The Council of Ambulance Authorities Inc.
Submission

Response to the AHMAC discussion paper on proposals for legislative support for Healthcare Identifiers and Privacy

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BACKGROUND

VACIS

The Council of Ambulance Authorities (CAA) is the peak body representing the principal statutory providers of ambulance services in Australia, New Zealand and Papua New Guinea. The CAA unites independent state and territory ambulance authorities to develop common views and approaches to ambulance industry issues.

The CAA aims to improve the health of the Australian community by providing high quality nation-wide pre-hospital care and medical transport.

In 2005 Ambulance Victoria introduced an episode based Electronic Health Record (EHR); 'VACIS'. VACIS is a sophisticated, integrated Ambulance Clinical Information System which allows Paramedics to record patient information electronically at the point of care on a ruggedised tablet PC. Other Australian ambulance services have introduced or plan to introduce this system.

The primary output of VACIS is an electronic Patient Care Record (ePCR); which replaces the handwritten, carbon-copy Patient Care Record (PCR) that had been in use for many years. Data from completed ePCRs is uploaded to a central database, before being integrated into a Clinical Data Warehouse for reporting and analysis. VACIS collects data on all emergency incidents attended by Paramedics, thus paving the way for research to further enhance Ambulance care and performance.

VACIS was designed and developed by the then Metropolitan Ambulance Service (now Ambulance Victoria) in cooperation with other participating Australian Ambulance Services.

VACIS Collaboration

In order to achieve consistency and standardisation of Ambulance clinical data collection throughout Australia, the VACIS Collaboration was established.

The nature of this not-for-profit Collaboration is for Australian ambulance services who elect to become members to work together collaboratively to develop, implement and enhance VACIS throughout Australia.

Ambulance Services in most states and territories are members of the Collaboration, and thus have either implemented or committed to implement VACIS.

VACIS Clinical Dataset

The VACIS Clinical Dataset is a comprehensive set of clinical reference data for selection by Paramedics as they complete an ePCR.

The premise of the Clinical Dataset is to:

- Provide an evidence base to clinical practice;
- Provide information to establish the level of compliance of Paramedics with clinical protocols and procedures;
- Provide information which enables comparisons between event assessments at call-taking, infield and hospital stages, for the purpose of refining dispatch protocols;
- Assist in determining training requirements of individual Paramedics as a consequence of clinical experience;
- Provide the means by which specific cases can be audited, reviewed and investigated;
- Systematically collect and provide high quality valid data for the purpose of Ambulance based clinical research;
- Provide a standard approach to documenting pre-hospital patient assessment and treatment;
- Ensure continuity of patient care; and
- Ensure the quality and safety of patient care.

A significant factor of the VACIS Collaboration Agreement is to maintain a shared and published National VACIS Clinical Dataset, allowing standardised data collection across Australian Ambulance Services. This will facilitate consistent performance reporting and benchmarking of key clinical indicators, and make possible the development of agreed national standards for Ambulance Service delivery.

NATIONAL HEALTHCARE IDENTIFIERS

The CAA and the VACIS Collaboration acknowledge the desirability and potential benefits of implementing National Healthcare Identifiers. These benefits align well with our focus on the quality, safety and continuity of patient care.

Individual Healthcare Identifiers (IHIs) in particular have the potential to enhance the value of VACIS data both within ambulance services and with respect to our interaction with other healthcare providers and organisations; thus ultimately benefiting the patient.

Given VACIS will be implemented throughout the majority of Australia; the ambulance sector will be well placed to take early advantage of IHIs and the Individual Electronic Health Records (IEHRs) which they will underpin. The future capability of paramedics being able to access critical patient information at the point of emergency care, as well as transmit (including pre-arrival) patient details including an IHI to the receiving health care facility will serve to improve patient care.

The ability to reliably perform ambulance to hospital data linkage will support improved analysis of the effectiveness of ambulance clinical practice, with an emphasis on patient outcome at hospital discharge.

Implications of implementing National Healthcare Identifiers

In an environment where National Healthcare Identifiers are part and parcel of delivering health services and facilitating information exchange between providers, the ambulance sector will be a key stakeholder in the pre-hospital setting. Further, the VACIS Collaboration members jointly fund the ongoing support, development and enhancement of VACIS, and are responsible for its governance.

Given the above, we anticipate the implementation of National Healthcare Identifiers may have significant implications for ambulance services both with regards to paramedic workflow and changes to our ICT systems, including VACIS.

We therefore request that AHMAC and NEHTA ensure the ambulance sector is included in any relevant stakeholder forums and consultations regarding this and other e-health initiatives.

RESPONSE TO PART A: NATIONAL HEALTHCARE IDENTIFIERS AND REGULATORY SUPPORT PROPOSALS

Proposal 1: Provide Medicare Australia with functions, in or under Commonwealth legislation, to establish and operate the HI Service for the purpose of accurately and uniquely identifying healthcare individuals, healthcare providers and provider organisations and enable communication between individuals, healthcare providers and provider organisations.

The functions would be conferred on the Chief Executive Officer of Medicare Australia and cover:

- assigning, collecting and maintaining identifiers to individuals, individual healthcare providers and organisations including by using information it already holds for existing purposes
- developing and maintaining mechanisms for users to access their own records and correct or update details
- collecting information from individuals and other data sources
- use and disclosure of these identifiers and associated data, including personal information, for the purposes of operating the HI Service.

Q1. Do you agree that the functions to be conferred on the Medicare CEO are sufficient?

Q1 Response

Agreed that these appear to be sufficient to establish and operate the initial HI Service. If the Service were to be later de-coupled from Medicare, the functions may certainly need revising.

Proposal 2: Where an IHI or HPI-I is associated with health information about an individual, the collection, use and disclosure of an IHI or an HPI-I will be subject to the privacy and health information laws applicable to that health information.

Misuse of an IHI or HPI-I by a healthcare provider will be able to be pursued as a breach of privacy in jurisdictions with privacy laws or will be subject to other penalties set out in relevant health records or health service legislation.

Q2. Are there significant issues raised by regulating the handling of healthcare identifiers by public and private health sector organisations through existing privacy and health information laws with some additional regulatory support through specific enabling legislation for healthcare identifiers?

Q3. Are there circumstances where penalties for misuse of a healthcare identifier and associated information that is held by a healthcare provider will be inadequate?

Q2 Response

There are no significant issues foreseen by considering National HIs just another element of health information and thus regulating their handling through existing relevant legislation.

Q3 Response

No such circumstances are anticipated – the existing penalties are considered sufficient.

Proposal 3: Definitions of healthcare service and healthcare service provider will be included in the legislation.

Q4. Is it appropriate that definitions contained in privacy law are adopted?

Q5. Are there other specific terms that should be defined?

Q4 & Q5 Response
The definition of a 'health service' recommended by the ALRC is appropriate for adoption.

It should be pointed out that the term 'health service provider' defined as '*an organisation that provides health service to the extent that it provides a health service'* is perhaps too close (and may be considered synonymous) to the term 'healthcare provider' which is often used to refer to an individual throughout the discussion paper. The more specific term 'individual healthcare provider' is also used, and 'individual providers' is used synonymously with 'health service providers' in section A.2.

A modification to the definition of 'health service providers' to include individual providers as well as organisations should be considered. If not, a consistent term for individual providers should also be defined.

Proposal 4: The HI Service Operator will only disclose an individual's IHI and the minimum personal information required to identify an individual to an authorised healthcare provider. Requests for an IHI must be supported by a minimum set of personal information.

Proposal 5: Healthcare providers will be authorised to use or disclose an individual's name, date of birth, sex and address details in order to request an IHI from the HI Service Operator.

Proposal 6: The HI Service Operator will disclose information held in the Service only to authorised users. The term 'authorised user' will be defined in the legislation.

Proposal 7: The HI Service Operator will be authorised to disclose the HPI-I and relevant data fields for professional registration and other purposes to bodies set up in legislation establishing the NRAS.

Proposal 8: Secrecy provisions similar to those set out in the Health Insurance Act or the National Health Act would apply to the disclosure of information by staff in undertaking the HI Service Operator function.

Proposal 9: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to secondary uses and disclosures of HI Service information.

Q6. Do the limits on disclosure set out in Proposal 4 provide adequate protection for an individual's personal information?

Q7. Is the authorisation for healthcare providers set out in Proposal 5 required to provide certainty to healthcare providers, noting that the use or disclosure could occur under existing privacy arrangements as a directly related and reasonably expected secondary use or disclosure of health information?

Q8. Does the limit on disclosure set out in Proposal 6 provide adequate protection for a healthcare provider's personal information?

Q9. Does the proposal to apply secrecy provisions similar to those set out in the Health Insurance Act or the National Health Act provide sufficient protection for personal information held by the HI Service Operator?

Q10. Is there a need to apply a specific penalty to unauthorised use or disclosure of healthcare identifiers by health sector or other participants who hold the healthcare identifier in association with health information?

Q11. Do you agree that existing health information regulation and administrative arrangements will provide sufficient secondary use requirements for organisations handling healthcare identifiers?

Q6 Response
The limits set out in Proposal 4 seem analogous to existing Medicare disclosure limits and are considered sufficient.

Q7 Response
The specific authorisation is not thought necessary, given that the disclosure will be *to* the HI Service Operator. Healthcare providers currently use such a process; disclosing these details to Medicare Australia in order to obtain a patient's Medicare number via a hotline.

Q8 Response
The disclosure limit should provide adequate protection, provided that only relevant fields are disclosed by HI Service staff.

Q9 Response
The secrecy provisions in Proposal 8 will provide sufficient protection for personal information:
- In the case of individuals, the personal information held will be no more than currently held in the Medicare CDMS; and
- In the case of providers, the personal information held will be no more than currently held by the relevant registration body.

Q10 Response
It is not believed there is a need to apply a specific penalty for this scenario; provided that existing privacy and health information legislation covers unauthorised use or disclosure of healthcare identifiers whether the offender holds the identifier in association with health information or not. If the health information itself is the subject of unauthorised use or disclosure, this is certainly covered by said legislation.

Q11 Response
The existing regulation and administrative arrangements are expected to provide sufficient secondary use requirements. The ambulance sector is particularly interested in utilising the IHI to perform ambulance – hospital data linkage for the purposes of research and monitoring health outcomes, and is confident these activities are sufficiently covered by authorised secondary use provisions.

Proposal 10: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to data quality.

Q12. Do you agree that existing health information regulation and administrative arrangements will provide sufficient data quality requirements for organisations handling healthcare identifiers?

Q12 Response
Existing regulation and administrative arrangements should provide sufficient data quality requirements.

Proposal 11: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply for data security.

Q13. Do you agree that existing health information regulation and administrative arrangements will provide sufficient data security requirements for organisations handling healthcare identifiers?

Q13 Response
Existing regulation and administrative arrangements should be satisfactory to provide sufficient data quality requirements.

With regards to the HI Service's audit logs (A.5.2.6) which '*will store all transactions and access attempts*'; it is suggested that at minimum all access attempts or 'queries' should require a 'reason for access' to be selected or automatically assigned (e.g. 'HPI-O [ID] phone request for IHI') and subsequently logged.

Proposal 12: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to openness.

Q14. Do you agree that existing health information regulation and administrative arrangements will provide sufficient openness requirements for organisations handling healthcare identifiers?

Q14 Response
Existing regulation and administrative arrangements are considered adequate with regard to openness.

Proposal 13: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to access and correction. No additional legislative requirements will be developed for access and correction.

Q15. Do you agree that existing health information regulation and administrative arrangements will provide sufficient access and correction capability for individuals?

Q15 Response
Existing regulation and administrative arrangements (especially Medicare Australia's in relation to the future HI Service) should provide sufficient access and correction capability.

Proposal 14: It is proposed that Commonwealth legislation provide that NPP 7 does not apply to the adoption, use and disclosure of the IHI or the HPI-I by private sector healthcare provider organisations for the purposes of accurately and uniquely identifying individuals and individual healthcare providers respectively for health information management and to enable communication between individuals, healthcare providers and provider organisations.

Proposal 15: It is proposed that Commonwealth legislation will provide that NPP 7 does not apply to the use and disclosure of Medicare numbers to Medicare Australia by private sector healthcare provider organisations for the purposes of the retrieval of individual identifiers.

Q16. Will the proposals to overcome current identifier restrictions on private healthcare providers effectively enable participation in the HI Service? Q17. Do these proposals raise any significant issues in relation to the handling of identifiers?

Q17. Do these proposals raise any significant issues in relation to the handling of identifiers?

Q16 & Q17 Responses
The proposals appear adequate to overcome the current restrictions on private healthcare providers. Although some ambulance services are public sector providers, proportion of non-emergency workload is contracted to private sector providers; thus any anticipated restrictions should be addressed prior to the HI Service being established. It is not foreseen that these proposals raise any significant issues.

Proposal 16: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to anonymity.

Q18. Do you agree that existing health information regulation and administrative arrangements will provide sufficient anonymity requirements?

Q18 Response
Existing regulation and administrative arrangements should provide sufficient anonymity requirements.

Proposal 17: Existing Commonwealth, state and territory health information regulation and administrative arrangements will apply to trans-border data flows.

Q19. Do you agree that existing health information regulation and administrative arrangements will provide sufficient requirements for trans-border data flows?

Q20. Does this proposal raise any significant issues in relation to the handling of identifiers?

Q19 & Q20 Responses
Existing regulation and administrative arrangements should provide sufficient privacy requirements for trans-border data flows. It is not anticipated that this proposal will raise any significant issues.

It is anticipated that this is becoming increasingly relevant for the ambulance sector as we begin to contemplate data sharing arrangements between services to realise the full research potential of respective VACIS data collections.

Proposal 18: The role of the Ministerial Council would be set out in an intergovernmental agreement. Key elements would be set out in legislation, including any processes for future consideration by the Ministerial Council about the operation or expansion of functions of the HI Service.

Proposal 19: Establish a process for controlling the expansion of the future uses of the HI Service. This could be done by:
- providing for the Minister who is responsible for the legislation to determine future operation or expansion of the service subject to a requirement to undertake a privacy impact assessment and seek agreement from all state and territory Health Ministers.

Proposal 20: It is proposed that these functions would be undertaken by Medicare Australia in its role as the initial HI Service Operator (see Proposal 1).

Q21. Do you think participation agreements are an appropriate mechanism for setting out the responsibilities of the parties involved (i.e. healthcare provider organisations and the HI Service Operator)?

Q22. If so, do you consider that legislation is necessary to underpin the participation agreements?

Q21 & Q22 Responses
Participation agreements would seem a practical and appropriate mechanism for setting out the necessary detail with regards to business rules for IT architecture, security, storage, backup and data management standards.

Such agreements may not, however, provide an adequate level of certainty around the gravity and consequences of breaching said business rules, as well as responsibility and power to audit compliance.

Legislative support could be necessary to underpin the participation agreements; not to cover the detail but to enforce compliance and define remedial mechanisms.

RESPONSE TO PART B: PROPOSED NATIONAL PRIVACY REFORMS

Proposal 22: National legislation include requirements such as: conciliation being a critical element in the approach to resolving complaints; an independent administrative or judicial mechanism; the length of time consumers have to lodge a complaint; powers of regulators; and sanctions for breaches of the law by agencies or organisations.

Guidelines including minimum standards be developed and agreed to by regulators to ensure that there is a consensus in the way in which privacy laws are to be applied across Australia.

Jurisdictional regulators be empowered to jointly determine a common approach to applying these minimum standards.

Q23. Are there any other requirements that should be specified in legislation?

Q24. Is it necessary that arrangements for and enforceability of directions or guidelines that are jointly agreed by privacy regulators to be supported by legislation?

Q23 Response

With regard to compliance with privacy provisions, it is agreed that to ensure a consistent national approach the national legislation should include and define the requirements for administering the privacy laws (regardless of jurisdiction).

If the above specified requirements are indeed included in the national legislation, it is thought prudent to also consider defining sanctions for breaches of the law by individuals.

Q24 Response

The national legislation should support arrangements for and enforceability of said directions or guidelines for application of minimum standards. Without this support, there is a substantial risk of these directions or guidelines not being considered binding by individuals, agencies or organisations. With regards to the handling of health information in the health sector, the environment is such that if requirements are not unequivocally compulsory (and tied to funding, legislation or both), they are often not complied with.

Proposal 23: Health information of deceased individuals should be subject to the same protection as other personal information about deceased persons whether this is through privacy law or other arrangements.

Q25. Are there any reasons for the privacy of health information about deceased persons to be treated differently to other personal information about them?

Q25 Response

It is not considered that there are any reasons why the privacy of health information about deceased persons should be considered or treated differently to other personal information about deceased persons; so long as the privacy requirements are no less rigorous than those applying to health information of living persons.

Proposal 24: Include a definition of ‘health service provider’ as ‘an organisation that provides a health service to the extent that it provides a health service’.

Q26. Is the proposed definition of health service provider appropriate?

Q27. Are there any other terms that need to be defined to support a health information privacy protection as part of a national framework?

Q26 & Q27 Responses
As previously noted in response to Q4 & Q5, it is thought that a 'health service provider' defined as '*an organisation that provides health service to the extent that it provides a health service'* may be considered synonymous with the term 'healthcare provider', which is often used to refer to an individual.

As individuals may conceivably provide health services outside of the setting and jurisdiction of an organisation, these individuals also need to be covered by a definition for legislative purposes.

A modification to the definition of 'health service providers' to include individual providers as well as organisations should be considered. If not, a term for individual providers should also be defined.

Proposal 25: Amendment of 2.5(c) to allow the collection of sensitive information where there is a serious threat to an individual's welfare.

Proposal 26: Deletion or modification to 2.5(d) to exclude the right for non-profit organisations to collect health information about their members.

Proposal 27: Amendment of 2.5(f) to provide that any guidance issued by the Privacy Commissioner in relation to the collection of sensitive information necessary for research purposes be required to be developed in conjunction with input from other appropriately qualified individuals or organisations in the field of research.

Proposal 28: Any rules or guidelines issued by the Privacy Commissioner in relation to the collection of identifying health information where it is necessary for the funding, management, planning, monitoring or evaluation of a health service be developed in conjunction with input from other appropriately qualified individuals or organisations in the health service management field.

Q28. Do you agree that the amendments proposed above are appropriate?

Q29. Are there any other circumstances where the collection principle might require amendment in relation to health information?

Q28 Response
The amendments proposed appear to be appropriate to add sufficient clarity and certainty for health service providers.

Q29 Response
The only other area identified where the collection principle might require amendment is 2.6 (de-identifying data collected for research). The extent to which research data is satisfactorily de-identified varies markedly. For example, some jurisdictions obscure counts of less than a certain number (e.g. 5) for de-identified episodes of diagnosis/procedure 'X' for a given postcode; others do not. 'Reasonable Steps' is a fairly broad term open to interpretation – the opportunity could be taken to strengthen this somewhat. It is acknowledged that the example given is likely too much specific detail for the legislative level.

Proposal 29: Amendment of 5.1(c) to allow the use or disclosure of sensitive information where there is a serious threat to an individual's welfare.

Proposal 30: Amendment of 5.1(f) to provide that any guidance issued by the Privacy Commissioner, in relation to the use or disclosure of sensitive information is necessary for research purposes, be required to be developed in conjunction with input from other appropriately qualified individuals or organisations in the field of research.

Proposal 31: Rules or guidelines issued by the Privacy Commissioner in relation to the collection of identifying health information where it is necessary for the funding, management, planning, monitoring or evaluation of a health service be developed in conjunction with input from other appropriately qualified individuals or organisations in the health service management field.

Proposal 32: An exception is proposed to allow personal information to be used or disclosed by an agency or organisation where an individual is known or suspected to be missing or deceased, subject to this not being contrary to any wishes expressed by the individual before they went missing or became incapable of consenting, with disclosure limited to a law enforcement officer for the purposes of ascertaining the whereabouts of the person.

Proposal 33: It is proposed that the definition of a 'person responsible for an individual' be altered to provide for:

- any person who has a personal relationship with the individual rather than only a person who has an intimate relationship, or
- a person who is responsible for providing support or care to the individual rather than only the person who is primarily responsible.

Guidelines could identify the grounds on which a personal relationship exists or that a person is responsible. These would include such things as whether there is a sufficient degree of intimacy or level of responsibility. Another alternative would be to set the list up as an inclusive rather than an exclusive list.

Q30. Do you agree that the amendments proposed above are appropriate?

Q31. Are there any other circumstances where additional guidance about the use or disclosure of information would be helpful?

Q32. In relation to Proposal 32, should an agency or organisation be required to have a reasonable expectation that the person responsible for the individual will act in the best interests of the individual in receiving that information? Would guidelines provide sufficient certainty?

Q30 Response

The amendments in proposals 29, 30 and 31 seem appropriate, as they are analogous in intent and rationale to those in 25, 27 and 28.

Proposal 32 also appears to be a practical and necessary exception.

The rationale for proposal 33 is generally agreed with; however this is an area where caution is required. If the guidelines approach were taken (and it is likely not practical to include an exclusive list enshrined in legislation), they would need to be extremely clear on the key factors for deciding whether or not a given individual can be considered a 'person responsible' under UPP 5.

Q31 Response

The various provisions in UPP 5 appear to be sufficient.

Q32 Response

It is presumed this is actually meant to refer to Proposal 33. This should be a requirement for an agency or organisation considering releasing an individual's health information to another person. To ensure this is taken most seriously and provide a high likelihood of compliance, it would be preferable for this stipulation to form part of the UPP rather than be relegated to associated guidelines.

Proposal 34: The consent of individuals is required to the use or disclosure of health information for direct marketing purposes.

Q33. Do you agree that the consent of the individual should be obtained for the use or disclosure of health information for direct marketing purposes?

Q33 Response
It is agreed that active consent (i.e. 'opt in' rather than 'opt out') should be required for the use or disclosure of an individual's health information for these purposes.

Proposal 35: Guidelines be developed by the Privacy Commissioner outlining key requirements for retaining health information (e.g. minimum retention periods and obligations owed by a healthcare provider to an individual where a healthcare service has been sold, amalgamated or closed).

Q34. Are guidelines sufficient to ensure that health information is retained for a suitable period of time?

Q34 Response
If UPP 8 is to speak to minimum retention periods for health information, then associated guidelines developed by the Privacy Commissioner are not considered sufficient to ensure health information is retained for a suitable period of time.

As stated in the discussion paper, records legislation in each jurisdiction generally specifies retention periods. Those responsible for retention and disposal are generally well versed in these requirements and the importance of compliance.

As such any similar stipulations (such as the suggestion guidelines) which are not enshrined in legislation are not likely have the same level of credence or authority, and thus are not as likely to be adhered to. As mentioned previously, the environment is such that if requirements are not seen as absolutely compulsory, they are often not complied with.

Proposal 36: It is proposed that the exception from providing access to health information where providing access would reveal the intentions of the organisation in relation to negotiations with the individual in such a way as to prejudice those negotiations does not include negotiations about provision of health services.

Proposal 37: A note be inserted into the Access and Correction Principle explaining that nothing in the principle compels an organisation to refuse to provide an individual with access to his or her health information.

Proposal 38: Guidelines be developed by the Privacy Commissioner that include detailed information about the process which should be followed to gain access to personal information, including guidance on requests for access, responses to those requests, how information is provided and fees.

Q35. Do you agree with these proposals?

Q36. Are guidelines sufficient to ensure processes for access to health information are understood by agencies and organisations?

Q37. Are any other amendments to the access principle required?

Q35 Response
The above proposals are agreed. Support is especially lent to proposal 37; currently all too often overzealous interpretation and application of privacy requirements by both administrative and clinical staff hinders timely and sometimes urgent transfer of health information to facilitate continuity of care. This is often the case both when the requester is a health provider with the patient currently under their care, and when it is the patient themselves requesting their information.

Q36 Response
Guidelines stipulating processes for access are considered sufficient if they are referred to under UPP 9, and if they are developed and issued by the National Privacy Commissioner and thus are consistent between jurisdictions.

Proposal 39: The identifier principle should permit the use or disclosure of information that includes an identifier for funding, management, planning, monitoring, improvement or evaluation of health services and for research purposes in the public interest subject to the same limits that apply to health information being used or disclosed for those purposes.

Q38. Do you agree with this proposal?

Q39. Are any other situations where the identifier principle might have an inappropriate effect on the use or disclosure of health information?

Q38 & Q39 Response
This proposal is agreed. Further, the identified restriction being addressed in the healthcare identifier legislation would be supported. No other situations are envisaged where this principle would have an inappropriate effect of the use or disclosure of associated health information.

Proposal 40: An agency or organisation should be allowed to use or disclose information outside Australia to lessen or prevent a serious risk to life, health, safety or welfare without continuing to be accountable for any misuse.

Q40. Do you agree with this proposal?

Q41. Are there any other exceptions for health information transferred outside Australia?

Q34 Response
It is agreed that in order to facilitate transfer of information where the situation dictates this is imperative, modification of UPP 11 would assist by preventing organisations from being overly cautious to the point of withholding said information.

However, it is considered prudent that the modification also stipulate something to the effect that there must be a reasonable belief by the organisation that such disclosure is indeed necessary, and that the location and identity of the requester should be verified as best as practical.

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