Health Information Privacy Code 2020 Amendment No 1

Final Information Paper

On 6 April 2022 the Deputy Privacy Commissioner (in her role as acting Privacy Commissioner) publicly notified her intention to amend the Health Information Privacy Code 2020 (the Code) and invited public submissions. The amendment aligns the Code with structural reforms within the public health and disability support sector. In particular, the Pae Ora (Healthy Futures) Bill (which will become the Pae Ora (Healthy Futures) Act 2022 after 1 July 2022) provides for the disestablishment of District Health Boards (DHBs), and the establishment of new entities, including Health New Zealand/Hauora Aotearoa and the Māori Health Authority/Te Mana Hauora Māori. In addition, a new Ministry for Disabled People has been established, and some functions that currently sit with the Ministry of Health will be transferred to Health New Zealand. The amendment also fixed two minor errors identified following the repeal and replacement of the Code in 2020. The amendment is technical in nature and does not enact policy changes beyond those provided for in primary legislation.

The acting Commissioner received 7 submissions, which broadly agreed that the changes to the Code were technical in nature. Some submitters raised concerns and queries about the operation of the National Health Index (NHI) system and asked for guidance about the operation of the NHI and the definition of 'assign' in the Code. The Office of the Privacy Commissioner has undertaken to provide more guidance on the interpretation of the Code, including the definition of 'assign' and the operation of rule 13 more generally. This information paper covers one change to the amendment since it was publicly notified as well as explaining the changes in Amendment No 1 that have not changed since public consultation.

Changes to the Code since public notification

Only one change has been made to the proposed amendment since public consultation.

During the consultation process, some submitters questioned whether the draft paragraph 15 of Schedule 2 may be too broad and inadvertently allow more health agencies than necessary to assign the NHI.

While Rule 13(1) is, and will continue to be, an important constraint on the assignment on NHIs, we have narrowed the drafting to mitigate against the risk of assignment of NHIs by unanticipated agencies while still ensuring that there is the necessary flexibility to accommodate the ways in which publicly funded health and disability services are commissioned. The amended paragraph 15 will allow a health agency that has a contract with, or is funded by, *any agency specified in Schedule 2* to provide health or disability support services to assign the NHI. This is narrower than the previous drafting which would have allowed any health agency that is funded directly or indirectly by any state sector agency to provide health or disability support services to assign the NHI. The Code does not

include the definition of ‘state service’ which was in the draft amendment, as this is no longer required.

Summary of changes to the Code by Amendment 1

Minor updates to the interpretation section of the Code

Many of the definitions in the Code are based on the definitions contained in the New Zealand Public Health and Disability Act 2000 (or prior legislation). However, the definitions in the Code exist independently, meaning that the repeal of the Act does not necessitate amendments to the definitions in the Code.

This amendment updated the definition of “disability services” to “disability support services” (without changing the meaning of that term). That is to reflect the shift in terminology that has occurred in the sector.

During the consultation process, we also considered whether to propose amendments to remove any doubt that the Code covers information about end-of-life services. Submitters generally agreed that end-of-life services are covered by the Code. While one submitter queried whether an amendment may be helpful to remove any doubt, we remain of the view that this is unnecessary.

Amendments to rule 13 – Health Provider Index/Common Provider Number

The Common Provider Number (CPN) is a unique identifier assigned to health practitioners by the Ministry of Health, and is one aspect of the Health Provider Index. The Health Provider Index also identifies organisations that provide health services and facilities/locations at which an organisation provides health services. It is used across the health sector to identify health practitioners, providers and facilities and reduce duplication of systems.

Rule 13(4) previously referred to “the Common Provider Number assigned to that individual by the Ministry of Health". We have amended Rule 13(4)(b) to remove the reference to the Ministry of Health. While submitters differed in their views as to whether it was preferable to explicitly state which agency is responsible for maintaining the CPN, HPI and NHI databases, we considered that no particular privacy risk was introduced by the Code being silent as to which agency is responsible as it will be provided for in guidance and communications material.

Amendments to Schedule 2 – Agencies approved to assign NHI number

The NHI number is a unique identifier that is assigned to every individual who uses health and disability support services in New Zealand. The NHI is used by health agencies to identify individuals and ensure they are matched with their correct health records. The NHI enables health agencies to more securely communicate with each other about a specified individual, as they do not have to provide additional information about the individual to make sure that each agency is communicating about the same person. This mitigates the risks of extraneous data sharing and sharing information about the wrong individual.

Schedule 2 of the Code sets out the agencies that are approved to assign an NHI number. Prior to Amendment No 1, this list referred to District Health Boards that will be de-established by the Pae Ora legislation on 1 July.

Amendment No 1 added the Māori Health Authority, Health New Zealand, and the Ministry for Disabled People to Schedule 2 of the Code as all had a need to assign the NHI.

As noted above, we also proposed to amend Schedule 2 to reflect the way in which funding flows within the sector. While funding within the health sector is often via back-to-back contracts (for example DHB to Primary Health Organisation (PHO), PHO to GP practice), the previous drafting required a health agency's contract to be with the DHB (or ACC/the Ministry of Health) directly. Given there will be more agencies that are likely to provide health and disability services, we amended Schedule 2 to make it clear that a health agency that has a contract with or is funded by one of the agencies specified in schedule 2 can assign the NHI to an individual. As with other existing agencies that can assign the NHI, health agencies must only assign the NHI for use in its operations where that is necessary to enable it to carry out its functions efficiently.

Updating the legislative reference in Schedule 3

Schedule 3 of the Code sets out use and disclosure rules in respect of information derived from newborn babies' blood spot samples (also known as the "Guthrie card"). One of the permitted secondary purposes of the derived information is to comply with a notice in writing from the chairperson of a mortality review committee. Previous drafting referred to a committee pursuant to Schedule 5 of the New Zealand Public Health and Disability Act. This reference was updated to reflect that the mortality review committee are continued and carried over by the new legislation.

Addressing technical errors

The Office has previously identified two minor drafting errors which were fixed in this amendment, at clause 6(2) and Rule 12(1)(g).