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Official Report of Debates (Hansard)

Wednesday 30 October 2002

Journal des débats (Hansard)

Mercredi 30 octobre 2002

Standing committee on government agencies

Intended appointments

Comité permanent des organismes gouvernementaux

Nominations prévues

Chair: James J. Bradley
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GOVERNMENT AGENCIES

COMITÉ PERMANENT DES ORGANISMES GOUVERNEMENTAUX

Wednesday 30 October 2002

Mercredi 30 octobre 2002

The committee met at 1004 in room 151.

SUBCOMMITTEE REPORT

The Chair (Mr James J. Bradley): We'll call the meeting to order, if we can. Our first order of business is the report of the subcommittee on committee business dated Thursday, October 24, 2002.

Mr Bob Wood (London West): I move its adoption.

The Chair: Any discussion? If not, all in favour? Opposed? The motion is carried.

INTENDED APPOINTMENTS

WATSON SLOMKE

Review of intended appointment, selected by official opposition party: Watson Slomke, intended appointee as member, College of Dental Technologists of Ontario.

The Chair: We now move to the appointments review. Mr Watson Slomke, intended appointee as member, College of Dental Technologists of Ontario, you may come forward. As you may be aware, sir, you have an opportunity, should you choose to do so, to make an initial statement. Subsequent to that, there are questions from members of the committee. We will be commencing those questions with the third party and going in rotation after that, with 10 minutes each allocated to the parties. Welcome, sir.

Mr Watson Slomke: Good morning, Mr Chairman and members of the committee. I would like to begin by thanking you for giving me the opportunity to appear before you to tell you a little about myself and answer any questions you may have regarding my proposed appointment to the College of Dental Technologists of Ontario.

I was born and raised on Manitoulin Island and have lived in northern Ontario all my life. Upon graduating from high school, I began my 42-year career with Ontario Hydro as an operator in training and, subsequently, an operator. During this time I worked at various generating stations throughout northern Ontario.

I have always involved myself in community affairs and served wherever possible. In all of these various affiliations I always attained executive positions, a brief description of which follows: Thunder Bay Independent Order of Oddfellows, Algoma Lodge number 267, a past Noble Grand; Oddfellows Thessalon Encampment, a past Chief Patriarch; New Ontario Lodge number 340, Thessalon, financial secretary for 12 years; Thessalon Curling Club, president for two years and curling club treasurer for four years; Thessalon Horticultural Society, president for two years and a director for 30 years; Zion United Church, Thessalon, an elder for 25 years, and I was official board chairman for two years; Thessalon Lions Club, president for two years and still an active member; and Algoma-Manitoulin Provincial PC Association, president for six years. I also served two three-year terms on the Algoma District Home for Aged board as the provincial appointee for Algoma.

I am presently mayor of the town of Thessalon, having been elected two years ago. This position has allowed me the opportunity to expand on my previous experiences. I must keep a topic on line, meet with and solve various citizen concerns, resolve conflicts as they arise, whether between councillors or employee-union disputes, and work with councillors to continually update infrastructure wherever possible and do the best we can to adhere to municipal regulations. I also serve as chairman of our police services board.

Throughout my life I have always enjoyed becoming involved in the community in which I lived. I am very fortunate to have travelled extensively in northern Ontario. I believe that this travelling and involvement with people from the north has put me in the unique position to see and hear varied views and concerns of individuals and municipalities.

As well, I firmly believe that in order for us to maintain the high standard of life we have today, it will take commitment. This commitment I believe will come in the ability of individuals to sit down, communicate, plan and effectively develop a strategy. These strategies can be realized by allowing individuals to come together and be involved. By allowing individuals to become involved, we empower. By empowerment, we allow them to have ownership. By ownership, we allow individuals to maximize efficiency. By maximizing efficiency, we begin to solve the problems as they arise.

Mr Chairman and members of the committee, thank you. I will be pleased to answer your questions.

The Vice-Chair (Mr Michael Gravelle): Thank you very much, Mr Slomke. As you are a former resident of Thunder Bay and I am a permanent resident, I want to welcome you as well.

Mr Slomke: Thank you.

The Vice-Chair: It's good to see you. We will begin our questioning with the third party today.

Mr Tony Martin (Sault Ste Marie): Good morning, Mr Slomke. It's nice to see you in Toronto. Whenever I've seen you recently, it's been in some community in Algoma. I agree that you're a very involved and active member of the northern community and have been for quite some time.

With your busyness, and I know you're a busy man, my first question is, how are you going to find the time, and why would you be interested in this particular appointment?

1010

Mr Slomke: Well, I had spent six years on the Algoma District Homes for the Aged board, and my term was up. I thought I'd like to be on another board, so I inquired around. I know there are about 23 different boards or commissions in the Ministry of Health alone, so I inquired to see what vacancies there were coming up. This was coming up and it kind of intrigued me, because I had never heard of it before—I don't think a lot of other people have—and I thought I had something to offer.

Another thing I looked at was that there are seven members on the board, dental technologists elected by their peers, and six appointees by the Lieutenant Governor. All six are from southern Ontario. I thought there should be one from northern Ontario. That's one of the reasons I applied for it.

But I think I have the ability to dedicate myself. I'm not an expert on this, but I figure there are seven experts on there. Any board I've been on, I've always given it all I had. Probably when I go in there, I'll ask dumb questions—at least the board members will think they are dumb questions—but I'm an ordinary citizen, and I think if I can understand it, well, Joe and Jane Citizen should be able to understand the question. I figure I have something to offer.

Mr Martin: I certainly agree with you: I've gone through the list of appointees to boards and commissions in this province, and we from the north are way underrepresented on most of them. I'm not sure whether it's just a question of convenience or what, but there doesn't seem to be the kind of effort any more to make sure the northern voice is heard at those tables. I think that's important.

The second part of the question was, why specifically this one? You said you looked at the list of appointments. Do you have knowledge or background? You said you could bring something. What is it that you would bring to this appointment?

Mr Slomke: Well, I read over the act from 1991; it was implemented in 1993. What do I think I could bring to it? I read that there are only 477 dental technologists in Ontario and they are down at present. The average age is 50 years or older, and they're going to be retiring in a few years. I think they should be promoting this to high school kids, and I'd be willing to help do that. Kids don't know what it's all about. I think they should be going out and putting some brochures out and speaking to high school kids, because what you need is a grade 12 education and a good background in chemistry, biology, mathematics and physics, but then you have to take a three-year course at George Brown College plus another year apprenticing under the tutelage of a dental technologist. So it's a four-year course. The population in Ontario is aging—what have we got, six or seven million? They are going to need more dental technologists. Dental technologists don't really work with the people. They take orders from the dentist and the orthodontist and so on.

I think I could give something to it. I'd ask a lot of questions. I think that with any job you take, you grow with the job. Ask me this question two years from now, if you appoint me to the board, and I'll give you a better answer. As you know, I was elected mayor of the town of Thessalon two years ago. I'm much more knowledgeable about municipal affairs now than I was two years ago.

Mr Martin: Do you know anything about the Regulated Health Professions Act?

Mr Slomke: Yes. It runs the affairs of the college—the board runs the affairs of the college—and regulates to make sure we have qualified people. And it—let's see; what does it do? It develops, establishes and maintains standards of qualifications, it makes sure the technologists are skilful and knowledgeable and it also sets professional ethics.

Mr Martin: When that act was passed, it was quite an undertaking, as I remember. There were a lot of hearings and a lot of participation by all the health professions. It didn't solve all the problems, in that there are still cross-jurisdictional, scope-of-practice issues. In this instance, the group you're going to be overseeing as a member of the College of Dental Technologists have some natural discussions, I suppose, to give it as positive a spin as possible, with some of the other professions in the dental field.

What in your mind are some of the bigger issues being debated at the moment, and what would your position be on some of those?

Mr Slomke: I'm not sure what the positions are. I'm going in there with an open mind. I think it would be very presumptuous on my part to go in there, the new boy coming in—I'd like to get to know the board members and take part in the discussion, and we can resolve it. I'd vote how I thought was best. But I think it's very presumptuous for me to go in there with an agenda.

Mr Martin: There is a fear out there among dental technologists that some of the work they do is being taken over by the dentists, for example, who are also into some interesting discussions with hygienists, and certainly the dental technologists want to retain control over the area they specialize in. Do you have any—

Mr Slomke: I was not aware of anything like that, that it was to be taken over, but I'd certainly be looking into it. I know they are highly regulated by the council or the college. They have to be licensed.

Mr Martin: That's all the questions I have this morning.

The Vice-Chair: We'll move to the government side.

Mr Bert Johnson (Perth-Middlesex): I had a couple of questions. In your resumé, you list New Ontario Lodge—

Mr Slomke: That's the Independent Order of Oddfellows.

Mr Johnson: In Thessalon?

Mr Slomke: Yes.

Mr Johnson: Help me with my geography. Where would I come across Thessalon if I were driving through the north?

Mr Slomke: You wouldn't quite meet Mr Martin's Sault Ste Marie. It's 50 miles, or 90 kilometres, this side of Sault Ste Marie on Highway 17, the Trans-Canada.

Mr Johnson: Would that put you in Mr Martin's riding or Mr Brown's?

Mr Slomke: Algoma-Manitoulin, Mr Brown's riding.

Mr Johnson: One of the reasons I ask that is that I am a little bit familiar with the Oddfellows Lodge, but I heard you mention the Knights of Columbus, and I have absolutely no—

Mr Slomke: I never mentioned the Knights of Columbus.

Mr Johnson: There was something else besides the Oddfellows Lodges.

Mr Slomke: The Lions Club, the horticultural society, the church.

Mr Johnson: OK. I'm familiar with the lodge's background of relieving the distressed, protecting the widow, educating the orphan and burying the dead. What I'm getting to is the background you bring, not only as the mayor of your community, but your well-rounded and deep experience in other organizations. I wonder how you will draw upon that to help you with this appointment.

Mr Slomke: When I joined the Oddfellows Lodge back in 1960—I'm still a member, an over 40-year member—I was a young fellow. Some of the older fellows talked me into joining.

Mr Marcel Beaubien (Lambton-Kent-Middlesex): You're still a young fellow.

Mr Slomke: I learned how to conduct meetings with the lodge. When I finally became Noble Grand, there were some elderly chaps, and they were very strict. If you didn't do it right, they reminded you. You learned how to conduct a meeting. It taught me not to be so shy and to be able to get up and speak to the public a little bit. I'm still learning. I still get nervous at times, as I'm sure we all do, but I think that is what helped me out, and of course all the organizations I've been on.

1020

As you know, we have delegations. I have town hall meetings as mayor. I've had to use the gavel a few times to bring the boys back into line. I think this will all help me in meetings. I think I have an ability to listen to all sides. When they start repeating themselves, that's when you—

Mr Frank Mazzilli (London-Fanshawe): You'd hate this place, then.

Mr Slomke: No, I watch you in the Legislature, all of you. I've seen you. In fact, a week ago I was watching it.

Mr Martin: Mr Mazzilli's always getting kicked out.

Mr Slomke: I enjoy it because I like to watch the different styles and techniques. It's good. I sit there and watch it. Sometimes I don't know what bill you're speaking to unless I watch the screen underneath, because you wander.

Mr Johnson: Tell me the number of people on council in Thessalon.

Mr Slomke: There are six councillors and the mayor.

Mr Johnson: And the population of Thessalon?

Mr Slomke: It's 1,350. It has gone down from 1,800 a few years ago. We need jobs up there.

Mr Martin: That's right. Northern Ontario needs jobs.

Mr Slomke: We need lots of jobs, and money for water and sewer filtration plants.

Mr Johnson: Those were all my questions. I'm impressed with your background: the horticultural society, the Lions Club and those other organizations that have given you a background.

The Vice-Chair: Any other questions for the government side?

Mr Beaubien: Mr Slomke, welcome to Queen's Park. It's interesting that you mentioned you need jobs in Thessalon and the member for Sault Ste Marie, Mr Martin, agreed with you. But he was also asking you personally what qualities you have from your background experience that you would bring to this position as a member of the college. I found that kind of intriguing, especially after the harangue you gave us on the background you had being a volunteer on different bodies in your community and in northern Ontario.

What intrigued me the most was that you pointed out you would be the only northern member on this body. To be honest with you, from the brief description you gave us of your background experience plus the fact you're from the north, I want to let you know that I'm going to support your candidacy for this position.

Mr Slomke: Thank you very much.

Mr Wood: We'll waive the balance of our time.

The Vice-Chair: We move to the opposition side.

Mr Jean-Marc Lalonde (Glengarry-Prescott-Russell): Thank you, Mr Slomke, for coming down this morning. I have quite a few questions on this issue this morning.

First of all, when we look at how colleges develop and maintain standards or practices, I wonder sometimes if those colleges are not there to dictate to the people who are sitting on the boards, that we have no knowledge of the profession and that we just sit down, listen to them, and put the rubber-stamp "approved as recommended by the college."

I know that through your past experience you've said that you are the mayor of a municipality and that you have the ability for sure to preside and to administer the day-to-day operations of a municipality, but when it comes down to the time to develop and maintain standards of practice, this is a completely different field. I

really wonder sometimes how serious we are with such an appointment. I've seen, in the past, another person who was appointed to this board a couple of years ago. That person had no knowledge at all in the dental practice field.

Today you've said that you are very much involved in the community. Tell me, when you walked in to the Thunder Bay Oddfellow lodge, with the fact that you have past experience with Hydro, did they have any questions for you about the strategy you have played in developing those new Hydro standards?

Mr Slomke: No, they did not.

Mr Lalonde: They did not?

Mr Slomke: No.

Mr Lalonde: Because when you said that you developed strategies for Ontario Hydro, for the Hydro you worked for, today we know the fiasco we are going through. It scares me every time I see that someone has worked for Hydro in the past.

Mr Slomke: I've been retired from Hydro for six years, seven years. It's completely changed from when I worked for Ontario Hydro.

Mr Lalonde: This fiasco we are facing at the present time was not in the process of happening, I would presume, in 1993. That's going back nine years ago. But anyway, my question would be, at the present time, do you belong to or are you affiliated with any party?

Mr Slomke: I'm a card-carrying member of the Algoma-Manitoulin PC Association, yes.

Mr Lalonde: Do you have any knowledge in the dental profession?

Mr Slomke: None other than when I go to the dentist. I went to see the dentist a couple of weeks ago. I asked him, "What do you know about dental technologists?" He said, "Oh, those are the lab boys we send our orders to." He didn't know too much more about them himself. He just says he sends the orders in and those are the lab boys.

Mr Lalonde: The dentist told you that?

Mr Slomke: He told me that, yes.

Mr Lalonde: Has he gone to the proper school, to the proper university, to learn what the board is supposed to be doing?

Mr Slomke: This is a dentist. I don't think he has anything to do with the dental technology board.

Mr Lalonde: They should know what their purpose is or the reasons they have a board in place.

Mr Slomke: That's to look after the public interest, to make sure—the way I understand it—the dental technologists are qualified to make dentures or crowns or whatever. They can't operate unless they're licensed by this board. That board was created by the government back in 1991 and it went into effect December 31, 1993. I think they grandfathered the ones from before. I'm not too sure what happened. I don't know whether they governed themselves or what it was, but the government thought they should have a governing board and they created it.

Mr Lalonde: You seem to have read the professions act. Do you know, yourself, if you have a complaint to lodge against a dentist, where it goes to?

Mr Slomke: To my lodge?

Mr Lalonde: No, if you have a complaint about the way the dentist you go to has proceeded. You've paid a visit to the dentist and you're not satisfied. Where do you go?

Mr Slomke: Where do you go? I understand the office for the council, for the members of the board, is in Scarborough. You could send a letter to them. They have seven or eight different committees there. If there are some who are not living up to the practice or are incompetent, the board will look at them. There's an executive committee, a communications committee, you name it—there are about seven or eight committees. If you've got a complaint, they'll deal with the complaint, and if the dental technologist is not up to it, they can pull them in. You ask them questions, fine them, whatever; they can even pull his licence. This is what the board does, to my understanding.

Mr Lalonde: Who is on that board?

Mr Slomke: Seven dental technologists elected by their peers, and six appointees by the Lieutenant Governor. Now, they're not experts. They're like myself; they're from the public. There are 13 on the board.

Mr Lalonde: Those people who have been appointed by the Lieutenant Governor, do they have any say in the position that—

Mr Slomke: I don't know. I haven't been on the board. I assume they do.

Mr Lalonde: Lately we've been getting a lot of complaints. The MPPs are getting a lot of complaints on the practice of the college of physicians. We go to the college of physicians and it stops right there. They don't even answer.

Mr Slomke: You appoint me to the board and if you've got any complaints, give me a call and I'll bring it up.

Mr Lalonde: It's a good way to do it, yes.

Those are the questions I had. It's just that the background of this gentleman was Hydro. I know he administers a municipality, being the mayor of a small municipality. But being on the board of the dental profession at the present time is completely different.

Those are all the questions I have, Mr Chair.

The Chair: Any further questions from anybody else on the official opposition? If not, that concludes the questioning. Thank you very much, Mr Slomke, for being with us, and you may step down, sir.

Mr Slomke: Thank you, Mr Chairman.

1030

ALLAN GREVE

Review of intended appointment, selected by official opposition party: Allan Greve, intended appointee as member and chair, Smart Systems for Health Agency board of directors.

The Chair: The next individual to come before us is Mr Allan Greve, who is intended appointee as member and chair, Smart Systems for Health Agency board of directors. Sir, you may come forward. You observed before. You have an opportunity to make an initial statement, should you choose to do so. Subsequent to that there will be questions from each of the parties represented in the committee, should they see fit to ask questions. Welcome, sir.

Mr Allan Greve: Thank you very much, and thank you for the opportunity of presenting to you this morning. I'm Allan Greve. I'm the past president of a hospital. I served as president and CEO for 18 years. I'm the past chair of the Ontario Council of Teaching Hospitals of Ontario and the hospital funding committee of the joint policy and planning committee of the Ministry of Health. In addition to that, in the past I have chaired the Hospitals of Ontario Pension Plan.

As CEO, I focused on an evidence-based practice and the empowerment of staff and clinical practitioners. With the support of tremendous staff and physicians, we were able to achieve high-quality standards, high staff retention and the lowest cost per case of any teaching hospital in Ontario.

As CEO, I focused on the major private sector partnerships with industries, and this included pharmaceutical companies, health technology, health information and laboratory services.

In performing my duties in the role of chair and in the role of CEO, I maintained a balanced budget, strong principles of accountability and good business practices. A strong understanding of the distinction between governance and management and the responsibilities of governors is one of the hallmarks.

If I look at an overview of the Smart Systems for Health, at the present time, when you are a patient and you enter the health care system, the speed and efficacy of the treatment is dependent on many separate paper and computer systems in any number of different organizations.

Smart Systems for Health will provide a health telecommunications network infrastructure to enable a secure, standardized and confidential information network that will deliver the right information to the clinical practitioners and patients for timely, effective and well-informed care; second of all, access to primary care and other specialist skills through information networks, telemedicine and telerobotic surgery that will improve health care and quality of life in communities across this province; third, elimination of expensive duplication of diagnostic tests and clinical assessments; fourth, the sharing of this clinical information for research and expertise amongst professionals; and lastly, new innovations to manage disease, coordinate services and control health care inflationary pressures.

I believe I have the skills and abilities to chair a board to achieve these goals.

I will be seeking consensus of the board of directors to enable and to indicate that the critical success factors for the Smart Systems will achieve the following: the creation of effective outcomes-oriented committee structures with clearly defined timelines to support the board; establishment and maintenance of an uncompromising accountability framework reporting to government and through government to the public; the development of a financing strategy to foster public and private sector partnerships for the province-wide telecommunications network that will encourage sustainable investments in infrastructure and operations; and a comprehensive process for the creation of rigorous standards for confidentiality and privacy of personal health information that will draw upon the best expertise available internationally to address ethical and technological issues.

As a major driver of change, Smart Systems for Health must ensure that its projects create the right incentives for sustainable behaviours and practices amongst consumers and providers to deliver health improvements with cost control and system-wide planning for health information.

The early creation of data and technical standards will allow health care providers the maximum time to prepare their systems to interface with Smart Systems for Health.

The next successful factor is the involvement of key opinion leaders in Ontario health care, who will become champions for Smart Systems for Health.

Next: effective tendering, reporting and auditing processes to ensure careful monitoring of progress against expected outcomes and costs for each of the projects.

Lastly: the evaluation and, when appropriate, the implementation of opportunities to improve health care system management and clinical practices through research, and analysis of aggregated health information that comes through Smart Systems and the whole health industry.

The Chair: Thank you very much, sir. We begin our questioning with the government caucus.

Mr Wood: We'll waive our time.

The Chair: We'll move to the official opposition.

Mrs Lyn McLeod (Thunder Bay-Atikokan): Mr Greve, this is certainly not a discussion about your qualifications. You're eminently qualified to take on any role in terms the service to the health care system, as are the members of the board who are being appointed; they are certainly well-qualified individuals.

The questions I have are a lot more about the mandate and purpose of the agency, and some very real concerns that we have around privacy issues related to health information gathering. The mandate that you've just described, and the consensus you want to build with your board, I assume is reflective of the mandate that the government has set out for the agency and discussed with you in appointing you as the chair.

Mr Greve: Yes. There are terms of reference and also a mandate. My words are not exactly and totally repetitive of what the government has sent to me. I think there's room for expansion opportunities that can be built into the system.

Mrs McLeod: Perhaps, Mr Chair, we could ask as a committee to see the terms of reference for the agency, if that's appropriate?

The Chair: Yes.

Mrs McLeod: I would just ask the clerk if that could be provided.

Between the estimates of a year ago and last year's estimates, there was a significant change in the government's approach to Smart Systems. Instead of being a Smart Systems system, it became the Smart Systems agency. So the setting up of the agency is new. It has been relatively unannounced, although I know it has been discussed in the field. One of the changes seems to be a physical setting for the agency, as well as the board of directors. One of my questions from that is, is there then to be a central database collection of health information in order to serve the purposes you've described?

Mr Greve: I have not taken on the chair yet, obviously. I appreciate the question. I believe at the present time there is going to be a culmination of issues that are going to be able to address that.

First of all, there is a discussion about a central repository. Secondly, there are networks and clusters in the different areas of the province. At the end of the day, what it entails is that the information of the people who are in the health care system, and the patients and clients of the health care system, obviously must be in the repository. There's a number of areas where in actual fact it's voluntary. Second of all, there's consent, and it's built on a layering of information on the basis of privacy and how we're going to ensure privacy of personal information. At the present time, the answer directly to your question is, that hasn't been decided.

1040

Mrs McLeod: One of my areas of confusion, and quite frankly concern, is that I feel a little bit as though we have a cart before a horse here. We don't have health privacy legislation, at this point. While there's a draft, there's no indication of when it will come forward. I assume from the mandate, the description you've set out, that you're talking about the gathering of identifiable health information. I make that assumption because I don't know how else the health information could be used for determining outcomes.

Mr Greve: Let me answer that on the following basis: you're correct that the Freedom of Information and Protection of Privacy Act, which is presently out in the field, is one that is being discussed, and that's the act for Ontario.

You're also aware, I'm sure, that under Bill C-6 of the federal government, which is the Personal Information Protection and Electronic Documents Act, that is already in the field and states how in actual fact this will go across Canada, provided that provinces—and Ontario obviously is in the process of looking at its own privacy of personal information and how it's going to treat that. Between now and January 1, 2004, if Ontario in actual fact passes that act, then that will supersede what the federal act is in respect to how information will be dealt with in this province. That is in the field. It has been modified. It has been written on the basis of how it can become, first of all, friendly but yet useful to the practitioners, but on the understanding that personal information has to be private and it has to be available only to those who in actual fact are utilizing it for the right purpose.

Mrs McLeod: And yet you've indicated a number of purposes, a fairly broad range of purposes. If I've made adequate notes, you've talked about using the information to look at health outcomes, you've talked about using it for reporting to government and you've talked about using it to foster public-private sector partnerships. You also mentioned, as you were just responding to one of the questions, that it would in fact be voluntary, and I think as the government has talked about Smart Systems, they have talked about voluntary participation. If it is voluntary, how can it be useful in those broad goals of either studying outcomes or reporting to government?

Mr Greve: Let's just take for an example—the one plank of the smart system is obviously to provide for an emergency health record for those people who are willing to put it into the data bank on a voluntary basis. Again, I would suggest to you that the majority of Ontarians are going to do that. Common sense tells you, and common sense tells me, that when I go to an emergency department, I want all the information to be there to address the issues I'm there for.

Based on that, and obviously through a process of encryption and a process of your having to unlock many different locks in order to get the information by people who are able to do that for different purposes—and that clinical practitioners obviously have a smooth way to get into there, whereas researchers can go only so far into the data bank. There are many different ways in which encryption can be put in place to protect just exactly what you said, and for that information to be utilized for different purposes. But when it comes to clinical patient care, then it must be available in its entirety for a physician to treat you or me when we're in that emergency department, as an example.

Mrs McLeod: Has it been indicated to you by the government that the ultimate product of the agency is to be the development of the smart card?

Mr Greve: No.

Mrs McLeod: So this is not about, in your view, developing smart cards? Or is that again something to be decided?

Mr Greve: I have not been given that direction. I think it's, as you suggested, an option that should be explored. It has been used in other provinces, as you are aware, but I have no mandate or direction or directive from anyone to do that.

Mrs McLeod: I'm just curious, because the smart card initiative, which has been a focus of the government since 1999, was put on hold last year for just a year in order to study some of the issues around smart cards. It almost seems coincidental with the agency being established. I would like to think at least that the government doesn't have a smart card initiative study going on somewhere else while they're setting up the Smart Systems agency. Do you not think the two things should at least

be integrated, that if you're doing the work on smart systems, that should be the government's investigation into smart cards?

Mr Greve: I think your point points out a lot of synergy between Smart Systems and the smart card. In my opinion, there's no doubt that the networks that are going to be part of the Smart Systems would be able to deliver the backbone for the smart card that you've articulated.

The issue here is that there's a significant body of knowledge here which has to be brought to bear. I think by bringing that discussion to the correct tables, we'll make the correct recommendations and/or the decision in respect of that. Personally, I think that is a smart way to go, and that's not a pun. But I would take that as advice—and be able to challenge to see in actual fact if that's in the cards, and where does this synergy meet?

Mrs McLeod: In terms of the options, do you begin with any personal views as to whether or not it's desirable to have a central database for health information and a smart card—on either of those issues?

Mr Greve: In actual fact, I haven't had the opportunity to give enough thought to that. There's no doubt that if I'm appointed, the board I'm going to represent, which is a pretty significant cross-section of the health field, is going to grapple with that. I'm not coming to this with a point of view to say, "This is the way we're going to go." It's open to establish that vision.

The Chair: We now move to the third party.

Mr Martin: Good morning. I don't think anybody will have an argument with the fact that we should be taking advantage of the best technology available to collect information and to use it to provide better service across the province. I certainly share the previous member's query and concern about privacy of information and the fact that the government is moving so quickly to gather it all into a central depository someplace, and what will happen to it there.

There are smaller entities out there already using IT. The Group Health Centre in Sault Ste Marie is one example. They've developed an excellent computerized system of records that they share with the physicians in the organization and other health providers and it works very nicely. But it's small, it's contained, it's controlled; people know each other.

My concern is that when you begin to centralize, as this suggests, and turn over control to one centre or central organization, you stand the chance of systems not working, particularly for people out in sort of the hinterland. We've seen this government, for example, take the Family Responsibility Office, where money is collected and distributed on behalf of couples who have separated, to look after children, and it has become a real nightmare. It's really, really hard to get hold of anybody. The system now is such that you've got to pay to get information that you used to get free.

What is to assure us that this isn't an attempt by the government, given that there are lots of difficulties out there in the health care system, in the end to simply control and manipulate the system, to the detriment of the consumer trying to get access?

Mr Greve: I'm not starting to chair with any board on the basis of that mandate. I'm starting this on the basis of a governance role with established outcomes and with established information that is to be real-time and virtual and to have a network system, as we talked about, which would be encrypted and obviously would ensure confidentiality.

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The role of Smart Systems is not to do what you've just articulated. Sault Ste Marie is a very good example of where there should be value added under that system. It's not a matter of taking over the information, how they do their work, their business, how they treat their patients, how they interact with the physicians and the patients and all the health workers in Sault Ste Marie. This is to be value added; as an example, to pull out all the data in the Sault Ste Marie area for doing population health studies or to look at technology that can be hooked up, as it already is from a skills point of view, to the bigger centres, where in actual fact you need superspecialists to interact with the family physician in Sault Ste Marie.

I talk here a little bit about telemedicine and telerobotics. Telerobotics is obviously in the future. Telemedicine is already here and is being utilized. This is to build on what is already there and not to supersede it. At the end of the day, the patient is the person who should have significant control of the system. We are the enablers to make all these resources available to assist that patient to have all that in regard to pharmaceuticals, testing, emergency health records and patient records. All that has to be across the system.

Mr Martin: I understand that, but my central concern is control. Is the government getting hold of a system like this and exerting undue and unnecessary control and, by doing so, creating the kind of fiasco we've seen in the Family Responsibility Office?

In reading the notes put together for today, I note that one of the organizations this group is looking at is community care access centres. There's already tremendous difficulty in that system, mostly a shortage of resources and money, but also setting the regulations and standards such that fewer and fewer people qualify any more. The government changed the laws where the delivery of social services and people with disabilities accessing support are concerned. The trend is to change the regulations, change the standards and make sure it's consistent across the province—not consistent for more access but consistent for less access. It really worries me that that's where we're going. Can you guarantee me today that that's not where it's going?

Mr Greve: I think you put the emphasis obviously on negatives. Where I'm coming from is that it never is negative to in fact deliver information at the right time to the right people to do the right thing. The issue you highlighted with the CCACs is that that information is basically not available to hospitals and family physicians'

offices on a real-time basis. If you're discharged from the hospital and/or if your family physician says you need support in the community, there has to be a mechanism for that information to be shared. Obviously the system I'm talking about here is going to take away that lag between the time the physician writes the order for you to be discharged and the time the CCAC picks it up with a full background of the clinical aspects of the patient and what in fact they're asking the CCAC to be involved with.

I would turn that around 360 degrees. It should in actual fact shorten that kind of time. Also, the information that is necessary would be there on a real-time basis. That's what Smart Systems is supposed to achieve.

Mr Martin: What if it turns out that it's not? What if it turns out that it's simply a mechanism by the government to gain more control over a health care system that is beginning to come apart at the seams? For example, some of the notes that have been prepared for us here say, "It's not unusual for agencies of the government of Ontario to be subject to binding policy directives. However, it is unusual for the legal framework establishing an agency to include an explicit provision for the appointment of a powerful temporary administrator, who may assume control over the agency at the minister's discretion."

It gives the minister tremendous power, something like the same power the government has exercised in terms of at least three school boards across the province, where they've simply dismissed the trustees, brought in their own person and begun to make decisions accordingly.

If you're appointed to this position and you begin to detect that this is going to happen, because there is the ability there, given this possibility, what would be your response?

Mr Greve: First of all, the legislation that makes that happen is for issues which of course are very significant. Either it's budget or it's quality, or there's some issue that has taken place. There's no doubt, at the end of day, that our society believes government has a role to ensure that the public gets proper care of the necessary quality at the time it should be delivered.

In respect to your specific question, the board I would chair basically works on outcomes and benchmarks. It works on the basis of efficiency and effectiveness. Those are the prerequisites and success factors I'm going to use. Obviously I've been involved, in my career, with the minister and the ministry and the government on a number of occasions, and I think this is a good working relationship. Should that happen, obviously you would hear directly from the chair and the board, if in actual fact it was not meeting the objectives we set for ourselves.

Mr Martin: I wonder, if in preparing to take on this very important responsibility and to move forward—it seems to me that we're going there whether we like it or not, because of the availability of the technology, if nothing else. My concern in terms of health care is that we're moving more and more away from a holistic taking care of the human person in all its dimensions to a more technical, almost "bring your car into the garage and get your muffler fixed" kind of thing. For example, a few years ago in our own hospital in the Soo, one comment that was made was, "We don't provide hotel services here. We don't bring you water; we don't give you a bath. If you want that kind of stuff, pay for it yourself." There was a big argument back and forth in various organizations.

Again, I guess my fear is that this is a further slide away from that holistic approach, where you have nurses and doctors and other professionals and people interested in the spiritual care of people who are sick in hospitals, more and more being pushed out of the way because we've got this new, high-tech supercomputer somewhere that will give us all the answers we need and we'll take care of everybody and we'll all be fine. That worries me. It scares me and concerns me deeply that this is where we're going. To be sitting here today considering appointments to this board that we're calling Smart Systems for Health makes it even more real. Are my concerns warranted?

Mr Greve: I take your concerns under advisement. I would only respond that there's never an excuse for not having good information to make the best decision clinically. That's what this system is all about. It's not indicating to you that there should not be good spiritual care or all that other care. There's no excuse for anybody not to have the data—information, best practices, research—at their fingertips to make better decisions and provide better care.

The Chair: That concludes the time allocated. Thank you very much, Mr Greve, for being with us. You may step down.

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WILLIAM OROVAN

Review of intended appointment, selected by official opposition party: William Orovan, intended appointee as member, Smart Systems for Health Agency board of directors.

The Chair: Our next intended appointee is Dr William Lennox Orovan, intended appointee as member, Smart Systems for Health Agency board of directors.

Welcome, Dr Orovan. As you are likely aware, you have an opportunity to make an initial statement should you see fit, and subsequent to that, there'll be questions from each of the political parties represented on the committee, who are allocated 10 minutes apiece. Just for the committee's sake, we'll note that we'll be beginning with the official opposition when the questions begin. Welcome, sir.

Dr William Orovan: I thank you for the opportunity to make an opening statement with respect to my intended appointment as member of the Smart Systems for Health Agency board of directors.

I've spent most of my adult life involved in health care delivery as a surgeon provider, physician leader, hospital administrator, and in the academic sphere as an acting dean and currently an academic chair in the department of surgery at McMaster University. I've had the opportunity to participate publicly in health care policy discussions, and as chief negotiator for the Ontario Medical Association, I've had the opportunity to play a role in developing new and innovative models of health care delivery, including primary care reform, the existing network system and the very important issue of information technology in improving quality care as well as organization and funding of care, both in the public sphere and in the academic health science centres.

Before entering medicine, I had an opportunity to work in several capacities in the business world, and I obtained an MBA from Queen's which has given me a unique perspective on health care issues and health care policy.

I'm keenly aware of the difficulties faced by our health care system and the very positive contribution that could be made to the provision of quality health care services through an enhanced role for information technology linking physicians, other health care providers and institutions in a common data network which will enhance information availability, while at the same time preserving patient confidentiality and building patient confidence.

There are, as well, significant opportunities beyond simple information transfer in the areas of telehealth, telediagnostics and telerobotics which will certainly have a significant impact on delivery in the coming decade.

I think that with my varied background and experience in health care systems, I can make a significant contribution to this agency and its deliberations and actions.

I'd be happy to answer questions. I'd just say, in addition to my active involvement in medical organizations such as the Ontario Medical Association, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada, I've taken an active interest in volunteer work in my community. I've been an active member of the board of the Hamilton Community Foundation for several years and currently act as chair of this significant community granting agency.

I look forward to this opportunity to contribute further to health care delivery in Ontario.

I'd be pleased to answer your questions.

The Chair: We'll begin with the official opposition.

Mrs McLeod: Thank you very much, Dr Orovan. It's good to have you here.

As I indicated to Mr Greve, our reasons in calling you and Mr Greve were not about a challenge to qualifications. Rather, it was an opportunity for us to find out what the government's intent is in establishing the Smart Systems for Health Agency. As I indicated to Mr Greve, the government's approach changed between the last two estimates books, whereas Smart Systems became a Smart Systems agency. Apart from what was in the estimates book, we had not really been able to get a handle on what was planned. We've now discovered that was because the entire agency has been set up by regulation and its terms of reference spelled out by regulation. So it's not something that we've had an opportunity to debate in the House, perhaps deliberately since the privacy legislation is still such a concern.

One of the questions I asked Mr Greve, and he said the decision had not been made, was whether or not the agency is to establish a central database of personal health information. I put the question to you again because it very clearly says in the estimates outline of what this agency will do that the data centre and physical space will be created to house the computer equipment and to securely house client databases. Doesn't that sound like a central database to you?

Dr Orovan: I've certainly received no directions other than the same documents that you have access to. I would echo what the previous applicant said in terms of the utility of having available timely, accurate data information in order to make clinical decisions, and that this information ought to be available to all clinical providers on a need-to-know basis. That clearly implies some sort of central database or central databases which could be accessed, of suitable encryption to protect that. I personally think that's a huge issue, the confidentiality issue, and building confidence in patients.

One of our major issues in enrolling patients in existing primary care reform projects is the requirement that they sign a consent that information be collected and made available to their providers, and some patients, frankly, have chosen not to sign simply because of that. So there's a confidence-building step that has to go along with this. This board is a public interest board; we are charged with protecting the public interest. As a physician and as a patient, I take that charge very seriously. I think in order to make the data accessible, it has to be in some kind of a repository that can be accessed, but at the same time we have to build confidence in the patients that their confidentiality will be protected.

Mrs McLeod: One of the things Mr Greve said in responding to my colleague was that you need to have a database that gives you the information to make the best clinical decisions. I think that's a point that raises the issue of whether you have to collect that data centrally or whether you collect it in, for example, the primary health care networks and share it with that individual's immediate health care providers—two very different kinds of consent and two very different kinds of trust.

I specifically want to explore with you the uses of the data, because I've raised that issue: if we're talking about using the data for better patient treatment, then the debate is about, is it sufficient to have that data at the local level with that person's providers. But Mr Greve indicated that some of what the data is to be used for, in his view, and I think he said we'd want to persuade the board to agree, is looking at health outcomes, reporting to government and fostering public-private sector partnerships. That's an expansion of what the government has set out in even its regulatory terms of reference. Would you basically agree

that those are the further purposes, beyond patient care, of this database?

Dr Orovan: First and foremost, the issue is patient care and excellence in patient care, so I would set that aside and say that's a given, we have to do that. If, after that, there are other things we can do with the data to which patients consent that can be useful in providing better health care services to Ontarians, I'd be interested in hearing those proposals and thinking about that. Whether that might entail a better means of managing demand, looking to where there is need for certain technology or certain services that aren't being met, I think that sort of database could assist us in making those decisions.

If there are other issues around outcomes that could be gleaned from that—the government, not only this government but previous governments, have spent a lot of money on the Institute for Clinical Evaluative Sciences and they use this kind of data, available in relatively fragmented form at the moment, to make those kinds of assessments on outcome information and they've published some excellent studies. If we can improve that without compromising patient confidentiality, I would be in favour of that. But the public-private partnership thing, I don't have a feeling of how this data would enable that. It's not that I'm opposed to public-private partnerships, but I don't see this data source as enabling in that regard.

Mrs McLeod: You anticipated my next question; nor do I, and I was curious to know how you might see the data fostering public-private sector partnerships.

Would you comment, then, on the reporting-to-government aspects of the use of the data? How would you see reporting to government and in what form would the information be needed in order to report adequately to government?

Dr Orovan: Again, I think the government's interest, as I understand it, is that they'd have a yearly report from our board about the progress of integrating patient care data into our system. I don't think it's necessary, in my reading of the mandate, at any rate, to report on outcomes or any of the other non-patient-care-related things but simply on our success in building these networks. I think that's a very substantive undertaking in and of itself.

Mr Martin alluded to the number of small networks that are currently available, and there are some huge ones, interestingly, within some of our major teaching hospitals, which are host hospitals for Cancer Care Ontario. These are like silos. They can't speak to each other, they can't access data one from the other, and we would make a huge contribution if we simply concentrated on integrating all of these small disparate data sets and brought them into an integrated whole where providers, again on a need-to-know basis, could access them. So I think that's a huge task in and of itself and the one that I see is the major mandate of this. If there are other issues out of that that the government wishes us to address or that we see are important from a public interest perspective, we'll certainly be willing to listen to that and to proposals in that regard.

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Mrs McLeod: How do you deal with the concern of physicians around the management of their own patients' records? You'll notice I said "their own patients' records." I think the records belong to the patient, but the physician feels he is the custodian of that information.

Dr Orovan: Physicians tend to be a proprietary lot, I wouldn't deny that, but the fact of the matter is that over 90% of patient care data are generated in or on the order of a family doctor. Historically, the most complete data set has been that data set kept usually in hard copy, but now increasingly electronically within small data sets. So I think many physicians are showing willingness to do that by subscribing to the current networks, making those data more readily available. They can see the benefits to themselves when they're on call for other physicians and they can certainly see the benefit to patients. Change is never easy and change for physicians maybe is more difficult than for some others, but I think they'll embrace it.

Mrs McLeod: I don't want to misquote you. I'll have to go back and read the record, but I think you've indicated that you see a purpose to a central database and I'm fairly convinced that's what the government is looking at, given the set-up they're creating with the agency. Do you think a central database needs to be identifiable patient information or would you see a central database as consisting of de-identified health information? You don't use the material in your central database for patient management. If you're talking about patient management, you're talking about the local network having access to that information. So when we get to the central database, we're talking about outcomes and about reporting to government. I don't know what private-public partnerships are in this context, but why would you need identified patient information? Would you say, as an incoming director with considerable experience in this, that we're talking about de-identified patient information in the central database?

Dr Orovan: I think when we're talking about health care outcomes or system management issues, there is very little need for identifiable patient data. Again, I wouldn't want to make that a blanket statement. I'm sure someone from ICES would come along and point out to me the error of my ways, and I would be willing to listen to that, but as a general principle, identifiable patient data ought to be used for patient care issues. Whether it's in a central database or several peripheral databases, it can be agglomerated or accessed centrally. I don't have strong opinions about it as long as confidentiality can be maintained. But on systems management issues, I think there are few reasons to have identifiable information.

Mrs McLeod: If the participation is to be voluntary—obviously my concern is that all of this is coming in advance of our having health privacy legislation. If we had that legislation, it would either answer the questions, satisfy our concerns or give us cause to be pursuing this with very real concern. The issues around the last draft of the privacy legislation were certainly around the central

database, around whether or not there should be a lockbox on that information. How knowledgeable and how broad is the consent the patient gives when they give voluntary consent to have their information used? My belief, and it's purely intuitive, is that a patient is saying to the trusted physician or to their caregiver in the primary care centre, "We trust you to share this with the people who are going to look after us." How do you have voluntary consent apply if you're going to use it for outcome measures? You have to have universal participation.

Dr Orovan: Two issues: first of all, I think this consent issue and the privacy issue is an interim process. We've been working and beavering away at that in Ontario for some years, and they have in other provinces as well. I don't think we'll ever reach a point where we're totally comfortable with that issue, but I think there are significant benefits to be achieved on the patient care and quality-of-care side by cautiously moving forward.

In terms of patient consent, the consents are quite explicit. As a matter of fact, it caused my own spouse to change her family doctor, because she wasn't willing to get involved in that. We'll see patients and physicians who will vote with their feet on this. You asked me earlier about the potential response of physicians. I think it will be positive. If the agency builds confidence in patients that this will be protected, I think there are real benefits to patients in participating in OFHN, the Ontario Family Health Network, and in this process, and I think they'll agree. But they do have to give explicit consent. The consent forms very clearly state that this could be used on an anonymized basis for research and outcomes, and those things have caused some patients some anxiety.

Mrs McLeod: But not reporting to government necessarily. Thank you.

The Chair: We now move to the third party.

Mr Martin: Do I need to read anything at all into the fact that both of you come from or have been connected in some way with St Joseph's Hospital in Hamilton?

Dr Orovan: Only that it's a technologically advanced method of patient care.

Mr Martin: You're not imposing something that's come out of there on the rest of the province.

Dr Orovan: If we are, I'm unaware of it.

Mr Martin: There's not a conspiracy of some sort happening here. OK.

Dr Orovan: A few conspiracies have arisen in Hamilton and I don't think this is one of them.

Mr Martin: You were here when I was asking questions of Mr Greve around the issue of control and the concern I have when you look at this government and its propensity to take more and more control, particularly when problems begin to happen. We've seen agencies taken over in Hamilton—the school board. There certainly is the provision in the regulation to do that. Need we be concerned, from your perspective, about that?

Dr Orovan: As I mentioned a few moments ago, ours is a public interest board and I personally take that charge very seriously. I can't speak to government actions or government intent in that regard. I would simply say that any time one speaks about information management, the issue of control is a shadow in the background. We have to assure, and as I said in response to earlier questions, build patient confidence that the confidentiality of their data, of their information, would be protected, while at the same time making it available to doctors, nurses and others to improve their health care. We sometimes have to take some risks in moving forward in order to achieve quality outcomes and quality care benefits. Perhaps that's one of the issues and it's up to us to do our due diligence to ensure that confidentiality and management of patients are the primary goal.

Mr Martin: There is an issue here in the province at the moment, though, about control of a number of systems. I mentioned earlier the Family Responsibility Office that was virtually folded up and placed in Toronto for decision-making and information-gathering. It has become a disaster for the whole province. Nobody can access it any more and nobody is happy with it.

We have a health care system out there that's struggling to find its feet in this, identified, as I said earlier, as the community care access centres that many of us have some real concerns about. It seems the move in health care is to a more, "Take your car in and get the muffler fixed" approach, as I said before, as opposed to a more holistic approach, and there's a move to public-private partnerships. The previous appointee in his resumé speaks about providing information to groups on outcome-oriented partnerships between the private and public sectors. I note in your resumé your affiliation with the C.D. Howe Institute. Is this indicating to us something happening here that we need to be concerned about?

Dr Orovan: You made several points. Maybe I could address a couple of them before I address the last one.

You mentioned the fragmentation of care, and there's no question that happens. As doctors can do more and more, they tend to concentrate on areas that are more and more technologically focused and less and less patient-focused. But part of that problem is that you tend to accumulate information on patients in only one small area. I think the accessibility and availability of a broader database, an integrated database, will work toward better overall patient care than the kind of segmentation you've talked about. So I see this as an opportunity to reintegrate care rather than to disintegrate it.

On the basis of the intent, I can't speak to that. My own view is that if a public-private partnership came forward with a compelling argument about how the database in an anonymized form could be used to improve overall quality of care for patients in Ontario, I would listen. I think any patient interest board of any agency should listen. That doesn't presuppose that we would co-operate or would not co-operate, but if there are issues there that can better patient care, we all better listen, because what we're doing now isn't good enough.

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Mr Martin: That causes me some concern, particularly when you consider the effort that a whole lot of

people are putting in out there to try to organize, in local regions, this family health network or, in Sault Ste Marie, the Group Health Centre, where the primary focus is the delivery of care and a continuum of health promotion, prevention and then after-care. We might be, in this instance, with the use of the new technologies that are available and the appointment of people such as yourself, moving to a system that is driven by public-private partnerships that's more about efficiency and cost savings and those kinds of things than the actual delivery of health care.

Dr Orovan: I think just the reverse. I think the doctors and those who participate in the Sault Ste Marie clinic or in the Peterborough clinic or in several other similar venues should be thrilled by this. We're talking about expanding that concept across the province. The only difference is that we're not talking about putting it in one bricks-and-mortar structure, we're talking about creating virtual clinics and virtual networks that can integrate all of the providers. They don't have to cancel their leases. They don't have to move into a common employment situation. They can continue to practise the way they choose, but they can be integrated into teams to provide better patient care.

Again, I see this as an additive to the kind of organizations that are set up in places like the Sault Ste Marie clinic rather than the obverse. Is Algoma Clinic the correct name?

Mr Martin: The Group Health Centre. I just have to tell you that I'm still not comfortable and convinced that this isn't an attempt by the government—given, as you have indicated, that information, where control is concerned, is absolutely central, and that's what you will be gathering here. We do have already in the health care system some very powerful groups, such as the OMA, which you belonged to and participated in at one point, the OHA and the ministry itself.

This could present, to somebody who was concerned about it, a fairly overt attempt by the government to get the information now that they need to actually take control. The provision in the act that I read earlier—the appointment of a powerful temporary administrator who may assume control over the agency at the minister's discretion—which gives the ministry, then, ultimate control, may in fact happen. We may see ourselves heading down a road that we don't want to go down, particularly given the very important debate that's happening across the country right now with the Kirby report and, soon to be delivered, the Romanow report, and where it is that we need to be going where health care is concerned.

Dr Orovan: I would simply say my name is Orovan, not Orwell. I'm not interested in that kind of centralized control. Call us back here in a year or two years or read our annual reports to the government, and I think you'll find that we've made significant progress.

The reference to Senator Kirby: that was one of the main tenets of Senator Kirby's interim report and his final report, that we need to reorganize primary health care delivery, and one of the important aspects of that is information technology and information management. I suspect, although one hesitates to predict what Mr Romanow may say next month, that he will say the same thing. This is a method, an important component of that reorganization and that improvement in primary health care services delivery.

Mr Martin: Thank you.

The Chair: That does complete your time, in any event. We now move to the government caucus.

Mr Wood: If an electronic information processing system were to be developed to your satisfaction, what sort of cost savings do you think you might see in terms of the processing of information? Have you given any thought to that? By cost savings, I'm thinking in terms of 5% saving, 50% saving. I'm not looking for a dollar number.

Dr Orovan: Probably between the two: more than 5% and less than 50%. One of the problems is that we just simply don't know. We have some access to survey data. We have some studies done by ICES that I referenced earlier that suggest there is a moderate amount of duplication within the system now in terms of diagnostic testing, both laboratory testing and diagnostic imaging. We really don't know how much.

We know as well that there are delays associated with gaining access to care that have costs associated with worsened outcomes, but we have no way of quantifying that, and some of the discussion around utilization of anonymized portions of this database to assess outcomes information and accessibility information may give us an answer to that question. I think at this point one of the most difficult things in all of this is that we spend in this province in the neighbourhood of $23 billion or $24 billion on health care annually and we have very little idea about what we get out of it.

Mr Wood: If we were to do what I think is probably needed with respect to health privacy legislation in the health area, how long do you think it might be before we would have a functioning electronic information processing system in health?

Dr Orovan: We have the beginnings of it now. Some people have developed it in isolated environments. We have the Ontario Family Health Network now; I think at last report about 65 or so doctors signed up. The government set an optimistic target of 80% of integrated family practices by 2004. This will not be easy in the beginning. There are confidence issues both for doctors and for patients, but I do think if we do this right, and that includes the primary care reform issues that are already in place in this adjunct, that physicians will come on board. I would hope that within a reasonable time, of the order of five years, we could have a significant integrated information system of the kind this agency contemplates.

Mr Wood: Setting aside the question of participation, would the five-year time estimate apply to having a functioning system regardless of how many may end up participating in it? Would you think it would take that long to get a functioning system?

Dr Orovan: I haven't discussed this with the chair, who is probably boring into my back at the moment, but I think that's a reasonable sort of time frame.

Mr Beaubien: Dr Orovan, you mentioned that change is difficult to embrace at times. For some medical practitioners, I think it's probably—

Dr Orovan: Everybody.

Mr Beaubien: I think for everybody. You talk about the linking of physicians through e-health. Sometimes I wonder whether we try to solve all our problems using computer and information technology. I do agree that there is an awful lot of merit with regard to telehealth and telediagnostics, especially for remote northern and rural areas that can benefit, and I come from a rural area.

The concern that I have when you're talking about linking of physicians through information technology or whatever you want to call it, is, in Ontario we've got a plethora of different delivery systems: we've got the single family physician working in remote areas or in large urban centres; we've got the family health network; we have community health care centres. As a director of this organization, how do you see the process proceeding into the future? You mentioned a period of five years because you said it's not going to be easy to get the program going. But as a director, what would be your vision, especially when we have, again, a mix of medical practitioners? I'm sure the younger ones would be more receptive to embark on this program as opposed to the people who may have blond hair like I have and may be a little more set in their ways. What's your vision on this?

Dr Orovan: In my capacity with the Ontario Medical Association, I always maintained vigorously that this ought to be a voluntary process, both for physicians and for patients. That's why I think it's so important, and I've stressed this several times in my responses, that we build confidence among both of those groups. That's not to exclude the other providers either, because there's a spectrum of opinion among nurses, for instance, on how they should be integrated into the system. As you know, this government has reacted recently in terms of nurse practitioners and created opportunities for them to be in independent practice. That's a little bit counter-productive to the direction that this initiative is going.

And you're right, there will be doctors, practitioners, who will never embrace this, no matter what the benefits. Those who are getting close to retirement will simply not see the benefit in investing time or resources in doing it. There are some who will protect their right to individual practice to the bitter end. But I think with the changing demographics within the medical profession that you alluded to, we'll see an increased willingness in the years to come to embrace this kind of team approach. Frankly, medical schools have to do better than we have done in the past in admitting physicians at least in part on the basis of their willingness to work in teams. As an acting dean, I can tell you that it was never a big thing, in terms of medical school admission criteria, whether or not you were likely to be a good team player. We have to change that. We need to look to skill sets within providers that fit more readily into the kind of environment that we foresee in five or 10 years.

So this agency board has a significant task ahead of it. It's only one of the components of this complex change that we're trying to promote, but it's an important one.

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Mr Beaubien: I think it has an awful lot of merit, but you pointed out that you do have some concerns with regard to some of the cultures that exist in the system. I think that's going to be a major challenge. Sometimes I wonder—you mentioned five years. Hopefully you're right. I'm not going to say whether you're Dr Orovan or Dr Orwell, but we'll leave it at that.

The Chair: Thank you very much for being with us, Dr Orovan. You may step down.

Mr Johnson: Is our time up?

The Chair: If you want to ask questions, I'll not see the clock.

Mr Johnson: Mine was a little bit of maybe asking a question, but of suggesting what I expect will be the outcome as well. I'm not part of the medical profession, and yet I have some expectations.

I can remember a few years ago suggesting—for instance, when a sick patient was discharged from the hospital, they were wheeled up to the exit door of the hospital and got into a car or an ambulance or whatever to take home. Then home care would take over. So the nurse would, as soon as the person got home, go in the house and first of all had to start with, "What's your name and address and why have you been in the hospital?" It seemed ludicrous to me at the time that the nurse at the hospital couldn't get in the car, fill in the report on the way home, go in, and whoever then came into the house could start the process seamlessly. So I guess that's one of my expectations, that the silos or however you want to describe it, the barrier between the hospital and home care, has to go.

The other comment I wanted to make was about the expectation of people. A couple of years ago I had angina. I lived in Listowel, by the way, and our medical clinic with doctors is right across the street from the hospital. They are computerized now, so that if I went into the hospital for an X-ray, the doctor could sit in his office and say, "The X-ray is all right; his blood pressure is all right. Send him home." Because I had this pain in my chest a few years ago, I went to the hospital here in Toronto because I was in Toronto when it happened. It isn't any good that that file sits in the doctor's office in Listowel and the specialist down here doesn't have access to it. With respect to the central database and everything, I don't care whether it's centralized. It has to be accessible to those who need it.

There's one other thing, Doctor, that I wanted to express. I come from an area very close to quite a community of Mennonites. I remember the VON nurse telling me about the first time that she established a pain pump in a Mennonite's home, on home care, and had to set it up to work on a 12-volt battery because they don't have electricity.

I guess I would like you to consider those three concerns and think about when you're establishing the criteria for information, because all of those expectations on my part are there for the solutions that you and your group will have to contemplate over the next few years.

Dr Orovan: I completely agree. You've documented one barrier, that between acute care institutions and home care. Certainly that's right, but there are similar barriers between acute care institutions and chronic care institutions, and private practitioners and chronic and acute care. So we have to look at all of those issues. That's why I'm personally excited about this initiative as allowing us an opportunity to break those down.

The accessibility is absolutely right, that not only should your doctor in Toronto have access to the information, but it ought to be in a usable form. That is to say, he or she ought to be able to access in digital form the X-rays that were taken or to be able to see the EKG tracing and not just read the report. So we have to make sure that we build a base that allows that to happen. I think there are tremendous possibilities here, none of them without some risk. We need to ensure that we gain the benefit at the least possible risk.

The Vice-Chair: Mr Mazzilli, I understand that you have a quick question you want to ask. We're running out of time.

Mr Mazzilli: A very quick question. I know that people talk about the savings, but this is all about better care and a more functional system for all the providers.

The one thing that does worry me when we talk about integration, whether it's silos or professions, is that as soon as you try to integrate everybody—probably 90% of the system can be integrated with very few providers, very few silos, and then you go broke trying to integrate the other 10%. I've seen it in other initiatives and that's what worries me about this initiative. People will be coming to you and saying, "Can we integrate this part of the system or that part of the system?" What I'd like to see is that it doesn't become a runaway train that becomes dysfunctional. It's like spending 90% of your money going after 10% of the business. Do you have any concerns in that regard?

Dr Orovan: I think you're absolutely right. It's probably the 80-20 or 90-10 rule, that we can achieve 90% of the benefit by involving 10% of the providers. Without being disrespectful or provocative—is it necessary that every naturopath has access to this and that we spend a whole lot of money integrating that? Probably not.

Mr Mazzilli: I've seen projects that likely will be cancelled because they try to integrate the 10% rule—

Dr Orovan: I think we understand the importance of the basic data set. The previous witness mentioned the emergency record. That's a pretty easy one to start with. I think we can move forward in a way, as I said in response to an earlier question, that maximizes the benefit at minimum risk and cost.

Mr Mazzilli: That's my only question and caution.

The Vice-Chair: Thank you very much, Dr Orovan. Thanks to all three parties for the questions.

We will now move to concurrence of the reviews that were done today.

Mr Wood: I move concurrence of you, Mr Slomke.

The Vice-Chair: Mr Wood moves concurrence of Mr Slomke, intended appointee as member of the council of the College of Dental Technologists of Ontario. Is there any discussion? All those in favour? None opposed.

I will now remove myself from the chair and allow Mr Bradley to come back into the chair. We're on the second appointment, Mr Bradley.

The Chair: Thank you very much.

Mr Wood: I move concurrence for you, Dr Greve.

The Chair: Concurrence has been moved re Mr Greve. Any comment?

Mrs McLeod: I won't be lengthy. I do think it's important to make note of the fact that while we will not be supporting these two appointments, it is not related to the qualifications of the individuals but is related to our very real concern about the way in which the agency is being established.

We certainly believe that there have to be smart systems for health and that those can lead to better patient care and better coordination and integration, but we have very real concerns about the government having, by regulation, established an agency which is in fact, as it is set out, to establish a central database. On that basis, we have to express our concerns with anybody being appointed to the agency at this point in time, given the privacy commissioner's very real concerns about the establishment of any central database for reporting.

It has been indicated by Mr Greve today that that is one of the goals he would bring to the agency: reporting to government and using a central database for that purpose. That is very much against what the privacy commissioner has recommended. In the absence of privacy legislation, we don't have answers to the questions we have.

We really do believe that the issue of trust Dr Orovan spoke about has not been established by the government. I'd just lastly say that the issue of trust becomes a concern. When I read the regulations, that you have to know exist before you go and look at them, in section 8 of the regulations it gives the minister the power to make binding policy directives for this agency. No matter how well-intended the directors may be, if the government's intention is to get hold of personal health information under the regulations establishing this agency, the minister can do exactly that. Given this government's history, given the concerns around health privacy, we just simply in good conscience cannot support appointments to an agency at this point in time.

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Mr Bradley: Any further comment?

Mr Wood: All I'd say in response to that is this committee has a mandate to review the functioning of any of the agencies. If anyone is concerned about how an agency is functioning or unfolding, they should bring before this committee the possibility of reviewing the agency. I think there are avenues available to find out the

information that people want and make recommendations where they think it's appropriate.

1140

The Chair: Thank you for that suggestion, Mr Wood. That's a very good suggestion. Members of this committee have to dwell on that fact from time to time. We do have an opportunity to try to call agencies before us and deal with them. I think your suggestion is a good one. Any further comment?

I'll call the vote. All in favour? Opposed? Carried.

Mr Wood: I move concurrence re Dr Orovan.

The Chair: Concurrence has been moved re Dr Orovan. Any comment? If not, I'll call the vote. All in favour? Opposed? Carried.

We have now completed our appointments review section.

Mr Mazzilli: Just for the record, I'm somewhat confused, because I heard from the official opposition that they were not disputing the doctor's qualifications, yet they voted against him. So I suspect there would be some kind of dispute. Just a clarification, because you say one thing and you vote a different way.

The Chair: Does anybody want to respond to that?

Mr Michael Gravelle (Thunder Bay-Superior North): I'm sure Mrs McLeod would want to respond to that. You made it very clear, I thought.

Mrs McLeod: I thought I made it quite clear that we couldn't support the appointment of any directors, no matter how qualified, to this agency because we can't support the appointment of the agency at this point in time in the way the government is establishing it.

Mr Mazzilli: That really clarifies it, Mr Chair. I have no other questions.

The Chair: I think that is clear for everybody.

COMMITTEE BUSINESS

The Chair: We now move to the Sudbury Community Care Access Centre agency review committee briefing.

Mr Gravelle: I think, as all members here know, we were hoping to move forward with the review of the Sudbury CCAC and begin with a briefing today, but I've had an opportunity to speak to Mr Martin and Mr Wood, and two of the people that Mr Martin and I both wanted to call forward for part of the agency review are not available. One of them actually declined, and that's an interesting issue all on its own in terms of appearing, but one person we very much wanted to appear is not available until January.

Certainly, Mr Martin and I are very keen to move forward on this, and perhaps move forward in sort of one piece, and it seems to me, in that we are very keen to do this, that it would make some sense to recommend, and I could do it by way of motion, that we delay the review of the Sudbury CCAC until the intersession if we cannot get those people to appear before us.

My understanding from speaking to Mr Wood is that it would be difficult for him to agree to that immediately, because there needs to be a resolution of the House in terms of us sitting during the intersession. But I am working on the presumption that indeed we will be able to meet. Again, it's a presumption, and I appreciate that Mr Wood has to do some work. But I would like to move that we defer the review of the Sudbury CCAC until the witness and/or witnesses are available, which is in January, and I ask that we defer this until the intersession between Christmas and March.

The Chair: Any comment?

Mr Wood: If I might, Mr Gravelle was kind enough to let me know that he was going to present this motion. I'd like a little time to digest it and discuss it with the other government members on the committee, so I'm going to propose that this particular motion be deferred one week for consideration.

However, we are going to have to give the committee staff some direction as to whether or not we are proceeding. So maybe what we have to do is decide today for the next few weeks. If we're not going to deal with the CCAC for the next few weeks, I think we've got to let our committee staff know today. I'd like to suggest, number one, that the motion be deferred a week for the reasons I just outlined, but having said that, I think we have to give some clear direction over the next few weeks to the staff as to whether or not we're going to be taking time to do the CCAC review. If we aren't, they can of course plug in intended appointees.

Mr Martin: It's certainly my strong feeling that we want to proceed. We've run into a bit of an obstacle at the moment in terms of some of the witnesses, one of them in particular, who can only appear in January. I agree with Mr Gravelle that it would be better, instead of breaking it up over a two- or three-month period, that we do it all in one day, for example, perhaps in January during the intersession. I certainly have no difficulty from our caucus getting agreement from the House leader to have that happen.

I would agree that for the next couple of weeks we can move forward with the consideration of appointments. It's not our intention to do this review until we're able to get down here at least the one witness who has agreed to come, but can't come until January, so that we can talk to him and do it in the context of the overall review.

Mr Wood: I'm wondering if we should indicate that we wish one week from today to be used solely for intended appointees, perhaps the two-week slot after that to be used only for intended appointees, and leave the time after that open to further consideration. In other words, I'm suggesting we give direction to the staff that the next two meetings are to deal with intended appointees and not the CCAC. After that, the question is open for further consideration and decision.

The Chair: That sounds like a motion to me.

Mr Wood: If that seems to be well received, I'll move—

The Chair: I'll find out if it's well received. Perhaps instead of an informal discussion, I'll get you to make a formal motion.

Mr Johnson: As a point of order, Mr Chair, I think there's a motion on the floor.

Mr Wood: I'd like to move that motion be deferred for one week, the consideration be deferred one week.

Mr Gravelle: I don't mean to talk in motions. I think that's fine and I think Mr Martin would agree it's fine too, as long as there's an understanding, Mr Wood. Obviously, one of the concerns you expressed last week was whether or not we would be using up time in our weekly sessions in terms of the CCAC review, which would not give us the ability to handle appointments.

I agree with Mr Martin in saying that if we are able to defer this and we are sitting during the intersession, this would allow us to do the review in one day. We've sat in intersessions before; we've sat throughout the day; we've gone from 10 in the morning to late in the afternoon. That would give us an ability to do the entire process in one day, which hopefully would be helpful. I guess I want some sense from you that indeed it is your intention, with agreement from the people who make these decisions, to let us work on the presumption that this will go forward during the intersession.

Mr Wood: No. All I'm saying is I want a chance to think about this, digest it, discuss it with the other members. I'm giving no indication one way or the other because I haven't come to any conclusion as to what my position might be. I want a week to consult and consider.

Mr Gravelle: But if we sat during the intersession?

Mr Wood: I understand that's the request. I'm sharing with you that I've come to no conclusion one way or the other. I don't want you to think I'm agreeing to anything in principle, because I'm not, nor am I disagreeing with anything. I'm requesting time to give careful—this being a deliberative body, I like to deliberate from time to time, as I know all the members do. Some of us are faster than others.

Mr Gravelle: Certainly I agree to have my motion deferred for a week. I'm here to vote on that, I suppose.

The Chair: Any further discussion?

Mr Mazzilli: Just a small comment. I know Mr Gravelle said that people are declining to come from Sudbury. I'm wondering if it's the new funding that they've received, the increased funding that's made the CCAC a better place that serves the community. That might be the reason people no longer have a reason to come before this committee.

The Chair: It was an excellent question. I wonder whether people have the right to decline to come before the committee, or whether the committee has subpoena power.

Mr Wood: I think we have the right to issue a Speaker's warrant. Whether we would do that, of course, would be a matter of discussion by us, and then by the House itself. I don't think the committee has the power to do that, I think the House has to do it, do they not?

1150

The Chair: Yes. As a Chair, as a member of this committee, it concerns me when anybody refuses to come before the committee. It helps our work, I think, when people will come before the committee, no matter what they say. They may say what some on the committee want to hear; they may say what others on the committee don't want to hear. I accept that. I just worry, as committee members, when we ask people to come before the committee and they refuse to do so. That concerns me. It limits the work we can do when people refuse to come before the committee. Any comment on that?

Mr Wood: My criteria on that might be a little narrower than yours. I think there are circumstances where a Speaker's warrant might be justified. If it's a matter of general policy advice, if someone really doesn't want to offer their opinions, I'm not very big on the idea of forcing them to do so. On the other hand, if there's information relating to a particular matter, there may be cases where we have to issue a Speaker's warrant. So my criteria might be narrower, but I think I'd agree there are circumstances where it may be necessary to compel testimony.

Mr Gravelle: It concerns me as well, but I would like to think we can discuss this in a week's time. I'm going to do whatever I can to try and perhaps speak to some other people involved and try and bring some other names forward. I think what we want to do is have peace. Mr Martin, I agree. It's very important that we do it.

Just to comment on Mr Mazzilli's comments, I suppose that's a possibility. The other one is that they're kind of afraid to come forward because they might be punished for speaking up publicly about some areas that they wouldn't like. So we need to find out.

Mr Mazzilli: When they hear you're considering issuing a Speaker's warrant to compel them to come before you, I would suggest that at that point, if I heard that, it would make me very nervous. When we talk about how people feel intimidated and threatened, there are many ways, Mr Gravelle. We chose to review these agencies. They were your picks. I would have suspected that they could hardly wait to get here. That's certainly not what we're finding. I leave it before the committee to go further on the matter.

The Chair: As legislators, putting aside our partisan hats, I think we worry, I can't speak for all, but there's always a concern that people would feel intimidated in any direction about appearing before a committee. Let's speak generically, not about a specific government. Over the years, in various Legislatures and parliamentary bodies, some people have felt that governments of the day, whatever they happen to be, exert some pressure on people not to express contrary views. There may be other, as you mentioned—

Mr Mazzilli: Or supportive views.

The Chair: Yes, there may be other circumstances. So it concerns me. I think the best thing for a committee is to have as many people appear as possible, express their views frankly and freely, so that our committee can do our job well.

Anyway, we're diverting a bit from Mr Wood's motion. But Mr Martin has a comment as to Wood's motion.

Mr Martin: In response to Mr Mazzilli's comment, the person we were hoping to bring before this committee

has been before committee before. He's a person who has, for very legitimate reasons, challenged a directive coming from the top in terms of how we deliver health care in this province on another occasion and found himself out of a job. In this instance, the very same thing happened. Acting on behalf of the constituents he serves—that this isn't going to work, that this isn't in their best interest—he found himself out of a job.

If you want to talk about intimidation, there's nothing more intimidating than actually participating in a public process, justifying that after you've done that, and depending on what you've said, you've lost your ability to support yourself and your family. That's the kind of intimidation that affects people, I would suggest, most directly. He came down and participated in a discussion on another agency, and the fact there is that even with the best of intentions, and the tremendous deputation here, it didn't make any difference. So it might be that the other thing is that he says, "What the hell's the point coming and talking to these folks and exposing yourself and making the effort when you know that in the long run it ain't going to make any difference with these guys anyway?"

We've seen, just looking at the appointments that have been made to community care access centres, on February 16 of this year there were literally well over 100 new appointments made to community care access centres right across the province. That means that for every appointment there was a disappointment, there was somebody turfed, somebody kicked out, somebody removed from this position of serving the public, and somebody else put in their place. We have chairs who have been appointed, we have members who have been appointed, and executive directors who have been appointed following the legislation that this government brought in before Christmas of last year that was likened by many of us to a hostile takeover of community care access centres.

There is a lot of fear and anxiety and sense of intimidation around this, and what's going to happen to you if you have the intestinal fortitude to come forward and to speak up. So it's not just a question of, you know, "Well, Sudbury got a lot of money." I suggest they probably didn't get much money and in fact the only reason that they're working within their budget any more is because they've been told to do so. New appointments have been made, both to the position of chair and to the executive director of that agency and told to follow suit, to do what they're told. It's the same in probably every community care access centre across this province, which we'll get into when we review those centres. But to suggest for a second that these people aren't coming forward because all of a sudden the situation in Sudbury has turned around and everybody's getting everything they need is just not where it's at.

Mr Mazzilli: I certainly want to touch upon appointments, whether it's CCAC or others, whether they're volunteer boards or paid boards. I mean, the one thing we hear continually is, someone was disappointed. These are not positions for life; they're an opportunity for members to serve their community either in a volunteer capacity or a paid capacity. So when I hear from members that this one person was disappointed after 10 years—

Mr Martin: If it was one person, it would be fine, Frank, but it's not. We're talking probably well over 100 people and all of a sudden one day in this province—

Mr Mazzilli: There have been people appointed to boards for the last 10 years. If they're paid jobs, they were never intended to be full-time-for-life jobs, and if they're volunteer positions you certainly want people in the community to get an opportunity to serve on those boards. You don't appoint someone and leave them there forever. So whether it's three years or six years, at some point you've got to give someone else a different opportunity to serve.

We can argue all day long. Perhaps things are a little bit better in Sudbury. That's all I suggested.

Mr Wood: We have a motion to—

The Chair: We have a motion, Mr Wood. Thank you for calling that to our attention again. All in favour of the motion?

Mr Johnson: Could I have that motion repeated? I've forgotten just what it is.

Mr Wood: I move that consideration of Mr Gravelle's motion be deferred one week.

The Chair: All in favour? The motion is carried unanimously.

Mr Wood: I will place another motion: that we indicate to staff that the next two meetings of the committee are to deal only with intended appointees and that the committee will give further direction as to the agenda for meetings after that.

The Chair: Any discussion? If not, I'll put the motion. All in favour? Opposed? The motion is carried.

Any other business for the committee?

Mr Wood: I move adjournment of the committee.

The Chair: Mr Wood has moved adjournment of the committee. All in favour? Opposed? The motion is carried.

The committee adjourned at 1159.

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Mr Wayne Wettlaufer (Kitchener Centre / -Centre PC)
Mr Bob Wood (London West / -Ouest PC)

Substitutions / Membres remplaçants
Mr Marcel Beaubien (Lambton-Kent-Middlesex PC)
Mr Jean-Marc Lalonde (Glengarry-Prescott-Russell L)

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Mrs Lyn McLeod (Thunder Bay-Atikokan L)

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