



## Commonwealth Department of Health and Aged Care

### Healthcare Identifiers Framework Project - Public Consultation

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#### Australian Clinical Trials Alliance (ACTA) Clinical Quality Registry Special Interest Group Feedback

ACTA and our dedicated Clinical Quality Registry Special Interest Group (CQR SIG) thanks the Commonwealth Department of Health and Aged Care for the opportunity to respond to the public consultation relating to the Healthcare Identifiers Framework Project. ACTA and the CQR SIG are strong supporters of this project and provide the following feedback in relation to this consultation.

#### Overview

The proposed Healthcare Identifiers are critical to creating an interoperable health system into the future, and to improving connectivity and patient care. To achieve the maximum benefit, IHIs need to be universally and nationally applied and replace as many other government identifiers as possible. Consideration should be given to the use of consumer IHIs to those groups that currently don't have access to Medicare including refugees and asylum seekers, and those on certain VISAs, so that IHIs can become truly universal in Australia.

Key consultation areas relevant to clinical quality registries (CQRs), and responses are provided below:

#### HI use in programs, services and systems

##### Individual and organisational provider IHIs

The use of healthcare provider and organisational **provider IHIs (HPI-Is and HPI-Os** respectively) as unique identifiers for healthcare clinicians and hospitals respectively will assist in accurate identification of providers. Hospitals often change their name or corporate ownership, so a unique organisational HI will maintain accuracy for organisational identity over time. This is important for CQRs as they follow the patient journey over time which may include multiple providers across the health system.

##### Individual IHIs

The use by healthcare providers (clinicians, organisations) of individual **consumer (patient) IHIs** will significantly enhance CQR data collection and linkage with other datasets that also use IHIs, such as with governments, hospitals and other agency datasets. Use of IHIs for **data linkage** purposes will reduce the need for CQRs to undertake data linkage using personal information such as patient name, DOB and address, which is currently used to increase linkage accuracy, thus reducing the risk of breach of identifying information during sharing or linkage.

CQRs that undertake patient follow up via PROMs (or clinical information) will still need to have patient name and contact details to administer longitudinal patient surveys. This is a specific data collection that requires direct contact with the patient. All other collection of secondary data would be able to be made via linkages using IHIs if they have been implemented by the providing organisation.

## Implementation of IHIs across the health system

The primary burden of implementing IHIs across the system will largely fall on the healthcare providers. My Health Record has shown that there are many reasons for poor provider uptake of national digital initiatives, including lack of incentives (drivers), training and technical issues, and lack of resources for implementation. Mandatory use of IHIs giving institutions time to introduce the changes to existing systems, together with incentives, support and funding are all critical to the successful uptake. All of these must be addressed to achieve the broader vision of interoperability using IHIs.

<b>Specific Consultation questions</b>	<b>Draft CQR SIG response (dot point)</b>
<i>1. Are there specific situations, systems, or areas of healthcare where IHIs should not be used by default?</i>	<p>CQRs support the use of IHIs for as broad a range of health and wellbeing services as appropriate and possible. In defined settings, use of IHIs should be mandatory, with opt-out provisions for patients/consumers.</p> <p>Use of IHIs for government reporting and funding purposes would extend IHIs beyond the EMR through other systems at the state government level (e.g. SafeScript, critical incident report) and Commonwealth Govt level (e.g. eScript, AIR).</p>
<i>2. What would be the most effective and achievable policy levers for increasing the use of IHIs in state and territory public hospital systems, and in private hospitals?</i>	<p>Incorporate the use of IHIs into the Commonwealth-Jurisdiction funding agreements for public hospitals/providers; and incorporation into Private Health Insurer - Provider agreements for private hospitals.</p>
<i>3. What would be the most effective and achievable policy levers for increasing the use of IHIs by allied health providers, and other small private providers?</i>	<p>Linking Medicare (including MBS &amp; PBS) funding to the use of the three IHIs.</p> <p>Small private providers will likely need one-off funding to support transition to IHIs.</p> <p>Access to ongoing technical support for small providers, including required software changes for providers.</p>
<i>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 IHIs?</i>	<p>Start with the introduction of IHIs at the provider level. Suggest an 18-month period for introduction of IHIs for individual clinicians (HPI-I) and organisations (HPI-O).</p> <p>Provider incorporation of patient/consumer IHIs into their systems will be a substantial piece of work. Suggest differentiating between prospective introduction of IHIs for patients by providers over e.g. a 3 year period.</p> <p>Consider priorities for addition of IHIs to retrospective patients/consumers by providers.</p>
<i>5. Which alternative unique identifiers for healthcare recipients or healthcare providers should be replaced by IHIs? What are the highest priorities?</i>	<p>Hospitals' current patient identifiers (UR/MR numbers) would ideally be replaced by the IHIs (as occurs in New Zealand).</p>
<i>6. Should a directory or registry provider only be authorised to use IHIs for the specific purpose they serve at the time of application? Or should they receive a set of standard authorisations, enabling greater flexibility?</i>	N/A
<i>7. Are there any reasons why Healthdirect should not be authorised to use the HI Service to support its directory and other healthcare services?</i>	N/A
<i>8. If Healthdirect had authority to use IHIs for the NHSD, would there be an ongoing need for the HPD?</i>	N/A

9. Do you have any other comments, questions, or concerns, relating to this problem statement?	N/A
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## Clarity around healthcare administration entities and uses

The HI service is primarily aimed at improving data sharing between healthcare providers. There is also provision for sharing with ‘**healthcare administration entities**’ for ‘healthcare administration purposes.’ While the Act currently includes ‘research’ as a ‘purpose’, it does not specifically include research organisations such as Universities or Research Institutes. It is critical that these entities are included within this list, as well as CQRs that are not based in universities (such as those based in Medical Colleges or Not For Profit organisations). This will require an organisational/individual authorisation process to be developed.

Specific Consultation questions	CQR SIG response
1. What safeguards should be in place to provide confidence in the use of HIs by healthcare administration entities?	CQR- managing entities such as Universities, Institutes and other incorporated entities (e.g. Not For Profits and Medical/Surgical Colleges) should apply for authorisation to access IHIs for quality improvement and research purposes. Appropriate authorisation criteria should be developed with input from the CQR sector.
2. Are there any types of healthcare administration entities that should be added to, removed from the list?	CQRs should be added to the list of healthcare administration entities, to allow them to access and use IHIs for data management and data linkage as described above. Currently universities and research institutes are not listed as ‘healthcare administration entities’ on page 19.
3. What safeguards would provide confidence in the use of HIs for healthcare administration purposes?	It is important to clarify the right for researchers and CQRs to access HIs for use in research and QI activities. It is recommended that the legislation clearly addresses how individual universities and/or researchers will be authorised to access HIs for these purposes.
4. Are there any other healthcare administration purposes that should be added to, or removed from the list?	Undertaking healthcare/health system quality improvement (CQRs).
5. Do you have any other comments, questions, or concerns, relating to this problem statement or policy objective?	N/A

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