

Good morning

WELCOME

Welcome to Regina and the very first Prairie Health Information Privacy Day.

I offer a special welcome to those of you from outside of Saskatchewan.

This Conference is hosted by the Manitoba Ombudsman, Alberta's Information and Privacy Commissioner and by the office of the Saskatchewan's Information and Privacy Commissioner.

Later this afternoon, the three of us will be on a panel to assess some of the lessons we have learned in our respective provinces when it comes to personal health information.- with a particular look at uses and disclosure of that phi for secondary purposes.

INTRODUCTION

So, let me start by introducing my two colleagues to you: Irene Hamilton (Manitoba Ombudsman) and Frank Work (Alberta IPC). I'll do that in order of seniority.

Frank oversees FOIP, HIA and PIPA. Large office [40 staff] between Calgary and Edmonton] His team reflects terrific depth and expertise. A number of them are here for this conference. The Alberta OIPC has been a wonderful resource to our much smaller Sask. office. Much useful information and materials available at the www.oipc.ab.ca website. Frank is very knowledgeable, practical and approachable.

Frank also has an interesting and unusual background. Master's Degree in Environment Design from U. of Calgary, Law degree from McGill, stints working in Bermuda for Attorney-General of Bermuda and United Nations Environmental Program. Contract work for World Bank in Mauritius. I first met Frank when he was Parliamentary Counsel for the Alberta Legislative Assembly where he worked for 5 years. So, he has expertise in legislative drafting and statutory interpretation. In 1996 he moved from the Leg. Assembly to the IPC to become Assistant Commissioner and General Counsel.

In 2001 he became the Alberta IPC.

Irene became Manitoba Ombudsman in March, 2005. She has 2 divisions within her office. One is for the Ombudsman work. The other is the Access and Privacy division. This includes approximately 9 persons doing access and privacy oversight. The laws she oversees are FOIP and PHIA.

Irene has her B.A. from University of Winnipeg, and a Law degree from University of Manitoba. She has held a number of senior positions within the Manitoba government. Prior to her appointment as Ombudsman, she was Assistant Deputy Minister of Justice, responsible for the Court division. She has been elected as a bencher (i.e. a member of the governing council) of the Law Society of Manitoba. Since Irene became Ombudsman, I have noticed a lot of innovation in her office- a lot of positive change. My impression is that there is now a much sharper focus in Manitoba on access and privacy compliance among trustees. She has had a very significant impact in her first two years of PHIA oversight.

I encourage you to chat with Irene and Frank throughout the day and also staff from their respective offices. It is not very often that we have this concentration of privacy experience and expertise in our province. Make the most of it.

INTERPROVINCIAL COOPERATION

Our three offices work closely together on a number of issues and projects. We value that information sharing. We decided that it would be helpful and productive if we could enlarge the sharing to include not just the investigators and staff in our three offices but also health providers, health regulators, health system managers and others who deal with phi..

After all, in Canada, if you are looking for experience with a stand-alone health information law you need to look at our 3 prairie provinces. In my experience it is not all that often that those in central Canada think to look to the prairies to learn anything. But since Ontario enacted PHIPA in 2004 Ontario custodians have a new interest in our experience as the original 3 members of the 'stand-alone health information law' club.

A BRIEF HISTORICAL PERSPECTIVE

Initially it looked like all three prairie provinces would enact health information laws at about the same time. 1997 and 1998 saw the development of bills in each prairie province.

But although *Personal Health Information Act*, (Manitoba) came into force in 1997. (1st of its kind anywhere in Canada), Alberta and Saskatchewan took a different and much longer route. Alberta's *Health Information Act (HIA)* came into force in 2001. Saskatchewan's *Health Information Protection Act (HIPA)* came into force in 2003 (in fact 4th anniversary in Sept.).

Incidentally, Marly Markin, a SIAST Health Information Management student who is doing a practicum in our Regina Office, has put together a compendium of features in the 3 laws, HIA, HIPA and PHIA. There is both a short form and a long form. These were done for one of the breakout sessions but we decided that it may

be of interest to others as well. So additional copies of the compendium are available on the SK OIPC display table.

It is not just the 3 laws we have in common on the prairies. We also provided the early leadership in regionalization of health services. The creation of large regional health authorities that integrated all health services from pre-natal care to palliative care in one large entity was led by Saskatchewan and then Alberta and Manitoba. These large organizational units were able to start focusing on developing integrated information managements systems in a way that wouldn't make sense in a hospital or site based system.

These three provinces made an early commitment to development of electronic health records. In fact if you examine the history of the three laws, you will see that the EHR was always part of the package. With We//net in Alberta, SmartHealth in Manitoba and SHIN in Saskatchewan. Smarthealth crashed and burned in Manitoba and we//net and shin have gone through many changes but the government commitment to the EHR has been consistent.

CHALLENGES

Speaking of EHR, it poses some very significant challenges for all of us. I know most physicians still have their patient files in hard copy form in a file cabinet and certainly HIA, HIPA and PHIA apply to those records too. One of the optional workshops tomorrow will feature speakers from Canada Health Infoway and they will give you a sense of what has been happening in terms of the EHR. But I can tell you now I expect that it is not a question of whether we will have electronic health records only a question of when and exactly how the system will operate.

We need to remember that there are already a significant number of Canadians who withhold some of their personal health information from their primary providers. That is already a significant problem.

The primary challenge for all of us is not just whether a trustee/custodian complies or does not comply with the applicable law. They of course need to do that. I suggest however that an even more important question as we move to electronic health records is whether our residents will be comfortable and confident that their privacy will be respected and the confidentiality of their phi protected. Everything we do with personal health information needs to be considered through that filter.

I always liked a passage in the final report of the Federal Advisory Council on Health Infostructure, entitled *Paths to Better Health* where the Council stated:

Patient-based health record are a fundamental cornerstone of provincial and territorial health infostructures. However, there is a potential for serious violations of privacy. The Council believes that, with particular care, electronic health records can actually enhance privacy protection, improve patient care,

enable telehealth, empower citizens through greater control of their own health records and serve as the foundation for an ever-improving information and evidence-based health system. [page 3-5]

I suggest that 1999 statement was something of a ‘high-water mark’ in terms of privacy. Also, the Romanow Report on the future of Health Care in its recommendation #10 urged the implementation of electronic health records but based on a feature of patient ownership of their personal health information. Ownership implies a degree of control by individuals over their phi.

COMMON PROBLEMS

We will be looking today at some common problem areas. In my experience there are four areas where problems most often crop up.

1. Access

Frequent type of complaint. In fact, I have begun to think that we may have made a mistake when we were busy assuring trustees and custodians that HIPA was not such a big deal. You already have a strong tradition and culture of protecting personal information. Over the last few years, I have come to conclude that our health care providers had a strong tradition certainly of confidentiality. I.e. protecting personal health information once it is shared with them. But we did not have a strong tradition or culture of privacy. In fact our health care system has traditionally been quite paternalistic. By privacy, I mean patient exercising a degree of control over their personal health information. That is at the core of any definition of privacy. This frankly is quite new for health trustees/custodians. What’s different? 30 calendar days to respond. The broad definition of phi captures more than just the chart information. The duty to assist is new. The role of oversight offices and the opportunity to complain without the need to go to court to try and force access.

2. Security

What kinds of security threats exist with everything from computer hard drives, unattended Fax machines, portable computing devices to the paper file in the doctor’s office? We will revisit this issue in the Commissioner’s panel later this afternoon.

3. Consent

In each province trustees/custodians have 3 different consent options available to them. (1) Express consent, (2) implied consent (both of which can be revoked) and (3) no consent or in Saskatchewan “deemed consent”. The initial focus in each province was largely on the no consent within the therapeutic context (the circle of care). I think increasingly that is seen as not ideal in many circumstances. What we see developing across Canada is more use of implied consent which is becoming a genuine national standard. I say this based on the following:

- Interpretation of PIPEDA by PCC

- **Pan Canadian Health Information Privacy Framework**
- **Charter of Rights and Freedoms**
- **Ontario's PHIPA**
- **CMA Privacy Code.**

We certainly see more trustees using implied consent with a right to opt-out (Prevention Program for Cervical Cancer, Chronic Disease Management Program, etc)

4. Disclosure

In Saskatchewan we have recently been debating when trustees can and cannot disclose phi without consent to police. This has revolved around section 27(4)(a) of HIPA.

That provides the trustee has the discretion to disclose without consent PHI where the trustee believes on reasonable grounds that the disclosure will avoid or minimize a danger to the health or safety of any person

Since this is an exception to the general rule that you can only disclose phi for a secondary purpose with consent, this disclosure requires 3 things:

- (a) **must be a reasonable expectation of probable harm**
- (b) **harm must constitute damage or detriment and not mere inconvenience**
- (c) **must be a causal connection between the disclosure and the anticipated harm**

ROLE OF OUR OVERSIGHT OFFICES

In each of our offices we:

- **Deal with decisions that trustees make on access requests**
- **Deal with breach of privacy complaints**
- **Provide advice and commentary to trustees, leg assembly and the public**
- **Provide education**

We will be able to discuss this more in our panel this afternoon.

Thanks to Verney Conference organizers for putting this together. Thanks also to the Advisory Committee of Gail Perry, Leroy Brower and Diane Aldridge for creating an excellent program.

Have a great conference.