
SUBMISSION TO THE STANDING COMMITTEE ON LAW AMENDMENTS

**On The Discussion Paper – Personal Health Information Access and Privacy
Legislation**

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INTRODUCTION

The Office of the Ombudsman is pleased to be provided with the opportunity to comment on the Discussion Paper on Personal Health Information – Access and Privacy Legislation. We feel this is an important initiative and a critical piece of legislation in light of the development of the electronic health record. While the electronic health record ensures personal health information will be available to health care providers at the touch of a button, it introduces new access and privacy concerns.

New Brunswick is not the first jurisdiction to embark on this journey as Quebec, Manitoba, Saskatchewan, Ontario, Alberta, British Columbia and most recently Newfoundland have legislation to govern the protection of personal health information. Nova Scotia has recently commenced a law reform process similar to New Brunswick's. While we can learn from the successes and mistakes of the preceding jurisdictions, it is important for the government of New Brunswick to turn its mind to what the future of personal health information management will hold and to tailor our legislation to these future needs and to our unique situation. With the ultimate goal of a one patient one record system it is important that we have the proper legislative mechanisms in place to protect patient privacy. The law will have to provide patients with access so that they can become more active participants with respect to their own health care management and balance these needs along with the goals for effective and efficient provision of health care.

This submission comments in turn on the several important questions raised by the Department of Health in its consultation paper. The Office of the Ombudsman has participated fully in the prior stakeholder consultations and in the Privacy Working Group established by the Department and will continue to confer with departmental officials as legislative proposals are brought forward. We hope that committee members will not hesitate to confer with our office with respect to any of the submissions herein or any questions pertaining to this important legislative proposal.

1.0 Purpose

Should the legislation provide for other purposes? If so, what purposes.

The suggested purpose clause is similar to the one for the Ontario's *Personal Health Information Protection Act* (ON - PHIPA) and is consistent with other clauses and preamble's in health information legislation across the country. The Office of the Ombudsman would like to see the addition of an accountability clause similar to the newly passed Newfoundland *Personal Health Information Act* (NFLD - PHIA) which includes:

'to establish mechanisms to ensure the accountability of persons having custody or control of personal health information and to safeguard the security and integrity of the personal health information in their custody or control'.

In Nova Scotia's *Green Paper Personal Health Information Legislation for Nova Scotia* (found at http://www.gov.ns.ca/health/phia/PHIA_%20Discussion_Document.pdf) the author's include a similar clause in the list of objectives:

“to enhance the accountability of individuals who collect, use and disclose personal health information by establishing and enhancing requirements for policies and practices for the protection of personal health information”

Accountability is an important component of privacy and access legislation and is the first of the ten principles outlined in the Statutory Code of Practice in Schedule A to the *Protection of Personal Information Act*. We believe it is important to include accountability in the purpose clause.

2.0 Application of Legislation

1. *Are there other types of personal health information that should be included under the new legislation? Are there other types of programs or services that should be included in the definition of health care and, therefore, covered by the new legislation?*

The Pan-Canadian Framework, which was agreed upon by the various Ministries of Health (including New Brunswick but not Saskatchewan or Quebec) in January of 2005 states that the framework applies to recorded and unrecorded information. Provinces that have older pre-framework legislation (Alberta – 2001, Manitoba -1997, Saskatchewan-2003) either restrict the definition of personal health information (phi) to recorded information or are silent. Newer legislation (Ontario-2004 and Newfoundland-2008) included oral and recorded information. In our opinion, in order to insure complete privacy protection, New Brunswick should include both recorded and unrecorded information.

In the Report of the New Brunswick Task Force on Personal Health Information (the Finn/Malone Report), the authors recommended that the definition of personal health information not include unrecorded information. In their view ‘the exclusion of unrecorded information would only marginally affect the completeness of an individual’s health record while considerably simplifying the implementation of PHI legislation’. In their report the authors cite the submission of the CBA – New Brunswick Branch which stated that inclusion of unrecorded information would have ‘potentially unworkable challenges’. As an example, the CBA questions whether or not a health care professional would be required to submit to an interview in order to allow an individual to obtain access to the personal health information that he or she has committed to memory.

Including unrecorded information in the definition of personal health information poses some concerns from the access provisions but this does not necessarily warrant the elimination of unrecorded information from the Act altogether. It is important that unrecorded information be protected from the collection, use and particularly disclosure portions of access and privacy legislation. For example, I may disclose personal health

information to my health care provider that they don't chart. By not including unrecorded information in the definition, the health care provider would be at liberty to disclose that information to whomever and in whatever fashion they choose and that information would not be protected by the legislation.

There are excellent reasons for including unrecorded information in the legislation in the use and disclosure provisions at a minimum. For example, in Ontario, Order HO-005 involved a situation in which a Methadone clinic used video surveillance to observe patients to insure they were providing proper urine samples. Images of a woman urinating were caught on a vehicle's back up camera in the clinic parking lot as the surveillance system used wireless technology. There was no recording device attached to the surveillance system, so the question is whether or not this situation would be caught by the legislation as the images were not 'recorded'. In this particular situation, the Privacy Commissioner did use a broad interpretation of the word 'record' in order to include these images under personal health information. However, this should not be left up to statutory interpretation. If the government wants to make it clear that protecting the privacy of personal health information is important, it should not limit the definition of personal health information to recorded information only.

2. *Should the legislation apply mostly to individuals and organizations that possess personal health information for purposes of providing health care or planning and managing the health system?*

The proposed provisions indicate that the legislation will apply to custodians who collect, maintain or use personal health information for the purpose of providing or assisting in the provision of health care or treatment or the planning and management of the health system. There is a long list of healthcare providers included in the definition of "custodians" which is excellent. It is important to expressly include organizations such as the Workplace Health Safety and Compensation Commission (although they should be listed under their new name – WorkSafe NB) in order to avoid any ambiguity. The included custodians must however be listed for clarity and illustrative purposes so that the list is not exclusive or determinative of who is a custodian or not. That should be determined by the definition and left to interpretation as new custodians appear.

We are concerned about employers and insurance companies being defined as non-custodians. How will the vast amounts of personal health information collected by these organizations be protected? Is it the province's contention that PIPEDA applies to this information? Is the proposed law about limiting hospital liability or is it about protecting personal health information? If it's about the privacy of New Brunswickers' personal health information, then the law should eventually contemplate how it will apply in schools, insurance companies, employment settings, courier companies, as breaches are as likely to happen within these organizations as they will within the healthcare setting.

Most jurisdictions limit the scope of the legislation to 'providing health care or planning and managing the health system' or similar wording. What is the public policy reason for

limiting the legislation in such a fashion? Doctors whose Hippocratic Oath includes the statement - "I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know" are covered by the legislation, but insurance companies who swear no similar oath are not. If the government truly believes that personal health information is in need of protection, it should in fact be protected in all circumstances regardless of by whom the information is being held. In the Ombudsman's view this expanded scope of the legislation is urgently needed, but should be contemplated in a phased or staged approach.

We also have concerns about whether the Department of Education, in particular individual schools, who often possess significant quantities of personal health information are covered. It has been indicated that in many cases they also 'provide health care or treatment'. The same is true with respect to all other public sector bodies that deal with personal health information. While a public sector agency may not be directly involved in the treatment and care of patients, from the patient's perspective the treatment of their personal health information by any agent of the Crown in right of the Province of New Brunswick may give rise to the same legitimate expectation of privacy and indeed to a greater and more reasonable concern that this information will be disclosed more freely within the public sector.

The Ombudsman would not submit that all public sector bodies should be brought within the circle of care. At the same time, it is recommended that the law make careful distinctions between the obligations of public sector bodies, which would otherwise be subject to the Access to Information and Protection of Privacy Act, and to private sector bodies which will be subject to PIPEDA in relation to client information, but who may be completely unregulated with respect to employee health records. In our view this situation gives rise to two clear priorities: 1) in the first place we must find an efficient means of quickly bringing employee-employer personal health records within the scope of the relevant legislative scheme (whether provincial or federal); and 2) we should make sure that our personal health information legislation governs the treatment of all personal health information in the public sector. This latter recommendation stems from the simple fact that we should avoid having two sets of rules to govern the treatment of personal health information in the public sector. More importantly though we believe there is a demonstrated need to improve the law and rules applicable to the sharing of personal health information between public sector agencies.

In the Ombudsman's recent reports *Connecting the Dots* and *Ashley Smith* we documented several cases where the failure to share personal health information between public sector service providers had materially and significantly compromised the quality of care provided to New Brunswick youth. As recently as last week, Claudette Bradshaw, now Chair of the Canadian Mental Health Commission's committee on homelessness and mental health, decried the same lack of information sharing between public agencies and not-for-profit service providers as the main impediment to improving the quality of care to mental health patients in our province. The Ombudsman submits that New Brunswick needs to show leadership in this field and develop legislative provisions which maximize patient care without compromising patient privacy. To date however, the application of

privacy principles has caused confusion, inhibition and a withdrawal into operating silos in a manner that has unduly compromised medical, social and educational service delivery. The new law must redress this situation. In the area of child welfare in particular our office has recommended that the Act include a special provision to ensure that notwithstanding all other provisions of the legislation nothing in the act should prevent or discourage the secure and reasonable disclosure of personal health information between custodians and other service providers where the best interests of the child will be served by such disclosure.

3. *Are there other Acts containing provisions about privacy of personal health information that should prevail over this legislation?*

Our office did not review every other statute in New Brunswick to determine if there were other ones that should prevail over the proposed legislation. However, the Ombudsman submits that the general approach of giving primacy to privacy legislation over all other statutory enactments should prevail. Exceptions should be limited and every effort should be made to reconcile other legislative enactments with this one rather than resorting to exceptions.

3.0 Right and Access to Information

Does this approach strike the right balance between an individual's right to access his or her personal health information and a Custodian's ability to respond to this right?

The proposed provisions are similar to other jurisdictions indicating that patients have a right of access but then providing a list of exceptions. In our opinion, any list of exceptions should be very narrow. The law should also formally provide what our courts have made clear and that is that the personal health information in question belongs to the patient concerned. The term custodian applied through the Act and the consent provisions all speak to that fact but the law should have an express provision to limit a health care provider's proprietary interest in any record created. In an electronic health record environment this principle becomes even more important.

Additionally, we are concerned about the long list of situations in which a Custodian may refuse access. While some are valid, allowing a Custodian to determine that a patient's request is frivolous and vexatious or in bad faith is not appropriate. From whose perspective is this decision made? A Custodian may feel that the patient's request is frivolous but it may not be the case for the patient.

These provisions are drafted in relation to how 'access' was defined in the past. The current right to information process requires an individual to write to the Minister with the Minister writing back either providing a photocopy of the record or the opportunity to review the records. This type of access is not keeping current with technology. In our opinion this section needs to be redrafted with a forward looking focus. We talk about the introduction of an electronic health record within the next few years. In the very near

future, patients are not going to consider access to be a photocopy of a record but a username and password to the system enabling them to view their health information online.

4.0 Consent

Implied knowledgeable consent for collection, use and disclosure of personal health information is the recommended consent model in the Pan-Canadian Health Information Privacy and Confidentiality Framework and is the model in the newer health information legislation like Newfoundland and Ontario. This should be the standard model for consent for the provision of health care; however, for other purposes, i.e. research and other secondary purposes express consent should be required.

We feel that implied knowledgeable consent is appropriate for the purpose of providing care or treatment and is consistent with the direction of the other provinces. When you break it down the addition of the word 'knowledgeable' moves it closer to express consent than implied consent. To ensure that the consent is 'knowledgeable' in my mind requires a dialogue between the Custodian and patient. It strikes the balance between the protection of privacy and the delivery of health care.

Our concern does not lie with the consent model itself but rather with how Custodians are going to be educated about this model. As recommended by the Finn/Malone report, "the proclamation of PHI legislation [should] be preceded by a public education campaign led by the Minister of Health with the objective of raising awareness and understanding of PHI privacy and consent issues". This is a crucial component of the introduction of health information access and privacy legislation.

In the discussion paper, it suggests that individuals have the right to withhold consent, or to withdraw consent, except: (a) where it is prohibited by law, (b) for the purposes of a program to monitor the prescription, dispensing, or use of certain classes of drugs (c) for the purposes of an electronic health record, and (d) in other instances where consent is not required to collect, use, or disclose personal health information by this legislation.

Our first concern with this proposed provision is - what does 'for the purpose of an electronic health record' mean exactly. The Finn/Malone Report had recommended that 'there be no exception or override to an individual's directive to withhold or withdraw consent in relation to the creation of an EHR' but this section indicates exactly the opposite.

Canada Health Infoway defines an electronic health record (commonly known as an EHR) as:

"a secure and private lifetime record of an individual's health and care history. Available electronically, it provides authorized health care professionals with immediate access to their patients' accurate health histories, including laboratory and radiology test results, past treatments, prescription drug profiles and

immunizations, while protecting privacy and confidentiality. The EHR supports improved clinical decision-making leading to more effective diagnosis and treatment, greater patient safety, increased efficiency and improved access to services.” (<http://www.infoway-inforoute.ca/en/WhatWeDo/Overview.aspx>)

Our interpretation of the proposed provision is that individuals cannot opt out of the electronic health record. Is this the correct interpretation and if so, has significant research been conducted to insure that this is the best public policy approach? If it is not the correct interpretation, the legislation should be made clearer to avoid confusion.

Our other concern lies with the phrase ‘in other instances where consent is not required to collect, use or disclose personal health information by this legislation’. As we have been provided with a discussion paper and not a draft bill, it is difficult to know what other instances the government is contemplating that do not require consent. Obviously we feel these circumstances should be limited.

5.0 Collection, Use and Disclosure of Personal Health Information

Are the situations described above wherein a custodian need not collect personal health information directly from an individual’s appropriate? Are there other situations wherein a custodian should be able to collect personal health information other than directly from an individual?

There are exceptions to every rule so it is important to recognize that there will be instances in which it is not possible to collect personal health information directly from an individual, in particular if they are unconscious. Setting out clear provisions that outline these situations is necessary. However, there appears to be a number of situations in which the Custodian is not required to collect information directly from the individual, for example, if the Custodian is ‘a Regional Health Authority or a board, council, committee, commission, corporation or agency established by an Authority’ or if the Custodian is a ‘department created under the *Executive Council Act*, or a branch of the executive government of the province when engaged in a function related to the delivery or administration of health care in the province’. What are the parameters for determining if the ‘function’ is related to the delivery or administration of health care? This section is excluding a number of organizations from the standard requirement for collecting information directly from the individual and the paper does not outline the reasons for this exclusion. As outlined above this approach may be appropriate in the delivery or administration of health care, but also in other situations as for instance, the delivery of specialized educational services to a pupil with special needs, or social services to a youth-in-care. Additionally the health record may at times need to be augmented by an information flow in the other direction. All these circumstances are much removed for instance from the myriad of situations where medicare numbers might be used as unique identifiers for government services.

Additionally, under this provision, direct collection is not required if the Custodian collects the information from a person who is not a Custodian for the purpose of carrying

out a research project that has been approved by a research ethics board or a research ethics body that meets the prescribed requirements of the legislation. Research is a secondary use and express consent should be the standard for secondary uses, this provision would seem to circumvent that express consent requirement.

Are the proposed uses of personal health information appropriate? Are there other appropriate uses that should be provided for in the legislation?

The Discussion Paper provides a long list of approved uses of personal health information by a Custodian which includes ‘for a research project approved by a review or ethics committee in accordance with the Act’ and where the Custodian is ‘a Regional Health Authority or a board, council, committee, commission, corporation or agency established by an Authority’ or where the Custodian is a ‘department created under the Executive Council Act or a branch of the executive government of the province when engaged in a function related to the delivery or administration of health care in the province’. Again we have issues with the terminology ‘engaged in a function related to’ as it could be interpreted broadly. Additionally, there is not a lot of information regarding the review or ethics committee, its mandate or composition. Some of the particular uses are ones that in our opinion should require express consent, such as research projects. Finally, the paper does not discuss de-identifying information in any detail and whether standards for de-identifying information will be laid out in the legislation or regulations.

Is it appropriate for a Custodian to disclose personal health information without the consent of an individual in the situations described above? Are there other situations in which a Custodian should be able to disclose personal health information without the consent of an individual?

In the *Protection of Personal Information Act* Principle Five addressed collection, use and disclosure in one sentence. Principle Five states that ‘personal information shall not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required or expressly authorized by law’. In the proposed provisions there is a long list of situations in which Custodians must disclose the information or have the discretion to disclose the information without the patient’s consent. We do not necessarily feel that more is better in this particular circumstance.

Our first concern with the disclosure sections is the inconsistent use of the words ‘may’ ‘must’ and ‘shall’. Custodians *may* disclose without consent for (1) health purposes/provision of care, (2) if the individual is deceased, (3) for health-related purposes (i.e. eligibility for services), (4) health and safety, (5) research purposes, and (6) if it is registration information, to verify its accuracy.

Custodians *must* disclose without consent when the information is requested in (1) relation to proceedings (discipline body) or complying with subpoena, warrant, etc., (2) required by law, and (3) monitoring health care payments. Custodians *shall* disclose personal health information for enforcement purposes. The drafters need to focus on

whether these requirements are mandatory or discretionary and use consistent terminology.

We were pleased to see the inclusion of the requirement to maintain disclosure information, especially given the long list of required disclosures. If the control over one's own personal health information is reduced due to the long list of required disclosures, it's important the individual at a minimum be able to track the flow of these disclosures. However, we would rather see limited disclosures without consent.

Are the proposed requirements regarding maintenance of disclosure information, disclosure of personal health information outside NB and use of an individual's Medicare number appropriate?

We believe that the Department of Health should take back ownership of Medicare numbers and reduce the instances in which it can be requested. The purpose of the Medicare number is to provide payment under the *Medical Services Payment Act* and should not be used for other purposes such as verification of identity for Moose Licenses and other similar non treatment and care situations. The proposed clause 'No person other than the Custodian or a person authorized by the regulations can require the production of another person's Medicare number or collect or use another person's Medicare number and an individual may refuse to provide his or her Medicare number to a person not so authorized' is similar to Manitoba's *Personal Health Information Act's* section 27(1) 'No person other than a trustee may require the production of another person's PHIN or collect or use another person's PHIN'. The difference between the two is that the proposed clause has added 'a person authorized by the regulations'. We would not like to see any people authorized by the regulations, unless it is required for the provision of health care.

6.0 Information Security

Are these the right requirements to ensure personal health information will be secure and individual privacy protected?

There are significant requirements contained in the proposed provisions that will assist in ensuring that personal health information is secure. We are pleased to see requirements for policies and procedures, physical, technical and security standards with particular emphasis on safeguarding information in electronic form. We believe it is important for the legislation and the regulations to be specific regarding these safeguards in order to remove the guesswork by Custodians as to what is sufficient.

We welcome the requirement by the Custodian to notify the Access and Privacy Commissioner when personal health information is stolen, lost or unlawfully disposed or disclosed. However, we are concerned about the limitation placed upon this requirement. The proposed section states that 'if the Custodian reasonably believes the theft, loss, unauthorized disposition, or improper disclosure or access of personal health information will not have an adverse impact on (a) the provision of health care or other benefits to the

individual who is the subject of the information, or (b) the mental, physical, economic or social well-being of the individual who is subject to the information' then the requirement to notify the Access and Privacy Commissioner does not apply. Custodians are experts in the provision of health care not in determining the economic or social effects of lost personal health information. That should be the role of the independent oversight office. Most other breach notification provisions in North America address this problem by requiring notification only in the case of "significant or substantial" breaches. We submit it is best to adopt that reasonable standard and allow the cases to determine it's reach. We also recommend that the provisions address separately the need for breach notification and breach reporting. All personal health information breaches, however trivial should be captured and logged and quarterly reports of such breaches should be made by custodians to central authorities, and then in a consolidated fashion to the oversight body. This, in addition to the timely and forthright reporting of significant breaches is the best means of ensuring adequate oversight of the privacy provisions.

The proposed provisions require the Custodian to have a written policy for the retention, archival storage, access and destruction of personal health information that meets requirements prescribed by the regulations. Given the ultimate goal of one patient, one record, our submission is that the regulation should provide specific time frames for retention for consistency purposes as well as guidelines for destruction.

The Finn/Malone report had recommended that new personal health information legislation specify the circumstances in which privacy impact assessments (PIA's) should be conducted. We are pleased to see a provision that addresses this particular issue.

7.0 Independent Oversight

Do the proposed provisions provide appropriate recourse for individuals seeking to enforce their rights or obligations of a Custodian under the legislation?

In our submissions to the Task Forces on Access & Privacy and Personal Health Information legislation we recommended a separate commissioner to handle access and privacy issues. We also recommended that this person be given order making power. The Discussion Paper proposes legislative provisions that provide for an independent office but without order making power.

The Personal Health Information Task Force recommended a separate office for Access and Privacy. Every province and territory has a separate access and privacy commissioner role but with differing titles except for Manitoba, the Yukon and New Brunswick. The Manitoba and Yukon Ombudsman are responsible for both Access and Privacy and Ombudsman issues. In New Brunswick this individual, in addition to having responsibility for access, privacy and ombudsman legislation is also responsible for Child and Youth Advocacy and Civil Service Appeals. While it is possible to have all these varying responsibilities under one officer of the legislature, especially if they are all Ombudsman models without order-making power, it is certainly not the ideal.

As it stands now, the Office of the Ombudsman resources are stretched to try to cover these varying mandates. The addition of personal health information access and privacy legislation will add significantly to that responsibility. Our concern is that in the past we have managed to get the work done; however, the proposed personal health information access and privacy legislation will expand our responsibility than the current mandate under the *Protection of Personal Information Act* and *Right to Information Act* as those two acts cover mainly public bodies and the new phi legislation will also cover the private sector. This will not only expand the role of the Ombudsman but will also pose difficulties if the Ombudsman/Commissioner does not have order-making powers. An Ombudsman trying to make recommendations to a public body is a very different situation than one trying to make recommendations to private physicians and other health-care providers.

Similarly, where Privacy and Information commissioners work best with Ombudsman type mandates these are augmented with power to refer matters to the courts when Ombudsman recommendations are not followed. But even this process is ineffectual in terms of costs, delays and procedure. Privacy, once breached, is lost and can't easily be regained. A commissioner with order-making power provides a strong deterrent to help keep custodians in line and ensure that breaches don't happen in the first place. It is also the surest means of resolving privacy complaints at low cost in an informal and timely manner. It also gives the process far more finality than an Ombudsman process. Most often unless these privacy issues can be resolved in this manner, most Canadians simply won't bother with attempting to enforce their privacy rights. Of all the "fragile freedoms", to use Tom Berger's term, these are no doubt the most fragile. Privacy in Canada is normally lost by a death of a thousand cuts. Strong enforcement mechanisms and everyday vigilance by all concerned is really the only cure.

8.0 Offences and Penalties

Are these appropriate offences and penalties to deter non-compliance with the legislation?

As far as we are aware, the penalty provisions in the various jurisdictions have only been significantly enforced once in Alberta when personal health information was accessed by a woman regarding her boyfriend's ex-wife's health status. It is difficult to determine whether or not the penalties are an appropriate deterrent or not. This would be something to address in a later mandatory review of the legislation.

Each jurisdiction's legislation has a different penalty. Manitoba makes violation a summary conviction with a fine not more than \$50,000. Ontario's provisions include "obstructing the Commissioner" as an offense and imposes a fine of \$50,000 for natural persons and \$250,000 for non-natural persons. Newfoundland has a lower fine of not more than \$10,000 or imprisonment for a term not exceeding 6 months or both. In Saskatchewan individuals are fined not more than \$50,000 and corporations not more than \$500,000. Alberta includes a provision for researchers who knowingly breach the terms and conditions of an agreement. The fines in Alberta range from \$2,000-\$10,000 for an individual and not less than \$200,000 and not more than \$500,000 for any other

person. British Columbia imposes a fine of up to \$200,000. Given the range of penalties proposed in other Canadian laws the proposed provisions appear to be somewhat on the low side. Given that this is new legislation we would recommend that the proposed maximum fines be doubled and that separate fine structures apply to natural persons and legal entities, in-line with other jurisdictions.

9.0 Review of the Legislation

Should personal health information legislation be subject to a mandatory review? If so, within what time period?

It is important to incorporate a mandatory review clause in this legislation given the length of time it has taken the province to review the *Right to Information Act* and the unknowns of the electronic health record. The paper has suggested five years. The best practice in other jurisdictions is to require not a one-time review but a regular review on, for instance a five year basis. Given the concerns noted above with respect to the scope of the proposed legislation and given also similar concerns with respect to the scope of the *Access to Information and Protection of Privacy Act* we are recommending that both pieces of legislation be reviewed initially within a three year period and thereafter on a five year basis.

CONCLUSION

We would like to thank the Standing Committee on Law Amendments for taking the time to consider our submission. As the process moves forward to the drafting of personal health information access and privacy legislation, the Office of the Ombudsman would like to offer our assistance in answering questions the Committee or the drafters may have on our submission and we hope to work together to ensure New Brunswickers are provided with the optimal personal health information access and privacy legislation.