningitis. At the present time, if you have the money, which can be $600 to $800 per child, you can have your child vaccinated. If you don't have the money, you don't have access to the vaccine. Yet at the present time British Columbia, Alberta and Nunavut all provide equal access to the meningitis vaccine. So I hope this government will move forward very quickly. When we talk about two-tier medicine and getting rid of it, it means that the government is going to have to provide the access, and so far we didn't have this vaccine readily available for every child in Ontario. Yet, do you know that it was made universally available to every child in the United States in 1998 and 1999? We need to make sure that we would introduce this as quickly as possible and that it would become part of the vaccination schedule. I understand that the government wants to move in this direction and I trust that they will. They have certainly talked about making sure that we improve access to health care.

As we move forward and we take a look at what we heard during the committee hearings and what were some of the recurring themes of interest, of concern, I want to draw the attention of this House, and to those watching, to some of those issues. One of the issues that was raised was the extensive regulation-making powers of the government. There were issues around fundraising. There are issues around the lockbox. I understand that some of those issues around the lockbox still remain as issues that are outstanding, and of course there were other issues that I will bring forward as well.

I want to deal first with the extensive regulation-making powers that Bill 31 confers to the government. Again, as I said at the outset, I hope the government will undertake the same type of consultation on the regulations as they did on the bill, and not only listen but also implement and include some of the recommendations.

The Ontario Medical Association, when they spoke to the extensive regulation-making powers, said: "I would like to note for this committee, however, our concerns about the extensive regulation-making powers found in the bill. They are so wide-ranging that they allow the government to change virtually any aspect of the law by regulation. This is contrary to the traditional division of legislative and regulatory authority and represents an intrusion of the government's executive powers into the lawful powers of the Legislature. Not only does it create the power to completely undermine the content of the act, it undermines the democratic process of the Legislature. We recommend that this committee review the proposed regulatory-making powers closely with a view to significantly curtailing them."

The Canadian Mental Health Association, Elgin branch, had similar concerns. They said: "The regulation-making authority under this legislation is expansive and affects every aspect of the legislation. ...it is overly broad and would, in our opinion, undermine the legislative intent."

So I think it's important that the government keep that in mind and certainly that they move forward in the development of the regulations in a very collaborative manner, and also that the approach be transparent.

One of the other key issues raised was fundraising. I know amendments have been made, but certainly many of the hospitals that came before the committee expressed concerns about their ability to fundraise. In this province today, most of the new hospitals, or the additions or renovations we're making to hospitals, happen because of fundraising. There simply are not enough taxpayer dollars to pay for the bricks and mortar, so fundraising is absolutely critical and we're certainly pleased. But these were some of the concerns.

We heard from the University Health Network: "To ensure ... funds, University Health Network cannot support an express consent requirement for the collection, use and disclosure of personal, non-health, demographic information for fundraising purposes."

We also heard from the Association for Healthcare Philanthropy in Canada, who said: "However, we are extremely concerned about an express consent requirement

in Bill 31 for health care fundraising purposes. We feel this requirement is inappropriate for five reasons and, therefore, we are requesting that the government consider an implied consent requirement for health care fundraising, to be achieved through notice and opt-out." I think it's important to bring these points forward.

We also heard from the Strathroy Middlesex General Hospital Foundation, who said: "When we talk about grateful patient programs and the return on investment, I want to talk to you a bit about the cost of fundraising. I'm sure many of you have been involved in your hospitals. The cost of fundraising is of constant concern to the community, professional development staff and to our volunteer boards....

"I wanted to also provide you with a bit of accountability on hospital foundations. This is taken from the Canadian Centre for Philanthropy's recent publication on charitable fundraising in Canada: 'Hospital boards are more frequently reported to be involved in almost all evaluation activities than are the boards of other types of charities.' What this, I'm hoping, is telling you is that we have to make sure our costs are reasonable and in line and that hospital boards are very diligent in ensuring that."

So again, the boards have indicated, and evidence shows, they are very accountable in their fundraising, and of course there's a desperate need for the money that is raised for these additions, renovations and new construction.

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I also want to bring to your attention a point that was made by the Ontario Hospital Association to the standing committee on justice and social policy. They say, "MPPs in this province," referring to all 103, "You are aware that the hospitals in your home communities and across your large ridings are governed by dedicated, voluntary boards. The members of these boards are community leaders, business people and others with a civic orientation to community service. Many of you will know them as your neighbours and friends. These people are entrusted with the oversight, fiscal stewardship, mission and strategic direction of their hospital, with a single purpose in mind, and that is to create healthier communities."

So this whole issue of fundraising is really extremely important. We have in this province today, new MRI's; we have new units for children, paediatric units; we have new birthing; we have cardiac care centres; we have cancer centres. There's new equipment in our hospitals today. That equipment and those new structures would not be there without the generous donations of many, many people in our local communities. This happens because of our boards and our foundations, who work so hard to raise the money to provide the needed services.

That gets us back to access. If we're going to improve the access to care, we're going to have to continue to make sure that we have these additional structures. Whether it's more cardiac care centres, more cancer centres, more dialysis centres, this is absolutely necessary. We're going to have to expand what we do in the way of treating people who have diabetes.

Now, one of the other issues of concern in Bill 31—I know the government has certainly tried to address it, and I think it would be difficult to actually reach total unanimous agreement on this issue—is the issue of the lock box, and also the time required to implement it and the whole process of implementation. It is a very complex, sensitive issue, and I think there is some concern among some of the health care providers that it's not going to be possible to have the systems required by the legislation in place by the date of implementation. So one of the suggestions I would make to the minister regarding the implementation of the lock box provision is that he may consider staggering its implementation over a period of time.

I just want to quote from a concern that has been expressed from the Ontario Hospital Association. "Secondly, the issue of the lock box: While we appreciate the need to ensure patients have an opportunity to control their personal health information, we do feel it's important to alert government as to how this may impact the quality of patient care in Ontario.

For many health care practitioners working within hospitals, the right of individuals to effectively block access to what may be very pertinent health information could pose real challenges. Hospitals have told us that such a provision may in some instances seriously impair the ability of a health care provider to disclose information for purposes that may be essential to the effective delivery of health care and may thus, inadvertently, undermine the quality and safety of care to that individual."

So we need to make sure that issue is completely resolved, because at no time do we want to undermine the quality and safety of care that is provided to any individual. Again, I would recommend that the government perhaps take a look at staggering the implementation of the lock box requirement to insure that it is implemented without any disruption or posing any risk to patient safety.

I'd like to now look at the whole issue of accountability. Within Bill 31 are 10 principles. Again, the first principle identified was accountability. I can't help but think of Bill 8 when I think of accountability, because accountability is also the cornerstone of Bill 8. Regrettably, within Bill 8, when we talk about accountability, the accountability goes all one way. The accountability applies to the health providers. Regrettably, it's not mutual accountability. I think we need to keep that in mind. There isn't an obligation on the part of the ministry or the minister of the government in the area of accountability.

In fact, Bill 8 is totally silent as to the government's obligations with respect to its support for the provision of health care or that it has even achieved the best use of public resources. Of course, when we talk about public resources, we are talking about the taxpayers' money. I do believe it is important that the government be account-

able for the use and be able to demonstrate to the taxpayers, just as the hospitals, the long-term-care facilities or any other health care provider are going to have to do, that they have made the best use of the public resources provided to them. I do believe that the government also should have the same obligation.

I know many people in this province are extremely disappointed that, on the issue of accountability, Bill 8 is totally silent on the government's obligations. If Bill 8 were to undergo some further amendments, which I trust and hope it will, it has to make explicit the mutual accountability of the government and providers and it certainly has to ensure the accountability of the government to the public for the best use of their tax dollars.

The rules need to be clear to all of the parties involved in these accountability agreements. I would just repeat one more time: If we're going to hold the hospitals accountable for the use of the money that they get from taxpayers and if they're going to be required to deliver a certain level of care and quality of care, which they already do today, by the way, then the government also needs to assume similar responsibility for funding the health care providers in order that they can provide that level and quality of care.

It might interest this House and people watching to know that Bill 8, unlike the Canada Health Act, makes absolutely no reference to funding the system adequately. If we're going to meet the health needs of Ontarians through comprehensive, accessible and high quality health care services, it is important that there be mutual accountability. If hospitals are going to be required to be accountable for the money, the services, the programs they provide, then they also have to know in a very timely manner what level of government funding they're going to be receiving and they're going to have to know that about three years out.

Accountability agreements are a key principle of this bill. They were a cornerstone of Bill 8. Again, I hope that the government will take a look at Bill 8. I hope that if they're going to force hospitals to sign performance agreements, they will also take a look at mutual accountability and making sure there are obligations on the government.

This government has repeatedly told us they want to be an open government. They want transparency and accountability. I hope that within Bill 8 we will see that. I hope we won't see what we see in Bill 8 today, and that is the one-sidedness.

I would also hasten to add that Bill 31, of course, was introduced after Bill 8. I don't know if the members remember, but Bill 8 was introduced in a way that gave the minister unprecedented, far-reaching powers of a like that we have never seen in this province before. And then the government hastily introduced Bill 31 because I think they realized they had breached the privacy rights of individuals in the province of Ontario. However, I would just remind the Speaker that Bill 8 continues to have far-reaching powers and certainly we really need to address that particular issue.

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The Deputy Speaker: The Speaker would remind the member for Kitchener-Waterloo that we are speaking about Bill 31 and I would just ask that you stick to that.

Mrs Witmer: Yes, Mr Speaker. There are similarities. As I say, if you take a look at Bill 31, it actually supersedes some of the parts of Bill 8 because of the fact that Bill 8 did contain some breaches of privacy rights and actually allowed the Minister of Health to collect, use and disclose personal information, and so the Ministry of Health has made corrections.

Let's take a look now at the issue of limited disclosure. This was an issue for some of the stakeholders who came before the committee on Bill 31. We had the Anglican, the Evangelical Lutheran and the Roman Catholic churches in Ontario come before us, and they wanted to make sure that chaplains and spiritual caregivers would continue to have access to patients to provide religious services. And certainly that amendment has been made. But they wanted to make sure that they could continue to do the work that they had been doing in the past and that no one in an institution, a hospital, would be denied access to their clergyperson or their spiritual caregiver.

The Canadian Institute for Health Information, CIHI, and the Institute for Clinical Evaluative Sciences, ICES, also came before us and spoke to us about the issue of data agents. That was another issue of concern. Those same two institutions, as well as the Information and Privacy Commissioner, the Ontario Council of Teaching Hospitals and the Baycrest Centre for Geriatric Care, talked to us about the issue of disclosure outside of the province of Ontario.

We also had some concerned stakeholders who came to give us recommendations to deal with access to health cards and health numbers; for example, the Cardiac Care Network and the Information and Privacy Commissioner.

We had stakeholders who appeared before the committee who wanted additions to health information custodians. We had Cancer Care Ontario, the Cardiac Care Network of Ontario and the Ontario Joint Replacement Registry appear as well.

I want to go back to the issue of hospital fundraising, because I think this was certainly the issue we heard the most about. We had so many, many interested and concerned stakeholders. I would just mention a few: the University Health Network, the Centre for Addiction and Mental Health, the Ontario Council of Teaching Hospitals, the Baycrest Centre for Geriatric Care, St Michael's Hospital and the Ontario Association of CCACs. As we've heard, the concerns of these stakeholders have certainly been addressed.

Just to give you some information about some of the stakeholding done in the province of Ontario, the University Health Network told us that their foundation raised $62 million in 2003. This accounts for over 12% of the approximately $500 million raised annually by all Ontario hospital foundations. I think that's an indication as to the amount of money that is raised. That's half a billion dollars raised every year in this province. If we

had to raise that money through taxes, it would certainly be a difficult challenge.

The University Health Network goes on to state that the charitable donations they receive are used on new health care facilities and on new medical technologies and equipment that reduce inefficiencies and waiting times in the Ontario health care system. It's used for new medical research, which results in improved clinical outcomes. So I think we can see that this fundraising is totally devoted to improving access to care for people in the province of Ontario, and also improving their clinical outcomes, which is extremely important—anything we can do to improve health outcomes.

They also shared with us that 43% of the donations in their current campaign were received directly from current or former patients or from individuals who had a family member who received services at the hospital. This again speaks to the fact that people in the province of Ontario do recognize that we have a good health system in this province and, by working together, we can continue to make it even better. They go on to say that in 2003, the Toronto General and Western Hospital Foundation received donations of $374,000-plus from grateful patients and, of that number, $308,000-plus went to the research fund. So again, a lot is happening. It's happening on behalf of patients improving patient outcomes.

If we take a look at this whole issue of philanthropy, which of course fundraising is all about, we heard from the Ontario members of AHP Canada that, again, they raised over $500 million on behalf of the province's 225 public hospitals. They also stressed that the money was spent on new health care facilities, medical equipment and technologies that reduced waiting times and improved efficiencies in the health care system. The money was spent on health research. Now, this health research that is undertaken by these fundraising dollars provides for tomorrow's life-saving drugs and therapies such as the vaccine—I'm sure I talked to you about this earlier—that is now available to prevent meningitis.

So this is how the money is spent. It's also spent in new programs for patient safety and infection prevention and control, required to support our health care workers after the devastating effects of SARS. I think we can all appreciate the fact that philanthropy fundraising is being used to help people in the province of Ontario.

We also know that over the next 10 years, the next decade, the public health care system is going to require a lot more money, and it is unlikely that the federal and provincial governments are going to be able to finance this solely through the tax dollars they collect. In fact, the Romanow report estimates that health care reforms over the next decade are going to cost nearly $15 billion between now and 2006. So I think we're going to see that fundraising is going to play an increasingly critical new role in supporting those reforms, in supporting research into communicable diseases and, of course, the construction of isolation facilities such as those we saw following the SARS epidemic.

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I would tell you as well that at St Michael's Hospital over the past three years, that foundation has raised close to $40 million for projects to support patient care. Hospital foundations in this province do play a very integral role in raising funds for equipment and facilities that enhance and improve patient care, patient outcome and patient access. So I'm very pleased that the government has moved forward and responded to some of the concerns about fundraising.

One of the other issues that continues to be of some concern to those who appeared before the committee, such as the Canadian Mental Health Association, the Centre for Addiction and Mental Health, the OMA, the OHA, the Ontario Dental Hygienists' Association, who were here this evening, the Ontario Association of CCACs and the Ontario Council of Teaching Hospitals, to name but a few, was the concern around the issue of implementation. This bill was originally going to become law on July 1. I'm pleased to say that the government did listen to the concern that that timeline was unrealistic and I'm pleased to see that the motion we put forward was approved and the new implementation date is going to be January 1, 2005. We hope that will allow for as smooth a transition as possible.

People were quite concerned about the need to educate and train those people who were going to be in contact and be responsible for Bill 31. They were going to need more time to make their associations compliant internally with the legislation. They were also going to need time to hold extensive consultations prior to establishing the regulations with, of course, the minister. Again, I would just encourage the minister to listen, as he has on this bill. So there was certainly a need for more time.

The people from the addiction and mental health centre said, "We recommended an extension of time to bring this into force ... to allow for those implementation issues to be worked out, and in particular to allow for consultation with stakeholders by the ministry and the government to develop regulations and to develop templates and materials that will be helpful to people." They also went on to say, "July 1 is just unrealistic. I think six months is a lot better," and they say, "There may still need to be some staged implementation." The Canadian Mental Health Association told us, "we would certainly support some extension of the time for implementation." The OHA indicated:

"We are also very concerned about the implementation date of July 1 and would strongly urge the committee to consider extending this date to a date no earlier than six months following the passage of Bill 31 and the filing of the regulations. This will allow health care providers an opportunity to ensure compliance with both the more general provisions of Bill 31 and the numerous specific regulatory requirements contemplated by the legislation."

We also heard from some of our stakeholders about the information manager designation issues. We heard again from CIHI and the Smart Systems for Health

Agency. We've talked a lot about the fact that the whole issue of the lockbox continues to be of concern to people even today, despite the amendments. Again, I do believe it is such a highly sensitive issue that I don't think we're ever going to have total unanimity on the bill. Our government and this government worked extremely hard to be responsive to the concerns. Certainly, if there's anything else that remains that can be done, we need to do that.

But we heard from the Baycrest Centre for Geriatric Care, St Michael's Hospital, the OHA, the OMA, the University Health Network, the Centre for Addiction and Mental Health and the Canadian Mental Health Association. Everybody was trying to strike that balance between an individual's privacy rights and the need for the caregiver to deliver treatment without limitations. People were looking for a compromise that would allow health care providers the access they need to patient information when there is, for example, an emergency situation, an issue of infection control or quality of care.

We heard concerns, particularly from the Centre for Addiction and Mental Health. They inquired about the effects of wide-open information sharing on the stigma—and the discrimination would be against their patients. This whole issue of the lockbox is delicate and sensitive. I guess I would quote the OHA, who say there are safety issues to consider:

"For many health care practitioners working within hospitals, the right of individuals to effectively block access to what may be ... pertinent personal health information" poses significant challenges, and that such a provision impairs "the ability of a health care provider to disclose information for purposes that may be essential to the effective delivery of health care, and may thus inadvertently undermine the quality and safety of care to that individual," resulting in adverse drug reactions and increased potential for a misdiagnosis and an increased number of unnecessary medical tests and interventions as a result of incomplete medical records. These are some of the concerns that you need to balance with some of the other concerns that were heard.

From St. Michael's Hospital we heard that in an emergency or urgent care situation, the inability of caregivers to access all relevant information may seriously affect outcomes. For example, a question to be asked: Is that patient taking certain medications, which may interact with drugs about to be administered? And from the OMA we heard that physicians are concerned about the notion of the lockbox but appreciate the addition of the flag so that at least they know when they are receiving incomplete information. Their issues are in terms of when physicians are asked about the health of a patient in an emergency situation, particularly when a physician is called in his office, yet there is a disclosure denial by the patient, who wishes that certain information be kept. So again, there's a delicate balance that must be maintained, but uppermost in our mind always has to be the quality of the health care provided and the safety of the individual.

I've tried to review some of the significant concerns that have been brought to our attention by the people in this province. I think that, at the end of the day, there is almost unanimous support for the bill. We will certainly be supporting this bill. We started work on this bill, it seems, many, many years ago. This government and the present government have all had the opportunity to make the bill better and I think we're at a point where we've accomplished that.

I think the key right now is going to be the issue of implementation. I hope the government will continue to consult with those who have an interest and are going be impacted by the legislation. A lot of work will need to be done on the regulations to make sure they support the legislation. Hopefully, they will also provide some financial resources. That's something I haven't mentioned, but I think it is important to bring to your attention, Mr Speaker, and the government's attention, that the implementation of this bill will not be cheap. There are systems to set up. There is a comprehensive education program that must be put in place to make sure that everyone who is required to comply with Bill 31 and has interaction with the legislation understands fully their responsibilities. So the key now will be for the government to get the implementation right.

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I'll maybe just end my comments by taking a look at the issue of implementation. I'll speak to how this is going to impact the hospitals in the province of Ontario because they probably are going to have more work to do than almost anybody else; certainly other organizations are going to have to undertake a lot of work, too.

The health care providers are going to have to develop very comprehensive privacy programs. The new legislation sets out some very detailed standards, so all of the health care providers are now going to have to develop new policies and new practices. They will also be looking for the government to be developing some guidelines, some templates, some audit tools for the stakeholders and the organizations that are affected by the legislation. They are also going to be looking for the government to put in place and provide pamphlets and posters for dissemination by the providers to the public. We do have a responsibility to make the public aware of this new piece of legislation, because certainly they have the power to access the information and to make corrections to the information.

I know that a lot of work has been done by various organizations already. In fact, the OHA has recently produced a document entitled Managing Privacy, Data Protection and Security for Ontario Hospitals. Certainly we're going to have to ensure that there are hospital templates and guidelines. We're going to have to create standardization throughout all sectors. People are going to be looking to the government for support and guidance. Certainly people are looking to the government to provide the tools that are tailored to meet the needs of the different organizations. They're going to need a lot of help, and the government needs to keep in mind the cost.

There are going to be new requirements on the part of the health care providers and associations and organizations, new costs related to information practices, obtaining consent, the rights of patients to access and correct their health records and the standards for electronic records, to name but a few. These are all going to have financial implications for hospitals. So, again, the government needs to keep in mind that there is a financial cost involved as well.

I appreciate the time that so many people in this province took to speak to the bill. I appreciate the co-operative manner in which all three parties worked to ensure that the bill could be amended and changes made. I hope some of the additional concerns will be corrected and amended. I know that some of the stakeholders have been reassured that further amendments are going to be made; I hope the government will do so.

The Deputy Speaker: Questions or comments?

Mr Marchese: I just want to say a few words about the member for Kitchener-Waterloo. I want to say how much I appreciate her contribution, and I want to say that I appreciate her contribution much more in her opposition role than I did when she was in government; I do. She is hard-working, she is thoughtful, capable of seeing both sides—something that she couldn't see when she was in government. It's really wonderful to see that in opposition. I wanted to say that.

I also want to say of my colleague from Nickel Belt, who will be speaking at approximately 9 o'clock this evening, for those of you who are watching, that Shelley Martel, the member from Nickel Belt, is an incredible member. She is the health critic, and she does much of the research, as most of us do, without any help or little help, unlike many Liberals. Most ministers have anywhere from nine to about 15 staff to help them out with their research and communications, legislative assistants and all that. We have probably one for the whole caucus, a couple of members for the whole caucus, and we do incredibly well.

Ms Kathleen O. Wynne (Don Valley West): But you're bright.

Mr Marchese: We are not brighter than you; no, we're not. Don't say that. One of the members says we are bright, and it's not true. I believe many of you are equally bright.

The Deputy Speaker: The Speaker feels a little left out of the conversation.

Mr Marchese: I beg your pardon, Speaker.

I just want to say that the member from Nickel Belt, our critic, who will be supporting the bill but expressing some of the concerns that she has gleaned from her study of it, including what other members said, will be speaking at approximately 9 o'clock. Please tune in.

Ms Wynne: Thank you for the opportunity to respond to the member from Kitchener-Waterloo's comments. I also want to talk about the process of being on this committee. This was the first time that I travelled with a committee to hear the delegations on Bill 31. I have to say, having been many times on the opposite side of the table as a delegate myself, it was a very edifying experience to be a member of the committee, to hear the community around the province talking to this bill.

It was especially educative because this is a bill that, as has been said, there was a large degree of consensus on already. So what we were hearing was a truly collaborative process, where people were coming to us and saying, "We agree with the direction this bill is going. We have a few comments that we think will make it better." One of the issues that a lot of people spoke to us about was the fundraising issue for community hospitals, the ability for community hospitals to tap into their grateful donor, their grateful patient banks by not having to get express consent. We heard that many times, and that amendment was made to the bill.

I think it was a really good process. It shows that when all parties can work together, that's the kind of good legislation we can produce. I think this government is going to be doing that as often as we can, presenting legislation that is well thought out, that we can work with all parties on.

Mr Marchese: Except Bill 8.

Ms Wynne: There are different processes, and Bill 8 is a different piece of legislation. I've already spoken to Bill 8. What we're talking about tonight is Bill 31. I think it is a really good example of collaborative process, and I commend the minister for putting it forward.

Mr Dunlop: I am pleased to rise this evening. It's not that often that we have a bit of a love-in with a bill, and I can tell you that it's not going to happen a lot of times here. There are some other medicare bills coming up that we have some concerns with. But I want to congratulate the minister for bringing it forward and my colleague Elizabeth Witmer, the former Minister of Health, for her comments this evening. She has presented a lot of really good points, and of course our party will be supporting this piece of legislation.

We understand that there are some financial issues with the implementation, and we look forward to those comments coming forward as well in the form of the budget from the Ministry of Health. We realize that with the Paul Martin budget, things aren't as well for the province of Ontario as we might have expected. We were all expecting billions of dollars more, but it didn't happen. We have to live with reality, and that is that he is going to continue with the Liberal government the same way he continued with our government. But anyhow, we are looking forward to further debate on this, further comments from all members of the Legislature.

Mr Marchese: The member for Nickel Belt.

Mr Dunlop: Yes, we are looking forward to Ms Martel's comments coming up. We know she has a lot of very positive issues with this bill. But we think that, overall, this piece of legislation is good for the province of Ontario and good for our health care system. We look forward to the debates this evening and for second and third reading as well. Thank you very much for this opportunity tonight.

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Mr Dave Levac (Brant): First, I want to commend the minister for bringing the bill forward and for the work that he, the committee, all the people who did the work and particularly the deputants who came forward across the province did to make sure that we put together the best possible bill we could. I want to offer my congratulations to the former Minister of Health on her discussions about privacy.

The one thing I will bring up is a little thing that I did a while ago in a private member's bill, asking all of the Legislature to look into the ways in which it makes information available to those who don't have honourable intentions, not just within Bill 31. We pointed out some faults that we hoped the previous government would deal with, and that is the information stolen by biker gangs and organized crime. Literally, we saw examples of biker gangs putting pictures of police officers on their Web sites and saying, "You're watching us. Well, we're watching you." They would show pictures of their family, their house, their address, their telephone numbers. That is not acceptable in this Legislature any more.

We need to take steps. I think Bill 31 speaks to that in terms of what we are doing in health care and the information that should be made private and be concerned and considerate of the patients inside those hospitals. We'd better be doing that again across this Legislature in all ministries in the way we disseminate and make information available. I think this is the starting post.

I want to congratulate the former Minister of Health, the member for Kitchener-Waterloo, for bringing forward her concerns. I want to talk about the NDP showing their support for this bill as well. I know they will make some recommendations that I believe will help us to make this a better bill yet. The Minister of Health will also be doing the same thing. As well, I want to challenge this Legislature; I want to challenge all members, not just the government but also the opposition side, to come up with ways to protect people's privacy, particularly from organized crime and biker gangs.

The Deputy Speaker: The member for Kitchener-Waterloo has two minutes to respond.

Mrs Witmer: I want to thank the member for Trinity-Spadina. I would concur with him that the member for Nickel Belt, Shelly Martel, has done an outstanding job, and continues to do so on behalf of their caucus, on health care issues. I want to thank the member from Don Valley West. We had the opportunity to sit together on the committee, and I certainly appreciated her comments during the deliberations. To my colleague from Simcoe North, who, I will tell you, has made an outstanding contribution in this House ever since they sent him here from—where was it? What's the name?

Interjection: Simcoe North.

Mrs Witmer: Simcoe North. That's right. But I was trying to find the name of that little place. Washago? What is it? Anyway, I appreciate the commitment he has shown. I know when he was a member, we were also able to introduce some dialysis services at one of his hospitals as well. He has always demonstrated how passionate he is to improve access to quality services for the people in his community, and he has worked really hard. I want to thank the member for Brant, whom I've had the pleasure to work with for many years and who, I know from personal experience, is extremely committed to the people in the riding that he serves.

I think it is a great night, folks. I think we've worked hard together to get to a point where we have a bill that we are all reasonably happy with. I understand it will have some further consultation for those issues that still present concern to members of the public, the Health Care Providers' Association and others. There will be one more opportunity. So I think we can all be very proud of what we've done together.

The Deputy Speaker: Further debate?

Ms Martel: It is a pleasure to participate in the debate tonight, and I will take the debate probably until the House closes at 9:30, so I will just let everyone know that now. As my colleague from Trinity-Spadina said, from the outset we supported this bill. But tonight I do want to talk a little bit about some of the concerns that we heard, which forced some change in terms of the clause-by-clause process, and some of the concerns that I still have, which I hope the government will seriously take into account as we move back into the committee process, because I assume that we will, and might at that time consider agreeing to some of the changes that I had proposed.

First of all, I should at the outset say it was a pleasure to be part of this committee. By and large, there was agreement. By and large, the people who came forward were in agreement with the bill. I want to say thanks to the bureaucratic staff, who were very helpful throughout the process and who contributed a lot of their time and their expertise, and also to the minister's political staff, and I see one of those staff sitting under the gallery now. He was very good to deal with. Thank you, Abid. I look forward to working with you in the future.

I know we won't see eye to eye on Bill 8. We've had discussions about that. But on this particular bill, I think we worked very hard to come forward with something that we can all agree with and something that we can all be proud of.

I do want to make mention of the former Minister of Health, because in fact it has taken us some long time to get here. The process around privacy legislation actually started in June 1996, under the former government. At that time, there was a consultation paper, which was entitled A Legal Framework for Health Information, that was released and resulted in a number of regional meetings and about 100 submissions to the government at the time.

That resulted, in November 1997, in a draft bill that was called the Personal Health Information Protection Act, which as well was released for public consultation. It went out to over 1,000 individuals and organizations. The overview itself went out to another 4,000 individuals and organizations. That bill didn't go any further.

It was then followed in October 2000 by another consultation paper, which was called Ontario's Proposed Personal Health Information Privacy Legislation for the Health Sector. That went to about 5,000 organizations. There were a number of round tables, and the ministry received written submissions.

That consultation paper led to a bill in December 2000 which was called the Personal Health Information Privacy Act, which did receive first reading. It went to a standing committee for public hearings but died on the order paper when the Legislature was prorogued in March 2001.

Finally, in February 2002, the Ministry of Consumer and Business Services released draft legislation, the Privacy of Personal Information Act, and again, there was consultation. It didn't specifically deal with the health sector and again it didn't move forward, which then led us to the bill that we have been dealing with, Bill 31, which was introduced last fall.

So it has taken us some time to get to where we are, but I think as a result of all of that consultation, the draft documentation and the regional round tables the minister was able to come forward with a bill last fall where many of the issues that had been in dispute were worked out.

Secondly, the bill also, frankly, follows on a need to do something in response to the federal legislation, the privacy legislation that came forward and went into effect on January 1, 2004. As you'll know, that legislation primarily affects the commercial sector, and there were many who suggested we needed something much more specific for the health sector. So a number of other Legislatures, including Saskatchewan, Manitoba and Alberta, have all moved forward with having their own health-specific privacy legislation, and Ontario's legislation follows in that regard.

So we are dealing with two things, one an initiative that began a long time ago in 1996 to deal with personal information. The need for that was reinforced, I think, by the federal legislation, but to have something more specific, because we heard throughout the process of the hearings that many provisions in the federal bill just did not apply to Ontario's health sector, were too onerous for Ontario health organizations to respond to. I'm pleased that we have a provincial bill that is patterned after some other provincial jurisdictions.

I won't go through the details of the bill in terms of what it does. I think that has already been well articulated by some of the other speakers here tonight. What I'd like to do is look at some of the concerns that we heard which resulted in change and some which didn't result in any change—for good reason, I think—and also some of the changes that I encourage the government to consider as we go through the process for second reading and as I assume we will go through clause-by-clause again.

Let me deal first with the changes around fundraising, which, it was clear as we started into this process, the government was going to have to respond to with an amendment that would allow for implied consent with respect to fundraising. Even on the first day of public hearings, one of the first presentations that we heard was from the University Health Network. Mrs Witmer has talked a little bit about their fundraising numbers, but I think it's important that I repeat them.

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Part of their concern, and their concern frankly was reflected and reinforced by other hospitals and other foundations that raise money for hospitals, was that if you had the requirement for express consent, which was in the original version of Bill 31, it would really be very onerous for hospitals to get that express consent. The net result would be a very significant drop in money raised through fundraising, money that is used by the hospitals, obviously, for research purposes but also for the purchase of capital equipment etc.

The University Health Network said in their presentation that an express consent requirement will limit the amount of time that care providers spend in patient consultations, because they would be expected to approach patients and try to get their express consent to send them fundraising letters after they'd left the hospital and their hospital stay had ended.

Secondly, an express consent requirement does not reflect the privacy expectations of University Health Network patients. They made it very clear that after many years of fundraising, they clearly have a track record and clearly have been able to record complaints. The level of complaints they had received with respect to their sending out fundraising letters and requesting funds just didn't, in their minds, necessitate changing from implicit consent to express consent of those patients.

Mr Richard Patten (Ottawa Centre): One in 10,000.

Ms Martel: Actually, one in 20,000 was the figure that the University Health Network gave to us.

They also said that fundraising is critical to supporting desperately needed health care reforms. They referenced the Romanow recommendations in that regard. They said that in their case specifically, but with respect to hospitals generally, hospitals are relying increasingly on foundations to support research in communicable diseases and new infection control and prevention measures in a post-SARS world.

Their fundraising efforts were quite significant. We heard from a number of hospitals and received individual information about fundraising efforts, but UHN was quite significant: some $62 million raised for hospital activities in 2003. That was from three foundations that had been established to support research efforts. They made it clear that despite all that, only one in 20,000 patients ever complained about actually being approached. So it was not a big problem, and they didn't really feel that express consent was required.

We heard the same, for example, in London. We had an excellent presentation there by London's four hospital foundations. They included the Children's Health Foundation, London Health Services Foundation, Parkwood Hospital Foundation and St Joseph's Health Care Foundation. Last year alone, those four foundations raised $31.4 million, both for research and the purchase of

equipment and technology. They also made the point that some of the money that was being raised was going toward the local share of their reconstruction projects that had flowed as a result of orders from the Health Services Restructuring Commission. They were looking at finding $100 million from fundraising to pay for the local share of the changes that had been ordered.

They made it very clear that their grateful patient program very much relied on being able to contact patients after they had left the hospital, talking to them about the wonderful services they had received when they were there and then making the specific pitch for a contribution. As a result of that first contribution, of course, many of those donors would give annually, and then many of those donors would actually put something in their wills in that regard. They told us that 14% of their patient donors indicated that their families had made a bequest averaging $15,000, which is quite a significant amount of money.

It was also their concern that if they had to obtain express consent for fundraising, that would probably cut off about 90% of their donors. Their fundraising efforts would essentially dry up.

They gave us some figures to attach to that 90%. They said that on this basis in the first year, they would have $1.2 million less in cash donations; in the fifth year, the lost cash donations would be in the order of about $2.9 million; and the cumulative lost cash donations would be $10.7 million. But based on historical patterns—and this was the most important point for the committee—the reduced level of contact with former patients would translate into a future loss of $45 million in bequests from the same former patients. That was just the situation in London with respect to four foundations. We heard that again and again. If you translate that kind of loss across the province, the OHA estimated in their brief to us that it would cost Ontario annually about half a billion dollars. And who was going to make that up? Well, in the province of Ontario, the government was not going to be able to make that up. Where else would hospitals fundraise? They weren't going to be able to raise their parking fees internally or cut services to raise that. It was really essential that the government change its mind.

As a result of hearing that, and as a result of hearing from the privacy commissioner—the privacy commissioner came in and addressed a number of other issues, and also addressed the fundraising aspect of the bill in particular. She was really clear that in her opinion, implied consent for fundraising from patients was enough. I just want to quote from her brief what she said in this regard:

"Before concluding, I would like to touch on one other important change that I believe would enhance this bill. As currently drafted, health care institutions, such as hospitals, will require express consent in order to use personal health information for fundraising purposes. Although at first blush this may appear to be desirable from a privacy perspective, this does not reflect the existing realities facing healthcare organizations. These organizations are heavily dependent on fundraising to meet their goals and serve the public. Requiring express consent for fundraising purposes will adversely impact their ability to raise funds."

Between what we heard from the hospitals, the foundations and then the commissioner, it was very clear that the government was going to have to change to move from express consent to implied, in order not to seriously affect the ability of hospitals to raise money. All three parties put forward amendments during the clause-by-clause to give effect to that change. I was pleased that there was agreement to do that.

The second issue that I want to raise has to do with the lockbox provisions. We heard a great deal about this. There were two different sides to this matter. We heard, for example, from the Ontario Hospital Association, who said the following:

"On the issue of the lockbox, while we appreciate the need to ensure patients have an opportunity to control their health information, we feel it is important to alert government to how this may impact the quality of patient care in Ontario.

"For many health care practitioners working within hospitals, the right of individuals to effectively block access to what may be pertinent personal health information poses real challenges.

"Hospitals have told us that such a provision may, in some instances, impair the ability of a health care provider to disclose information for purposes that may be essential to the effective delivery of healthcare, and may thus inadvertently undermine the quality and safety of care to that individual."

That's what we heard from the OHA.

On the other hand, and we heard really compelling evidence from people who work in mental health services, for example, and people who work with patients who suffer from HIV/AIDS, who said very clearly that the release of some of their personal information could be devastating, much more for people who had other diseases which are, I guess the best way to describe it, not so controversial, or don't carry the stigma that those two do. They were very clear that these are patients' personal health records; patients should have the right to decide if they will refuse to disclose some of that information to other healthcare providers, physicians, institutions, hospitals etc and expect their wishes in that regard to be respected. So, very clearly on the other side was a concern that for some people the release of their personal health information, even done inadvertently, poses a much greater risk, a much greater challenge, than for other members of the general population. There are good reasons why many patients would want some of that information to be withheld.

At the end of the day, we asked the ministry staff what happens in other jurisdictions. The staff informed us that in dealing with Manitoba in this regard in particular, because they have similar provisions, government officials there who have had experience with these provisions made it clear that in their view there has not been a

breakdown in these provisions. There have not been instances where a patient's life, a patient's health care, was compromised by a physician or compromised in a hospital situation because not all of the personal health information of that patient had been disclosed. Manitoba officials said there were really no compelling reasons to change those provisions, the provisions that allowed people to refuse to disclose some of their personal health information. I think it was on that basis, on hearing that information, that the committee members felt much more comfortable about retaining those particular provisions in the bill. At some point this bill will be reviewed. That is written into the bill. I think we all felt very clearly that those lockbox provisions should be under intense scrutiny at that time, but what we heard about other jurisdictions gave us reason to believe that it will work in Ontario and that there's no compelling reason to change the legislation as it came forward in its original fashion.

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There are four concerns I want to raise that I hope the government will take into account as we deal with this process of clause-by-clause again. The first involves section 37(3). It's the section that talks about a health care facility providing information to a member of the general public who calls to ask for information about a patient in that facility. It says the following:

"(3) A health information custodian that is a facility that provides health care may disclose to a person the following personal health information relating to an individual who is a patient or a resident in the facility if the disclosure is not contrary to the express request of the individual:

"1. Confirmation that the individual is a patient or a resident in the facility.

"2. The individual's general health status described as critical, poor, fair, stable or satisfactory, or in terms indicating similar conditions.

"3. The location of the individual in the facility."

I remain concerned that, in a number of facilities, providing information about where a patient is located will immediately give information to a caller that that patient, for example, is in a mental health wing of an institution. Frankly, I think that is a disclosure that could be very hurtful or very harmful to a patient who, for example, may have not disclosed to his own family or friends, or her friends and family, that they actually have a mental illness. I think the evidence around that that was most compelling was provided to us by the Psychiatric Patient Advocate Office, which advocates for people who are in the psychiatric institutions in the province. They said the following:

"... section 37 is not appropriate in the mental health context. The provision allowing a facility to contact a relative or friend if the person him or herself is unable to consent where they are 'injured, incapacitated or ill' is far too broad a statement. Many persons with mental illness entering hospital may be in crisis and unable to immediately communicate their wishes regarding contact. That same person may feel very strongly that he or she does not wish to have family involved due to embarrassment or other factors.

"Further, the ability to share information with those inquiring relating to whether or not the person is a patient, their general health status and location in the hospital is inappropriate. If the facility is a psychiatric hospital, informing someone that the person is a patient also discloses that the person is likely to have a mental illness. The person's general status could mean disclosing that the person is acutely ill and in four-point restraints. Location in a facility, when it is a general hospital could mean stating the person is being held on the psychiatric ward. Many persons with mental illness would not want this information shared, particularly if the inquirer were an employer, probation officer or a separated spouse involved in a custody dispute."

The organization, the office, then suggested to us that only in circumstances where it was an emergency, where the person is in the facility because of a life-threatening illness, should information about their condition, that they are indeed a patient and where they are located in that facility be released.

Similar concerns were expressed by the Canadian Mental Health Association, the Ontario division, with respect to this particular section. They, as well, essentially said that disclosure to a caller of the kind of information that is now in the amended bill should, frankly, not occur unless the patient is severely injured, is ill, or is incapacitated, and their life is at risk.

During the clause-by-clause I said to the committee that we should look at that type of disclosure only in the cases that have been outlined by the Canadian Mental Health Association and the patient advocate office. We were not able to come to an agreement about that. So the amendment or the clause that appears in the current bill continues to allow for a disclosure that I think is too excessive and that I think is unfair and unreasonable because clearly it will identify patients and illnesses that they themselves as patients may not have disclosed to their family and friends. In fact, it may be very harmful to them and may put them at risk.

As we go through the bill again, I encourage the government, the minister and his staff to take a look again at the sections and to take a look again at what was said to us by those two organizations in particular and to recognize that, for some people with some illnesses, we have to go the extra mile in terms of protecting their personal health information and their privacy. AIDS patients are one group; those suffering from mental illness are another. This is a clear case where I think the committee needs to look at this matter again and go the extra mile to ensure that we are only disclosing information to callers in the event that someone is incapacitated, severely ill or facing a life-threatening illness. I hope the government will consider making that change.

The second area where I hope the government will take another look has to do with section 72(11). This is a section that deals with the regulation-making process that the minister will establish in the bill. I commend the

government for having a regulation-making process that is going to be a public matter. For far too long under the former government, regulations were excessive in terms of their place in a number of bills. We got the framework, and the rest of the bill was dealt with by regulation. That regulation-making process went on behind closed doors, was dealt with at cabinet. There was no public consultation, public input and a chance for the public to see what was going on. I commend the government because the regulation-making process that exists in section 72 is quite an open process. The details with respect to that are listed. There will be a notice of the proposed regulation change in the Ontario Gazette. There will be other notices. There will be specific time periods that will be laid out where members of the public can make their concerns known, etc. That's all listed in section 72.

The concern that I have, because the minister is moving to a public process and I think that's a really good idea, is that at the end of the day there is clause 11, which says that if the minister makes a decision that a regulation will not be part of a public process—ie, it will just go to cabinet; there won't be notice and there won't be an ability for the public to participate—if the minister gets to that point with a regulation or a certain set of regulations, there is not any provision for a review of that, either by the Information and Privacy Commissioner or by a court. I find that a bit bizarre because the rest of the section allows for a very public process. It seems to me that if the minister and the ministry are confident about their public process around regulation-making they would not want to come forward with a provision that would allow for no review of those regulations that they decide to do without a public process. There may be very good reason to do that. The bill says that any regulation that is done in that manner will automatically be rescinded after two years, but I don't see why they want a provision that would not allow for a review.

I particularly don't understand that because the bill is going to be overseen by the Information and Privacy Commissioner. I agree with that. That is similar to other legislation in other jurisdictions. It will be an independent third party, so to speak, who will have oversight for this bill. But this particular section even says that there will be no opportunity for a review by the minister not to have a public process around regulations, and that also extends to the Information and Privacy Commissioner, the same commissioner who has an oversight function for the whole bill. I don't understand why every other provision of the bill would be a matter of oversight for the commissioner, but those regulations that the minister does not want to have a public process for will not also be allowed to be overseen by the commissioner.

To get the government out of this would be a much better position for the government to be in. If the process is working, then there should be no reason for the minister to worry about, or to fear, a review of a decision not to have a public process for some regulations. My concern is that it leaves the perception that the government or the minister has something to hide. I don't know why you'd want that perception, because the rest of the process has been quite open. For everything else that has been good about this bill, it doesn't make much sense, and it's wrong, for the government to have a provision that would allow some parts of the regulation-making process not to be reviewed by either a court or the commissioner.

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I say to the government, I just think you should do yourselves a favour. You should ensure that even if the minister makes this decision, it is subject to review. If you are confident about your process, then the review will clearly show that the decision was correct. Do not have the provision that appears in section 11, which gives the appearance that you have something to hide. The bill has been agreed to, and I think you don't want to put yourself in that position. I hope the government will, as I proposed during the clause-by-clause, just rescind or delete that particular section.

Thirdly, we did hear, and Mrs Witmer referenced this, from a number of faith communities who did a joint presentation, which was much different from most of the other presentations we had heard. I think all of us appreciated the concerns they raised, because they were not concerns that I had thought about in the context of this bill. They came to make a presentation, and a number of their recommended changes were in fact dealt with in the clause-by-clause portion of the bill.

However, there is another concern that has not been dealt with, and I'd just like to reference that this evening in the hope that the government, when we deal with the bill again, will respond to the final concern that has come forward. The faith communities include the Evangelical Lutheran Church in Canada, the Ontario Conference of Catholic Bishops and the Anglican Church of Canada. They say the following in this letter they wrote to committee members on February 27, after the committee hearing process was over:

"We ... spoke of the broader concerns we have that members of our churches, and of all faith communities, in provincial government-operated and -funded institutions have access to their clergy and spiritual care providers when they need them. We would not want to see the act that passes the House, unintentionally, become an obstacle to that same individual's desire and constitutional right to live out their freedom of religion....

"We believe that the first two of our concerns have been addressed in the bill.... We continue to have concerns, however, about the third point but think this can also be addressed with the addition of a section: 'Where an individual who is a resident or patient in a facility that is a health information custodian is in a life-threatening condition the health information custodian shall inform a representative of the individual's religious or other organization where that group is known by implication or otherwise."

The members of the faith community say:

"In asking for the inclusion of this amendment we recognize that we will also create an obligation on our-

selves to provide these institutions with the contact information that they will need, and that if we fail in responding to this it will be very clear that the responsibility for this failure lies with us and not with the institution. We have no doubt that we will be able to discuss and agree on" some "very simple procedures that will be needed to implement this with groups such as the Ontario Hospital Association and others."

The government went some long way in dealing with the first of the two concerns that had been raised with us by the faith communities, and I would encourage the government to respond in a positive way to the letter that was sent to us on February 27. The concerns they raised were very legitimate. I think that all members of the committee agreed with what was being said, and we should take the extra step and deal with the third concern they have raised, which is to ensure that a hospital, for example, or long-term-care facility will let a member of the clergy know if there is a patient in their hospital who is facing life-threatening circumstances. It will be up to the clergy, those particular churches, to make each hospital and each long-term-care facility aware of whom they can call in that event.

The final point I want to raise in the last minute has to do with the cost of implementation. We heard over and over again from many groups that while they support this legislation, it will be very costly for them as organizations to actually implement it. In hospitals, in long-term-care facilities and in doctors' offices it may very well require a change in computer technology that will be very expensive.

The Canadian Mental Health Association, for example, told us that many of their branches are so small that they don't even have computer technology, so they weren't sure how they were going to implement it. But they were certainly going to need some financial assistance from the government if the government wanted them to put this bill into effect in the way they do.

It's very clear to me that the government is going to have to come forward with some money for both technology and training if this bill is going to be implemented satisfactorily across the health sector. I hope that when we deal with this bill again, the minister will let us know how much money will be allocated.

That is the end of my remarks. It was a pleasure to participate in the committee. I hope we can make the other changes that will make this good bill even a bit better.

The Deputy Speaker: Questions or comments?

Mr Wayne Arthurs (Pickering-Ajax-Uxbridge): I have certainly enjoyed the debate tonight, and the comments by the member from Nickel Belt in particular, as well as members from the official opposition, on Bill 31.

I had the opportunity for one day of the hearings to fill in for the member for Peterborough, who was busy with some constituency work on that particular day. I heard the comments of a number of the deputations and the concerns that were expressed then. I appreciated hearing from them about issues such as fundraising as a major concern; how hospitals need the community funding and how Bill 31 would be debated in the context of allowing that to happen, and the co-operation from the members opposite from both parties in debating that matter with the government members such that the matter could move forward effectively.

The timing issue occurred during that debate and there was off-line discussion going on as well. Certainly, the extension of the timing for implementation into the beginning of 2005 will allow for an appropriate time frame for transition. I think it was recognized during the committee hearings that it would be difficult to bring the bill forward, have the necessary debate occur, actually get the bill through to the point of being approved and move forward, get royal assent and get regulations in place, and allow the appropriate time for the organizations that will have to deal with this matter to train those on their staff and put their own process in place, such that when the bill is enacted into law, it will result in an effective bill, to ensure the protection of the privacy of individuals in the province of Ontario as it relates to health care concerns. There is probably nothing worse that could happen than to have this bill move forward into legislation, in effect have it implemented, and have errors in early goings. Thus, the extension of time is an appropriate one.

I thank you for the opportunity to comment.

Mr John Yakabuski (Renfrew-Nipissing-Pembroke): It was certainly a pleasure for me to sit with other members of this House on the standing committee on general government that was dealing with Bill 31. It was a new experience for me as well, and I want to thank the member for Nickel Belt for guiding me through much of the process as we sat side by side through much of those hearings.

This bill has been a kind of work in progress through this government and previous governments. It appears that for the most part it has been gotten right after a few kicks at the cat, so to speak.

There were definitely many stakeholders who approached the committee to offer their viewpoints as to where they felt the bill was weak and where some improvements could be made. That was an opportunity for us to understand a little better just how the legislation that we enact in this House can have such an effect on the stakeholders and on the people they serve. It was good for me, personally, to be able to sit there and listen to people from hospital boards with respect to, for example, how this bill in its unamended form would have affected their ability to raise funds to support the foundations that allow them to operate their hospitals in such a tremendous fashion in this province. We were talking about a half a billion dollars in donated funds to these hospitals that would have been in jeopardy without the kinds of amendments that were put forward and brought to bear in this bill.

In essence, of course, our party is supporting the bill, amended as it is. We think that, while it's not perfect, it goes a long way to protecting the privacy of people in

Ontario with respect to health care, and also to respect the needs of the stakeholders.

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Mr Marchese: I want to thank the member from Nickel Belt and congratulate her for her thoughtful and thorough analysis, all the more remarkable because, again, we have been operating with just a couple of staff people, with one researcher. Remember, every minister has anywhere from 10 to 15 people, and the caucus has loads of researchers. We operate with one, two or three people. Hopefully we'll be able to hire a couple of more soon, but that's it.

That's why people like Shelley Martel from Nickel Belt need to be congratulated for the work that they do remarkably well. The suggestions she made for changes are practical, not complicated. If it took 10 years, literally close to 10 years, to bring a bill on this matter, if we don't consider some of the changes that Shelley Martel made today, it could take yet another 10 years to bring another bill to deal with some of the suggestions that have been made by Shelley Martel and others.

Interjection.

Mr Marchese: Dave Levac, are you OK?

Mr Levac: You're right.

Mr Marchese: Yes, that's my worry: that if we agree on some of the things that she just spoke about, including the need to deal with the issue of the cost of implementation of this bill—because you remember, we used to attack the Tories all the time for introducing bills that were passed on to other levels—municipalities—and they have to pick up the tab. Not once has the minister or anyone else said, "There are costs. We will make sure that the money will flow so that organizations will not be burdened with the excessive costs that this could imply."

So I urge the minister and the government to reflect on that and reflect on some of the suggestions that can be made now, so we don't wait another 10 years to deal with these matters that have been dealt with today.

Mr Jeff Leal (Peterborough): Having had the opportunity to sit on the general government committee and tour many communities in Ontario to get the very thoughtful insight from people who came forward at that particular time, to essentially build a piece of legislation that has brought together all parties in this House in common cause to produce a bill that I think is going to be very acceptable to the people of Ontario—I think it has broad-based support.

I want to say that personally I learned a great deal from the member from Kitchener-Waterloo, who had been a very distinguished minister in the previous government, and the insight that she brought to the table in this bill; and the member from Nickel Belt, who as a former minister in the Rae government has been through this legislation before, for bringing together the thoughts. The member from Northumberland made an enormous contribution in committee to improve that bill.

It's really an example, I think, that when an issue has common cause for the good of the community, all parties can come together. For a newcomer to this House, it's very refreshing to see people from all parties come together on a bill like this and really listen to the community of Ontario.

I believe Ms Martel, the member from Nickel Belt, was with us in London, Ontario, when the lady came forward to talk to us about false memory syndrome. I'd never heard of it before in my life. So in terms of personal education through the committee work, it was a good opportunity to be on that committee, to travel through the province and really get an understanding of privacy legislation, what it's all about and how the Ontario legislation could be a signature piece of legislation for other provinces in this country that don't have similar legislation to follow our lead on.

The Deputy Speaker: The member for Nickel Belt has two minutes to respond.

Ms Martel: I'll be brief. I want to thank all members for the comments that they made in response. Let me just focus on the implementation costs again. I think we have a good bill. I'm hoping that we can make some of the changes that I suggested and make it a bit better.

The thing that I remain very concerned about is, there has been no discussion whatsoever by the minister or the government about the costs to implement this. They are real, and we heard that during the course of the public hearings. We heard it from hospitals, we heard it from community health centres, we heard it as well from many community-based organizations, who made it clear that they don't even have the basic technologies right now, and if you are asking them to be in a position to implement this bill to ensure the security of information as it flows, security of information being held in their offices, there was going to have to be some money that was going to have to come from somewhere to make it happen.

I worry particularly about some of the small community-based organizations. I think the requirements here are going to become very onerous if the government is not in a position to put some money on the table to help make this happen; they really are.

We all know the consequence of the last number of years: that many community-based organizations—mental health, addictions in particular—haven't seen a funding increase in 10 years. They don't have money in their budgets to try to put together the computer systems that are going to be necessary for this legislation or to do the training of staff that will be necessary to ensure that their staff can comply. There are very serious penalties—and there should be—but what I don't want to see is an organization whose staff don't comply inadvertently because they weren't trained and didn't understand what their obligations and responsibilities were. That can happen if we don't put in place the money to make sure that both the training and the technology will be in place, in big institutions and small, to make sure that this bill works in the way we all want it to work.

I really encourage the government to take a serious second look at the costs here and how they will deal with the costs for these organizations.

The Deputy Speaker: I want to compliment all the members this evening for the spirit of co-operation in this debate. It has been a pleasure to be in the chair. However, it is past 9:30 of the clock, and this House stands adjourned until tomorrow, Wednesday, March 31, at 1:30 of the clock.

The House adjourned at 2136.

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