Delivering quality care more efficiently – Interim report

Harnessing data and digital technology – Interim report

Productivity Commission

Submission by the Australasian Institute of Digital Health (AIDH)

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AUSTRALASIAN INSTITUTE OF DIGITAL HEALTH

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Introduction

The Australasian Institute of Digital Health (AIDH) welcomes the opportunity to provide feedback to the Productivity Commission Five pillars consultation.

AIDH is providing comments to the *Delivering quality care more efficiently – Interim report* and to the *Harnessing data and digital technology – Interim report*.

We support the Productivity Commission's focus on harnessing data, technology and quality care reforms to boost productivity, provided these reforms are framed through a health outcomes-first lens. Digital health is central to this agenda, enabling safer, more connected and equitable care through interoperable information sharing, virtual models of care, responsible AI, strengthened workforce capability and sustained investment in prevention.

Our guiding principles when looking at data and digital technologies are: quintuple aim of care (which aligns with pursuit of productivity while ensuring individual health outcomes, population

health uplift, and health professional wellbeing), patient-centred healthcare and safe by design, interoperable and standards-led information sharing.

We would welcome discussing further any of the points below with the Productivity Commission.

High-level summary

Our submission highlights the central role of digital health in improving patient outcomes while supporting the Government's productivity agenda. We emphasise that productivity in healthcare must be considered through the broader quintuple aim of care rather than a narrow efficiency lens.

Key points include:

- **Quality and safety regulation:** We support greater alignment across care sectors, including a single digital portal and standardised reporting frameworks, provided these interoperate with national initiatives such as Health Connect Australia. This will reduce duplication, improve transparency, and allow resources to be redirected to frontline services.
- **Collaborative commissioning:** We support the Commission's recommendation to embed collaborative commissioning and stress that interoperable data sharing, shared care plans, and outcome dashboards are essential enablers.
- **Prevention:** Digital health is critical in prevention by enabling risk monitoring, improving health literacy, and allowing earlier intervention through tools such as telehealth, apps, wearables, and data-driven decision support.
- **Artificial intelligence:** We recognise AI's potential to improve productivity and quality in healthcare but stresses the need for careful, risk-based governance. We support the Productivity Commission's view that existing legal frameworks should be the starting point, but highlight that in health, incremental amendments alone may not be sufficient. Healthcare is a high-risk environment where harms can be irreversible, and as such, robust guardrails and human-in-the-loop oversight are essential.
- **Data access and privacy:** We support expanding data access through interoperable standards and improved use of My Health Record, while calling for stronger protections for sensitive health data. Privacy regulation should be outcomes-focused but must address the specific risks of health data use.
- **Workforce capability:** Realising productivity benefits requires a digitally capable workforce. We recommend a national minimum set of digital capabilities for all health roles, recognised digital career pathways, and investment in ongoing training to embed safe and effective use of digital health tools.

Preliminary comments

Productivity in healthcare

Seeking productivity gains in healthcare is a component of the quintuple aims of care:

- Improving patient experience
- Improving population health
- Reducing per capita healthcare costs
- Enhancing health professionals' wellbeing
- Advancing health equity

Productivity gains can be (and must be) made in healthcare by leveraging data and technology (PC, 2024), however, we caution against adopting a 'productivity only' lens: all productivity gains need to be aligned with the other dimensions of the quintuple aims of healthcare. We agree with the Productivity Commission that 'To harness these opportunities, governments must ensure that regulatory settings support innovation while managing its risks.'[1]

It's crucial to reinforce that healthcare productivity is unique and that gains in productivity must be assessed not just in terms of efficiency but also through the lens of delivering more equitable services, bringing care closer to home, enabling connected care, reducing workforce burn out. We highlight that productivity improvements in healthcare ultimately aim at better outcomes for patients.

When looking at productivity in healthcare, it is critical to adopt a holistic view that takes into accounts gains for all stakeholders - consumers, healthcare providers, businesses, and funders.

Leveraging digital health

In the last few years, myriad reviews made recommendations to leverage digital health to enable reform that would unlock productivity gains in the healthcare sector.

For example, health information sharing and digital health technologies underpins the Scope of Practice review recommendation 12 regarding reforming referral pathways, which aims to avoid unnecessary GP visits where a direct referral can be made by an allied health professional, nurse or midwife to a non-GP specialist.

Investing in health information sharing and digital health technologies is key to unlocking productivity gains by removing unnecessary activities, reducing duplication, preventing potential harm and more importantly is instrumental to achieve better health outcomes.

[1] Page 7 of the *Delivering quality care more efficiently – Interim report*.

Recommendation 12 The Australian Government implement new direct referral pathways for consumer access to specified non-General Practitioner (GP) specialist Medicare Benefits Schedule (MBS) items which meet the following criteria:

A. The direct referral made by the health professional is within their scope of practice

B. The referral is accompanied by appropriate, timely notification of the consultation to relevant treating team members including the patient's GP, and registered practice via digital mechanisms as available.

Source: Unleashing the potential of our healthcare workforce – Scope of practice review Final report. 2024.[2]

On the other hand, we are mindful that pushed to the extreme, the principle of all health professionals only working at the top of their scope of practice, in the current funding mechanism of primary care that focuses on through put, could lead to GPs being left with only the most complex of their clinical load. In this scenario, we can't expect GPs to be working the same number of hours per week as the intellectual and mental burden would become quickly unmanageable. Ultimately, this would lead to burn-out, exodus from the profession, and decrease of new entrants as there is a risk the profession would become unattractive to new doctors.
In short, short term productivity gains would jeopardise long term sustainability.
In practice, this means that remuneration of GPs will need to be reformed accordingly to reflect the increased complexity of the clinical load and allow for time between consults and fewer consults on any given day. Unchecked pursuit of rationalisation could have unintended effects and in the long run be detrimental to productivity in healthcare.

Workforce capability

Lifting the digital and digital health capability, and the data literacy of the entire care workforce must be a priority to achieve productivity gains from digital health.
AIDH recommends a national minimum set of digital capabilities for all health roles; recognised career pathways for digital health professionals; and formal recognition of digital roles in workforce planning and funding.
The Australian Digital Health Capability Framework[3] provides a stepped and consistent approach to digital capability and digital health literacy uplift across roles. Building these capabilities in the workforce is critical to unlock productivity gains from digital health. AIDH has made recommendations to Ahpra and to the Department of Health, Disability and Ageing (DoHDA) in recent submissions.[4]

[2] Available at https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf

[3] Available at https://digitalhealthworkforce.org.au/wp-content/uploads/2024/08/Australian-Digital-Health-Capability-Framework-V1.2.pdf

[4] We recommend the Productivity Commission reads our submission to Ahpra on Draft guidance on professional capabilities (https://digitalhealth.org.au/wp-content/uploads/2024/12/FINAL_AIDH_PUB_sub_Ahpra-draft-guidance-on-professional-capabilities.pdf) and our submission to DoHDA on the aged care registration scheme (https://digitalhealth.org.au/wp-content/uploads/2025/04/FINAL_AIDH_sub_AC_registration_Apr_25.pdf).

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Delivering quality care more efficiently – consultation sections

Section 1 - Reform of quality and safety regulation

Draft recommendation 1.1 The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

- We support the recommendation and suite of actions; we particularly endorse the standardised quality and safety reporting framework and data repository, and the single digital portal for providers. We agree immediate action is required and this work should be prioritised.
- The single digital portal for quality and safety should interoperate with Health Connect Australia[5] and the National Healthcare Identifiers Roadmap[6] to avoid duplicative portals and reporting burdens.
- Coordination to align quality and safety regulation across the care economy couldn't be more topical, and more urgent, as the Aged Care sector, the National Disability Insurance Scheme (NDIS) and the Childcare sector are all currently reviewing or exploring options regarding their registration schemes and/or quality and safety reporting frameworks. As seen currently in the Aged Care sector, none of this can happen without robust digital infrastructure and workforce training.

Section 2 – Collaborative commissioning

Draft recommendation 2.1 Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

- We support the recommendation.
- Digital transformation and adoption of information sharing standards FHIR[7] across the sector need to be part of the design of collaborative commissioning. We agree commissioned services should include shared outcomes dashboards.
- We agree that it is essential that in any collaborative commissioning arrangements Aboriginal Community Controlled Health Organisations (ACCHOS) must retain community control.
- We agree that data-sharing is essential, not only for joint needs assessments and evaluation of outcomes but also in the implementation and delivery of collaborative

[5] On Health Connect Australia see https://www.digitalhealth.gov.au/health-connect-australia.
[6] Available at https://www.digitalhealth.gov.au/sites/default/files/documents/national-healthcare-identifiers-roadmap-2023-2028-v1.1.pdf.
[7] The Fast Healthcare Interoperability Resources (FHIR) standard is a set of rules and specifications for the secure exchange of electronic healthcare data.

commissioning. Data sharing agreements must be in place with priority consideration given to consent and privacy.

- Digital health infrastructure and active information sharing underpin successful collaborative commissioning: interoperable data flows across primary, hospital and community settings enable partners to undertake joint needs assessments, design and deliver services, and monitor shared outcomes through formal data-sharing arrangements that underpin evaluation.
- Virtual models of care should be a core focus of collaborative commissioning programs of work, with LHNs, PHNs and ACCHOs jointly planning and procuring services that shift appropriate care from hospital to home and community. The Commission's interim report notes that collaborative commissioning can "foster new innovative models of care," creating the platform to virtual wards, telehealth-enabled multidisciplinary care, and remote patient monitoring (RPM). Examples and case studies cited in the interim report demonstrate how virtual-at-home models commissioned across settings can deliver measurable outcomes and savings. In parallel, RPM—using wearables and connected devices—enables earlier detection of deterioration and timely intervention, preventing adverse events and avoidable hospital presentations; these capabilities should be explicitly specified in local commissioning plans and outcome measures.
- Further to the point that *LHNs, PHNs and ACCHOs should be sufficiently resourced to undertake comprehensive joint governance*, they also should be sufficiently resourced (infrastructure and governance) to implement the required data-sharing arrangements mentioned above and other digital health enablers such as shared care plans, virtual care pathways, and common outcomes dashboards.

Section 3 - National framework for investment in prevention

Draft recommendation 3.1 Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

- We fully support initiatives that will see greater investment in prevention in healthcare.
- Digital health plays a critical role in prevention by enabling earlier detection, improved health literacy, and more effective management of chronic disease risks. The National Preventive Health Strategy 2021–2030[8] explicitly recognises the need to *"embrace the digital revolution"* so that technology empowers Australians to be as healthy as possible, supports hybrid models of care, and helps closing the access gap for priority populations. Digital health tools – including telehealth, remote monitoring, apps, wearables, and data-driven decision support – help individuals manage risk factors and allow health services to intervene earlier, thereby preventing illness progression.

[8] Available at https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf.

- As indicated below, better data access for researchers—under robust governance—should support population-level prevention and evaluation of what works.
- Investment in health prevention should be a whole-of-government approach to tackle all the social determinants of health that range across housing, employment, environment, education, etc. It also requires a cultural and mindset shift from health policy funders to invest heavily in prevention and not only on postvention.
- We support Public Health Prevention Australia target of 5% of total health spending dedicated to preventive health by 2030. https://www.phaa.net.au/common/Uploaded%20files/Briefing%20papers/Budget%20attachments%202025-2026/PHAA%20Budget%20Submisson%202025-26%20-%20appendix%205%20-%20implementing%20prevention%20strategy.pdf

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Harnessing data and digital technology – consultation sections

Section 1 – Artificial intelligence

Draft recommendation 1.1 - Productivity growth from AI will be built on existing legal foundations. Gap analyses of current rules need to be expanded and completed.

Draft recommendation 1.2 - AI-specific regulation should be a last resort.

Draft recommendation 1.3 - Pause steps to implement mandatory guardrails for high-risk AI.

AIDH somewhat supports the intent of the recommendations.

- In our submissions to the Department of Industry, Science and Resources (DISR), and to the Department of Health, Disability and Ageing (DoHDA)[9] on Safe and Responsible AI, AIDH supported the idea of the introduction of a whole-of-economy AI Act supported by Health specific legislation / regulation where appropriate.
  We also supported the introduction of mandatory guardrails in high-risk settings such as healthcare.
- Our members note, with concern, that throughout the interim report examples supposedly related to AI are actually examples of automation. The conflation between automation and AI can lead to ignoring other technologies available to automate activities and can lead to ignore other productivity benefits of AI that are not linked to automation (such as quality improvement, easing cognitive burden, etc.).
- Research found that "GenAI informs rather than assisting or automating clinical service functions in health care. There is potential in clinical service, but it has yet to be actualised for GenAI. More clinical service–level evidence that GenAI is used to streamline some functions or provides more automated help than only information retrieval is needed. To transform health care as purported, more studies related to GenAI applications must automate and guide human-performed services and keep up with the optimism that forward-thinking health care organizations will take advantage of GenAI."[10]
- Similarly, the definition of AI at Box 1.2 focuses on generative AI. This is a narrow definition of AI and we encourage the Productivity Commission to be more granular in their approach to AI. An example of classification available is Classification of AI Algorithms (Kumar, 2018; Russell & Norvig, 2016).[11]
- Recommendation 1.1 – AIDH agrees with the idea that we don't need to create new laws when existing law is appropriate or just needs to be amended.

[9] Respectively available at https://digitalhealth.org.au/wp-content/uploads/2024/11/FINAL_Pub_AIDH_sub_DISR_guardrails_AI_Sept_24.pdf and https://digitalhealth.org.au/wp-content/uploads/2024/12/FINAL_AIDH_sub_DoHAC_SanR_AI_Oct24.pdf.

[10] Yim D, Khuntia J, Parameswaran V, Meyers A Preliminary Evidence of the Use of Generative AI in Health Care Clinical Services: Systematic Narrative Review *JMIR Med Inform* 2024;12:e52073 doi: 10.2196/52073.

[11] Rodgers, Mark & Mukherjee, Sayan & Melamed, B. & Baveja, Alok & Kapoor, Ajai. (2024). Solving business problems: the business-driven data-supported process. *Annals of Operations Research*. 332. 1-37. 10.1007/s10479-023-05770-z.

However, in its report, DoHDA has already identified the limits of current legislation (both heath specific and whole-of-economy) in ensuring safe and responsible use of AI in healthcare.[12] The interim report 'reads' the findings as requiring 'minor amendments', however, some of the amendments are required against critical themes such as standards of care, data access and disclosure, or responsibility and liability. In healthcare, harm can be life altering, irreversible, with no way of compensation.

- In the absence of a specific approach to AI, it's critical to clarify of how existing rules currently apply, especially when the introduction of AI in a tool of device blurs the line of its definition (or purpose).
  The issue of regulation of AI scribes provides a good case study. The Therapeutic Goods Administration (TGA) only recently clarified how the regulation of medical device software applies to AI scribes. For a (rather long) period that saw mass adoption of AI scribes in healthcare, there was uncertainty around their regulation, with little oversight and a lack of guidance for clinicians and health professionals using them. The uncertainty and lack of clarity led to state jurisdictions to announce blanket bans on the tools in public hospitals.
  Given the extraordinary pace of adoption of new AI technology (from emergence to mass adoption), we can't wait months (or years) for new devices to stress test regulation. If current legislation and regulation are appropriate, then regulators need to get better and faster at providing clear and robust advice on how those legislation and regulation apply to emerging tools – in a technology agnostic manner.
  In the absence of clear advice and guidance, there is a real risk that these matters will be tested in Court; that is after something has gone wrong. AIDH members have noted that complex healthcare matters should be resolved through clear legislation and regulation not through a contested court process.
  We already see varying points of view from the health sector regarding where the liability should lie when using AI supported tools in healthcare.
  It is a matter of urgency to complete the gap analyses and to provide very clear guidance on which legislation and regulatory instruments apply to AI in healthcare and how, and where there are gaps to fill them appropriately and swiftly.

- Recommendation 1.2 – AIDH understands and supports the intent to avoid duplication of regulation, however, we do not support the expression 'last resort' and recommend adopting better wording that wouldn't suggest inertia or vacuum.

- Recommendation 1.3 - AIDH posits Health is a high-risk sector that requires specific attention. Many in the healthcare sector have adopted and adapted the voluntary guardrails. Making the guardrails mandatory would ensure a consistent national framework and would provide clarity and reassurance to consumers.
  If steps to implement mandatory guardrails are paused, a time-boxed plan should be set to complete gap analyses and publish interim guidance, with dates and responsibilities. It also must be accompanied by robust education on the voluntary guardrails – what they are and how to implement them.
  The interim report notes a risk of duplication of reporting against several legislative

[12] Available at https://www.health.gov.au/sites/default/files/2025-07/safe-and-responsible-artificial-intelligence-in-health-care-legislation-and-regulation-review-final-report.pdf.

frameworks. This can be solved by putting in place the right infrastructure to allow for streamlined and portable reporting.

- AIDH supports the introduction of a National AI in Healthcare Council, as outlined in the Australian Alliance for AI in Healthcare National policy roadmap[13].

Further comments on AI and productivity gains

We must consider the externalities of artificial intelligence, particularly the environmental impacts. This includes energy and water usage associated with AI models. We need to integrate a sustainability lens into productivity calculations and cost modelling, encouraging the use of lower data-usage models that consider downstream costs like electricity.

Also, there is a concern about the sustainability of the business models of some AI providers. The market is highly concentrated around a small number of large language model providers, which currently operate at a loss. This concentration poses a risk to market sustainability and may influence the long-term viability of these technologies in healthcare.

Time for decisive action

Continued reviews and pauses create uncertainty that the Productivity Commission's interim report flags as detrimental to innovation and safety, stifling investment and leaving clinicians and consumers without clear guardrails. Australia now needs decisive action on AI regulation; even the European Union (27 countries negotiating across languages and legal systems) has enacted an AI Act, demonstrating that clear, risk-based rules are achievable at pace (regardless of one's views on the actual content of the Act).

It's time for the government to move from consultation to implementation: adopt an outcomes-focused, risk-tiered framework with health-specific safeguards (including clinical governance and human oversight), clear accountability for high-risk uses, and a firm timeline for commencement and completion. Regulatory clarity will enable safe innovation, accelerate digital productivity gains, and, most importantly, deliver better outcomes for patients.

Section 2 – Data access

Draft recommendation 2.1 - Establish lower-cost and more flexible regulatory pathways to expand basic data access for individuals and businesses.

- AIDH agrees that a one-size-fits-all approach to data access is impractical. In healthcare, pathways should leverage the existing Health Connect Australia / My Health

[13] Available at https://aihealthalliance.org/wp-content/uploads/2023/11/AAAiH_NationalPolicyRoadmap_FINAL.pdf.

Record stack, Sharing by Default present and future legislation, and the Healthcare Identifiers Act, rather than creating parallel pipelines.

- As noted in the interim report, the health sector is already making sharing of health information a priority–from the individual level of health practitioners and health services to infrastructure like My Health Record and Health Connect Australia to legislative change via the Sharing by Default legislation–and exploring multiple pathways.
- Complexities related to health data, fragmentation of the healthcare sector, and varying degrees of digital maturity mean there are many hurdles that prevent moving rapidly but the sector is certainly going in the right direction and taking into considerations all the issues covered in the interim report. The Productivity Commission should recommend to government to increase its support and resourcing for all initiatives that improve health information sharing.
- A dimension missing from the interim report is opportunities that can be leveraged by formally considering health data as a national asset. The Digital Health CRC has recently published a report that provides insights into the benefits of taking such an approach.[14]
- Work done by the Australian Institute of Health and Welfare (AIHW) with the Primary Health Networks (PHNs) on the National Primary Health Care Data Collection (NPHCDC) needs to be prioritised and seriously invested in – including capacity building investment.[15]
- As the modernisation of My Health Record (MHR) progresses, it is critical to explore opportunities for secondary use of MHR data for research and public health purposes. AIDH has welcomed legislation to establish permanently the Australian Centre for Disease Control (CDC). The success and productivity gains we can expect from a high-performing CDC will hinge on access to high-quality real-time (or near-real time) health data.
- On data as it relates to prevention, AIDH is aware of the lack of access to health data by researchers. Poor access to health datasets is hindering the ability of researchers to provide the evidence base needed to support the adoption and implementation of innovative programs in health prevention and population health.
- The Interim report mentions risks associated with bias in data used to train AI models. In healthcare, equity issues can arise when the underlying data reflects existing social and systemic inequalities, such as underrepresentation of certain populations, poorer quality of data from disadvantaged groups, or biases in how care is delivered and recorded. If these inequities are not addressed, AI models risk perpetuating or even amplifying disparities in diagnosis, treatment, and access to care. This has direct productivity implications: inequitable AI systems can lead to misallocation of

[14] Digital Health CRC. (2025). *Heath data is a national asset*. Available at https://digitalhealthcrc.com/wp-content/uploads/2025/08/FINAL_Health-Data-is-a-National-Asset.pdf.
[15] More information on this program is available at: https://www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/primary-health-care-data-development/work-program-summary.

resources, increased errors, and the need for corrective interventions, all of which reduce efficiency. Embedding equity considerations into training data and model design can improve the accuracy and applicability of AI across diverse populations, ultimately driving more effective, sustainable, and productive healthcare delivery.

The PC is seeking feedback on how to introduce lower-cost and more flexible data access pathways for a broad range of use cases.

In line with draft recommendation 2.1, we are also seeking feedback on the sectors and use cases where the new pathways could most valuably enhance data access in the short term. We note that the banking and energy sectors are already covered by the Consumer Data Right.

• **What types of data should be covered by the pathways?** Are there any issues with the data types proposed in table 2.2 that should be considered?

• **How should data be made available under each of the pathways?** Could the scope and requirements outlined for the proposed industry-led basic data exports and standardised data transfers pathways effectively support a broad range of use cases?

• **Where should data access be prioritised in the economy?**

– Which sectors or data holders already enable individuals or businesses to access data overseas due to local laws, but are not meeting comparable standards of sharing in Australia?

– Which sectors or data holders in the economy have data that could be accessed in a useful, digital format to support high value use cases at low cost?

– Which sectors or data holders are already trading data about individuals or businesses with third parties, so that access to that data could be achieved at a low incremental cost?

The PC is seeking feedback on how the new data access pathways could be expanded over time in a methodical and predictable way, while enabling innovation. We are also interested in views around how the Australian Government can best support this process.

• **What should the readiness review process look like?**

– How should sectors and data holders be identified to undergo the readiness review?

– What criteria should be considered in the readiness review?

– Which body – either new or existing – should do the assessment?

• **How do we best engage data holders or promote an ecosystem of intermediaries and third-party providers?**

– Should data holders be able to apply fees and charges?

• **What role should the Australian Government play in the development and coordination of the pathways, and supporting its success?**

• **What is a reasonable timeframe for designing and implementing data access pathways?**

The private healthcare providers, private health insurance and primary health care industries are critical sources and holders of health care data (which can be de-identified and/or have information sharing restrictions), which when securely shared with at a national level via Health Connect Australia (a suite of initiatives that includes the national Health Information Exchange (HIE)), will greatly contribute to the richness of population-level health data and can be used to improve preventative health measures or influence health-related policies and legislation.

This can be facilitated through supporting the adoption of electronic health records and participation in the national HIE, and through the introduction of legislation such as sharing by default legislations to include the private sector, primary health and allied-health providers.

Section 3 – Privacy regulation

Draft recommendation 3.1 - An alternative compliance pathway for privacy.

Draft recommendation 3.2 - Do not implement a right to erasure.

- AIDH supports outcomes-based privacy compliance, with explicit health safeguards for clinical safety, patient control and secondary use. AIDH would welcome the opportunity to discuss further specifics of the recommendations as they would apply to healthcare but not in a sector agnostic manner.
- *Comment: The interim report presents a view of the right of erasure that lacks nuance and focuses on compliance burden. That something is hard to do is not a reason not to do it if it's the right thing to do. In overseas jurisdictions, the right to erasure was implemented with limitations when it contradicts other legal or professional requirements, as it is the case in healthcare.*

Section 4 – Digital financial reporting

NA

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Endorsement

AIDH endorses the submission of the Public Health Association of Australia (PHAA) to this consultation.

Conclusion

Our submission reinforces that digital health is not only about efficiency gains but about delivering safer, more connected and equitable care. With the right regulatory settings, investment in capability, and commitment to interoperability, Australia can unlock significant productivity benefits while ensuring that patient outcomes remain at the centre.

As a final word, we would like to highlight the findings of Mark Considine in *The Careless State: Reforming Australia's Social Services* that show that seeking productivity gains in the care sector without the appropriate safeguards can (and will) produce unintended consequences and lead to poorer outcomes for people and increased costs to the tax payer.

About AIDH

The Australasian Institute of Digital Health (AIDH) represents a diverse and growing community of professionals at the intersection of healthcare and technology.

The Institute has more than 250 distinguished Fellows who are experts or pioneers in digital health, and has a growing membership of professionals comprising doctors, health informaticians, nurses, midwives, allied health, other clinicians, administrators, and health technology business leaders.

The Institute provides objective, non-partisan, and independent advice on the use of technology and health informatics to improve consumer outcomes and solve the most pressing challenges facing our healthcare system.

The Institute's unique composition and reach brings together an extraordinary network of Australia's leading digital health experts across the private, public and community sectors to advance our nation's transition to a digital health future.

AIDH acknowledges and thanks the valuable contributions of our Advisory Subject Matter Expert panels to this submission.