Australian Government
Department of Health and Aged Care

Healthcare Identifiers Framework Project

Public consultation outcomes summary

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Executive summary

On 2 December 2022 the Department of Health and Aged Care released a public consultation paper to inform reforms to the Healthcare Identifiers Framework (the HI Framework) as part of the Healthcare Identifiers Framework Project. The consultation paper presented eight key 'problem statements', which were the focus of the consultation. These problem statements posed questions about the HI Framework and the *Healthcare Identifiers Act 2010* (Cth) (the Act). We received 49 submissions, ranging from full submissions to letters providing background context and general comments.

The purpose of this document is to summarise the feedback from stakeholders on each question under the key problem statements in the HI Framework Project consultation paper. This document does not state a final policy position on the key problem statements.

As responding to all questions was not mandatory, and not all respondents consented to having their feedback published, we have decided not to publish any responses. Instead, we are providing a collective overview via this document. We have attempted to broadly reflect the overall nature of the feedback, including where there were divergent views.

An analysis of the submissions reveals general support for the HI Framework Project. This includes support for:

- expanding the use of Healthcare Identifiers (HIs) to connect health, aged care, disability and allied health care
- administration entities to be able to use HIs
- healthcare support providers and organisations being able to use HIs
- health technology services being able to use HIs, with a set of standards and a conformance framework
- directory/registry providers – including the National Health Services Directory – being able to use HIs, with a set of standard authorisations.

Stakeholders did not support amending current prohibitions against using HIs for underwriting or determining insurance or for employment purposes.

Findings from the public consultation are informing draft legislative amendments. They are also informing:

- the **Commonwealth policy position** which will outline when and how HIs can be used
- the **policy implementation plan** which will outline how the Commonwealth policy position will be implemented
- the **privacy impact assessment** which will
  - identify how changes to the HI Framework might affect the privacy of individuals
  - make recommendations for managing, minimising or eliminating those impacts
- the **policy impact analysis** which will consider how changes to the HI Framework will affect businesses, individuals and community organisations, as well as broader economic and other impacts
- **education material** to support the adoption and use of HIs.

The HI Framework Project aims to introduce to Parliament the proposed legislative changes in 2024. We will conduct further consultation as the scope of the legislative changes is refined.

Consultation problem statements and outcomes summary

1. HI use in key programs, services, and systems

Increasing the number of programs, services and providers that use HIs is fundamental to increasing interoperability and achieving connected care.

Findings

There was strong support for Healthcare Identifiers (HIs) to be used by default across key programs, services and systems, to enable better patient identification and information sharing.

Responses to the consultation paper raised questions about how HIs would be used 'by default' in terms of being used as a primary or secondary identifier, as local identifiers currently serve operational purposes. They identified numerous situations where HIs should not be used by default.

Upholding the privacy and security of patient information, particularly for vulnerable populations, was flagged as important. Responses raised questions about how HIs would be used for people experiencing vulnerability that seek healthcare for sexual health services, child health services and domestic and family violence services.

Stakeholders identified a variety of policy levers (policy changes designed to influence behaviour) that would support increased use of HIs in hospital systems. Suggestions included making HI use mandatory, financial incentives, standards and ways of applying existing legislation.

Stakeholders supported harmonising national infrastructure. They noted that this would require an evaluation of the role of the Healthcare Provider Directory once Healthdirect Australia is authorised to connect to the HI Service. They recognised an extensive list of identifiers that could be replaced by HIs.

Stakeholders advised giving consideration to what happens in situations where a person:

- does not have an Individual Healthcare Identifier (IHI) – such as newborns, visitors, refugees, and migrants under some visas
- has multiple IHIs or has IHIs in different names – such as people experiencing vulnerability.

Responses identified several practical considerations in relation to the implementation, adoption and use of HIs. There was consensus that an appropriate timeframe to expect services and programs to transition to the use of HIs is between two and five years.

2. Scope of healthcare and provider eligibility

Achieving connected care relies on the use of HIs across a broad range of healthcare programs and services. Healthcare recipients may benefit from broader provider and service eligibility for HIs.

Findings

Stakeholders considered that the definition of 'health service' in the *Privacy Act 1988* (Cth) sufficiently covers the current range of services and programs needed to support people's health, care and wellbeing and achieve a connected care environment. However, they thought that it might not cover future expanded services.

Responses indicated that access to HIs should be tied to healthcare or healthcare-related activities that have a defined benefit/outcome for the consumer.

Further, they indicated that professions and organisations defined as 'healthcare support providers' should be able to use HIs when the above requirement is met. They noted that these professions and organisations should engage with national standards or industry-recognised standards that feature clinical governance practices and a complementary accreditation process.

Stakeholders supported the idea that 'healthcare support providers' should be able to obtain their own HI in a different category of identifier. The purpose of this would be to ensure differentiation between fully trained healthcare providers who provide primary or acute healthcare services, and employees whose primary function is to provide support services that enable quality of life services.

Responses identified an extensive list of professions, organisations and services that should be included in the 'healthcare support provider' category. In addition, they identified a list of healthcare professionals for possible inclusion as eligible for an HPI-I. On the other hand, they identified volunteer-staffed organisations, system administrators and unregulated health support providers as professionals that should not be able to use HIs.

Stakeholders advised giving consideration to matters of consent. They agreed that current security and privacy provisions should remain for any expanded use of HIs.

Suggested changes to the Act to increase connected care outcomes and health system interoperability include:

- a requirement for software vendors to integrate HIs into clinical information systems
- clarifying the definition of 'health service' in the Privacy Act
- recognising the increased role of private health insurers as funders, facilitators, and providers of healthcare and associated support services.

3. Clarity around healthcare administration entities and uses

HIs were always intended to be used in all aspects of healthcare, including administration. But many organisations currently cannot use them to their full potential due to real and perceived legislative limitations.

Findings

Responses identified several legislative and operational safeguards that should be implemented to provide confidence in the use of HIs by healthcare administration entities and for health administration purposes. Examples are:

- clear specifications in the legislation for the use of HPI-Is
- defined minimum requirements for cybersecurity and IT protection in all healthcare systems that use HIs
- alignment of requirements across the Commonwealth, states and territories
- implementation of a standards framework.

Stakeholders did not consider that any entities should be removed from the current list of recognised types of healthcare administration entities. They identified a broad range of government health or health service delivery agencies and individual/private entities that should be included as administration entities. But they also identified certain healthcare administration purposes that should not be recognised, including:

- healthcare research, monitoring and evaluation
- debt recovery
- managing claims and payment processes
- managing incidents and complaints
- workforce planning and management
- contracting third parties.

4. Applications and structures of HPI-Os and HPI-Is

Identifying and communicating with individual healthcare providers and provider organisations should be logical and simple. HIs should be usable in a range of healthcare programs.

Findings

Stakeholders noted the need for flexibility to enable use of HPI-O and HPI-I structures across all health and healthcare related information, communication and administration. They agreed that HPI-I and HPI-O structures need to be simple, logical, and transparent to mitigate the operational burden of managing a complex structure and support maximum interoperability.

Responses identified the need to consider how programs, services and systems using HPI-Os can be aligned to enable more flexibility and opportunities for future reuse.

Some responses noted that resourcing and support will be needed to enable the use of HPI-Os and HPI-Is in programs and services, especially in the priority areas of regional and remote health, community and preventive healthcare and First Nations health.

There was general consensus in favour of using HPI-Os to identify both locations and services. There was general agreement with the problem statement that in complex settings, it is burdensome to manage HPI-Os for multiple services, across multiple locations.

Stakeholders noted the need for robust processes to ensure that HI data is accurate and – as locations and service offerings can change rapidly – up to date. They pointed out that poor-quality data in terms of consistency, timeliness, trustworthiness, completeness and accuracy will undervalue the use of HIs.

Suggested policy levers to encourage the implementation of HPI-O structures include:

- clear policy and guidelines on the benefits of HPI-Os
- models of appropriate structures
- service agreements between state/territory health departments and health service organisations
- adoption of consistent national interoperability requirements and standards to promote conformance and consistency across the health sector.

Stakeholders mentioned that an existing barrier to HI use is the current policy regarding which employees of a healthcare provider organisation can manage HPI-O information. They recommended reviewing HPI-O policy to address the restrictions on ‘responsible officer’ access and any unintended risks of relaxing these restrictions.

Stakeholders are seeking clear direction and guidance from government on HPI-I and HPI-O structures. They emphasised that any changes to the Act should support and inform healthcare organisations in their decisions about implementing organisational structures in a way that supports seamless delivery of healthcare, organisational accountability and transparency, and data quality.

5. Healthcare consumer and provider choice

Individuals should be able to be active participants in their healthcare. The Act and the HI Service should empower each individual to disclose their own IHI for more purposes to enable better healthcare outcomes.

Findings

There was consensus among stakeholders that consumers or their representatives should have the right to consent to, or withdraw consent for, the disclosure or use of their IHI. But some responses identified specific situations where consumers should not be able to consent to the disclosure or use of their IHI. Evidently there is a need for caution in sensitive circumstances.

Several safeguards were identified that would assist healthcare consumers in feeling confident in disclosing their IHI in safe and secure ways. These include:

- clear consent models
- clear guidelines
- information for consumers that provides assurance about how authorised organisations can use their HI
- a standards framework around cybersecurity and data governance.

These safeguards would also support provider organisations in their use of HIs.

There was general agreement that the current prohibitions on the use of HIs for underwriting or determining insurance and for employment purposes should continue. Regarding the risks of removing the current prohibitions, stakeholders raised issues around the potential for:

- loss of consumer confidence in the health system
- discrimination against individuals based on accessed health information
- coercion into disclosing health information.

Most stakeholders advised that insurers and employers should only be able to collect, store and use HIs for authorised purposes limited to the provision of healthcare. Further, they considered that insurers and employers should not be able to use an IHI as a unique identifier for a healthcare consumer in their own systems. The reason for this view is that insurers provide many other types of insurance and employers hold a range of other personal information, so there is potential for them to use HIs for purposes outside of healthcare.

Stakeholders who supported the view that private health insurers should be treated differently to other insurers in the Act did so on the grounds that private health insurers have a health service delivery function (for which they may already be eligible for an HPI-O) and play a key role in remuneration of private hospitals and day surgeries. Those who disagreed that private health insurers should be treated differently did so on the grounds that these insurers offer other types of insurance and that it would be difficult to consistently apply conditions for HI use to insurance companies.

6. Support for healthcare technology services

To support a modern healthcare environment, the Act and the HI Service must allow for flexibility in how platforms and applications connect an individual to their healthcare data, and how providers connect to one another.

Findings

Most responses supported the idea of consumer-facing and intermediary software being able to collect, use, disclose and adopt HIs. They agreed that this would encourage adoption, improve data quality and efficiency and enable consumers to be active participants in their own healthcare delivery and decision-making. Some noted that the use of HIs by consumer-facing and intermediary software could also contribute valuable insights on public health.

Stakeholders considered that HI conformance requirements and safeguards should be higher for consumer-facing and intermediary software than for healthcare providers, to:

- ensure clinical safety
- ensure data quality and accuracy, and consistency in the way data is handled
- build healthcare consumers' trust that their data is secure.

They noted that these requirements and safeguards should be supported by strong legislation and regulation.

There was consensus that the use of HIs by consumer-facing and intermediary software should be underpinned by strong privacy, security and compliance requirements stated in the legislation.

There was support for a standard set of authorisations if information is only collected, used or disclosed for the purposes of healthcare, to allow for future flexibility for the framework to adapt to new consumer and provider use cases. There was also the suggestion to adopt the default position that consumer-facing and intermediary software is only authorised to use HIs for the specific purpose they serve at the time of application. This approach would help to reassure the most risk-averse consumer.

Stakeholders expressed a range of views on the level of HI conformance testing in complex organisations. For reasons of patient safety, some considered that where a complex organisation (e.g., a hospital) uses one system to integrate with the HI Service and then sends HIs to other systems in the organisation (e.g., to an electronic medications management system), those other systems also should be required to undergo HI conformance testing. However, other stakeholders considered that unless those other systems are directly engaging with the HI Service, there should be no need for further conformance testing, as clinical and data quality processes are already in place to ensure the correct passage of data from one system to another.

Stakeholders also noted that if use of HIs (which could include access to a patient's medical history) is permitted to enable software providers to develop applications, we need to give careful consideration to preventing unauthorised use. This would include vetting of security and privacy controls and compliance with the relevant legislation and procedures.

Some responses raised the concern that this problem statement assumes that the Australian healthcare system is now digital. Stakeholders advised that to increase the uptake and use

of HIs, there will need to be a commitment to significant investment to expand the digital storage of information in a manner that enables it to be shared between healthcare providers.

7. Clarity around permitted uses and concerns about penalties

We need clear policy and legislation to provide confidence about what is and isn't permitted and how privacy and security are protected.

Findings

Responses identified several areas of the Act as being unclear and hard to interpret, including:

- whether registration authorities can disclose HIs independently
- the scope of 'permitted purposes' – currently it seems both limited and open to wide interpretation
- the contracted service provider provisions
- when it is appropriate to use, store and disclose HIs
- why HIs are not considered health information per se, and how/why they can only be used for health-related activities.

Stakeholders want clarity on the permitted uses of HIs, particularly HPI-Os. They also want confirmation that contracted service providers are not held liable for unauthorised actions of the providers they support. Evidently there is a need for clear policies, guidelines and educational material, providing examples, data quality statements and technical information.

Stakeholders told us that misalignment of legislative obligations between Commonwealth and state/territory law should be addressed, but no clear example was provided in the feedback received.

With regard to current penalties in the Act, stakeholders considered the financial penalties relatively low given the value of the information and the confidence required in the system to make it effective. They also advised adding penalties for misuse of HIs and failure to meet conformance requirements.

8. Flexibility and agility to support evolving use cases.

The Act and the HI Service must allow for current use cases. They must also be adaptable to new models of healthcare as they evolve.

Findings

Responses identified that the current provisions in the Act around the collection, use and disclosure of HIs are limiting and reduce flexibility to support evolving use cases.

Most stakeholders backed a broader authorisation model to support emerging technological solutions and models of care. However, they advised that in developing such a model we need to consider:

- parameters regarding purpose
- penalties for misuse that fit a broader authorisation model
- stipulation about who is an authorised entity
- provision of accompanying material that outlines specified data flows.

Stakeholders supported the idea of amendments to the Act to provide additional flexibility. They emphasised the need to ensure that the Act not only supports contemporary use cases but also has provisions that will support and enhance new models of care as they evolve. Asked what safeguards would provide confidence if the Act were changed to allow more flexibility, their answers included:

- a regular audit/reporting program that provides information about the use of the identifiers
- a formalised governance framework which fully defines roles and responsibilities.

We also asked stakeholders to consider whether certain types of decision-making powers under the Act should be devolved from parliament – e.g. to the Minister – and, if so, to what level. Many stakeholders were of the view that decision-making powers should remain with parliament. Some mentioned that if decision-making powers were to be devolved, a strong business case would need to be demonstrated for this change.

However, some stakeholders identified that the use of delegated legislation might be useful for granting and managing authorisations. Their comments included:

- the appropriate use of subordinate legislation and disallowable instruments would provide greater flexibility than primary legislation
- using legislative instruments to manage authorisations could provide more flexibility, with guiding principles and consultation or approval requirements in place to provide assurance
- schedules could be used to define which professions are healthcare provider organisations as opposed to healthcare support organisations.

List of abbreviations

Term	Full term
HI	Healthcare Identifier
HPI-I	Healthcare Provider Identifier – Individual
HPI-O	Healthcare Provider Identifier – Organisation
IHI	Individual Healthcare Identifier

Glossary of terms

Term	Definition
Adoption	In the context of Healthcare Identifiers, an entity 'adopts' an identifier where it uses Healthcare Identifiers as one of the entity's own identifiers for authorised purposes and associates their data with the identifier.
Allied health	The allied health sector represents a broad range of health professionals who are not doctors, dentists, nurses or midwives – for example, optometrists, pharmacists and psychologists. Generally, the Australian Government recognises allied health professions that meet the following criteria: • all practising professionals have a university level qualification of Australian Qualification Framework level 7 or higher in a recognised allied health field, that is accredited by their relevant national accreditation body • a national professional organisation with clearly defined membership criteria • clear national entry level competency standards and assessment processes • autonomy of practice and • a defined scope of practice.
Connected care	The ability for healthcare providers to safely connect, and seamlessly share high-quality patient information.
Clinical information system	A computer-based system for collecting, storing, and making available clinical information important to healthcare delivery. These systems are used in healthcare provider settings such as general practice or pharmacy.
Digital health	An umbrella term referring to the use of technology in delivering health services, including diagnosis, treatment, management, and information collection and sharing.
Directory or registry	An entity that holds and systematically monitors records of information about healthcare providers, healthcare interventions, individuals receiving healthcare or the healthcare choices of individuals.
Healthcare	In this consultation, 'healthcare' means all healthcare and health related services. This includes primary care, aged care, disability care and allied care.
Healthcare administration entity	An organisation that manages health information and services, or provides administrative, planning, research and policy functions related to healthcare.
Healthcare Identifiers Act 2010 (the Act)	The legislation that underpins the HI Framework. The Act specifies the circumstances in which Healthcare Identifiers can be collected, used or disclosed, and who can do so.

	Any references to the Act in this document also include the Healthcare Identifiers Regulations 2020.
Healthcare Identifiers Framework Project	The current task of the Department of Health and Aged Care to make changes to the Healthcare Identifiers Framework (including the Act and Regulations) and the key policy settings for the Healthcare Identifiers Service.
Healthcare Identifiers Regulations 2020 (the Regulations)	Delegated legislation under the Act. The Regulations provide additional guidance regarding how the provisions of the Act are applied and enable additional authorisations to handle Healthcare Identifiers.
Healthcare Identifiers Service (HI Service)	A national system for consistently uniquely identifying consumers and healthcare providers for healthcare purposes. The HI Service assigns Healthcare Identifiers (a unique 16-digit number) to individuals, individual healthcare providers and healthcare provider organisations. The purpose of this is to ensure that health information is correctly matched to an individual or entity.
Healthcare recipient or consumer	A person using health services from a healthcare provider.
Healthcare provider	A provider of health services.
Healthcare Provider Identifier – Individual (HPI-I)	Unique number used to identify an individual healthcare provider (e.g., a doctor or specialist). An HPI-I is automatically assigned to an individual provider when they register with the Australian Health Practitioner Regulation Agency (AHPRA). Members of other professional associations with certain characteristics can also apply for an HPI-I.
Healthcare Provider Identifier – Organisation (HPI-O)	Unique number used to identify a healthcare provider organisation (e.g., a doctor practice or a hospital). Organisations must register with the HI Service to obtain an HPI-O.
Healthcare Provider Directory (HPD)	A directory of healthcare provider organisations and individuals operated as part of the HI Service.
Healthcare settings	The term healthcare setting represents a broad array of services and places where healthcare occurs, including GP clinics, hospitals, rehabilitation centres, aged care and other long-term care facilities, specialised outpatient services (e.g., haemodialysis, dentistry, podiatry, chemotherapy, endoscopy, and pain management clinics), and outpatient surgery centres.
Individual Healthcare Identifier (IHI)	Unique number used to identify an individual healthcare consumer for healthcare purposes. IHIs are automatically assigned to individuals eligible for Medicare. They are also available on request to other healthcare consumers).
Interoperability	The ability of separate computer systems or software to exchange and make use of the same information using standardised interfaces.
Medicare	The approved schedule of medical services in Australia against which eligible practitioners may claim for reimbursement.
Problem statements	Problem statements are clear and concise descriptions of the problems or issues the Department of Health and Aged Care aims to address in the Healthcare Identifiers Framework Project.
Use case	A specific situation in which a product or service could potentially be used.

Appendix A – Consultation questions

The following consultation questions underpin the problem statements identified by the Healthcare Identifiers Framework Project.

Problem Statement 1: HI use in key programs, services and systems

1. Are there specific situations, systems, or areas of healthcare where HIs should not be used by default?
2. What would be the most effective and achievable policy levers for increasing the use of HIs in state and territory public hospital systems, and in private hospitals?
3. What would be the most effective and achievable policy levers for increasing the use of HIs by allied health providers, and other small private providers?
4. Given the importance of unique identification to increasing health system interoperability and overcoming several current challenges, what is an appropriate timeframe to expect services and programs to transition to the use of HIs?
5. Which alternative unique identifiers for healthcare recipients or healthcare providers should be replaced by HIs? What are the highest priorities?
6. Should a directory or registry provider only be authorised to use HIs for the specific purpose they serve at the time of application? Or should they receive a set of standard authorisations, enabling greater flexibility?
7. Are there any reasons why Healthdirect should not be authorised to use the HI Service to support its directory and other healthcare services?
8. If Healthdirect had authority to use HIs for the National Health Services Directory (NHDS), would there be an ongoing need for the Healthcare Provider Directory (HPD)?
9. Do you have any other comments, questions, or concerns, relating to this problem statement?

Problem Statement 2: Scope of healthcare and provider eligibility

1. Does the definition of 'health service' in the Privacy Act sufficiently cover the range of services and programs that are required to support people's health, care and wellbeing and achieve a connected care environment?
2. Should the types of professions defined here as 'healthcare support providers' be able to use HIs? If so, how should they be able to use them? If not, why not?
3. Should the types of organisations defined here as 'healthcare support provider organisations' be able to use HIs? If so, how should they be able to use them? If not, why not?
4. Are there any types of professions, organisations or services that should be added to, or removed from, the 'healthcare support provider' lists?
5. Should the types of professions defined as 'healthcare support providers' be able to obtain their own HI? If so, should it be a different type of identifier to an HPI-I?
6. Are there any health professionals that are currently not eligible for an HPI-I but should be?
7. Are there any types of professionals, programs and services that should not be able to use HIs?
8. Are there any other possible changes to the Act that would increase connected care outcomes and health system interoperability?
9. Do you have any other comments, questions, or concerns, relating to this problem statement?

Problem Statement 3: Clarity around healthcare administration entities and uses

1. What safeguards should be in place to provide confidence in the use of HIs by healthcare administration entities?
2. Are there any types of healthcare administration entities that should be added to, or removed from the list?
3. What safeguards would provide confidence in the use of HIs for healthcare administration purposes?
4. Are there any other healthcare administration purposes that should be added to, or removed from the list?
5. Do you have any other comments, questions, or concerns, relating to this problem statement or policy objective?

Problem Statement 4: Applications and structures of HPI-Os and HPI-Is

1. What are the key policy, program, and operational objectives and benefits that HPI-O and HPI-I structures must support?
2. Given that other location specific organisation identifiers exist, should HPI-Os be used to identify locations, or services, or both?
3. What would be the most effective and achievable policy lever or operational support mechanism for getting organisations to implement an effective HPI-O structure, further to the provision of direct funding?
4. How could we change legislation or policy to make HPI-O and HPI-I relationships easier for healthcare providers to create and manage?
5. What operational or procedural changes to the HI Service would be required to support these changes?
6. Do you have any other comments, questions, or concerns, relating to this problem statement?

Problem Statement 5: Healthcare consumer and provider choice

1. Are there specific situations or systems where you think healthcare consumers should not be able to consent to the disclosure or use of their IHI?
2. What safeguards should be in place to ensure that healthcare consumers can disclose their IHI in a safe and secure way?
3. Should the current prohibitions around the use of HIs for underwriting or determining insurance and employment purposes continue? Or should they be amended in some form, or removed?
4. Should there be any unauthorised purposes for insurers or employers to use HIs?
5. Should insurers and employers be able to use an IHI as a unique identifier for a healthcare consumer in their own systems, so that consumers have fewer identifiers overall?
6. Given the different business models for health service delivery and insurance functions operating in private health insurance and the increasing role they play in delivering health services, should health insurers be treated differently from other insurers in the Act?
7. Do you have any other comments, questions, or concerns, relating to this problem statement?

Problem Statement 6: Support for healthcare technology services

1. Should consumer facing and intermediary software be able to collect, use, disclose and adopt HIs?
2. Should consumer facing and intermediary software have the same HI conformance requirements and safeguards as software used by healthcare providers, or higher?

3. Should consumer facing and intermediary software only be authorised to use HIs for the specific purpose they serve at the time of application? Or should they receive a set of standard authorisations, enabling greater flexibility?
4. If a complex organisation (e.g. a hospital) uses one system to integrate with the HI Service and then sends HIs to other systems in the organisation (e.g. an electronic medications management system), should these other systems also be required to undergo HI conformance testing?
5. What safeguards should be in place to ensure that healthcare recipients can disclose their IHI in a safe and secure way?
6. Should there be any unauthorised uses for software providers?
7. Do you have other comments, questions, or concerns, relating to this problem statement?

Problem Statement 7: Clarity around permitted uses and penalties

1. Are there areas of the Act, or supporting policy, that are unclear, confusing, or hard to interpret?
2. What additional information, advice, or support would provide confidence in the use of HIs?
3. Are there any examples of where the Act (or the direction of these proposed changes) conflict with other legislation or policy?
4. Are the current penalties for misuse appropriate, and if not, what changes could be made?
5. Do you have any other comments, questions, or concerns, relating to this problem statement?

Problem Statement 8: Flexibility and agility to support evolving use cases

1. What are the key areas of the Act or policy, that lack flexibility?
2. Should the Act continue to specify data flows and purposes, or should the Act move to a broader authorisation model?
3. Where would the use of schedules, rule-making powers, or other legislative instruments be useful for granting and managing authorisations?
4. Should decision-making power be devolved from parliament, and if so, to what level?
5. What types of decision-making power under the Act approved by parliament should be devolved, and if so, to what level (e.g., the Minister for Health and Aged Care or the Secretary for the Department of Health and Aged Care)?
6. If additional flexibility is provided in the Act, what safeguards should be in place to provide confidence?
7. Do we need any other changes to the HI legislation or policy to ensure the HI Service can perform its core functions in an optimal way?
8. Do you have any other comments, questions, or concerns, relating to this problem statement?

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All information in this publication is correct as at September 2023