

Submission by the Australian Nursing and Midwifery Federation

Submission to the Joint Select Committee on Artificial Intelligence

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**Australian
Nursing &
Midwifery
Federation**



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Key Points

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country. The ANMF thanks the Joint Select Committee on Artificial Intelligence for the opportunity to provide feedback on the Terms of Reference.
2. This submission responds selectively to the terms of reference and builds on the ANMF's previous work on artificial intelligence (AI), digital health, and data infrastructure. The ANMF approaches AI from both a professional and industrial perspective, recognising that its use can affect care, clinical decisions, workload, staffing, job design, and conditions at work.
3. The ANMF does not approach AI as inherently beneficial or inherently harmful. Rather, its value will depend on how it is implemented and applied in practice. AI should augment the existing expertise of nurses, midwives, and care workers to provide safer, more connected care and should improve, rather than diminish, the quality of their work experience.
4. ANMF members have raised concerns about patient safety, loss of professional autonomy and judgement, inadequate training and support, technology-driven job redesign without consultation, and increased workload or documentation burden.
5. Human therapeutic touch, literally and metaphorically, is core to nursing and midwifery. AI should support the human work of care by reducing avoidable burden, improving access to useful information, and giving professionals more time with the people they care for. AI should never be used as a substitute for human-delivered care.
6. For the ANMF, the productivity dividend from AI in health should be measured in hours returned to care, not care hours removed. AI must never be used to justify reductions in safe staffing, nursing or midwifery positions, skill mix, ratios or care hours. It can support the work of expert clinicians, but it cannot replace them.



7. The adoption of AI must be accompanied by clear, enforceable, and coordinated regulation. Nurses, midwives, care workers, and their unions must be meaningfully engaged prior to important decisions being made and throughout the implementation and review process to ensure that any AI implemented remains fit for purpose and any potential harms to patients, models of care or the workforce are avoided.
8. Professional judgement must be protected, Australian control over sensitive data and critical infrastructure must be strengthened, and accountability must sit with the people and organisations that have the power to make and control decisions about systems change.

Terms of Reference

(a) the opportunities presented by artificial intelligence (AI) to lift Australia's resilience, productivity growth, economic competitiveness, and living standards

9. AI offers real opportunities in health. Previous ANMF work has identified potential uses in reducing repetitive and time-consuming work,¹ improving access to information, supporting diagnostics and risk identification, remote monitoring, workforce planning, research, and professional education and training.² Used well, AI can reduce duplication and digital burden and create more time for patient care.
10. However, these gains should not be used to justify workforce reductions. In health, productivity should be judged by whether care is safer, more accessible and therapeutic, whether unnecessary work is reduced, and whether nurses, midwives and care workers have more time and capacity to provide high-quality care. Time returned to care includes assessment, clinical reasoning, communication, care planning, clinical supervision and professional reflection and safe handover. Documentation and clinical handover can themselves be part of clinical care, supporting communication, reflection, informal coaching opportunities and care planning, AI should augment these practices rather than treat them as low-value tasks that can be automated out of clinician's hands.



11. AI must never be viewed as a solution to workforce shortages or used to mask or bridge chronic understaffing. Any efficiencies should strengthen care capacity, not be converted into staff cuts, reduced skill mix, or fewer care hours. AI-generated efficiencies must not be counted as equivalent to nursing or midwifery hours or used to alter staffing establishments, reduce rostered hours, dilute skill mix, undermine nurse-to-patient ratios or midwifery staffing models, or reduce mandated care minutes in aged care.

(b) the opportunities for the benefits of AI to be spread across Australia's suburbs and regions

12. AI has the potential to improve access to health care in regional, rural, and remote communities. It may improve access to specialist knowledge, support clinical decision-making and diagnostics, enable remote monitoring, and provide new opportunities for education and professional support. These benefits are particularly relevant where distance and limited access to specialist services already affect care. AI should be used to strengthen the capacity of local health services and the nurses, midwives, and care workers who provide them.
13. These benefits will not be shared equally without deliberate attention to digital access and readiness, as not all communities, health services and workers will begin from the same position when it comes to digital access. Differences in connectivity, access to reliable technology, digital capability, and local support may determine whether AI improves care or creates another barrier to it. AI systems must also be appropriate to the population and setting in which they are used. A system that performs well in one service or population cannot simply be assumed to be suitable elsewhere.
14. The expansion of AI must not become a pathway to reducing people's access to nurses, midwives and care workers. The ANMF has previously cautioned against AI being used to gatekeep access to human practitioners, particularly for people and communities who already experience poorer access to health care. People in regional, rural and remote communities should not receive a lower standard of care because an automated or virtual option is available, and these systems should not replace a person's access to human practitioners as a means of cost-saving. ANMF members have also raised concerns about internet access, digital



literacy, reduced face-to-face assessment, additional workload, and inadequate backup in digitally-enabled models of care. Human care, including face-to-face assessment where required, must remain available.

(c) the opportunities of AI and robotics to drive research and innovation, new industries and business, and export opportunities, including in sectors of Australian comparative advantage such as agriculture, resources, health and medical research, advanced manufacturing, financial services and defence industry

15. AI research and innovation in healthcare should address problems that matter to people receiving care and the workforce. Nurses, midwives, and care workers should be involved in defining the problem, designing and testing systems, piloting their integration into models of care, and evaluating their effects after implementation. Too often, our members, who represent the largest group of health professionals in Australia, tell us they are left out of early discussions on technological change and that decisions are made by those who have little understanding of how care is delivered on the floor and whether a new system can realistically integrate into how things are done. Consultation at the end of development is too late to meaningfully influence a system that has already been selected or designed. Nurses, midwives and carers who will use these systems should be involved in problem identification, planning and procurement, testing and decision-making before any vendors are confirmed.
16. Technical performance alone does not determine whether an AI system is effective in health care. A system that performs accurately in testing may still duplicate work, fragment care, or constrain professional judgement once implemented. Systems should be evaluated in the clinical settings and workflows in which they will be used, including through staged implementation, simulation or other formative evaluation where appropriate, and monitored after implementation. Where AI supports clinical decisions, nurses and midwives must retain a genuine ability to question, disregard, override, or escalate an output.³



(e) the opportunities for Australian sovereign AI capability, including the measures required to build, retain and commercialise domestic capability, grow research and development, and attract and retain investment and talent

17. Australian sovereign AI capability should include the capacity to develop, host, inspect, govern, adapt and, where necessary, replace the AI systems on which essential public services depend. Sovereignty is not achieved simply because data or servers are physically located in Australia. Data sovereignty can be breached if an overseas entity retains operational control over the infrastructure or model, determines contractual terms, or can restrict access to the technology. Domestic computing infrastructure and sovereign data centre capability are therefore part of Australia's capacity to exercise meaningful control over AI.
18. Australia does not need to reproduce the largest overseas models to build useful sovereign capability. There is a strong case for investment in smaller and specialised systems suited to Australian economic, cultural, and public service needs. The National AI Plan identifies targeted, high-value applications, including health care, as an area of Australian strength and notes that locally developed models may better reflect Australian cultural and language contexts and mitigate data security risks.⁴
19. Public investment in AI capability should deliver enduring public benefit, including secure jobs, workforce development, access to domestic computing and research infrastructure, local supply chains, and the retention of intellectual property and economic value in Australia. Capability should not be measured only by the presence of multinational providers or data centres in Australia.



(f) the importance of data sovereignty, and the opportunities presented by narrow, domain-specific AI models trained on Australian data in areas of Australian sectoral expertise

20. Patient, workforce and organisational data must be protected throughout the lifecycle of AI technologies, including where products are transferred, acquired, outsourced or managed by another owner. Protections should cover secondary use of data, model training and fine-tuning, ownership changes, subcontracting, and workable exit arrangements. Data sovereignty is often reduced to the physical location of servers, but storing data in Australia does not establish sovereignty where an overseas entity retains access to the data, controls the infrastructure or model, determines contractual terms, or can use Australian data to improve a proprietary product. Effective sovereignty requires jurisdictional and operational control over how information is accessed, processed, transferred and repurposed, including secondary use, model training and fine-tuning, ownership changes, subcontracting and workable exit arrangements. These protections must extend to information generated through AI use, such as prompts, outputs, logs, embeddings, inferred information and model telemetry, not only the original dataset supplied to a system. Sensitive clinical and workforce data should not be transferred or made available for AI training without clear lawful authority, strict governance, and demonstrable public benefit.
21. The ANMF considers health and other public sector data to have significant public value. Where Australian public data is used to develop or improve AI, its use should have a defined purpose and duration, preserve public control, prevent unauthorised incorporation into proprietary models and deliver a clear public benefit. Publicly generated data should not simply be converted into privately controlled products that governments must later licence back from external providers.
22. Aboriginal and Torres Strait Islander Data Sovereignty is distinct from Australian data residency. The Australian Government's Framework for Governance of Indigenous Data recognises the importance of Aboriginal and Torres Strait Islander peoples having greater agency over government-held Indigenous data across the data lifecycle.⁵ Where AI systems



use data relating to Aboriginal and Torres Strait Islander peoples, governance and evaluation should involve Aboriginal and Torres Strait Islander communities, Aboriginal Community Controlled Health Organisations, Aboriginal health workers and practitioners, and Aboriginal nurses and midwives as relevant. Systems should also be assessed for cultural safety and should not reinforce deficit-based assumptions or reduce access to culturally safe, community-led care.

23. Narrow or Australian-trained health models may offer benefits where they are better suited to local populations and clinical settings. Australian data is not, however, a substitute for good governance, cultural safety or clinical validation. Systems still need to be tested for the populations and settings in which they will be used, with nurses, midwives, and affected communities involved in judging whether they are safe and useful.

(g) the workforce and skills implications of AI, including the adequacy of Australia's education system, job creation and displacement, and the effects on the quality and security of jobs

Workload and job quality

24. AI should improve jobs, not remove the workforce from health and care. It should not be used to reduce nursing or midwifery positions, weaken staffing or skill mix, or reclassify workers in ways that diminish professional standing, responsibilities, conditions, or pay. Its value to the workforce is in reducing avoidable digital burden, supporting people to work safely and to their full scope of practice and returning time to care.
25. AI can create work as well as remove it. Nurses and midwives may need to check generated content, respond to additional alerts, reconcile discrepancies, learn new systems and manage failures. Human oversight of AI can itself become a workload if it is poorly designed. Recent national survey findings reported by Hannan (2026) reinforce the need not to assume that AI automatically reduces work: among more than 6,600 workers surveyed for Unions NSW, 63% reported no change in unpaid overtime after AI was introduced, 13% reported more unpaid overtime, and one in five said their employer expected higher output because of AI.⁶ These



findings are not specific to health care, but they illustrate how productivity gains can be absorbed into higher expectations rather than returned to workers.

26. The workload effects of AI should therefore be assessed before implementation and evaluated after implementation, including the time required for checking, escalation, training, workarounds, and system failure. In health care, a claimed efficiency should not be treated as a workforce saving unless it can be shown to reduce unnecessary work without reducing care, increasing risk, or shifting work elsewhere.

Consultation and worker rights

27. Nurses, midwives and carers must be involved in decisions relating to the implantation of AI from the outset, not consulted once key decisions have already been made. Nurses, midwives, care workers, and their unions should be involved from problem definition and procurement through design, testing, implementation, and review. Consultation should be iterative because the effects of AI on work may only become clear once a system is used in practice. The ACTU has also emphasised employers' obligations to consult when AI is likely to change employees' jobs or how work is performed.⁷
28. AI and digital technologies can introduce or increase physical and psychosocial risks. Safe Work Australia's 2026 guidance states that these risks must be managed through the usual work health and safety risk-management process and that workers and their health and safety representatives should be consulted before digital technology that may affect health and safety is introduced.⁸ Work intensification also a risk with increased AI use; where routine or basic tasks are automated and workers are left with a greater proportion of work requiring extensive thought and focus. This is particularly pertinent to the caring professions such as nursing and midwifery – reducing time on spent on documentation seems a productivity gain but in fact may have allowed for pace change and consolidation from the essential and demanding emotional work of supporting people who need care and their families. In this way, over-using AI to remove 'mundane' tasks could risk increasing burnout in already overexerted professions.



29. Employers should assess AI as a workplace change, including its effects on workload, pace of work, surveillance, autonomy, staffing and psychological safety. The best way to evaluate these impacts is always through close and iterative consultation with staff and others involved to ensure the system remains fit for purpose, is not having unforeseen impacts and hear any creative solutions to how its use could be amended or expanded.
30. Workers should have enforceable rights to information, consultation, paid training and retraining, review of AI-influenced decisions and union representation. AI should not be used to analyse performance, discipline, recruit, roster or allocate work without transparency, meaningful human review and a clear way for affected workers to challenge a decision. There must also be limits placed on the collection and use of worker data.

What ANMF members are telling us

31. Recent ANMF member feedback shows that AI is already affecting practice, but many members do not have a clear understanding of how it is being used in their workplace or what guidance applies. Members raised concerns about patient safety, loss of professional autonomy and judgement, inadequate training and support, technology-driven job redesign without consultation, and increased workload or documentation burden.
32. Members are also considerably concerned about the advent of increasing workplace surveillance. Members highlighted limited clarity about the scope of surveillance, data collection and use, and the potential for information to be misinterpreted or used in performance management or disciplinary processes. Our members also raised concerns about AI in recruitment, rostering, monitoring, and performance management. Workers should *always* know when AI or surveillance technologies are being used, how they affect decisions about work, and how those decisions can be questioned or challenged. Data from AI that is ostensibly used for one process, such as medication administration, should never be used for surveillance of another purpose, such as monitoring staff breaks, without their knowledge.



Education and capability

33. Workforce capability in AI will be essential, but expectations need to be realistic. It is not reasonable to expect every nurse or midwife to understand in detail how a model was trained or configured. They do need practical, role-specific guidance about when AI is being used, what it is intended to do, its known limitations, what must be checked, when to stop, override or escalate, what information can be entered and where responsibility sits. Education should build practical AI risk literacy so nurses, midwives and care workers can recognise risks and limitations in AI outputs and know when to question, stop or escalate its use.³ Training and implementation support should be ongoing, accessible, and provided in paid work time.
34. The health system also needs specialist nursing and midwifery informatics, education, research, and digital leadership capability. These roles allow the professions to help shape systems and provide expert support, rather than expecting every frontline practitioner to become an AI specialist.
35. Education for nurses and midwives should be delivered by subject matter experts that understand both the IT system and the environment it is intended to function in (including healthcare). For example, where possible, training should be delivered by the nurse informatics experts described above. Members frequently report that training is delivered by someone who understands the information system but not the complexities and risks of care delivery. As a result, critical questions about implementation and clinical safety frequently go unanswered.
36. AI capability must also be addressed in pre-registration nursing and midwifery education. Education providers and accreditation bodies such as the Australian Nursing and Midwifery Accreditation Council should consider how AI affects curriculum, assessment and preparation for practice, while educators need appropriate support and professional development. AI must not be used to reduce access to clinical educators, preceptors, supervision or supported transition to practice. Students and early-career nurses and midwives may be particularly vulnerable if they are expected to rely on AI outputs before they have developed the experience to recognise when those outputs should be questioned.



(h) the adoption of AI by Commonwealth departments and agencies to improve services for Australians, and the transparency and accountability measures that apply to AI use

37. The Commonwealth should set a high standard in its own use of AI, especially in health, aged care and other services delivered to the community. This includes appropriate procurement, privacy, security and governance, as well as early workforce consultation, staff education, and ongoing monitoring of how AI affects services and work.
38. The AI Plan for the Australian Public Service 2025 provides useful foundations. It commits to foundational training, staff consultation and engagement, and GovAI as an Australian-based, vendor-agnostic platform intended to provide secure access to multiple models and reduce vendor lock-in.⁹ These commitments should be implemented in ways that allow workers and their unions to influence system design and provide transparent evidence about effects on service quality, workload and employment.
39. Transparency and accountability must also be meaningful to the worker using an AI-enabled system. Organisational policies often focus on procurement, data storage, privacy, and governance. These matters are important, but they do not necessarily tell a worker what they need to know when using a system while providing care. Worker-facing guidance should explain, in plain language, whether AI is being used, what the system is intended to do, its important limitations, what the worker is expected to check, when an output can be questioned or overridden, and how concerns should be escalated.
40. The burden of establishing whether an approved workplace system has appropriate data-storage arrangements, context-appropriate training data, or adequate technical safeguards should not fall exclusively on the shoulders of frontline workers. Rather, these are organisational and employer responsibilities requiring due diligence before implementation, consultation with impacted workers throughout and ongoing evaluation thereafter. Nurses, midwives and care workers should nonetheless have a genuine role in selecting, testing and evaluating systems that affect their work and care delivery.



41. Commonwealth procurement should also protect service continuity and public control. Data portability, interoperability, open standards, auditable access arrangements and workable exit provisions should be built into contracts so agencies can change providers without losing access to data or disrupting essential services. These safeguards are particularly important where health, aged care, disability or social services depend on proprietary cloud or AI infrastructure.⁹

(i) the adequacy of Australia's existing laws and regulatory frameworks as they apply to AI and whether there are any gaps that warrant reform

Clear, enforceable regulation

42. The ANMF supports clear, enforceable, and coordinated regulation of AI. AI is already being used in health and care, and regulation cannot wait for widespread adoption or a serious adverse event before responsibilities are made clear. The purpose of regulation should be practical: to support safe care, protect workers and patients, and make clear who is responsible for decisions made across the design, procurement, implementation, and use of AI. Voluntary guidance alone is not sufficient for high-impact uses of AI in health and care.
43. The ANMF supports the call made by Australian Council of Trade Unions (ACTU) Secretary Melissa Donnelly for a licensing regime for AI models that would require proactive risk mitigation by developers and deployers, ongoing transparency, regular safety auditing, guardrails against high-risk use, effective governance and mandatory reporting of major incidents, backed by meaningful penalties for non-compliance.¹⁰ An approach such as this warrants serious consideration, both for high-impact and general-purpose AI systems, as well as sector-specific regulation in industries like healthcare.



Regulation must reach clinical practice

44. Australia currently relies on a number of existing health and professional regulators applying their respective responsibilities to AI. Ahpra and the National Boards have published guidance explaining how existing professional obligations apply when practitioners use AI, and the Australian Commission on Safety and Quality in Health Care has developed clinical guidance for AI use.^{3, 11} While these are important developments, profession-specific guidance has not kept pace with the speed and diversity of AI adoption. Nurses and midwives need greater clarity about what AI means within their own scopes of practice, particularly where an AI output affects assessment, care delivery, documentation, and escalation.
45. Nursing and midwifery practice cannot simply be treated as interchangeable with other clinical work. The consequences of AI depend on where it enters the workflow, the professional responsibilities of the person using it, and the decisions it is allowed to influence. Ahpra, the Nursing and Midwifery Board of Australia, the Commission and other relevant regulators should work with nurses, midwives and their representatives to provide clearer profession-specific guidance as AI use develops.
46. Regulation and assurance should also examine settings where AI-enabled technologies are already being used. Primary care, aged care and disability services provide examples where AI tools, virtual care and automated assessment systems are already entering practice, possibly prior to the existence of rigorous mechanisms to ensure their appropriateness. ANMF members have identified examples where algorithms may restrict professional judgement or provide no meaningful ability to override an outcome. Early-use settings should therefore be actively evaluated while systems and models of care can still be adapted safely.

Accountability must follow control

47. Registered nurses and midwives remain accountable for their professional practice, but they should not become the final repository of responsibility for an AI system they did not choose, design or control. A practitioner may have no role in selecting the model, determining its training data, procuring or configuring the system, approving software updates or deciding the



staffing and workflow within which it is used. Lawton et al. (2024) describe the risk of clinicians becoming 'liability sinks', carrying responsibility for AI-supported decisions without equivalent power or knowledge to control the system.¹²

48. Complex or fragmented regulation must not push responsibility disproportionately onto individual practitioners. Accountability should sit with the people and organisations that have control over the relevant decision. Nurses and midwives must have enough information, time and authority to question, disregard or escalate an AI output. Staff should be able to report concerns without reprisal, and there should be clear escalation pathways when AI outputs conflict with clinical judgement. Employers, boards, procurers, developers, vendors, and system operators must remain accountable for the systems and decisions they control.
49. Australia should not wait for harm to arise, where responsibility should have sat. Where AI is already being used in health and care, regulators should proactively identify and close gaps now.

(k) the risks and harms arising from AI, including fraud and scams, deepfakes and risks to the safety and wellbeing of children and vulnerable Australians

Human care and public trust

50. Within health care, AI systems should support rather than replace human practitioners. Nursing and midwifery care is more than a series of tasks that can be substituted. It relies on observation, communication, responsiveness, reassurance, dignity, continuity, contextual professional judgement and human touch. AI should serve as a tool for practitioners in delivering safe, dignified, and equitable health care.
51. Human touch in this context is both literal and broader than physical contact. It includes being present with a person, noticing subtle changes, listening, explaining, reassuring, and understanding what matters to them.¹³ These parts of care are not inefficiencies to automate away. AI should reduce avoidable burden, so nurses and midwives have more time for this work.



52. AI can cause harm through inaccurate or biased outputs, automation bias, poor workflow design, or by making access to a human professional harder. People should not be forced into AI or automated pathways because they are cheaper. Human or non-AI pathways must remain available where they are clinically required or better suited to a person's circumstances, preferences or needs.
53. AI-driven representations of health professionals also raise issues of public trust and professional identity. There must be regulated protections against the misleading use of protected professional titles such as 'nurse' and 'midwife' for AI chatbots or other automated systems where a registered professional is not providing the service.
54. AI-enabled harms can also be workplace harms. Donnelly (2026) has identified deepfakes, harassment and intrusive surveillance among harms already experienced by workers.¹⁰ Health and care workers should have clear avenues to report such harms, have material removed or corrected where possible, and obtain workplace and regulatory support.

Bias, cultural safety and validation

55. AI has considerable potential to support diagnosis and clinical decision-making. Research in breast cancer screening, for example, has demonstrated AI systems performing at or above the level of human readers in some mammography tasks.¹⁵ However, good performance in one population or setting does not establish that a system will be safe or accurate in another.
56. The performance of an AI system is shaped by the data used to develop and test it. If particular populations are poorly represented, or if underlying health data reflects existing inequities, those problems can be carried into the model. Using Australian data may improve relevance, but it does not by itself remove bias. Systems need to be tested for the populations and clinical settings in which they will actually be used, including populations historically poorly represented in health research and data.¹⁶



57. The consequences of inadequate testing can be significant. The proprietary Epic Sepsis Model was implemented across hundreds of hospitals in the United States before independent evaluation identified poor performance.^{17, 18} In one external validation, the model failed to identify 67% of patients who developed sepsis while generating alerts for 18% of all hospitalisations, when the true prevalence was closer to 7%.¹⁹ This example demonstrates why independent validation in the intended clinical setting, and continued evaluation after implementation, are necessary even where a system is already widely used.
58. We propose that organisations undertake an ‘algorithm health equity assessment’ before high-impact AI systems are introduced in health care. Such an assessment should examine whether development and testing data adequately represent the population in which the system will be used, whether performance differs between population groups, whether use of the system could change access to care or resources unfairly, and what safeguards, clinical oversight and monitoring are required. Cultural safety should be considered explicitly, with particular attention to Aboriginal and Torres Strait Islander peoples and other populations who may be poorly represented in existing datasets or affected by historical bias in health data.

(I) the national security and cyber security opportunities to protect Australians, as well as the foreign interference risks, associated with AI, including the security and resilience of supply chains and of systems supporting critical infrastructure

59. Health, aged care, disability and public services are increasingly dependent on cloud, data, and AI infrastructure. Dependence on a small number of multinational providers can expose essential services to service withdrawal, changed licensing arrangements, vendor lock-in, foreign legal demands or geopolitical disruption. Agencies and health services may also lack the technical access needed to inspect or adapt a model, or to move an essential service to another provider without substantial disruption.



60. Resilience therefore requires more than cyber security controls. Data portability, interoperability, open standards, clear subcontracting arrangements, Australian control over sensitive information, and tested exit and business-continuity arrangements should be treated as part of critical infrastructure planning. Sovereign Australian computing capability can complement, rather than replace, strong international partnerships by reducing single-provider dependence and ensuring essential services can continue if commercial or geopolitical conditions change.

(m) the implications of emerging AI capability for Australia's national security and strategic resilience, including the ability of regulators, the Australian AI Safety Institute and the intelligence and security community to identify and respond to emerging risks

Regulator expertise

61. The ANMF notes the establishment of Australia's AI Safety Institute to analyse and test emerging AI models and support regulators and agencies to respond to emerging risks. However, the Australian Government has stated that the Institute is not itself a regulator which risks leaving a regulatory gap.²⁰ The Institute's technical capability is important, but it will not replace the need for capable health, professional, workplace, and other sector regulators to provide clarity.

62. Regulators such as Ahpra, the Nursing and Midwifery Board of Australia, the Australian Nursing and Midwifery Accreditation Council and the Therapeutic Goods Administration must be resourced with specialist expertise and dedicated staff to monitor AI use, prepare the workforce and assess and the contribution of AI to poor clinical or professional outcomes. Members' uncertainty about their professional responsibilities, and the absence of clear regulation and guidance on AI use, reinforce this need. . Regulatory capability must include nursing, midwifery, clinical and workforce expertise, not technical and digital health expertise alone, where historically much of the decision-making to date has sat.



63. The Committee should also consider whether the current distribution of powers is sufficient for high-impact and general-purpose AI. We support the ACTU proposal calling for a strengthened AI Safety Institute administer a model-licensing regime.¹⁰ Whatever institutional model is adopted, there must be a clear pathway from technical testing and incident detection to enforceable regulatory action, while retaining the responsibilities of health, professional, workplace and other specialist regulators.

Conclusion

64. AI is already becoming part of the health and care infrastructure. The ANMF supports its use where it makes care safer, reduces avoidable burden, improves access and supports nurses, midwives and care workers to practise well. The ANMF does not support AI being used to replace jobs, weaken staffing, displace professional judgement or reduce access to human care.

65. The benefits of AI will depend on the conditions under which it is introduced. Nurses, midwives and care workers need a genuine voice in decisions that affect their work; workload and safety impacts must be tested in practice; Australian data and critical infrastructure require effective sovereign control; and regulation must be enforceable, coordinated and clear about where responsibility sits. In health and care, the measure of successful AI should remain whether it supports safer, more equitable and more human care.



References

1. Zhao J, Liu H, Chen Y, Song F. Application of artificial intelligence tools and clinical documentation burden: a systematic review and meta-analysis. *BMC Med Inform Decis Mak*. 2025;26(1):29. doi:10.1186/s12911-025-03324-w. Available from: <https://doi.org/10.1186/s12911-025-03324-w>
2. Davenport T, Kalakota R. The potential for artificial intelligence in healthcare. *Future Healthc J*. 2019;6(2):94–8. doi:10.7861/futurehosp.6-2-94. Available from: <https://doi.org/10.7861/futurehosp.6-2-94>
3. Australian Commission on Safety and Quality in Health Care. *AI Clinical Use Guide: guidance for clinicians*. Sydney: ACSQHC; 2025. Available from: <https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/ai-clinical-use-guide.pdf>
4. Department of Industry, Science and Resources. National AI Plan. Canberra: Australian Government; 2025. Available from: <https://www.industry.gov.au/publications/national-ai-plan>
5. Australian Government. Framework for governance of Indigenous Data. Canberra: National Data Commissioner; 2024. Available from: <https://www.niaa.gov.au/sites/default/files/documents/2024-05/framework-governance-indigenous-data.pdf>
6. Hannan E. AI creating more unpaid work for Australians [Internet]. *The Australian*. 2026 [cited 2026 Sep 18]. Available from: <https://www.theaustralian.com.au/>
7. Australian Council of Trade Unions. AI: unions put corporate Australia on notice [Internet]. 2026 [cited 2026 Sep 18]. Available from: <https://www.actu.org.au/>
8. Safe Work Australia. New AI and digital technologies guidance now available [Internet]. Canberra: Safe Work Australia; 2026 [cited 2026 Sep 18]. Available from: <https://www.safeworkaustralia.gov.au/media-centre/news/new-ai-and-digital-technologies-guidance-now-available>
9. Australian Government. AI Plan for the Australian Public Service 2025. Canberra: Australian Public Service Commission; 2025. Available from:



<https://www.digital.gov.au/policy/ai/australian-public-service-ai-plan-2025>

10. Donnelly M. Tech leaders' safety alert our last chance to reset AI trajectory. *Aust Financ Rev.* 2026 Sep 17 [cited 2026 Sep 18]. Available from: <https://www.afr.com/technology/tech-leaders-safety-alert-our-last-chance-to-reset-ai-trajectory-20260915-p60xo6>
11. Magrabi F, Bates L, Brooke-Cowden K, Jayawardena T, Wang A, Coie E, et al. Literature review and environmental scan report: AI implementation in hospitals – legislation, policy, guidelines and principles, and evidence about quality and safety. Canberra: Australian Institute of Health Innovation; 2024 [cited 2024 May 29]. Available from: <https://researchers.mq.edu.au/en/publications/literature-review-and-environmental-scan-report-ai-implementation/>
12. Lawton T, Morgan P, Porter Z, Hickey S, Cunningham A, Hughes N, et al. Clinicians risk becoming "liability sinks" for artificial intelligence. *Future Healthc J.* 2024;11(1):100007. doi:10.1016/j.fhj.2024.100007. Available from: <https://doi.org/10.1016/j.fhj.2024.100007>
13. Suki NM, Lian JCC, Suki NM. A comparison of human elements and nonhuman elements in private health care settings: customers' perceptions and expectations. *J Hosp Mark Public Relat.* 2009;19(2):113–28. doi:10.1080/15390940903041567. Available from: <https://doi.org/10.1080/15390940903041567>
14. Parliament of Australia, Select Committee on Adopting Artificial Intelligence. *Official committee Hansard, 17 July 2024.* Darmanin SL, editor. Canberra: Commonwealth of Australia; 2024. Available from: <https://www.aph.gov.au/>
15. McKinney SM, Sieniek M, Godbole V, Godwin J, Antropova N, Ashrafian H, et al. International evaluation of an AI system for breast cancer screening. *Nature.* 2020;577(7788):89–94. doi:10.1038/s41586-019-1799-6. Available from: <https://www.nature.com/articles/s41586-019-1799-6>
16. Straw I. The automation of bias in medical artificial intelligence (AI): decoding the past to create a better future. *Artif Intell Med.* 2020;110:101965. doi:10.1016/j.artmed.2020.101965. Available from: <https://doi.org/10.1016/j.artmed.2020.101965>



17. van der Vegt A, Campbell V, Zuccon G. Why clinical artificial intelligence is (almost) non-existent in Australian hospitals and how to fix it. *Med J Aust*. 2024;220(4):172–5. doi:10.5694/mja2.52195. Available from: <https://doi.org/10.5694/mja2.52195>
18. Schootman M, Wiskow C, Loux T, Meyer L, Powell S, Gandhi A, et al. Evaluation of the effectiveness of an automated sepsis predictive tool on patient outcomes. *J Crit Care*. 2022;71:154061. doi:10.1016/j.jcrc.2022.154061. Available from: <https://doi.org/10.1016/j.jcrc.2022.154061>
19. Wong A, Otles E, Donnelly JP, Krumm A, McCullough J, DeTroyer-Cooley O, et al. External validation of a widely implemented proprietary sepsis prediction model in hospitalized patients. *JAMA Intern Med*. 2021;181(8):1065–70. doi:10.1001/jamainternmed.2021.2626. Available from: <https://doi.org/10.1001/jamainternmed.2021.2626>
20. Department of Industry, Science and Resources. Australian Government response: Senate Select Committee on Adopting Artificial Intelligence (AI) report [Internet]. Canberra: Australian Government; 2026 [updated 2026 Apr 1; cited 2026 Sep 18]. Available from: <https://www.industry.gov.au/publications/australian-government-response-senate-select-committee-adopting-artificial-intelligence-ai-report>