Information and Privacy
Commissioner of Ontario
Commissaire à l'information et à la
protection de la vie privée de l'Ontario

VIA ELECTRONIC MAIL

April 6, 2022

Ernie Hardeman
Chair of the Committee
Standing Committee on Finance and Economic Affairs
Legislative Assembly of Ontario
99 Wellesley Street West
Room 1405, Whitney Block
Queen's Park
Toronto, ON M7A 1A2

Dear Chair Hardeman:

RE: Schedule 4 of Bill 106, the *Pandemic and Emergency Preparedness Act, 2022*

I am writing with reference to Schedule 4 of Bill 106, the *Pandemic and Emergency Preparedness Act, 2022* (Schedule 4), which would amend the *Personal Health Information Protection Act, 2004* (*PHIPA*) by introducing new regulation-making powers in respect of the:

I. Obligations and authorities of Ontario Health Teams regarding personal health information, and

II. Right to access records of personal health information in electronic format.

In the following submission, I will address each of these proposed regulatory powers in turn and offer recommendations for the Committee's consideration as you pursue your study of Bill 106.

I. Regulation-making authority with respect to Ontario Health Teams

A significant portion of Schedule 4 pertains to the regulation-making powers under *PHIPA* with respect to Ontario Health Teams (OHTs). Clause 73(1)(n.3) of *PHIPA* currently provides that regulations may be made prescribing:

(i) under what circumstances a person or entity or group of persons or entities designated under subsection 29 (1) of the *Connecting Care Act, 2019*[1] may collect, use and disclose personal health information,

(ii) conditions that apply to the collection, use and disclosure of personal health information by a person, entity or group mentioned in subclause (i), and

[1] Subsection 29(1) of the *Connecting Care Act, 2019* is: "The Minister may designate a person or entity, or a group of persons or entities, as an Ontario Health Team."

2 Bloor Street East
Suite 1400
Toronto, Ontario
Canada M4W 1A8

2, rue Bloor Est
Bureau 1400
Toronto (Ontario)
Canada M4W 1A8

Tel/Tél : (416) 326-3333
1 (800) 387-0073
TTY/ATS : (416) 325-7539
Web : www.ipc.on.ca

(iii) disclosures of personal health information that may be made by a health information custodian or other person to a person, entity or group mentioned in subclause (i).

Clause 73(1)(n.3), as amended by the proposal in Schedule 4, would allow for regulations to be made governing:

(i) under what circumstances a person or entity, or group of persons or entities, described in subsection (1.1) may collect, use and disclose personal health information,

(ii) conditions that apply to the collection, use and disclosure of personal health information by a person, entity or group mentioned in subclause (i),

(iii) security requirements, records retention, information practices and rules for access and correction for personal health information held by a person, entity or group mentioned in subclause (i),

(iv) disclosures of personal health information that may be made by a health information custodian or other person to a person, entity or group mentioned in subclause (i),

(v) any requirements with respect to the collection, use and disclosure of personal health information that a person, entity or group must comply with if they used to fall under the description in subsection (1.1) but no longer fall under that description.[2]

OHTs have the potential to significantly improve patient-centered care by integrating various health and community-based services to make it easier for patients, their families, and caregivers to "navigate the system and transition between providers".[3] Coordinating and facilitating the journey of individuals through the system could improve not only the quality of care provided, but the entire patient experience itself.

While the OHT model could fundamentally improve the delivery of health care in Ontario, it brings with it significant related changes to flows of personal health information between various participants in OHTs. Many of the participants of OHTs are health information custodians (custodians) who have been subject to *PHIPA* for decades and are well versed in their statutory obligations to protect the privacy and security of personal health information. Other participants, social and community service providers for example, may not be subject to *PHIPA* and have never been educated to comply with its provisions (non-custodians).

The proposed amendments in Schedule 4 seek to introduce new regulation-making powers, including to prescribe rules governing the sharing of personal health information between various participants of OHTs, both custodians and non-custodians. We maintain that changes of this magnitude should be made in the legislation itself, rather than its regulations.[4] While *PHIPA*

[2] See s. 2(2) of Schedule 4.
[3] See Ministry of Health and Ministry of Long-Term Care, "Ontario Health Teams" (accessed April 6, 2022).
[4] See Comments of the Information and Privacy Commissioner of Ontario on Bill 138 (December 2, 2019), page 1.

contains a very good model for public consultation before making regulations,[5] we believe amendments of this nature should be introduced by way of legislation to offer even more visibility and therefore an enhanced opportunity for public scrutiny, debate, and challenge.

My views in this regard are consistent with those of my predecessor, which I summarize here below:

A. Bill 74, *The People's Health Care Act, 2019*

In April 2019, Bill 74 introduced the *Connecting Care Act, 2019*.[6] The preamble of the *Connecting Care Act, 2019*, noted that "[t]he people of Ontario and their government … [a]re establishing a new model of integrated public health care delivery which will put each patient at the centre of a connected care system anchored in the community, and where possible, at home, all across Ontario and respecting regional differences…"[7] This new model introduced the concept of OHTs, which were at that time called "integrated care delivery systems".

While Bill 74 was at committee, my office — the Office of the Information and Privacy Commissioner of Ontario (IPC) — made a submission recommending, among other things, that OHTs be designated as custodians under *PHIPA*. The IPC explained:

> As these [OHTs] will be delivering health care services, they should be designated as health information custodians under section 3 of *PHIPA*. In order for [OHTs] to be able to effectively integrate services provided by health service providers who are all health information custodians under *PHIPA*, the [OHTs] must themselves be subject to the same legislative framework as health service providers.
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> Designating integrated care delivery systems as health information custodians will also assist with integration by ensuring uniform health information policies and procedures are in place. It would further ensure that Ontarians' privacy and access to information rights are protected and that integrated care delivery systems are subject to the IPC's oversight.[8]

Despite these recommendations, OHTs have not been designated as custodians under *PHIPA*.

B. Bill 138, *Plan to Build Ontario Together Act, 2019*

In December 2019, Bill 138, *Plan to Build Ontario Together Act, 2019*, amended *PHIPA* by adding s. 73(1)(n.3), the regulation-making power that pertains to OHTs.[9]

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[5] *PHIPA* generally requires proposed regulations to be posted for public consultation for at least 60 days. See s. 74 of *PHIPA*.
[6] See Bill 74, *The People's Health Care Act, 2019*, S.O. 2019, c. 5, Sched. 1.
[7] See *Connecting Care Act, 2019*, Preamble.
[8] See Comments of the Information and Privacy Commissioner of Ontario on Bill 74 (March 29, 2019), pages 3-4.
[9] See Bill 138, *Plan to Build Ontario Together Act, 2019*, S.O. 2019, c. 15, Sched. 30, s. 8(1).

While Bill 138 was at committee, the IPC again made a submission recommending, among other things, that the government ensure accountability for OHTs. The IPC wrote that it was:

> …significantly concerned with the possibility that non-custodians be able to participate in Ontario Health Teams and not be subject to the same privacy obligations as custodians under *PHIPA*. Going forward, the government must ensure that only custodians are permitted to collect, use and disclose personal health information as part of Ontario Health Teams, unless there is a comprehensive privacy framework that applies equivalent obligations on non-custodian participants in the teams. These non-custodian participants must also be subject to IPC oversight. Until such a framework is in place, the ability to collect, use and disclose personal health information should be limited to custodians…[10]

Again, despite these recommendations, non-custodian members of OHTs have not been made subject to equivalent privacy obligations as custodians under *PHIPA*, under direct IPC oversight.

C. Bill 106, Schedule 4

With respect to Bill 106 currently before your Committee, the portion of Schedule 4 pertaining to OHTs continues to raise many of the same concerns the IPC has previously expressed with the OHT model. Specifically, there continues to be a gap between the OHT model and the law regulating personal health information. Under *PHIPA*, custodians[11] are subject to various obligations, including restrictions on the collection, use and disclosure of personal health information, the obligation to retain personal health information in a secure manner, the obligation to provide individuals with access to their health records subject to limited exceptions, the requirement to be transparent about their information practices, and the obligation to notify individuals of privacy breaches, as well as my office when those privacy breaches exceed a certain threshold. Custodians are also subject to oversight by the IPC.

However, as noted above, an OHT is not, in and of itself, a custodian, nor is it a requirement for the various participants of OHTs to be custodians. The IPC remains concerned therefore that non-custodian participants of OHTs may not be subject to the same oversight and privacy obligations as custodians, introducing significant risks into the desired flow of personal health information between various providers. Moreover, amendments made to *PHIPA* in 2020 introducing administrative penalties to encourage compliance and to prevent *any* person (custodian or non-custodian) from deriving, directly or indirectly, any economic benefit as a result of a contravention of *PHIPA* or its regulations, are still not operative. Until such time as these administrative penalties become operative, non-custodians in particular, are even less incentivized to protect the privacy of individuals.

Like my predecessor, I continue to maintain that OHTs, or every participant of OHTs, should be accountable for protecting the privacy of the individuals whose personal health information they receive and for maintaining the confidentiality of that information. This can either be done by making OHTs, themselves, custodians, or by ensuring that non-custodian participants of OHTs are subject to equivalent privacy and security duties and obligations as custodians. Until such time,

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[10] See supra note 4, page 2.
[11] See *PHIPA*, s. 3.

personal health information should not be shared with non-custodians participating in OHTs without the express consent of the individual to whom the information relates.[12] While this position might seem antithetical to a model intended to facilitate an individual's journey through the health system, it is a necessary implication of the fact that the basic privacy protections have not yet been established to protect an individual's privacy as they transition between various providers. Without those basic privacy protections in place, non-custodian members of OHTs must be treated in a manner consistent with how any other non-custodian is treated generally under *PHIPA*.

If Schedule 4, as currently drafted, becomes law, regulations could be made permitting non-custodians participating in OHTs to collect, use and disclose personal health information, among other things.[13] While the regulations may specify the circumstances, conditions and requirements under which collection, use and disclosure between participants of OHTs may occur, without seeing the regulations, the IPC continues to have significant concern about the potential collection, use and disclosure of personal health information by largely unregulated entities. My office has been advised that the Ministry of Health does not intend to permit the disclosure of personal health information to non-custodians participating in OHTs, except where already permitted by law. However, we remain concerned that the regulation-making power has not been sufficiently circumscribed to exclude this possibility.

Until we can be assured that non-custodians participating in OHTs are subject to the same or equivalent privacy and security duties and obligations as custodians, we recommend that non-custodians be excluded from any new regulatory authorities for OHTs to collect, use and disclose personal health information made under s. 73(1)(n.3) of PHIPA.

In addition, we would recommend that the regulation-making power granting authority to collect, use or disclose personal health information between participants of OHTs be expressly limited to only that which is necessary for their purposes and that only the minimum amount of personal health information be used for such purposes.

For example, the proposed new regulation-making power set out in Schedule 4 would apply to both designated and authorized OHTs. According to s. 2(3) of the Schedule:

- "Designated" OHTs are those that are designated under s. 29(1) of the *Connecting Care Act, 2019* as an Ontario Health Team.
- "Authorized" OHTs are those that have not yet been designated as an Ontario Health Team under s. 29(1) of the *Connecting Care Act, 2019* but that have received written authorization from the Minister approving them to:
    - use the title "Ontario Health Team", and
    - collect, use and disclose personal health information in accordance with the conditions and other requirements made under s. 73(1)(n.3) of *PHIPA*.[14]

[12] Or other current authority in *PHIPA* to disclose personal health information without consent.
[13] The IPC notes that this risk already exists with the current version of s. 73(1)(n.3) of *PHIPA*. As described above, the IPC made a similar submission when the current provisions were added. See supra note 4.
[14] See also s. 43.4 of the *Connecting Care Act, 2019.*

The IPC understands that few, if any, OHTs have been "designated" under s. 29(1) of the *Connecting Care Act, 2019*. Rather, various persons, entities or groups have been "authorized" to use the title "Ontario Health Team" as they work towards eventual designation. The IPC understands that the rationale for granting non-designated OHTs the authority to collect, use and disclose personal health information under the regulations is so that they can conduct the planning and analysis necessary to apply to become a designated OHT.

To the extent that authorized OHTs only require additional authority to conduct the planning and analysis necessary to *apply* to become a designated OHT, the regulations should limit their authority both in time and scope to collect, use and disclose personal health information for that narrowly defined purpose. Designated OHTs might have informational needs different from the needs of authorized OHTs.

Accordingly, we recommend that any new authorities be tailored so that OHTs do not collect, use or disclose personal health information if other information will serve the purpose, and do not collect, use or disclose more personal health information than is reasonably necessary to meet the purpose.

II. Access to records of personal health information in electronic format

Another portion of Schedule 4 pertains to an individual's right to access their records of personal health information in electronic format. Section 52 of *PHIPA* affords individuals with the right to access their records of personal health information, subject to limited exclusions and exceptions. More specifically, subsection 52(1.1) currently states:

> The right to access a record of personal health information includes the right to access the record in an electronic format that meets the prescribed requirements, subject to any restrictions, additional requirements or exceptions that may be prescribed.[15]

Schedule 4 would amend s. 52(1.1) by introducing an additional method for establishing the required electronic format, namely by way of specifications issued by Ontario Health in accordance with the regulations. The amended subsection 52(1.1) would state:

> The right to access a record of personal health information includes the right to access the record in,
>
> (a) an electronic format that meets the prescribed requirements, subject to any restrictions, additional requirements or exceptions that may be prescribed; or
>
> (b) an electronic format specified by the Agency [Ontario Health] in accordance with the regulations.[16]

[15] To date, one regulation has been proposed under this s. 52(1.1), but it has not yet been made; see Ontario Regulatory Registry proposal number 21-HLTC024. The IPC made a submission on the proposed regulation on December 1, 2021.
[16] See s. 1 of Schedule 4.

Schedule 4 would also amend the regulation-making powers under *PHIPA* (which are listed in s. 73) by adding the authority to make regulations authorizing Ontario Health to establish these specifications in accordance with certain requirements:

> authorizing the Agency to specify electronic formats for the purposes of subsection 52 (1.1), which may include requirements, conditions, restrictions or exceptions that apply to the authorization;[17]

While we have no objection to this new regulation-making power, I would like to publicly register two comments now in order that they may be eventually addressed in any regulations giving effect to these proposed amendments pertaining to access to records in electronic format.

A. Require Ontario Health to consult with the IPC and the public

The electronic formats specified by Ontario Health will have significant implications for individuals exercising their access to information rights, and for the IPC in adjudicating those rights. Subsection 52(1.1) of *PHIPA* currently requires that electronic access formats be prescribed in regulation. This means that any draft regulation will be subject to the public consultation requirements in s. 74 of *PHIPA*. We would recommend that the government ensure a similarly open and rigorous consultation process for the electronic formats specified by Ontario Health.

Specifically, we recommend that any regulations eventually authorizing Ontario Health to specify electronic formats for access to records of personal health information in accordance with certain requirements, include a requirement for Ontario Health to consult with my office.

A similar obligation to consult my office currently exists when Ontario Health is establishing or amending certain interoperability specifications under sections 26 to 34 of O. Reg. 329/04 under *PHIPA*. Specifically, Ontario Health is required, for certain interoperability specifications, to "(a) consult with the Commissioner, in a manner [Ontario Health] and the Commissioner mutually consider appropriate in the circumstances; and (b) consider the recommendations, if any, made by the Commissioner…".[18] In my view, the consultation process between Ontario Health and the IPC with respect to interoperability specifications has been highly collaborative and working well. Ontario Health has been providing the IPC with numerous opportunities to review and provide feedback on drafts of interoperability specifications as they are being developed, working towards a better end result.

We further recommend that any regulations eventually made under these proposed amendments require Ontario Health to consult the public by providing them with an opportunity to comment on the electronic formats under consideration for access to records of personal health information.

For example, the proposed formats could be posted on Ontario Health's website with an invitation for the public to provide submissions. I understand Ontario Health is already doing this in relation to the interoperability specifications.

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[17] See s. 2(1) of Schedule 4.
[18] See O. Reg. 329/04, s. 27(6).

B. Require Ontario Health to publish the specified electronic formats

We also recommend that any regulations eventually made relating to Ontario Health's authority to specify electronic formats for access to records of personal health information require Ontario Health to make its specifications publicly available by posting the most up-to-date version of them on its website.

This is important because such specifications will no longer be required to be set out in the regulations accompanying *PHIPA*, which are necessarily made publicly available. This is also important because my office is responsible for adjudicating complaints about whether custodians have complied with their obligation to provide access in the specified electronic formats. To do so, the IPC will need to reference a current and publicly available version of the specified electronic formats.

Again, a similar obligation currently exists for Ontario Health with respect to interoperability specifications. Ontario Health is required to "make the interoperability specifications available to the public by posting them on [Ontario Health]'s website or by such other means as [Ontario Health] considers advisable" and must "ensure that the most up-to-date specifications" are posted.[19] We recommend that Ontario Health be required, at a minimum, to do the same for any electronic formats of access it has specified.

In the spirit of openness and transparency, I am providing a copy of this letter to the Ministry of Health, as well as the Chief Executive Officer of Ontario Health. I will also be posting this letter on my office's website.

Thank you for receiving my comments on Bill 106 and I would be pleased to answer any questions Committee members may have.

Sincerely,

Patricia Kosseim
Commissioner

cc: Hon. Christine Elliott, Minister of Health
Dr. Catherine Zahn, Deputy Minister of Health
Mr. Matthew Anderson, President and Chief Executive Officer, Ontario Health

[19] See O. Reg. 329/04, s. 29.