



Request for surgical complications data

Legislation	Official Information Act 1982, ss 9(2)(a), 18(f), 18(g)
Requester	Martin Johnston, New Zealand Herald
Agencies	Southern District Health Board Auckland District Health Board Waikato District Health Board Capital & Coast District Health Board Canterbury District Health Board
Request for	Complications data by named cardiothoracic surgeon and neurosurgeon
Ombudsman	Professor Ron Paterson
Case numbers	402136/402138/402140/402142/402144
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Summary

The New Zealand Herald made a request to five District Health Boards (DHBs) for information about the nature and outcomes of public hospital work by cardiothoracic surgeons and neurosurgeons. The DHBs refused the request in order to protect the privacy of the surgeons and because the information could not be made available without substantial collation or research.

Under the Official Information Act 1982 (OIA), the DHBs should not have refused the request for the number and type of procedures performed by individual surgeon. Surgeons have a low privacy interest in such information, outweighed by public interest considerations favouring disclosure. Concerns about the limitations of the information can be addressed by providing explanatory information.

However, the DHBs were entitled to refuse the request for standardised, risk-adjusted information relating to major complications, readmissions and deaths, since that information is not currently held. The DHBs were also entitled to refuse the request for numbers and crude rates relating to major complications, readmissions and deaths at individual surgeon level.

Releasing individual surgeons’ outcomes data in its current state would do more harm than good given the current state of information in the New Zealand health sector. Public reporting

of data that is misleading, incomplete or otherwise of poor quality could erode public confidence in the health system, undermine teamwork and result in surgeons seeking to avoid complex procedures.

New Zealand lags behind other comparable healthcare systems in disclosure of performance and outcomes information. Professionalism in a 21st century doctor should include a commitment to the collection and publication of meaningful outcomes data. Professional colleges, such as the Royal Australasian College of Surgeons, have an important leadership role to play.

It is, however, encouraging to see a greater commitment within the health sector to collect, analyse and publish data on the outcomes of healthcare interventions.

The Ombudsman has recommended that the DHBs release the numbers and types of procedures performed by individual surgeons, and that the Ministry of Health and Health Quality & Safety Commission provide publicly available, annual updates, from June 2017, on progress towards publication of meaningful quality of care measures across specialties by June 2021.

Background

The request

1. In December 2014, a journalist from the New Zealand Herald, Martin Johnston, emailed the Southern, Auckland, Waikato, Capital & Coast, and Canterbury DHBs with the following request:

I seek information from your DHB regarding the work done at its premises by vocationally registered cardiothoracic surgeons and neurosurgeons.

I seek information in respect of each vocationally registered cardiothoracic surgeon and neurosurgeon, listed by name of the surgeon and for the financial years 2012/13 and 2013/14:

1. *The number of surgery cases (patients), broken down by type of surgeries,*
2. *The number of patients who had surgery and experienced major complications,*
3. *The number of patients who had surgery and were readmitted to a hospital within 30 days of discharge,*
4. *The number of patients who had surgery and died within 30 days of discharge from hospital.*

In addition to the numbers in the answers to questions 2, 3, and 4, I seek the crude rates of complications, readmissions and mortality for each surgeon; and if they have been calculated, the standardised rates of complications,

readmissions and mortality adjusted for case mix, complexity or other factors that might reflect different patient risk profiles in each surgeon's patient group.

2. Mr Johnston had also forwarded his request to the Ministry of Health and the Health Quality & Safety Commission (HQSC), in case it should more properly be considered by them. He commented that the United Kingdom's National Health Service (NHS) had begun publishing the kind of information he was requesting.

Responses from DHBs

3. The five DHBs consulted each other before responding to Mr Johnston in March 2015. Although the DHBs responded individually, their explanations as to how they had dealt with the request were largely the same. The DHBs did not cite specific grounds under the OIA for refusing Mr Johnston's request.

4. The Southern, Waikato, Capital & Coast, and Canterbury DHBs advised Mr Johnston:

The information you have requested represents, with current systems, a complex data extraction followed by an analysis that is not possible. In particular the system from the NHS requires adjustments to the raw mortality figures based on other clinical information not currently readily available here. It has not proved possible therefore to supply the information that you request.

In order to produce the type of reporting that the NHS has we need to start with clinically accurate data collected as part of the process of care. The good news is that work commenced last year to do exactly this for cardiac interventions. A specialised data collection system has been commissioned to cover these interventions which will include the process steps and outcomes in some depth. This project was recently discussed at a meeting of health professionals and DHB staff led by the Ministry of Health. There was support to extend this type of approach to other interventional speciality areas and an undertaking to explore this further.

Noting the limits on available data and the work required to do complex analysis we have provided information which differs to that you requested. Attached you will find the data related to major cardiac procedures—being that which was definable and classifiable.¹

¹ There were some variations in the information each of the DHBs provided, but in all cases the information was at DHB level, not surgeon specific.

- Southern DHB provided responses to each of the requester's questions for cardiothoracic procedures and neurosurgery. The information was broken down into 6 categories of cardiothoracic procedure with 10 complication types, and 9 categories of neurosurgery with 10 complication types. The information was provided for the years 2012-13 and 2013-14 as requested.

5. In relation to neurosurgical data, the Waikato, Capital & Coast, and Canterbury DHBs stated:

Neurosurgery data is more complex with a wide range of interventions and was therefore not possible without considerable work, and even then has significant limitations as a result of our current systems.

6. Auckland DHB also noted that neurosurgical data was more complex with a wide range of interventions, and said that the information could not be provided without considerable work, for which the DHB would need to charge.
7. All five DHBs advised that they were providing data grouped to DHB level, for the following reasons:
- a. The numbers of procedures per person are at a level that would not allow statistically secure conclusions to be drawn.
 - b. The case type by surgeon will differ meaning that some surgeons will have undertaken cases that were more complex or had greater risk factors, which cannot be accounted for by adjustment. Apparent differences would not reflect real differences in mortality or other outcomes.
 - c. Focus on individual clinicians may lead to changes in case selection and therefore potential avoidable harm to patients. For example, clinicians may feel less willing to take on complex patients because that may lead to an apparent poor outcome rate.
 - d. Focus on individual clinicians may also lead to less active participation in measures to improve quality of care through collection of information, such as that collated for cardiac interventions.
 - e. Clinicians have a reasonable expectation of protection from unfair criticism based on information that is not statistically valid. This is a different situation from when there is already justifiable concern about the practice of an individual.
8. Auckland DHB gave one further reason for providing the information at DHB level:
- f. It is not always possible to specify a single surgeon — for example, there may be a team of surgeons involved in a case, or there may be multiple interventions by different surgeons during one admission.

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- Auckland DHB provided the total number of operations and overall mortality rates for heart transplant patients, all cardiothoracic patients, and all bypass patients. The information was provided by calendar year and financial year.
 - Waikato, Capital & Coast, and Canterbury DHBs provided the total number of operations, deaths in hospital and deaths within 30 days of discharge, for three categories of cardiothoracic surgery (coronary artery bypass graft, aortic dissection and valve replacement). The information from Waikato DHB was by calendar year, and from Capital & Coast and Canterbury DHBs for the years 2012-13 and 2013-14 as requested.

9. The DHBs concluded by suggesting that if Mr Johnston wished to meet with one or two clinical leaders to discuss the matter in more detail, he could contact Canterbury DHB's Chief Medical Officer.

Medical Council of New Zealand discussion paper

10. In March 2015, the Medical Council of New Zealand released a discussion paper to generate debate on the subject of the value of performance and outcome data, and how such data promotes the competence of doctors.²
11. The Medical Council noted the value of publishing reliable and accurate data. It noted its own roles, both in assuring the public that their doctors are competent and fit to practice, and in promoting discussion about the potential benefits of accurate data and establishing principles to define the framework within which information is used.
12. The Medical Council stated:

It is important to examine the arguments for making more performance and outcome data publicly available, particularly where it relates to individual clinicians. It needs to serve more than just a 'right to know' purpose. Given the public have little choice in terms of where they receive publicly funded secondary and tertiary hospital treatment it may be argued that the release of data could be somewhat meaningless in terms of patient choice.

But this could risk ignoring many of the potential wider benefits of better informing the public. Done well, publicly available data should be reassuring to the public, it should encourage better engagement in decision making around service provision, and it should aid informed choice because local outcome figures will be available. Benchmarking to best practice would add significantly to the value of the data.

The populations of our DHBs are not homogenous and therefore neither should be the data we rely on to inform health care decision-making. Again, the complexity of this mandates a carefully considered approach to the whole question of data acquisition and its use, including the public release of data.

The Council therefore believes the profession and stakeholders should determine the nature and context of data to be considered in relation to quality improvement, performance appraisal, and recertification. Separately, the profession and stakeholders should raise with the public the value of releasing data to the public, and what form that data would take.

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² Available at: <https://www.mcnz.org.nz/news-and-publications/media-releases/better-data-the-benefits-to-the-profession-and-the-public/>

Gathered accurately, used correctly and explained well, qualitative data down to individual clinician level could be of considerable benefit to clinicians, administrators, regulators and the public. This does not however answer the question of who should have access to the data? Access should be based on the benefits of such access. These groups may well have differing needs and differing emphasis in terms of data and how it is reported. The Council would encourage the profession, managerial colleagues, the Colleges and the public to engage in meaningful debate around data and how best to use it.

Complaint

13. In April 2015, Mr Johnston complained to the Ombudsman. He noted that other health systems have produced the kind of data he had requested, so it should be possible for the New Zealand DHBs, the Ministry of Health, or the HQSC to build such a system.
14. Mr Johnston responded to the points raised by the DHBs as follows:
 - a. Concern about low numbers of procedures compromising the validity of the information could be addressed by releasing the data in ‘chunks’ of two years or longer.
 - b. Statisticians routinely assign risk weightings to adjust data so that comparisons can be made. Assumptions made are refined over time.
 - c. The risk of individual clinicians altering their case selection should arise only if there is no attempt to adjust the data for patient complexity. Contextual information could be provided, and *‘[the] public would, over time, become familiar with the proper reading of this kind of data’*.
 - d. The risk of surgeons losing trust in the system and withdrawing from quality assurance measures that rely on voluntary reporting is *‘unlikely to happen if the DHBs and the HQSC front-foot the issue and provide robust data that surgeons and the public can rely on’*.
 - e. Similarly, the risk of unfair criticism against a surgeon can be minimised by the production of reliable data. If the criticism is justified, *‘the DHB and the [Medical Council] will have started to deal with the surgeon through competence review and re-training long before the data is made public’*.
 - f. In most operations there is a lead surgeon who holds overall responsibility; relatively few operations involve multiple consultants with roughly equivalent clinical responsibility.
15. Mr Johnston stated that rather than resisting his request, the DHBs should embrace it as the way forward:

In their quest for zero harm in the health system, they should be aiming to produce robust surgeon-specific complication data as an early warning system for DHBs as employers and for the Medical Council as a body charged

with protecting the public from harm in medicine. In reality there will be very few surgeons who are outliers. In the current environment outliers tend to be found out only when a number of patients have experienced and made complaints to the Health and Disability Commissioner. These are necessarily slow processes which could potentially in some cases be obviated by the production of robust data to inform employers and the Medical Council's recertification processes.

Investigation

16. In May 2015, I notified the five DHBs of my investigation. I requested from each DHB a copy of the information at issue to the extent that it was held, and a report setting out the grounds relied on under the OIA to refuse the request and any further comments on the specific prejudice or harm predicted from disclosure of the information.
17. I also advised the Ministry of Health and the HQSC of my investigation, and invited their comments.

Comments during investigation

The DHBs

18. Responses from the DHBs were received between late May and late July 2015.

Auckland DHB

19. Auckland DHB stated that it had not provided the information as it had not been collated.
20. Auckland DHB maintained that it did not refuse the request. Rather, it had explained to the requester that its datasets do not meet the parameters of the request, but in *'the spirit of the request and public transparency'* it had provided data relating to major cardiac procedures.
21. Auckland DHB noted that there was ongoing consultation nationally regarding the disclosure of information about the performance of individual surgeons, and suggested meeting with the Ministry and other DHBs.

Capital & Coast DHB

22. Capital & Coast DHB advised that in preparing its response to the requester, it had extracted approximately 726 pages of information, which includes patients' personal information.

23. Capital & Coast DHB stated that providing all the requested information would have required substantial collation or research, and it was therefore refused under section 18(f) of the OIA.

We believe that to provide the information it will require approximately 100 hours of a senior analyst's time, 25 hours of clinician verification time and five hours of CMO time at an estimated cost of \$10,000.

With regard to the names of clinicians, we have refused this information under s 9(2)(a) of the OIA and having weighed the public interest in disclosing names, believe that it would be more detrimental to public interest in naming these clinicians.

24. In addition to the points outlined in its response to the requester, Capital & Coast DHB raised the following points:

- a. While there is no doubt that Mr Johnston is a responsible reporter who will give a balanced story, the nature of the way in which the media operates is such that *'it is unlikely that the data will be disclosed with the level of detail necessary to explain the complications arising from surgery, or reasons why a patient died'*. Space in news media is limited meaning the full facts cannot be published. Misconceptions will be created, which may lead to *'unfair criticism or judgement of a particular clinician'*.
- b. The reporting of surgeon outcomes does not provide valuable information for the public.³
- c. The Medical Council and the Royal Australasian Council of Surgeons are responsible for ensuring surgeons are practising safely. Unlike the United Kingdom, New Zealand has many forums, accessible to the public, through which surgeons are accountable, including the Health and Disability Commissioner, the Coroner, professional bodies and ACC. Surgeons have a responsibility to provide audit information to their College, and the College has the ability to manage public interests arising from poor performing surgeons.

25. Capital & Coast DHB also noted that it had consulted with its surgeons about the request. Some indicated they had no objection to the release of their information while others *'expressed disquiet'*.

³ The DHB referenced the following article: Walker, K. Neuberger, J., Groene, O., Cromwell, D A, van der Meulen, J. *'Public reporting of surgeon outcomes: low numbers of procedures lead to false complacency'*. *Lancet* (2013); 382: 1674–1677.

Waikato DHB

26. In response to my request for a copy of the information at issue to the extent that it is held, Waikato DHB provided the following in respect of individual cardiothoracic surgeons and neurosurgeons:
- a. the number of procedures, broken down by type;
 - b. the number and crude rate of patients who died before discharge or within 30 days of discharge;
 - c. the number and crude rate of patients readmitted acutely; and
 - d. the number and crude rate of patients who were returned to theatre.

27. The information was separated into acute and elective surgeries, but not by year.

28. Waikato DHB advised that it withheld the requested information in reliance on section 9(2)(a) of the OIA, to protect the privacy of natural persons. Waikato DHB stated:

It is the DHB's view that the number of surgeries performed and complication data sought is part of the private employer/employee relationship. Moreover, the complication data has a high privacy interest for the surgeons. The number of surgeries performed in and of themselves [has] a lower privacy interest.

29. Waikato DHB accepts that surgeons are publicly employed and there is a legitimate public interest in the data sought, but submits that the ground for withholding is not outweighed by other considerations which make it desirable in the public interest to disclose the information. The DHB considers that, given the data that is held, its release would be problematic and likely to have significant adverse consequences.

30. Waikato DHB set out its reasons as follows:

1. Certain information is currently available from hospital records. The primary purpose of this information is to document the types of procedures performed and details of the hospital stay, for funding and operational management purposes. Surgeon information is recorded as well as theatre information, but this is more by way of supplementary information. This information is not reviewed or audited to the extent that would be required for external reporting of individual surgeon performance. Indeed, each speciality within Waikato DHB currently discusses events leading up to adverse individual mortality and morbidity outcomes as part of a continuous quality improvement process. The data for these discussions does not come from the central hospital records, but rather from patient notes collated regularly by the individual speciality.

To this end, the previous Minister of Health (Tony Ryall), has acknowledged the weakness of the current data set and has supported setting up the Dendrite database to assist the New Zealand cardiac

surgeons with quality control. In Waikato DHB, this database now has 6 months of data and will require at least a further 6 months of data before being collated and used to improve quality control. Similar robust database sets would need to be introduced for other groups of clinicians for useful quality control.

2. *The request is to identify data by surgeon. Within the New Zealand public health system surgeons do not work as individuals. They are part of a number of complex teams which include the patient, general practitioner, referring physician or cardiologist, surgeon, anaesthetist, surgical registrar, scrub team, intensive care team, ward team, convalescent facility team, and possibly rest home team. Each one of these team members will contribute to the patient's outcome. Within the New Zealand public health system, surgeons are not able to select the other members of the team, and so cannot be held individually accountable for adverse outcomes.*
3. *As in many teams, there are surgeons within the New Zealand public health system who are more skilled in certain areas/operations than others. In the best interests of very ill patients requiring complex surgery, these surgeons often perform a disproportionately high number of these complex operations. Very ill patients, or those requiring a particularly complex procedure may even be transferred from one DHB to another to provide the best care available in New Zealand. Often, the outcomes for these complex operations on very ill patients are not as good as the outcomes for routine operations performed by their colleagues.*

The perverse outcome that current data will show is that some of the most skilled surgeons have the highest crude mortality rate because they do the most risky operations. At face value, this information will tell the wrong story. Until any data collected is able to undergo robust risk adjustment (which we are unable to do with the current data), it would be both misleading and unhelpful.

4. *Mr Johnston requests data on the number of patients who we re-admitted within 30 days, and the number of patients who had surgery and died within 30 days of discharge from hospital. Neither readmission within 30 days nor death within 30 days of discharge from hospital are useful markers unless attributable to the surgical procedure.*
5. *We believe that mixing acute and elective procedures will be misleading. Acute cases, in general, are difficult to classify from a risk perspective because of variable patient condition on arrival in hospital. Other jurisdictions attempting to publicise data on surgical outcomes have excluded data on acute surgery. We strongly believe any reporting of patient outcomes should cover only outcomes of elective procedures.*

6. *A significant amount of neurosurgery performed on patients in our DHB is performed on patients who have been involved motor vehicle accidents (often transferred in from far afield). The neurosurgical procedure is only one of a number of interventions by many different teams. To then allocate responsibility for the outcome (death, complications and return to hospital) to the neurosurgeon would be unfair in the extreme.*
7. *Our neurosurgeons do, on occasions, provide a technical service for their intensive care colleagues (e.g. decompression craniectomy in patients with uncontrollable intracranial hypertension). Once again, to lay responsibility at the feet of the neurosurgeons is likely to result in neurosurgeons withdrawing from providing this service. This may result in a number of patients being denied a life-saving procedure.*
8. *There are a number of palliative care operations provided by neurosurgeons (e.g. patient with secondary tumours in the brain), and thoracic surgeons (e.g. pleurodesis in patients with end stage disease in the lungs), where the surgery is performed to try to improve the quality of life in a patient who is dying. This group of patients are also likely to be denied access to this palliative care if the current data is presented in the form that [the requester] has requested.*

We agree that hospitals and clinicians are accountable for their outcomes. At Waikato DHB, we strive for excellence and already have systems in place for timely and active review of adverse clinical outcomes. We are also supportive of the release of robust performance data in the future, subject to:

- i) The creation of a central (New Zealand) database plus associated standards to ensure there is consistency of recording and classification as well, to allow a risk-adjusted measure e.g. Dendrite database*
- ii) We note that, even with risk adjustments, there have been some unintended consequences of individual surgeon disclosure in other countries. We also note that surgeons in New Zealand tend to perform a wider range of procedures than their counterparts in the U.K. and the U.S., with lower numbers of any given procedure. Therefore, there are smaller numbers in New Zealand on which to standardise outcomes and there is more statistical uncertainty of results. For some operations in New Zealand, the small numbers will make it difficult to read much into the information.^[4]*
- iii) There is also the argument that outcomes are a function of the team, rather than just an individual. We believe individual disclosure should be at a speciality level within the DHB, rather than at individual surgeon level.*

⁴ Walker, Neuberger et al, above footnote 3.

Waikato DHB supports the public release of the data requested once appropriate databases are established for that purpose. Prior to that, it is not in the interests of the public or individual surgeons for the current data to be in the public domain. Presenting such data in a public forum is likely to result in unfair scrutiny of individual surgeons and erode their confidence.^[5] It will not provide meaningful information to patients, their families or the wider public and as such is likely to erode the confidence of the public in the New Zealand public health service.

Canterbury DHB

31. Canterbury DHB provided the following in respect of individual cardiothoracic surgeons and neurosurgeons, for the years 2012/13 and 2013/14:
 - a. the number of procedures, broken down by type;
 - b. the number of patients readmitted within 30 days of discharge;
 - c. the number of patients who died during admission; and
 - d. the number of patients who died within 30 days.
32. The information provided by Canterbury DHB also included a patient clinical complexity level (PCCL) for each procedure. The PCCL ranges from 0 (no complication or comorbidity effect) to 4 (catastrophic complication or comorbidity effect).
33. With respect to its reasons for refusing the request, Canterbury DHB advised that these were as set out in its response to Mr Johnston, and that it agreed with the contents of Waikato DHB's response [see paragraph 30].

Southern DHB

34. Southern DHB advised:

We have not provided the information in the way that it was requested and have withheld any data on crude rates of complications, readmission and mortality for each surgeon, due to the limitation of available data and the work required undertaking the complex analysis of the data requested.

In regard to withholding the requested data we rely on section 18(f) of the OIA as a withholding ground—substantial collation and research. In regard to identifying individual surgeons' crude rates of complications, readmission and mortality, we rely on section 9(2)(a) of the OIA, namely that withholding the information necessary to protect the privacy of natural persons.

⁵ Letter dated 19 January 2015 from the Society for Cardiothoracic Surgery in Great Britain & Ireland to Simon Stevens, Chief Executive of the NHS, England.

35. Southern DHB believes releasing the data *'will tell the wrong story to the public'*, because the data is not reviewed or audited to the extent required for the external reporting of individual surgeon performance.
36. Furthermore:
- a. health care is delivered with a team-based approach, and outcomes cannot be seen solely in terms of surgeon performance;
 - b. the skill mix of patients will vary from surgeon to surgeon based on their relative expertise in subspecialisation, and the *'perverse outcomes that current data will show is that some of the most skilled surgeons have the highest crude mortality rate because they do the most risky and complex operations'*; and
 - c. until the data is able to undergo robust risk adjustment, which is currently not possible, it would be both misleading and unhelpful to release it.

Ministry of Health and Health Quality & Safety Commission

37. In response to this investigation, the Ministry of Health advised:

The Ministry supports publication of information that consumers find meaningful and useful to underpin their decision-making and understanding of health interventions and outcomes. To that end the Ministry is working closely with the Health Quality & Safety Commission to enable the publication of accurate and meaningful surgical information in the future.

The Ministry and Commission have initiated conversations about this matter...

38. The Ministry of Health and the HQSC facilitated two one-day workshops on the release of surgical data: one for health sector representatives in May 2015 and one for consumer representatives in July 2015. I attended both workshops, which provided a useful opportunity for participants to debate the issues.
39. In June 2015, the HQSC advised me of its intention to prepare a position paper on the transparency of information related to health care interventions in the context of current OIA requests.
40. In September 2015, the HQSC provided me with its final position paper, which is a valuable contribution to the debate.⁶
41. The HQSC states:

Increased transparency and openness are among our core values. Most consumers and clinicians concur. We believe transparency and openness are

⁶ The *Position paper on the transparency of information related to health care interventions* was released publicly in March 2016 and is available at: <http://www.hqsc.govt.nz/publications-and-resources/publication/2463/>.

best achieved by the public reporting of judiciously chosen, adequately risk-adjusted measures at the team, unit or organisational level. We discourage reporting at an individual level, as it is likely to be statistically unsound and counterproductive by undermining the teamwork we wish to encourage. Unit-level data would provide the necessary reassurance to the public and contribute to improvement in quality of our health care services. This view has been almost universally supported in feedback to our draft position paper.

Public reporting at the unit level would provide information needed for clinicians, organisations and central agencies to drive quality improvement. It could potentially lead to a meaningful national data set from which risk and benefit could be determined for common procedures, and assist in planning investment in health systems.

Publication needs to be in a manner that is meaningful and understandable to a wide range of people. Context must be explained. Results should be presented in different formats and media to ensure inequities are not increased through failure to address differences in health literacy and access to information.

We recommend that, through a co-design process, consumers, colleges, professional bodies and employers define a simple initial group of outcome and process measures for each specialty group.

These measures must reflect the different needs of the interested parties so all may agree separate or overlapping sets of consumer-, clinician- and organisation-focused measures. Once agreed, the information should be collected nationally in a standardised way. Reporting by DHB should be via their websites and annually in their quality accounts. These measures would complement the Commission's current suite of reporting, such as the quality and safety indicators and the New Zealand Atlas of Healthcare Variation. Measures should be kept under review and revised when necessary as part of the quality improvement journey.

Cost is important – money spent on this activity represents an opportunity cost in relation to other priorities for improving the quality of our health services. An assessment of what data are currently available and of what reporting could be undertaken currently from registries or other data sets should be made. Building more registries may address the medium-term need, but in the long run IT systems that capture the required information as part of routine care are needed, and investment in these may be more cost-effective. The National Health IT Board must be integral to this process.

The Commission supports the direction the Council of Medical Colleges, the Medical Council of New Zealand and the Ministry of Health are taking in strengthening and aligning processes to demonstrate doctors' ongoing competence, the outcomes of which we suggest should be made more

transparent and publicly available. We also recommend strengthening of recertification and credentialing of health care practitioners. We suggest organisations should be asked to attest to the presence of such processes and to their confidence that all practitioners are participating and achieving acceptable standards.

The Association of Salaried Medical Specialists

42. On 12 August 2015, the Association of Salaried Medical Specialists (ASMS) advised me that it was increasingly concerned at the growing number of requests under the OIA for the release of personal information about DHB employees, including its members.
43. With regard to requests for statistical data on health outcomes at the clinician-specific level, the ASMS stated:

We understand DHBs are adopting the quality and safety approach to responding to OIA requests for clinician-specific data by releasing aggregated 'performance' data at a department or hospital level. The Association supports this approach as our analysis of the evidence on the matter echoes that of the Health Quality & Safety Commission in their recent discussion paper.
44. The ASMS also provided me with a legal opinion it obtained from barrister Graham Taylor, on the application of Information Privacy Principle 11 to requests under official information legislation for information on identifiable doctors at DHBs.

Provisional opinion

45. On 29 April 2016, I advised the parties of my provisional opinion, that the DHBs:
 - a. should not have refused the request for the number and type of procedures performed by individual surgeon;
 - b. were entitled to refuse the request for risk-adjusted information relating to major complications, readmissions and deaths, on the basis of section 18(g) of the OIA; and
 - c. were entitled to refuse the request for numbers and crude rates relating to major complications, readmissions and deaths, at individual surgeon level, on the basis that section 9(2)(a) of the OIA applies and is not outweighed by public interest considerations favouring disclosure.
46. Mr Johnston, the five DHBs, the Ministry of Health and the HQSC were invited to comment.

Responses to provisional opinion

47. Responses were received from all parties, including one individual surgeon. Most respondents expressed support for increased openness and transparency in relation to the reporting of health outcomes. Waikato DHB advised that it was comfortable with my opinion overall, but noted the need to highlight important contextual information if additional information is to be released. Other parties raised additional concerns, including in relation to the privacy interests of surgeons.
48. The following comments and concerns from the parties are noted:
- a. In the event that I recommend release of data relating to the number and type of procedures performed by individual surgeons, relevant contextual information will need to be highlighted, including that:
 - i. some procedures are performed by surgeons in training, under the delegation of a consultant surgeon;
 - ii. some procedures are performed by multiple surgeons;
 - iii. surgeons work in teams, not as individuals;
 - iv. some procedures are performed by doctors when they are on-call, outside their area of specialty;
 - v. the data will not include procedures performed at private hospitals;
 - vi. account needs to be taken of procedures performed in private on behalf of a DHB; and
 - vii. numbers may reflect unfairly on surgeons who operate primarily in the private sector or who have, for good reason, not operated in the public sector for a period of time.
 - b. Given these and other caveats, raw data relating to the number and type of procedures may result in an unreliable and inconsistent dataset, from which it would be difficult to draw useful conclusions. There is a consequent risk of loss of public confidence, and a risk of undermining team-based behaviour.
 - c. It is important to avoid any perception that incomplete workload data equates to quality.
 - d. Several DHBs expressed a preference for releasing the names of the surgeons in each unit, and the numbers and types of procedures performed by those units.
 - e. The HQSC noted that the evidence cited supporting an association between individual surgeon volumes and outcomes was limited to an investigation of eight procedures with data derived from the US Medicare database and its relatively consistent coding protocols, and subsequently risk adjusted.

- f. Some surgeons are not convinced that their privacy interest in the numbers and types of procedures they perform is low.
- g. Alternatively, it is suggested that although the privacy interest in the numbers and types of procedures performed may be low, it is not outweighed by the public interest.
- h. In the event that I recommend release of DHB level data relating to complications, readmissions and deaths, relevant contextual information will need to be highlighted, including that:
 - i. the data was not collected for this reporting purpose;
 - ii. there is no standardised data collection across DHBs, so information provided by each DHB may be quite different, not comparable, and not useful for improving patient care;
 - iii. there may be privacy issues for patients in the case of surgeries performed very infrequently; and
 - iv. some surgeries are palliative and performed at the request of another team.
- i. There is a risk that reporting raw data or data derived from datasets not designed for clinical outcome reporting could undermine public confidence.
- j. If outcomes data are to be collected for publication purposes, it would make more sense to have well-defined key performance indicators (and adequately funded systems to collect them) so the data are accurate and meaningful.
- k. In relation to both numbers and types of surgeries, and outcomes, the validity of the data increases and the impact of poor quality data or error is minimised when analysed at DHB level.

Analysis and findings

Application of OIA⁷

- 49. The requested information is ‘official information’ as defined by section 2(1) of the OIA, being held by an ‘organisation’, which is in turn defined to include DHBs (OIA, s 2(1) and Ombudsmen Act 1975, Schedule 1, Part 2).
- 50. Official information often includes information about identifiable individuals, who have privacy interests in that information. That is the situation in this case, where the requested information includes information about the workload and performance of individual surgeons.

⁷ The relevant grounds of the OIA are set out in **Appendix 1**.

51. If an individual surgeon requests his or her own workload or performance information from a DHB, that access request falls to be determined as a request for personal information governed by Information Privacy Principle 6 under the Privacy Act 1993, section 6.
52. Where, as here, a third party requests official information that includes personal information about others, that request is governed by the OIA. This point is discussed further below, under 'OIA and Privacy Act'.
53. The starting point for considering, under the OIA, whether any official information is to be made available, is the principle that '*information shall be made available unless there is good reason for withholding it*' (s 5). The OIA specifies circumstances where a request for official information may be refused.⁸ Three situations are relevant in the present case, and are discussed below.

Section 9(2)(a)

54. Subject to any overriding public interest considerations, the OIA provides that good reason for withholding official information exists where that is necessary to protect the privacy of natural persons (ss 9(1), 9(2)(a)).
55. Key questions for determination are whether and to what extent it is '*necessary*' to withhold the requested information to protect the privacy of individuals and whether the public interest in release of the information outweighs the need to withhold.

Section 18(f)

56. Under section 18(f) of the OIA, a request may be refused when '*the information requested cannot be made available without substantial collation or research*'.
57. The following factors are relevant when assessing whether meeting a particular request would involve substantial collation or research in terms of section 18(f):
 - a. the amount of work involved in determining what information falls within the scope of the request;
 - b. the difficulty involved in locating, researching or collating the information;
 - c. the amount of documentation to be looked at;
 - d. the work time involved;
 - e. the nature of the resources and the personnel available to process requests for information; and
 - f. the effect on other operations of the diversion of resources to meet the request.

⁸ Sections 6, 9 and 18.

58. Before deciding whether section 18(f) of the OIA provides grounds to refuse a request, agencies must, under sections 18A and 18B, first consider:
- a. whether imposing a charge for the supply of the information at issue or extending the time frame for responding to the request would enable the request to be granted; and
 - b. whether consulting with the requester would assist the requester to make their request in a manner which would not involve substantial collation or research.

Section 18(g)

59. Under section 18(g) of the OIA, a request may be refused if the information is *'not held'* and the agency has no grounds for believing that the information is held by, or more closely connected with the functions of, another department, Minister of the Crown, organisation or local authority.

OIA and Privacy Act

60. As noted above, the ASMS provided a copy of a legal opinion from barrister Graham Taylor. Dr Taylor effectively claims that the Privacy Act 1993 prevails over the provisions of the OIA in relation to disclosure of personal information about doctors.
61. Dr Taylor relies on the High Court decision in *Watson v Chief Executive, Department of Corrections* [2015] NZHC (*Watson*) at [22] as authority for the propositions he advances.⁹
62. The High Court decision in *Watson* was not concerned with the relationship between the Privacy Act and the OIA. The issue before the Court in *Watson* was whether a redacted or unredacted copy of an affidavit should be served on the applicant. The reference to the OIA in paragraph 22 of the Court's decision was incidental and made in the context of ongoing court proceedings. It does not purport to be a general statement about the interface between the OIA and the Privacy Act.
63. The relationship between the two Acts is directly addressed in the High Court's decision *Director of Human Rights Proceedings v Commissioner of Police*.¹⁰ The issue before the

⁹ *Watson v The Chief Executive of the Department of Corrections* [2015] NZHC 718 at [22] states:

While I accept that the privacy interests of individuals, including victims, must be respected by entities such as the respondent, considerations of whether it is appropriate to disclose personal information must be reconsidered where proceedings are on foot in a Court. Privacy principle 11, which places limits on disclosure of personal information, permits non-compliance with that principle where it is 'necessary ... for the conduct of proceedings before any court'. Thus, a decision that is made about non-disclosure of private information for the purposes of an Official Information Act request will normally need to be revisited when that information is directly relevant to the conduct of proceedings (as it is here, because it is incorporated in the respondent's affidavit evidence for hearing and because it was one of the considerations that was balanced in arriving at the impugned decision).

Court in that case was whether the Human Rights Review Tribunal had been correct in declining jurisdiction to consider a complaint where personal information had been made available in response to a request under the OIA. The Court confirmed the correctness of Human Rights Review Tribunal's decision to decline jurisdiction and held that the OIA prevails over Information Privacy Principle 11 by virtue of both section 7(1) of the Privacy Act and section 48 of the OIA.

64. Having considered the relevant statutory provisions and case law, I conclude that the Privacy Act does not prevail over the OIA where a third party requests information about doctors, held by a DHB. Where a DHB receives a request for official information, its obligations are governed by the OIA, which recognises individual privacy interests in section 9(2)(a), subject to any overriding public interest (s 9(1)), and provides protection to an agency that discloses official information in good faith, in response to a request, under section 48.

Question 1 — number and type of procedures performed

65. The first part of Mr Johnston's request is for the number of surgeries, broken down by type, performed by each vocationally registered cardiothoracic surgeon and neurosurgeon during the financial years 2012–2013 and 2013–2014.
66. In 2014, I investigated a complaint about Tairāwhiti DHB's decision on a request for work-related information about one of its general surgeons.¹¹ The request was for information about the number and types of procedures the surgeon had performed, and his complaints history. I formed the opinion that for statistics about a surgeon's workload, the surgeon has a privacy interest, albeit low, in that information sufficient to engage section 9(2)(a). I concluded that the privacy interest was outweighed by other considerations which rendered it desirable, in the public interest, to make that information available.
67. With respect to the public interest considerations, I stated:

When considering the nature of the considerations favouring disclosure of information in the public interest, section 4(a) of the OIA provides a useful starting point. One purpose of the OIA is 'to increase progressively the availability of official information to the people of New Zealand'. The purpose clause also specifically recognises the public interest in promoting accountability.

¹⁰ *Director of Human Rights Proceedings v Commissioner of Police*, 14 August 2008, French J, High Court Christchurch, CIV-2007-409-002984.

¹¹ See <http://www.ombudsman.parliament.nz/resources-and-publications/documents/request-for-information-concerning-a-general-surgeon>.

The fact that such information has not been made available in the past illustrates the extent to which aspects of the publicly funded health system have remained shrouded in secrecy...

68. I noted the changing health environment, and that transparency has been identified as a key lever for improving the quality of health care and confidence in the public health system. New Zealand lags behind other comparable healthcare systems in disclosure of performance and outcomes information.
69. I concluded that with respect to quantitative workload information — the number and type of procedures performed by an individual surgeon — there is a valid public interest in disclosure. The volume-outcome relationship is well recognised in the medical literature,¹² and any concern about potential false assumptions being drawn by readers of the information could be addressed by the release of an accompanying contextual statement.
70. The first part of Mr Johnston’s request is similarly for the number and type of procedures performed by individual surgeons.
71. The Privacy Commissioner has commented that, consistent with his advice in respect of the Tairāwhiti DHB investigation, any privacy interest in statistics about a surgeon’s case types and numbers is low, and would appear to be overridden by the public interest in transparency and accountability.
72. I have considered the issues raised in response to my provisional opinion, including concerns about the completeness, reliability and usefulness of the data. I am aware that in other jurisdictions, including the UK, publicly available data of this type takes account of procedures performed in both public and private practice. I note the HQSC’s concern that the evidence cited in relation to the volume-outcome relationship is limited, and acknowledge that the magnitude of the association is not the same for all procedures.
73. I also acknowledge the preference of some parties for releasing unit level data along with the names of the surgeons in the unit, on the basis that this would be better quality, more useful data. However, the fact that an agency considers there is better information than the information requested is not a sufficient basis for refusing a request.
74. I see no reason to depart from the opinion I formed in the case of the Tairāwhiti DHB surgeon. Concerns about the limitations of the information can be addressed by providing explanatory information to give the necessary context and assist with understanding and interpretation. Accordingly, I have concluded that section 9(2)(a) applies but is outweighed by public interest considerations favouring disclosure.
75. I note Auckland DHB’s view that section 18(f) of the OIA *prima facie* applies to the information and the corollary right to fix a charge for undertaking any work agreed with

¹² Birkmeyer JD, Stukel TA, Siewers AE, et al. ‘Surgeon volume and operative mortality in the United States’. *N Eng J Med* 2003, 349: 2117-2127.

Mr Johnston. The Chief Ombudsman has recently issued a guide to charging for official information, which includes guidance on when it may be reasonable to charge and how a charge should be calculated.¹³

Questions 2 to 4 — major complications, readmissions and deaths

76. The remainder of Mr Johnston's request relates to major complications, readmissions and deaths. For each of these categories, he requested the raw numbers, crude rates, and *'if they have been calculated, standardised rates adjusted for case mix, complexity or other factors that might reflect different patient risk profiles'*.

Standardised rates — section 18(g) applies

77. Outcomes data for individual surgeons is not currently collected and analysed in New Zealand so as to produce standardised, risk-adjusted information. It is also evident that producing robust, risk-adjusted data is no simple task, particularly at the level of individual practitioner. The HQSC's position paper highlights several reasons why this is so.¹⁴
78. Work is under way in some specialties, including cardiac surgery, to produce better health care intervention outcomes data for New Zealand. It is important work and, in my view, not before time.
79. However, I am satisfied that as things stand, section 18(g) applies to Mr Johnston's request for standardised rate information, as the information is not currently held.

Raw numbers and crude rates — section 9(2)(a) applies

80. Information about major complications, readmissions and mortality following surgery conducted by individual surgeons may properly be characterised as personal information about those surgeons — and as health information about the patients whose surgical history is recorded. In the present context, all patient identifiers are removed from the information at issue.
81. Commenting on the strength of the surgeons' privacy interests in such information, the Privacy Commissioner states:
- In my view, information that may tell a story about the quality of a surgeon's work is inherently sensitive and I consider that this information carries a high privacy interest.*
82. In general terms, there is a high privacy interest in information relating to a person's employment, arising from the expectation of confidentiality that exists in the

¹³ Available at: <http://www.ombudsman.parliament.nz/resources-and-publications/documents/new-charging>.

¹⁴ See footnote 6.

employment context. That expectation of confidentiality applies to a range of information, including a person's conduct and performance in their employment.

83. There are many factors with the potential to affect the outcome of surgery, including the performance of an individual surgeon. Information about major complications, readmissions and mortality may be used to assess the competence of surgeons and compare one surgeon with another.
84. I accept that there is a high privacy interest in this category of information, and section 9(2)(a) applies.

Public interest

85. This investigation was, at least in part, the impetus for the work undertaken over the past year by the Medical Council and the HQSC on transparency of information related to health care interventions. In its position paper, the HQSC has made a number of recommendations pertaining to the collection, analysis and public reporting of that information. In terms of public reporting, the HQSC comments on information that it considers should be released proactively; ie, information that DHBs and other agencies or bodies within the health sector should be publishing of their own volition.
86. Proactive release can be an excellent way of addressing strong public interest considerations in favour of disclosing official information. However, it is important to recognise that an Ombudsman's role in respect of a request such as Mr Johnston's is to apply the law as set out in the OIA. The tests for what information should be proactively released, and what information can legitimately be withheld under the OIA, are not the same.
87. On the question of public interest in this category of information, the Privacy Commissioner comments:

It is of course vital that health professionals are held to account for weaknesses or performance issues that may create serious risk to patients. However, there are well established and robust processes already in place to ensure that such accountability exists.

...

It is not clear to me how the release of this surgeon-specific data would improve accountability or otherwise be in the public interest. The data has not been risk-adjusted, is incomplete and may in many cases be misleading. Providing it to the media for public release in a way that may exacerbate these problems would not in any way serve the public interest. Conversely, releasing the data may be contrary to the public interest if it unnecessarily undermines public confidence in particular surgeons or the wider health system.

In my view, therefore, there is little public interest in the release of his category of information and so privacy considerations should prevail.

88. There is a public interest in the availability of information about the outcomes of health care interventions, including surgery.¹⁵ Aside from the general public interest in transparency, such information is important for:
- a. patient autonomy and choice — information about a particular service, practitioner, or treatment can assist patients making decisions about their health care;
 - b. accountability — the generation and supply of information to the public is a means by which health care organisations and practitioners can be held accountable for the services they provide; and
 - c. quality improvement — there is good evidence that collecting, analysing and publishing risk-adjusted data on key indicators leads to improvements in quality.
89. Professionalism in a 21st century doctor should include a commitment to the collection and publication of meaningful outcomes data. Professional colleges, such as the Royal Australasian College of Surgeons, have an important leadership role to play. As noted by leading UK cardiac surgeon Ben Bridgewater:¹⁶
- The profession needs to furnish a public appetite for information. Some of that will inevitably be comparable information and to continue to maintain patients' trust in this era, putting some transparency and accountability systems in place are essential.*
90. However, looking specifically at the information Mr Johnston requested, I consider that disclosing the raw numbers and crude rates, by individual surgeon, would do little to satisfy those interests. The importance of data being statistically sound is an important consideration. In its current state in the New Zealand health sector, such information does not allow for meaningful conclusions to be drawn or comparisons made. I accept that there is potential for disclosure of the information currently held to damage the public interest. The public reporting of data that is misleading, incomplete or otherwise of poor quality could erode public confidence in the health system. It might also undermine teamwork and result in surgeons seeking to avoid complex procedures.
91. In my opinion, at the current time, the public interest in disclosure of major complications, readmission and mortality data, by individual surgeon, does not outweigh those surgeons' high privacy interests. Accordingly, I consider that the DHBs were entitled to refuse that part of Mr Johnston's request.
92. It is worth noting that if the DHBs held risk-adjusted surgical outcomes data, the exercise of weighing the surgeons' privacy interests against the public interest would be much

¹⁵ The arguments are canvassed in Paterson, R. *The Good Doctor: What Patients Want*. Auckland University Press, 2012, at 112–115, 126–133.

¹⁶ Quoted in S. Boseley, 'Heart surgeons push for other specialists to reveal death data', *Guardian*, 21 March 2011.

more finely balanced. As Waikato DHB notes, surgeons in DHBs are publicly employed and there is a legitimate public interest in the data sought.

93. In its position paper, the HQSC considers the public reporting of information related to health care interventions generally, not just surgery. It recommends the public reporting of *'judiciously chosen, adequately risk-adjusted measures at the team, unit, or organisational level rather than at the individual level'*. I commend the HQSC on the clear commitment to public reporting of outcomes data at DHB level.
94. Although many will agree with the HQSC's position, I do not consider the arguments against reporting outcomes at individual practitioner level are as conclusive as the HQSC suggests. In jurisdictions and specialties where data collection and analysis is more advanced, such as cardiothoracic surgery in the UK, it has been accepted by the profession itself that there is good reason to publish information at the level of individual practitioner.¹⁷ Such information is readily accessible by the public on the NHS Choices website.¹⁸
95. I acknowledge the particular difficulties for countries such as New Zealand, where the relatively small population means individual practitioners may not perform a sufficient volume of an intervention to generate statistically meaningful data. However, I am not convinced that this is necessarily as insurmountable an obstacle as has been suggested.
96. I recognise the force of Mr Johnston's submission:
- In their quest for zero harm in the health system, [DHBs] should be aiming to produce robust surgeon-specific complication data as an early warning system for DHBs as employers and for the Medical Council as a body charged with protecting the public from harm in medicine. In reality there will be very few surgeons who are outliers. ...*
97. The issue of whether outcomes data by individual practitioner should be published is undoubtedly a question for further debate and, potentially, for consideration by a future Ombudsman.
98. In the meantime, I acknowledge that there is now a greater level of commitment in the health sector with regard to the collection, analysis and publication of healthcare intervention outcomes data at team, unit or organisational level.¹⁹ That is a positive result from Mr Johnston's request for information.

¹⁷ Society for Cardiothoracic Surgery in Great Britain & Ireland, *Maintaining Patients' Trust: Modern medical professionalism*, Dendrite Clinical Systems: Henley-on-Thames, 2011.

¹⁸ See <https://www.nhs.uk/service-search/performance/Consultants>.

¹⁹ I commend the work of Dr Andrew Kerr and his colleagues at the ANZACS – QI (All New Zealand Acute Coronary Syndrome Quality Improvement) registry, on the collection, analysis and publication of cardiac intervention data.

99. In responding to Mr Johnston's request, the DHBs did provide some of the information he requested at DHB level.²⁰ Southern DHB provided the raw numbers for both cardiothoracic surgery and neurosurgery in all four categories (ie, the numbers and types of surgeries performed, the number of patients who experienced major complications, the number of patients readmitted within 30 days, and the number of patients who died within 30 days of discharge).
100. Given this, and with no identified privacy interests in the DHB level data, I consider it reasonable for the Auckland, Waikato, Capital & Coast, and Canterbury DHBs to review Mr Johnston's request with a view to providing him with all categories of information he requested, at DHB level. I note the concerns raised by some parties about providing this information, including that the data currently collected is not standardised across the DHBs, and is not comparable. Such concerns can be addressed by providing relevant explanatory information. In my view, it would be appropriate to provide Mr Johnston with this data, as Southern DHB was able to do. I note that Waikato DHB has indicated that it will provide Mr Johnston with this information.

Ombudsman's opinion

101. For the reasons set out above, I have formed the opinion that the DHBs:
- a. should not have refused the request for the number and type of procedures performed by individual surgeon;
 - b. were entitled to refuse the request for risk-adjusted information relating to major complications, readmissions and deaths, on the basis of section 18(g) of the OIA; and
 - c. were entitled to refuse the request for numbers and crude rates relating to major complications, readmissions and deaths, at individual surgeon level, on the basis that section 9(2)(a) of the OIA applies and is not outweighed by public interest considerations favouring disclosure.

Recommendations

102. I recommend that the DHBs provide Mr Johnston with the information he requested under point 1 of his request.
103. I recommend that the Ministry of Health and Health Quality & Safety Commission work together to provide a publicly available, annual update (commencing in June 2017) on the sector's progress towards, in five years (ie, by June 2021), the selection, development

²⁰ See footnote 1.

and public reporting of a range of quality of care measures (including outcomes data) across specialties that:

- are meaningful to health care consumers;
- are meaningful to the clinicians who provide their care;
- are meaningfully attributable to the clinicians or service providing that care; and
- increase the availability of information to the people of New Zealand.

104. Under section 32 of the OIA, a public duty to observe an Ombudsman's recommendation is imposed from the commencement of the 21st working day after the date of that recommendation. This public duty applies unless, before that day, the Governor-General, by Order in Council, otherwise directs.

Professor Ron Paterson
Ombudsman

Appendix 1. Relevant statutory provisions

Official Information Act 1982

4 Purposes

The purposes of this Act are, consistently with the principle of the Executive Government's responsibility to Parliament,—

- (a) to increase progressively the availability of official information to the people of New Zealand in order—
 - (i) to enable their more effective participation in the making and administration of laws and policies; and
 - (ii) to promote the accountability of Ministers of the Crown and officials,—
and thereby to enhance respect for the law and to promote the good government of New Zealand:
- (b) to provide for proper access by each person to official information relating to that person:
- (c) to protect official information to the extent consistent with the public interest and the preservation of personal privacy.

5 Principle of availability

The question whether any official information is to be made available, where that question arises under this Act, shall be determined, except where this Act otherwise expressly requires, in accordance with the purposes of this Act and the principle that the information shall be made available unless there is good reason for withholding it.

...

9 Other reasons for withholding official information

- (1) Where this section applies, good reason for withholding official information exists, for the purpose of section 5, unless, in the circumstances of the particular case, the withholding of that information is outweighed by other considerations which render it desirable, in the public interest, to make that information available.
- (2) Subject to sections 6, 7, 10, and 18, this section applies if, and only if, the withholding of the information is necessary to—
 - (a) protect the privacy of natural persons, including that of deceased natural persons; ...

18 Refusal of requests

A request made in accordance with section 12 may be refused only for 1 or more of the following reasons, namely:

...

- (f) that the information requested cannot be made available without substantial collation or research:
- (g) that the information requested is not held by the department or Minister of the Crown or organisation and the person dealing with the request has no grounds for believing that the information is either—
 - (i) held by another department or Minister of the Crown or organisation, or by a local authority; or
 - (ii) connected more closely with the functions of another department or Minister of the Crown or organisation or of a local authority:

...

18A Requests involving substantial collation or research

- (1) In deciding whether to refuse a request under section 18(f), the department, Minister of the Crown, or organisation must consider whether doing either or both of the following would enable the request to be granted:
 - (a) fixing a charge under section 15:
 - (b) extending the time limit under section 15A.
- (2) For the purposes of refusing a request under section 18(f), the department, Minister of the Crown, or organisation may treat as a single request 2 or more requests from the same person—
 - (a) that are about the same subject matter or about similar subject matters; and
 - (b) that are received simultaneously or in short succession.

18B Duty to consider consulting person if request likely to be refused under section 18(e) or (f)

If a request is likely to be refused under section 18(e) or (f), the department, Minister of the Crown, or organisation must, before that request is refused, consider whether consulting with the person who made the request would assist that person to make the request in a form that would remove the reason for the refusal.

Privacy Act 1993

Information Privacy Principles

Principle 11 — Limits on disclosure of personal information

An agency that holds personal information shall not disclose the information to a person or body or agency unless the agency believes, on reasonable grounds—

- (a) that the disclosure of the information is one of the purposes in connection with which the information was obtained or is directly related to the purposes in connection with which the information was obtained; or
- (b) that the source of the information is a publicly available publication and that, in the circumstances of the case, it would not be unfair or unreasonable to disclose the information; or
- (c) that the disclosure is to the individual concerned; or
- (d) that the disclosure is authorised by the individual concerned; or
- (e) that non-compliance is necessary—
 - (i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or
 - (ii) for the enforcement of a law imposing a pecuniary penalty; or
 - (iii) for the protection of the public revenue; or
 - (iv) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation); or
- (f) that the disclosure of the information is necessary to prevent or lessen a serious threat (as defined in section 2(1)) to—
 - (i) public health or public safety; or
 - (ii) the life or health of the individual concerned or another individual; or
- (g) that the disclosure of the information is necessary to facilitate the sale or other disposition of a business as a going concern; or
- (h) that the information—
 - (i) is to be used in a form in which the individual concerned is not identified; or
 - (ii) is to be used for statistical or research purposes and will not be published in a form that could reasonably be expected to identify the individual concerned; or

- (i) that the disclosure of the information is in accordance with an authority granted under section 54.