



# **Proposed Amendment No 6 to the Health Information Privacy Code 1994**

## **Information Paper**

April 2007

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# **Proposed Amendment No 6 to the Health Information Privacy Code 1994 Information Paper**

## **Introduction**

This paper provides the background to decisions made in presenting these proposed amendments (Amendment No. 6) to the Health Information Privacy Code 1994 (HIPC). It also draws out the reasoning behind the more significant changes.

The Privacy Commissioner announced her intention to amend the HIPC in 2005. A range of possible amendments were considered.<sup>1</sup> Some of the amendments raised pressing issues, such as items 8 and 13 (on pages 9 and 16 of this paper, respectively), while the remainder were of a technical nature.

It was considered that a number of possible changes were better addressed as additions to the explanatory Commentary on the HIPC, rather than in the HIPC itself. These were put aside for later attention. The Commentary to the HIPC is currently scheduled to be revised in late 2007.

The current HIPC in full can be found at <http://www.privacy.org.nz/privacy-act/health-information-privacy-code>.

The proposed amendments can be found on the Privacy Commissioner's website at [www.privacy.org.nz](http://www.privacy.org.nz).

As some of the proposed amendments relate to the National Health Index (NHI) number, a research report on the NHI has been prepared as background to this paper, and can also be found on the Commissioner's website.

Preliminary discussions were held with a variety of stakeholders in relation to the more significant amendments. Those discussions have been extremely useful and have informed our decision making to date.

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<sup>1</sup> The assistance of the Ministry of Health in collating suggestions for change from the health and disability sector is acknowledged.

## **Proposed Amendments to the Health Information Privacy Code**

### **1. Clause 3(1): Definition of 'Health or Disability Services'**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

'Health services' and 'disability services' are currently defined in the HIPC the same way as they were in the Health and Disability Services Act 1993:

**disability services** includes goods, services, and facilities:  
(a) provided to people with disabilities for their care or support or to promote their independence; or  
(b) provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the independence of such people;

**health services** includes goods, services, and facilities provided to people for health purposes or provided for related or incidental purposes;

This Act has been repealed and replaced by the New Zealand Public Health and Disability Act 2000, which defines a number of terms, including 'personal health services', 'public health services' and 'disability support services'. The definitions in that Act are as follows:

**disability support services** includes goods, services, and facilities—

(a) provided to people with disabilities for their care or support or to promote their inclusion and participation in society, and independence; or  
(b) provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the inclusion and participation in society, and independence of such people

**health services** means personal health services and public health services

**personal health services** means goods, services, and facilities provided to an individual for the purpose of improving or protecting the health of that individual,

*whether or not they are also provided for another purpose; and includes goods, services, and facilities provided for related or incidental purposes*

**public health services** means goods, services, and facilities provided for the purpose of improving, promoting, or protecting public health or preventing population-wide disease, disability, or injury; and includes—

- (a) regulatory functions relating to health or disability matters; and*
- (b) health protection and health promotion services; and*
- (c) goods, services, and facilities provided for related or incidental functions or purposes*

However, the Commissioner proposes to use the combined definition of 'health or disability services' from section 5(1) of the Health and Disability Services (Safety) Act 2001 as the basis for the proposed amendment to this definition, because of its more comprehensive nature and in the interest of using the definition that most accurately incorporates current practice.

The definition in the Health and Disability Services (Safety) Act 2001 reads:

**5. Health or disability services defined**

*(1) In this Act, health or disability services—*

*(a) means services of any of the following kinds:*

*(i) chiropractic services, dental services, fertility services, geriatric services, gynaecological services, habilitation services, maternity services, medical services, mental health services, obstetric services, osteopathy services, rehabilitation services, physiotherapy services, and surgical services:*

*(ii) collecting, storing, or transporting human tissue or human bodily substances for the purposes of, or in connection with, the provision or prospective provision of health or disability services:*

*(iii) services, provided to people with disabilities or people who are frail (whether because of their age or for some other reason),*

- for their care or support or to promote their independence; and*
- (b) includes services intended to prevent, or lessen the prevalence or severity of, illness or injury; and*
- (c) includes any services within the meaning of the New Zealand Public Health and Disability Act 2000; and*
- (d) includes services intended to enable the detection, the diagnosis, the determination of the nature or extent or prognosis, or the monitoring, of any illness, injury, or other condition, the treatment of which (or the treatment of the effects of which) is or would be providing health or disability services of any kind, for example—*
- (i) biochemical, chemical, cytogenetic, cytological, haematological, histopathological, immunological, microbiological, sensory, or serological analysis, examination, scanning, screening, or testing;*
- (ii) examining, scanning, screening, or testing people using electro-magnetic or ionising radiation, magnetism, or sound; and*
- (e) includes administering the provision of health or disability services.*

As clause 5(1)(c) makes plain, this proposed definition incorporates the definition from the New Zealand Public Health and Disability Act 2000.

## **2. Clause 3(1): Definition of 'Ethics Committee'**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

Ethics committees play an important part in the HIPC. Rules 2, 10 and 11 all have exceptions allowing collection, use and disclosure of information for research purposes.<sup>2</sup> However, these exceptions are all dependent on approval having been given by an ethics committee, where such approval is necessary.

<sup>2</sup> Rule 2(2)(g)(iii), rule 10(1)(e)(iii) and rule 11(2)(c)(iii) Health Information Privacy Code 1994

The proposed amendment adds, in clause (d), a reference to any ethics committee established by or pursuant to any statute. This would include, for example, ethics committees created under section 27 of the Human Assisted Reproductive Technology Act 2004.

### **3. Clause 3(1): Definitions of 'health professional body', 'health registration enactment', 'registered health professional' and 'health practitioner' (also affecting clauses 4(2) and 5)**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

Prior to the passage of the Health Practitioners Competence Assurance Act 2003 (HPCA), registered health professionals were regulated by statutory bodies. Each of these bodies was created by its own Act, for instance:

- Chiropractors Act 1982
- Dental Act 1988
- Dieticians Act 1950
- Medical Practitioners Act 1995
- New Zealand Register of Osteopaths Incorporated Act 1978
- Nurses Act 1977
- Optometrists and Dispensing Opticians Act 1976
- Physiotherapy Act 1949

The amendment proposes to remove from the HIPC the definition of "health registration enactment" as it is no longer necessary. "Health professional body" is given the same meaning as an "authority" under the HPCA. "Registered health professional" is removed from the HIPC and replaced with "health practitioner".

The HPCA created a unified framework for the regulation of health professionals. The advantage of adopting the same definitions of these terms is that the health sector will be able to use common concepts when considering coverage of the two enactments. It will help to improve the clarity of decisions made in relation to health practitioners' personal information.

#### **4. Clause 3(1): Definition of 'hospital'**

*This proposed amendment removes an unnecessary definition and is viewed as technical.*

The definition of hospital in the HIPC currently refers to the Medical Practitioners Act 1995, which has been repealed. The definition in that Act made reference to two other Acts, the Alcoholism and Drug Addiction Act 1966 and the Health and Disability Services (Safety) Act 2001.

It would be possible to use the definitions from these two Acts. However, "hospital" is a word in common usage and the Commissioner therefore proposes to leave it undefined.

#### **5. Clause 4(2)(j): Reference to Accident Insurance Act 1998**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

The Accident Insurance Act 1998 has been replaced by the Injury Prevention, Rehabilitation and Compensation Act 2001 (IPRCA).

The proposed amendment simply reflects this change.

#### **6. Clause 4(2)(la): Reference to district inspectors and deputy district inspectors under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

Section 144 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides for district inspectors and deputy district inspectors to be appointed. The individuals fulfilling these roles will be collecting, using and disclosing health information in much the same way as people appointed to the equivalent roles under the Mental Health (Compulsory Assessment and Treatment) Act 1992.



This proposed amendment provides that they would be considered as health agencies and therefore subject to the HIPC.

## **7. Clause 4(2)(o): Coroners Act 2006**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

Clause 4(2)(o) currently has the effect of defining the Department for Courts as a health agency, but only in respect of documents referred to in section 44(2) of the Coroners Act 1988. There are two ways in which clause 4(2)(o) is outdated.

The first is that the Coroners Act 1988 has been replaced by the Coroners Act 2006, which comes into force on 1 July 2007. The 2006 Act sets out, in section 29(1), a scheme giving the public a degree of access to documents relating to coroners' investigations in a similar way to that in section 44(2) of the 1988 Act.

The second is that the Department for Courts no longer exists and its functions have been taken over by the Ministry of Justice.

This proposed amendment provides that the Ministry of Justice would be considered as a health agency with regard to documents relating to coroners' investigations as set out in section 29(1) of the Coroners Act 2006.

## **8. Clause 5: Rule 11(2)(I): Genetic information**

*This proposed amendment allows health practitioners to disclose genetic information under certain circumstances and is viewed as significant.*

In 2003 the Australian Law Reform Commission (ALRC) issued a report on the protection of genetic information.<sup>3</sup> One of its recommendations was that the Australian Privacy Act should be amended:

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<sup>3</sup> ALRC, *Essentially Yours: The Protection of Human Genetic Information in Australia*, 1996, available at <http://138.25.65.50/au/other/alrc/publications/reports/96/>

*[T]o permit a health professional to disclose genetic information about his or her patient to a genetic relative of that patient where the disclosure is necessary to lessen or prevent a serious threat to an individual's life, health or safety, even where the threat is not imminent.<sup>4</sup>*

An amendment was made to the Australian Privacy Act 1988 in 2006, putting this recommendation into effect.

The proposed amendment to the New Zealand HIPC provides a new exception to the general prohibition on disclosure of personal health information in rule 11 of the HIPC. It is a slightly narrower provision than the Australian model, but has essentially the same effect.

An additional proposed change is adding a definition of "genetic relative" to the HIPC. This definition is identical to that used in the Australian Privacy Act.

*Why is the proposed amendment needed?*

*In some circumstances the disclosure of genetic information can prevent serious health consequences for genetic relatives by allowing the early detection and treatment of inherited genetic disorders. Issues surrounding the disclosure of information to genetic relatives may become increasingly important as further preventive measures become available to mitigate genetic risk.<sup>5</sup>*

Genetic information is different from other types of health information in that information about an individual is, to an extent, also information about his or her family members.

It is possible that a health practitioner might discover information about a patient that has serious implications for his or her patient's family members. Currently, rule 11(2)(d) allows the disclosure of personal health information where necessary to prevent or lessen a serious and imminent threat to someone's life or health. However, it is unlikely that genetic information would ever present a risk that was 'imminent', even if it was indisputably 'serious'.

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<sup>4</sup> ALRC, *Essentially Yours*, Recommendation 21-1

<sup>5</sup> NSW Genetics Service Advisory Committee, *Submission to Australian Law Reform Commission, Submission G094*, January 2002

A disclosure of information about the existence of a relevant genetic condition to a family member would normally require either the consent of the individual concerned,<sup>6</sup> or that the disclosure was one of the purposes for which the information was obtained.<sup>7</sup> The Privacy Commissioner's view is that agencies must be clear about their purpose for holding information and open about what they plan to do with that information. Accordingly, using either of these exceptions would be preferable to having to rely on the genetic information exception in the proposed amendment.<sup>8</sup>

However, the Commissioner recognises practical reality. Sometimes an individual may refuse their consent to disclose. In such a situation the proposed amendment will allow limited disclosure, by a health practitioner, to prevent serious harm to a genetic relative of the individual concerned even where consent to do so has been refused or obtaining consent is not otherwise possible.

#### *Other changes considered to Rule 11(2)(d)*

A possible amendment that was considered, and rejected, by both the ALRC and the Privacy Commissioner was changing 'serious and imminent' in some way to relax the restrictions on disclosure in a more general way. It was determined that this would amount to an unacceptable weakening of the confidentiality of personal health information, particularly if it meant that health information might be less well protected than other types of personal information.

An additional safeguard recommended by the ALRC was that the Australian Federal Privacy Commissioner should be given the ability to approve guidelines for the ethical use of genetic information, to be issued by the National Health and Medical Research Council. This recommendation was implemented in the Australian Privacy Act 1988, as section 95AA(1).

The New Zealand Privacy Commissioner has not chosen to implement a parallel provision in this amendment to the HIPC. However, this should not be taken as indicating that she views the moral and ethical

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<sup>6</sup> Rule 11(1)(b), Health Information Privacy Code 1994

<sup>7</sup> Rule 11(1)(c), Health Information Privacy Code 1994

<sup>8</sup> For instance, see this address by Bruce Slane, former Privacy Commissioner; *Health Information: Some Issues at the Close of the 20<sup>th</sup> Century* <http://www.knowledge-basket.co.nz/privacy/media/endmil.html>

implications of this form of disclosure lightly. The Commissioner would anticipate being consulted on privacy aspects of any ethical guidelines relating to the disclosure of genetic information to family members.

It is important to note that exceptions to the rule 11 prohibition on disclosure are purely discretionary. It is entirely possible that a health professional might choose *not* to disclose health information, for ethical reasons, even though he or she is legally entitled to do so.

The HIPC deals only with privacy matters. It does not aim to dictate the ethical standards to which health professionals have to conform.

#### *Other points to note about rule 11*

The proposed amendment would be placed in rule 11(2) of the HIPC. This is significant because rule 11 of the HIPC deals with anticipated and unanticipated disclosures separately, (in rules 11(1) and 11(2) respectively).

Exceptions in rule 11(1) (anticipated disclosures) do not need the disclosing agency to have sought the permission of the individual concerned before they disclose his or her personal information. For instance, if an individual is a patient in a hospital, basic information about his or her presence, location and condition may be passed on as an anticipated disclosure.<sup>9</sup> Also, if disclosure was one of the purposes for which the health information was obtained, it may be disclosed under rule 11(1). In the interests of openness, individuals should be notified of all anticipated disclosures when their information is collected.

Rule 11(2) deals with unanticipated disclosures. In order to make a disclosure under rule 11(2), the agency must have a reasonable basis for believing that it is not desirable or practicable to obtain the permission of the individual to make the disclosure. The individual does not have a veto right over disclosure of his or her information. However it is important to note that the agency *does* have an obligation to either attempt to obtain permission, or to have a good reason why it did not do so, before making an unanticipated disclosure.

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<sup>9</sup> Rule 11(1)(e), Health Information Privacy Code 1994

For instance, a doctor who was concerned about his or her patient's risk of suicide may disclose without permission if he or she thought seeking the patient's permission to disclose would put the patient at risk. However, the disclosure would have to be to someone who could act to prevent or lessen the potential harm.

Another important point to note about unanticipated disclosures is that only as much information as is necessary to carry out the purpose must be disclosed.<sup>10</sup> Thus, under the proposed amendment, disclosure would only be permissible where some action could be taken by the genetic relative to prevent or lessen the threat to his or her life or health, and the agency had attempted to obtain the individual's permission for the disclosure or had a good reason why it was unable to do so.

## **9. Clause 5: Rule 12(4) Registration number**

*This proposed amendment relaxes a restriction on the use of health practitioner unique identifiers and is viewed as technical.*

Currently, under rule 12(4), health agencies need to notify the Commissioner in writing before they use a practitioner's registration number to identify him or her. In other words, if a hospital wishes to list its doctors by their Medical Council registration number, rule 12(4) of the HIPC requires it to notify the Commissioner in writing.

Few written notifications have been received by the Commissioner, but it is anecdotally apparent (from preliminary discussions) that practitioners' registration numbers are still being used to identify them.

The proposed amendment to rule 12(4) of the HIPC will remove the requirement for written notification.

*Why is this proposed amendment needed?*

The proposed amendment will allow health agencies to use the registration numbers of health practitioners to identify them. This may have the effect of reducing the profusion of identifying numbers and codes health practitioners need to carry out their work.

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<sup>10</sup> Rule 11(3), Health Information Privacy Code 1994

In practice, this amendment will have a minimal effect on the privacy protections for health practitioners, since health agencies can already assign unique identifiers to health practitioners. The aim of the proposed change is to remove a bureaucratic impediment.

*Other points to note about the proposed amendment.*

Creation and implementation of the Health Practitioners Index is a high priority for the Ministry of Health as part of the current New Zealand Health Information Strategy.<sup>11</sup> The Ministry has suggested that a broader modification to rule 12(4) would be appropriate, creating a unique identifier for all health sector workers. However the Commissioner proposes to proceed cautiously, as she would prefer to reserve such broad changes for more fundamental reviews of the HIPC.

#### **10. Clause 6(2)(b): Charging for Magnetic Resonance Imaging (MRI) Scan Photographs**

*This proposed amendment updates the HIPC to accommodate a technological development and is viewed as technical.*

The Privacy Act permits private sector agencies to levy a reasonable charge for providing copies of personal information in response to a request. In recognition of the importance of access by people to their own health information, clause 6 of the HIPC limits the circumstances under which a charge may be levied for access to health information.

Under clause 6(2)(a) a private sector health agency may only charge for information it has already provided within the last 12 months. Under clause 6(2)(b) a private sector health agency may charge for providing a copy of an x-ray, a video recording or a CAT scan photograph, because of the expense of providing this information.

The HIPC makes few references to specific technological devices or developments. Clause 6(2)(b) is a rare exception. Amendments need to be made to accommodate technical change. We understand that the cost of making a copy of an MRI scan photograph is around \$90. By comparison, most medical information can be provided to requesters by relatively inexpensive photocopies.

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<sup>11</sup> The New Zealand Health Information Strategy is available at [http://www.hisac.govt.nz/moh.nsf/Files/healthinformationstrategy/\\$file/healthinformationstrategy.pdf](http://www.hisac.govt.nz/moh.nsf/Files/healthinformationstrategy/$file/healthinformationstrategy.pdf)

Accordingly the Commissioner proposes to add MRI scan photographs to the list of specific medical information storage devices for which a charge may be levied.

### **11. Schedule 1: Communicable Disease Centre**

*This proposed amendment removes an outdated reference and is viewed as technical.*

The Communicable Disease Centre no longer exists, and it is therefore proposed to remove its listing as a specified health agency in Schedule 1.

### **12. Schedule 1: ACC Regulator**

*This proposed amendment aligns the HIPC with related legislation and is viewed as technical.*

The Accident Insurance Act 1998 established the role of the Accident Insurance Regulator. This person was, and to some extent still is, responsible for ensuring that the law and regulations are adhered to in relation to the competitive provision of workplace accident insurance between 1 July 1998 and 1 July 2000.

Since the return to a single public accident insurance scheme (administered by the Accident Compensation Corporation, or ACC) on 1 July 2000, the Regulator's role is greatly reduced. However, the existence of a small number of active claims from 1 July 1998 to 1 July 2000 means that the Regulator is still required to monitor claims and investigate complaints relating to these claims from time to time. Therefore the reference to the Accident Insurance Act 1998 remains in the HIPC.

This amendment simply adds a reference to ACC's current enabling statute, the Injury Prevention, Rehabilitation and Compensation Act 2001.

### **13. Schedule 2: Agencies approved to assign National Health Index number**

*This proposed amendment expands the list of agencies permitted to assign the NHI number and is viewed as significant.*

Nearly every New Zealander has an NHI number assigned to him or her, but public awareness about the scheme is very low.<sup>12</sup> Some stakeholders have expressed concern about the lack of consumer input into the development and operation of the NHI system.

Rule 12 of the HIPC prohibits unique identifiers from being assigned by different agencies. The NHI number is an exception to that prohibition, as rule 12(3) allows agencies to assign the NHI as long as the agency is listed in Schedule 2.

The proposed change to Schedule 2 significantly expands the list of agencies able to assign the NHI number as a unique identifier.

#### *Why is this proposed amendment needed?*

Schedule 2 is out of date, and contains agencies that no longer exist, such as the Health Funding Authority. There is anecdotal mention of agencies that are using the NHI but are not on the Schedule. A common theme from preliminary discussions was that a faster and more responsive method of amending Schedule 2 is necessary. Since 2000, a number of agencies have been requesting that they be added to Schedule 2.

The possibility of simply adding extra groups of practitioners (for instance, optometrists and pharmacists) was considered. However, that would be a more resource intensive option over time. In addition, the proposed change is more closely aligned with the actual structure of the health sector.

The proposed amendments are broad, adding classes of agencies such as Primary Health Organisations, District Health Boards and agencies

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<sup>12</sup> A discussion of the importance of the word 'assign' may be found in this document under the heading "Rule 12: Unique Identifiers".



providing services to the Ministry of Health, District Health Boards and ACC. However, they represent a more accurate response to the current and future nature of the health sector in New Zealand.

As a result of the uncertainty concerning the interpretation of the word "assign", the New Zealand Health Information Service has taken a conservative view that agencies which are not listed on Schedule 2 (as being permitted to assign the NHI) do not have a right of access to it. This can mean that agencies not on Schedule 2 find it harder to receive funding and obtain necessary information from other parts of the health sector.

The New Zealand Health Information Service currently regulates access to the NHI by way of a user agreement. This agreement sets out obligations on agencies accessing the NHI, particularly with regard to the privacy and confidentiality of health information. In order to preserve those privacy safeguards in the user agreement, and as a necessary partner to an agency being listed in Schedule 2 of the HIPC, the Commissioner has confirmed with the Ministry of Health that no changes will be made to the privacy-related areas of the user agreement without consultation with the Commissioner.

A research paper on the NHI has been prepared as a background document to these proposed changes, and may be found at [www.privacy.org.nz](http://www.privacy.org.nz).

## **Possible amendments that were considered and rejected**

The Commissioner has, to date, decided not to proceed further with some of the proposed amendments. Nonetheless, we would welcome your views on these proposals.

### *Rule 11: Disclosure*

As noted above, the Commissioner considered the possibility of an amendment modifying in a more general way the ability for health agencies to disclose information, where necessary, to prevent a serious and imminent threat, for instance by allowing the disclosure of health information to prevent a threat that was serious but not imminent.

However, preliminary discussions with stakeholders indicated that, in general, the current formulation works well and reflects clinical practice. Attempting to make the standards of disclosure for health information less stringent was viewed as problematic by some stakeholders, particularly if it were to result in health information being more readily disclosed than other, less sensitive, forms of personal information.

Another possible amendment that was considered was to allow the disclosure of information about individuals subject to compulsory status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

The HIPC already has a similar provision, rule 11(1)(g), which allows disclosure where:

*The information to be disclosed concerns only the fact that an individual is to be, or has been, released from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the disclosure is to the individual's principal caregiver.*

The Mental Health (Compulsory Assessment and Treatment) Act 1992 allows for people who may be a risk to themselves or others to be placed under compulsory status. That status affects many of their rights and freedoms. Rule 11(1)(g) was intended to address situations where a person may have been released from compulsory status, but where the agency releasing the person might have been refused

permission to disclose that information to the person's principal caregiver. In those circumstances it allows the agency to disclose limited information about the person's release to his or her principal caregiver, even against the person's express request.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act also has provisions, in sections 29-46, for placing individuals under compulsory status. The proposed amendment would have given agencies a similar ability to that already in rule 11(1)(g).

The Commissioner decided not to proceed with this amendment, partly because the two statuses were not strictly comparable. For instance, while a person with a mental illness may well recover their mental health and be released from compulsory status, a person with an intellectual disability may have that disability permanently. There have been no complaints to the Commissioner showing a need for a change in this area. During preliminary discussions stakeholders did not consider it a necessary addition to the HIPC.

### *Rule 12: Unique Identifiers*

An issue that was of common interest and concern in the preliminary discussions was unique identifiers, in particular the NHI number.

Unique identifiers are useful tools for efficient administration. They present a danger which is, in a sense, tied to this utility. A unique identifier acts as a common identifier across a wide range of files and stores of information. Once the structures have been set up to use that identifier, it is tempting for organisations to tie other sets of data to the same number and to use the collected information for other purposes. This is called 'function creep'.

An appropriate example is the United States Social Security Number, which began as a method to administer a national benefit, but has become a de facto national identifier used for tax, employment and even medical purposes.<sup>13</sup>

Rule 12 of the HIPC attempts to prevent, or at least slow down, this process by restricting agencies from *assigning* unique identifiers that have already been assigned by another agency.

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<sup>13</sup> A useful summary can be found at <http://www.americanchronicle.com/articles/viewArticle.asp?articleID=3911>.

Rule 12 prohibits a single unique identifier being used across multiple agencies, unless one of the exceptions applies. Where an exception applies rule 12 then has little further effect – the unique identifier can be used freely. Because of this ‘all or nothing’ effect, it is not a regulatory method that affords detailed control over the use of unique identifiers. For instance there is no way to control the purpose for which unique identifiers are assigned, and little obligation of transparency about their use.

A major issue identified in the preliminary discussions with stakeholders was that the word ‘assign’, as used in rule 12, was not thought to have a clear meaning. In relation to the NHI number, ‘assigning’ a unique identifier was variously thought to amount to:

1. creating a new NHI number for a client who had not already been assigned one;
2. looking up a patient on the NHI and adding that patient’s NHI number to his or her records;
3. having the NHI number as the primary means of internal records management.

The first entry on the list represents a relatively common understanding, but one that is almost certainly incorrect, since rule 12(2) prohibits the assignment of a unique identifier that has *already been assigned*. If ‘assignment’ were to mean ‘creation’, then rule 12(2) would have no effect. It would not make sense for the legislation to prohibit an agency from creating the unique identifier for an individual that had already been created for the same individual.

As discussed earlier, the New Zealand Health Information Service, which administers access to the NHI, has taken a conservative view on the interpretation of the word “assign”. Therefore it will, currently, only provide access to the NHI database to agencies that are allowed to assign the NHI by virtue of being listed on Schedule 2.

The Commissioner considers that to assign a unique identifier number to a person means simply to uniquely identify that individual using the number for operational purposes – meaning 3 in the list above. This is the interpretation that most plainly accords with the intent of rule 12, which is to regulate the use of unique identifiers and prevent function creep.

It was noted in preliminary discussions that 'assign' could be defined in the HIPC. However, it was suggested that a more appropriate way of clarifying the issue would be to address it in the revised Commentary to the HIPC, which is currently scheduled to be completed in late 2007. This is the way the Commissioner currently proposes to address this issue.

It is also useful to note that the fact that an agency might be entitled to assign the NHI number does not give it a legal right to use and disclose health information it receives in connection with that NHI number. Whether an NHI number may be assigned is a separate question from whether the health information associated with that NHI number will be handled in a privacy protective manner.

Rule 12 specifically deals with unique identifiers. If an agency wishes to collect, hold, and use or disclose health information it must also comply with rules 1 to 11 of the HIPC whether or not that information includes or is referenced by the NHI. A unique identifier, by itself, is relatively innocuous – it is the use that can be made of it in linking disparate collections of health information that may present problems.

## **Submissions**

The Commissioner invites submissions on the proposed amendments to the HIPC. Closing date for submissions is 28 May 2007, and submissions may be emailed to [submissions@privacy.org.nz](mailto:submissions@privacy.org.nz) or mailed to:

Submissions: HIPC  
Office of the Privacy Commissioner  
PO Box 10094  
Wellington

Any enquiries may be addressed to Sebastian Morgan-Lynch, Policy Adviser (Health) on (04) 474 7593.