Regulatory Impact Statement for the Health Records Regulations 2023

Prepared for the Victorian Department of Health

June 2023

Contents

Glossary

Abbreviation	Stands for
ACT	Australian Capital Territory
BRV	Better Regulation Victoria
Privacy Act	*Commonwealth Privacy Act 1988*
HPP	Health Privacy Principles
Health Records Act, the Act	*Health Records Act 2001*
The current Regulations, the Regulations	*Health Records Regulations 2012*
FOI Act	*Freedom of Information Act 1982*
GP	General Practitioner
MCA	Multi criteria analysis
RIS	Regulatory Impact Statement

Forward

This Regulatory Impact Statement (RIS) has been prepared with respect to the proposed Health Records Regulations 2023.

The RIS should be read in conjunction with the proposed Regulations, which are provided as a separate document.

This RIS sets out the objectives of the proposed Regulations, explains their effect and assesses the nature and scope of the problem that the proposed Regulations seek to address. It also sets out the likely impacts (costs and benefits) and discusses alternatives.

How to respond to the proposed Regulations

Individuals, health service providers, non-health service providers and other interested groups are invited to make submissions responding to the RIS or the proposed Regulations.

The closing date for submissions is 16 July 2023.

Comments may be provided via email to the following email address: legandregreform@health.vic.gov.au

For further assistance about the public comment process, or to obtain copies of the RIS and proposed Regulations, please contact the Legislative and Regulatory Reform team at Department of Health at legandregreform@health.vic.gov.au.

Executive summary

Purpose of this RIS

The *Health Records Regulations 2012* (the Regulations), which are made under the *Health Records Act 2001* (the Act), balance facilitating access to health information for individuals with allowing private health providers to offset the associated cost.

The Regulations are due to sunset on 19 August 2023. This RIS assesses the impact of different options for replacing the current Regulations or allowing the Regulations to expire and not be replaced.

The Department of Health (DH) has engaged Sapere Research Group to prepare this RIS in accordance with Better Regulation Victoria's Victorian Guide to Regulation and the *Subordinate Legislation Act 1994*.[1]

Problem analysis

The Act recognises as a fundamental right that people can access health information about themselves. The Act provides a framework that guarantees a right of access regardless of where a person's health information is collected or held, whether by a public or a private organisation. The Act does not require a person to provide a reason as to why they want to access their information.

To provide reasonable cost recovery for health service providers but avoid 'unreasonable' fees being set that would still unfairly preclude access, the Act allows regulations to be made that set maximum fees that can be charged and prohibits the charging of fees under the Health Records Act unless maximum fees have been prescribed in regulations.

By setting maximum fees, the Regulations ensure that fees are not set too high as to preclude people's right to access their health information. Other legislation that may apply, for example, the Commonwealth Privacy Act, do not set maximum fees, instead relying on a test of excessiveness. By setting maximum fees at a level that does not unfairly preclude an individual from requesting access to health information, the Regulations protect the right of individuals to exercise their rights under the Act.

Objectives

The objective of government action in this case is to allow individuals to obtain health information related to themselves in an equitable, efficient and effective manner. This involves balancing the following:

- Ensuring that any fee charged for access to health information does not unfairly preclude an individual from requesting access to health information; and

[1] Under section 7 of the Subordinate Legislation Act 1994, a RIS is required to be prepared for proposed regulations. The responsible Minister must ensure a RIS is prepared for public consultation.

- Allowing reasonable cost recovery for organisations providing access to health information.

Options

Three options have been considered as part of this RIS against the base case:

- **Base case: regulations expire and no new regulations are introduced** i.e. no maximum fee prescribed.
- **Option 1: Replication of current regulations** with minor clarifying amendment to regulation 9 to make clear those situations where health information can be collected about a person connected to the individual.[2]
- **Option 2: Higher level of cost recovery** than what the maximum fees prescribed in the current Regulations allow.
- **Option 3: Option 1** *plus* Concession discount.

The impacts of Options 1, 2 and 3 are assessed against the base case.

It is noted that, under the base case:

- Organisations will no longer be able to charge for providing access to information under the Act, as under the Act a fee cannot be charged unless a maximum fee is prescribed in regulations. However, most private organisations would be able to charge a fee to a person accessing health information under the Commonwealth Privacy Act, so long as the fee is not excessive[3].
- In terms of transferring information between providers, public and private health service providers would be able to charge any amount, as under the Act, the absence of maximum fees does not preclude them from charging a fee.
- Nominated health service providers would also be able to charge any amount for performing services under section 42 (see section 2.1.3 for explanation of this function), as under the Act the absence of maximum fees does not preclude them from charging a fee.

[2] For example, for the purposes of preparing a family history of a patient. Regulation 9 sets out the prescribed circumstances for collection of health information. Under the Act, HPP 1 limits the health information that may be collected to specific circumstances and permits the making of regulations to set out any additional circumstances.

3 Although noting there will be a small number of private organisations that will not be able to charge any fees - non-health service organisations with an annual turnover of over $3 million are not subject to the Commonwealth Privacy Act, so rely solely on the Health Records Act for charging a fee.

Options analysis

The options in this RIS have been assessed using Multi-Criteria Analysis (MCA). This approach provides a structured and transparent way of evaluating the options given the very limited quantitative data that is available to assess the costs and benefits of the options.

The criteria and weightings used to assess options for this RIS are shown in the following table. These draw on the objectives for the Regulations outlined above. Each option is given a score from -10 to +10 against each criterion.

Table 1 MCA criteria and weightings

Criteria	Description	Weighting
Facilitate access to health information	The extent to which the option ensures that any fee charged for access to health information does not unfairly preclude an individual from requesting access to health information, requesting transfer, or seeking review of decision to refuse access. The approach adopted in this analysis is that the lower the maximum fee that is set, the less likely it will unfairly preclude access to health information.	40%
Reasonable cost recovery for organisations	The extent to which the option allows recovery of reasonable costs in providing access to health information, or other functions under the Act. Not allowing reasonable cost recovery may have adverse impacts on services provided by the organisation, for example, they may charge more for other health services to subsidise the provision of access to health records. It is in the interests of individuals and the whole community that health providers operate sustainably.	40%
Easy and simple to understand and administer	The ability to easily determine what fee applies, including the ability for organisations to communicate, calculate and collect the fee, and for individuals to understand the fees to be applied in advance. This also includes consideration of the level of administrative costs associated with calculating and levying fees.	20%

A summary of MCA scores is provided in Table 2.

The three options analysed are likely to deliver a net benefit compared to the base case.

- Each option will facilitate access to health information because it is expected that most providers would charge lower fees than under the base case. Under each option maximum fees would be prescribed, whereas under the base case most organisations would be able to charge fees and be less constrained (being allowed to charge fees that are not 'excessive'). Each option receives a positive score against the facilitate access to health information criterion.
- As noted above, most organisations would charge lower fees under each option than under the base cost, so each option receives a negative score for the cost recovery criterion.

- Each option is simpler to understand and administer than the base case, where most private organisations would rely on the Commonwealth Privacy Act. The Commonwealth Privacy Act is a more extensive and complex piece of legislation which would be more difficult and burdensome for private organisations to navigate to understand their obligations and rights. By comparison, the maximum fees able to be set under the Regulations are clearly specified in the Regulations providing more clarity and certainty. Hence, each option receives a positive score for the simplicity criterion.

The option with the highest score, and therefore the preferred option, is **Option 1: Replication of current Regulations with minor clarifying amendments**. Option 1 is expected to best achieve the balance between facilitating access to health information with allowing reasonable cost recovery for organisations. Option 2 – higher cost recovery – will increase the level of cost recovery but will have too large an impact on facilitation of access to health information. Providing a concession discount under Option 3 will provide slightly improved facilitation of access to health information but will reduce cost recovery and add to administrative costs of organisations. Option 3 would also introduce an inconsistency in approaches to charging whereby private organisations would be required to offer a concession discount for providing health information but not for other fees charged (e.g. standard GP consult fees).

Table 2 Summary of MCA scores

Criteria	Base Case – no Regulations	Option 1 – replication of current Regulations	Option 2 – higher level of cost recovery	Option 3 – concession discount
Facilitate access to health information (40%)	0	+7.0	+3.5	+8.0
Reasonable cost recovery for organisations (40%)	0	-5.0	-2.5	-6.0
Simple to understand and administer (20%)	0	+5.0	+5.0	+3.0
Total weighted score	**0**	**+1.8**	**+1.4**	**+1.4**

The preferred option of replicating the current Regulations reflects the Department's view that there is no significant case to be made for changing the current fee structure and fee levels:

- There is a low level of complaints about access to health information in relation to fees.
- Many health service providers provide access for no charge, or a charge below the maximum fees, which facilitates access to health information.
- The current Regulations are well understood by industry.
- The burden and impact of the current Regulations is low, particularly when compared with overall health costs. In its ongoing engagement with organisations,

- DH has received very limited feedback on these Regulations and it is not aware of significant problems with the Regulations.

Sensitivity of findings

It is noted that the scores for the options are close e.g. an increase in the score of Option 3 from +8 to +9 for facilitating access to health information would be sufficient to equalise the weighted total. While the scores are subjective, they are transparent assessments of how each option will contribute to the criteria and reflect the discussion outlined for each option. Small business and competition impacts

The Victorian Guide to Regulation requires a RIS to assess the impact of regulations on competition. Regulations can affect competition by preventing or limiting the ability of businesses and individuals to enter and compete within particular markets.

The proposed Regulations are not expected to materially impact competition. There will be a small positive impact on small private non-health provider organisations with a turnover not greater than $3 million as, in the absence of the proposed Regulations, they would not be allowed to charge a fee for access to health information under the Commonwealth Privacy Act.

Data limitations

There are significant limitations on what quantitative data is available to inform this analysis.

- Importantly, it is noted that fees are charged directly by organisations to the individual and DH does not administer the cost recovery process. Under the Act and Regulations, organisations are not required to collate and provide this information.
- The Act has wide application, encompassing all private organisations that hold health information. Requiring organisations to provide information to DH would represent a substantial and unjustifiable regulatory burden on organisations covered by the Act[4].

Implementation

The proposed remade Regulations largely continue the substance and form of the current Regulations. DH will communicate the making of the new Regulations to key stakeholders. This will provide an opportunity for DH to provide education and guidance about key matters set out in the Regulations. DH will review feedback received through the public comment period to determine how to tailor any education and guidance to be provided.

Evaluation

The proposed Regulations will sunset in 2033. This will be the next time the Regulations are due for a full formal evaluation, undertaken via preparation of a future RIS. In light of the current data limitations relating to the operation of the Regulations, DH proposes to consult with stakeholders on how the Regulations are working and if they remain fit for purpose and enable the gathering and

[4] For example it is noted that one large health services provider engaged with noted it does not collect and collate data on the cost of health information across its multiple hospital and clinic sites.

provision of information that is required in a cost-effective manner. DH will undertake targeted engagement with organisations to estimate:

- the number and types of requests for health information
- the level of fees that are charged for requests (including whether organisations are charging the maximum prescribed amount, a lower fee or no fee)
- the costs to organisations of responding to requests
- the overall level of cost recovery achieved by organisations.

This will help DH understand the burden of the regulations and any problems. Engagement undertaken will be proportionate to the significance of the problem and the effect of likely potential options to address it. Reflecting this, DH will aim to minimise the burden of information requests to estimate the numbers of requests and how fees are charged. DH will undertake targeted engagement to collect information rather than seek information from most/all organisations in scope.

1. Background

This chapter provides background to the RIS that is being undertaken.

The Health Records Regulations 2012 balance facilitating access to health information for individuals with allowing private health providers to offset the associated cost. The Regulations are due to sunset on 19 August 2023. This RIS assesses the impact of different options for replacing the current Regulations in accordance with Better Regulation Victoria's Victorian Guide to Regulation and the Subordinate Legislation Act 1994.

Health information about Victorians is held by a wide range of organisations, from public hospitals, doctors, dentists, through to private health service providers (e.g. aged care providers) and other organisations (e.g. insurance companies and schools).

The community expects that they can access health information held about themselves when they wish. However, providing access requires time and effort by the organisation holding that information. For this reason, legislative arrangements were put in place to facilitate access, balancing the provision of access to individuals and the recovery by organisations of the reasonable costs of providing that access.

1.1 Current legislative framework

The Victorian Health Records Act 2001

The Victorian *Health Records Act 2001* (the Act) provides the framework for controlling the collection and handling of individuals' personal health information. The Act sets out Health Privacy Principles (HPPs), based on international standards, designed to protect privacy, promote patient autonomy, and ensure the safe and effective delivery of health services (see Appendix A for high level description of the HPPs). The Act provides people with a legal right to access health information about them.

The Act specifies fees that may be charged by organisations for providing access to information in relation to:

- Providing access to information to individuals
- Transferring information between health providers
- Reviewing refused access.

The key requirements relating to access to health information by individuals are provided in section 32 of the Act:

- A fee may not be charged for providing a manner of access to health information unless a maximum fee has been prescribed for that manner of access.[5]
- An organisation must not charge a fee exceeding the prescribed maximum fee.

[5] An exemption exists under section 29(1)(d) of the Act but this is not relevant to this RIS.

HPP 11.1 of the Act provides that a person may direct health service providers to provide health information about them to another health service provider. Fees may be charged not exceeding a prescribed maximum fee. Unlike for access to health information by individuals, the Act does not prevent a fee being charged if no maximum fee has been prescribed.

Division 3 of the Act sets out requirements relating to the review of refusal of access to information on the grounds of a serious threat to life or health of the individual requesting access. For example, an organisation could refuse access to information they hold if they reasonably believe giving access would cause significant distress to the individual and deterioration of their mental health condition such that it would pose a serious threat to their life or health. The individual being refused access could then ask for a review of that decision by a nominated health service provider.[6] Section 42(3) of the Act states that a nominated health service provider may charge a fee not exceeding a prescribed maximum fee for performing a review of a refusal of access to health information that has been refused based on a serious threat to the individual. As per the fee for transfer of information between health providers, the Act does not prevent a fee being charged if no maximum fee has been prescribed.

Other relevant legislation

There are two other key pieces of legislation that apply to the access of health information by the Victorian community. These are relevant to the analysis undertaken in this RIS because they provide some rights for individuals to access health records.

The Victorian *Freedom of Information Act 1982* (the FOI Act) gives people the right to access information held by public sector organisations. It outlines the process for requesting access to information and provides for reasonable costs to be charged by the agency to meet the costs associated with access. The FOI Act applies to health information held by public providers (e.g. public hospitals).The *Commonwealth Privacy Act 1988* is the principal piece of Australian legislation protecting the handling of personal information about individuals. This includes the collection, use, storage and disclosure of personal information in the federal public sector and in the private sector.[7] The Privacy Act is applicable to all private health service, and applies to non-health service providers that hold health information, for example, gyms (both private and federal public sector providers with a turnover of more than $3 million a year). The Privacy Act allows for an organisation that is covered under the Act to charge the individual for giving access to health information; the charge "must not be excessive and must not apply to the making of the request".[8] In the explanatory memorandum of

[6] A nominated health service provider is a health service provider, as defined under the Health Records Act, that is nominated by an individual to assess ground for refusal.

[7] Like the Health Records Act, the Privacy Act sets out privacy principles, but they are not the same as those set out in the Health Records Act. The Health Records Act privacy laws allow patient identifier and sharing of health information for benefits of persons health in certain circumstances, which is not permitted in Commonwealth law but limits sharing of health personal information otherwise. See Schedule 1 of the Privacy Act for further reference.

[8] The *Commonwealth Privacy Act 1988* is currently subject to review. See *Privacy Act Review Report 2022*. This has the potential to impact aspects of the Privacy Act that are relevant to the Health Records Act, for example the small business exemption is being reviewed with a recommendation for it to be removed. However, it is not anticipated that changes to the Privacy Act will be material for the purpose of this RIS analysis and timing and final outcomes of the review are also not known.

the 2012 amendments to the Privacy Act, "an excessive charge amount would include recouping costs above the actual amount incurred by the organisation".[9] This indicates that full cost recovery of actual costs would be allowed under the Commonwealth Privacy Act.

The Commonwealth arrangements are complementary to any state-based regulations setting maximum fees; service providers must comply with both. As the Commonwealth arrangements do not prescribe a maximum fee, there is no inconsistency created between the Commonwealth and Victorian regulations.

Table 3 sets out the coverage and applicability of the three different Acts relating to access to health information to different types of organisations. The Act is the only legislation providing for access to health information for private non-health service providers with turnover less than or equal to $3 million, which means it is the only applicable legislation enabling cost recovery for the provision of health information for these organisations (by regulation maximum fees).

Table 3 Application of Acts relating to access to health information

Type of organisation		**Commonwealth Privacy Act[10]**	**Victorian Health Records Act***	**Victorian FOI Act**
Health service providers (defined under s6FB of the Privacy Act)	Public	✓	*Providing access* x	✓
			Transferring to another provider ✓	
			Reviewing refused access ✓	
	Private	✓	✓	x
Non-health service providers that hold health information (e.g. gyms)	Public	✓	*Providing access* x	✓
			Transferring to another provider x	
			Reviewing refused access x	

[9] Explanatory memoranda to the Privacy Amendment (Enhancing Privacy Protection) Bill 2012, accessed at https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fems%2Fr4813_ems_00948d06-092b-447e-9191-5706fdfa0728%22

[10] Applies to federal public sector.

Type of organisation		Commonwealth Privacy Act[10]	Victorian Health Records Act*	Victorian FOI Act
	Private with turnover >$3 million	✓	✓	✗
	Private with turnover ≤$3 million	✗	✓	✗

Note to Table:
* Section 16(1)(i) of Health Records Act states that Part 5 of the Act (access to health information) does not apply to a document containing health information that is a document of an agency within the meaning of the FOI Act. However, the circumstances of nominating a health service provider to review refused access in the Health Records Act applies to both public and private health service providers (s.33(4) of the Victorian Freedom of Information Act specifically states that the procedure set out in the Health Records Act applies, and the document is considered exempt document under the FOI Act). In addition, the provisions relating to transferring information between health service providers under HPP 11 applies to both public and private health service providers.

1.2 Current regulations

The Health Records Regulations 2012 (the Regulations):

- Set a maximum fee an organisation may charge for granting an individual access to health information.
- Set a maximum fee a health service provider may charge for making health information available to another health service provider.
- Set a maximum fee a health service provider may charge for providing a second opinion where access to health information has been refused by an organisation based on a serious threat to the individual.

Under the Regulations, fees must be set in a way that:

- Ensures that any fee charged does not unfairly preclude an individual from requesting access to health information.
- Allows reasonable cost recovery for organisations.
- Recognises current practice regarding the transfer of health information between health service providers at the request of an individual for the purpose of continuity of care.

Essentially, the Regulations balance the facilitation of access to health information for individuals with reasonable cost recovery by private organisations of the cost of providing access i.e. maximum fees should only be set to a level that does not preclude access, even if it means maximum fees are set below a level of full cost recovery for a provider.

- The fee schedules prescribed in the Regulations are set out in Appendix B of this RIS, ranging from 20 cents per page for a black and white photocopy up to $143.73 (9.4 fee units) for an accurate summary of health records. When considering the level of fees, the fee for providing

a copy of records is most relevant, as most individuals who are seeking access request a copy of their records: A fee of $38.23 (2.5 fee units) for 'assessing and collating' health information.
- A fee for providing a copy of the health records to the person of 20 cents per page for A4 black and white.

The creation of an accurate summary of health information would require significantly more work by the provider and so the maximum fee is set higher: including the usual consultation fee (if a health service provider) or $44.30 (2.9 fee units) per quarter hour up to $143.73 (9.4 fee units), whichever is greater.[11] The Regulations also set out the prescribed circumstances for collection of health information under regulation 9. Under the Act, HPP 1 limits the health information that may be collected to a list of circumstances to ensure that information is only collected about a person in appropriate circumstances. The Act permits the making of regulations to set out any additional circumstances where health information may be collected. Currently, regulation 9 sets out these additional circumstances, namely, allowing health information to be collected about a person connected to the individual (e.g. for the purposes of preparing a family history of a patient).

1.3 Proposed regulations

The Health Records Regulations 2012 will be automatically repealed (sunset) on 19 August 2023. They are proposed to be remade in their current form with minor clarifying amendments relating to the prescribed circumstances for collection of health information, subject to the outcomes of consultation on this Regulatory Impact Statement.

1.4 Regulatory Impact Statement

Under the *Subordinate Legislation Act 1994* (SL Act), a RIS is required to be prepared for proposed regulations that are expected to have a significant impact. The responsible Minister must ensure a RIS is prepared for public consultation.

DH has engaged Sapere Research Group to prepare this RIS in accordance with BRV's Victorian Guide to Regulation[12] and the *Subordinate Legislation Act 1994*.

[11] Under section 29(1)(b)(ii) of the Act, if the requester agrees, the organisation can provide an accurate summary of the health information, instead of providing copies of the information.

[12] Office of the Commissioner for Better Regulation, 2016, Victorian Guide to Regulation: A handbook for policy makers in Victoria, Department of Treasury and Finance, Melbourne.

1.4.1 RIS process

The key purpose of this RIS is to assess the impact of different options for replacing the current Regulations. The rigorous assessment of regulatory proposals within a RIS ensures that regulation best serves the Victorian community. The general approach to the assessment was as follows:

(1) Identification of the problem

This involved consideration of the nature and extent of the problem that the proposed Regulations aim to address, including the need for government intervention, the risks of non-intervention and the objectives of such intervention.

(2) Identification of the options to achieve the objectives of the proposed Regulations

Options that could address the defined problems were identified. Options which were deemed less feasible or less relevant were identified but not pursued any further.

(3) Assessment of the costs and benefits, and identification of preferred option

Assessment of the costs and benefits under all options, relative to a Base Case of no regulations, was undertaken consistent with the requirements of the Victorian Guide to Regulation. Fees options are also assessed against the Department of Treasury and Finance's *Pricing for Value Guide*.[13] The analysis uses data sourced from DH and the Health Complaints Commissioner, and data gathered through independent research.

Based on the analysis undertaken, a preferred option was identified.

(4) Assessment of other impacts

We have considered the likely small business and competition impacts of the preferred option.

(5) Implementation and evaluation

The arrangements for implementation and evaluation of the preferred option are described.

1.4.2 Stakeholder consultation

DH regularly engages with health providers (at a board and senior executive level) and other relevant sector stakeholders including about issues arising with the operation of health legislation and regulations. This helps to inform if there are any issues with the operation of this legislation. While the matters prescribed in the Regulations are not of a sufficiently material nature to require specific engagement, the engagement that does take place gives an opportunity for any feedback (such as material difficulties) to be provided.

Under the Act, complaints about access to health information, including complaints about fees for access, are made to the independent Health Complaints Commissioner. The Commissioner's published data and any specific engagement by them with DH are key sources of information about whether

[13] Department of Treasury and Finance, 2013, *Pricing for value*, July 2021.

individuals are experiencing problems with access to health information, including fees (with the usual limitations of complaints-related data reflecting complaints not resolved at agency level). Complaints data is discussed further in section 2 of this RIS.

DH has undertaken targeted consultation with some health service providers to inform its review of the sunsetting Regulations and this RIS. No consultation has been undertaken with non-health service providers who are regulated (e.g. gyms, schools), noting they are too disparate and dispersed to consult, with relatively small impacts under the proposed Regulations, to warrant specific consultation.

Further feedback on the proposed Regulations and RIS will be sought through a public comment process.

1.4.3 Public comment

The proposed Regulations and this RIS will be released for 28 days (the minimum required) to provide individuals, organisations regulated under the proposed Regulations and other key stakeholders the opportunity to provide feedback. The process for responding to the RIS is outlined in the foreword to this report.

DH welcomes and will consider all submissions received during the period of public comment. DH will prepare a Response to Public Comment summarising the submissions received and its response, including a decision on whether any amendments to the proposed Regulations are needed. Submissions to the review, and the Response to Public Comment document, will also be made available on DH's website.

Interested parties are encouraged to provide any views on the proposed Regulations. In providing feedback, interested parties may wish to comment on the following:

- Problem being addressed
  - In what ways, if any, do you think the underlying problem addressed by the Regulations has changed since the remaking of the Regulations in 2012?
  - What is the case for continuing to set maximum fees as prescribed in the Regulations, noting this enables fees for providing information to be charged?
  - What is the case for allowing the Regulations to lapse and not be replaced so that no maximum fees for the provision of health information are set?
  - How many requests per year do you receive for health information (please indicate the type of organisation you represent)? How many requests have you received in the past five years?
- Fees charged by organisations
  - What fees do you (or would you) charge for providing health information, and how does this vary with the nature of request, source of request or nature of your information systems, or other reason?
  - Do you charge a fee for requests for access to information? If you charge a fee, do you charge for some, most or all requests?
  - What are the cases when you don't you charge? In such cases why don't you charge a fee?

- Current costs and charges of providing health information
  - What are the costs of providing health information, and how does this vary with the nature of request, source of request or nature of your information systems, or other reason?
  - Are you able to provide cost estimates (on average) for a typical health information request? For example, for provision of a typical health record to an individual, or cost of photocopy etc, or typical transfer of health information to another provider.
  - Are you able to estimate the extent to which the prescribed maximum fees enable service providers to recover costs e.g. 25%, 50%, 100%?
- Effectiveness in meeting objectives of the Regulations
  - Do you believe that the proposed Regulations appropriately balance the facilitation of access to health information with reasonable cost recovery for organisations, and why?
  - Please provide any other feedback on the likely effectiveness of the Regulations.

2. Problem analysis

This chapter discusses the underlying problem that is being addressed by the proposed Regulations.

If the current Regulations are allowed to sunset, there will not be sufficient protections to ensure fees are not charged at a higher level that unfairly preclude access to information.

2.1 The problems addressed by the Regulations

The Act recognises as a fundamental right that people access health information about themselves. The Act provides a framework that guarantees a right of access regardless of where a person's health information is collected or held, whether by a public or a private organisation. The Act does not require a person to provide a reason as to why they want to access their information.

To provide reasonable cost recovery for health service providers but avoid 'unreasonable' fees being set that would still unfairly preclude access, the Act allows regulations to be made that set maximum fees that can be charged and prohibits the charging of fees under the Act unless maximum fees have been prescribed in regulations.

By setting maximum fees, the Regulations ensure that fees are not set too high as to preclude people's right to access their health information. Other legislation that may apply, for example, the Commonwealth Privacy Act, do not set maximum fees, instead relying on a test of excessiveness (discussed in section 1.1 of this RIS). By setting maximum fees at a level that does not unfairly preclude an individual from requesting access to health information, the Regulations protect the right of individuals to exercise their rights under the Act.

2.1.1 Providing access to individuals

Providing access to individuals can include:

- allowing inspection of documents
- providing copies of documents
- providing a summary of information
- providing an explanation of information.

These activities place a cost on the organisation providing access to the information. Dependent on the nature of the request, and the volume of records kept on an individual, these costs can be substantial.

As the Act prohibit the charging of fees under that Act unless maximum fees are set in regulations, in the absence of the Regulations, relevant private organisations would need to rely on the Commonwealth Privacy Act to recoup costs for providing access to health information. Under the Commonwealth Privacy Act, a private sector organisation may charge a fee for access, but this charge "must not be excessive". There is no maximum fee cap in Commonwealth arrangements and as set out in section 1 of this RIS, this is likely to allow full cost recovery being allowed (see section 1.1 for

discussion). The impacts of the option of not having Regulations are discussed in detail in section 4, Options Assessment.

The Office of the Australian Information Commissioner has released guidance material on fees for access to health information under the Commonwealth Privacy Act. It outlines that fees may include reasonable costs of resources and time, noting the objective that the cost of giving access should not create an unreasonable burden on relevant service providers. The guidance material recommends that providers:

- discuss likely fees with patients before processing a request; and
- consider the individual's capacity to pay.

There are limitations to the reliance on the Commonwealth Privacy Act if the current Regulations were allowed to lapse:

- Compared to the Act, the Commonwealth Privacy Act is a more extensive and complex piece of legislation (over 400 pages) which would be more difficult and burdensome for private organisations to navigate to understand their obligations and rights.
- Related to this, there may be uncertainty for private organisations in determining whether the fee they propose to charge is 'excessive' and what to consider in determining whether a fee is excessive, for example, level of cost recovery and equity of access factors.
- As there are no maximum fee caps under the Commonwealth Privacy Act, organisations may set fees as they wish so long as fees are not 'excessive' (a term not defined under the Privacy Act, but the explanatory memorandum of the 2012 Privacy Act amendments suggest that full cost recovery of actual costs is allowed, as discussed in section 1.1. of this RIS). This increases the risk that fees are set too high to enable individuals to fairly access their health information or request a transfer of information, which would undermine the objective of facilitating access to information.
- Access to information is only regulated by the Commonwealth's legislation for private non-health service providers, with an annual turnover of over $3 million. This means smaller organisations that collect and hold health information are not required to comply with the Commonwealth legislation. As these organisations do have to provide access under the Act, in the absence of regulations setting a maximum fee, they would not be able to charge any fee for providing access to individuals.[14]
- As the Commonwealth and Victorian arrangements have some differences in terms of when access must be provided (through exceptions and criteria for refusing access), it is possible that there are situations where practical access to health information exists only under the Victorian Health Records Act and not the Commonwealth Privacy Act. In such cases, in the absence of regulations setting a maximum fee, Victorian health providers would be unable to charge any fee for providing access to individuals (i.e. because the

[14] It should be noted that the small business exemption is currently subject to review as part of the Privacy Act Review being undertaken by the Commonwealth Government

Commonwealth legislation would not apply in such cases). This is a very minor issue likely to impact very few cases.

2.1.2 Transfer of information between health service providers

HPP 11 of the Act enables an individual to request that health service information held by one health service provider be made available to another health service provider. This applies to both public and private sector health providers (but not non-health service providers holding health information). This provision is relevant where an individual does not want to personally access their health information but requires it to be made available to another provider.

Under HPP 11, fees may be charged for transferring health information not exceeding a prescribed maximum fee. In the absence of regulations, there would be no cap on the fee that public or private health service providers could charge for this service. There is potential for health service providers to charge high fees for transferring this information, either because it would reflect actual high-cost structures in their management of health information, or as a strategy to prevent individuals from moving to another health service provider. This may make it prohibitive for an individual seeking to have their personal health records transferred, therefore unfairly affecting an individual's rights under the Act. In addition, there is a risk that not transferring health records may affect the choice, consistency and quality of care a patient receives.

2.1.3 Nominated health service providers reviewing refused access

The Act states that an organisation must refuse a request to access health information if the organisation, on reasonable grounds, believes that providing access would pose a serious threat to the life or health of that individual (s.26). In these situations, there are two possible options:

- An organisation may offer to discuss the information with the requesting individual; or
- The individual may choose to nominate a health service provider to view the information and, at the decision of that nominee, explain the health information or explain the grounds for refusal.

The ability to seek review by a nominated health service provider is a safeguard in the Act which recognises that refusing access affects a person's rights. Section 42(3) of the Act allows for a fee to be charged by the nominated health service provider. There is no corresponding function in the FOI Act, but section 33(4) of that Act states that the procedure in the Health Records Act detailed above applies in such situations.

Under section 42(3) of the Act, a nominated health service provider may charge the individual a fee not exceeding the prescribed maximum fee for performing a review. In the absence of regulations, there would be no cap on the fee that public or private health service providers could charge for this service. This may make it prohibitive for an individual to seek timely and reasonable review of a decision to refuse access, therefore unfairly affecting an individual's rights under the Act.

2.2 Extent of the problem

2.2.1 Data analysis

There are significant limitations on what quantitative data is available to inform this analysis.

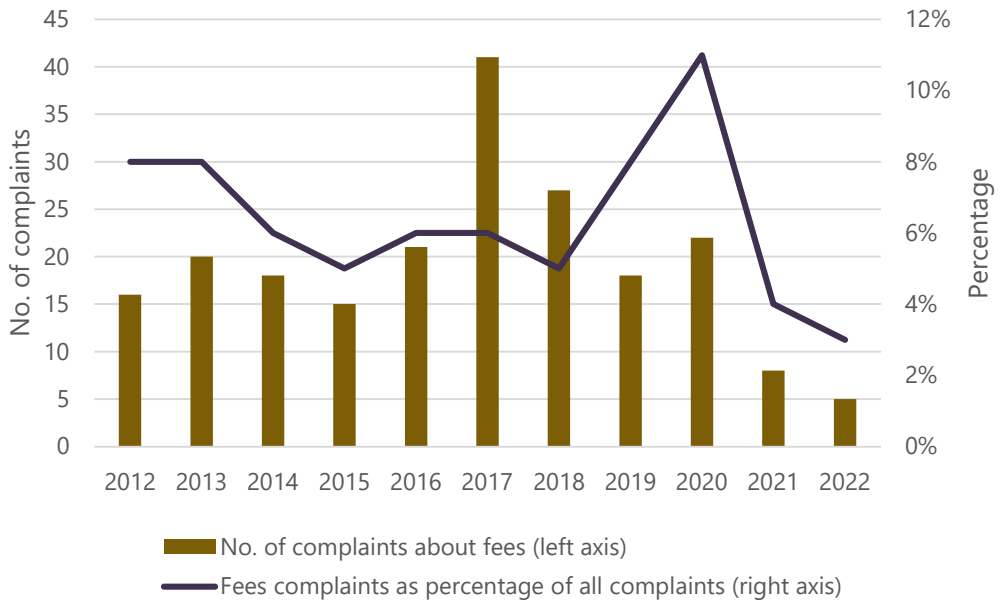
- Importantly, it is noted that fees are charged directly by organisations to the individual and DH does not administer the cost recovery process. Under the Act and Regulations, organisations are not required to collate and provide this information.
- The Act has wide application, encompassing all private organisations that hold health information. Requiring organisations to provide information to DH would represent a substantial and unjustifiable regulatory burden on organisations covered by the Act[15].

In the absence of such data, complaints data about access to health information, including complaints about fees, provides some reflection of the consumer experience of the current Regulations. It should be noted that this data represents a group who chose to make a complaint, as such, they may not be representative of all individuals that make a request for health information under the Act. There may be requesters who were unaware of the complaints mechanism or were unwilling to make a complaint about fees charged.

If complaints cannot be resolved by the organisation, they are made to the Office of the Health Complaints Commissioner. From 2012 to 2022, fees complaints represented between 3% and 11% of total complaints made under the Act (see Figure 1). Overall numbers of fees complaints are low, totalling between 5 and 41 per year between 2012 and 2022. While data on the total number of requests for health records information is not collected, it is reasonable to assume that the number of complaints represents a very small proportion of the total number of requests for health records by individuals.

[15] For example it is noted that one large health services provider engaged with noted it does not collect and collate data on the cost of health information across its multiple hospital and clinic sites.

Figure 1: Complaints about fees under the Health Records Act[16]



Source: Health Complaints Commissioner

The number of fees complaints as a percentage of all complaints under the Act spiked in 2020, which is likely to be a result of a drop in the total number of complaints due to the COVID-19 pandemic resulting in an overall reduction in instances of health care provision and therefore fewer total complaints.

2.2.2 Conclusion on the extent of the problem

While there is a lack of specific data on the nature and extent of the problem, the existing data discussed above, combined with feedback from health service providers received by DH through the life of the Regulations, indicate the Regulations have been effective in balancing facilitation of access and reasonable cost recovery. It is important to note that:

- There is no evidence to indicate that individuals are being precluded from accessing health information because fees charged are too high.
- The maximum fees set are relatively low compared to the overall costs of healthcare provision.

[16] Consisting of complaints against HPP6 and HPP1 under the Act.

2.3 Are the Regulations still needed and are they fit for purpose?

In this section we consider whether the fee indexation has kept pace with organisational costs. We then consider whether structural changes in the operating environment, namely digitisation trends and improvements in records management mechanisms through patient identifiers and *My Health Record* use impacts the need for the regulations or whether they remain fit for purpose.

2.3.1 Has the fee indexation kept pace with costs of providing information?

The maximum fees that can be charged in the Regulations are expressed in fee units.[17] The value of a fee unit for the financial year commencing 1 July 2022 is $15.29, compared with $12.53 for the financial year commencing 1 July 2012 – a total increase of 22% or 2.01% per annum.

To inform the assessment of whether the current Regulations allow for reasonable cost recovery, we consider whether the annual fee indexation of the maximum fee has kept pace with health service provider costs.[18] We can compare to different benchmarks, each of which is a useful but not perfect representation of the costs to a health service provider of providing health information:

- Scheduled fee for a standard General Practitioner (GP) consultation: used as a proxy for medical practitioner costs.
- Health CPI: used as a proxy for broader health costs.
- Average adult full-time ordinary time weekly earnings: used as a general proxy for the staff costs of a provider.

In practice, the costs of the health service provider would vary significantly across the spectrum of health service providers but would likely be made of, to varying extents, the costs of medical practitioners, administrative staff and other costs such as file storage and retrieval (which would, in some cases, be outsourced).

The scheduled fee for a standard GP consultation under the Medicare scheme is $39.75.[19] The current scheduled fee compares to the same fee of $35.60 that was prevailing at the time the current Regulations were last updated in 2012. This represents an increase of around 12% over the past 11 years or 1.01% per annum. This rate of increase is less than the fee unit indexation that has been applied to maximum fees.[20] For the Health CPI benchmark, from March 2012 to March 2023, the CPI –

[17] Within the meaning of the *Monetary Units Act 2004*. Under this Act, the Victorian Treasurer sets the value of the fee unit each financial year. Using fee units allows for indexation each year by an amount fixed by the Treasurer.
[18] Focusing on the costs of health providers rather than non health providers as they represent where most of the impact of the Regulations will be – see discussion in section 3.3 on non health providers.
[19] Medicare Benefits Schedule – Item 23, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=23
[20] It is noted that, based on anecdotal evidence in the public domain, the current scheduled fee for a standard GP consultation is likely to be on the low side compared to actual GP costs, however the scheduled fee is the best available benchmark for the purpose of this RIS and is not feasible to conduct a detailed analysis of medical

Health group has increased from 101.5 to 157.6 – an increase of 55%. This is compared to a 33% increase in the overall CPI over the same time period (ABS 6401.0, released 26 April 2023).[21] The CPI – Health group includes all expenditure relating to health goods and services, including pharmaceuticals, therapeutic appliances/equipment, and medical/hospital/dental services.[22] The increase in the Health CPI is therefore higher than the fee unit indexation that has been applied to maximum fees, although the bucket of goods and services covered by this index is considered a less relevant benchmark for the cost of providing health information because it covers such a wide spectrum of specialised goods and services not related to staff time.

From November 2012 to November 2022, the average adult full-time ordinary time weekly earnings for Victoria increased from $1,324.90 to $1,790.70 – an increase of 35% (ABS 6302.0, released 23 February 2023, trend data) or 3.06%over 10 years.[23] This rate of increase is slightly higher than the indexation of the maximum fees.

Overall, the rates of increase have not been consistent, and it is difficult to conclude with a strong level of confidence about the extent to which fee indexation has kept pace. However, given the increase in average weekly earnings and the likelihood that the increase in the scheduled GP fee has not itself kept pace with actual costs, it seems reasonable to say that the fee indexation is most likely at the lower end of actual cost increases.

Having said that, the fee indexation that was introduced in 2012 appears to have substantially achieved its purpose in ensuring that the proportion of costs recovered has not declined significantly over time. What is a reasonable level of cost recovery, balanced against the objective of facilitating access to health information, is discussed further in the options analysis section of this RIS.

2.3.2 Increasing digitisation of health records

Generally, there has been a strong trend to digitisation in health organisations[24], reflecting technological advances, which could potentially affect ease of access to health information and reduced labour costs for information requests due to more efficient storage and easier gathering of information by organisations, for example a shift to digital from paper-based. The Health Complaints Commissioner has raised the issue digitisation of records and whether consideration of what is reasonable to charge for digital records is needed.

practitioner costs for the purpose of this RIS. The significant reduction in bulk billing practices in Australia has been linked to this increase being insufficient to meet practice costs. In the recent 2023-24 Commonwealth Budget, the government announced some increases to certain payments for GP consultations.

[21] https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release

[22] https://www.abs.gov.au/statistics/detailed-methodology-information/concepts-sources-methods/consumer-price-index-concepts-sources-and-methods/2018/price-collection#health

[23] https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/latest-release

[24] Noting we are focusing on health organisations in this section, although non-health providers are also covered. Non-health providers such as schools and gyms may have more advanced digitation of systems, but this is unknown.

Consultation with health service providers indicates that digitisation amongst individual organisations varies widely, with some hospitals still being mainly paper based. A heavy reliance on paper-based approaches remains a common feature in the health industry, for example many records are still paper-based and faxes are still in use. Therefore, while there have been advances in technology since 2012, indications are that digitisation is not widespread enough to reduce the costs to organisations of providing health information to individuals.

Direct access to information could also be facilitated as more individuals can access their health information via the 'My Health Record' system established a decade ago.[25] 'My Health Record' is an Australian-wide initiative aimed at providing a secure platform for accessing health information, by both the person and their healthcare provider. 5.86 million Victorians (about 90%) currently have a My Health Record[26], however there is evidence of gaps in information uploaded and usage by health practitioners. For example, only 36% of specialists are registered while only 17% have used My Health Record.[27] Only about 20% of diagnostic imaging are uploaded to My Health Record.[28] As at April 2023, 945 million documents had been uploaded in the system by consumers or healthcare providers, but this represents a very small proportion of all the documents produced in the health care system, At this stage, there is insufficient evidence to demonstrate that My Health Record could substitute for the health information access provided in the Act and Regulations.

More importantly, given that the Act establishes the objectives and framework for facilitating access to health information, it is not within the primary scope of this RIS to assess whether requirements for provision of access to information are still required.

[25] Australian Digital Health Agency, https://www.digitalhealth.gov.au/initiatives-and-programs/my-health-record.
[26] Australian Digital Health Agency, Annual Report 2021-22, https://www.transparency.gov.au/annual-reports/australian-digital-health-agency/reporting-year/2021-22-11
[27] Australian Digital Health Agency, *My Health Record Statistics and Insights APRIL 2023*.
[28] Minister for Health and Aged Care - press conference - 3 February 2023, https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-3-february-2023.

3. Identification of options

This chapter identifies the set of options considered for the proposed Regulations.

As part of the RIS process, it is important to consider different options that could achieve the Victorian Government's objectives. The *Subordinate Legislation Act 1994*, the Subordinate Legislation Act Guidelines, and the Victorian Guide to Regulation recommend that this includes considering a range of approaches, including non-regulatory options, approaches in other jurisdictions, and improvements to existing regulatory regimes and regulatory practice.

3.1 Objectives

The objective of government action is to allow individuals to obtain health information related to themselves in an equitable, efficient and effective manner. This involves balancing the following:

- Ensuring that any fee charged for access to health information does not unfairly preclude an individual from requesting access to health information.
- Allowing reasonable cost recovery for organisations providing access to health information.

3.2 Feasible options

Three options have been considered as part of this RIS against the base case:

- **Base case:** regulations expire and no new regulations are introduced i.e. no maximum fee prescribed.
- **Option 1:** Replication of current regulations with minor clarifying amendments.
- **Option 2: Higher level of cost recovery** than what the maximum fees prescribed in the current Regulations allow.
- **Option 3: Option 1** *plus* Concession discount.

3.3 Base case

The base case is a 'do nothing' scenario, against which other options can be assessed. It reflects the likely outcomes over the next 10 years if the current Regulations are allowed to lapse, and all other activities continue.

Under the base case there will be two types of organisations: those that can charge any amount for providing access to health information (subject to other laws such as the Commonwealth Privacy Act), and those that are unable to charge any fee for providing access.

In the absence of regulations, many private organisations will not be able to charge for access under the Health Records Act. However, under the Commonwealth Privacy Act they are able to charge any 'non-excessive' amount for a person accessing health information.

There are a small number of private organisations that, in the absence of regulations, would not be able to recover any of the cost of providing access to health information. This could arise in two cases:

- Due to minor differences in the arrangements under the Victorian Health Records Act and the Commonwealth Privacy Act, there may be cases where an individual may only be able to request access under the Victorian Act and not the Commonwealth Act (for example, different exceptions and reasons for refusal).
- While the Commonwealth Privacy Act applies to all health service providers, it only applies to other (non-health service) organisations with an annual turnover of over $3 million. These are all likely to be small businesses.

No data is available on the proportion of private organisations that fall into these categories. However, it is considered likely to represent a small proportion of organisations for the purpose of this RIS. First, it is only smaller non-health providers that the Commonwealth Privacy Act does not apply to, which are likely to comprise a small proportion of the overall number of organisations covered by the Health Records Act (turnover equal to or less than $3 million). Compared to health providers where it is standard practice to hold health information about individuals, far fewer non-health provider organisations (such as gyms, personal trainers and schools) do so. It is also less likely that requests for health information will be made to these organisations.

In terms of transferring information between health service providers, public and private health service providers would be able to charge any amount under the Act. Nominated health service providers would also be able to charge any amount for performing services under section 42 of the Act.

It is therefore possible that cases will arise where access to information relies solely on the Health Records Act. In the absence of regulations, specific private organisations would be unable to charge any fees for providing access to information due to the wording of section 32 of the Act not allowing a fee to be charged unless a maximum fee has been set in regulations.

3.4 Option 1: Replication of current regulations with minor clarifying amendments

The current regulations would be almost entirely replicated in the proposed regulations, including indexation and the current maximum fee units.

Additionally, a clarifying amendment to regulation 9 would be made to make clear those situations where health information can be collected about a person connected to the individual, such as for the purposes of preparing a family history of a patient. Regulation 9 sets out the prescribed circumstances for collection of health information. Under the Act, HPP 1 limits the health information that may be collected by an organisation to where the information is necessary for one or more of its functions and where at least one of a set of conditions applies (e.g. the individual has consented) and permits the making of regulations to set out any additional circumstances.

Essentially, the wording is changed from "the individual to whom the information relates" to "a person to whom a health service is being provided" – to make it clearer who the regulations are referring to in these situations. It is anticipated that the wording of regulation 9(1)(c) and (d) would be changed from:

(c) the information is collected from

(i) the individual to whom the information relates; or

(ii) if the individual to whom the information relates is incapable of providing the information, from an authorised representative, immediate family member, or the primary carer of the individual

(d) the information does not contain any more identifying information about the individual referred to in paragraph (b) than is reasonably necessary to ensure that health services are provided safely and effectively to the individual.

To:

(c) the information is collected from

(i) a person to whom a health service is being provided; or

(ii) an authorised representative, an immediate family member, or the primary carer of a person to whom a health service is being provided, if the person is incapable of providing the information.

(d) the information does not contain any more identifying information about the individual referred to in paragraph (b) than is reasonably necessary to ensure that health services are provided safely and effectively to the person referred to in paragraph (c)(i) or (c)(ii).

Additionally, minor clarifying amendments to the wording of regulations 6 and 7 would be made but these are extremely minor.[29,30]

These proposed amendments represent drafting clarifications and do not indicate a change in policy. These amendments are not anticipated to create any impact on the sector or the public and do not impose any additional costs. These clarifying amendments are not considered further in this RIS.

3.5 Option 2: Higher level of cost recovery

This option would adjust the maximum fees to allow for a higher level of cost recovery. The purpose of assessing this option is to provide consideration of what is a reasonable level of cost recovery, balanced against the objective of facilitating access to health information. A higher level of cost recovery is chosen as the option rather than a lower level reflecting cost increases for health providers

[29] Regulation 6 would be changed from "For the purposes of section 32 of the Act, the prescribed maximum fee for providing access to health information is the relevant fee **set out in Schedule 1**. " to "For the purposes of section 32 of the Act, the prescribed maximum fee for providing access to health information **in a manner specified in Column 2 of Schedule 1 is the fee set out in the corresponding entry of Column 3 of Schedule 1.**"

[30] Regulation 7 would be changed from "For the purposes of section 42(3) of the Act, the prescribed maximum fee for performing **a function** set out in section 42(1) is the reasonable cost incurred by the nominated health service provider in performing **that function**, not exceeding the lesser of" to "For the purposes of section 42(3) of the Act, the prescribed maximum fee for performing **functions** set out in section 42(1) is the reasonable cost incurred by the nominated health service provider in performing **those functions**, not exceeding the lesser of…"

providing access to information that are likely to have slightly outpaced fee indexation (see discussion in section 2.3.1).

3.6 Option 3: Concession discount

This option would amend the fee structure to allow for a lower fee for lower income groups holding a recognised concession card, for example, those with a Pensioner or health care card (noting this eligibility criteria is used for the purpose of this RIS and would need further consideration if the option was preferred). The mechanism would be a flat discount on any fees charged. Lowering the potential fee could make it more likely that those with a lower income would feel comfortable with exercising their rights under the Act.

As described in section 3.8, which outlines approach in other jurisdictions, the Australian Capital Territory (ACT) allows for a 50% discount for health card holders.

3.7 Options considered but not progressed

3.7.1 A separate fee structure for accessing and providing digital health information

The possibility of introducing a fee structure that recognises the differing costs associated with accessing and providing[31] health records electronically was considered. However, while there is an increasing use of digital records, informal consultation identified that not all organisations have shifted to a digital record, and some are still heavily paper-based. The Regulations apply to a wide range of organisations, meaning the adoption of digitisation will vary.

Activities relating to sourcing and providing digital records are already provided for in the schedule of fees in the regulations.

Where electronic records make the locating, collating and assembling of records faster, this will be reflected in lower costs to providers (which will potentially flow through to consumers) through less time needed to be able to compile and share information to consumers (e.g. 1 hour's work could be reduced to 15 minutes). While this may mean that the time needed to locate and compile some records may be well below the impact of the fee cap (possibly by only by a small amount but this is uncertain), the proposed Regulations continue the requirement for charges to represent only costs reasonably incurred where below the prescribed maximum fee. The maximum fee provides a safety net for consumers while providing flexibility for health providers to set a fee below this, if costs have decreased. An additional fee structure strictly relating to access and provision of digital health information may introduce uncertainty, for example, during the initial transition to an additional fee

[31] It is noted that health information is not usually provided via email, as the organisation has a duty to ensure the security and confidentiality of health information, and email is generally not a secure means of transmitting information.

structure. Additionally, as record-keeping practices evolve, there will be future transition costs to accommodate changes relating to increasing digitisation.

3.8 Other jurisdictions

Statutory rights to health information held by private organisations also exist in New South Wales (NSW) and the Australian Capital Territory (ACT). Other Australian jurisdictions do not have a legislative framework for access to health information held by private organisations, instead relying on the Commonwealth Privacy Act. It is noted that, when considering approaches in other jurisdictions, careful consideration to the full architecture of acts and regulations is needed as there may be material differences that mean approaches to fees are not directly comparable. For the purpose of this RIS, it is disproportionate to undertake a detailed review of the different approaches.

The *New South Wales Health Records and Information Privacy Act 2002* states the any fee charged must not exceed a fee prescribed in regulations but does not have the same provision as the Victorian Act prohibiting the charging of fees unless a maximum fee has been set in regulations. To date, NSW has not set any fees in regulations relating to the access of health records.

The *ACT Health Records (Privacy and Access) Act 1997* allows for fees to be set as a disallowable instrument. Like NSW, the ACT *Health Records (Privacy and Access) Act 1997* does not prohibit the charging of fees unless a maximum fee has been set. The current fees for access are set out in the *Health Records (Privacy and Access) (Fees) Determination 2023* and allow for a 50% discount for health card holders. The fees are not set as maximums, rather are set as actual fees that can be charged (although organisations have the discretion to waive the fees in part or in full if they are satisfied the fee would result in hardship or would otherwise be unreasonable to charge).

4. Assessment of options

This chapter assess the options considered for the proposed Regulations.

4.1 Methodology

The options in this RIS have been assessed using Multi-Criteria Analysis (MCA) supported by quantitative information where available. This approach provides a structured and transparent way of evaluating the options given the limited quantitative data that is available to assess the benefits of the options.

MCA requires judgement of how the proposed options will contribute to a series of criteria that are chosen to reflect the benefits and costs associated with each option. Each criterion is assigned a weight reflecting its importance to the policy decision, and a weighted score is then derived for each option. The option with the highest weighted score is the preferred option.

MCA enables options to be compared in a way that utilises quantitative and qualitative evidence fully. The approach enables the inclusion of a wider range of criteria — including social and environmental considerations for example — than used in a typical financial analysis. In addition, the approach is transparent — necessarily subjective judgements and assumptions made to determine options and criteria, and to assign scores and weights are made explicitly. The preferences of the decision maker reflected in these judgements and assumptions can be readily changed in a sensitivity analysis or to incorporate alternative indicators of community preference.

4.1.1 MCA framework

The criteria and weightings used to assess options for this RIS are shown in Table 4. These draw on the objectives for the Regulations identified in Chapter 3.

Facilitating access to health information (criterion one) is central to supporting one of the main purposes of the Act and weighted at 40%. Through the Regulations, this criterion is balanced against providing reasonable cost recovery for organisations providing health information (criterion two). Not allowing reasonable cost recovery may have adverse impacts on the other services provided by the organisation, for example, charging more for other core health services. It is in the interests of individuals and the whole community that these organisations operate sustainably. Criterion two is therefore given an equal weighting to criterion one of 40%.

The third criterion, *Easy and simple to understand and administer*, is important and should be taken into account, but should not of itself be the dominant driver of setting fees. It therefore has a smaller weighting (20%).

Table 4 Criteria and weightings

Criteria	Description	Weighting
Facilitate access to health information	The extent to which the option ensures that any fee charged for access to health information does not unfairly preclude an individual from requesting access to health information, requesting transfer, or seeking review of decision to refuse access. The approach adopted in this analysis is that the lower the maximum fee that is set, the less likely it will unfairly preclude access to health information.	40%
Reasonable cost recovery for organisations	The extent to which the option allows recovery of reasonable costs in providing access to health information, or other functions under the Act. Not allowing reasonable cost recovery may have adverse impacts on other services provided by the organisation, for example, charging more for other core health services i.e. to subsidise the provision of access to health records. It is in the interests of individuals and the whole community that health providers operate sustainably.	40%
Easy and simple to understand and administer	The ability to easily determine what fee applies, including the ability for organisations to communicate, calculate and collect the fee, and for individuals to understand the fees to be applied in advance. This also includes consideration of the level of administrative costs associated with calculating and levying fees.	20%

Each of the three feasible options has been scored against each criterion above. The score can range from -10 to +10, with the scores then weighted by the above weightings. The scores reflect how well the option improves (a positive score) or worsens (a negative score) each criterion objective relative to the base case.

Table 5: MCA scale

Score	Description
-10	Much worse than the base case
-5	Somewhat worse than the base case
0	No change from the base case
+5	Somewhat better than the base case
+10	Much better than the base case

4.2 Analysis using the MCA

4.2.1 Base case: regulations expire and no new regulations are introduced

If no new regulations are introduced:

- Organisations will no longer be able to charge for providing access to information under the Act as under the Act a fee cannot be charged unless a maximum fee is regulated. Most private organisations would be able to charge a fee to a person accessing health information under the Commonwealth Privacy Act, so long as the fee is not excessive.
    - However, there will be a small number of private organisations that will not be able to charge any fees - non-health service organisations with an annual turnover of over $3 million are not subject to the Commonwealth Privacy Act, so rely solely on the Health Records Act for charging a fee. See section 3.3 for discussion of this cohort.
- In terms of transferring information between providers, public and private health service providers would be able to charge any amount, as under the Act the absence of maximum fees does not preclude them from charging a fee.
- Nominated health service providers would also be able to charge any amount for performing services under section 42, as under the Act the absence of maximum fees does not preclude them from charging a fee.

Under the MCA scoring scale, the base case is given a score of 0 on all criteria.

Criteria 1: Facilitate access to health information

Access for individuals

In the absence of Regulations individuals would still have a right of access under the Act but it is possible that in the absence of a maximum fee some private providers would charge a higher fee for providing that access. The Commonwealth Privacy Act allows a fee to be charged for accessing health information but it must not be excessive. An excessive fee is likely to be a fee that is set above the level of full cost recovery (see discussion in section 1.1, suggesting full cost recovery of actual costs would be allowed under the Commonwealth Privacy Act). There is a lack of clarity under the Privacy Act about what constitutes an excessive fee, as the guidance on what is an excessive fee resides in an explanatory memo to amendments made to the Act in 2012. Additionally, the Act itself is long and difficult to navigate. This increases the potential for providers to charge a fee that is even higher than the level of full cost recovery, if they do not understand what "excessive" means. It is likely that there would be some guidance provided to organisations by industry bodies, but this is uncertain.

For the purposes of the RIS, it is assumed that health providers are currently setting fees at a level that recovers around half of the costs involved in fulfilling requests for information. This assumption has been tested with some large health service providers. Using this as a basis for comparison, the fee for providing a copy of health information could potentially increase from $38.23 to $76.47 (100% cost

recovery).[32] The fee for creation of an accurate summary of health information could increase from $143.73 to $287.46. These are estimates only (due to lack of information about costs of health providers) but indicate the potential for fees to increase substantially. In practice, it is difficult to predict what organisations may charge in the absence of regulations setting maximum fees. Maximum fees have been in place since the commencement of the legislative right of access to health information since 2002, which means no data exists on the case where there are no maximum fees. On the one hand, some providers currently charge no fee and would continue to do so. On the other hand, it is likely that some providers who are currently charging at the maximum fee level and are not recovering all their costs will increase the fee charged (up to full cost recovery or even greater). This significantly increases the likelihood of unfairly precluding access to health information for individuals.

Because small private non-health service providers with turnover of $3 million or less cannot charge a fee for access under either the Health Records Act if maximum fees are not prescribed or under the Commonwealth Privacy Act, access would be increased in this case (but likely to be a small number).

While there is uncertainty about the extent to which organisations would charge higher fees, without maximum fees there would be no protection from higher fees being charged.

Under the base case, no maximum fees are set for transferring information, or for being a nominated health service provider, and there is no legislative limit on what fees could be charged as under the Act the absence of maximum fees does not preclude them from charging a fee. It is likely that in some cases higher fees would be charged in comparison to the case under the current Regulations, which in some cases could present a barrier to access.

Criteria 2: Reasonable cost recovery for organisations

As discussed for the previous criterion, it is likely that some organisations would charge higher fees, potentially up to full cost recovery for access to information for individuals (or possibly higher for transfer of information and nominated health providers depending on commercial decisions). Health providers are likely to recover more costs under the base case than if the current Regulations are remade.

Criteria 3: Simple to understand and administer

It is reasonable to assume that organisations that are allowed to set fees under the Commonwealth Privacy Act would not set fees in a way that imposes high administration costs on their business; it is unlikely they would design and implement a fee structure that is difficult to understand for their staff or adds unnecessary administrative burden.

On the other hand, as noted in discussion of Criteria 1, the Commonwealth Privacy Act is a more extensive and complex piece of legislation which would be more difficult and burdensome for private organisations to navigate to understand their obligations and rights. By comparison, the maximum fees able to be set under the Regulations are clearly specified in the Regulations and also set out on

[32] This is an indicative estimate only, based on a small sample of information provided by large health providers. The level of cost recovery of all organisations is not known and an assumption of around 50% is used in the absence of other information.

DH's website. Therefore this is a potentially negative impact in terms of simplicity to understand and administer.

For individuals requesting access to information, in the absence of maximum fees, there may be less clarity and certainty around what fees can be charged as they are unlikely to be able to understand what an "excessive fee" is under the Commonwealth Privacy Act. In the event of being charged what they perceive as an unnecessarily high fee and seeking to question such a fee, it could be difficult for an individual to be able to navigate and interpret the Commonwealth Privacy Act or find supporting guidance.

4.2.2 Option 1: Replication of current Regulations with minor clarifying amendments

Under this option, the proposed Regulations would remain the same as prescribed in the current Regulations. Specifically, there would be no change to the objectives of the Regulations or the fees prescribed in Schedules 1 and 2 of the Regulations.

As the fees are expressed in fee units provided in the *Monetary Units Act 2004* which are indexed each year, there would be annual indexation to ensure maximum fees reflect current costs. As noted in section 2.3.1 of this RIS, the value of a fee unit for the financial year commencing 1 July 2022 is $15.29, compared with $12.53 for the financial year commencing 1 July 2012 – a total increase of 22% or 2.01% per annum.

Criteria 1: Facilitate access to health information

Under Option 1, maximum fees under the Regulations will be less than what could be set under the Commonwealth Privacy Act, where fees can be set up to a level that is not excessive, It is assumed that health providers are currently setting fees at the maximum fee level allowed under the Regulations, which some large health providers report recovers about half of their costs[33].

Compared to the base case, where they could potentially charge up to double this, prescribing maximum fees at the current level, will reduce the likelihood that individuals are unfairly precluded from accessing health information.

It is difficult to judge the level of fee at which some individuals would be unfairly precluded from accessing their health information, however the small number of complaints received by the Health Complaints Commissioner about fees, combined with feedback from health service providers received by DH through the life of the Regulations, suggest that maximum fees are currently set at an appropriate level to facilitate access.

In assessing whether maximum fees are too high or too level, it is also important to consider the overall context of healthcare costs and also what happens in practice in relation to fees charged by organisations.

[33] As noted for the base case analysis, around 50% cost recovery is an assumption only, based on a small sample of information provided by large health service providers. The level of cost recovery of all organisations is not known and an assumption of 50% is used in the absence of other information.

It is noted that the maximum fees set are low compared to the overall costs of healthcare provision, for example the fee for the most standard request for a copy of health information is $38.23 (2.5 fee units) for 'assessing and collating' health information plus 20 cents per page for A4 black and white copies. In the context of the whole cost of healthcare and fees charged by private health providers, this fee does not comprise a material component of health care costs in most cases. To illustrate, an emergency attendance fee at a major private hospital in Melbourne is $400 for a Medicare card holder, with no rebate by Medicare or refund through private health insurance available. Capped out of pocket costs for a pathology fee are $150 and medical imaging $245. At another major private hospital the fees for these services are $485, $110 and $420 respectively. For GP visits, the average out of pocket fee in 2023 is $42.44 for a 15-minute visit, as shown by Australian Government data.

In addition, typical minor requests by an individual for a health record at a small provider such a local general practice or a discharge summary at a private hospital would often not be charged at all.

As an example of a task that commands a higher fee, the maximum fee for creating an accurate summary of health information is $143.73. Larger requests are often in the context of litigation, for which larger providers typically charge a fee at the maximum fee level allowed. It is noted that this fee for access would be a negligible cost compared to the total cost of litigation.

Setting a maximum fee will reduce the likely barrier for some people in accessing their health information, requesting it to be transferred, or requesting a review of refusal by a nominated health service provider where the fee set in the absence of maximum fees would unfairly preclude access.

Small private non-health service providers with turnover of $3 million or less would be able to charge a fee up to the maximum fee level under Option 1, compared to no fee under the base case, which means facilitation of access is reduced for this cohort (but likely to be a small number).

Overall, Option 1 is given a **score of +7** for this criterion reflecting that health providers will be prevented from increasing their fees (e.g. up to a level of full cost recovery, as some would be expected to do), but moderated by the fact that providers will continue to charge no fees in many cases (whether Regulations are prescribed or not).

Criteria 2: Reasonable cost recovery for organisations

Setting a maximum fee at the current level means that health providers may not be able to recover a share of the actual costs that they incur in providing access to health information. This will vary across providers and depend on their individual cost structures, with some having higher cost levels than the maximum fees set and some having lower cost levels (e.g. the extent of file digitisation could drive different cost levels). In engagement with large health providers, one health provider said they outsource the delivery of health information in response to requests to an external provider and estimate the level of cost recovery to be about 50%.[34] In the absence of better data this RIS assumes an average cost recovery under the current Regulations of 50%, noting however the high level of

[34] We note there was another estimate provided by a second large health services provider which provided a high level estimate that cost recovery could be up to 80% however this provider noted it can't provide cost information without collecting further data from its large number of sites i.e. it does not collect and collate data on the cost of providing health information across its sites.

uncertainty with this assumption and also that different businesses will have higher and lower cost recovery levels depending on their cost structures.

While the Regulations do not define what a "reasonable" level of cost recovery is, to support this analysis against the MCA criteria we note:

- A reasonable level of cost recovery could be up to the efficient costs of providing the service (consistent with principles in DTF's Pricing for Value Guidelines which state organisations should aim to the full costs of service provision).
- Cost recovery approaching zero is not reasonable, as fees would be so low as to not even recover the administrative costs of charging. Given the typical fee of $38.23 for an information request, a fee half this level at $19.11 is approaching the low end of what could be considered reasonable as below this the costs of administering the fee could begin to outweigh the fee charged.

It is noted that organisations that are only subject to the Act and not the FOI Act or the Privacy Act (non-health service private providers with turnover of $3 million or less) cannot charge any fee unless there are regulations under the Act specifying a maximum. Therefore, there is a small benefit for these organisations compared to the base case – offsetting the initial negative score, albeit only by a small amount[35].

To score this option against the base case, we define full cost recovery as a score of 0 (same as the base case), -5 as 50% cost recovery and -10 as zero cost recovery (essentially establishing a scoring scale). The option of replicating the current Regulations is given **a score of -5**, reflecting an assumption that cost recovery of 50% is allowed by the maximum fees, although given data availability this estimate is highly uncertain.

Criteria 3: Simple to understand and administer

Setting maximum fees imposes some administration costs on organisations as they need to understand and ensure they are complying with the Regulations. The fee structure that organisations choose to use themselves in the absence of maximum fees might be different to what is prescribed in the Regulations, so there may be implementation costs for businesses to understand and implement the required fee arrangement.

On the other hand, there is likely to be a lack of clarity for organisations on what fees may be charged under the Commonwealth Privacy Act for those organisations allowed to do so (see discussion regarding the base case in section 4.2.1 about potential difficulties involved in navigating and understanding the Commonwealth Privacy Act). The regulation of maximum fees may provide more clarity and certainty for organisations.

It is noted that many organisations do not charge fees for providing access to health information. These organisations will not be impacted by the Regulations.

It is difficult to assess the overall impact of the offsetting impacts on organisations discussed above. Conservatively, it is judged that there will be a small overall negative impact on organisations for this

[35] Less than 1 point on the scoring scale.

criterion (i.e. the avoided costs from not having to comply with the Regulations outweigh the potential benefits of clarity provided by the Regulations).

For individuals requesting information, there is likely to be a positive impact in terms of having more clarity and certainty around what fees can be charged. In the event of being charged what they perceive as an unnecessarily high fee and seeking to question such a fee, an individual could find information on the maximum fees able to be set on either DH's website or the Health Complaints Commissioner website, unlike under the Commonwealth Privacy Act which is more difficult to navigate and understand. Therefore the regulation of maximum fees significantly increases simplicity and ease of understanding for individuals.

Option 1 is given a **score of +5**, taking into account the impacts on both organisations and individuals.

Summary

Overall, Option 1 receives a **total weighted score of +1.8**, as shown in Table 6.

Table 6 MCA summary – Option 1

Criteria	Score	Weighting	Weighted score
Facilitate access to health information	+7	40%	+2.8
Reasonable cost recovery	-5	40%	-2.0
Simple to understand and administer	+5	20%	+1.0
Total			**+1.8**

4.2.3 Option 2: Higher level of cost recovery

This option has similar impacts to the base case, in that most regulated service providers will be able to charge a higher fee. A difference though is that non-health service private providers with turnover of $3 million or less will be able to charge a fee, whereas they cannot under the base case.

Criteria 1: Facilitate access to health information

Allowing a higher level of cost recovery means that there may be increased cost barriers for people accessing their health information, requesting it to be transferred, or requesting a review of refusal by a nominated health service provider. The impact of this option depends on what level of cost recovery is selected. If maximum fees are increased to the full level of cost recovery, the impacts of this option could substantially mirror the impacts of the base case (scored 0).

However, it is assumed for this analysis that maximum fees higher than are currently in place but less than full cost recovery are set (hypothetically, say 75%[36]). This would represent a small improvement in facilitation of access to health records compared to the base case, but lower than Option 1 as higher maximum fees increase the likelihood that the fees may unfairly preclude access to information. A

[36] Assuming cost recovery levels are currently about 50%, noting this is highly uncertain based on the limited information available.

score of +3.5 is therefore given. It is noted that these scores are indicative only, reflecting subjective judgement about how to scale scores for the different options.[37]

Criteria 2: Reasonable cost recovery for organisations

Setting maximum fees at a higher level of cost recovery means that organisations will be able to recover greater costs associated with providing health information. Compared to the base case where they are unable to recover any costs, non-health service private providers with turnover l of $3 million or less would also be able to recover some costs.

A **score of -2.5** is assigned to Option 2 for this criterion, reflecting that it gives a somewhat higher level of cost recovery than Option 1.

Criteria 3: Simple to understand and administer

For this criterion, there is no difference for either organisations providing health information or individuals requesting health information between Option 1 and Option 2. Therefore Option 2 is given **a score of +5**.

Summary

Overall, Option 2 receives a **total weighted score of +1.4**, as shown in Table 7.

Table 7 MCA summary – Option 2

Criteria	Score	Weighting	Weighted score
Facilitate access to health information	+3.5	40%	+1.4
Reasonable cost recovery	-2.5	40%	-1.0
Simple to understand and administer	+5	20%	+1.0
Total			**+1.4**

4.2.4 Option 3: Replication of current Regulations (Option 1) plus concession discount

A discount of 50% could be required to be offered against all maximum fees for holders of certain concession cards seeking their health information.

Criteria 1: Facilitate access to health information

Providing a concession discount will remove a barrier for some people in accessing their health information, requesting it to be transferred, or requesting a review of refusal by a nominated health service provider. This would improve the ability for more people to exercise their rights under the Act. Based on data about the numbers of Victorians who hold a concession card, approximately 25% of

[37] A better estimate would require information about willingness to pay for health information, including at different income levels.

Victorians have some form of a concession card[38] and could be entitled to a discount (depending on the eligibility criteria established). This gives an indication of the size of the potential cohort that would benefit from this discount.

However, it is difficult to estimate how large the impact would be and there are a number of factors to consider. DH understands that many providers do not provide a fee for the relevant information services or already choose to charge no fee to low-income individuals. Therefore Option 3 will not change current practice in these cases.

It is also important to consider the application and context of the regulations, as they apply to private health providers and other organisations (e.g. schools, gyms). Given the costs of attending private hospitals are in most cases borne by the individual and not paid by government[39] (compared to treatment as a public patient in a public hospital), it is reasonable to assume that a smaller number of concession card holders are attending private hospitals due to inability to pay. Therefore, it is likely that significantly less than 25% of individuals requesting information will be entitled to a discount.

It is also noted that private health providers are not required to offer a concession discount for visits (although many providers such as general and specialist practitioners do offer a discount to any co-contribution charged). Large private hospital providers with fees for attendance at emergency of $400 and $485, as discussed in section 4.2.2 for Option 1, do not offer a concession discount on their fees. It would be inconsistent to require providers to provide a discount on a very small part of the overall cost of health treatment when discounts are not required to be offered on the charges that represent much greater costs to individuals.

A **score of +8** is given for this option reflecting that there will be improved facilitation of access to information for lower income individuals, however the impact is considered small given that many providers do not currently charge a fee to low-income individuals and this cohort is less likely to be attending private organisations such as private hospitals where these fees are relevant.

Criteria 2: Reasonable cost recovery for organisations

Providing a discount for concession holders means that an increased share of the actual costs will be borne by the organisation. Given concession card holders represent a relatively small proportion of total individuals expected to request access to information, this is likely to be a small impact.

A **score of -6** is therefore given for reasonable level of cost recovery which is slightly worse on this criterion than for Option 1.

Criteria 3: Simple to understand and administer

Option 3 is similar to Options 1 and 2 as all of these options prescribe maximum fees, but there is one key difference: the addition of a concession card discount for lower income groups.

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[38] 25% is calculated using the total of 433,820 health care card holders, 1,061,302 pensioner concession card holders and 110,004 seniors health card holders in Victoria, as a percentage of the Victorian usual resident population as at June 2021 of 6,503,491 – as set out in the Social Health Atlases of Australia, accessed at https://phidu.torrens.edu.au/social-health-atlases/data.

[36] Small exceptions such as special arrangements applying to veterans may apply, where the government pays the cost of the private hospital.

There will be increased administrative costs to check whether people have a concession and apply the discount. The potential inconsistency with other health fees charged by organisations, where no discount is required to be offered, would be an anomaly which contributes to this cost. For example, some private GPs do not charge a concession cate for consults, but would have to for providing health information (if they set a fee for this).

There will also be a transition cost as DH will need to educate organisations about the change to fee structures and will need to implement a change to their charging systems and educate staff.

This option is given **a score of +3**, reflecting it is considered simpler than the base case but more complex than Options 1 and 2.

Summary

Overall, Option 3 receives a **total weighted score of +1.4**, as shown in Table 8.

Table 8 MCA summary – Option 3

Criteria	Score	Weighting	Weighted score
Facilitate access to health information	+8.0	40%	+3.2
Reasonable cost recovery	-6.0	40%	-2.4
Simple to understand and administer	+3.0	20%	+0.6
Total			**+1.4**

4.3 Summary of MCA scores and preferred option

A summary of MCA scores is provided in Table 9. All options are likely to deliver a net benefit compared to the base case.

Option 1 (Replication of current Regulations with minor clarifying amendments) has the highest score and is the preferred option. This option is expected to best achieve the balance between facilitating access to health information with allowing reasonable cost recovery for organisations. Option 2 – higher cost recovery – will increase the level of cost recovery but have too large an impact on facilitation of access to health information. Providing a concession discount under Option 3 will provide slightly improve facilitation of access to health information but will reduce cost recovery and add to administrative costs of organisations. Option 3 would also introduce an inconsistency in approach to charging whereby private organisations would be required to offer a concession discount for providing health information but not for other fees charged (e.g. standard GP consult fees).

The preferred option of replicating the current Regulations reflects DH's view that there is no significant case to be made for changing the current fee structure and fee levels:

- There is a low level of complaints about access to health information in relation to fees
- Many organisations provide access for no charge, or a charge below the maximum fees, which facilitates access to health information
- The current Regulations are well understood by industry
- Low regulatory burden.

Table 9 Summary of MCA scores

Criteria	Base case – no Regulations	Option 1 – replication of current Regulations	Option 2 – higher level of cost recovery	Option 3 – concession discount
Facilitate access to health information (40%)	0	+7	+3.5	+8
Reasonable cost recovery for organisations (40%)	0	-5	-2.5	-6
Simple to understand and administer (20%)	0	+5	+5	+3
Total weighted score	**0**	**+1.8**	**+1.4**	**+1.4**

Sensitivity of findings

It is noted that the scores for the options are close e.g. an increase in the score of Option 3 from +8 to +9 for facilitating access to health information would be sufficient to equalise the weighted total. While the scores are subjective, they are transparent assessments of how each option will contribute to the criteria and reflect the discussion outlined for each option.

5. Competition and small business impacts

This section assesses the competition and small business impacts of the preferred option.

5.1 Competition impacts

The Victorian Guide to Regulation requires a RIS to assess the impact of regulations on competition. Regulations can affect competition by preventing or limiting the ability of businesses and individuals to enter and compete within particular markets.

A measure is likely to have an impact on competition if any of the questions in the Table 10 can be answered in the affirmative. For this RIS, the size of the impact of the proposed Regulations is very small and not considered significant enough to impact on competition.

Table 10 Analysis of competition impacts

Test question	Assessment	Reason
Is the proposed measure likely to affect the market structure of the affected sector(s) – i.e. will it reduce the number of participants in the market, or increase the size of incumbent firms?	No	Providing access to health information comprises a negligible part of an organisation's business operations. As such, there will be no impact on the market structure of the affected sector.
Will it be more difficult for new firms or individuals to enter the industry after the imposition of the proposed measure?	No	For the same reason as above.
Will the costs/benefits associated with the proposed measure affect some firms or individuals substantially more than others (e.g. small firms, part-time participants in occupations etc.)?	Minimal	While the setting of maximum charges may disproportionately impact certain businesses (e.g. organisations that may spend longer fulfilling a request due to lack of digitisation), the effect size is likely to be minimal in terms of a business's overall operations.
Will the proposed measure restrict the ability of businesses to choose the price, quality, range or location of their products?	No	The proposed maximum fee caps do not impact product choices. Access to Health Information is not a 'product' and is instead a right established under the Act.

Will the proposed measure lead to higher ongoing costs for new entrants that existing firms do not have to meet?	No	The costs imposed on new entrants will be the same as for existing businesses. Some mature businesses may have a more efficient records management system, but on the other hand newer entrants could be expected to use more modern, digital systems that result in lower costs of providing access.
Is the ability or incentive to innovate or develop new products or services likely to be affected by the proposed measure?	No	The scale of the maximum fee caps are such that the impact on small business from costs recovered for retrieving health information will be minimal and will not impact services provided by organisations. Moreover, access to Health Information is not a 'product' and is instead a right established under the Act.

It is further noted that organisations are free to charge fees below the capped amounts, or no fee at all, and consultation suggests that this does occur.

5.2 Small business impacts

The Victorian Guide to Regulation also considers it good practice for a RIS to consider the impacts of proposed Regulations on small businesses. Small businesses may experience disproportionate effects from regulation for a range of reasons. This may include that the requirement applies mostly to small businesses, or because small businesses have limited resources to interpret compliance requirements or meet substantive compliance requirements compared to larger businesses. Small businesses may also lack the economies of scale that allow regulatory costs to be spread across a large customer base.

There is no reason why small businesses should be disproportionately impacted because of the proposed Regulations, noting there is no evidence that small businesses have a lower level of cost recovery under the maximum fees proposed.

Additionally, in the absence of the proposed Regulations, private non-health service providers with an annual turnover of $3 million or less would not be able to charge under the Act or the Commonwealth Privacy Act, and therefore would be unable to recoup any costs involved with providing access to health information. The proposed Regulations therefore lead to a positive outcome for these businesses.

6. Implementation and evaluation

This chapter discusses key issues to be considered in the implementation and evaluation of the Regulations.

6.1 Implementation

Finalise the remade Regulations

The release of the proposed Regulations and this RIS for a 28-day public comment period will provide key stakeholders and members of the public the opportunity to consider the proposed changes to the Regulations and provide feedback. At the conclusion of the public comment period, the Victorian Government will review and consider each submission and take account of the feedback on both the proposed Regulations and the RIS in finalising the Regulations.

On behalf of the Victorian Government, DH will prepare a Response to Public Comment document, which will discuss the comments provided in the public comment submissions and respond to those comments.

The Office of Chief Parliamentary Council (OCPC) will review and settle the Regulations, which will then be submitted to the Minister for Health for approval.

Implementing the new Regulations

The proposed remade Regulations largely continue the substance and form of the current Regulations. DH will communicate the making of the new Regulations to key stakeholders. This will provide an opportunity for DH to provide education and guidance about key matters set out in the Regulations. DH will review feedback received through the public comment period to determine how to tailor any education and guidance to be provided.

6.2 Evaluation

The proposed Regulations will sunset in 2033. This will be the next time the Regulations are due for a full formal evaluation, undertaken via preparation of a future RIS. In light of the current data limitations relating to the operation of the Regulations, DH proposes to consult with stakeholders on how the Regulations are working and if they remain fit for purpose and enable the gathering and provision of information that is required in a cost-effective manner. DH will undertake targeted engagement with organisations to estimate:

- the number and types of requests for health information
- the level of fees that are charged for requests (including whether organisations are charging the maximum prescribed amount, a lower fee or no fee)
- the costs to organisations of responding to requests
- the overall level of cost recovery achieved by organisations.

This will help DH understand the burden of the regulations and any problems. Engagement undertaken will be proportionate to the significance of the problem and the effect of likely potential options to address it. Reflecting this, DH will aim to minimise the burden of information requests to estimate the numbers of requests and how fees are charged. DH will undertake targeted engagement to collect information rather than seek information from most/all organisations in scope.

The main purpose of this process will be to formalise the collection of information relating to the regulations, for example, whether the maximum fees are still appropriate, the fee charged by organisations for services under the Regulations, issues arising with the application of the Regulations, and costs of organisations in providing health information. Engagement undertaken will be proportionate to the significance of the problem and the effect of likely potential options to address it.

Appendix A Health Privacy Principles in the Act (Schedule 1)

Principle 1—Collection

- When health information may be collected
- How health information is to be collected
- Information given in confidence

Principle 2—Use and Disclosure

Principle 3—Data Quality

Principle 4—Data Security and Data Retention

Principle 5—Openness

Principle 6—Access and Correction

- Access
- Correction
- Written reasons

Principle 7—Identifiers

Principle 8—Anonymity

Principle 9—Transborder Data Flows

Principle 10—Transfer or closure of the practice of a health service provider

Principle 11—Making information available to another health service provider

Appendix B Maximum fees in the Health Records Regulations (Schedule 1 and Schedule 2)

SCHEDULE 1

Maximum Fee for Granting an Individual Access to Health Information

Item No.	*Manner of access under Part 5 of the Act*	*Maximum fee*
1	Inspecting health information or printout of health information stored in electronic form, with opportunity to take notes of contents	The total of the following amounts— (a) 1·2 fee units per half hour (to be calculated in increments of quarter hours or parts thereof) in respect of supervision time of inspection; and (b) the organisation's reasonable costs incurred in assessing and collating the health information, not exceeding 2·5 fee units; and (c) if it is necessary to use equipment that is not in the organisation's possession to inspect the health information, the organisation's reasonable costs incurred in obtaining the equipment; and (d) if the health information is contained in a document not stored at the organisation's usual place of business, 1·2 fee units.
2	Viewing health information, with no explanation of contents	The total of the following amounts— (a) 1·2 fee units per half hour (to be calculated in increments of quarter hours or parts thereof) in respect of supervision time of inspection; and (b) the organisation's reasonable costs incurred in assessing and collating the health information, not exceeding 2·5 fee units; and (c) if it is necessary to use equipment that is not in the organisation's possession to inspect the health information, the organisation's reasonable costs incurred in obtaining the equipment; and (d) if the health information is contained in a document not stored at the organisation's usual place of business, 1·2 fee units.

Note: Section 32(4) of the Act provides that a person who gives an explanation of health information under section 29(1)(d) of the Act may charge a fee for the service that does not exceed the amount of the person's usual fee for a consultation of a comparable duration.

3	Receiving a copy of health information	The total of the following amounts— (a) if a copy is in the form of black and white A4 pages, 20 cents per page; and (b) if a copy is in a form other than a black and white A4 page, the organisation's reasonable costs incurred in providing the copy; and (c) the organisation's reasonable costs incurred in assessing and collating the health information, not exceeding 2·5 fee units; and

		(d) if the health information is contained in a document not stored at the organisation's usual place of business, 1·2 fee units; and (e) if the person requests the copies to be posted, the actual postage costs incurred by the organisation.
4	Receiving an accurate summary of health information	The total of the following amounts— (a) if the organisation is a health service provider and an accurate summary does not exist before the request is made, an amount (not exceeding 9·4 fee units) that is calculated by reference to the time taken to prepare the accurate summary— (i) based on the usual fee of the health service provider for a consultation of a comparable duration; or (ii) at the rate of 2·9 fee units per quarter hour (or part of a quarter hour)— whichever is the greater; and (b) if the organisation is not a health service provider and an accurate summary does not exist before the request is made, the organisation's reasonable costs incurred calculated by reference to the time taken to prepare the accurate summary, not exceeding the lesser of— (i) 2·9 fee units per quarter hour (or part of a quarter hour); or (ii) 9·4 fee units; and (c) if the health information is contained in a document not stored at the organisation's usual place of business, 1·2 fee units; and (d) if the person requests the summary to be posted, the actual postage costs incurred by the organisation.

SCHEDULE 2

Maximum Fee for Making Health Information Available to Another Health Service Provider

Item No.	*Manner of access under HPP 11.1*	*Maximum fee*
1	Provision by a health service provider of a copy of health information to another health service provider	(a) If the copy consists of at least 20 black and white A4 pages, 20 cents per page; (b) if the copy is in a form other than a black and white A4 page, the health service provider's reasonable costs incurred in providing the copy.
2	Provision by a health service provider of an accurate summary of health information to another health service provider	If an accurate summary does not exist before the request is made, and it takes the health service provider at least a quarter of an hour to prepare an accurate summary, an amount (not exceeding 9·4 fee units) that is calculated by reference to the time taken to prepare the accurate summary— (a) at the rate of 2·9 fee units per quarter hour (or part of a quarter hour); or (b) based on the usual fee of the health service provider for a consultation of a comparable duration— whichever is the greater.

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