

The “Hidden Story” of Bill C-54: The Personal Information Protection and Electronic Documents Act and Health Information

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Introduction

On October 1, 1998, the federal Minister of Industry introduced Bill C-54, the *Personal Information Protection and Electronic Documents Act*¹ as part of Canada’s strategy on electronic commerce. If passed, this law would represent a significant development in information and privacy law in Canada, establishing mandatory principles for the protection of personal information in the hands of private organizations.

After its second reading in the House of Commons, the Bill was referred to the Standing Committee on Industry (“the Committee”), which received submissions and conducted a section-by-section analysis of the Bill. Some of the witnesses who presented briefs to the Committee spoke to the law’s potential impact on health information, health care and research. As realization of their significance began to emerge, one member of the Committee described Bill C-54’s implications for health information as “the hidden story of this legislation.”²

Bill C-54 had not yet been passed when the House of Commons rose for its summer break on June 11, 1999. However, Industry Canada asserts that the Bill remains a priority and that it will be passed by the end of the year.³ The amended Bill is expected to proceed or be re-introduced when the session resumes in the fall.⁴

Summary of Bill C-54

The *Personal Information Protection and Electronic Documents Act*, as its name suggests, deals with two subjects: the protection of personal information and the use of electronic documents. By addressing privacy issues and clarifying the legal status of electronic documents, the federal government hopes to clear the way for the growth of electronic commerce in Canada.

For the health care sector, the most important part of Bill C-54 is Part 1, which deals with “Protection of Personal Information in the Private Sector.” These provisions would introduce privacy protection for information held by private organizations. Until now, the privacy legislation enacted by the federal government and every provincial government except Québec has covered only personal information held by government bodies. Québec has a law applying to the private sector which has been in place since 1994, as do many countries including the members of the European Union and New Zealand. For most of Canada, however, the provisions in Part 1 would be a new and significant development in the protection of personal information.

Although the stated focus of the Bill is on electronic information, the provisions in Part 1 apply to personal information in any form. Personal information is defined as “information about an identifiable individual” except the name, title or business address or telephone number of an organization’s employees.

Part 1 applies to all organizations except a government institution already under the *Privacy Act*. An “organization” can be an association, partnership, trade union or even an individual person. Personal information that is collected, used or disclosed by an organization “in the course of commercial activities” is subject to Part 1. Personal information about an employee of the organization that the organization collects, uses or discloses in connection with a work, undertaking or business that is under the federal government’s authority (a bank, for example) is also included. Part 1 does *not* apply to personal information collected only for personal or domestic, journalistic, artistic or literary purposes.

Schedule 1 contains the principles that were developed by the Canadian Standards Association (CSA) as its “Model Code for the Protection of Personal Information,” a voluntary code for private sector organizations. If Bill C-54 is passed, it will make compliance with these principles mandatory, subject to some modifications set out in Part 1.

Although we commonly refer to “privacy” interchangeably with personal information protection, the CSA Code contains the range of principles for fair information practices, including access and correction rights and safeguards for the accuracy and integrity of data, that are common to virtually all modern data protection legislation and policies.⁵ There are ten basic principles in the CSA Code and Part 1:

1. *Accountability*: An organization is responsible for personal information under its control and for complying with these principles. It should designate an individual or individuals to be responsible for ensuring compliance.
2. *Identifying Purposes*: An organization may collect and use personal information only for purposes which have been specified and made known to individuals when the information is collected from them. All purposes must be appropriate in the circumstances.
3. *Consent*: An individual’s knowledge and consent are required for the collection, use or disclosure of personal information,

Bill C-54 contains provisions which are designed to define the relationship between this law and provincial legislation.

subject to certain exceptions. Consent must be meaningful, voluntary and obtained in a manner appropriate to the context and the kind of information.

4. *Limiting Collection*: An organization may only collect personal information that is necessary for the purposes identified, and must collect information in a fair and lawful way.
5. *Limiting Use, Disclosure and Retention*: Personal information must only be used or disclosed for the purposes for which it was collected, unless use or disclosure for another purpose is agreed to by the individual, required by law or allowed by certain exceptions in Part 1. Organizations should develop appropriate policies on retention and disposal of information.
6. *Accuracy*: Personal information should be as accurate, complete and up-to-date as needed for the organization’s purposes and for decision-making.
7. *Safeguards*: Personal information should be protected by whatever physical, organizational and technological measures are appropriate for the type of information and its sensitivity.
8. *Openness*: Information about the personal information an organization collects and uses and its policies and procedures with respect to personal information should be readily available and easy to understand.
9. *Individual Access*: Subject to certain exceptions, an individual should, upon request, be able to be informed as to what information an organization has about him or her and how the information has been used or disclosed, to have access to the information, and to request a correction to inaccurate information.
10. *Challenging Compliance*: An individual must be able to make complaints or



inquiries about an organization's compliance with these principles, and the organization must respond to any complaints.

Part 1 provides for measures to enforce compliance with the principles, including investigations, reports and audits by the federal Privacy Commissioner and remedies that may be granted by the Federal Court.

Bill C-54 contains provisions which are designed to define the relationship between this law and provincial legislation. During a three year transitional period, Part 1 will not apply to the collection, use and disclosure of personal information that a province has the power to regulate, unless the information is collected, used or disclosed in connection with a federal undertaking, or if it is collected, used or disclosed outside the province. After three years, the federal law will apply to all personal information within the scope of Part 1. However, the Governor in Council can order that certain organizations or activities are exempt from Part 1 if they are governed by a "substantially similar" provincial law. This exemption only applies to collection, use and disclosure that occur within the province.

Bill C-54 and Health Information

Bill C-54's application to personal health information has emerged as one of the most important issues relating to the proposed law. It has, at the same time, revived all the familiar debates and disagreements about health information privacy which have been ongoing in Canada and elsewhere in recent years. It is an indication of the difficulties surrounding this issue that although the witnesses who addressed the Committee on the subject of health information agreed that the Bill's application to health information was problematic in some respects, there was only limited agreement among their criticisms and recommendations.

Definitions and Scope of Application

The first question of concern is the scope of the law's application. Part 1 applies to personal information that is collected, used or disclosed "in the course of commercial activities." "Commercial activity" is defined as "any particular transaction, act or conduct or any regular course

of conduct that is of a commercial character" – a definition that arguably raises as many questions as it answers. As a result, the scope of Part 1's application is "among the major areas of uncertainty" in the Bill.⁶ In the health context, for example, is a consultation with a physician an act or transaction "of a commercial character"? What about filling a prescription? Medical tests carried out at a diagnostic facility? What difference does it make whether the service provider is a private or public entity, or whether the service is paid for with private or public funds? Many acts or transactions that are part of the provision of health care could fairly be described as "commercial" in some aspect.⁷ At least some health information will clearly be covered—information collected by health or life insurance companies is an obvious example—and the Bill's scope could potentially be very broad.

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CMA Brief

Another definition of particular interest to the health care sector is the definition of "personal information." Part 1 only applies to "personal information," which is defined as "information about an identifiable individual" (except certain basic

information about employees). Nowhere in this definition or in any part of the Bill can one find any reflection of the difficulty of distinguishing identifiable and non-identifiable information. Information which does not clearly reveal its subject's identity may still be traced back to the individual subject by linking, data matching, or other means. As a result, it has been recognized that it is more accurate to speak of a spectrum of identifiability, ranging from identifiable information, through coded or linkable information, to information which is truly anonymous.⁸ Different levels and types of protection may be appropriate for information at different points on this spectrum.⁹ Part 1 deals only with one category, personal (identifiable) information, without adequately defining it,¹⁰ and without recognizing the nuances of other possible categories.¹¹ In the context of health information this may be a significant failing. The problem is exacerbated by the fact that Bill C-54 contains no controls or prohibitions on the data matching, which could be used to link otherwise unidentifiable information and compile personal profiles. It also lacks any restrictions on the use of personal health identifiers, an important measure to prevent or control the linking of sensitive health data with other personal information.¹²

The fact that Part 1 only applies to identifiable information may itself be cause for concern. It has been acknowledged

that individuals and groups may still have concerns and interests with respect to information which cannot be individually identified but may, for example, be linked to a certain region or ethnic group.¹³ At the same time, the Part's limited coverage may alleviate concerns that the principles will be too restrictive for health research, since they will not affect statistical data or other anonymous information. However, certain types of research do demand identifiable personal information. An important component of the health information projects being developed by Health Canada and the Canadian Institute for Health Information is "person-oriented information" which requires identifiable or at least coded information to track an individual's activities and progress in the health care system.¹⁴

Bill C-54's place in the context of other legislation is also a major issue in the health context. The success of the Canada Health Infoway, a federal initiative to develop a nation-wide health "infrastructure," and similar projects under way at the national and provincial levels will depend on the development of a comprehensive and consistent legislative framework for the protection of personal health information. The Final Report of the Advisory Council on Health Infostructure noted that "a real danger exists that Canada could end up with many different approaches to privacy and the protection of personal health information" and recommended that harmonization of provincial and federal approaches be encouraged and that "all governments in Canada should ensure that they have legislation to address privacy protection specifically aimed at protecting personal health information through explicit and transparent mechanisms."¹⁵ In addition, it recommended that privacy legislation applicable to health information bind the public and private sectors.¹⁶ Bill C-54, however, is not consistent with any of these recommendations. It would put into place a federal legislative regime which would preempt provincial legislation in some, but not all, cases, subject to exemptions at the discretion of the Governor in Council. Its provisions do not specifically address health information, and the federal public sector is not subject to its privacy principles.

Some of these concerns could be alleviated if health information covered by provincial health information legislation were exempted by order of the Governor in Council as allowed by s. 26(2)(b).¹⁷ The emphasis would then be on harmonizing provincial legislation, with the ultimate goal a consistent system of health information laws at the provincial level. The federal public sector, and activities excluded from the scope of s. 26(2)(b)—collection, use or disclosure outside the province—would still fall beyond this system. It is also problematic that the exemption would apply to organizations and activities, not types of information, so an exemption for

health information as a category is not possible as the Bill currently stands. Furthermore, the exemption is dependent on an assessment by the Governor in Council that the provincial legislation is "substantially similar" to Part 1. Concerns have already been raised that provincial health legislation such as Ontario's draft Act¹⁸ might not be judged substantially similar because of the disclosures permitted for health administration and research.¹⁹

Personal Information Protection Principles

Although the various submissions to the Committee on Industry raised different concerns regarding the Bill's application to health information, they all reflect the fact that the principles as stated in Bill C-54 were not designed to deal with health information and its particular characteristics. Health information, on one hand, is perhaps the most sensitive category of personal information, and requires a level of protection appropriate to this sensitivity. On the other hand, health information is subject to a number of potential uses which are extremely useful, and even essential, to both the individual and to society at large. These specialized aspects require proper consideration in legislative provisions.

Some concerns have been addressed in the amended version of the Bill. For example, the Bill as originally drafted contained virtually no limit on the purposes for which information could be collected. Under the CSA Code's principles in Schedule 1, organizations are required to identify the purposes for which information is collected²⁰ and may only collect information necessary for those purposes,²¹ but there is no restriction on the purposes which may be specified. The amended version of Part 1 includes a provision that an organization "may collect, use or disclose personal information only for purposes that a reasonable person would consider are appropriate in the circumstances."²² Although it may be difficult to interpret, this provision at least places some limits on purposes and hence on the collection, use and disclosure of personal information.

Bill C-54 has been criticized as providing "no additional protection to information that is highly sensitive (such as health information)."²³ Part 1 and Schedule 1 do not define specific categories of sensitive information that would be subject to different rules or standards. However, the principles in Schedule 1 do acknowledge that certain information requires a higher level of protection. Paragraph 4.3.4 states that organizations must take into account the type of information, including its sensitivity, when determining the form in which consent is sought, and suggests that medical records are an example of information

that “is almost always considered to be sensitive.” Paragraph 4.3.6 states that an organization “should generally seek express consent when the information is likely to be considered sensitive,” whereas implied consent may be appropriate if the information is less sensitive. The principles relating to security safeguards mandate that those safeguards must be appropriate to the sensitivity of the information.²⁴

Although these principles will require further elaboration, the recognition of different needs relating to means of securing consent and security for different kinds of information is a useful starting point. However, sensitive information—and we can assume that health information as a general category should be considered “sensitive”—may also require additional protection with respect to collection, use, disclosure and disposal.

It is in the area of informed consent for collection, use and disclosure that we encounter the most difficulties with respect to the Bill’s application to health information, and also the greatest variety of perspectives. According to some, the principles in the CSA Code and Part 1 provide insufficient protection for personal health information. Others argue, however, that the principles are *too* restrictive and would interfere with essential health research and the effective operation of the health care system.

Section 7 in Part 1 sets out the exceptions to the requirement of informed consent for collection, use and disclosure in subsections (1), (2) and (3), respectively. The exceptions include collection without consent where the collection is “clearly in the interests of the individual and consent cannot be obtained in a timely way”; information thus collected may also be used without consent. Collection, use and disclosure is allowed without consent in certain circumstances relating to the investigation of a breach of Canadian or provincial law. Information may be disclosed without consent for the purpose of collecting a debt owed by the individual to the organization, to comply with a subpoena, warrant or court order, or whenever required by law. Use and disclosure of personal information without consent is also permitted for “statistical, or scholarly study or research,” provided that certain conditions are met.

The Brief of the Canadian Dental Association (CDA) states that the CDA opposes the consent provisions in the CSA Code. It argues that the patient must be “the ultimate authority to be in control of the health record” and that informed consent should be required for any secondary use of identifiable patient information.²⁵ The Canadian Medical Association (CMA) also criticizes the Bill for permitting collection, use and disclosure of personal information

without an individual’s knowledge or consent on a number of grounds and suggests that “these grounds should be subject to intense scrutiny to determine their relevance and legitimacy” in the context of health information.²⁶

By contrast, three other witnesses before the Committee raised concerns that the consent requirements in Part 1 would be too restrictive. The Brief of the Canadian Pharmacists Association expressed the fear that “unless health information is explicitly excluded from the purview of Bill C-54, the...rules will prevent the [Canada Health Infrastructure] network from being built.”²⁷ The Canadian Institute for Health Information (CIHI) was concerned that its existing databases contained individual patient information collected indirectly from hospitals, which would be precluded by the Bill. It further pointed out that the exceptions designed to make information available for research were restricted to “scholarly” research, which might be unduly restrictive.²⁸

The Ontario Ministry of Health also raised a number of concerns about the Bill’s potential effect on its operations, arguing that the Bill “would lead to an ineffective, inefficient health system. It would be impossible to carry out the objectives of Health Canada and the provincial ministries of health, to realize the potential of the health information highway.”²⁹ The Ministry’s submissions highlighted concerns relating to consent for incompetent individuals,³⁰ and access to information for health system management,³¹ research³² and the detection of fraud or abuse.³³ It suggested that the Bill would frustrate attempts to harmonize provincial health information legislation and that electronic patient records, telehealth and other initiatives would be “stalled at their inception.”³⁴

In response to the questions raised by the Ontario Ministry of Health, Industry Canada requested an analysis from Raymond Doray of the law firm of Lavery, de Billy.³⁵ Mr. Doray reviewed the concerns expressed by the Ontario Brief and concluded that most of them are unfounded. In his opinion most of the problems indicated by the brief can be resolved because there is an applicable exception in Bill C-54, because the collection, use or disclosure of information is required by an Ontario statute (which brings it within an exception to consent for disclosure under s. 7(3)(i) as being “required by law”), or because consent “would likely be easy to obtain.”³⁶ However, it is also conceded that the rules in Bill C-54 would be more restrictive in some respects.³⁷

This analysis does address many concerns, but some issues remain unresolved. The scope of the analysis focused on the Ontario Brief and thus was not designed to deal with concerns raised by other stakeholders. Several of these

concerns remain valid and quite serious: for example, as the CMA Brief indicates, some of the exceptions to the consent requirement, such as collection without consent for “journalistic, artistic or literary purposes,” are inappropriate in the context of health information. Furthermore, the conclusion that most of the problems indicated in the Ontario Brief can be resolved by the Bill in its current form rests on a number of assumptions which require further scrutiny.

First, the analysis assumes that, in a number of instances, the consent requirement may be satisfied by implied consent,³⁸ or by a statutory provision creating deemed consent in certain circumstances.³⁹ It is acknowledged that the validity of deemed consent in the context of Bill C-54 may be questioned.⁴⁰ Reliance on implied consent could also be problematic in the Bill’s current state, since paragraph 4.3.6 of Schedule 1 states that “An organization should generally seek express consent when the information is likely to be considered sensitive,” and health information is indicated to be “sensitive” information. The circumstances in which implied consent may be sufficient for collection, use and disclosure of sensitive information will need to be clarified.⁴¹ Second, there is repeated reference to the use of an “opt-out” procedure as a means of obtaining consent. Paragraph 4.3.7(b) does say that a form allowing an individual to request that information not be disclosed may be used as one means of obtaining consent. However, it is questionable whether such a procedure is appropriate in the case of sensitive information such as personal health information, and if an opt-out procedure may be used in this context, it must still meet the standards of informed, meaningful and voluntary consent. Therefore, it should not necessarily make the consent requirement less onerous.⁴² More generally, the analysis assumes in several instances that consent will be easy to obtain, and dismisses concerns about the consent requirement on this basis, which is problematic.⁴³

The question of the scope of application of Part 1, which is discussed at various points in Doray’s report,⁴⁴ will also require further analysis. Doray states that “public sector health information custodians” will not be subject to Bill C-54 “since these organizations do not conduct commercial activities.”⁴⁵ Upon closer examination, it seems that more refined distinctions between “public” and “private” entities and “commercial” and “non-commercial” activities may be required. It is also likely that further issues will arise regarding the use of the exception to consent where disclosure is “required by law” since it could allow the provinces to circumvent the Bill’s consent requirements by enacting provincial laws requiring disclosure.⁴⁶

In summary, this analysis and the additional points raised in the other briefs presented to the Committee indicate that there are some important unresolved issues concerning the Bill’s application to personal health information. The next section will review the various options for addressing these issues in the legislation.

Possible Approaches

Industry Canada’s request for an analysis of the concerns raised by the Ontario Ministry of Health indicates that there is at least some awareness of and willingness to deal with the issues relating to Bill C-54 and health information, although the fact that this analysis dismissed many concerns and did not address others may lead observers to doubt how effective these attempts will be. There are several options for addressing the particular needs of personal health information in the context of this legislation.

The first approach would be to avoid making any substantive changes to the Bill and rely on provincial legislation to deal with the specific issues involving health information. It is possible, though by no means guaranteed, that organizations and activities covered by such legislation would be declared exempt from Part 1 of Bill C-54 by order of the Governor in Council, as provided in s. 26(2)(b). This exemption would not cover information transfers between provinces, however. The Bill also allows for more detailed codes of practice and policies to be developed by organizations with the encouragement of the Privacy Commissioner.⁴⁷ These codes or policies would not be binding and they would be designed to help an organization comply with Part 1, not to modify any of the Part’s requirements. Therefore, this option offers only a limited scope for addressing issues specific to health information.

The second possibility would be to exempt health information, as a category, from the operation of Part 1. This is the approach favoured by the Canadian Pharmacists Association⁴⁸ and the Ontario Ministry of Health.⁴⁹ Health information would therefore be governed only by dedicated provincial legislation, where it exists. This approach has some potential advantages, if the vision of harmonized provincial health information legislation becomes a reality—it could provide consistent protection applicable to the private sector and provincial public sector—but to date that reality has been slow to materialize.

Finally, the government could attempt to incorporate special rules for health information into Bill C-54 by various means. This could be accomplished by amendments to the provisions of Part 1 itself or by regulations setting out requirements specific to health information and necessary

modifications of the Part 1 and Schedule 1 principles as they apply to personal health information. The CMA and CDA both recommend introducing amendments to the legislation to address health information concerns and the CMA suggests that any such amendments should be based on its Health Information Privacy Code. This may be the best option in many respects although introducing further exceptions and rules of limited application to the already complex Bill might pose daunting problems of drafting and interpretation.

In considering these various options, it may be useful to draw on the experience of other jurisdictions. In Australia, legislation similar to Bill C-54 has recently been proposed; the federal law would apply to the private sector and would be based on a set of voluntary principles developed by the Australian Privacy Commissioner for businesses in Australia.⁵⁰ The Privacy Commissioner has engaged in extensive discussions regarding the application of the legislation to health information, whether health information should receive special treatment and if so how.⁵¹ The options being considered include having the Privacy Commissioner produce guidelines which would supplement and modify some of the principles in their code as they apply to health information, or variations, amendments or deletions to the principles themselves.⁵² New Zealand, the first non-European country to introduce privacy legislation applying to the private sector, enacted a special Code to deal with health information as a regulation under the *Privacy Act 1993*.

Privacy advocates and the health care sector will be watching with interest in the fall of 1999 when Bill C-54 again comes before the House of Commons. It should soon become clear to what extent these concerns about health information will be addressed and what approach will be taken. The process shows signs of tension between the desire to move forward quickly with legislation in this rapidly evolving area, and the need to thoroughly evaluate the Bill's provisions and their impact, and make the necessary changes. A satisfactory outcome will be important to the coherence of Canadian law in this area and to the health care system.

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1. Bill C-54, *An Act to support and promote electronic commerce by protecting personal*

information that is collected, used or disclosed in certain circumstances, by providing for the use of electronic means to communicate or record information or transactions and by amending the Canada Evidence Act, the Statutory Instruments Act and the Statute Revision Act, 1st Sess., 36th Parl., 1998. The summary and discussion of the Bill below will refer to the amended version of the Bill, reprinted as amended by the Standing Committee on Industry and reported to the House of Commons on April 12, 1999 (available on the Parliamentary Internet site, www.parl.gc.ca).

2. House of Commons Standing Committee on Industry, Evidence (18 March 1999) at 1020, per Mr. Jim Jones; at http://www.parl.gc.ca/36/pb_cob-house-e.htm (hereinafter Committee Minutes).

3. Industry Canada, "Bill C-54 Part 1: Protection of Personal Information in the Private Sector," at <http://e-com.ic.gc.ca/english/privacy/632d32.html>.

4. *Ibid.* An update dated September 27, 1999 states that when the new session resumes on October 12, the Government is expected to move to reinstate several bills including this one.

5. These principles are largely based on the OECD Guidelines, which were formulated in 1980 and have been adopted by a number of countries, including Canada. Organization for Economic Cooperation and Development, *Guidelines on the Protection of Privacy and Transborder Flows of Personal Information* (Paris: OECD, 1981).

6. Privacy Commissioner of Canada, "Presentation by Bruce Phillips, Privacy Commissioner of Canada on Bill C-54 - Personal Information Protection and Electronic Documents Act," submitted to House of Commons Standing Committee on Industry, December 2, 1998, at <http://www.privcom.gc.ca/c-54test.htm>. See also

Committee Minutes, *supra* note 2 at 1145.
7. The Canadian Medical Association's Brief to the Committee states that "there is no clear way of distinguishing commercial activity from health care activity in a way that ensures that the health care record is subject to different rules than those pertaining to other records."

Canadian Medical Association, "Listening to our Patient's Concerns: Comments on Bill C-54," Brief submitted to House of Commons Standing Committee on Industry, March 18, 1999, at <http://www.cma.ca/advocacy/political/1999/03-18/index.htm> (hereinafter "CMA Brief"), Section II.B.

8. See e.g. B. Woodward, "Medical Record Confidentiality and Data Collection" (1997) 25 J. L. Med. & Ethics 88 at 92-93.

9. L.O. Gostin, "Health Information Privacy" (1995) 80 Cornell L. Rev. 451 at 519-21.

10. By contrast, recent U.S. legislative initiatives have attempted to define "identifiable" and "nonidentifiable" information more precisely. For example, the *Medical Information Privacy and Security Act*, S.573/H.R.1057, 106th Congress, 1999, defines "de-identified health information" in s. 4(3) as "any protected health information, with respect to which—

(i) all personal identifiers, or other information that may be used by itself or in combination with other information which may be available to re-identify the subject of the information, have been removed; and

(ii) a good faith effort to evaluate the risks of re-identification of the subject of such information in the context in which it will be used or disclosed, has been made."

The *Health Care PIN Act*, S.578, 106th Congress, 1999, defines an "anonymous link" as "a number assigned to nonidentifiable health information which, by itself, contains no information about an individual, but which, under

specific, controlled conditions, can be used to link to additional health information about the same individual which may be used to identify that individual" and provides that "disclosure of an anonymous link with any information which, together with information previously disclosed with the same link might reasonably be used to identify and individual" is considered to be disclosure of protected health information; s. 4(3).

The report of the U.S. Secretary of Health and Human Services on *Confidentiality of Individually-Identifiable Health Information* recognizes the difficulty of adequately defining "identifiable" information and proposes that: "Information is identifiable if there is a reasonable basis to believe that the information can be used to identify an individual" but not "if there is a remote chance that somebody might possibly be able to identify a patient from a general description." Secretary of Health and Human Services, *Confidentiality of Individually-Identifiable Health Information: Recommendations of the Secretary of Health and Human Services, pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996*, September 11, 1997; at http://www.epic.org/privacy/medical/hhs-recommendations_1997.html or <http://www.aspe.os.dhhs.gov/admsimp/PVCREC1.HTM>.

11. See CMA Brief, *supra* note 7, section IV.B; Advisory Council on Health Infostructure, *Canada Health Infoway: Paths to Better Health* (Ottawa: Health Canada, 1999) at 3-8 (hereinafter Infoway Report).

41. The CMA's *Health Information Privacy Code* offers some helpful guidance on this point; see Canadian Medical Association, *Health Information Privacy Code*, 12 *Can. Med. Ass. J.* 1211 (1998).

42. The report uses the term "explicitly identified" as easier than obtaining consent through an opt-out procedure. *Code*, at 12. The *Code* also states that health information should be collected "and used in a manner that is consistent with the individual's expectations of privacy." *Code*, at 12. The *Code* also states that "the individual's expectations of privacy are affected by the nature and purpose of the collection, use and disclosure of the information." *Code*, at 12. The *Code* also states that "the individual's expectations of privacy are affected by the nature and purpose of the collection, use and disclosure of the information." *Code*, at 12.

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52. The *Code* also states that "the individual's expectations of privacy are affected by the nature and purpose of the collection, use and disclosure of the information." *Code*, at 12.

53. Office of the Privacy Commissioner, *Bill C-54: Personal Information Protection and Access Act*, 1999, at 1.

54. *Code*, at 12.

55. *Code*, at 12.

56. *Code*, at 12.

57. *Code*, at 12.

58. *Code*, at 12.

59. *Code*, at 12.

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61. *Code*, at 12.

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100. *Code*, at 12.



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