Private Healthcare Australia
Better Cover. Better Access. Better Care.

Healthcare identifiers framework

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14.4 million Australians.

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

Are there specific situations, systems, or areas of healthcare where HIs should not be used by default?

No.

What would be the most effective and achievable policy levers for increasing the use of HIs in state and territory public hospital systems, and private hospitals?

Linking HIs with private health insurance and billing data would provide significant incentives for providers and funders to use HIs by default, which would provide greater coverage across the health system. This should provide a framework for greater interoperability and capacity.

What would be the most effective and achievable policy levers for increasing the use of HIs amongst allied health providers, and other small private providers?

Linking HIs with private health insurance and billing data would provide significant incentives for providers and funders to use HIs by default, which would provide greater coverage across the health system. This should provide a framework for greater interoperability and capacity.

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?

The rollout may be slow, particularly where consumers need to provide consent. However, greater interoperability will provide incentives for consumers to consider who they would like to use HIs and thus provide incentives for providers. Linking HIs to private health insurers would provide greater value as funds could help fill in gaps for consumers where their provider does not use HIs.

Which alternative unique identifiers for healthcare recipients or healthcare providers should be replaced by HIs? What are the highest priorities?

Some health funds may choose to use IHIs to help identify their customers if that option is available. If consumer consent is required, it will take a long time for private health insurers to use HIs as the only mechanism to identify customers. Further, existing systems may not support HI formats, and may need to be modified.

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?

Standard authorisations would be preferred.

Are there any reasons why Healthdirect should not be authorised to use the HI Service to support its directory and other healthcare services?

Nil comment.

Problem Statement 2 - Scope of healthcare and provider eligibility

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?

Yes.

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?

All healthcare providers should be able to use HIs. There are currently significant difficulties for health funds in adequately identifying some providers where there is no clear accrediting body – an HI would have significant benefits for this group and funders such as health insurers.

The group of healthcare support providers will be evolving – we already see weaknesses in the Private Health Insurance Act where new and emerging professions, such as mental health peer support workers, are unable to be recognised quickly and effectively. The use of delegated instruments would ensure more flexibility.

Should the types of organisations defined as 'healthcare support provider organisations' be able to use HIs? If so, how should they be able to use them? If not, why not?

Nil comment.

Are there any types of professions, organisations or services that should be added to, or removed from, the 'healthcare support provider' lists?

Registered health benefits organisations (private health insurers) should be added.

Private health insurers and their agents assist customers through both direct services and Chronic Disease Management Programs as defined in the Private Health Insurance Act 2007.

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?

Yes, and the type of HI should distinguish between different types of health professionals.

Are there any healthcare professionals that are currently not eligible for an HPI-I but should be?

Nil comment.

Are there any types of professionals, programs and services that should not be able to use HIs?

No.

Are there any other possible changes to the Act that would increase connected care outcomes and health system interoperability?

Recognising the increased role of private health insurers as funders, facilitators and providers of health care and associated support services.

Problem Statement 3 - Clarity around healthcare administration entities and uses

What safeguards should be in place to provide confidence in the use of HIs by healthcare administration entities?

Similar safeguards to those required by organisations holding health information are necessary. Private health funds are well practised at holding health information, and would welcome similar standards for the use of His.

Are there any types of healthcare administration entities that should be added to, or removed from the list?

Registered health benefits organisations (private health insurers) should be added.

Are there any other healthcare administration purposes that should be added to, or removed from the list?

Nil comment.

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

Given that other location specific organisation identifiers exist, should HPI-Os be used to identify locations, or services, or both?

Both. It is important in many instances to know what service was provided at which location. For example, there is a significant difference for a consumer from Burke between a service provided in Burke, in Dubbo or in Sydney – even if it is the same provider.

What would be the most effective and achievable policy lever or operational support mechanism for getting organisations to implement an appropriate HPI-O structure, further to the provision of direct funding?

Over time, using a clear identifier will make it significantly easier for payors and providers to exchange payment for services. The inbuilt efficiencies may drive uptake, leading to contractual obligations.

How could we change legislation or policy to make HPI-O and HPI-I relationships easier for healthcare providers to create and manage?

Nil comment

What operational or procedural changes to the HI Service would be required to support these changes?

Nil comment

Problem Statement 5 - Healthcare consumer and provider choice

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?

Nil comment

What safeguards should be in place to ensure that healthcare consumers can disclose their IHI in a safe and secure way?

Consumers should be given the choice to opt-in, and not be coerced to do so.

However, where there are demonstrable efficiencies that can be gathered by a business from using an IHI, it should be permissible to share those gains with the consumer. For example, consumers consenting to use their IHI with a private health fund may be able to attract rebates more quickly than those that do not, as their identity as the patient receiving the service has been established.

The identifiers should only be used for the purposes for which the business seeks consent. For example, if those identifiers are collected by a private health funds, they should not be shared with any supplier businesses without specific consent.

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?

Private health insurance should be exempted from current provisions as it is community rated, which means that funds may not discriminate on the basis of health status. This existing legislative protection means that consumers can be confident that their HI will not be used to disadvantage them.

Private health insurers should be eligible to use IHIs where:

- The person has given consent, and
- The health fund has made reasonable efforts to establish the person's identity, for example through 100 points of ID.

Should there be any unauthorised purposes for insurers or employers to use HIs?

Nil comment

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?

Yes.

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?

Yes. Private health insurance is community rated, which means that funds may not discriminate on the basis of health status. This means that consumers can be confident that their HI will not be used to disadvantage them.

Problem Statement 6 - Support for Healthcare Technology Services

Nil comment

Problem Statement 7 - Clarity around permitted uses and concerns about penalties

Nil comment

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

Should the Act continue to specify data flows and purposes, or should the Act move to a broader authorisation model?

An authorisation model would be more appropriate.

Where would the use of schedules, rule-making powers, or other legislative instruments be useful for granting and managing authorisations?

The use of subordinate legislation for types of individuals and organisations eligible for an HI would provide greater flexibility than primary legislation.

Should decision making power be devolved from Parliament, and if so, to what level?

The use of disallowable instruments from the Minister or their delegate would be appropriate for many of functions.