

HEALTH INFORMATION ACT (HIA) BACKGROUND INFORMATION

Alberta's [HIA](#) was brought into force in 2001. The Act permits healthcare providers to collect, use and disclose an individual's health information, without their consent, for the purpose of providing the individual with health care, which includes by non-healthcare providers. This is known as the "circle of care model." These provisions were enacted when healthcare delivery was mainly paper-based, and these provisions were intended to be transactional - between an individual and their care provider.

Prior to the enactment of the HIA, in 1992 in [McInerney v. MacDonald](#), the Supreme Court of Canada (SCC) recognized the following about health information in the context of a doctor-patient relationship¹:

- Medical records contain information about the patient revealed by the patient, and information is acquired and recorded on behalf of the patient. These records contain information that is highly private and personal to the individual. It is information that goes to the personal integrity and autonomy of the patient. Such information remains one's own, in a fundamental sense, for the individual to communicate or retain as they see fit. Professional secrets acquired from a patient by a physician in the course of their practice are the patient's secrets and, normally, are under the patient's control. An individual may decide to make personal information available to others to obtain certain benefits, such as medical advice and treatment, and has a basic and continuing interest in what happens to this information and in controlling access to it.
- A physician begins compiling a medical file when a patient chooses to share intimate details about their life in the course of medical consultation. The patient entrusts this personal information to the physician for medical purposes. The relationship between physician and patient is one in which trust and confidence must be placed on the physician, which relationship is characterized as "fiduciary and confidential". Certain duties arise from the special relationship of trust and confidence between doctor and patient. Among these are the duty of a doctor to act with utmost good faith and loyalty and to hold information received from or about a patient in confidence. When a patient releases personal information in the context of the doctor-patient relationship, they do so with the legitimate expectation that these duties will be respected.
- The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in their records. Information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The

¹ [1992 CanLII 57 \(SCC\)](#), at pp. 148 to 153.

confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.

- The ability of a doctor to provide effective treatment is closely related to the level of trust in the relationship. A doctor is in a better position to diagnose a medical problem if the patient freely imparts personal information. The duty of confidentiality that arises from the doctor-patient relationship is meant to encourage disclosure of information and communication between doctor and patient. Reciprocity of information between the patient and physician is *prima facie* in the patient's best interests. It strengthens the bond of trust between physician and patient which, in turn, promotes the well-being of the patient.

In effect, the HIA codified the findings in *McInerney v. MacDonald* by establishing a custodian model of accountability for health information and by establishing rules to facilitate a patient's ability to control their own health information and to have access to it. This is clear from the purposes of the HIA which are²:

- (a) to establish strong and effective mechanisms to protect the privacy of individuals with respect to their health information and to protect the confidentiality of that information,
- (b) to enable health information to be shared and accessed, where appropriate, to provide health services and to manage the health system,
- (c) to prescribe rules for the collection, use and disclosure of health information, which are to be carried out in the most limited manner and with the highest degree of anonymity that is possible in the circumstances,
- (d) to provide individuals with a right of access to health information about themselves, subject to limited and specific exceptions as set out in this Act,
- (e) to provide individuals with a right to request correction or amendment of health information about themselves,
- (f) to establish strong and effective remedies for contraventions of this Act, and
- (g) to provide for independent reviews of decisions made by custodians under this Act and the resolution of complaints under this Act.

In 2016, in [*Alberta \(Information and Privacy Commissioner\) v. United Food and Commercial Workers*](#), the SCC declared privacy rights in Canada as quasi-constitutional³. It recognized that the purpose of these rights is to provide an individual with a measure of control over their personal information which is intimately connected to their individual autonomy, dignity and privacy. These rights have been declared as fundamental to the preservation of a free and democratic society. The SCC also said that privacy laws enhance an individual's control over their personal information by restricting who can collect, use and

² Section 2 of the [HIA](#).

³ [2016 SCC 53 \(CanLII\)](#), at paras. 65 to 67.

disclose personal information without that individual's consent, as well as the scope of such collection, use and disclosure. Health information is, of course, some of the most sensitive information because it goes to the biological core of an individual.

The HIA was the first of its kind in Canada and is the only health information privacy law that is not consent-based. All other health information privacy laws in Canada are consent-based, which means that the primary authority for collecting, using and disclosing health information is with a patient's consent. The primary reason for this is the Federal *Personal Information Protection and Electronic Documents Act* (PIPEDA), which applies in any province or territory for commercial activities in the private sector. This law applies to any private sector health care provider unless another law is enacted in a province or territory that is substantially similar. PIPEDA applied to the private health care sector in Alberta as of 2004. The majority of health information privacy laws in Canada were enacted post-PIPEDA and have been declared substantially similar to PIPEDA. The HIA is not substantially similar to PIPEDA because it is not consent-based.

The consent provisions in these other health information privacy laws permit consent to be obtained in a number of ways, including by implication and by way of notice. The latter is the commonly used method to obtain consent. The requirement to obtain consent to collect, use and disclose health information in consent-based health information privacy laws aligns with the requirement of healthcare providers to obtain consent to provide treatment.

The HIA prohibits any collection, use and disclosure of health information except in accordance with its provisions. The current model of the HIA applies to custodians, which includes designated regulated healthcare professions⁴. This makes each custodian accountable for complying with the HIA, including the collection, use, disclosure and security of health information. Custodians are responsible for their affiliates⁵ compliance with the HIA. Under the current circle of care model, a custodian would be prohibited from disclosing health information about a patient to another care provider unless there is a care relationship between the patient and the provider to whom the health information is being disclosed. As a security measure, the HIA does not permit providing access to health information unless a disclosure is first permitted.

The HIA also requires effective access controls that ensure health information is only accessed by the custodian's affiliates on a need-to-know basis. It also limits collection, use and disclosure to information that is necessary for the intended purpose⁶.

The HIA was amended in 2009 to permit electronic sharing of prescribed health information among authorized custodians by way of the electronic health record (EHR – i.e., Netcare). Apart from these provisions, which restrict sharing to specified purposes, the current HIA model does not support the sharing of health information among all healthcare providers in the province. It is also unclear whether, under the current model,

⁴ See section 2(2) of the *Health Information Regulation*, Alta Reg 70/2001.

⁵ "Affiliate" is defined in the *HIA* to include an employee, a service provider under a contract, an appointee, volunteer, student, an agent, and an information manager. See section 1(1)(a) for a complete definition.

⁶ Section 58 of the *HIA*.

health information can be used by a custodian to innovate in the delivery of healthcare with the use of certain technology, such as artificial intelligence.