

# **Confidentiality and Privacy Provisions in Public Health: The Transfer of Information Between Australian Jurisdictions**

## **Introduction: the Nature of the Issue**

Australia is a large country but its population is very mobile. Interstate capitals are typically separated by no more than an overnight bus ride or an aeroplane journey of one or two hours. States and Territory borders can be crossed with no more formality than a sign by the roadside. Yet, the legal systems, including those that relate to infectious disease control, are, because they are creations of the State and Territory governments, constrained by the lines on the map that are their borders. So, while Australians increasingly think of themselves as a single nation, the effect of the regional legislative arrangements in the area of disease control (as in many other areas of State and territory law) is to impose restrictions and barriers on the exercise of power and the flow of information across borders. This creates issues for the national surveillance and monitoring of persons whose behaviours may be placing others at risk.

This report considers these issues and makes recommendations for a common basis on which information flow across Australia should occur. Firstly, it considers general issues in privacy; then examines the State, Territory and National laws that affect information flow; and finally, examines a basis on which information flow might be standardised.

## **The Scope and Terminology of This Report**

This Report considers the current state of the law relating to privacy and confidentiality in Australia as it applies to the transfer of personal information between jurisdictions for the purpose of national disease control (this is referred to throughout as *notification across jurisdictions*). The applicable law is the general common law principles as modified by the statutes of the nine Australian jurisdictions. In this Report:

- the term *privacy* is used to relate to the interest that persons are said to have in the integrity of information relating to them.
- the term *confidentiality* is the general obligation to keep that information confidential - not to release it to others. Under Australian law this obligation arises from a relationship the person has with a range of advisers or service

providers (typically the doctor / patient relationship) or as specified by specific statutory requirements.

- References to *disease* in this Report: the general principles relating to privacy and confidentiality discussed in this Report apply to all diseases controlled as notifiable diseases under Australian public health laws. As will be seen, the discussion often focuses on HIV/AIDS. This is because that issue has been the catalyst for so much consideration of disease control policy in the context of human rights and much has been written about these issues that is specifically in the context of HIV/AIDS. However, that fact should not mask the general applicability of the matters under discussion here to all notifiable diseases such as hepatitis, tuberculosis and all the other conditions that might be of concern in the context of notification across jurisdictions. However, it should also be recognised that while the general principles do not alter between diseases, there might be quite different social contexts between a case of tuberculosis and a case of hepatitis for example. The application of the general legal principles will be shaped by its particular context.

In the case of notification across jurisdictions, the personal information has originated from the doctor / patient relationship but the notification is done not by the patient's doctor but by persons involved in public health surveillance and at that stage is not part of the doctor / patient relationship. However, the information is still protected by confidentiality requirements.

### **The Size and Context of the Problem under Consideration**

Although disease control and the regulation of behaviours likely to spread disease are done by the State and Territory health authorities, there are national networks that co-ordinate policy and information. There is also contact between agencies across borders. The links and channels of communication thus formed can provide important mechanisms for the timely warnings of individuals whose movements may be placing others at risk. Generally, where notification does occur at present it is via personal communication between officers responsible for disease surveillance in the relevant jurisdictions. Significantly, any breach of privacy is, and should be, limited to the person in the other jurisdiction who has a legitimate interest in the information.

It is also the case that notification across jurisdictions occurs rarely; in New South Wales, it is understood that the issue would arise on about 6 occasions per year (this

would be for all diseases of concern including tuberculosis). In the case of HIV, the issue might arise in less than one case per year. These are small numbers and while each individual notified is affected by it, the issue is very confined. Also, contemporary public health practice takes account of rights; where notification does occur, privacy issues are seen as central. More generally, the administration of public health “police” powers are characterised by a regard for the well being of the individual and a willingness to commit the resources to manage these persons effectively within the community. This contrasts markedly with earlier periods in Australian history where both cases and suspects were subject to punitive and restrictive controls.

### **Some Values in Privacy Protection**

The protection of personal information is one of the key elements of patients’ rights; it is said to be part of the Hippocratic Oath and has been a component of contemporary charters of rights or laws relating to the provision of health services. It is also an important component of effective health practice - people who trust the health system and believe that it will respect their interests are more likely to cooperate with it, to the public benefit. In the English case *X v Y*, Justice Rose considered the protection of privacy interests within public health practice. He said:

In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients “will not come forward if doctors are going to squeal on them.” Consequently, confidentiality is vital to secure public as well as private health.<sup>1</sup>

Both good public health practice and a respect for the integrity of the individual require that patient privacy is respected. However, privacy is not absolute; in cases of pressing public need, confidential information can be given to others, even if the person to whom the information relates objects. This Report considers this issue generally and then in the context of public health surveillance in Australia.

### **Privacy: the Common Law Position**

There is no right to privacy as such, recognised by Australian law. A person cannot bring an action in the courts simply on the basis that the information about them has been publicised to others, even where it has been widely publicised through the

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<sup>1</sup> *X v Y* [1988] 2 AllER 648 at 653.

media. In *Victoria Park Racing and Recreation Grounds v Taylor*,<sup>2</sup> a radio station was reporting the results of races at the plaintiff's race track from a point overlooking the course. They brought an action for breach of privacy. The court held in that case, and the view has been maintained since, that the natural rights of an occupier of land do not include freedom from view and inspection. There is no right to privacy as such unless one is imposed by parliament. No Australian jurisdiction has yet legislated for a right to privacy.

At this fundamental level the laws of privacy remain unreformed in Australia. However, courts will remedy breaches of privacy rights where the information was obtained in the course of a relationship that is recognised as confidential. Thus the law of torts has been used to protect the breach of a doctor patient relationship;<sup>3</sup> courts have restrained the release of information that had been provided as part of a recognised confidential relationship such as a commercial arrangement or information provided to an ethnographer by an indigenous community.<sup>4</sup> In addition to court based remedies, the statutory registration and complaints boards of the various health professions would see a breach of privacy in the course of the practice of the profession as prima facie evidence of unprofessional or unsatisfactory conduct, unless the breach could be justified.<sup>5</sup> This focus on the relationship, rather than on the protection of the personal information as such, distorts the privacy laws: a flagrant breach of privacy by a person who simply finds or is given personal information is subject to no sanction, while a medical practitioner who breaches patient confidence must give very good reasons why the breach occurred.

### **Legislated Privacy Rights - General Statute Law**

The statute law in Australia has been modified to provide specific rights for breaches of privacy under specific circumstances. These exist in a number of statutes and cover a range of areas such as social security, taxation and health (both health services generally and public health in particular). At this stage, only three Australian jurisdictions, the Commonwealth, the Australian Capital Territory and New South Wales, have laws in place that cover privacy interests generally.<sup>6</sup>

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<sup>2</sup>(1937) 58 CLR 479

<sup>3</sup>*Furness v Fitchett* [1958] NZLR 396

<sup>4</sup>*Foster v Mountford* (1976) 14 ALR 71- Supreme Court of NT

<sup>5</sup>This is discussed below

<sup>6</sup>Queensland has an *Invasion of Privacy Act* 1971, but it is limited to particular contexts and is not relevant to the issues canvassed in this Report. It should also be noted that Australian freedom of information laws generally exclude personal information relating to persons other than the inquirer from information that can be obtained under those Acts.

The most significant privacy enactment in Australia is the *Privacy Act 1988* (Cth), relating to Commonwealth government records and passed as implementation of the Commonwealth's obligations under the *International Covenant on Civil and Political Rights*, which includes the right of persons "not to be subjected to arbitrary or unlawful interference with their privacy, family, home or correspondence."<sup>7</sup> This has been interpreted to mean that any law (or public policy) that abridges this freedom must apply or be done in such a way as to leave the core principle of privacy intact.<sup>8</sup> The Act establishes 11 "Privacy principles", which provide rights to persons to be informed about the purpose to which personal information about them will be put, safeguards in the security and accuracy of record keeping and rights to access records.<sup>9</sup> The Act is enforced by a Privacy Commissioner with the power to investigate complaints and make non-binding determinations. Enforcement of the Act is through the Federal Court with the Commissioner as complainant.

Most recently, the Australian Capital Territory has passed the *Health Records (Privacy and Access) Act 1997*, which applies to both public and private health records held within the Territory. The Act also establishes a series of information privacy principles, which (among other things) limit the use and disclosure of personal medical information<sup>10</sup>

The New South Wales *Privacy Committee Act 1975* creates a statutory Privacy Committee with functions that include:

Subject to this Act, the Committee:

- (a) may conduct research and collect and collate information in respect of any matter relating to the privacy of persons;
- (b) may and, if directed by the Minister so to do, shall make reports and recommendations to the Minister in relation to any matter that concerns the need for or the desirability of legislative or administrative action in the interests of the privacy of persons;
- (c) may make reports and recommendations to any person in relation to any matter that concerns the need for or the desirability of action by that person in the interests of the privacy of persons;
- (d) may receive and investigate complaints about alleged violations of the privacy of persons and in respect thereof may make reports to complainants;
- (e) may, in relation to any matter relating to the privacy of persons generally, disseminate information and undertake educational work;

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<sup>7</sup> Art 17

<sup>8</sup> For a discussion of the circumstances under which a person's privacy can be abridged see *Malone v United Kingdom* (1981) 4 EHRR 330; *Klass v Fed Republic of Germany* (1978) 2 EHRR (pt 2) 214.

<sup>9</sup> The two important principles relating to public health are discussed below

<sup>10</sup> Section 6(1) imposes a general obligation to comply with the requirements of the privacy principles.

- (f) may, in relation to any matter relating to the privacy of persons generally, make public statements; and
- (g) may, for the purposes of this Act, conduct such inquiries and make such investigations as it thinks fit.<sup>11</sup>

Individual breaches of privacy could be the subject of an adverse report by the Committee, but beyond this, the powers of redress are limited.

South Australia has *Information Privacy Principles* in place. These are not legislated but were approved by a Cabinet Instruction in 1989 and reissued in 1992.<sup>12</sup> The Principles are binding on the State “public sector” and those agencies and instrumentalities that are “subject to the control and direction by a Minister.” There are 6 principles established relating to the collection, storage, disclosure, access and use of personal information. The particular relevance of these Acts and principles will be discussed in the context of the discussion of each jurisdiction, below.

### **Legislated Privacy Rights - Specific Laws**

As indicated, there are a range of laws that seek to protect privacy interests in their particular contexts. As their common theme they seek to ensure that personal information is used only for the purposes for which it is collected. The privacy protection principles written into public health laws are examples of this group of laws. These are discussed, jurisdiction by jurisdiction below.

### **Breaches of privacy in the interests of public health: The general context**

There is a tension in the monitoring and control of infectious disease. It is between the respect for the privacy and rights of persons who come within the public health regulatory system and the need to maintain surveillance and control necessary to prevent the spread of disease through the community. Traditionally, this tension is resolved by a balancing process which allows breaches of confidence when it can be seen to be in the public interest.

The protection of privacy interests is not an absolute value; the importance placed on privacy varies between communities and over time. For example, early health public health laws gave scant attention to the protection of the privacy of those controlled

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<sup>11</sup>Section 15(1)

<sup>12</sup> South Australian Government, Cabinet Instruction No 1 of 1989.

under the legislation. By contrast, modern legislation, including public health laws have explicit privacy protections. Nor are privacy interests uniformly respected in the community. Breaches are more likely to occur if the information is newsworthy (a well known identity with HIV) or the person has some “outcast” status such as being a prostitute, a paedophile, or a drug user.

The Australian approach to privacy interests has been fragmented by our federal system, which means that the nine governments have all dealt with privacy in varying ways. Public health privacy interests are further complicated by the fact that some references to privacy are to be found within the health statutes and others are to be deduced from the general laws relating to privacy where these exist.

Privacy protection has increased in Australia over recent years. This is evidenced particularly by the special purpose privacy laws which establish general principles for record keepers. In public health practice, it is recognised that controlling disease is best done through co-operation and the development of a trusting relationship between client and clinician, rather than through the application of public health threats and penalties. As canvassed in the introduction, a vital part of that trust is the client’s belief that his or her privacy will be respected; that personal information will be kept securely and used only for the purposes for which it was gathered.

Good public health practice thus requires the protection of privacy interests but it also requires the flow of information in order to prevent the spread of the disease. Some of this flow is clearly established and required by legislation, most notably the reporting of notifiable diseases or contact tracing. Other situations are less clear and have formed the subject of classic “medico legal dilemmas”: should a clinician inform a spouse who is unknowingly at risk from an infected partner; must a person with HIV inform an employer of this fact? In some jurisdictions, legislation has clarified the legal obligations associated with some of these issues, while the HIV/AIDS Legal Working Party made a number of recommendations about clarifying these grey areas.<sup>13</sup> These involved issues such as notification of partners and also where there were threats to public health. In particular recommendation 2.3 provided that :

Service providers should be prohibited by public health legislation from providing identifiable data on HIV/AIDS cases without the individual’s consent except in the following circumstances: [which included] -disclosure in good faith to health

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<sup>13</sup> This was a working party established by the Intergovernmental Committee on AIDS and chaired by Dr Charles Watson that, over the period early 1990 to late 1992, produced a number of discussion papers and a Final Report canvassing and then recommending changes to the law relating to HIV/AIDS, including public health controls.

authorities of the identity of an HIV-infected person whose behaviour is unreasonably causing exposure of infection to others without their knowledge or consent.<sup>14</sup>

The Working Party also recommended that privacy protection principles be developed in all Australian jurisdictions, along the lines of the draft provided in Appendix B of its Report.<sup>15</sup>

### **Penalties for putting others at risk: why they are relevant to privacy questions?**

It should also be noted that the problems of placing others at risk from transmission of disease (and now from HIV infection in particular) has also been an important element in discussion about public health legislation. Since the 19th century, there have been penalties for persons who place others at risk.<sup>16</sup> These supplemented the common law criminal offence of public nuisance which could also apply.<sup>17</sup> The penalties have been expanded in public health laws and more recently, by the introduction in some States of serious criminal penalties. Overall, the act of placing another at risk of infection has been regarded as warranting a substantial legislative and judicial response. This has also been reflected in public policy documents. In 1988, the Commonwealth Discussion Paper *A Time to Care: a Time to Act* identified the following elements of a policy that addresses this problem:

- the imposition of legal penalties for those knowingly spreading the virus
- the isolation of infected persons thought to be knowingly running the risk of infecting others
- the education and counselling of infected persons who might bear risk of infecting others
- the involvement of community groups in support measures, counselling and guidance<sup>18</sup>

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<sup>14</sup> Other circumstances included needle stick injuries, assaults and medical treatment where the need to know a patient's HIV status was for the patient's benefit.

<sup>15</sup> Recommendation 2.3.3. Note, this is discussed in more detail below.

<sup>16</sup> See the discussion generally in HIV/AIDS Legal Working Party Discussion Paper. *Legislative Approach to Public Health Control of HIV-Infection*. Canberra: Commonwealth Dept of Community Services and Health 1991;12.13.

<sup>17</sup> See the case *R v Vantandillo* (1815) 4 M&S 73 or 105 ER 762, which allowed such an action to be brought as a public nuisance, triable under criminal law.

<sup>18</sup> At p127

The application of the available penalties against persons who place others at risk is controversial and fraught with uncertainty. As such, Australian health policy sees prosecution and punishment as a “last resort” to be used when other options such as counselling and warning have failed.<sup>19</sup> However, this should not mask the fact that persons who place others at risk are engaging (for whatever reason) in behaviours which are dangerous to the community and liable to severe penalties.<sup>20</sup> As discussed below, the seriousness of these behaviours is an issue that should be considered relevant in any decision to breach confidentiality, insofar as it is material to the balancing process that is instrumental in considering a breach of privacy.

It is also worth noting that the agreed procedures(emanating from the 1989 Guidelines) illustrate considerable administrative flexibility and a departure from the “strict letter of the law”. Public health practitioners must often reject “black and white” views; theirs is a subtle approach, informed by the “lessons of history” and aware of the need to balance the interests of individuals against the interests of the community and in particular, those who might be put at risk. The thoughtful flexibility demonstrated in this area should commend itself to other areas of infectious disease control where “best policies” have to be developed. This includes the issue that prompts this study where notification across jurisdictions clearly involves a

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<sup>19</sup> Draft guidelines were prepared in 1989. The guidelines have generally been adopted by public health agencies across Australia. Broadly, these are “staged” approaches, that increasingly place restrictions on the infected person’s liberty. They are broadly as follows.

Stage 1: Counselling, education and support

Stage 2: A request for formal involvement by the public health agency, the establishment of a “case management panel” with interventions that include peer support, medical and psychological assistance, housing and financial support, therapies that reduce the risk behaviours such as methadone and a warning letter, indicating the person’s legal responsibilities to not place others at risk

Stage 3: the application of formal public health sanctions such as the restriction of the person’s movement or activities and if necessary an order requiring the person to attend for a health review or counselling

Stage 4: the application of detention and/or isolation orders in an appropriate facility.

See the discussion in Gibson S. *Knowingly and Recklessly?: Uncovering the Meanings of the Policy and practice of Managing People who place Others at Risk of HIV Infection*. Unpublished thesis (Masters of Policy and Admin), Flinders Univ of SA 1996.

<sup>20</sup> (NSW) *Crimes Act* 1900 s36

“A person:

- (a) who maliciously by any means causes another person to contract a grievous bodily disease; or
- (b) who attempts maliciously by any means to cause another person to contract a grievous bodily disease,

with the intent in any such case of causing the other person to contract a grievous bodily disease, is liable to penal servitude for 25 years.”

(VIC) *Crimes (HIV) Act* 1993 s19A

“A person who ,without lawful excuse, intentionally causes another person to be infected with a very serious disease [HIV] is guilty of an indictable offence”.

The maximum penalty is 25 years imprisonment.

breach of privacy done only for the “public health interest” and to minimise the risk of further infection.

## **When Can Disclosure of Confidential Information Occur: The Common Law Position**

### **1 when the person to whom the information relates has consented to the release**

Disclosure with consent is the most common way in which personal information is disclosed to others. Generally, this means that if a person freely agrees to provide information on the basis that it will be, or might at some later stage be, provided to others then that is an authorised disclosure. As can be seen from the discussion in this Report consent is regarded as the normal and expected way in which personal information is passed on to others. This point is also reflected in the Privacy Principles written into the Commonwealth *Privacy Act* 1988 and also by the Privacy and HIV/AIDS Working Party (discussed below). In these cases, a proper consent requires a clear understanding of the circumstances and the context in which information might be passed on to a third person. Notification across jurisdictions with the consent of the person to whom the information relates is of course the most desirable option because it does not involve the need to override the person’s interests in privacy and it avoids the public interest arguments made below which are premised on an absence of consent. It is understood that the Intergovernmental Committee on AIDS and Related Diseases and the Australian National Council on AIDS and Related Diseases have endorsed a process of disclosure that is grounded in the person’s consent.

However, the purpose of this Report is to consider the limits to cross jurisdiction public health surveillance, and it is assumed that for the most part consent has not been provided to allow the transfer of data, either because it has not been possible to obtain it - the person has already left for interstate - or because it may not be given. For this reason it was felt that the practical relevance of “consented” cross border information flow is still limited. It should also be noted that consent even if provided, can be revoked by the person, which further limits its value in this area.

The scenario has been raised where information relating to children is transferred across jurisdictions with the consent of their parents or guardians. Children should be regarded as independent of their parents (or guardians) for the purposes of their

medical affairs at age 16.<sup>21</sup> In most cases then, parental consent applies to only a limited category of very young persons but it would appear to allow notification across jurisdictions if it were given. In such cases it could also be argued that notification would be in the best interests of the child as well as having public health significance. However, in these cases, the parents may be overriding the child's wishes, which may then be problematic in other respects.

## **2 where there is an overriding public interest in making the disclosure**

The common law position is that privacy interests are not absolute and that they can be overridden if there is a compelling public interest. This point was made clear in a number of cases. *W v Edgell* (1990) was a case where a psychiatrist was asked to examine W, an inmate seeking early release. The examination was arranged by W's lawyers and the report was to be made to them on W's behalf. However, Dr Edgell was so concerned about what he had heard in his interview with W (which he knew would not be reported by W's lawyers) that he breached the professional relationship by reporting and explaining his concerns to the authorities responsible for the hospital in which W was detained. W then brought an action in respect of this breach of professional confidence. Edgell claimed that the breach was justified under the circumstances. The English Court of Appeal made the following points:

The decided cases very clearly establish (1) that the law recognises as important public interests in maintaining professional duties of confidence but (2) that the law treats such duties not as absolute but as liable to be overridden where there is held to be a stronger public interest in disclosure. (per Bingham LJ)<sup>22</sup>

Lord Justice Bingham further concluded that where a person exercising sound professional judgment and considering that there was "a real risk of danger to the public" then Dr Edgell was justified in breaching the confidence of his patient.

In a New Zealand case, *Duncan v Medical Practitioners Disciplinary Committee* (1986) Jefferies J held that:

There may be occasions ... when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgment based on the circumstances, and if he fairly and reasonably believes such a danger exists he must act unhesitatingly to prevent injury or loss of life even if there is to be a breach of confidentiality<sup>23</sup>

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<sup>21</sup> This is an arbitrary figure but it is based on consent legislation and common law principles. There may also be exceptions, such as the case where the person/child has a mental disability and a guardianship order was in force.

<sup>22</sup> [1990] 1 All ER 835, cited in Kennedy I and Grubb A. *Medical Law: Text and Materials*. London, Butterworths, 1994 at 653.

<sup>23</sup> [1986] 1 NZLR 513 at 521.

In the absence of any statutory provisions which address this question, the common law position would apply and the cases discussed above can be taken to reflect the Australian position.<sup>24</sup> As expressed in these and other cases, it seems to be the position that even a clinician / patient relationship can be breached if the circumstances of not disclosing are sufficiently serious. The problem is whether the risk that an infected person might pose to others is sufficient to justify a breach of confidentiality.

*W v Edgell* involved a clinician / patient relationship and here the court made the point that W (particularly given his circumstances) necessarily placed a great deal of trust in Edgell who was *his* doctor (though there was not an ongoing doctor/patient relationship; Edgell was simply doing an evaluation). Persons undertaking public health surveillance are generally not in this position (though they may be) and also have an explicit obligation to protect the community (in the sense that it is a substantial part of their job), which private clinicians do not have. Given this, it is likely that a court would be inclined to approve a transfer of information that entailed a breach of privacy provided it is reasonable under the circumstances and made in good faith. This conclusion is strengthened by the fact that the harm that is being prevented attracts such serious penalties.

The discussion so far has been restricted to the case where a decision to notify another jurisdiction can be *authorised* by decisions such as *Edgell*. On some arguments, the law may at some future stage go further - it may impose an *obligation* on a person to notify in order to prevent harm occurring to another person. This was the essence of the Californian case *Tarasoff v Regents of the University of California* (1976).<sup>25</sup> The case involved a failure by a psychologist to warn a potential victim of murderous threats made by a person who was involved in counselling with the psychologist. When these threats were carried out it was argued that the psychologist had a duty to warn the victim. The court firstly held that although the law did not normally impose a positive duty of care on persons, a doctor or therapist may stand in a “special relationship”, owing a positive duty “either to a person whose conduct needs to be controlled or to a foreseeable victim of that conduct - a doctor has an affirmative duty for the benefit of a third party”. Having so concluded, the court went on to say:

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<sup>24</sup> See *R v Lowe* [1997] 2 VR 465 (Vic Court of Appeal) “It has not been, and cannot be suggested that health service providers are under a duty (in the interests of the patient) not to disclose confidential information if such disclosure will aid the protection of the public from a specific and identifiable threat.” (at 485)

<sup>25</sup> 551P 2d 334 (1976).

if the exercise of reasonable care to protect the threatened victim requires the therapist to warn ... we see no sufficient societal, interest that would protect and justify concealment.<sup>26</sup>

At present it is likely that *Tarasoff* does *not* represent the law in Australia, the High Court has been reluctant to impose positive duties such as this<sup>27</sup> but the possibility cannot be discounted. In *R v Lowe*, the Victorian Court of Appeal observed that there “is an emerging trend that a duty of disclosure exists”, though it could cite no Australian cases on the point.<sup>28</sup>

Overall, it is most likely to be the case that notification across jurisdictions, when done in good faith and in order to avert a reasonable concern that a person with an infectious disease is placing, or may be likely to place, others at risk, is justifiable at common law. It falls within the *Edgell* principle as supported by *Lowe*. However the common law position is subject to statutory provisions and these do constrain persons who might hold data for public health surveillance.

These are the various privacy provisions written into health laws across Australia. They will now be considered jurisdiction by jurisdiction.

### **Public health notification requirements**

Notification has always been an essential element of disease control law in Australia. It was a feature of the first health and quarantine acts and in 1884, the Australian Sanitary Conference resolved that “the notification of infectious diseases should be made compulsory in all the Colonies.” Three years later at the Intercolonial Medical Conference, Sir Edward Stirling the South Australian politician and medical practitioner put the view that, despite the unwise tendency of some doctors to see reporting of disease as a breach of confidential relations, it was important to encourage and extend notification.<sup>29</sup> Notification continues as the mainstay of disease surveillance; where criticism has occurred it appears to have been directed in

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<sup>26</sup> See the discussion of this case in Abadee A. The Medical Duty of Confidentiality and Prospective Duty of Disclosure: Can they Co-exist? 1995. *J of Law and Medicine* 3: 75-93 at 80.

<sup>27</sup> See Deane J in *Sutherland Shire Council v Heyman* (1985) 157 CLR 425 at 502.

<sup>28</sup> *Op cit* at 485. The Queensland *Medical Act* 1939 requires medical practitioners to divulge relevant information to police where there is a suspicion of a crime and a doctor who fails to comply with the requirement may be charged with professional misconduct under the Act. (s35(IX) - (XI))

<sup>29</sup> See Cumpston JHL. *Health and Disease in Australia* (1928) republished by AGPS 1988; pp394,395.

order to increase surveillance not to reduce it.<sup>30</sup> Notification serves two obvious purposes. One allows the compiling of data on the incidence and prevalence of particular diseases in the community. The other purpose is to follow up and manage specific individuals who may either have the disease or have been exposed to the disease (contacts). This necessarily involves the transfer of personal information from the registry holding the initial reports to the staff involved in contact tracing. There is an established tradition of confidential information being transferred within branches of public health administrations where that is necessary for the operation of the legislation. The question is: “can similar information be given by one public health agency to another agency on the same basis?” This is considered below.

At this stage it is useful to provide a comparison of both reporting and confidentiality requirements as they apply to each Australian jurisdiction.

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<sup>30</sup> Recommendation 9 of the South Australian Coroner’s Report of the Inquest of Nikki Dearne Robinson (28 September 1995 - the “Garibaldi inquest”) was to tighten up and speed up the process of notification of disease. This was taken up by an amendment to s30 of the *Public and Environmental Health Act 1987*. (SA)

## **Powers To Acquire Information: And Accompanying Confidentiality Requirements**

### **The Commonwealth**

The Commonwealth has no direct responsibility for the domestic regulation and surveillance of infectious disease though it may have cause to consider these issues through its responsibility for the *Quarantine Act* 1908. There are no specific privacy provisions written into this Act but personal information emanating from the Act that is held by the Commonwealth would be subject to the provisions of the *Privacy Act* 1988. Other Commonwealth health laws do have privacy requirements written into them. This includes the *National Health Act* 1951<sup>31</sup> and the *Health Insurance Act*.<sup>32</sup> However, these are not directly relevant to the issues in this Report. As a general principle, though, it is important to consider some the provisions of the *Privacy Act* (since it has broad application to all Commonwealth record keepers) and it establishes Privacy Principles, that have been emulated in other jurisdictions including New Zealand,<sup>33</sup> and arguably reflect best practice.

#### *Principle 4 Storage and security of personal information*

A record-keeper who has possession or control of a record that contains personal information shall ensure:

- (a) that the record is protected, by such security safeguards as it is reasonable in the circumstances to take, against loss, against unauthorised access, use, modification or disclosure, and against other misuse; and
- (b) that if it is necessary for the record to be given to a person in connection with the provision of a service to the record-keeper, everything reasonably within the power of the record-keeper is done to prevent unauthorised use or disclosure of information contained in the record.

#### *Principle 9 Personal information to be used only for relevant purposes*

A record-keeper who has possession or control of a record that contains personal information shall not use the information except for a purpose to which the information is relevant.

#### *Principle 10 Limits on use of personal information*

1. A record-keeper who has possession or control of a record that contains personal information that was obtained for a particular purpose shall not use the information for any other purpose unless:

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<sup>31</sup> S135A

<sup>32</sup> PartVC

<sup>33</sup> See *Privacy Act* 1993 (NZ) and the Information Privacy Principles established under it

(a) the individual concerned has consented to use of the information for that other purpose;

(b) the record-keeper believes on reasonable grounds that use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person;

(c) use of the information for that other purpose is required or authorised by or under law;

(d) use of the information for that other purpose is reasonably necessary for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue; or

(e) the purpose for which the information is used is directly related to the purpose for which the information was obtained.

2. Where personal information is used for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue, the record-keeper shall include in the record containing that information a note of that use.

#### Principle 11 *Limits on disclosure of personal information*

1. A record-keeper who has possession or control of a record that contains personal information shall not disclose the information to a person, body or agency (other than the individual concerned) unless:

(a) the individual concerned is reasonably likely to have been aware, or made aware under Principle 2, that information of that kind is usually passed to that person, body or agency;

(b) the individual concerned has consented to the disclosure;

(c) the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or of another person;

(d) the disclosure is required or authorised by or under law; or

(e) the disclosure is reasonably necessary for the enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue.

2. Where personal information is disclosed for the purposes of enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the purpose of the protection of the public revenue, the record-keeper shall include in the record containing that information a note of the disclosure.

3. A person, body or agency to whom personal information is disclosed under clause 1 of this Principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.

It should be noted that both Privacy principles 10 and 11 allow for the disclosure of personal information where “there cord-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen *a serious and imminent threat to the life or health* of the individual concerned or of another person.” (10.1(b); 11.1(c)). To the extent that notification across jurisdictions needs to occur where the information emanates from the Commonwealth these exemptions are relevant.

#### *Assessment*

The phrase “serious and imminent threat to the life or health” implies an urgency to notification that may not always appear to be present in cases of notification across jurisdictions. However, it is to life or health and it can be argued that any infectious person who is believed on reasonable grounds to be placing others at risk is at the least presenting an imminent threat to the health of another, the threat being the imminent possibility of infection, which (especially if undetected and untreated, as is likely to be the case with the transmission of HIV) is the commencing point for a disease process that will threaten health and life. On this argument the imminent danger is the threat of infection as the first step in this process.<sup>34</sup>

On this basis it can be argued that, as it stands, the *Privacy Act* 1988 permits notification across jurisdictions

#### **The Australian Capital Territory**

Part VI of the new *Public Health Act* 1997 substantially updates the laws relating to disease control in the Australian Capital Territory. Section 99 of the Act establishes general principles against which Part VI should be administered. This includes the following:

- (a) the investigation of notifiable conditions, and any action taken as a consequence, shall be carried out in order to minimise the adverse public health effects of such conditions;

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<sup>34</sup> This point will be made generally where criteria such as these apply in case law or in information principles.

(c) a person who has, or may have, a notifiable condition, or who engages in activities that are known to carry a potential risk of exposure to a notifiable condition, shall be accorded the following rights, to the extent that their exercise does not conflict with the requirements of this Part and does not infringe unduly on the well being of others:

(i) the right to privacy;

(ii) the right to receive all reasonably available information about the medical and social consequences of the condition and any proposed treatment.

Within this framework, the ACT legislation requires notification of specified conditions (sections 102(4), 103(2), 104, 105). Information can also be requested under section 106. The notification of others (contacts) is dealt with by sections 108 and 109.

Privacy interests are dealt with by section 109 which deals generally with the use to which notified information can be put. It provides that:

Information acquired by the Territory as a result of notification under this Division may be used for the following purposes:

(a) the prevention and control of notifiable conditions in the Territory *and elsewhere*;

(b) the prevention and control of risks to public health *generally in the territory and elsewhere*.<sup>35</sup>

A general disclosure requirement relating to named data is imposed by section 110 as follows:

A person shall not, without good reason, disclose information notified under this Division in such a manner that the person to whom the notification relates who has, or who may have, the relevant notifiable condition is reasonably able to be notified, unless -

(a) the disclosure is for the purposes of this Act or another law of the Territory, the Commonwealth, a State or another Territory, or is authorised under a Code of Practice; or

(b) the person to whom the notification relates consents in writing to such disclosure

Restrictions on the disclosure of the identities of medical staff etc are also imposed by section 111.

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<sup>35</sup>My italics

Also, the *Health Records (Privacy and Access) Act 1997* imposes privacy principles on record keepers, in relation to “personal health records”<sup>36</sup>. In particular, section 6 prohibits record keepers from contravening the privacy principles “without lawful authority.” The relevant principles are

*Principle 9 Limits on use of personal health information*

1. Except where personal health information is being shared between members of a treating team to the extent necessary to improve or maintain the consumer’s health or to manage a disability of the consumer, a record-keeper who has possession or control of a health record that was obtained for a particular purpose shall not use the information for any other purpose unless—

- (a) the consumer has consented to use of the information for that other purpose;
- (b) there cord-keeper believes on reasonable grounds that use of the information for that other purpose *is necessary to prevent or lessen a significant risk to the life or physical, mental or emotional health of the consumer or another person*;
- (c) use of the information for that other purpose is required or authorised by—
  - (i) a law of the Territory;
  - (ii) a law of the Commonwealth; or
  - (iii) an order of a court of competent jurisdiction;
- (d) the purpose for which the information is used is directly related to the purpose for which the information was obtained; or
- (e) the use of the information is related to the management, funding or quality of the health service received by the consumer.

2. In relation to the sharing of information among a treating team, unless it is obvious from the circumstances or context of the health service, the person in charge of the treating team shall inform the consumer of the identity of all members of the treating team who will have access to the consumer’s personal health information.

3 The treating team leader is not required to notify the consumer of the identity of individuals, or of classes of individuals, who are required for the management, funding or quality of the health service received by the consumer to handle health records or personal health information.

*Principle 10: Limits on disclosure of personal health information*

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<sup>36</sup> This is defined as

“personal information

(a) relating to the health, an illness or a disability of the consumer; or

(b) collected by a health provider in relation to the health, an illness or a disability of the consumer; whether or not the information is recorded in a health record;”(s5)

1. Except where personal health information is being shared between members of a treating team only to the extent necessary to improve or maintain the consumer's health or manage a disability of the consumer, a record-keeper who has possession or control of a health record shall not disclose the information to a person or agency (other than the consumer) unless—

- (a) the consumer is reasonably likely to have been aware, or made aware under Principle 2, that information of that kind is usually passed to that person or agency;
- (b) the consumer has consented to the disclosure;
- (c) the record-keeper *believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent risk to the life or physical, mental or emotional health of the consumer or of another person*;
- (d) the disclosure is required or authorised by—
  - (i) a law of the Territory (including this Act);
  - (ii) a law of the Commonwealth; or
  - (iii) an order of a court of competent jurisdiction; or
- (e) the disclosure of the information is necessary for the management, funding or quality of the health service received by the consumer.

2. In relation to the sharing of information among the treating team, unless it is obvious from the circumstances and context of the health service, the person in charge of the treating team shall inform the consumer about the identity of all members of the treating team who will have access to the consumer's personal health information.

3. The treating team leader is not required to notify the consumer of the identity of individuals or of classes of individuals, who are required for the management, funding or quality of the health service received by the consumer, to handle health records or personal health information.

4. A person, body or agency to whom information is disclosed under clause 1 of this Principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.

5. Where there is an emergency and a consumer is unable to give or withhold consent to the disclosure of personal health information, the treating health service provider may discuss relevant personal health information with an immediate family member of the consumer to the extent that it is reasonable and necessary to do so for the proper treatment of the consumer.

### *Assessment*

Sections 109 and 110 provide the most complete and explicit way of dealing with the transfer of information across jurisdictions. It specifically allows notification of persons provided that disclosure is “for the purposes of” among other things an

equivalent law of a State or Territory. An example would be a person with an active infection moving from say Canberra to Melbourne, where unknown to the Victorian public health authorities both the person and those exposed to him or her may be at risk and thus potentially subject to provisions of the *Health Act 1958 (Vic)*. Any such disclosure should be done with caution and must conform to the general principles set out in section 99.

The relevant Privacy Principles (9 and 10) set out in the *Health Records (Privacy and Access) Act 1997* allow notification across jurisdictions, in the circumstances italicised in the extracts above. In particular, 9.1(b), where there is a reasonable belief by the record keeper that the notification “is necessary to prevent or lessen a significant risk to the life or physical, mental or emotional health of the consumer or another person” and Principle 10.1 (c) where there is a reasonable belief that the disclosure “is necessary to prevent or lessen a serious and imminent risk to the life or physical, mental or emotional health of the consumer or of another person”. Both grounds would appear to cover the scenarios considered in this report.

## **The Northern Territory**

In the Northern Territory notification provisions and associated regulation is dealt with under the (NT) *Notifiable Diseases Act* 1981. Notification generally occurs through the requirements imposed under section 8. Section 9 obliges an “infected person” or a “suspect person” (a person suspected of being an infected person or who has or may have been exposed to an infected person) to provide the names and addresses of contacts. Section 19 provides wide powers to obtain information.

Section 29 of the *Notifiable Diseases Act* 1981 imposes general and seemingly unqualified confidentiality requirements on persons involved in the administration of the Act.

29(1) An employee within the meaning of the Public Service Act or other person, who acts or assists in the administration of this Act or who is present in a room or at a place where a matter under this Act concerning another person is being discussed, shall preserve and aid in preserving secrecy concerning all matters and things which come to his knowledge whilst so acting, assisting or being present, except so far as his duties under this Act require or except in answer to a question he is bound to answer.

Disclosures of information obtained in the course of administering the Act is protected from liability by section 30 but only where done

in good faith in the exercise or purported exercise of a power or performance or purported performance of a function under this Act [the NT Act], for the purpose of giving effect to the provisions or objects of this Act, or for discharging an obligation placed upon that other person or the Crown by this Act.

It does not cover information passed on to persons outside the jurisdiction for the purpose of administering another public health act.

### *Assessment*

As the Northern Territory legislation stands, it seems that section 29 is sufficiently wide as to prevent a person who “acts or assists in the administration of this Act” from disclosing a “matter under this Act concerning another person” except to the extent that the duties are required under the Northern Territory Act. On the current position, it seems that Northern Territory health officials are unable to disclose information for the requirements and in the contexts envisaged here.

## New South Wales

Notification of disease in New South Wales, is provided for by the *Public Health Act* 1991. The diseases listed in Schedule 3 (notifiable diseases) must be notified by hospitals as required by sections 68 and 69.<sup>37</sup> In addition medical conditions (generally diseases) are separately listed in Schedule 1, falling into any one of 5 categories.<sup>38</sup> Section 14 of the Act requires medical practitioners to notify category 1 and 2 conditions and category 3 conditions are to be notified by laboratories.<sup>39</sup>

There are 2 category 5 conditions, HIV and AIDS. These are of interest because special privacy provisions apply to them in order to protect the identity of persons with the disease. In particular, section 17 provides as follows:

### Category 5 medical condition

#### S17 Protection of identity

- (1) A medical practitioner must not state the name or address of a patient:
  - (a) in a certificate sent to the Director-General under section 14 in relation to a Category 5 medical condition, or
  - (b) except as may be prescribed, in a written or oral communication made by the medical practitioner for the purpose of arranging a test to find out whether the patient suffers from a Category 5 medical condition.
  
- (2) A person who, in the course of providing a service, acquires information that another person:
  - (a) has been, or is required to be, or is to be, tested for a Category 5 medical condition, or
  - (b) is, or has been, infected with a Category 5 medical condition, must take all reasonable steps to prevent disclosure of the information to another person.
  
- (3) Information about a person that is of a kind referred to in subsection (2) may be disclosed:
  - (a) with the consent of the other person, or
  - (b) in connection with the administration of this Act or another Act, or
  - (c) by order of a court or a person authorised by law to examine witnesses, or
  - (d) to a person who is involved in the provision of care to, or treatment or counselling of, the other person if the information is required in connection with providing such care, treatment or counselling, or
  - (e) in such circumstances as may be prescribed.

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<sup>37</sup> The chief executive officer of a hospital has a duty to provide the Director-General, in accordance with the regulations, with information concerning persons suffering from a notifiable disease who are, or have been, patients at the hospital.

<sup>38</sup> In effect 4 categories, since category 1 is birth, perinatal death and sudden infant death syndrome.

<sup>39</sup> Section 16

(4) A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.

There are some exceptions to the general rule against disclosure. These are:

- Firstly, where the disclosure is in the course of “the administration of this Act or another Act” (17(3)(b)). It is not restricted to New South Wales Acts; on a literal reading the phrase could apply to the public health act of another jurisdiction.
- Secondly, section 17(3)(e) which allows disclosure under prescribed circumstances. These have been taken up by (NSW) *Public Health Regulation* 1991

Regulation 7(2) For the purposes of section 17 (3) (e) of the Act, information may be disclosed by a person to the Director-General if the person has reasonable grounds to believe that failure to provide the information could place the health of the public at risk.

Other disclosure provisions are also provided for in Section 18, which allows the District Court to authorise “the service on a medical practitioner of a notice under section 19 requiring disclosure of a name and address that would otherwise be protected by section 17 from disclosure.” if “identification of the person is necessary in order to safeguard the health of the public.”

The above provisions relate to HIV / AIDS (Category 5 medical conditions). Patient privacy is also protected more generally (and therefore in relation to other conditions) by section 75 which provides

(1) A person who discloses information obtained in connection with the administration of this Act is guilty of an offence unless the court is satisfied that there was a lawful excuse for the disclosure.

(2) The reference in this section to a lawful excuse for the disclosure of information includes a reference to disclosure of the information:

- (a) with the consent of the person to whom it relates, or
- (b) in connection with the administration or execution of this Act, or
- (c) for the purposes of legal proceedings arising out of this Act or of a report of any such legal proceedings, or
- (d) in accordance with a requirement imposed under the *Ombudsman Act* 1974; or
- (e) in any other prescribed circumstances.

Circumstances are prescribed for the purposes of section 75(2)(e) by regulation 81A of the Public Health Regulation which provides for epidemiological research.

For the purposes of section 75 (2) (e) of the Act, circumstances in which it is a lawful excuse to disclose information include circumstances where the Chief Health Officer, Department of Health, has approved (with or without conditions) the disclosure To a specified person or class of persons of information consisting of epidemiological data of a specified kind and the disclosure is in accordance with that approval.

A general protection of health data is imposed by the New South Wales *Health Administration Act 1982*. As “health service” is broadly defined, it is almost certainly the case that it applies to public health surveillance services within the Department of Health.<sup>40</sup> Section 22 provides that:

If a person discloses any information obtained in connection with the administration or execution of this Act or any other Act conferring or imposing responsibilities or functions on the Minister, Department, Director-General, Corporation or Foundation and the disclosure is not made:

- (a) with the consent of the person from whom the information was obtained;
- (b) in connection with the administration or execution of this Act or any such other Act;
- (c) for the purposes of any legal proceedings arising out of this Act or any such other Act or of any report of any such proceedings;
- (d) with other lawful excuse; or
- (e) in any other prescribed circumstances, that person is guilty of an offence against this Act

Prescribed circumstances have been set out in the *Health Administration (General) Regulation 1995* as follows

Regulation 13. (1) The object of this clause is to prescribe certain circumstances in which the disclosure of information obtained in connection with the administration or execution of the Act (or any other Act conferring or imposing responsibilities or functions on the Minister, Department, Director-General, Corporation or Foundation) will not constitute an offence under the Act.

(2) For the purposes of section 22 (e) of the Act, the prescribed circumstances are that:

- (a) the disclosure is approved in writing by the Chief Health Officer of the Department (in the case of information that is epidemiological data that does not

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<sup>40</sup> “health service” means any medical, hospital, ambulance, paramedical, community health or environmental health service or any other service (including any service of a prescribed class or description) relating to the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease or injury to persons; (section 4(1))

- identify any individual to whom the information relates) or by the Director-General (in any case); and
- (b) the disclosure is made in accordance with such approval.

(3) The Director-General is not to approve the disclosure of information that may identify an individual to whom the information relates unless:

- (a) the Director-General is satisfied that the individual consents to the disclosure of the information; or
- (b) the Director-General is satisfied that the disclosure is urgently required in the interests of public health; or
- (c) the information is required for the purpose of medical research and the Director-General is satisfied that the research is being conducted in accordance with any guidelines of the National Health and Medical Research Council the Director-General considers relevant, in particular any guidelines relating to the circumstances where the consent of an individual the subject of research need not be obtained and the protection of individual privacy.

(4) An approval:

- (a) must describe the information authorised to be disclosed; and
- (b) must name the person or body to whom the disclosure is authorised; and
- (c) may be given subject to conditions specified in it.

Section 23 also protects information obtained in the course of research into morbidity or mortality occurring within New South Wales and authorised under this section. In particular, section 23(3) provides that

If a person discloses any information obtained in connection with the conduct of research or investigations in accordance with an authorisation under this section (whether or not the authorisation is still in force at the time of the disclosure) and the disclosure is not made:

- (a) with the consent of the person from whom the information was obtained; or
- (b) with the approval of the Minister,

that person is guilty of an offence against this Act

### *Assessment*

Overall, the New South Wales legislation does appear to provide the capacity for the disclosure of patient information in the context discussed in this Report, though the position should be clearer than it is.

### *The Public Health Act 1991*

In the case of HIV / AIDS (category 5 conditions) the provisions of s17(3)(b) arguably extend to any Australian public health act, while the phrase “safeguard the health of the public” as the prescribed circumstances for the purpose of s17(3)(e) (as

specified in r7(2)) is arguably sufficiently broad to encompass an Australian public as much as a New South Wales public.

In the case of other notifiable diseases which may be of concern, it should be noted that the provisions of section 75 are not absolute and that a “lawful excuse” defence applies (s 75(1)). Although what amounts to a lawful excuse is spelt out in 75(2), it is not meant to be exhaustive (“lawful excuse ... includes”) and it is arguable that circumstances where there was good reason to alert public health authorities in other jurisdictions amounts to a lawful excuse for the purposes of the section, since it closely mirrors s75(2)(b). Again one could argue that the *Edgell* scenario would amount to a “common law lawful excuse”. However, the point is not clear. While it is likely that regulation 81A was intended to encompass only epidemiological research, the grounds for disclosure could be extended to include the matters under consideration in this Report.

#### *Health Administration Act 1982*

In the case of the general provisions of the *Health Administration Act*, it can be argued as follows: In the case of section 22:

- that the phrase “the administration or execution of this Act or any other such Act” would encompass an interstate equivalent of the *Public Health Act 1991*,
- that the phrase “lawful excuse” which is used in section 22(d) may well encompass the common law *Edgell* type disclosure and
- that the “prescribed circumstances” in section 22(e) allow disclosure of information that “is urgently required in the interests of public health” provided it is done in the way set out in regulation 13 of the *Health Administration (General) Regulation*.

In the case of section 23, the Minister’s approval is required, but since it appears to relate to research and investigation it is not so obviously relevant to the issues being considered in this Report..

#### **Queensland**

The Queensland *Health Act 1937* represents a traditional public health approach to disease control. Reporting of notifiable diseases is required by of section 32A and

further information can be required by sections 32A(9) and 32B. The provisions of this Act are not subject to any provisions seeking to preserve the rights of persons who may be subject to notification.

The main provision designed to protect privacy is section 49 which provides as follows:

- (1) Every person who acts or assists in the administration of the provisions of this Act relating to controlled notifiable diseases shall preserve and aid in preserving secrecy with regard to all matters which come to the person's knowledge in the person's official capacity except in the performance of the person's duties.
- (2) The chief health officer at the chief health officer's discretion may give such information to another government official or department as the chief health officer considers necessary for the purposes of administering this Act and may give information to and department or official of the Government of the Commonwealth having, in the chief health officer's opinion a legitimate interest in possessing the information.

Additional secrecy provisions are provided by sections 48(7) and (8) of the *Health Act 1937* which provides that prosecutions in respect of section 48 (putting someone at risk from or infecting them with a controlled notifiable disease shall be held in camera and that no report (other than those specified in the sub-section) be made of the proceedings.

General provisions are also written into the *Health Services Act 1991*. Section 63 provides that:

An officer, employee or agent of the department must not give to any other person, whether directly or indirectly, any information acquired by reason of being such an officer, employee or agent if a person who is receiving or has received a public sector health service could be identified from that information

Exceptions are listed in section 63(2) and the following paragraphs are relevant. The general prohibition in section 61(1) does not apply

- (e) to the giving of information required in connection with the further treatment of a patient in accordance with the recognised standards of the relevant medical or other health profession; or
- (f) to the giving of information to an official that is relevant to the performance of the official's functions stated in the official's instrument of appointment; or
- (g) to the giving of information to the Commonwealth or a State, or an entity of the Commonwealth or a State, by the chief executive if the giving of information -

(i) is determined by the chief executive to be in the public interest

It should be said that the *Health Services Act 1991* relates to health services and district health services. Where information is held centrally by communicable disease control officers, the Act appears to have no impact on them. But it may be relevant in some circumstances.

#### *Assessment*

In terms of releasing information to other jurisdictions, section 49 is the key section and it would appear to prevent such disclosure. The discretion given to the chief health officer by subsection (2) is only with regard to the administration of the Queensland *Health Act 1937* (“this Act”) and there is no permission to give information to the other States and Territories even if that relates to the administration of their acts. This conclusion is supported by the reference to the Commonwealth as the exception to the general rule of secrecy. A new public health act may wish to reflect a position similar to the New South Wales or the Australian Capital Territory, which would then allow disclosure if this is in the interests of public health.<sup>41</sup>

For the reasons discussed above, the *Health Services Act 1991* would have a limited role in this area, though even if persons were affected by its confidentiality requirements in section 63, there is a strong argument that a combination of paragraphs (e), (f) and (g) would permit notification across jurisdictions.

#### **South Australia**

Reporting of notifiable diseases is required under section 30 of the *Public and Environmental Health Act 1987*. In addition, section 41 allows the Health Commission<sup>42</sup> or a local council to require such information as it “reasonably requires” for the purposes of the Act. It is an offence for a person not to comply with such a requirement, but is not obliged to provide incriminating information. Section 42a allows persons “employed or engaged by the State” (typically staff of the Health Commission) who are engaged in epidemiological work or in furthering public health

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<sup>41</sup> In this respect, the *Draft Policy Paper on the Review of the Health Act 1937* issued by the Queensland Minister for Health indicates that the preferred position is a “public interest” exception to the general duty of confidentiality, where the Minister of Health certifies on the advice of the Chief Health Officer that the information may be released in the public interest. Information on the extent to which this provision is used will be reported annually. See paras 6.1.6 -6.6.9.

<sup>42</sup>. References to the SA Health Commission will be replaced when the new Department of Human Services is formally established by legislation.

to have access to confidential(patient) information. Information can be provided to such a person without breach “of any law or any principles of professional ethics.”

Patient privacy is protected in South Australian legislation through general health legislation and also through the specific provisions of the (SA) *Public and Environmental Health Act 1987*. General patient confidentiality is provided for by the *South Australian Health Commission Act 1976* as follows:

s 64. (1) Subject to subsection (2), an officer or employee of the Commission, an incorporated hospital or an incorporated health centre must not divulge any personal information, relating to any patient, obtained in the course of employment otherwise than as he or she may be authorised or required to divulge that information by law or by his or her employer.

(2) This section does not prevent a person from divulging statistical or other information that could not reasonably be expected to lead to identification of patients to whom it relates.

This provision is limited in two ways. Firstly, it relates only to persons operating within the Department of Human Services (Health Commission) framework and not to information held within the general practice or private hospital system. However, persons administering the SA public health legislation are subject to these provisions.

A second set of privacy provision has been written into the *Public and Environmental Health Act 1987*. Section 42 which imposes a general obligation of confidentiality in relation to personal information except where that release is in the course of official duties, consented to by the person to whom it relates or required by a court or tribunal.

- S42. Where a person, in the course of official duties, obtains-
- (a) medical information relating to another; or
  - (b) information the disclosure of which would involve the disclosure of information relating to the personal affairs of another, the person shall not intentionally disclose that information unless-
  - (c) the disclosure is made in the course of official duties;
  - (d) the disclosure is made with the consent of the other person; or
  - (e) the disclosure is required by a court or tribunal constituted by law.

It is also important to consider a specific confidentiality provision that relates to public health information obtained under particular circumstances. Section 42a applies to information obtained by the following class of persons

(1) This section applies to a person employed or engaged by the State for the purpose of-

- (a) monitoring public health in the State;
- (b) investigating public health problems within the State; or
- (c) assessing and improving the quality of public health in the State.

(2) The Governor may, by instrument in writing, authorize a person to whom this section applies to have access to confidential information relating to the performance of any function referred to in subsection (1).

(3) Confidential information may be disclosed to a person authorized under subsection (2), and to any person providing technical, administrative or secretarial assistance to that person, without breach of any law or any principle of professional ethics.

(4) A person must not disclose confidential information obtained directly or indirectly pursuant to this section unless-

- (a) the disclosure is made in the course of official duties;
- (b) the disclosure is made with the consent of the person to whom the information relates; or
- (c) the disclosure is required by a court or tribunal constituted by law.

(5) In this section-

"confidential information" means-

- (a) medical information; or
- (b) information relating to a person's personal affairs.

The term "official duties" as used in sections 42 and 42a is not defined. It is best determined by what the SA Health Commission (Department of Human Services) as the relevant employer determines are official duties.

Lastly, the *Information Privacy Principles Cabinet Instruction*. is also relevant, to the extent that clause 7 relates to the use of personal information. In particular that it "should not be used except for any purpose to which it is relevant." As a general point it could be argued that using the information held in South Australia to prevent the spread of disease in Melbourne involves the same purpose as is using it in Adelaide or Whyalla.

Clause 10 is also important: it generally prevents disclosure of personal information to a third person but allows an exception where

the person disclosing the information believes on reasonable grounds that the disclosure is reasonably necessary to prevent or lessen a serious or imminent threat to life or health of the record-subject or some other person<sup>43</sup>

This exception could apply equally to an infected person who, if remained untreated, was risking their own health in the manner described above, as well as a person who may become infected as a result of his or her contact with the them.

### *Assessment*

Taken together, the provisions of section 64 of the *South Australian Health Commission Act 1976* and 42 of the *Public and Environmental Health Act 1987*, it is likely that disclosure of named information to other jurisdictions is, or can be made, acceptable if it is authorised by the Commission as the relevant officer's employer and determined to be in the course of "official duties." Also, it might be argued that the word "authorised" in section 64(1) permits the *Edgell* type disclosure. Finally, if it is argued that disclosure is part of a nationwide system of public health surveillance, for which jurisdictions are individually and collectively responsible, it is quite reasonable to have a relevant public health officer whose duties include liaison with his or her counterparts in other jurisdictions. On this argument, the South Australian provisions present no major obstacles to national transfer of data. It is felt that the *Information Privacy Principles Cabinet Instruction*. do not prevent notification, given the interpretation of the extracts offered above.

### **Tasmania**

Tasmania has separate legislation for HIV/AIDS and for other notifiable diseases. Consequently two sets of confidentiality provisions apply, depending upon the disease to which the release of information relates.

Part 3 of the Tasmanian *Public Health Act 1997* provides general provisions relating to the reporting of notifiable diseases and the regulation of behaviours in order to limit their spread. Under section 48, reports of notifiable disease (as declared under section 40) are to be made to the Director of Public Health. The Director is also obliged to make reports to local councils of "any notifiable disease within its municipal area" (s49(1)) and may give "information to any person who may be directly affected by the occurrence of- any notifiable disease" (section 49(2)). It should be noted that section 49 does not exclude patient identifiable data and that

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<sup>43</sup> Clause 10(b)

section 49(2) does not limit this giving of information only to persons in Tasmania - but they must be directly affected.

General confidentiality provisions are covered in two sections. Section 61 provides a general prohibition on disclosure.

s 61(1) A person, unless authorised to do so under s147, must not disclose any information in relation to -

- (a) any notification relating to a notifiable disease; or
- (b) any investigation or inquiry into a notifiable disease; or
- (c) the identity of any person to whom any notification, investigation or inquiry relates.

(2) A person who acquires information that a person has been or is required to be tested or has or had a notifiable disease must not disclose that information unless authorised to do so under section 147

Section 147 provides a series of exceptions to the general rule against non disclosure. The following circumstances encompassed within the section are set out as they are relevant to cross jurisdictional notification:

s 147 A person must not disclose any information obtained for the purpose of this Act relating to a person except in accordance with any relevant guidelines and -

- (a) with the written consent of the person or parent or guardian of a child or person to whom the information relates
- (b) to a registered medical practitioner who is directly involved in the treatment of that person; or
- (c) to a person apparently in charge of any institution or facility which is involved in the diagnosis or treatment of that person; or
- (d) to a person authorised by the Director [of Public Health]
- (e) for the purpose of notifying a notifiable disease
- (h) for the purpose authorised or required by this Act or another Act

In relation to HIV/AIDS, section 17 of the *HIV/AIDS Preventive Measures Act 1993* requires the issuing of privacy guidelines, which must have regard to the privacy guidelines issued by the National Health and Medical Research Council and Information Privacy Principles established under the (CTH) *Privacy Act 1988*.<sup>44</sup> The Privacy Guidelines apply broadly to any persons or organisations who “have occasion to collect information which includes HIV/AIDS related information.” The requirements relating to use or disclosure are set out in Guideline 8. The relevant extract is set out as follows:

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<sup>44</sup> See Community and Health Services (Tas) *Privacy Guidelines relating to the HIV/AIDS Preventive Measures Act 1993*, 1994.

(a) If an agency has collected HIV/AIDS-related person information for a specific purpose, it must not use or disclose that information for a specific purpose unless:

.....

(ii) the use or disclosure is both:

- necessary to protect another person from serious and imminent risk of HIV infection;
- the only reasonable way likely to eliminate or substantially reduce that risk; and
- the person concerned has been given an opportunity to disclose the information or consent to the disclosure but has refused ...; or

(iii) the use of the disclosure is reasonable and or necessary:

- to enforce the criminal law or administer public health policy as they relate to the transmission of HIV;

Both (ii) and (iii) allow disclosure. (ii) with the rider that the person must be informed and given the “reasonable opportunity”. (iii) appears to allow notification on the basis that criminal sanctions are attached to transmission and it is also an issue for public health policy.

Section 18 of the *HIV/AIDS Preventive Measures Act 1993* also requires that records relating to an HIV test be kept confidential.

A person must not, in any records or forms used in relation to -

- (a) a request for an HIV test by persons in respect of themselves; or
- (b) an instruction by a medical practitioner to a laboratory for an HIV test to be conducted; or
- (c) the laboratory testing of HIV or HIV antibodies; or
- (d) the notification to the medical practitioner of the result of the HIV test; or
- (e) the notification under section 15(1)(b) to the Secretary [of the Health Department] of a positive result -

include any information which directly or indirectly identifies the person to whom an HIV test relates, except in accordance with any privacy guidelines issued under section 17.

Section 19 provides general restrictions on the disclosure of information “concerning the result of an HIV test... including the HIV or HIV antibody status or the sexual behaviour of a person or the use of drugs by a person”. This is a broad provision; there are exceptions to it, relating to consent, guardianship, medical treatment and court orders. The following categories of authorised disclosure may be relevant to cross jurisdictional notification

s19(1) A person must not disclose any information concerning the result of an HIV test or immune function test, including the HIV or HIV antibody status or the

sexual behaviour of a person or the use of drugs by a person to any other person except -

- (a) with the written consent of that person
- (b) if that person has died, with the written consent of that person's partner, personal representative, administrator or executor; or ....
- (g) to a person being an approved health care worker, approved specialist medical practitioner, a dentist, a medical practitioner or a nurse who is directly involved in the treatment or counselling of that person; or ...
- (j) if authorised or required to do so under this Act

However, see also section 20(7), (8) which allows disclosure by a medical practitioner responsible for treating a person of that person's HIV status to his or her sexual contacts.

Other confidentiality provisions also apply; these are in relation to hearings leading up to an assessment or detention order made by a magistrate under s21. They are to be in closed court and details of them cannot be published. This prohibition is very wide and covers "any information relating to, the whole or any part of the proceedings under this section (s21(7), (8)). In addition, section 42 contains a general provision relating to closure of courts and the prohibiting of the disclosure of information about a case if the HIV status is relevant to that case and the inadmissibility of certain HIV related evidence (s43).

There is an issue of the interaction between the *Public Health Act 1997* and the *HIV/AIDS Preventive Measures Act 1993*. Both claim to prevail over other acts in the case of an inconsistency (sections 5 and 4 respectively). In the case of an inconsistency, it would be necessary to reconcile two issues: (1) the *Public Health Act 1997* is the later piece of legislation but (2) the *HIV/AIDS Preventive Measures Act 1993* is the more specific and for this reason it is not easy to say which act predominates. In my opinion, it is not clear that section 5 of the *Public Health Act 1997* intended to replace the provisions of the *HIV/AIDS Preventive Measures Act 1993* to the extent that an inconsistency might exist.<sup>45</sup> Therefore, it is best to assume that the provisions of both Acts should be complied with, and the Assessment (below) makes that assumption.

### *Assessment*

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<sup>45</sup> The general issue of whether or not an inconsistency exists is never clear as the many cases and various tests on s109 of the Constitution illustrates.

Notification of cases to other jurisdictions appears to be permitted under the *Public Health Act 1997*, if the person to whom the notification is made is “a person authorised by the Director [of Public Health]” (section 147(d)). Also, section 49(2) appears to allow the giving of named information to “to any person who may be directly affected by the occurrence of - any notifiable disease.” This might be a person at risk even though that person is not resident in Tasmania.

In the case of HIV / AIDS, cross jurisdictional notification should be encompassed in the privacy guidelines envisaged under section 17 of the *HIV / AIDS Preventive Measures Act 1993* (as it is in the Commonwealth Privacy Guidelines - cited above). If this disclosure were permitted by the Guidelines, it would arguably then fall within the scope of section 19(1)(j), which allows disclosure. In any event, the disclosure envisaged by sections 19(1)(g) and 20(7) of the Act are not limited to Tasmania.

Overall, and subject to the comments made here, there appears to be a number of ways in which cross jurisdictional notification of cases to relevant public health officials can occur.

## **Victoria**

The Victorian *Health Act 1958* contains a range of privacy provisions that have a bearing on the questions under consideration here. Overall, the Act is relatively new legislation, extensively updated in 1988, and is sensitive to the need to respect privacy interests. The Act tends to focus on HIV/AIDS, which was the “neon” issue when it was being passed. However, beyond the specific provisions cited below there is no general privacy provision as applies in other jurisdictions.

The *Health Act 1958* requires that the administration of the disease provisions occur in a framework that establishes certain principles, protecting both the rights of the person with the disease, who is the subject of the statutory control and also of those in the community who might be affected by the person’s behaviours.

The following principles apply for the purposes of the application, operation and interpretation of this Part--

(a) the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy;

- (b) a person at risk of contracting or being infected with an infectious disease must take all reasonable precautions to avoid contracting or being infected with the disease;
- (c) a person who suspects that he or she has an infectious disease must ascertain--
  - (i) whether he or she is infected; and
  - (ii) what precautions should be taken to prevent others being infected;
- (d) a person with an infectious disease must take necessary measures to ensure that others are not unknowingly placed at risk of becoming infected;
- (e) a person with an infectious disease or at risk of contracting or being infected with an infectious disease has a right--
  - (i) to be protected from unlawful discrimination; and
  - (ii) to have his or her privacy respected; and
  - (iii) to receive information about the medical and social consequences of the disease and any proposed treatment; and
  - (iv) to have access to available and appropriate treatment--
 so long as those rights do not infringe on the well-being of others.<sup>46</sup>

A balancing approach is implicit in these principles -the rights of the individual are not to infringe on the well-being of the community and not put others at risk. But within that limit, the person's privacy must be protected and no undue limitations can be imposed on it.

In a number of ways, the *Health Act* 1958 imposes particular privacy requirements. Section 128 requires persons in the course of providing a service which involve testing for HIV or acquiring information about the HIV status of persons to take "all reasonable steps to develop and implement systems to protect the privacy" of those persons.

A person who, in the course of providing a service, acquires information that a person has been or is required to be tested for HIV or is infected with HIV, must take all reasonable steps to develop and implement systems to protect the privacy of that person.<sup>47</sup>

Other privacy provisions are also to be found in Section 120D which in specified circumstances requires that the identity of a person who undertakes a test be preserved when advising of the results.<sup>48</sup> Section 129 provides for courts or tribunals that hear matters where evidence of HIV status is being given to order that the

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<sup>46</sup>Section 119

<sup>47</sup> Section 128

<sup>48</sup> This is where the Chief General Manager can order tests under s120A.

evidence be given in closed session if, in the court's or tribunal's opinion, it is necessary "because of the social or economic consequences to a person if the information is disclosed."

General health services legislation, the *Health Services Act* 1988 (Vic) also provides confidentiality requirements. Most significantly, section 141 provides that

s141(2) A person to whom this section applies must not, except to the extent necessary--

(c) to give any information he or she is expressly authorised, permitted or required to give under this or any other Act-- give to any other person, whether directly or indirectly, any information acquired by reason of being a person to whom this section applies if a person who is or has been a patient in, or has received health services from, a relevant health service could be identified from that information.

There are some exceptions spelt out in sub-section 3, which includes the consent of the person to whom the information relates, the giving of information in the course of criminal proceedings, and also as follows:

(c) to the giving of information concerning the condition of a person who is a patient in, or is receiving health services from, a relevant health service if the information--

(i) is communicated in general terms; or

(ii) is communicated by a member of the medical staff of a relevant health service to the next of kin or a near relative of the patient in accordance with the recognised customs of medical practice; or

(d) to the giving of information to the Australian Red Cross Society for the purpose of tracing blood, or blood products derived from blood, infected with any disease or the donor or recipient of any such blood; or

Section 141 applies to the following classes of persons

"person to whom this section applies" means--

(a) a relevant health service; or

(b) the board of a relevant health service; or

(c) a person who is or has been a member of the board of a relevant health service; or

(d) a person who is or has been the proprietor of a relevant health service; or

(e) a person who is or has been engaged or employed in or by a relevant health service, or performs work for a relevant health service;

Confidentiality requirements are also imposed on casemix auditors not to

“either directly or indirectly, make a record of or divulge or communicate to any person any information that is or was acquired by the person by reason of being, or having been, a case mix auditor or make use of any such information for any purpose other than the performance of official duties or the performance or exercise of that function or power.”<sup>49</sup>

Finally, section 137 protects pathologists from legal action if they provide information under the following circumstances:

“ If a pathologist gives information to the Chief General Manager about an infectious disease, an action does not lie against that pathologist--  
(a) for giving that information; or  
(b) because the information is given without the consent of the person to whom it relates or the person for whom it was prepared.”

Victoria also appears to have a general policy on confidentiality and privacy which related generally to health and welfare records.<sup>50</sup> Its scope is broad and may include HIV/AIDS related information, however, it does not include the *Health Act* 1958 in its list of relevant legislation. Overall, the applicability of this policy to public health practice is unclear but probably very limited in practice. However, it also allows as an exception to the general rule of confidentiality cases where the release “is necessary to prevent or lessen serious threat to life or health of an individual.” As discussed this is likely to include the scenario contemplated in this Report.

Finally, it should be noted that Victoria has recently (July 1998) issued a Discussion Paper outlining details of a proposed *Data Protection Bill*. As currently proposed, the Bill will establish a series of Information Privacy Principles and Voluntary Codes. In relation to health data, the Discussion Paper envisages that the Victorian proposal will “provide a similar level of certainty” to the new Australian Capital Territory Act discussed above.<sup>51</sup>

### *Assessment*

Overall, there is no direct prohibition in Victorian legislation that prevents notification across jurisdictions. This is despite the fact that privacy is protected in general terms by section 119 of the *Health Act* 1958. The *Health Services Act* 1988

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<sup>49</sup> Section 18E

<sup>50</sup> Community Services Victoria. *Policy Series: Confidentiality and Privacy*, January 1992.

<sup>51</sup> Victoria, Dept of State Development. *Discussion Paper Information Privacy in Victoria: Data Protection Bill*, July 1998.

does not apply to persons responsible for public health surveillance and monitoring since they are not health providers and do not come within the group of persons listed in section 141.

Administrative systems developed under section 128 of the *Health Act* 1958 should reflect the concern of notification across jurisdictions and can relatively easily be amended if it does not. Further it applies only to HIV / AIDS and not to the other diseases in respect of which such notification may be necessary.

The new Data Protection legislation is likely (on the experience of the ACT and the Commonwealth) to allow notification across jurisdictions where necessary in the interests of public health.

### **Western Australia**

Western Australia operates with very old public health legislation that provides few rights or safeguards to persons who may be the subject of its provisions. The Infectious Disease provisions - Part IX of the *Health Act* 1911 make no reference to confidentiality or privacy requirements. The now obsolete special provisions relating to venereal disease, Part XI of the Act does provide a provision relating to secrecy. Section 314 of the Act provides that generally:

every person employed in the administration of this Part who does not preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment, and communicates any such matter to any other person except in the performance of his duties under this Act commits an offence.

While in broad terms, this provision has a limited context and does not prevent notification across jurisdictions. Where the disease is a venereal disease as defined by the Act (section 3 includes the traditional diseases such as gonorrhoea, syphilis etc) it is arguable that section 134 is an obstacle to notification but it could also be argued that the purpose of the section was to prevent unauthorised and unprofessional disclosures.

There also appears to be no provision in the *Hospitals and Health Services Act* 1927 or related acts that impose privacy requirements.

*Assessment*

Overall, there appears to be no obstacle in Western Australia to notification across jurisdictions but when new public health legislation is prepared it would be desirable for this point to be addressed clearly and also in the broader context of privacy requirements.

## Templates for Protecting Privacy Interests

In addition to the privacy principles and legislative provisions discussed so far in this Report, it is important to consider the recommended principles established by:

- the *Report of the Privacy and HIV/AIDS Working Party*, September 1992<sup>52</sup>
- the *Final Report of the HIV/AIDS Legal Working Party*, November 1992<sup>53</sup>

Both reports recognise the importance of protecting privacy interests, but with the recognition that the public interest may demand limited disclosure to certain persons for certain purposes. Importantly, these disclosures are embedded into a general framework of privacy protection.

The circumstances in which information can be used as recommended by the *Privacy and HIV/AIDS Working Party*, are seen in the proposed guidelines 7 and 8.

### *Guideline 7*

Subject to guidelines 8 and 9<sup>54</sup>, an agency may use HIV/AIDS-related personal information only:

- (a) for the particular purpose for which it was obtained; and
- (b) if it is based upon reasonable medical or scientific information opinion or consistent with it; and
- (c) if there are reasonable grounds to believe that the information remains accurate and complete; and
- (d) if the benefits or potential benefits resulting from its use are likely to outweigh the harms or potential harms

### *Guideline 8*

1 If an agency has collected HIV/AIDS-related personal information for a particular purpose, it must not use or disclose that information for a different purpose unless:

- (a) the person concerned has received notice of the matters set out in guideline 3<sup>55</sup> and has given express consent to the use or disclosure;
- or
- (b)
    - (i) the use or disclosure is both
      - necessary to protect another person from a serious and imminent risk of HIV infection; and
      - the only reasonable way likely to eliminate or substantially reduce that risk; and
    - (ii) the person concerned has been given the opportunity to disclose the information or consent to the disclosure but has refused; and

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<sup>52</sup> Published by the Commonwealth and chaired by Kevin O'Connor the Privacy Commissioner at the time

<sup>53</sup> discussed above

<sup>54</sup> Guideline 9 relates to medical and social research and is not considered here.

<sup>55</sup> A guideline relating to the information that must be given to a person

- (iii) where the disclosure is made to persons who may themselves have been exposed to HIV, it is made by persons with appropriate experience in partner notification and counselling or other similar notification;
- or
- (c) the use or disclosure is reasonably necessary:
  - (i) to administer the criminal law or administer public health law as they relate to the transmission of HIV; or
  - (ii) to investigate a reasonable suspicion in a specific case that a fraud on the public revenue may have occurred; or
- (d) the use or disclosure is specifically required by law.

The *HIV/AIDS Legal Working Party*, picked up these guidelines in Appendix B of the Final Report with the recommendation that

Privacy protections for HIV/AIDS-related information should exist in State and Territory public health legislation with obligations to develop and implement Information Privacy Principles (including rights of access to records concerning oneself) and provision of penalties for unauthorised disclosure. State and Territory governments should consider implementing the guidelines which are contained in the Report of the HIV/AIDS and Privacy Working Party (Appendix B).

#### *Assessment*

The HIV/AIDS and Privacy Working Party Guideline 8 allows disclosure in the circumstances envisaged in this Report in the sense that any notification across jurisdictions may well be relevant to the administration the criminal law or administration of public health law “as they relate to the transmission of HIV” (guideline 8(1)(c)(i)). Certainly, it is not likely that a person who maybe placing others at risk would be prosecuted, but their management is part of a staged process, potentially leading up to some formal action being taken under the public health legislation or even general criminal law. For this reason every involvement by health authorities (monitoring, counselling, support etc) in the jurisdiction to which the person has gone is underpinned by the provisions of the public health laws in force in that jurisdiction and notification from the State or Territory from which the person has come is reasonably necessary for the operation of the public health law of the jurisdiction.

#### **Administrative Protocols**

The survey of Australian legislation suggests that for the most part notification across jurisdictions can occur. But, it is important that the “unconsented to” information

flow (the breach of privacy) be as limited as possible, consistent with the public health needs. Protocols for disclosure need to be determined. There should be officers nominated to make contact with their appropriate counterparts in the other jurisdictions. Notification should be made in good faith and only when there is a reasonable need and on the best and most recent evidence available. Where a case management or assessment committee is involved comments and advice should be sought prior to a notification being made. Persons who may subsequently be the subject of a notification should be made aware of the possibility as part of their normal management process.

## **Conclusion and Recommendations**

There are strong arguments for notification across jurisdictions, when it is genuinely necessary in the interests of public health. Indeed, the whole “problem” of legislative prohibition is created by the federal system and the fact that public health responsibility has historically been broken into 8 regional and 1 national jurisdiction. When a national approach to public health is taken, it is illogical that the flow of public health information should be restricted in some directions but not others when the purpose of the flow and the safeguards that attach to it are the same. A journey between Melbourne and Sydney is short and relatively commonplace, even easier to make than a journey between Sydney and Broken Hill. Yet information is more restricted if it flows along the interstate route, than if it had been within the State. Our federal system and its laws create these differences, however illogical they might be in terms of public health needs.

The suggested approach is that, for both human rights interests and effective public health practice, privacy interests be strongly protected and that any release of personal information to any person should only occur when there is a demonstrable need to do this. However public health surveillance should reflect national perspectives consistent with the ease with which people can move across state and territory boundaries.

### ***It is suggested that the following changes occur***

- Australian jurisdictions agree on a common set of principles that focus on the protection of privacy interests. There are a number of templates that have the making of a national set of principles and while there is no pressing need that identical wording be used, a common approach is desirable. The Privacy Guidelines determined by the *Privacy and HIV/AIDS Working Party*, and endorsed by the *HIV/AIDS Legal Working Party Report* should be considered for adoption as governing principles for all Australian jurisdictions.
- Where the public health laws provide difficulties with notification across jurisdictions they should be amended to allow notification in cases where a breach of privacy is otherwise authorised. This should be reflected in the privacy guidelines referred to above and allow notification in cases where there is a public

interest based on a reasonable fear, that the person is exposing or may expose others to the risk of infection.

- The public interest exception should apply to all diseases covered by public health legislation. Although much of the energy devoted to reforming public health law in recent years has been fuelled by concerns about HIV/AIDS, the issues are no less important for many other infectious diseases such as tuberculosis or hepatitis
- Administrative protocols should be developed to operate in conjunction with the guidelines. These might usefully consider how the consent of the person to whom the information relates could be a part of the procedures. While the focus of this Report has been on the scope of public health laws to allow notification across jurisdictions on the basis of public health needs, rather than on questions of consent, it is important to explore how processes that respect individual privacy interests by seeking consent to disclosure can be a prominent part of any protocols.