# Regulatory Impact Statement

## Health Records Regulations 2012

Department of Health
May 2012

This Regulatory Impact Statement has been prepared in accordance with the requirements of the *Subordinate Legislation Act 1994*
and the *Victorian Guide to Regulation*

**HEALTH RECORDS REGULATIONS 2012**

# REGULATORY IMPACT STATEMENT

In accordance with the *Victorian Guide to Regulation*, the Victorian Government seeks to ensure that regulations are well targeted, effective and appropriate, and that they impose the lowest possible burden on Victorian businesses and the community.

The Regulatory Impact Statement (RIS) process involves an assessment of regulatory proposals and allows members of the community to comment on proposed regulations before they are finalised. Such public input provides valuable information and perspectives, and improves the overall quality of regulations.

The proposed regulations are made under section 100 of the *Health Records Act 2001*.

This RIS has been prepared to facilitate public consultation on the proposed Health Records Regulations 2012. A copy of the proposed Regulations is attached to this RIS.

Submissions are now invited on the proposed Regulations. Unless requested by the author, all submissions will be treated as public documents and may be made available to other parties.

Written comments and submissions should be forwarded by no later than **5:00pm, 13 July 2012** to:

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# ABBREVIATIONS

**the Act** – *Health Records Act 2001*

**the current Regulations** – Health Records Regulations 2002

**the proposed Regulations** – Health Records Regulations 2012

**FOI** – Freedom of Information

**HPP** – Health Privacy Principles

**MCA** – Multi-criteria Analysis

**NCP** – National Competition Policy

**OHSC** – Office of Health Services Commissioner

**Premier's Guidelines** – Subordinate Legislation Act 1994 Guidelines

**RIS** – Regulatory Impact Statement

**VCEC** – Victorian Competition and Efficiency Commission

# SUMMARY

## Objectives

The *Health Records Act 2002* regulates the collection of health information about individuals by private sector health service providers and other organisations, and establishes a right of individuals to access to that information.

The objective of the proposed Regulations is to allow individuals to obtain health information related to themselves by balancing the following:

- ensuring that any fee changed for access to health information does not unfairly preclude an individual from requesting access to health information
- allowing reasonable cost recovery for organisations providing access to health information.

## Nature and extent of the problem being addressed

Providing a right of access to health information imposes a burden on organisations that collect and hold that information. The *Health Records Act* recognises this by anticipating that organisations may charge individuals to recover some of the costs associated with providing access to information or transferring information to another health service provider at the request of the individual.

However, as the aim of the Act is to grant people the right to access their health information, it was also anticipated that allowing organisations to charge any amount may impede the ability of some to exercise their rights. For this purpose, the Act foreshadowed the setting of maximum fees that may be charged for granting access to health information. In other words, the Act recognises that creating a right of access to health information imposes a cost on society, and allows the making of regulations to determine an appropriate sharing of those costs between those requesting access and those providing it.

Previous consumer surveys have indicated that the most critical factor in the design of a health records system is to ensure an ability to access their health information.[1] Understandably, cost factors may inhibit this access, creating a barrier to a person's right of access. This is important not only in terms of protecting an individual's rights, but also because access to health information is likely to result in better choice and quality of health care, which is beneficial to the individual as well as the community as a whole. Capping the fees for accessing health information therefore represents a useful and effective safety net in the promotion of responsive and effective care.

These fee caps have been in place since the commencement of the legislative right of access to health information via the Health Records Regulations 2002. It is therefore difficult to determine what organisations may charge in the absence of regulations setting fee caps. However, it is considered important to the effective operation of the *Health Records Act* that maximum fees are in place to act as a protection from cost barriers.

[1] Submission made by Consumers Health Forum Australia, February 2012.

There are no available data on how often the Act is used to access health information, or the fees that are charged. Complaints about excessive fees have been very low since the commencement of the current Regulations, and preliminary consultation for the purposes of this Regulatory Impact Statement indicate that it is very common for access to be given to free of charge, or for a standard charge below the current maximum amounts. Anecdotally, the number of requests for access to health information under the Act is infrequent for most organisations, and any cost burden above the maximum cap is likely to be very small in the context of their overall business.

There are also a small number of cases where, in the absence of making regulations setting maximum fees, some organisations may not be able to charge any fee for providing access under the Act. This would be unfair to these organisations, and therefore reasonable maximum fees need to be prescribed in order to allow an appropriate balance of costs in these circumstances.

## Summary of the proposed measures

The proposed Regulations have no direct net cost to the community. Allowing fees to be charged enables the costs of the access to be transferred between different segments of the community—in this case from health service providers and other organisations to the individuals requesting access. The proposed Regulations merely regulate how much of that cost can be transferred. To that end, any cost that is imposed on one group is a benefit to another. The Regulations must therefore decide the appropriate trade-off between these groups.

As costs and benefits cannot be meaningfully quantified in this matter, this Regulatory Impact Statement has employed a multi-criteria analysis (MCA) approach to assess the impacts of various options. It is noted that there is limited flexibility in the options available, as the Act only allows maximum fees to be set. The options therefore consider the levels of these maximum fees.

The MCA outcome determined, based on qualitative judgments about the impacts on the operation and effectiveness of the Act, that there was overall benefit in setting maximum fees, and further, that the maximum fees in the current Regulations should be increased. It was also considered beneficial that the maximum fees should be increased over time, rather than being fixed for the life of the Regulations.

The reasons for increasing the maximum fees reflects the outcomes of preliminary consultation in the preparation of this Statement, as well as recognising that the current fee caps were set after consideration of relevant labour costs and professional health service provider costs prevailing at the time the regulations were made. These have increased considerably since that time, and it is therefore appropriate to increase the fee caps to reflect these changes.

The increase is also considered acceptable in terms of resetting the balance between individuals and health providers based on the anecdotal evidence that in many cases fees are charged well below the caps, or at zero charge, and that there are very few complaints about excessive fees being charged. It is therefore considered that an increase in the fee caps, reflecting the increases in the costs to businesses, should not have a significant impact on individuals' right to access their health information.

Consultation has also highlighted that copies of health information are often posted to individuals, but are not currently reflected in the costs allowed to be recovered. It has therefore been included in the proposed Regulations, but only when the individual specifically requests that the information be posted.

The current and proposed fee caps are summarised in the table below. The new fee caps are proposed to be expressed in 'fee units', the value of which is determined each year by the Treasurer under the *Monetary Units Act 2004*. This allows the fee cap to increase each year in line with general cost increases.

| Item | Current fee cap | Proposed fee cap* | % change |
|---|---|---|---|
| Time for supervising inspection of records | $5 per quarter hour | 1.2 fee unit (currently equal to $14.70) per half hour or part thereof** | 47% |
| Time for collating health information | $20 | 2.5 fee units ($30.50) | 53% |
| Transporting records held off site | $10 | 1.2 fee units ($14.70) | 47% |
| Use of equipment not in organisation's possession | Reasonable costs incurred | Reasonable costs incurred | n.a. |
| Copy of health information to individual | 20 cents per page for A4 b/w<br>Reasonable costs otherwise | 20 cents per page for A4 b/w<br>Reasonable costs otherwise | No change |
| Providing a summary of information to individual | Greater of usual consultation fee (if a health service provider) or $25 per quarter hour, up to $80 | Greater of usual consultation fee (if a health service provider) or 2.9 fee units per quarter hour ($35.40), up to 9.4 fee units ($114.90) | 42%<br>44% |
| Postage | Nil | Actual postage cost, if request to be posted | n.a. |
| Copy of health information to another health service provider | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise | No change |
| Summary of health information to another health service provider | Greater of usual consultation fee or $25 per quarter hour, up to $80, where the time is at least 30 minutes | Greater of usual consultation fee or 2.9 fee unit per quarter hour ($35.40), up to 9.4 fee units ($114.90), where the time is at least 30 minutes | 42%<br>44% |
| Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding $40 per quarter hour up to $200 | Reasonable costs not exceeding 4.7 fee units per quarter hour ($57.40) up to 23.6 fee units ($288.40) | 44%<br>44% |

* The indicative fee amounts reflect that fee unit values are rounded to 1 decimal point, and that in calculating fee amounts, fees are rounded to the nearest 10 cents. The fee unit value of $12.22 applies to 2011-12 and has been used in the above calculations, although will increase to $12.53 from 1 July 2012.

** The current fee for supervision is expressed in terms of quarter hours. However, in order to make use of the Monetary Units Act, the fee units must be expressed as 1 fee unit or more. Therefore this has changed to be expressed in terms of a half-hour, although the proposed Regulations provide for charges to be made in quarter-hour increments.

No change in cap has been proposed for the cost of providing copies of documents. This reflects that copying costs remain low, and ongoing technological advancements suggest that these costs should not increase over time like labour-related costs. It is also considered important that the fee caps encourage the most

efficient means to provide access to health information, and the cost of copying is one area where there is a readily available commercial market that can provide copying services within the allowed cap. As discussed above, the overall cost of handling copies has also been addressed by allowing the cost of postage to be added to existing fee items.

## Consultation

A primary function of the RIS process is to allow members of the public to comment on the proposed Regulations before they are finalised. Public input provides valuable information and perspectives and improves the overall quality of regulations. Accordingly, feedback on the proposed Regulations is welcomed and encouraged.

All interested parties are invited to provide comment on this Regulatory Impact Statement. Parties may wish to respond to any part of this Statement or the draft Regulations, although particular comment is invited on:

- whether there are any specific unforseen impacts of the proposed changes
- whether the assumption that most instances of access are currently provided below the maximum fees, or at no charge, is reasonable
- whether the assumption that the proposed increases in maximum fees will not have a material impact on people accessing their information is reasonable.

Responses are to be received by the Department no later than xxxx 2012.

# 1 INTRODUCTION

## 1.1 Regulation of personal health records

The *Heath Records Act 2001* provides a framework for controlling the collection and handling of individuals' personal health information and establishes a legislative right for people to access health information about themselves kept by private entities. The Health Privacy Principles (HPPs) set out in the Act are based on international standards and are designed to protect privacy, promote patient autonomy, and ensure a safe and effective delivery of health services. HPP 6 sets out an individual's right to obtain access to health information about themselves.

The arrangements are contained mostly in legislation, however, some matters are contained within regulations. The Health Records Regulations 2002:

- set a maximum fee a private sector organisation may charge for granting an individual access to health information
- set a maximum fee a health service provider may charge for providing a second opinion where access to health information has been refused on the basis of a serious threat to the individual
- set a maximum fee a health service provider may charge for making health information available to another health service provider
- specifies additional health information that may be collected by an organisation (namely, about a person's relative).

The Health Records Regulations expire on 12 June 2012. They are proposed to be remade, with some changes to the maximum fees, subject to the outcomes of consultation on this Regulatory Impact Statement.

## 1.2 Purpose of this Regulatory Impact Statement

This Regulatory Impact Statement (RIS) formally assesses the proposed Regulations against the requirements in the *Subordinate Legislation Act 1994* and the *Victorian Guide to Regulation incorporating: Guidelines made under the Subordinate Legislation Act 1994*.

The Victorian Government's principles in relation to regulation are to:

- ensure that regulations are well targeted, effective and appropriate
- reduce the regulatory burden on business and not-for-profit organisations.

The proposed Regulations have been assessed in the context of these principles.

The assessment framework of this RIS:

- examines the nature and extent of the problem to be addressed
- outlines the objectives of the proposed Regulations
- explains the effects of the proposed Regulations on various stakeholders
- assesses the costs and benefits of the proposed Regulations.

Feasible alternatives to the proposed Regulations are also considered and assessed. The RIS also examines the potential impact on competition.

# 2 THE REASONS FOR REGULATION

## 2.1 Background

Health information about Victorians is kept by a range of entities, including public hospitals and other public health care services, doctors, dentists, other private health service providers (e.g., aged care providers), and other organisations such as insurance companies, schools, sporting clubs and employers.

While health information is owned by the organisation holding the records, the community expects that they are able to access health information held about themselves when they wish. However, providing access to such information can often be a burden on the organisation holding the information. Therefore, legislative arrangements have been put in place to facilitate access.

In Victoria, access to health information held by public sector entities, such as public hospitals, has been regulated for some time under the *Freedom of Information Act 1982*. The FOI Act outlines a process for requesting access to information, conditions for granting or refusing access, and provides for fees to be paid to meet some of the costs associated with access.

Complementing the FOI Act, since 1 July 2002 the *Health Records Act 2001* has provided people with a legal right to access health information about them held by private sector entities.

The *Health Records Act* anticipated that these private sector entities should be allowed to charge a fee for providing access to health information in a similar way that individuals are charged to access public information under the *Freedom of Information Act*. However, to avoid exploitation, the Act:

- allows regulations to be made that placed caps on the fees that can be charged
- provides that unless such fee caps are in place, the private sector entities cannot charge any fee for providing access under the Act.

The *Health Records Act* also provides that a person may direct health service providers to provide health information about them to another health service provider. In these circumstances, the entities must be health service providers as defined in the Act, but can be either public or private. Fees may be charged not exceeding a maximum to be set by regulations.

The proposed Regulations set these fee caps.

## 2.2 Nature of the problem

The *Health Records Act* recognises as a fundamental right that people should be able to access health information about themselves. In extending provisions similar to those in the *Freedom of Information Act*, the *Health Records Act* provides a framework that guarantees a right of access regardless of where a person's health information is collected or held.

The stated purpose of the *Health Records Act* is to promote fair and responsible handling of health information by providing individuals with a right of access to their health information.

People may wish to access health information kept about them for a number of reasons. These include to better informing themselves of their health status, checking the accuracy of information, or satisfying themselves in the event of any concerns over the appropriateness of treatment. A person may also wish to transfer information to another health service provider when changing service providers, when being referred to a specialist, or to seek a second opinion. It is important to note that under either the FOI Act or the *Health Records Act*, people are not required to provide a reason for why they wish to access the information.

### *Providing access to individuals*

Providing access to individuals may take a number of forms, including:

- allowing inspection of documents
- providing copies of documents
- providing a summary of information
- providing an explanation of information.

All these activities place a cost on the entity providing access to the information. This cost can be substantial, depending on the nature of the request and the volume of records kept on any individual.

While the *Health Records Act* prohibits the charging of fees under that Act unless maximum fees have been set in regulations, private sector entities may be still be able to charge fees for granting access under the Commonwealth *Privacy Act 1988*.

The *Privacy Act* requires private sector organisations to give a person access to personal information about themselves if requested (unless an exception applies).[2] The *Privacy Act* provides that, if a private sector organisation charges a fee for providing access to health information, such a fee "must not be excessive". The Commonwealth arrangements are complementary to any state-based regulations setting maximum fees; service providers must comply with both. As the Commonwealth arrangements do not prescribe a maximum fee cap, there is no inconsistency created between the Commonwealth and Victorian regulations.

The Office of the Australian Information Commissioner has released guidance material on fees for access to health information under the *Privacy Act*. It outlines that fees may include *reasonable* costs of resources and time, noting the objective that the cost of giving access should not create an unreasonable burden on health service providers.

There is no set limit on the fee that may be charged, however, the guidance material recommends that providers:

- discuss likely fees with patients before processing a request
- consider the individual's capacity to pay.

[2] See Section 16A of the *Privacy Act 1988* and National Privacy Principles in Schedule 3 of that Act.

Notwithstanding the provisions in the Commonwealth legislation, there are a number of reasons why maximum fees should be set under the *Health Records Act*:

- The Commonwealth arrangements do not include any schedule of fees or caps, so fees may still be a disincentive to people exercising their right to access information
- Prescribing fee caps provides greater certainty for organisations in what may be charged, rather than relying solely on whether the fee will be considered 'excessive' (it is noted that review at the Commonwealth level is necessarily subjective and may occur even where a person has agreed to the fees prior to gaining access)
- Access to information is only regulated by the Commonwealth's legislation for organisations, other than health service providers, with an annual turnover of at least $3 million. This means smaller organisations that collect and hold health information are not required to comply with the Commonwealth legislation. As these organisations do have to provide access under the Victorian Health Records Act, in the absence of regulations setting a maximum fee, they would not be able to charge any fee for providing access to individuals
- As the Commonwealth and Victorian arrangements have some differences in terms of when access must be provided (for example, via difference in exceptions and criteria for refusing access), it is also theoretically possible that there are other situations where a right to access health information exists only under the Victorian *Health Records Act* and not the *Privacy Act*. In such a case, in the absence of regulations setting a maximum fee, Victorian organisations would not be able to charge any fee for providing access to health information.

### *Transfer of information between health service providers*

HPP 11 enables an individual to request that health service information held by one health service provider be made available to another health service provider. These arrangements:

- apply only to health service providers (not any organisation holding health information)
- apply to both public and private sector health service providers.

This provision is relevant where an individual does not wish to personally obtain their health information, but does require that it be made available to another provider.

HPP 11 allows for providers to charge a fee for transferring health information, subject to a maximum fee to be prescribed in regulations. In the absence of regulations, there would be no cap on the fees that could be charged.

There is potential for health service providers to charge high fees for transferring information. This may be due to failing to address actual high cost structures in the management of health information, or as a strategy to prevent individuals from going to another health service provider. High charges not only directly impinge on an individual's legislative right to achieve a transfer of health information to another health service provider, but may in individual cases affect the choice and quality of care they receive.  A cap provides an incentive for a business with high cost structures to review their costs to minimise the costs incurred by the business.

### *Nominated health service providers reviewing refused access*

Under section 26 of the *Health Records Act*, an organisation must refuse a request to access health information if the organisation believes, on reasonable grounds, that providing access would pose a serious threat to the life or health of that individual. An organisation may offer to discuss the information with the individual, or the individual may choose to nominate another health service provider to view the information and, at the decision of that nominee, explain the health information or explain the grounds for refusal to the individual.

If another health service provider is nominated, their functions under section 42 of the Act are:

- to notify the individual that the provider will discuss with the organisation the basis for the refusal of access by the organisation
- to contact the organisation that refused access in order to discuss the nature of its concerns
- to form an opinion on the validity of the refusal to provide the individual with access on the ground that providing access would pose a serious threat to the life or health of the individual
- if the nominated health service provider thinks it appropriate to do so, to explain the grounds of the claim to the individual
- if the nominated health service provider thinks it appropriate to do so, to discuss the content of the health information with the individual
- if the provider is satisfied that to do so would not constitute a serious threat to the life or health of the individual, to allow the individual to inspect the health information or, if the individual so wishes and the organisation agrees, to have a copy of it
- if the provider is not satisfied, to decline to allow the individual to have access to the health information.

The arrangements in the Act recognise that refusing access to health information should only occur in special circumstances, and as this affects a person's rights, safeguards are included in the Act including the ability to seek review by a nominated health service provider.

Section 42(3) of the Act allows the nominated health service provider to charge a fee for this function, not exceeding any maximum fee prescribed in regulations. In the absence of regulations, there would be no cap on the fee that providers could charge. This may make it difficult or prohibitive for an individual to seek timely and reasonable review of a decision to refuse access, and therefore may unfairly affect the ability of an individual to exercise their rights under the Act.

## 2.3 Extent of the problem

In consultation conducted by the Consumers Health Forum of Australia in relation to the Personally Controlled Electronic Health Record (PCEHR) system, it was found that consumers ranked the availability of their own health information and high-quality information on their own condition as the single most important feature of any health system.

When asked what changes would be most likely to increase quality of care, consumers wanted access to more of their own health information as the most common response.

There is no available data on what fees are currently charged for providing access to health information. Anecdotally, consultation has identified that:

- it is common for organisations to provide access to information informally, rather than under the *Health Records Act*, for which no charge is applied
- even for requests made under the Act, it appears that fees are not charged in many common situations, particularly by GPs referring patients to specialists
- fees charged at the maximum amounts are therefore relatively infrequent.

Against this, consultation has indicated:

- a growing share of requests for information under the *Health Records Act* is by legal representatives for the purposes of determining whether litigation may be commenced
- while the fees caps have been expressed in a dollar amount that has not changed since 2002, actual costs of providing access have increased.

The Department of Health understands that it is common practice that such transfers occur without charge. For example, the Department is not aware of cases where a general practitioner charges a fee for transferring information to a specialist to whom they have referred a patient.

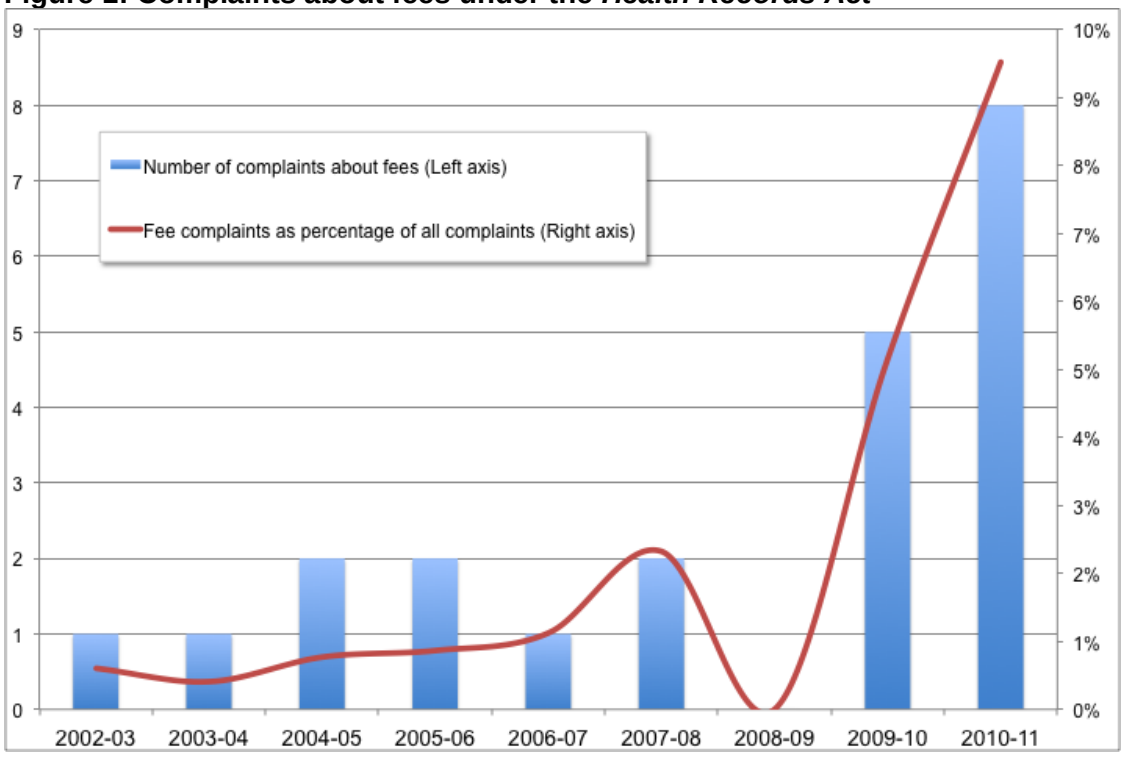
Complaints about access to health information, including complaints about fees, are made to the Office of the Health Services Commissioner. In 2010-11 there were 84 complaints accepted under the *Health Records Act*, down slightly from 97 in 2009-10. Of the complaints in 2010-11, eight complaints related to excessive fees (four for access by an individual and four for transferring to another health service provider). This is less than ten per cent of total complaints made under the Act.

Of the complaints made in 2010-11, four were for organisations charging flat fees (between $50 and $55 per instance) for transfers of information between health services providers, without regard to the prescribed caps. Another complaint involved an attempted charge of $495 when the maximum allowed under the regulations would have been $133. The evidence from complaints indicates most cases were due to lack of knowledge of the fee caps rather than knowing non-compliance. This provides evidence that there are likely other organisations that would seek to recover a higher amount of their costs in the absence of fee caps prescribed in the regulations.

Figure 1 below indicates that the number of complaints about excessive fees has increased in the past two years, suggesting an increase in the number of cases of

organisations attempting to recover costs higher than allowed under the current Regulations. It is noted, however, that the total number of complaints about fees is very low overall, and is in general the least frequent source of complaints about access to health information.

**Figure 1: Complaints about fees under the *Health Records Act***




*Source: Office of Health Services Commissioner Annual Reports*

This data indicate that the key objective of the current Regulations, which was to strike an appropriate balance between allowing adequate cost recovery and ensuring that fees are not prohibitive, has been met. The Office of the Health Services Commissioner (OHSC) agrees with this conclusion.

The OHSC also runs a telephone enquires line. It receives around 100 enquiries per year about fees to access health information. This is around 2 per cent of the total enquiries made.

It is also difficult to establish what fees might be charged in the absence of regulations, as the current regulations have been in place since the introduction of the legislative right to access health information in 2002.

Canada is a jurisdiction where a right to access health information exists (as a common law right rather than a statutory right) but where there are no caps in place for the costs that may be recovered by a service provider.

A relevant case study[3] is Ontario, which formalised access arrangements under the *Personal Health Information Protection Act* (PHIPA) in 2004. PHIPA permits custodians of health information to charge the amount of “reasonable cost recovery”

[3] This discussion is taken from the Ontario Information and Privacy Commissioner Annual Report 2010.

when providing access to information. However, since the commencement of the PHIPA, the Ontario Information and Privacy Commissioner has urged the provincial government to bring in a regulation to prescribe specific fees that health information custodians may charge individuals. The Commissioner based this need on the complaints it has received under the PHIPA, with the conclusions that:

- any interpretation of the term "reasonable cost recovery" that imposes a financial barrier or deters individuals from exercising their right of access to records must be avoided
- with widespread observed discrepancies across the health sector, some custodians charge excessive fees that pose barriers to access, resulting in complaints.

### *Changes since 2002 – the need for continued or changed regulations*

The key change since the current Regulations were in place has been the costs to health service providers of providing access to health information. While there are no specific data available on actual costs to individual providers, actual costs are likely to vary significantly across providers. Stakeholder consultation has noted a number of instances where providers are seeking an increase in the fee caps to reflect higher costs.

A large component of the costs of providing access to health information is likely to be labour-related costs. This includes the time of staff to search and collate information, supervise inspection of information, and provide summaries or explanations of information. It is therefore relevant to consider labour-related cost indicators:

- from November 2001 to November 2011, average adult full-time ordinary time weekly earnings for Victoria has increased by 55 per cent (ABS 6302.0 released 23 February 2012, trend data)
- the scheduled fee for a standard GP consultation under the Medicare scheme is now $35.60—this represents a benchmark minimum value for the time of a health professional, and compares to the $25 allowed to be charged under the current fee caps for a health professional to provide a summary of health information. The current schedule fee compares to the same fee of $24.45 that was prevailing at the time the current Regulations were designed—giving an increase of around 46% since that time.

Because the current Regulations set the fee caps as certain monetary amounts, they have not increased since 2002. There is therefore a compelling argument to consider increasing the fee caps to keep them up to date and to better reflect current costs, to continue to enable "reasonable" costs to be recovered where a health provider chooses to pass on these costs to consumers. It is also sensible to consider an option to express the fee caps in fee units that can be automatically indexed each year.

## 2.4 Additional element of the proposed Regulations

The proposed Regulations also prescribe circumstances in which an organisation may collect health information about an individual.

HPP 1 governs the collection of health information by private and public sector organisations. It provides that information about an individual cannot be collected

unless the information is necessary for one or more of the functions or activities of the organisation.

HPP 1 also limits the health information that may be collected to a list of circumstances set out in the HPP. These are intended to ensure that identifying health, disability or aged care information is only collected about a person in appropriate circumstances. The Act permits the making of regulations to set out additional circumstances where health information may be collected.

The proposed Regulations permit limited collection of health information from an individual who attends a health service provider about a relative, in a way that reflects community standards. By permitting the information to be collected (in addition to the information that may already be collected under the Act), the proposed Regulations ensure that the individual can receive safe and effective health services while respecting the privacy of the relative. Specifically, the collection of identifying information about the relative is required to be kept to a minimum.

This regulation recognises that it is now an accepted part of some health service delivery, especially medical practice, that a health provider will prepare a basic family history from information provided by the person seeking health services, to assist in diagnosing and treating that person.

The Act does not prohibit a patient giving this information to a health service provider. The proposed Regulations will ensure that the reciprocal act of collecting the information from a patient by a provider is also lawful. The collection of information on family members will still be subject to HPP 1.1 (i.e., the information must be necessary to the functions of the service) and must be appropriately protected. The information cannot be used for any purpose other than treating the patient.

Failure to make this regulation could compromise patient care by limiting the health service providers' ability to collect information on family medical history that would be relevant to the diagnosis and treatment of an individual. This could impede effective care in relation to illnesses that have a genetic element.

The proposed Regulation is considered reasonable. It:

- mirrors arrangements under the Commonwealth *Privacy Act 1988*, which allows the collection of health information for the purposes of compiling a family medical history
- is specifically addressed in the Australian Standard AS 4400, *Personal privacy protection in health care information systems*, which contemplates personal information collected for the purpose of assembling a family or genetic history of a person.

This regulation is designed to expand the information that is allowed to be collected, and therefore does not impose a cost. This component of the regulations is not considered further in this RIS.

# 3 IDENTIFICATION OF OPTIONS

## 3.1 Objective

The objective of government action is to allow individuals to obtain health information related to themselves in an equitable, efficient and effective manner. This involves balancing the following:

- ensuring that any fee changed for access to health information does not unfairly preclude an individual from requesting access to health information (equity)
- allowing reasonable cost recovery for organisations providing access to health information (efficient and effective).

## 3.2 Base case

The base case is a 'do nothing' scenario, against which other options for action can be assessed. It reflects the likely outcomes over the next ten years if the current Regulations are allowed to lapse and are not replaced, and all other activities continue on a business-as-usual basis.

Under the base case there are two types of organisations: those that can charge any amount for providing access to health information (subject to other laws), and those that are unable to change any fee for providing access.

In the absence of regulations, most organisations would be able to charge any amount for a person accessing or requesting the transfer of health information (subject to other legal constraints such as the Commonwealth *Privacy Act* previously outlined). Nominated health service providers would also be able to charge any amount for performing services under section 42 of the Act.

High fees are likely to discourage people accessing health information, which is contrary to the aims of the *Health Records Act*. However, it is not possible to determine what fees might be charged in the absence of regulations as fee caps have been in place since the creation of the legislative right to access health information. However, the prevalence of cases where access is provided for free, or below the current caps, indicates that high prices are not likely to be frequent in the absence of fee caps. That said, individual cases of excessive charges are likely to have significant impact on individuals who are not able to afford to exercise their legislative rights, which may in turn have impacts on their choice or quality of care.

There are also a small number of organisations that, in the absence of regulations, would not be able to recover any of the cost of providing access to health information. This could arise in two cases:

- Due to minor differences in the arrangements under the Victorian *Health Records Act* and the Commonwealth *Privacy Act*, there may be cases where an individual may only be able to request access under the Victorian Act and not the Commonwealth Act (for example, different exceptions and reasons for refusal). The Department of Health is not aware of any specific cases where this has caused concerns, but it remains a potential problem.
- Further, while the *Privacy Act* applies to all health service providers, it only applies to other (non-health service) organisations with an annual turnover of at

least $3 million. This is expected to only include a small number of organisations, such as small gyms/personal trainers. These are all likely to be small businesses.

It is therefore possible that cases will arise where access to information relies solely on the *Health Records Act*.

## 3.3 Options to achieve the objectives

Section 32 of the *Health Records Act* anticipates the setting of maximum fees in regulations. In fact, such maximum fees must be prescribed in order to allow fees to be charged under the Act.

Section 100 of the Act allows for regulations to be made for or with respect to:

- prescribing maximum fees for providing access to health information
- prescribing maximum fees for performing functions under section 42
- prescribing maximum fees for transfers of health information between service providers.

In identifying options, it seems reasonable to assume that in certain cases, the regulations are the only viable option because they 'give effect' or 'operationalise' key elements of the Act. While these suppositions should generally be avoided, clause 51 of the Premier's Guidelines states when the Act requires that a thing or matter be prescribed in regulations, then it must be provided in the Regulations:

> where the authorising legislation dictates what kind of instrument may be created. For example, *where the authorising legislation provides for fees to be prescribed in statutory rules, there may be no discretion to set those fees by another method*. (emphasis added)

Available options therefore go to the level at which the maximum fees may be set in the regulations.

Section 100 of the Health Records Act allows that:

- regulations may have general or limited application
- the power to make regulations prescribing maximum fees for providing access to health information by way of a summary may be exercised by reference to the time taken to prepare the summary based on the usual fee of the health service provider for a consultation of a comparable duration.

The Act provides that a person's right of access may be exercised in a number of different ways. These are:

- viewing health information contained in a record, with or without an explanation of the information
- provision of a copy or print-out of the health information
- provision of a summary of the health information
- inspection of the health information with the opportunity to take notes.

The key option to be assessed is whether the current Regulations should be remade at the same amounts. Following this, consideration will be given to a series of potential amendments to the current Regulations. These are:

- increase the current fee caps
- index the fee caps.

Given that many of the caps were set in 2002 with reference to costs at that time, there is little basis for reducing any of the caps. The low level of complaints about access to health information in relation to fees suggests that there is no significant case to be made for reducing the caps—especially since it appears most organisations provide access for no charge, or a charge below the caps.

### 3.3.1 Option 1: Remake the current Regulations

The current fee caps are summarised in the following table.

**Table 3.1: Fee caps in the current regulations**

| Item | Current fee cap | Rationale for current cap |
|---|---|---|
| Time for supervising inspection of records | $5 per quarter hour | This is equivalent to FOI Act for this function. At the time of introduction, consultation indicated that this task is usually done by administrative staff rather than health professions. |
| Time for collating health information | $20 | This was originally based on administrative staff collating information in most cases, although a health professional may be involved in some instances to assess suitability to release information. |
| Transporting records held off site | $10 | Assumed to represent half an hour of time for administrative/general staff to retrieve documents from a nearby location. |
| Use of equipment not in organisation's possession | Reasonable costs incurred | This is necessarily case-specific and no cap is appropriate. |
| Copy of health information to individual | 20 cents per page for A4 b/w<br>Reasonable costs otherwise | Equivalent to the FOI Act for copies. It was also considered equivalent to a reasonable approximation of costs likely to be charged by a commercial photocopying service.<br>Other types of copying are necessarily case-specific, as may range from simple paper copies to copying x-rays, photographs, videos, disks, etc. |
| Providing a summary of information to individual | Greater of usual consultation fee (if a health service provider) or $25 per quarter hour, up to $80 | This cap recognised that consultation fees may vary widely. The cap of $80 was applied in order to ensure that effective access is maintained and that health service providers are not able to recover more than their reasonable costs. This formula is consistent with the FOI Act. |
| Copy of health information to another health service provider | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise | As above, with the minimum number of pages and consultation time reflecting the practices at the time. |
| Summary of health information to another health service provider | Greater of usual consultation fee or $25 per quarter hour, up to $80, where the time is at least 30 minutes | |
| Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding $40 per quarter hour up to $200 | The fee reflected that the role of nominee was done voluntarily, and that the function was intended to be an initial, low-cost means of dispute resolution. Fee caps must therefore ensure there is a sufficient supply of service providers willing to act in this role. |

The fees to be prescribed in the Regulations are maximum fees only. There is no requirement that these fees, or any fees, be charges when access is granted.

When an organisation voluntarily gives information to a third party, as permitted under HPP 2, this is considered to be 'disclosure' rather than 'access' and will not be affected by the proposed Regulations.

### 3.3.2 Option 2: Increase the fee caps

An option to increase the fee caps is proposed as a means of "re-setting" the caps to reflect inherent cost increases over the past ten years.

**Table 3.2: Increasing the fee caps**

| Item | Alternative fee cap | Rationale for change |
|---|---|---|
| Time for supervising inspection of records | $7.50 per quarter hour | As this is a labour cost, the increase reflects the increase in general wage costs since 2002. |
| Time for collating health information | $30 | As this is a labour cost, the increase reflects the increase in general wage costs since 2002. See discussion below. |
| Transporting records held off site | $15 | As this is a labour cost expected to be performed by general staff, the increase reflects the increase in general wage costs since 2002. While some providers may now use document management companies or couriers to perform this task, consumers should not required to pay higher amounts where this is more expensive than a cheaper method. Therefore, limiting the increase to wage cost increases is appropriate. |
| Use of equipment not in organisation's possession | Reasonable costs incurred | Remains case-specific. |
| Copy of health information to individual | 20 cents per page for A4 b/w<br>Reasonable costs otherwise | See section 3.4 below. |
| Providing a summary of information to individual | Greater of usual consultation fee (if a health service provider) or $36 per quarter hour, up to $115 | Reflects the minimum opportunity cost for a health professional, based on standard consultation fee under Medicare. |
| Copy of health information to another health service provider | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise | See section 3.4 below. |
| Summary of health information to another health service provider | Greater of usual consultation fee or $36 per quarter hour, up to $115, where the time is at least 30 minutes | Reflects the minimum opportunity cost for a health professional, based on standard consultation fee under Medicare. |
| Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding $58 per quarter hour up to $288 | Maintains the relativities between this function and providing a summary of health information above. |

As the costs of supervision of record inspection and collating of information in general reflect the time taken by general staff, increasing the fee caps in line with indicative labour costs is reasonable. From November 2001 to November 2011,

average adult full-time ordinary time weekly earnings for Victoria has increased by 55 per cent (ABS 6302.0 released 23 February 2012, trend data). This particular wage measure was chosen because it reflects the general increase in labour costs over the period—while the access arrangements in the Act apply to health services and may be carried out by health sector administrative or support staff, or in some instances other health professionals, the regulations also apply to health information held by all organisations, not necessarily health service providers. The staff undertaking particular tasks such as supervision or collating information would therefore represent a range of different staff types, which is unlikely to have changed since the introduction of the current Regulations, and a general wages growth measure is therefore appropriate.

Therefore, this option increases the fee caps for supervision, collation, and transportation by around 50 per cent.

The $30 fee in relation to collation of information is a general labour cost and reflects the increase in general wage costs since 2002 from the previous $20 cap. The fee cap equates to one hour of labour by general or administrative staff. One hour was the benchmark used when the regulations were first introduced in 2002 and this is still considered suitable for those providers who have yet to move to electronic record keeping. One hour of time is considered sufficient to obtain and provide health information to a patient. To provide the information requested the following steps need to be undertaken by the staff member:

- find and access the patient file
- read through the file to obtain the necessary documents and extract the information requested
- possibly confirm with the medical supervisor the information is what was requested
- envelope the documents to post or handover to the patient.[4]

The fee cap for collating information is set at a $30 maximum fee to allow for the range of provision of health information that may occur. As it is a maximum fee it allows suitable cost recovery for those organisations who are not able to access or provide the information electronically. There are still some health service providers in this situation. For those providers that can access and provide the information electronically, as the fee set is a maximum, it allows them to charge a lesser fee to reflect their actual costs. Setting a maximum fee at $30 both allows for the change in labour costs over the past ten years and provides flexibility to allow charging of lower fees where health service providers have moved to a lower cost electronic health information storage system.

In contrast, the activity of providing a summary of health information is more likely to be carried out by a qualified health professional such as a doctor. The scheduled fee for a standard GP consultation under the Medicare scheme is now $35.60. This option therefore increases the cost of providing a summary to $36, reflecting the minimum opportunity cost of providing the service. This is similar to when the current fee cap was fixed at $25 at a time when the prevailing standard consultation amount was $24.45. This is an appropriate benchmark of efficient cost of providing this service, and remains an appropriate approach to setting this fee cap. Increasing the amount that can be recovered for this function is consistent with the fee that may be

[4] A separate fee cap is prescribed for photocopying and that is not included in this fee cap.

charged for providing an explanation of health information, which is set under the Act (not the regulations) to not exceed the person's usual fee for a consultation of a comparable duration. The Department expects that this has risen by a similar percentage during the life of the current Regulations.

Recognising the special circumstances of ensuring supply of health service providers that are willing to be nominated to perform functions under section 42 of the Act, the fee cap for that function has also been increased proportionately.

For this option, the fee cap for copies of documents is not changed. This is discussed separately in the next section.

### 3.3.3 Option 3: Indexing the fee caps

Under this option, caps on fees under the *Health Records Act* would be increased as per Option 2 to better reflect current costs, and then converted to a number of equivalent fee units. Each year as the value of a fee unit is changed, the maximum amount that can be charged for access to health information would also change.

The *Monetary Units Act 2004* provides for fees in various Acts and other instruments to be expressed as certain 'fee units' and calculated by reference to a fee unit value determined under that Act. The current value of a fee unit is $12.22 has been used, although the fee unit value will increase to $12.53 from 1 July 2012.

**Table 3.3: Indexing the fee caps**

| Item | Fee cap units* |
|---|---|
| Time for supervising inspection of records | 0.6 units ($7.35) per quarter hour |
| Time for collating health information | 2.5 units ($30.50) |
| Transporting records held off site | 1.2 units ($14.70) |
| Use of equipment not in organisation's possession | Reasonable costs incurred |
| Copy of health information to individual | 20 cents per page for A4 b/w<br>Reasonable costs otherwise |
| Providing a summary of information to individual | Greater of usual consultation fee (if a health service provider) or 2.9 units ($35.40) per quarter hour, up to 9.4 units ($114.90) |
| Copy of health information to another health service provider | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise |
| Summary of health information to another health service provider | Greater of usual consultation fee or 2.9 units ($35,40) quarter hour, up to 9.4 units ($114.90), where the time is at least 30 minutes |
| Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding 4.7 units ($57.40) per quarter hour up to 23.6 units ($288.40) |

** dollar amounts show the value of the fee caps based on the current fee unit value of $12.22 per unit. This will increase to $12.53 per unit from 1 July 2012.*

The monetary value based on the current fee unit value is the same as Option 2, subject to minor rounding, however, these will increase each year over the life of the Regulations.

The value of a fee unit for each financial year is fixed by the Treasurer under section 5 of the *Monetary Units Act*. The value of a fee unit for a financial year must be

published in the Government Gazette and a Victorian newspaper before 1 June in the preceding financial year.

The rationale of this approach would be to recognise that the core costs in providing access—staff time—is likely to increase over time.

As with Option 2, the fee cap for providing copies of information is not changed in this option, and is discussed in the next section.

## 3.4 Special consideration of copying costs

The fee cap for copying (20 cents per page for black and white A4 pages) was set in the current Regulations in 2002, matching the same charges under the *Freedom of Information Act*. It is noted that the FOI Act is a fixed fee (although this may be waived in some cases), while under the *Health Records Act* the current Regulations can prescribe only a maximum charge.

Consultation as part of the review of the current Regulations has highlighted divergent views on the appropriate cap on making copies of documents.

A number of stakeholders stated that the 20 cents per page fee was still appropriate. However a smaller number of submissions argued for a higher limit. In particular, attention was drawn to a 2005 case (within the Commonwealth arrangements) where a court found that $1 per page for copying documents totalling 32 pages by a health service provider was reasonable. Supreme Court fee scales also imply costs of over $1 per page.[5]

However, no submissions from stakeholders have provided evidence as to the actual costs of making copies. The Department is aware that:

- commercial printing services can make copies for as little as 10 cents per page for A4 black and white (based on a website search in March 2012)
- A4 paper can be bought for less than 1 cent per page, and printing costs from modern printers and copiers averages around 4 to 8 cents (based on a website search in March 2012).

The current cap of 20 cents per page does not therefore appear unreasonable.

It is noted that these estimates reflect what is commonly available, and there may be cases where particular health service providers have higher costs. This may be due to the type of technology used, or that the equipment used requires higher than usual human involvement (e.g., having to place each page individually rather than using a document loader or printing off from an electronic source). However, it is noted that if a provider is not able to make copies within the allowed fee cap, they could avail themselves of readily available commercial alternatives that could.

Further, while the majority of items where fee caps are set in the Regulations will be unique to the individual and the service provider, the commercial photocopying market must be seen as the 'market test' of the efficient per page cost of photocopying. Efficient costs are important to ensure the community is not paying more than it needs to achieve the objectives of the Act. To allow high fees that are

[5] The Supreme Court fees will be subject to a RIS in 2012 and may change from their current levels.

seen to be high relative to a known market test provides incentives for inefficiency, and unnecessary cost to the community as a whole. In this special case, there is benefit to ensuring that costs of copying remain efficient.

In addition, as the fee caps are intended to reflect the community's expectations of the costs of exercising their legislative rights, there is likely to be public opposition to substantial increases in the fees allowed for copies of documents. This stems not only from the comparison to commercial printing and copying prices, but also when compared to the cost of the same item under the *Freedom of Information Act*.

It is therefore proposed to keep the fee cap for copies of information at 20 cents per page. Indexation is not justified as, unlike labour-related costs, technological improvements tend to keep the costs of printing down. It is noted that the commercial costs of copying, paper and equipment has in general not increased since the introduction of the current Regulations.

It is further noted that since the commencement of the current Regulations, the roll out of electronic records by health service providers has likely reduced the cost of making copies of information.

One theme identified in the initial consultation and research was that the current Regulations do not specifically allow for an amount to be recovered for postage. It is uncertain how often copies of requested information are posted to individuals, although it is noted that these costs could be substantial (it is assumed that, given the nature of the information, registered or priority postage would be expected). In recognition that postage may be part of the costs of handling copies of requested information, the proposed Regulations include an item specifically on postage, with the conditions that:

- The costs recovered are the actual costs incurred, removing any incentive for organisations to use a more costly method that is not required
- Costs can be recovered only in cases where an individual requests that the information be posted. (The Act requires that individuals be notified of estimated fees prior to gaining access to information, providing a point for individuals to decide whether or not they want the information to be posted).

## 3.5 Other options considered but not analysed

### 3.5.1 Structure of the fee caps

The Department gave consideration to reducing the number of different fee caps in the Regulations. However, this was not considered to be an improvement as:

- the fee caps set for an individual accessing their own health information is already aligned with the same activities for transferring health information between health service providers
- there is a need to distinguish between activities that are likely to involve a health service professional and those that are more routine and could be carried out by other staff
- the current (and proposed) Regulations distinguish between activities where the consumer controls the time used (hence a fee cap per time unit) versus those where the health service provider controls the time used (hence an overall cap is appropriate)

- the special factors in relation to ensuring a ready supply of health service professionals available for performing functions under section 42 of the Act warrant a different fee cap arrangement in these cases.

Therefore, the structure of the proposed maximum fees remains the same as the current structure.

### 3.5.2 Paper-based versus electronic records

The Department notes that with the increasing use of electronic-based records, the costs of providing access to health information could potentially reduce. While there is scope to distinguish in the regulations different fee caps depending on how the records are stored, this is considered unnecessary as:

- where electronic records make the locating, collating and assembling of records faster, this will be reflected in lower costs to consumers through less time needed to be charged against the time-based fee caps (e.g., 1 hour's work could be reduced to 15 minutes). While this may mean that the time needed to locate and compile some records may be well below the impact of the fee cap (possibly only a few minutes), the proposed Regulations continue the requirement for charges to represent only costs reasonably incurred where below the prescribed cap. A separate fee cap for electronic records is therefore not considered warranted at this time, as the proposed Regulations limit the amounts that can be recovered by an organisation while still maintaining the overall effective safety net of a fee cap for consumers.
- costs of providing copies of documents would be the same as the cost of a photocopy is considered to be about the same as the cost of printing an electronic record.

The Act also allows copies of records to be given other than in page form (e.g., as electronic copies on a disc).[6] In these instances, the current Regulations do not provide a fee cap, but limit fees that can be charged to the organisation's reasonable costs incurred in providing the copy. This is proposed to be continued under the proposed Regulations. The Department recognises that with the roll-out of the electronic health records system across health service providers, the frequency of providing electronic-based access to health information is expected to increase, and the Department may consider whether specific fee caps are appropriate once the system matures.

## 3.6 Arrangements in other Australian jurisdictions

Statutory rights to health information held by private organisations also exist in New South Wales and the Australian Capital Territory. Other Australian jurisdictions do not have a legislative framework for access to health information held by private organisations, relying solely on the Commonwealth's *Privacy Act*.

The ACT has established a schedule of maximum fees that a private sector organisation may charge. These are generally higher than the Victorian current fees, although there are some differences (see Attachment B).

[6] It is noted that health information is not usually provided via email, as the organisation has a duty to ensure the security and confidentiality of health information, and email is generally not a secure means of transmitting information.

While the NSW legislation envisages that fee caps may be prescribed, no maximum fees are currently in place. However, an important distinction to note is that section 73(2) of the NSW *Health Records and Information Privacy Act 2002* provides only that any fee charged must not exceed a fee (if any) prescribed by the regulations; while section 32(2) of the Victorian *Health Records Act* provides that no fee may be charged under the Act unless a maximum fee has been prescribed for that manner of access in the regulations. While in many instances organisations may still charge fees under the Commonwealth *Privacy Act*, there will be some cases that rely on the Victorian Act in order to recover part of their costs.

# 4 ASSESSING THE OPTIONS

It has not been possible to quantify the impacts of any of the identified options, as no data is collected on the incidence of access under the Act, or the amounts that are charged.

It is noted that setting maximum fees imposes no **net** cost on the community, as it only affects how much may be transferred between different groups within the community for the functions in the Act.

It is therefore appropriate to assess the options using multi-criteria analysis (MCA). An MCA allows a qualitative assessment of options based on desired outcomes. Options are assessed against a number of criteria that allow the option to be ranked in relation to the base case and alternative options. The full MCA process is described in Attachment C.

For the purposes of this RIS, options were assessed against the following criteria and associated weightings.

**Table 4.1: Multi-criteria analysis criteria and weightings**

| Criterion | Description | Weighting/rationale |
|---|---|---|
| Access to health information | The extent to which the option ensures that any fee charged for access to health information does not unfairly preclude an individual from requesting access to health information, requesting transfer, or seeking review of decision to refuse access. | 40%<br><br>This criterion is central to the rights established in the Act. High costs may impede the exercise of these rights, which may have subsequent consequences on choice and quality of care. |
| Minimise burden of organisations | The extent to which the option allows recovery of reasonable costs in providing access to health information, or other functions under the Act | 40%<br><br>The objective of the regulations is to balance this criterion with the first, giving it equal weighting. Not allowing reasonable cost recovery may have adverse impacts on the other services provided by the organisation, for example, charging more for other core health services. It is in the interests of individuals and the whole community that these organisations operate sustainably. |
| Efficiency | The extent to which fee caps promote access to health information being provided efficiently | 20%<br><br>It is in the interests of the community as a whole, and of individual persons, that the fee arrangements do not create an incentive for organisations to 'over-service' or sustain inefficient methods. The legislative rights established under the Act should be supported to operate at the least cost possible to society as a whole. |

For each criterion, options are scored from -10 to +10, relative to the base case (which is by definition scored zero on all criteria).

Of course, these are not the only important factors in making regulations. It is also important that regulations allow the fee arrangements to be predictable, transparent, and offer simplicity in how they work. However, given the limited range of options available under the Act, all options would score equally on such factors.

## 4.1 Option 1: Remaking the current Regulations

Given increases in actual costs over the past decade, the current fees now represent under-recovery of full costs in many circumstances.

As the fee caps are set at nominal levels, they would decrease in real terms over the life of the regulations, further enhancing people's ability to access their health information.

**Table 4.2: Multi-criteria analysis of remaking current regulations**

| Criterion | Analysis | Score | Weighted score |
|---|---|---|---|
| Access to health information (40%) | Capping fees that may be charged removes a barrier for some people to access their health information or request it be transferred. This improves the ability for more people to exercise their rights under the Act. Over time this would increase, as the fee caps are fixed at nominal levels. | +8 | +3.2 |
| Minimise burden of organisations (40%) | Capping fees means that a share of actual costs will be borne by the health service provider or other organisation. This therefore incurs a negative score as it represents a cost to these organisations compared to the base case. The magnitude of the negative score is, however, less than that of the first criterion because setting caps provides some certainty to organisations, and because there may be cases where some organisations cannot charge any fee unless there are regulations specifying a maximum (hence a small offsetting benefit for those organisations compared to the base case). | -7 | -2.8 |
| Efficiency (20%) | Retention of low fee caps maintains an ongoing incentive for organisations to seek efficiency improvements | +3 | +0.6 |
| **OVERALL SCORE** | | | **+1.0** |

## 4.2 Option 2: Increasing the fee caps

Higher fees means organisations are able to recover a greater share of the actual costs of providing access to health information. However, as the fee caps are fixed and not indexed, the amount that can be recovered will fall in real terms over time.

**Table 4.3: Multi-criteria analysis of increasing the fee caps**

| Criterion | Analysis | Score | Weighted score |
|---|---|---|---|
| Access to health information (40%) | Capping fees that may be charged removes a barrier for some people to access their health information or request it be transferred. This improves the ability for more people to exercise their rights under the Act. However, as the cap is higher than Option 1, it received a lower score. | +6 | +2.4 |
| Minimise burden of organisations (40%) | While the fee caps have been increased, this has been to maintain the balance struck when the access arrangements were established. In most cases, even with the proposed increase in fee caps, organisations' actual costs will be higher than the fee caps, and hence they continue to bear a share of the costs of providing access to health information. However, as the fee cap in this option is higher that Option 1, reflecting the rate of change in actual costs over the past decade, the score is less negative. Again, the magnitude of the negative score is also less than that of the first criterion because setting caps provides some certainty to organisations, and because there may be cases where some organisations cannot charge any fee unless there are regulations specifying a maximum. | -4 | -1.6 |
| Efficiency (20%) | The fee caps are less than full cost recovery, therefore, there remains incentive to pursue efficient costs, although this is less than Option 1. | +2 | +0.4 |
| **OVERALL SCORE** | | | **+1.2** |

## 4.3 Option 3: Indexing the fee caps

As well as increasing fee caps to better reflect current costs, indexing the fee caps allows the proportion of costs recovered to remain steady over time.

**Table 4.4: Multi-criteria analysis of indexing the regulations**

| Criterion | Analysis | Score | Weighted score |
|---|---|---|---|
| Access to health information (40%) | Capping fees that may be charged removes a barrier for some people to access their health information or request it be transferred. This improves the ability for more people to exercise their rights under the Act. However, as the cap is higher than Option 1 and over time will be higher than Option 2, it received a lower score. | +5 | +2.0 |
| Minimise burden of organisations (40%) | Even with the proposed increase in fee caps, organisations' actual costs will be higher than the fee caps, and hence, they continue to bear a share of the costs of providing access to health information. However, as the fee cap in this option is higher that Option 1, reflecting the rate of change in actual costs over the past decade, and the fee caps will be indexed over the life of the Regulations, the score is less negative than Options 1 & 2. | -2 | -0.8 |
| Efficiency (20%) | The fee caps are less than full cost recovery, therefore there remains an incentive to pursue efficient costs, although this is less than Options 1 and 2. | +1 | +0.2 |
| **OVERALL SCORE** | | | **+1.4** |

# 5 PREFERRED OPTION

## 5.1 Preferred option

The decision criterion used in this RIS is the scores produced by the multi-criteria analysis detailed in Chapter 4. An option with a positive MCA score is considered, based on informed qualitative judgement, to demonstrate superiority to the base case. A higher MCA score is preferred over a lower score. Based on this approach, the highest scoring option is to increase the fee caps by a modest amount.

**Table 5.1: Comparison of options**

| Option | MCA score |
|---|---|
| Remake the current regulations | +1.0 |
| Increase fee caps | +1.2 |
| Increase fee caps and index annually | +1.4 |

The preferred option is to increase the current fee caps, and allow the caps to be further increased each year in line with the increase in other government fees. The proposed Regulations therefore include the following fee caps, expressed in terms of fee units, whereby the actual monetary amount is equal to the product obtained by multiplying the number of fee units by the amount fixed from time to time by the Treasurer under section 5(3) of the *Monetary Units Act*.

**Table 5.2: Proposed fee caps**

| Item | Proposed fee cap |
|---|---|
| Time for supervising inspection of records | 1.2 fee unit per half hour* |
| Time for collating health information | 2.5 fee units |
| Transporting records held off site | 1.2 fee units |
| Use of equipment not in organisation's possession | Reasonable costs incurred |
| Copy of health information to individual | 20 cents per page for A4 b/w<br>Reasonable costs otherwise |
| Providing a summary of information to individual | Greater of usual consultation fee (if a health service provider) or 2.9 fee units per quarter hour, up to 9.4 fee units |
| Postage | Actual postage cost, if the postage is requested. |
| Copy of health information to another health service provider | 20 cents per page for A4 b/w if at least 20 pages<br>Reasonable costs otherwise |
| Summary of health information to another health service provider | Greater of usual consultation fee or 2.9 fee unit per quarter hour, up to 9.4 fee units, where the time is at least 30 minutes |
| Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding 4.7 fee units per quarter hour up to 23.6 fee units |

** Note that the assessed option was based on 0.6 fee units per quarter hour, however the proposed Regulations are required to express fee units of 1 fee unit or more. Therefore a half-hour rate is included, however the Regulations provide that this cost should be charged in quarter-hour increments.*

The Department acknowledges the very close scoring of the options in table 5.1 and notes that a slight change in the weightings of the criteria or scoring of options could alter the outcome.

### *Groups affected*

While no data is collected about when access to health information is sought under the Health Records Act, the OHSC considers that possibly more than 90 per cent of requests are made to GPs, specialist doctors, or to private hospitals. This would range from a sole practitioner (often in rural areas) to large corporate medical clinics, and extending large private hospitals. It is therefore expected that the impact of the fee caps will fall most heavily on this group.

The beneficiaries of the proposed Regulations are individuals seeking access to the health information, or seeking to transfer health information to another health service provider. The regulations ensure that costs of accessing health information do not impede a person's legislative right to access that information.

An individual can make an access request orally or in writing. If they make an oral request, the organisation can ask them to put it in writing. Consultation for this RIS indicated that, where fees are to be charged, organisations prefer requests to be in writing.

While requests may initially be by phone or email, all organisations have a responsibility to verify the identity of the person making the request, and therefore requesting information in person is nearly always required.

The organisation has an obligation to keep records secure. This means records are in general not able to be emailed, as this form of transmission is not considered secure. Therefore, sending the records by post or collection by the individual is usually required.

The community as a whole will also benefit from the proposed Regulations as supporting the right to access health information is likely to lead to improved choice and quality of health services, while creating incentives to keep the costs of access to reasonable amounts.

## 5.2 Implementation and enforcement

There are no implementation issues identified, as the regulations are a continuation of current arrangements. In terms of changes to the fee caps, information will be provided via the Department of Health's website and via the Office of the Health Services Commissioner's website to assist organisations and individuals determine the actual fee cap at any time. This will be updated in a timely way each year following determination of the relevant fee unit value. Attention will be drawn to the new Regulations via information provided through peak bodies and other forms such as industry newsletters.

The *Health Records Act* does not create an offence for failing to comply with the fees regulations, and the government does not actively intervene to require reporting or audits. There are two mechanisms available to protect individuals:

- Section 34(2)(b) of the Act requires organisation to notify a person requesting access of any fees applicable prior to access being granted. An individual can at that time object to a proposed fee.
- Section 45 of the Act provides that an individual may complain to the Office of the Health Services Commissioner where a provider charges a fee exceeding the prescribed maximum or, if applicable, where it is claimed a fee exceeds the organisation's reasonable costs incurred for the activity.[7] The OHSC has powers to investigate the complaint, conciliate a disagreement, or make an order.

It is considered that these arrangements provide an adequate degree of assurance of widespread compliance with the regulations. As noted earlier in this RIS, there is a very low level of complaints made about excessive fees, indicating a high level of voluntary compliance with the fee caps.

It is further noted that individuals have recourse under the Commonwealth *Privacy Act* to the Office of the Australian Information Commissioner where they consider that fees charged by an organisation are "excessive", whether or not they exceed any cap prescribed in Victorian regulations.

## 5.3 Evaluation

While the sunsetting nature of regulations in Victoria means there is an automatic review timeline built into the regulation process, it is appropriate to consider a proportionate evaluation strategy so that the effectiveness of the proposed Regulations can be evaluated over time. This is particularly important in light of current data limitations.

The Department therefore proposes to conduct a survey of health service providers during the life of the proposed Regulations. This would occur a number of times to allow any emerging trends to be identified, and the Regulations amended if needed. It is intended that a survey would be conducted two to three years' time to enable feedback and analysis on the charging practices and patterns over time. This would be done with reference to the Office of the Health Services Commissioner.

[7] Fees must not exceed the organisation's reasonable costs incurred in relation to collating health information, obtaining necessary equipment to assisting inspection of information, copies of information other than A4 black and white, and providing a summary when the organisation is not a health service provider. This is notwithstanding that the fee charged may still be less than any other fee cap specified in the Regulations.

# 6 IMPACTS ON COMPETITION

This section of the RIS discusses the impact of the proposed Regulations on competition. A measure is likely to have an impact on competition if any of the following questions can be answered in the affirmative:

| Test question | Assessment |
|---|---|
| Is the proposed measure likely to affect the market structure of the affected sector(s) – i.e. will it reduce the number of participants in the market, or increase the size of incumbent firms? | NO |
| Will it be more difficult for new firms or individuals to enter the industry after the imposition of the proposed measure? | NO |
| Will the costs/benefits associated with the proposed measure affect some firms or individuals substantially more than others (e.g. small firms, part-time participants in occupations, etc.)? | NO |
| Will the proposed measure restrict the ability of businesses to choose the price, quality, range or location of their products? | YES |
| Will the proposed measure lead to higher ongoing costs for new entrants that existing firms do not have to meet? | NO |
| Is the ability or incentive to innovate or develop new products or services likely to be affected by the proposed measure? | NO |

The proposed Regulations set caps on the fees that private sector organisations may charge for providing access to information.

However, such interference with free-market pricing is not expected to have a material impact on competition. Access to health information is a right established under the *Health Records Act*, and is not considered a genuine 'product' that is offered to the market. The Act places private health care providers on a similar footing to public health care provide that operate under the *Freedom of Information Act*.

It is not the intention of the Act that access to health information becomes a marketable product. Indeed, this is the antithesis of the aim of the Act, which is to establish a legislative right of access. Allowing providers to recover fees recognises only the reality that providing access creates a cost burden, but that recovery of costs should not unreasonably interfere with the right of access.

As concluded by the assessment in this RIS, capping fees is found to be superior to the absence of fee caps, in terms of striking the right balance between facilitating access to information and allowing recovery of costs. Achieving this balance is an improvement over the 'base case' and therefore, in the judgment of the Department, represents a net benefit to the community as a whole.

It is further noted that organisations are free to charge fees below the capped amounts, or no fee at all, and that this routinely occurs.

# 7 STAKEHOLDER CONSULTATION

In anticipation of the sunsetting of the current Regulations, in February 2012 the Department of Health commenced a review of the current Regulations. This first step of this review was targeted consultation.

The Department contacted representatives of key stakeholders, as well as inviting general comments via the Department's website.

The Department received eight submissions from a number of individuals, private sector health service providers, and peak bodies. The relevant issues raised by stakeholders are summarised below, as well as how these have been addressed in this RIS.

| Comment | Response |
|---|---|
| Three health service providers considered that the current Regulations have balanced cost recovery and accessibility appropriately. | The current Regulations have been assessed in the RIS. Cost recovery and access to information are the objectives of the regulations and were the basis for assessing options. |
| Two health service providers thought that there should be no fee cap when an application has been received by a lawyer as it is likely that the information is being requested for legal proceedings, for which cost is not a factor. | The Department notes that once legal proceedings are initiated, people may seek access to information by way of discovery, and the *Health Records Act* does not apply.<br>It also notes that individuals may use the *Health Records Act* as part of preliminary investigations as to whether or not to commence legal proceedings. However, this may or may not occur through a legal representative, and the Act does not require an individual to provide a reason for seeking access to health information. Therefore, this matter cannot be directly addressed via the regulations. |
| Two health service providers commented that while they understood the need to balance competing needs, they stated that the current fee caps meant costs were not able to be fully recovered in most cases, particularly as costs had risen since the fee caps were set in 2002. To this end, three submissions sought the ability to charge fees higher than the current caps in some instances. That said, the overall cost burden was small as requests were infrequent and in many cases the provider voluntarily waives fees. | An option assessed in the RIS aims to reflect increases in costs since the introduction of the current Regulations. |
| Two submissions drew attention to the fact that the current fee items do not specifically include postage, which can be as high as $20 in some cases. | The Department considers this is a genuine concern, noting that postage is separately allowed in other jurisdictions. It is proposed to allow postage costs to be added to the fees allowed to be charged. |

The consultation sought views on whether there were any types of access that should be provided on a minimum, cost-recovery or 'no charge' basis. While there was some interest in these concepts, there were no views expressed as to any particular types of access costs that should or could fall into these categories.

Following these submissions, the Department conducted further specific consultation with a sample group of organisations. Interviews were held with 15 organisations during March 2012 in order to ascertain the prevalence of requests for access to health information and charging arrangements. This sample covered organisations that were health service providers (private hospitals, GPs, specialist and pharmacists) and other organisations (large employers, fitness clubs, schools). The OHSC was also interviewed in preparing this RIS.

While not providing definitive data, this consultation has provided anecdotal evidence of the following:

- requests for inspections of documents has been low since the commencement of the access arrangements
- it is common for organisations to provide access to information informally, rather than under the *Health Records Act*, for which no charge is applied
- even for requests made under the Act, it appears that fees are not charged in many common situations, particularly by GPs referring patients to specialists. Commonly, the Department found that access to and copies of small volumes of information (less than 10 pages) is generally provided without charge
- fees charged at the maximum amounts is therefore relatively infrequent—6 of the 15 organisations interviewed said they charged fees at the current caps, and would like to charge more, in some instances (i.e., while wanting the ability to charge higher fees, all 6 acknowledged they would continue to provide information for no charge in many cases)
- a growing share of requests for information under the *Health Records Act* is by legal representatives for the purposes of determining whether litigation may be commenced
- while the fees caps have been expressed in a dollar amount that has not changed since 2002, actual costs of providing access has increased.

The next stage of consultation is to invite responses to this RIS. The *Subordinate Legislation Act 1994* requires that the public be given at least 28 days to provide comments or submissions regarding the proposed Regulations. As the proposed Regulations are short and not complex, the Department considers that 28 days is adequate. Written submissions are required by 5.00 pm 13 July 2012.

# ATTACHMENTS

## Attachment A

**DESCRIPTION OF PROPOSED REGULATIONS**

| Regulation | Description |
|---|---|
| 1 | States the Objectives of the proposed Regulations |
| 2 | States that the proposed Regulations are made under section 100 of the *Health Records Act 2001* |
| 3 | States the intended commencement of the proposed Regulations. It is intended that they will commence at the expiration of the current Regulations |
| 4 | Provides definitions of terms used in the Regulations |
| 5 | Sets the maximum fees for providing access to health information under section 32 of the *Health Records Act*, by way of the table included at Schedule 1 of the Regulations. |
| 6 | Sets the maximum fee for a nominated health service provider performing functions under section 42 of the *Heath Records Act* |
| 7 | Sets the maximum fees for transferring health information to another health service provider, by way of the table in Schedule 2 of the Regulations |
| 8 | Prescribed further circumstances for the collection of health information |
| 9 | Clarifies that, where GST is payable on a fee charged under the *Health Records Act,* that the amount of the maximum fee prescribed in the Regulations may be increased by the amount of GST payable |

## Attachment B

**COMPARISON OF CURRENT ACCESS CHARGES**

| | Element of Victorian regulations | Current Regulations | Similar costs under the FOI Act (Vic) | Access under the Privacy Act (C/wealth) | Fees in other states |
|---|---|---|---|---|---|
| *Access by an individual* | Time for supervising inspection of records | $5 per quarter hour | $5 per quarter hour | Fees must not be "excessive" | ACT: $13 |
| | Time for collating health information | $20 | $20 per hour for 'search time' | | |
| | Transporting records held off site | $10 | N/A | | |
| | Use of equipment not in organisation's possession | Reasonable costs incurred | Reasonable costs for audio or visual arrangements | | |
| | Copy of health information | 20 cents for A4 b/w<br>Reasonable costs otherwise | 20 cents for A4 b/w<br>reasonable costs otherwise | | ACT: $36 for first 50 pages then 30c/page |
| | Providing a summary of information | Greater of usual consultation fee (if a health service provider) or $25 per quarter hour, up to $80 | Reasonable costs up to $25 per quarter hour up to a maximum of $80 | | ACT: $74.50 |
| *Transfer of info* | Copy of health information | 20 cents for A4 b/w if at least 20 pages<br>Reasonable costs otherwise | N/A | N/A | ACT: $36 for first 50 pages then 30c/page |
| | Summary of health information | Greater of usual consultation fee or $25 per quarter hour, up to $80, where the time is at least 30 minutes | | | ACT: $74.50 + postage |
| *S. 42* | Functions of nominated health service provider under s. 42 of the Act | Reasonable costs not exceeding $40 per quarter hour up to $200 | N/A | N/A | N/A |

**Note**: s. 32(4) of HR Act provides that a person who gives an explanation of health information under the Act may charge a fee for the service that does not exceed the amount of the person's usual fee for a consultation of a comparable duration. This compares to the FOI Act which limits FOI charges to reasonable costs up to $25 per quarter hour up to a maximum of $80 where the agency is a health service provider, or if not a health service provider, the usual fee of the suitably qualified health service provider for a consultation of a comparable duration.

# Attachment C

**Multi-criteria Analysis**

In many cases the benefits specific to the proposed Regulations proved difficult to quantify in monetary terms. Multi-criteria Analysis (MCA) is presented in this RIS as an alternative assessment tool to complement the quantitative analysis. The MCA approach is described in the *Victorian Guide to Regulation*.[8] This approach is useful where it is not possible to quantify and assign monetary values to the impacts of a proposed measure (e.g., measures that have social and environmental impacts). Furthermore, it represents a convenient way of comparing a range of alternative approaches.

This technique requires judgements about how proposals will contribute to a series of criteria that are chosen to reflect the benefits and costs associated with the proposals. A qualitative score is assigned, depending on the impact of the proposal on each of the criterion weightings, and an overall score can be derived by multiplying the score assigned to each measure by its weighting and summing the result. If a number of options are being compared, then the option with the highest score would represent the preferred approach.

[8] Department of Treasury and Finance, 2011, 2.1 ed, *Victorian Guide to Regulation incorporating: Guidelines made under the Subordinate Legislation Act 1994*, August 2011, Melbourne, p. 85