RACGP response to the Department of Health Disability and Ageing's *Review of the My Health Records legislative instruments*

September 2025

RACGP

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Replication of RACGP response to online survey questions

Question 1

Restrictions on uploading certain health information

1. Should rule 19 of the My Health Records Rule 2016, which relates to restrictions on uploading certain health information, be reviewed? If so, what amendments would you propose and why?

The RACGP believes the current rule is appropriate and supports the intention behind Rule 19 to ensure appropriate, structured, and clinically significant documents are uploaded into the My Health Record system.

Allowing other users, that aren't healthcare providers with a Healthcare Provider Identifier – Individual (HPI-I), to author health information could dilute the quality and trustworthiness of the information held in the My health Record.

1a. What considerations should guide the review of this rule?

The RACGP suggests that if this rule were to be expanded to allow upload access a compromise could be to have a dedicated section for information uploaded by non-health professionals.

Question 2

Nominated healthcare provider

2. Should the definition of a 'nominated healthcare provider' be expanded to include other health professionals involved in patient care (e.g. pharmacists, or enrolled nurses, or midwives who are not registered nurses)? Explain why or why not.

No.

The RACGP does not support the definition of a nominated healthcare provider being expanded.

A nominated healthcare provider has a long term and continuing care-based relationship with a patient. Allowing other healthcare providers who do not have this established relationship to be considered as a nominated provider will dilute the quality of shared health summaries and their helpfulness in acute clinical settings.

As medical generalists, GPs are the only healthcare providers who engage with patients in an undifferentiated, non-specialised manner, managing a broad range of health issues across all life stages. This positions them uniquely to provide comprehensive, continuous, and coordinated care which is documented in a shared health summary.

Some health professionals by nature will not have a broad understanding of a patient's health. For example, a pharmacist could have a thorough understanding of the medicines a person is taking, but limited knowledge or understanding of their overall health. Similarly, healthcare providers such as midwives are typically only involved in a patients care for a relatively short period of time, and for a specific condition.

The RACGP does not believe it is appropriate for these types of healthcare providers to be nominated healthcare providers.

Question 3

Shared health summary

3. Should other health professionals also be able to author a shared health summary? If so, what types of health professionals and why?

No.

The RACGP does not support other health care providers being able to author a shared health summary.

As per our answer to question 2, a nominated healthcare provider has a long term and continuing care relationship with a patient, and they should remain as the sole author of a shared health summary.

There would be no value in having multiple shared health summaries, authored by various people, particularly in acute clinical settings.

Allowing multiple shared health summary authors, including other GPs who are not the nominated healthcare provider, will dilute the quality of information shared in My Health Record and contribute to fragmented care.

An event summary is an appropriate avenue for other healthcare providers to share relevant health information.

Question 4

Shared health summary

4. Do you think that shared health summaries are still relevant as we modernise the MHR system? Explain why or why not and if possible, detail your experience with shared health summaries.

Yes.

The RACGP supports shared health summaries as a valuable source of information.

Real-time sharing of general practice data would improve patient safety and overall healthcare outcomes. The RACGP recommends patient data is automatically and continuously shared with My Health Record from general practice clinical information systems and national repositories like the Australian Immunisation Register (AIR). This could be done in a way that reflects the structure of a current Shared Health Summary.

Question 5

MHR participation requirements

5. Are the participation requirements as set out in the My Health Records Rule 2016 fit for purpose?

Yes.

The RACGP supports the current participation requirements and has provided guidance and resources to assist general practice, and GPs meet their participation requirements for the My Health Record.

Question 6

Cyber security

6. Do the provisions in the My Health Records Rule 2016 need to be more specific in their application to cyber security?

The RACGP supports the current rules supporting access, data handling and other security measures in the My Health Record.

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Question 7

Emergency access

7. Are Rules 7 and 8 under the My Health Records Rule 2016, which pertain to emergency access, still fit for purpose in their current form?

Yes.

The RACGP supports the emergency access provisions as an important function where access to a person's My Health Record can provide information to support patient care.

Reports of misuse or inappropriate access do not necessarily mean the process is not fit for purpose. The RACGP would support further education and training regarding this feature for all health care providers.

Emergency access is often used where a patient cannot remember the document access code they have set up to protect information in their My Health Record. The RACGP suggests creating alternate methods of document recovery when a patient has forgotten their access codes to minimise the emergency access function being used.

Question 8

Deceased recordholder

8. Should authorised and nominated representatives continue to have access to a deceased recordholder's MHR? Explain why or why not.

Yes.

The RACGP supports the current access provisions to My Health Record after a person is deceased.

The My Health Record may contain important information that authorised and nominated representatives may need to access following the record holder's death including information for coroners, for legal purposes or public health purposes.

The current process where the record is suspended by the System Operator, with very limited recourse for access, seems unnecessarily prohibitive.

8a. If access was to be continued, should this apply equally to authorised and nominated representatives? If not, why?

Yes.

The RACGP's view is that given both authorised and nominated representatives had access when the recordholder was alive, it could be presumed access after death is permissible.

8b. What should that access involve? (e.g. view all or limited information?)

Access to documents/information should remain the same as when the record holder was alive, however, access should be 'view only'.

8c. For what purposes should access be granted?

If access is provided by default, no purpose would need to be specified. Representatives may want to access the record to assess inheritable conditions or complete paperwork related to the deceased.

8d. If applicable, for how long should such access be retained?

Access could align with retention of other medical records, typically 7 years for adults or up until aged 25 for people under 18 years of age.

Question 9

Deceased recordholder

9. Should nominated healthcare providers and/or other healthcare providers continue to have access to a deceased recordholder's MHR? Explain why or why not.

Yes.

The RACGP supports access remaining in place for healthcare providers who had previously cared for the recordholder and had access while the recordholder was alive.

9a. What should that access involve? (e.g. view all or limited information?)

Healthcare providers should have the same access to information they had prior to the recordholders death, however, access should be limited to 'view only' with no ability to upload, edit or delete.

9b. For what purposes should access be granted?

As per the answer to question 8c - if access is provided as a default, no reason needs to be specified.

9c. If applicable, for how long should such access be retained?

As per the answer to 8d - access could align with retention of other medical records, typically 7 years for adults or up until aged 25 for people under 18 years of age.

Question 10

Assisted registration

10. Is there an ongoing need for assisted registration?

Yes.

The RACGP recognises there is a limited need for assisted registration, however, it is still useful to have this option if the need arises.

Question 11

Assisted registration

11. If assisted registration is to be retained, should any revisions to the process be considered?

No.

Question 12

General feedback

12. Are there any instruments that you believe are no longer fit for purpose, necessary or require revision? If yes, please explain reasoning.

No comment.

13. Are there any specific provisions in the instruments that you believe are no longer fit for purpose, necessary or require revision to better support the operation of the MHR system? If yes, please explain reasoning.

No comment.

14. Are there any issues that you would like to address that have not been covered by any other questions? If yes, please explain reasoning.

No comment.

Question 15

National Application Rules

15. Do you have any concerns or comments about the My Health Records (National Application) Rules 2017 being repealed and remade into a new instrument with alignment of the other instruments?

No comment.

16. Do you have any other comments related to the scope of the review?

No.

17. Do you have any overall feedback or comments about the operation of the MHR system?

The RACGP welcomes ongoing efforts to modernise the legislative tools governing the My Health Record system. We hope work will also continue on improving usability, data quality, and integration with general practice systems and workflows.

Adopting structured data that can be easily shared, tracked, and used in other healthcare systems and reports must be a priority. The RACGP supports the adoption of Fast Health Care Interoperability Resources (FHIR) standards to enhance interoperability and enable seamless data exchange.

The RACGP supports the My Health Record as a tool to complement, not replace, direct communication between healthcare providers. Overall, the RACGP sees the improvements suggested in this paper as essential to making My Health Record a more effective, efficient tool that supports better patient care.