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The Public Interest in Health Care

Qualified Privilege

Issues Paper

August 2001

The Australian Council for Safety and Quality in Health Care was established in January 2000 by all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. Council reports annually to Health Ministers.

This document is an attachment to Council's second report to Health Ministers - *Safety in Practice — Making Health Care Safer, Second Report to the Australian Health Ministers' Conference 1 August 2001*.

Further information on the work of the Council can be found at www.safetyandquality.org or from Council Secretariat tel 02 6289 4244, fax 02 6289 8470 or email safetyandquality@health.gov.au

Acknowledgments

The Australian Council for Safety and Quality in Health Care would like to acknowledge the role played by the Standards and Accreditation Working Group of Council, in particular Dr Heather Wellington, in the production of this report and the contribution of Council and the State Quality Officials Forum in the process to produce this document.

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RECOMMENDATIONS

It is recommended that Health Ministers:

- **endorse the Council’s view of the continued need for qualified privilege in the current quality improvement environment to encourage greater participation by health care professionals in open and honest review of clinical processes due to concerns about potential litigation;**
- **endorse national principles to underpin qualified privilege schemes and promote greater consistency where appropriate (Appendix 1); and**
- **note national actions to be taken forward by the Council, in conjunction with jurisdictions, in the year ahead to strengthen the integrity of existing qualified privilege schemes. These actions will include:**
 - **information strategies designed to educate both the public and participants of the purpose and scope of qualified privilege schemes. For example, an information brochure developed by a consumer representative organisation and protocols to support participants to effectively use the privilege and comply with obligations;**
 - **production of a report on the objectives, processes and achievements of qualified privilege and the outcomes and improvements resulting from projects protected under qualified privilege legislation; and**
 - **clear articulation of the specific scope of protection intended to be provided by each qualified privilege scheme.**

1. INTRODUCTION

All States, the Australian Capital Territory (ACT) and the Commonwealth have legislation in place designed to:

- maintain the confidentiality of health care safety and quality information collected in defined circumstances; and
- in some States, the Commonwealth and the ACT, protect from civil suit members of safety and quality committees who act in good faith.

While the form of the legislation varies between jurisdictions, it generally protects:

- the confidentiality of individually-identifying information that became known solely as a result of declared safety and quality activities; and
- from civil liability persons engaging in good faith in declared safety and quality committees or activities.

Some of the prevailing legislative regimens specifically limit protection to individually-identifying information. Source documents (for example, medical records) are not protected by this legislation.

The rationale for the introduction of this legislation was that, by eliminating the risk of disclosure of certain information, it would remove barriers that discourage health care professionals from participating freely and openly in peer review and other safety and quality activities.

The legislation is commonly referred to as ‘qualified privilege’ legislation.

Recently, the public interest in maintaining this protection and the effectiveness of current legislative approaches have both been questioned. This paper primarily considers the appropriate balance between the public interest in freedom of information and the public interest in removing barriers to participation by health care professionals in safety and quality programs.

It should be noted that the research underpinning this paper was conducted on behalf of the Commonwealth some 18 months ago and, consequently, the paper does not necessarily reflect more recent developments or publications.

2. THE RATIONALE FOR QUALIFIED PRIVILEGE

2.1 Known Incidence of Preventable Adverse Events

The occurrence of adverse events in health care and the need to develop strategies to improve safety and quality has been identified in the literature for at least three decades.^{1,2} The increasing technical sophistication of modern health care, the capacity for patients to be harmed by health care interventions and the complex systems from within which health care is delivered have made this need more acute.

¹ Shimmel EM, The hazards of hospitalisation. *Ann Intern Med* 1964;60:100-101.

² Wilson R, Runciman W, Gibbert R, et al. The quality in Australian health care study. *MJA* 1995;163:458-71.

Most stakeholders believe that the safety and quality of care in the Australian health care system is high. However the Quality in Australian Health Care Study³ identified a high rate of preventable adverse events in Australian hospitals and confirmed the need for ongoing and intensive effort to reduce their incidence and to improve the safety and quality of care. Internationally, there is recognition of a large gap between how health care could perform and how it does perform.⁴ In fact, one commentator has described the excellence of the status quo as a “sentimental illusion.”⁵

Although debate will continue about the extent of the gap between the existing and optimal level of safety and quality in the Australian health care system, there is significant potential to enhance its performance through a more systematic and comprehensive approach to a clearly identified problem.

2.2 The Need for Medical Participation in Safety and Quality Programs

All effective safety and quality programs are critically dependent on the support and involvement of those providing the service under review. This is recognised in manufacturing and airline industry environments. The following quote is from Wilson and Goldschmidt: “Quality Management in Health Care”:

*“The Mercedes factory takes quality control very seriously indeed ... unlike the current situation in our hospitals, the quality program involves the entire factory and everyone working in it. The quality control program is not something left to the whim of the professional engineers and we certainly do not find the fragmented arrangements so common in hospitals, where one group of professionals may be engaged in some quality management activity but not the remainder. The idea that key professionals, such as the medical staff, could opt out of a total quality control program, when translated to the environment of the Mercedes factory, would be seen as ludicrous.”*⁶

The need for active professional participation in assessing and improving safety and quality is especially important in relation to complex health care services, where:

- the gathering and interpretation of a great deal of relevant information cannot be performed accurately without direct professional participation; and
- the implementation of remedial strategies has been shown to depend on the involvement of medical practitioners in the process of assessing their own practices.⁷

Without medical participation, there is little likelihood of improving the safety and quality of care.⁸ Therefore, involvement of the medical profession is a key prerequisite to effective safety and quality programs in health care.

³ *Ibid.*

⁴ Berwick D. Medical associations: guilds or leaders? *BMJ* 1997; 314:1564.

⁵ Physicians as leaders in the improvement of health care systems. *Ann Int Med* 1998;128:289-292

⁶ Wilson L and Goldschmidt P. Quality Management in Health Care. In: Commitment to Quality Enhancement. The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care, 28 April 1998.

⁷ O’Neil AC et al. Physician reporting compared with medical-record review to identify adverse medical events. *Ann Internal Med* 1993;119:370-6.

2.3 Medical Attitudes to Safety and Quality Programs

Early approaches to improving health care safety and quality were focussed on the doctor-patient interaction and primarily took the form of medical peer review, which was advocated from very early in the 20th century as an aid to the systematic improvement of hospital treatment.⁹ The focus was primarily on the technical expertise and interpersonal skills of doctors.¹⁰

Despite the early advocacy of peer review, the medical profession was relatively slow to adopt it on a systematic basis. The Federal Minister for Health is reported to have threatened, in 1976, that the Australian Government would institute peer review if the medical profession did not do so within three years.¹¹ In 1981 it was reported in the United Kingdom that “Some members of the medical profession maintain that such pressures [public and parliamentary, to bring medical practice under closer scrutiny] are to be resisted without argument and without compromise, and that we should have nothing to do with medical audit, quality control or whatever”.¹²

Difficulty in engaging doctors in safety and quality programs remains a common complaint by other practitioner groups and managers in Australian hospitals. While participation by medical practitioners is thought to have increased significantly over the past two decades, assisted and encouraged by the leadership of professional colleges, health care organisations and bodies such as the Australian Council on Healthcare Standards, attitudes vary. Many physicians remain sceptical about the motivation for and the utility of safety and quality programs.¹³

In addition, a major barrier to participation by the medical profession in safety and quality programs is fear of exposure of less than optimal practices or results. This fear is contributed to by:

- a prevailing medical culture that personalises error and seeks and expects perfection in clinical care;^{14,15}
- public and media attitudes to accountability of the medical profession that tend to be individually focussed, punitive and blame-based;
- health care professionals’ concern that safety and quality data are generally not risk adjusted or scientifically validated and may be subject to inappropriate interpretation by the public or the media; and
- the potential for adverse medico-legal consequences from exposure of data generated through safety and quality programs.

The need to modify medical cultural expectations and thereby to enhance efforts to improve health care safety and quality has been widely recognised. Medical peer review has, however, been

⁸ Greco PJ, Eisenberg JM. Changing physicians’ practices. *NEJM* 1993;329:1271-4.

⁹ McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethics. *BMJ* 1983;287:1921.

¹⁰ Laffel G. The case for using industrialised quality management science in health care organisations. *JAMA* 1989;262:2870.

¹¹ Cass M, Brook CW. Quality assurance: a state perspective. *Aust. Clin. Rev.* 1990;10:129.

¹² McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethics. *BMJ* 1983;287:1921.

¹³ Black D. Apples of discord. In: Chassin M. Improving the quality of care (quality of health care). *NEJM* 1996;335(14):1063.

¹⁴ Hilfiker D. Facing our mistakes. *NEJM* 1984;310(2):118-22.

¹⁵ McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethics. *BMJ* 1983;287:1919-1923.

characterised as reactive, inappropriately individualised and punitive.¹⁶ Increasingly, the need for a multi-disciplinary approach that removes the focus from the individual practitioner and reflects the complexity of interactions contributing to each health care intervention has been recognised.¹⁷

Contemporary approaches to health care safety and quality:

- are multi-disciplinary in focus;
- emphasise learning rather than punishment; and
- explicitly recognise the systemic, rather than the individual, basis of sub-optimal performance.

However, these approaches, while fostering more conducive organisational environments, do not address fears of medico-legal consequences or adverse public perception as a result of disclosure of individually-identifying information generated through safety and quality programs.

These fears create a particularly pernicious disincentive to medical participation in health care safety and quality programs. The potential for individualised medico-legal or adverse public perception consequences from participation is incompatible with the goal of fostering non-punitive, systems-based improvements. It is hardly surprising that doctors (and to a lesser extent other health care professionals) have identified confidentiality as a fundamental prerequisite to their participation.

However, an inevitable tension is created between:

- the need to improve the effectiveness of health care safety and quality programs by removing medical practitioners' fears that information they contribute will be used to their detriment; and
- the public interest in accessing information about the safety and quality of the health care system.

3. COMPETING PUBLIC INTERESTS

The state of our health care system consistently rates as the first or second most important public issue for Australians. There is clearly a strong public interest in ensuring that the system provides care of the highest possible safety and quality. If health care safety and quality programs are impeded by lack of participation by health care professionals, there is a consequential public interest in removing known barriers to participation. This is the basis for the argument that there is a public interest in maintaining the confidentiality of information generated through health care safety and quality programs, if that confidentiality is a prerequisite to effective participation by health care professionals in those programs.

However, the public interest in encouraging participation by health care professionals in safety and quality programs needs to be balanced against the public interest in access to information.

¹⁶ Leape L. Error in medicine. JAMA 1994;23:1853.

¹⁷ Enthoven AC, Vorhaus CB. A vision for quality in health care. Health Affairs 1997;16(3):48.

The trend towards freedom of information (FOI) commenced in the United States of America in 1966 when legislation was enacted first at a federal level and subsequently by each state.¹⁸ The development was followed in Australia with enactment of the Commonwealth FOI Act in 1982. The debate surrounding the introduction of FOI legislation in Australia concerned the merits of open and accountable government versus the potential for FOI legislation to render our Westminster system of government inefficient and inoperable through suppressing ‘frank and candid discussions’ between Ministers and their departments.¹⁹

The basis of FOI legislation is an absolute right in any person to access “government” documents. This right is limited only by a small number of exemptions.

Consistent with the trend towards FOI, many health care systems are developing frameworks for the public reporting of their performance. The publication of health care performance data has been proposed as a direct stimulus to improving health care safety and quality through the enhancement of competition in health care markets.²⁰ It has also been promoted as a tool to enhance consumer empowerment, individual choice and public accountability for health care expenditure.

Many states in the United States of America routinely publish outcome data. In the United Kingdom, the National Health Service (NHS) fulfilled a commitment to publish information about the results achieved by each part of the NHS with the June 1999 publication of comparative data for six clinical indicators for all NHS trusts and health authorities.²¹ Publication of more specific indicator data is planned as they become available.

Public reporting of individual provider performance has, however, been recognised as a “two edged sword whose effects can motivate and reward but also discourage and punish.”²² Leatherman and McCarthy propose that public reporting should be viewed as distinct from but interrelated to quality improvement approaches that focus on collaborative efforts to correct systemic problems.²³

In terms of fundamental principles, there is considerable overlap between the public interest rationale for health care qualified privilege legislation and the exemption provisions in FOI legislation. In effect, FOI legislation is based on a philosophy of openness and accountability of government agencies and contains specific, limited exemptions to the release of information based on public interest considerations. Health care qualified privilege legislation recognises a class of documents for which there is considered to be an overriding public interest in maintaining confidentiality.

While FOI exemption clauses may protect confidentiality of documents on the basis of public interest, reliance on these clauses requires a document by document analysis to determine whether they meet specific exemption criteria. It cannot be assumed that, were they subject to individual analysis, all documents to which health care qualified privilege protection may otherwise apply would meet the requirements necessary for exemption from release under the various State and

¹⁸ Streets S. *Administrative law*. Melbourne: Butterworths, 1997. 223.

¹⁹ *Ibid.*

²⁰ Phillips Fox and Casemix Consulting. *Health services policy review discussion paper*. March 1999: 120.

²¹ National Health Service. *Quality and Performance in the NHS. High Level Performance Indicators and Clinical Indicators*. June 1999.

²² Leatherman S, McCarthy D. *Public disclosure of health care performance reports: experience, evidence and issues of policy*. *International Journal for Quality in Health Care* 1999;11(2):96.

²³ *Ibid.*

Commonwealth FOI legislative regimens. In any event, exemption from release under FOI legislation will not protect from discovery in court or tribunal proceedings.

Nevertheless, FOI exemption clauses have been effective in limited circumstances in preventing disclosure of health care safety and quality information, on the basis that such disclosure would impede the future flow of information and therefore would be against the public interest. These decisions are consistent with the underlying public interest rationale of qualified privilege legislation.

4. JUDICIAL ATTITUDES TO QUALIFIED PRIVILEGE

The effect of specific health care qualified privilege legislation has rarely been tested in Australian courts or tribunals. In a limited number of cases, however, courts and tribunals have considered requests to maintain the confidentiality of information generated through health care safety and quality programs.

In the inquest into the death of Adolf Herman, the Victorian Coroner's Court considered the public interest in the confidentiality of documentation relating to health care safety and quality. Counsel appearing on behalf of the family sought documents relating to the deceased's care that had been generated through a hospital quality activity. The application for production was opposed by Counsel appearing on behalf of the hospital, on the basis that to order production would be against the public interest. It was suggested to the Court that a failure of confidentiality would compromise patient treatment in the future and investigations as to alternative and, hopefully, better forms of management. The Deputy State Coroner accepted this argument, holding that the public interest in maintaining uncompromised patient care in the future and improvements in hospital procedures and protocols must prevail over the desirability for the disclosure of "every bit of evidence" relevant to the deceased's management.

The public interest in maintaining confidentiality of some classes of information about health care safety and quality has also been accepted by the Victorian Civil and Administrative Tribunal (VCAT).

In a 1998 Freedom of Information application to VCAT,²⁴ journalists from The Age newspaper sought release of a range of documents relating to safety and quality programs at the Inner & Eastern Health Care Network, The Alfred Hospital, Peter MacCallum Cancer Institute, Box Hill Hospital, Maroondah Hospital and The Angliss Health Service. Arguments against release were based on FOI exemption clauses rather than on qualified privilege legislative provisions (the relevant qualified privilege provisions of the Health Services Act 1988 being, in any event, ineffective to protect all of the documents from release). The case incorporated a very useful discussion on the competing public interests in these circumstances.

Deputy President McNamara identified the following public interests:

- in public hospitals being open to scrutiny of their management;
- in enhanced accountability of such hospitals;

²⁴ Tribunal Application No. 1998/082805.

- in promotion of consumer rights amongst users of health care services;
- in permitting the public to be informed as to the occurrence of adverse medical events and programs such as quality improvement programs in these institutions; and
- in non-disclosure where disclosure would be reasonably likely to impair the collection of similar information in the future which would show clinicians in a bad light.

He suggested that public confidence is likely to be enhanced in hospitals and medical practitioners who are seen to be candid and forthcoming rather than secretive.

Nevertheless, he agreed that in circumstances where material identified:

- particular individuals; or
- small units that indirectly had the capacity to identify individual practitioners or patients because of the relatively small number of individuals to whom the anonymous references might apply,

based on the evidence before him, clinician resistance and apprehension would be sufficient to create the necessary prejudice to further information gathering that would justify non-disclosure.

He was sceptical about claims that the release of aggregate, non-identifying data that did not disclose practices relating to individual clinicians or individual incidents relative to individual patients would have the effect of discouraging clinicians from providing similar information in the future. He suggested that “members of the medical establishment are given to excessively pessimistic predictions on these sorts of matters.”

It should be noted that the relevant exemption under Victorian FOI legislation required the agency to demonstrate both that the information in the document was communicated in confidence and that the release of the information would be contrary to the public interest for the reason that its disclosure “would be reasonably likely to impair the agency’s ability to obtain similar information in the future.”

Involvement of medical practitioners in safety and quality programs at The Alfred Hospital was reported to have substantially decreased as a consequence of the decision in this case to release some non-individually identifying material. This confirmed the significance of the qualified privilege legislation to medical practitioners and their view of the importance of its integrity. In the ACT Administrative Appeals Tribunal, in *Waterford John E and Department of Health*,²⁵ President Curtis found that disclosure of individual obstetricians’ caesarean section rates could be expected to have an unreasonable adverse effect on the obstetricians’ professional interests and therefore disclosure was not permitted. However he noted that if there were no other grounds of exemption preventing release of documents, as there were in this case, the threat of an information boycott by doctors would frustrate the public interest purposes of the FOI Act. He suggested that there might be other cases where the overall public interest would require disclosure notwithstanding the likelihood of an information boycott.

²⁵ [1995] ACTAAT 104.

These interpretations of the appropriate balance of the public interest reflect the balance promoted by qualified privilege legislation, which, in most cases:

- limits confidentiality to information that is individually identifying; and
- has an overriding requirement that the Minister be satisfied that declaration of an activity or a committee is in the public interest.

On the other hand, these cases demonstrate that some members of the medical profession consider that qualified privilege legislation should protect the confidentiality of aggregate, non-identifying information, as well as that of individually identifying information. This raises the possibility that the various legislative regimens are or will be inadequate to allay the profession's concerns.

5. INTERNATIONAL TRENDS IN QUALIFIED PRIVILEGE

In the United Kingdom (UK) there has been considerable concern about the effectiveness of health care safety and quality measures following public disclosure of poor clinical outcomes and inadequacy of quality control systems in the Bristol Royal Infirmary's paediatric cardiac surgical program. Professional self-regulation has been widely perceived to be inadequate. The recently developed clinical governance framework for UK hospitals reflects this concern and defines accountability structures for setting, maintaining and monitoring clinical standards, including a requirement for systems of clinical risk management and audit.

In the UK, audit activities are not protected by statute or case law. The merits of qualified privilege have been debated in the medical literature with the Australian qualified privilege regimen being cited as successful and calls being made to amend the law to remove this impediment to raising clinical standards.²⁶

Although they vary in form, every state of the United States of America, except one, has enacted legislation protecting from discovery various records and deliberations of peer review committees.²⁷ However, the adequacy of these protective regimes has been questioned because of the release, in one state, of peer review information under federal legislative provisions, despite its protection under state law.

In a 1999 suit brought under federal law by the parents of a baby who died following referral from a rural Californian hospital, state-based qualified privilege legislation was insufficient to prevent disclosure of information generated from medical peer review of the baby's management. The United States District Court ruled that the state law precluding discovery of documents did not apply because it was pre-empted by federal rules of discovery. The Californian Supreme Court²⁸ refused to intervene in the District Court's ruling that peer review documentation relating to the management of the child was discoverable, prompting considerable alarm among health care practitioners, hospitals and their professional organisations.

²⁶ Beresford N, Evans T. Legal safeguards for the audit process. *BMJ* 1999;319:654-655.

²⁷ Kohn, LT, Corrigan JM and Donaldson MS. To err is human. Building a safer health system. Committee on Quality of Health Care in America. 1999. Institute of Medicine. 103.

²⁸ *Redbud Community Hospital vs. USDC for Northern California*, 98-1513 and *Schug vs. Burrows*, 98-1526.

The arguments for and against disclosure in this case reflected the competing public interests in the accountability of health care organisations and the removal of barriers to medical participation in safety and quality programs. The Californian Medical Association, the Californian Academy of Family Physicians, the Californian Health Care Association and the American Medical Association joined in the unsuccessful appeal to the Supreme Court. The question of how to ensure an appropriate level of coverage through a federal qualified privilege scheme was then referred to Congress.

The decision described above rested on the particular facts of the case and the prevailing legislation. However, by their vigorous pursuit of qualified privilege in this case, the various medical and hospital associations clearly demonstrated their belief that the confidentiality of peer review information deserved legislative protection.

In the late 1990s, New Zealand undertook a review of Part VI of its Medical Practitioners Act 1995, which is modelled on Australian qualified privilege legislation. The Medical Practitioners Act 1995 (New Zealand) provides for declaration of quality improvement activities when it is in the public interest to do so. The review recommended continuation of the legislation.

Issues raised during the New Zealand review that were of relevance to Australia include:

Issue	Conclusion
Whether the definition of quality assurance activities in the Act provides sufficient assurance that findings of quality assurance activities would be actively acted upon to ensure improved health services	<p>Specifying the type of feedback and actioning mechanisms in regulation is likely to create unnecessary restriction on quality activities</p> <p>A condition of declaration should be a requirement to provide the sponsors of the activity, and in the case of hospitals, hospital management, with quarterly reports and the Minister of Health with an annual report. These reports should be issues and action based.</p> <p>Criteria on which a declaration may be revoked should include failure to report or unsatisfactory reporting or failure to make satisfactory progress in the activity.</p>
Whether the Minister's power to authorise disclosure of information in limited circumstances (for the purposes of investigation and prosecution of offences, for the purposes of a Royal Commission or for the purposes of a commission of inquiry appointed by an Order in Council made under the Commissions of Inquiry Act 1908) should continue.	No amendment recommended.
Whether credentialling should be included as part of a 'declared' quality assurance activity	If credentialling activities fulfil the definitional requirements of the Act and are in the public interest, they may be declared.
Whether quality assurance activities should be declared on a case by case basis, or whether a more generic system should be adopted	The present system of declaring quality assurance activities on a case by case basis should be retained.

6. COMMONWEALTH QUALIFIED PRIVILEGE LEGISLATION

The Health Insurance (Quality Assurance Confidentiality) Amendment Act 1992 (the Act) inserted Part VC into the Health Insurance Act 1973. The object of Part VC is to encourage efficient quality assurance activities in connection with the provision of certain health services.

The relevant provisions were carefully drafted to reconcile:

- the need to remove a disincentive for health care professionals to participate in safety and quality programs; and
- the public interest in freedom of information.

The Minister must not declare a quality assurance activity to be one to which Part VC applies unless he is satisfied that the quality assurance activity is being or will be conducted by a person who is appropriately authorised to do so (section 124X(3)(a)) and that it is in the public interest that the activity be declared (section 124X(4)).

The legislation seeks to achieve the required balance in the public interest by:

- ensuring confidentiality of individually-identifying information to facilitate its continuing availability (s.124Y);
- protecting the persons engaged in declared quality assurance activities from civil liability (s.124ZB);
- supporting freedom of information sufficient to meet the public interest in accountability of health care organisations by:
 - limiting application of the Act to declared quality assurance activities (s.124X);
 - limiting protection from disclosure to individually-identifying information (s.124Y(3)); and
 - requiring publication of non-individually identifying information unless the Minister is satisfied on reasonable grounds that it is not appropriate to disclose the information (reg.23C).

The key features of the Commonwealth legislation are:

Key Feature	Public Interest	
	Improving the effectiveness of quality assurance activities by maintaining participation and information flow	Public accountability and freedom of information
A provision for quality activities to be declared by the Commonwealth Minister for Health when he or she is satisfied that a declaration is in the public interest (s.124X).	✓	✓
A requirement that the protection of the Act is a pre-requisite to the effectiveness of the activity (regs. 23E(2) and 23F(2))	✓	✓
A requirement that no record be made of information that is known only through the conduct of declared activities (except for the purposes of those activities) (s.124Y(1)).	✓	
A requirement that information known only as a result of declared quality assurance activities or documents brought into existence solely for the purposes of declared quality assurance activities not be disclosed to another person or to a court (s.124Y(1) and (2)(b)) or produced to a court (s.124Y(2)(a)).	✓	
Exclusion from protection for non-individually identifying information (s.124Y(3)).		✓
A requirement for disclosure of non-individually identifying information (reg. 23C).		✓
Provision for the Minister to release factual information about serious criminal offences (s.124Z).		✓
Protection of members of credentialling committees that conduct their activities in good faith and according to procedural fairness ((s.124ZB and reg. 23G).	✓	✓

7. STATE AND TERRITORY APPROACHES TO QUALIFIED PRIVILEGE

All states and the Australian Capital Territory (ACT) have enacted qualified privilege legislation.²⁹

The Commonwealth legislation is intended to provide a system that complements, rather than replaces, state-based legislation (section 124ZC). Quality activities are generally only declared under Commonwealth legislation if they are:

- conducted in jurisdictions where no qualified privilege legislation is available; or
- activities in which practitioners from several states are participating.

In limited circumstances, specified in the regulations accompanying the Act, an activity that is conducted in one state or territory may be declared by the Minister to be an activity to which the legislation applies (regulation 23E).

Generally, state and territory legislation provides for the granting of qualified privilege to approved quality assurance or quality improvement committees. This contrasts with the Commonwealth legislation, which provides for qualified privilege to be linked to declared activities that can be described by reference to:

- the nature of the activity;
- a person who is engaging or proposes to engage in the activity; and/or
- the circumstances in which the activity is being, or is proposed to be, engaged in.

Like the Commonwealth legislation, legislation in all states (with the exception of South Australia) and the ACT specifically requires that the Minister is satisfied that:

- the functions of the committee would be facilitated by the immunities provided in the legislation; and
- it is in the public interest that the immunity be provided

before a committee can be declared for the purposes of attracting the benefit of the immunities.³⁰

²⁹ ACT Health Act 1993, NSW Health Administration Act 1982 (ss.20D-20K), Qld Health Services Act 1991 (ss.30-38), South Australian Health Commission Act 1976 (s.64D), Tas Health Act 1997, Vic Health Services Act 1988 (s.139), WA Health Services (Quality Improvement) Act 1994

³⁰ ACT Health Act 1993 s.13AC(2)(d) and (e) (private sector quality assurance committees only), NSW Health Administration Act 1982 s.20E(2)(d) and (e), Qld Health Services Act 1991 s.31(3)(d) and (e), Tas Health Act 1997 s.4(2)(c) and (d), Vic Health Services Act 1988 s.139(2)(c) and (d), WA Health Services (Quality Improvement) Act 1994 s.7(2)(d) and (e).

Key features of the various state, ACT and Commonwealth acts are described in the following table:

	Activity based immunity	Committee based immunity	Activity must be facilitated by declaration	Public interest requirement for declaration	Members not to make record or divulge	Reports or info. not to disclose identity of individual	Evidence not admissible	Members not required to produce docs or provide info	Confidentiality only for individually identifying info	Provision to require non-identifying info to be disclosed	Members protected from suit
Comm	✓		✓	✓	✓			✓	✓	✓	✓
ACT		✓	✓	✓		✓	✓	✓			✓
NSW		✓	✓	✓	✓	✓	✓	✓		✓	✓
QLD		✓	✓	✓	✓	✓	✓	✓		✓	✓
TAS		✓	✓	✓	✓		✓	✓			
VIC		✓	✓	✓	✓		✓	✓	✓		
WA		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SA	The SA Act does not provide for activity or committee-based immunity. It provides persons involved in assessing and improving the quality of health care services with access to confidential information for that purpose. The Act restricts a court, tribunal or board from asking questions to obtain information revealed under this section and a person is not required to answer such a question. If a person does answer such a question or any information is volunteered that answer or information is not admissible.										

8. QUALIFIED PRIVILEGE AND FREEDOM OF INFORMATION

Commonwealth FOI legislation sets out a number of acts that take precedence over it. The Health Insurance Act is not included and therefore it appears, on initial assessment, that an FOI application for the release of documents otherwise protected by qualified privilege legislation may succeed. Unless the relevant qualified privilege legislation specifically states that protected information is not accessible under FOI legislation, the better view is that FOI legislation will apply.

Although not specifically researched, it is likely that a similar situation applies in some states.

This apparent anomaly needs to be reviewed in the context of a reassessment of the public interest arguments underpinning qualified privilege legislation. Many health care professionals and managers believe that declaration of their safety and quality activities under Part VC of the Health Insurance Act 1992 or declaration of their committees under the relevant state legislation protects against release of information under FOI legislation. If it is accepted that the balance of public interest lies in continuing the protection of confidentiality of some health care safety and quality information, because disclosure of such information will prejudice its ongoing availability, then such protection needs to be complete. Accessibility of such information through FOI legislation will jeopardise its future collection in the same manner as discovery through court and tribunal processes.

9. CONCLUSION

There is a clear tension between the competing public interests of:

- freedom of information; and
- removal of a barrier to health care professionals' participation in effective safety and quality programs, by providing for confidentiality of some information generated by those programs.

The objective of qualified privilege legislation is to improve participation by health care professionals in safety and quality programs. By removing an identified barrier to this participation, it necessarily reduces access to some categories of information – information that may be of great interest and relevance to the public and to individuals.

FOI legislation itself, however, also recognises, through exemption clauses, that there are some categories of information for which disclosure would not be in the public interest. Judicial decision-making in relation to health care safety and quality information has also recognised circumstances in which the public interest requires that such information should remain confidential.

Most legislative regimens attempt to redress the reduction in access resulting from qualified privilege legislation by:

- limiting the available protection to defined categories of information; and
- requiring reporting and publication of aggregate, non-individually identifying information.

It is submitted that most of the current qualified privilege legislative regimens achieve, through these mechanisms, an appropriate balance between the competing public interests. The relationship between qualified privilege legislation and FOI legislation, however, is unclear. In addition, there are considerable differences between jurisdictions in the extent of protection provided by qualified privilege legislation.

10. NEXT STEPS

There has been significant discussion amongst jurisdictions about the rationale and need for qualified privilege and the effectiveness of current legislative schemes. These discussions have been based on the issues raised in:

- this paper;
- the ‘Qualified Privilege for Quality Improvement Committees & Programs in Health – Issues Paper for comment’ developed by NSW Health; and
- the ‘Final Report of the Review of the Achievements of the Commonwealth Statutory Immunity Scheme’ prepared by Dr Heather Wellington, Corrs, Chambers, Westgarth Lawyers.

From these discussions it is recommended that Health Ministers:

- endorse the Council’s view of the continued need for qualified privilege in the current quality improvement environment to encourage greater participation by health care professionals in open and honest review of clinical processes due to concerns about potential litigation;
- endorse national principles to underpin qualified privilege schemes and promote greater consistency where appropriate (Appendix 1); and
- note national actions to be taken forward by the Council, in conjunction with jurisdictions, in the year ahead to strengthen the integrity of existing qualified privilege schemes. These actions will include:
 - information strategies designed to educate both the public and participants of the purpose and scope of qualified privilege schemes. For example, an information brochure developed by a consumer representative organisation and protocols to support participants to effectively use the privilege and comply with obligations;
 - production of a report on the objectives, processes and achievements of qualified privilege and the outcomes and improvements resulting from projects protected under qualified privilege legislation; and
 - clear articulation of the specific scope of protection intended to be provided by each qualified privilege scheme.

NATIONAL PRINCIPLES TO UNDERPIN QUALIFIED PRIVILEGE

- **Qualified privilege schemes should seek to strike an appropriate balance between the public interest in access to information, and the public interest in removing barriers to participation by health care professionals in meaningful safety and quality activities.**
- **Organisations and individuals that benefit from qualified privilege should have a corresponding duty of openness to publish or disclose non-individually identifying information obtained in the course of the safety and quality activity. Specific requirements should be established to disclose to the public meaningful, non-individually identifying information about safety and quality activities.**
- **Qualified privilege should provide specified protection against defamation and certain other forms of civil litigation to participants of effective safety and quality activities.**
- **The sort of information that is accorded protection through qualified privilege should be clearly specified for each qualified privilege scheme.**
- **An avenue should be available for referral to appropriate professional, administrative and legal bodies where there is evidence that:**
 - **a serious offence may have been committed; and**
 - **there are serious and continued variations in performance from what would be regarded as an acceptable standard of care.**
- **Participants of protected activities and the broader community should be aware of qualified privilege schemes and have a clear understanding of the scope of protection provided by the legislation.**
- **The application and monitoring of compliance with the legislation needs to be administratively simple and transparent to both the public and the health care industry.**