Australian Government

Australian Digital Health Agency

Australian
Digital Health
Agency

Annual Report 2016–17

Vale Medical Centre Pharmacy, Brookvale NSW

Front cover: Clare, SA
Back cover: Awabakal Medical Service, Hamilton, NSW

Guide to this report

This Annual Report describes the operations and performance of the Australian Digital Health Agency (the Agency) during 2016-17. The report was prepared in accordance with legislated reporting requirements under the *Public Governance, Performance and Accountability Act 2013* and other Commonwealth legislation including the *My Health Records Act 2012*.

Part 1 – Introduction and overview

Introduces the Agency, and provides an overview of its operations, its achievements in 2016-17, and priorities for 2017-18.

Part 2 – Performance

Details the Agency's performance against work plan priorities captured in its 2016-17 Corporate Plan and against Ministerial targets published in the Health Portfolio Budget Statements 2016-17. It also addresses reporting obligations under the *My Health Records Act 2012*.

Part 3 – Management and accountability

Discusses the Agency's governance arrangements, external scrutiny, human resources and mandatory reporting obligations concerning workplace health and safety, advertising and market research, ecologically sustainable development and environmental performance.

Part 4 – Financial statements

Includes the Report by the Auditor-General and the Agency's Financial Statements for 2016-17.

Part 5 – Navigation aids

Contains references to assist the reader to use the report – an index of compliance with annual report content requirements, and a list of abbreviations and acronyms.

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Further information about the Australian Digital Health Agency and an online version of this report are available on the Agency website: www.digitalhealth.gov.au

Feedback and inquiries

If you have any questions or feedback regarding this report, please direct them to:

Performance Reporting
Australian Digital Health Agency
56 Pitt Street, Sydney NSW 2000, Australia

Phone: 1300 901 001
Email: help@digitalhealth.gov.au

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Australian Digital Health Agency Annual Report 2016-17

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Letter of transmittal

Australian Government
Australian Digital Health Agency

Level 25, 56 Pitt Street
Sydney NSW 2000
Telephone: (02) 8298 2600
Facsimile: (02) 8298 2666
www.digitalhealth.gov.au

16 October 2017

The Hon Greg Hunt MP
Minister for Health and Aged Care
Minister for Sport
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the board of the Australian Digital Health Agency (the Agency), I am pleased to present our annual report for the period 1 July 2016 to 30 June 2017.

The Agency was established on 30 January 2016, following registration of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2016, and commenced operations on 1 July 2016. The report reflects on our first year of operations and addresses the requirements of section 46 of the *Public Governance, Performance and Accountability Act 2013,* including annual performance statements under paragraph 39(1)(b) and audited financial statements as required by subsection 43(4) of that Act.

The report also incorporates reporting obligations under other Commonwealth legislation: Section 107 of the *My Health Records Act 2012*, Schedule 2, Part 4 of the *Work Health and Safety Act 2011,* section 311A of the *Commonwealth Electoral Act 1918,* and section 516A of the *Environment Protection and Biodiversity Conservation Act 1999.*

The report was approved for presentation to you in accordance with a resolution of the board on 11 October 2017.

In compliance with sections 68 and 69 of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2016, the Agency will notify each State and Territory Health Minister of the availability of the report, and provide a copy on request.

Yours sincerely

Jim Birch AM
Chair
Australian Digital Health Agency

Australian Digital Health Agency ABN 84 425 496 912

Albany, WA

Contents

Chair's message

The Australian Digital Health Agency was established on 30 January 2016 and tasked with improving health outcomes for all Australians through the use of digital health technologies. I am honoured to be the founding Chair of the Agency's Board, with the privilege of overseeing the way in which the Agency supports and drives this transformation in the delivery of healthcare.

Technology has changed almost every part of our lives. It is already transforming our ability to predict, diagnose and treat disease. But there is much more we can do to realise its full potential for the health of every Australian: giving consumers more control of their health and care, connecting and empowering healthcare providers and promoting Australia's global leadership in digital health and innovation.

If we are to fulfil the potential of new and emerging digital health technologies to drive greater safety, quality and efficiency in the healthcare system, this important work must be carried out through deep engagement with key stakeholders in the health system. In this past year the Agency has demonstrated, and remains deeply committed to, meaningful consultation across the health system.

This collaborative approach has been evidenced through the extensive 'Your health. Your say.' consultation process, showing the Agency's commitment to openness and transparency, and to listening to the views and perspectives of the many stakeholders of the health system. This process was a major input into the recent publication of the National Digital Health Strategy, a pragmatic strategy that will guide the delivery of Australian digital health initiatives through 2022.

In addition to renewed momentum in digital health and the co-production of the National Digital Health Strategy, the Agency's achievements include: building a new organisation, co-producing a 2017-18 work plan with jurisdictions, connecting hospitals and health services to the My Health Record whilst driving adoption, successfully improving the user experience of My Health Record and growing the volume of clinical document sharing.

As I look forward to the next year, I am excited to work with a team of people who are passionate about delivering the benefits of digital health to Australia. On behalf of the Board I thank staff for their ongoing commitment and the community for their continued support.

As Chair of the Australian Digital Health Agency I am proud to be associated with work that will have a positive impact on the future health of all Australians. Our first year has been a highly productive one, and I am confident that we are in excellent shape to advance the national digital health agenda, and to show how data and technology can be used to deliver digital health services that are safe, seamless and secure.

Jim Birch AM
Chair, Australian Digital Health Agency

Chief Executive Officer's review

The Australian Digital Health Agency (the Agency) was established on 30 January 2016 and commenced operations on 1 July 2016, integrating the activities and resources of the National E-Health Transition Authority (NEHTA) and My Health Record system operations of the Department of Health. I was appointed Chief Executive Officer in August 2016.

Since the establishment of the Agency, our purpose has been clear, and is succinctly captured in the National Digital Health Strategy:

> *"Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy to use tools for both patients and providers."* [1]

Supporting our purpose is our strong commitment to collaboration and co-production in all that we do, driving openness and transparency into the culture of the organisation.

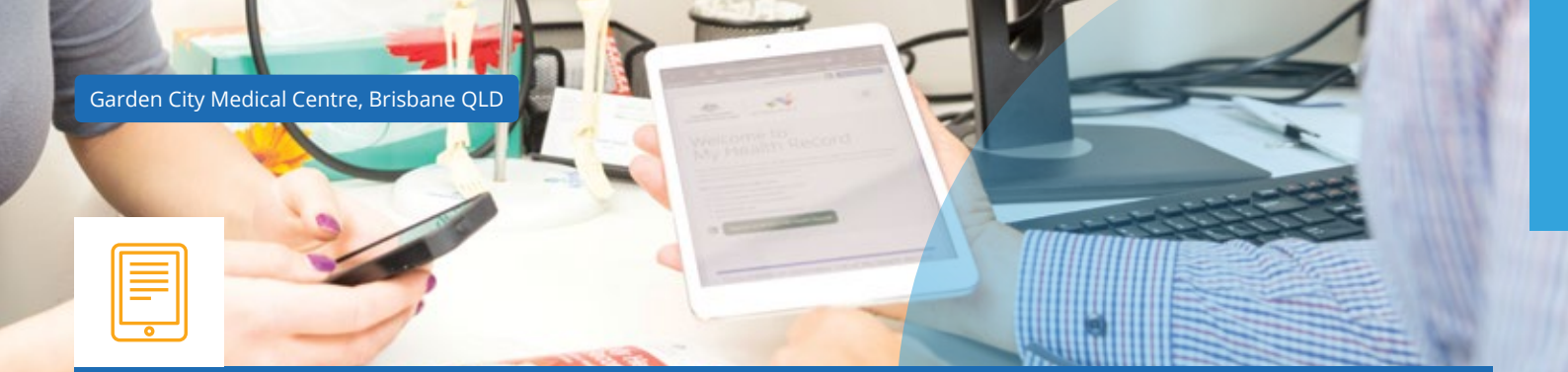
Digital information is the bedrock of high quality healthcare. Healthcare providers need to have instant access to a patient's medical information – especially in the case of an emergency. Australians want safe access to their personal health information such as their vaccinations and medical tests. Better use of information drives transformation of how services are coordinated and integrated, improving efficiency and delivering better health outcomes for all Australians.

The benefits for patients of digital health are significant and compelling: hospital admissions avoided, fewer adverse drug events, reduced duplication of tests, better coordination of care for people with chronic and complex conditions, and better informed treatment decisions. It can help save and improve lives.

Although much work remains, the Agency has made substantial progress over the past 12 months. Key achievements include:

- **Building momentum in digital health** by developing strong relationships and networks across the community and establishing six Board Advisory Committees;
- **Building a new organisation** including recruitment of a leadership team and establishing policies and processes to operate under a new Rule as a Commonwealth corporate entity;
- **Co-producing a National Digital Health Strategy** with input from the community, governments, technology industry and the healthcare sector, which was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) and subsequently approved by the COAG Health Council on first presentation. A four year work plan (2018-22) for the Agency was also agreed subject to approval of an Inter-Governmental Agreement in 2018;
- **Delivering the 2016-17 work plan[2] and co-producing a 2017-18 work program with state and territory health departments** that was approved by AHMAC and the COAG Health Council on first presentation;

1. *Australia's National Digital Health Strategy, https://www.digitalhealth.gov.au/australias-national-digital-health-strategy, 2017.*
2. *See note 7.*



Case study: **Secure messaging program**

The Agency launched the secure messaging program in October 2016 in response to feedback from healthcare providers and jurisdictions that electronic secure messaging was not usable. The Agency's 2016-17 work program includes a number of initiatives designed to remove barriers to the use of secure messaging services, so the use of secure messaging is likely to grow across Australia, as more and more clinical practices discover its benefits.

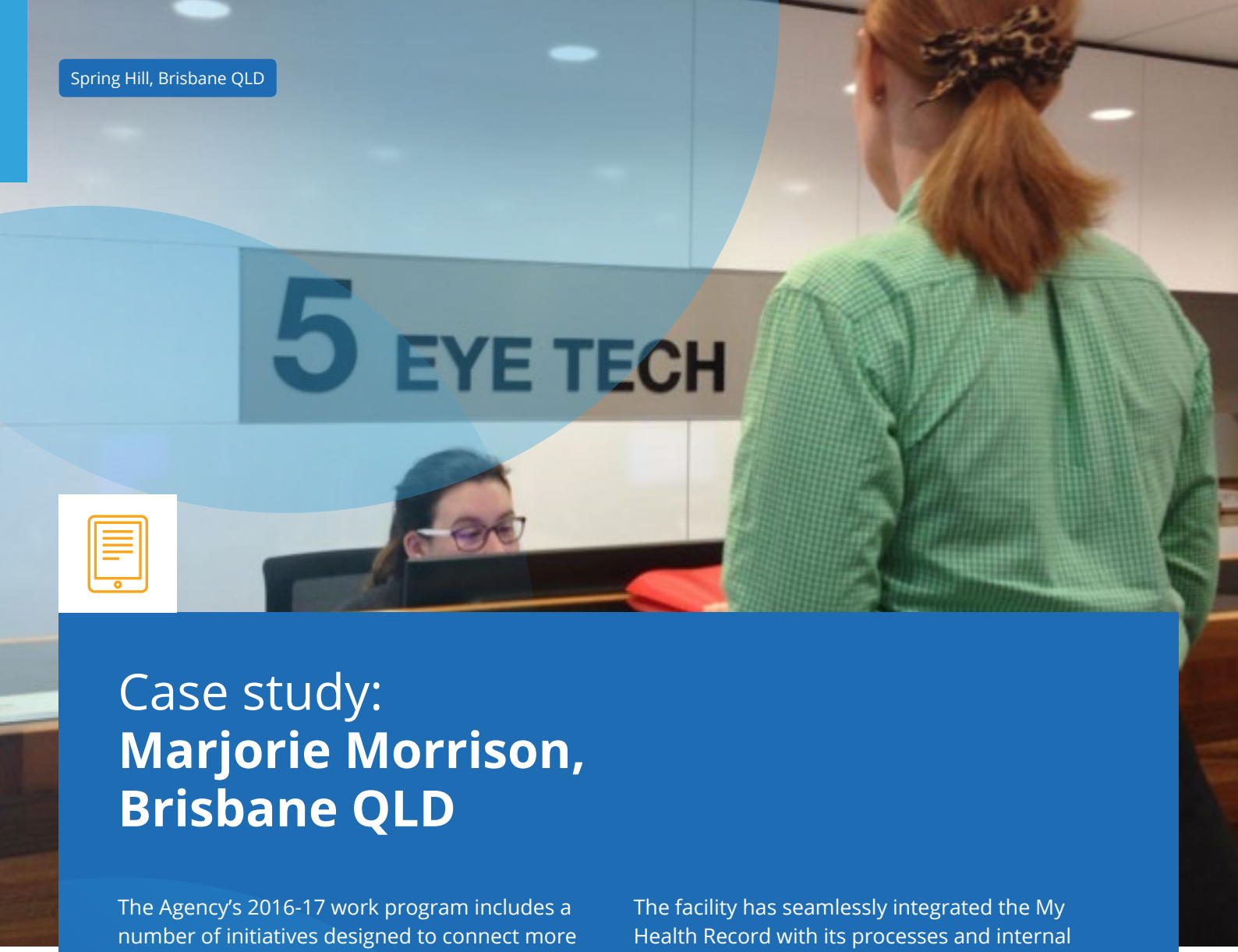
One of the initiatives in this program is a proof of concept study named 'The HealthLink project', which was launched in partnership with industry, clinical leaders and jurisdictions.

This project involves secure electronic referrals sent from five different general practices using Medical Director to five specialist groups using Genie and Best Practice software, via the ReferralNet and Argus messaging systems. Once fully implemented, this initiative will enable the sending of referrals from general practices to specialist healthcare providers that could be scaled to a national level.

> "Alignment and partnerships between jurisdictions, local health networks, clinicians and patients will be critical to deliver the national digital health agenda and work program. Many jurisdictions already have a significant program of digital health activities already underway, that could support development and implementation of a National Digital Health Strategy."
>
> **eHealth NSW submission**

- **Taking on responsibilities for system operation of My Health Record** and being charged by the Commonwealth Government to implement the Expansion of My Health Record so that all Australians will have a My Health Record by the end of 2018, unless they choose not to do so; and
  - **Reaching 5 million citizens with a My Health Record** as at 12 July 2017;[3]
  - **Reaching the Agency's first agreement with a diagnostic services provider to share pathology reports with the My Health Record;**
  - **Commencing projects with five jurisdictions to upload pathology reports to the My Health Record** with 16 labs currently connected and uploading;
  - **Commencing projects with five jurisdictions to upload diagnostic imaging (DI) reports to the My Health Record** with three DI practices having uploaded 53,000 reports to the My Health Record by end of June 2017;

3. *As at 30 June 2017, there were 4,969,017 consumers registered for a My Health Record.*



Case study: **Marjorie Morrison, Brisbane QLD**

The Agency's 2016-17 work program includes a number of initiatives designed to connect more surgeries and hospitals to My Health Record. One of these is Eyetech Day Surgeries Spring Hill, a Brisbane facility that provides cataract surgery and other services.

Marjorie Morrison is the Business Office Manager at Eyetech, and she's an enthusiastic advocate of the My Health Record, which she sees as providing a great opportunity to deliver better outcomes for her patients.

Many of her patients are elderly "grey nomads" for whom eliciting a useful medical history prior to surgery can be a difficult and error-prone exercise. Despite the relatively early stages of the national rollout, the My Health Record is already proving to be a boon for Marjorie. Many of the patients at her facility already have established My Health Records, which allows Marjorie to check the patient's history in advance, greatly streamlining pre-operative consultation and improving safety.

The facility has seamlessly integrated the My Health Record with its processes and internal clinical systems, and routinely sends My Health Record information to patients alongside other communications. Marjorie calls this "drip feed communications".

This strategy is clearly working, and many of her patients are taking the opportunity to sign up. In fact, she was approached a little while ago by a very elderly gentleman and his wife, who asked, "Now, where do we sign up to this My Health Record thingy?"

"Great!" said Marjorie, "Do you have a computer?"

"No, no, don't you worry about that," he replied. "My son has got a computer. We just want all the doctors to know what we're on, because we keep forgetting!"

  - **Connecting hospitals and health services to the My Health Record** with more than double the number of private hospitals uploading to the My Health Record system in July 2017 than in July 2016;
  - **Successfully deploying Release 8 of the My Health Record**, including a new Medicines View; and
  - **Laying the groundwork for improved access to health information through a developer program** that supports innovators to safely and securely connect to the My Health Record.
- **Establishing the Cyber Security Centre** to ensure best-in-class protection for Australia's digital health foundations;
- **Initiating projects to implement end-to-end secure messaging solutions** so that all healthcare providers will be able to send and receive clinical correspondence without need for paper and a fax machine, making Australian healthcare safer, more effective and reducing the administrative burden on frontline professionals. The program involves ten healthcare providers, two clinical information systems, two messaging vendors and federated directories – where those judging the success of the projects will be the healthcare providers sending and receiving messages;
- **Initiating a program to develop a framework for Interoperability** that will support clinical information to flow between health providers, patients and carers;
- **Reviewing Clinical Terminology Services** so that the Agency optimises adoption of SNOMED CT in Australia;
- **Driving an evidence-based approach to the delivery of digital health** and the establishment of a Benefits Measurement program to ensure all Agency activity monitors and realises defined benefits;
- **Supporting the establishment of the National Collaborative Network for Child Health Informatics;** and
- **Developing international partnerships** with a number of countries to support knowledge sharing and innovation in digital health services.

Since I was appointed CEO, I have had the privilege of meeting many people – consumers, citizens and care professionals – who want Australian health services, already among the best in the world, to take full advantage of the opportunities that digital technology offers.

I reflect on what Fiona Panagoulias told me. Fiona cares for her disabled husband in Perth and now co-chairs the Agency Steering Group for Secure Messaging. 'We have an amazing health system in Australia,' she said. 'I've seen others in the world. We really must do our best to make it better.'

Tim Kelsey
Chief Executive Officer,
Australian Digital Health Agency

"The National Digital Health Strategy will help facilitate the sharing of high-quality commonly understood information which can be used with confidence by GPs and other health professionals. It will also help ensure this patient information remains confidential and secure and is available whenever and wherever it is needed."

Dr Bastian Seidel, President, RACGP

2016–17

Funding for **My Health Record expansion to every Australian**

Global Digital Health Partnership

Embedding telehealth in clinical consultations

National Collaborative Network for Child Health Informatics

COAG Health Council endorsed **2017-18 work program**

400%
increase in Shared Health Summaries uploaded to the My Health Record

My Health Record Release 8 with Medicines View

Uploading Pathology and Diagnostic Imaging reports to the My Health Record

Safe, Seamless, Secure: the **National Digital Health Strategy**

3,000+ people attended 103 forums

1,000+ submissions and survey responses

Evidence-based approach to delivery of digital health

5 million My Health Records
(at 12 July 2017)

200% **increase in My Health Record connections** from private hospitals

Princess Alexandra Hospital, Brisbane QLD

1.0

Introduction and overview

This part provides a view of the Agency 'at a glance', the Chief Executive Officer's review of the 2016-17 financial year, an overview of the Agency's purpose, role, strategy and functions, and an outline of the path ahead.

Garden City Medical Centre, Brisbane QLD

1.0

Introduction and overview

The Agency 'at a glance'

Purpose

The Agency was established to improve health outcomes for Australians through the delivery of digital innovation, health systems and services.

Focus

The Agency's focus is on engagement, innovation and clinical quality and safety – putting data and technology safely to work for patients, consumers and the healthcare providers who look after them.

Foundations

The Agency was established on 30 January 2016 and commenced operations on 1 July 2016, with a vision of:

"Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy to use tools for both patients and providers."

Enabling legislation

Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016 (Agency Rule) created the Agency and governs its operations.

The Rule was made by the Commonwealth Minister for Finance under Section 87 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) which allows for the creation of commonwealth corporate entities. The Agency is the first in the Commonwealth to be established by this new mechanism.

Governance structure

The Agency is a statutory authority designated as a Corporate Commonwealth entity under the PGPA Act, and is a body corporate with a separate legal personality from the Commonwealth.

Information about our governance, management and accountability frameworks can be found in Part 3 of this report.

Delivery priorities for 2016-17

The Agency's 2016-17 Operational Plan, produced in accordance with the Agency Rule requirements, prioritised the following programs of work:

- My Health Record;
- Secure messaging;
- Medicines safety;
- Pathology and diagnostic imaging;
- National Digital Health Strategy;
- Core clinical programs; and
- Organisational excellence.

These priorities were published in the Agency's Corporate Plan 2016-17, and performance against each priority is captured in Part 2 of this report.

Products and services

The Agency has a lead role in operating and developing Australia's digital health foundations, the national infrastructure underpinning the delivery of digital health in Australia.

These digital health foundations include:

- The My Health Record system;
- The Healthcare Identifiers (HI) Service;
- The National Authentication Service for Health (NASH);
- Secure Messaging Delivery;
- Supply Chain;
- Australian Medicines Terminology (AMT) and SNOMED CT-AU; and
- Clinical Document Specifications.

Operating and maintaining this infrastructure is a core activity for the Agency. Part 1 provides further detail on work in this important space.

Board as an Accountable Authority

During the 2016-17 year, an 11 member Board, chaired by Jim Birch AM, is the Accountable Authority of the Agency. As Accountable Authority, the Board sets the strategic direction for the Agency and is responsible for its operations.

Inherited functions – My Health Record System Operator

The Agency became the My Health Record System Operator from 1 July 2016. On that date, all of the My Health Record operations managed by the Department of Health and the resources and digital health governance activities of the National e-Health Transition Authority (NEHTA) transitioned to the Agency.

Advisory committees

The Board is supported in the performance of its functions by independent advisory committees. Some are established expressly by the Agency Rule:

- Clinical and Technical Advisory Committee
- Jurisdictional Advisory Committee
- Consumer Advisory Committee
- Privacy and Security Advisory Committee

One is created by the Board, pursuant to a power under the Rule:

- Digital Health Safety and Quality Governance Committee

Another is compulsory under the PGPA Act:

- Audit and Risk Committee

Portfolio and ministerial oversight

The Agency sits within the Health portfolio and is accountable to the Commonwealth Minister for Health. During 2016-17, two ministers were responsible for the Health portfolio:

The Hon Sussan Ley MP: 1 July 2016 to 23 January 2017

The Hon Greg Hunt MP: 24 January 2017 to 30 June 2017

The Agency also reports to state and territory health ministers through the COAG Health Council.

Inter-jurisdictional

The Agency operates under an Intergovernmental Agreement between members of the Council of Australian Governments (COAG). Under this agreement the Agency works closely with the states and territories to align the implementation of national infrastructure with jurisdictional health IT strategies and investments.

Our people and their location

At 30 June 2017, the Agency had 247 staff (permanent and temporary) working from offices in Brisbane, Sydney and Canberra.

Funding 2016-17

The Agency is jointly funded by the Commonwealth ($120.892 million) and the states and territories ($32.25 million) reflecting the commitment at all levels of government to the delivery of digital health reform.

Financial outcome

Comprehensive Income of $20.213 million

- Operating revenue – $144.099 million
- Operating expenses – $181.361 million
- Other gains and revaluations – $57.475 million

The Agency's financial performance, and ANAO-audited financial statements are presented in Part 4 of this report.

Overview of the Agency

Our role

The Agency is the accountable organisation for the evolution of digital health in Australia through the leadership, coordination and delivery of a collaborative and innovative approach.

The Agency's functions, as defined in Section 9 of the Agency Rule[5], are:

a. To coordinate, and provide input into, the ongoing development of the National Digital Health Strategy;

b. To implement those aspects of the National Digital Health Strategy that are directed by the Ministerial Council;

c. To develop, implement, manage, operate and continuously innovate and improve specifications, standards, systems and services in relation to digital health, consistently with the national digital health work program;

d. To develop, implement and operate comprehensive and effective clinical governance, using a whole of system approach, to ensure clinical safety in the delivery of the national digital health work program;

e. To develop, monitor and manage specifications and standards to maximise effective interoperability of public and private sector digital health systems;

f. To develop and implement compliance approaches in relation to the adoption of agreed specifications and standards relating to digital health;

g. To liaise and cooperate with overseas and international bodies on matters relating to digital health;

h. Such other functions as are conferred on the Agency by the Agency Rule or by any other law of the Commonwealth; and

i. To do anything incidental to or conducive to the performance of any of the above functions.

The Agency's responsibility for all national digital health operations, functions and activities includes the role of the My Health Record System Operator (the System Operator), which transitioned from the Department of Health to the Agency upon its creation.

The System Operator works with a range of agencies and organisations to deliver the My Health Record system. Many of the System Operator's functions are delivered by Accenture, contracted by the System Operator as the My Health Record system's National Infrastructure Operator (NIO), and the Chief Executive Medicare, Department of Human Services (DHS).

National Digital Health Strategy

Having been developed during the 2016-17 financial year, the National Digital Health Strategy was approved by Australia's health ministers on 4 August 2017, and made publicly available on the same day. It is titled *Safe, seamless and secure: evolving health and care to meet the needs of modern Australia*.[6]

The Strategy articulates the need for a coordinated approach to the delivery of digital health within Australia, as well as the strategic priorities to be delivered by 2022 and the principles that will underpin its execution.

5. *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016, https://www.legislation.gov.au/Details/F2016L00070, 2016.*
6. *Australia's National Digital Health Strategy, https://www.digitalhealth.gov.au/australias-national-digital-health-strategy, 2017.*

The seven strategic priorities described in the National Digital Health Strategy were formulated from the inputs of the extensive 'Your health. Your say' consultation process, and are as follows:

1. Health information that is available whenever and wherever it is needed;
2. Health information that can be exchanged securely;
3. High-quality data with a commonly understood meaning that can be used with confidence;
4. Better availability and access to prescriptions and medicines information;
5. Digitally-enabled models of care that improve accessibility, quality, safety and efficiency;
6. A workforce confidently using digital health technologies to deliver health and care; and
7. A thriving digital health industry delivering world-class innovation.

Our principles

The following guiding principles support the ongoing operation of the Agency, and underpin the National Digital Health Strategy.

- **Putting users at the centre** – User needs and their context of use are placed at the centre of decision making, supporting improved prioritisation and user experience.
- **Ensuring privacy and security** – Australians expect strong safeguards to ensure their health information is safe and secure, respected, and their rights protected. They expect that their health data is only used when necessary and with their consent. The strategic priorities described in the National Digital Health Strategy consider security, privacy and the protection of sensitive personal information, balanced with safe information sharing and maintaining consumer and clinician trust.
- **Fostering agile collaboration** – Appropriate co-design and co-production methodologies are important for ensuring that digital health solutions developed for use in Australia meet the evolving needs of users and stakeholders.
- **Driving a culture of safety and quality** – The safety and quality of digital health solutions and services are of critical importance. The National Digital Health Strategy will embed a systems approach to safety, quality and risk management throughout the design, development, implementation and use of digital health solutions and services.
- **Improving equity of access** – Digital health solutions and services have the potential to empower and to address longstanding barriers to equity of access in healthcare. All Australians deserve to benefit from the opportunities presented by digital health, and the strategic priorities are aimed at improving health system accessibility across the socio-economic spectrum.

"We know that when consumers are activated and supported to better self-manage and coordinate their health and care, we get better patient experience, quality care, and better health outcomes. Digital health developments, including My Health Record, are ways in which we can support that to happen. It's why patients should also be encouraged to take greater control of their health information."

Leanne Wells, CEO, Consumers Health Forum of Australia

Case study: **My Health Record 'connects the dots' for mother of five**

As more providers connect to the My Health Record, more patients and carers will benefit, especially those who see multiple providers. The Agency's 2016-17 work program includes a number of initiatives designed to improve user experience by connecting more providers to My Health Record.

Paige, a mother of five children from Northern Queensland, is one such example. She was diagnosed with epilepsy at the age of 15 and hearing loss after the birth of her first child.

"I have several health conditions and was pregnant with my fifth child earlier this year," Paige explained.

"At one point during my pregnancy I had to keep track of more than 12 obstetric outpatient hospital visits, three neurology appointments, various pathology tests as well as GP visits. To add to this, my husband and I have five children. I'm often required to 'join the dots' between my healthcare providers to ensure I am provided with the best possible outcome for my family, but it became increasingly difficult to keep track of everything. My Health Record helps me keep a single record of my own health information, and the whole family has an individual My Health Record that is accessible by both me and my husband. Personally, it means my medical history is easily accessible to manage my health and this gives me the assurance that I'm receiving the best possible care. As a parent, it empowers me to take control and gain visibility of my family's healthcare and make the most informed decisions. Knowing that my family's medical history is easily accessible to treating clinicians and other healthcare providers is extremely reassuring."

"Doctors need access to secure digital records. Having to wade through paperwork and chase individuals and organisations for information is archaic. The AMA has worked closely with the Agency on the development of the National Digital Health Strategy and looks forward to close collaboration on its implementation."

Dr Michael Gannon, AMA President

- **Leveraging existing assets and capabilities** – Australia is making significant advances in the delivery of digitally enabled health and care across Australia, through the development and operation of national digital health foundations.
- **Judicious use of taxpayer money** – Development of strategic activities is based on sound investment of funds to eliminate waste, deliver value for taxpayers, and to ensure that investments are assessed on the basis of delivering the best health and care outcomes for all Australians. Whether it be through increasing our proportion of public transport versus taxi trips for official purposes, a policy of economy fares for all domestic travel and high compliance with best fare of the day flights, or adopting the policy of compliance with Commonwealth Procurement Rules – we are building a culture to think like a patient, act like a taxpayer.

Our values

The values and culture of the Agency, reflected in conduct, interactions, and how decisions are made are an integral part of living out the Agency's purpose and strategy.

As a new Commonwealth public sector organisation, the Agency embraces the Australian Public Service (APS) **ICARE** values found in section 10 of the *Public Service Act 1999*: Impartial, Committed to service, Accountable, Respectful and Ethical.

To strengthen our values-based culture, the Agency has developed its own set of complementary values with the purpose of embedding them in both policy and practice.

- **Working together** – We get our best results working collaboratively. We set challenging but realistic goals and pursue them together. We value the open and robust exchange of opinions, views and ideas. We approach our work with balance, enjoyment and passion.
- **Respect and trust** – All our intentions are based on trust, support and open feedback. We show consideration and support for one another and for our customers. We embrace diversity in people, opinions and skills.

1.0

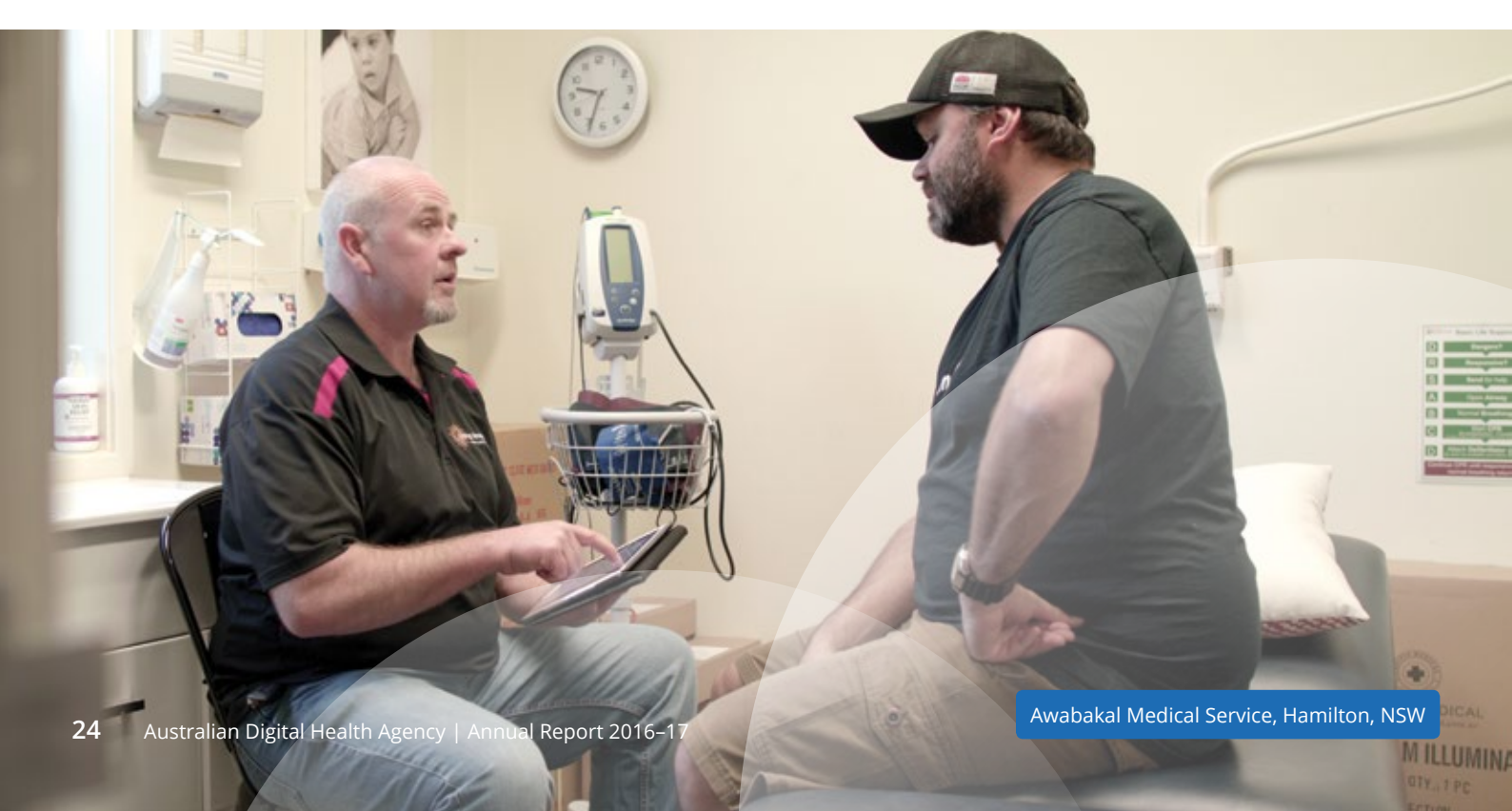
Introduction and overview

- **Transparency** – We take stewardship of public resources seriously. We are open in the way we do our work. We are open to scrutiny. We operate ethically and with professionalism.
- **Leading through learning** – We learn from others. We seek new information and find bold ways to apply that learning to digital health. We continuously evaluate and improve the way we do our work. We support innovative health solutions that have a positive impact.
- **Customer focus** – We never lose sight of the impact our work will have on patient care and the safety and efficiency of the Australian healthcare system. Understanding customer needs is our first priority. We maintain effective internal and external customer relations. We listen to understand.

"The Guild is committed to helping build the digital health capabilities of community pharmacies and advance the efficiency, quality, and delivery of healthcare to improve health outcomes for all Australians."

"We are working with the Agency to ensure that community pharmacy dispensing and medicine related services are fully integrated into the My Health Record – and are committed to supporting implementation of the National Digital Health Strategy as a whole."

George Tambassis, President, Pharmacy Guild of Australia



Awabakal Medical Service, Hamilton, NSW

Our structure

The Agency is structured to support its purpose, strategy, principles and values by providing clear lines of reporting and responsibility, aligning resources to core priorities, and supporting stakeholder engagement activities.

The CEO of the Agency, Tim Kelsey, is responsible for the overall management of the Agency. He is assisted by a Chief Medical Adviser and five Executive General Managers, as shown in the following diagram.

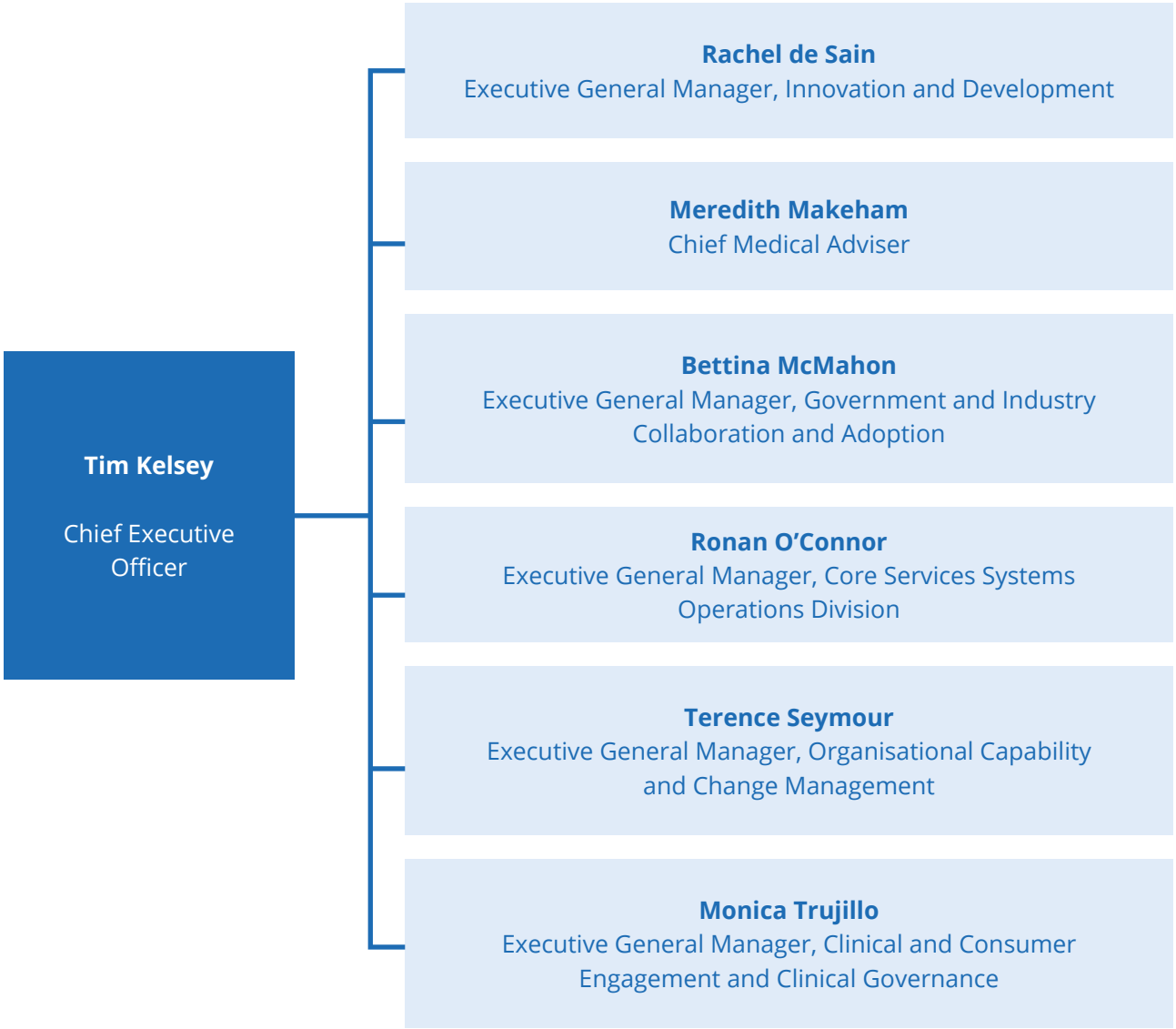


Figure 1 – Agency CEO and EGMs (as of 30 June 2017)

These Executive General Managers lead the following divisions.

- **Government and Industry Collaboration and Adoption Division** – Is responsible for leading and driving collaboration and education, and the non-clinical input to the strategy, design, implementation of national digital health systems and non-clinical adoption approaches. The division has a key role in the management of strategic relationships with consumers, states and territories, the federal government, health Non-Government Organisations (NGOs), software vendors and professional association stakeholders. Additionally, it oversees the coordination and management of the National Digital Health Strategy and associated work program, and is responsible for the Digital Program Office which guides the successful delivery of the organisation's annual program of work.
- **Core Services Systems Operations Division** – Operates the core national digital health systems and services providing technical support and leadership. These include the My Health Record and other foundation systems and services such as the Health Identifier (HI) Service, National Authentication Service for Health (NASH), eHealth reference platform, National Clinical Terminology Service (NCTS) and Clinical Informatics. The division provides the Cyber Security Centre function and is responsible for the development, operation and risk management of the security, privacy, fraud compliance conformance, release management and testing functions for Agency and core digital health systems.
- **Clinical and Consumer Engagement and Clinical Governance Division** – Leads the engagement of the healthcare provider community and members of the public to raise awareness of the value of digital health in both clinical practice and the broader community, and to build knowledge and ability to use the My Health Record System effectively and appropriately. It also manages the clinical and clinical informatics input to the design of digital health systems, as well as the development, implementation, operation and monitoring of a clinical governance framework, clinical functional assurance, clinical incident management and safety review programs. The division is also responsible for the oversight, management and coordination of Clinical Programs, including the Medicines Safety, Pathology and Diagnostic Imaging programs.

> "If our complex health system is to realise the benefits from information and technology, and become more sustainable, we need clinical leaders with a sound understanding of digital health."
>
> **Dr Louise Schaper, CEO, Health Informatics Society of Australia**

- **Innovation and Development Division** – Coordinates the innovative and technical aspects of the digital health program. It focuses on open innovation, specifications and standards, and product development. It provides overall design integration for all of the services developed to ensure that the national digital health systems and services provide the best user experience and deliver measurable improvements that are derived from evidence of user needs and deliver tangible benefits across the health ecosystem.
- **Organisational Capability and Change Management Division** – Is responsible for the provision of quality delivery of a significant program of organisational capability and change management. This includes financial

services, people and capability management, knowledge management and information and communications technology support, Agency performance reporting and Board and Advisory Committee secretariat and legal services. The division also leads and collaborates with internal and external stakeholders to manage the day-to-day operations of the Agency.

These divisions are supported by the **Office of the CEO**, which includes the **Office of the Chief Medical Adviser** and communications and media functions. The Chief Medical Adviser is responsible for leading the approach to Research and Evaluation at the Australian Digital Health Agency coordinated by the Research Programs team, and provides advice and support to the Executive across all Agency divisions. This includes the current domestic and international evidence to guide our policy, project and program delivery, and the application of digital health services and technologies to clinical practice settings. In addition, the Chief Medical Adviser quality assures our clinical governance approaches relating to the clinical safety processes applied to the development of our digital health systems and services.

Our engagement approach

The Agency's accountability extends beyond the Commonwealth and state and territory health departments, to a diverse group who have a stake in digital health improving the reach, impact and efficiency of modern healthcare. These include clinicians delivering frontline health services, patients, the community, and industry and government bodies:

- The Australian community;
- Clinicians and health care providers;
- Peak and advisory bodies;
- Industry associations;
- Advocacy groups;
- Government departments and agencies;
- Technology sector;
- Research and science community;
- Business community;
- Private health insurers; and
- Primary Health Networks and other regional health service organisations.

In our own staff mix, we aim to reflect the communities we serve. Women hold 55% of executive leadership roles in the Agency, counting General Managers and Executive General Managers.

"The National Digital Health Strategy recognises the vital role industry plays in providing the smarts and innovation on top of government infrastructure. This means improved outcomes, research, and productivity. Industry is excited to work with the [Agency] to develop the detailed actions to achieve the vision which could lead to Australia benefitting from one of the strongest health software industries in the world."

Emma Hossack, President, Medical Software Industry Association

Awabakal outreach truck, Hamilton, NSW

Case study: **Awabakal's Medical Service & Outreach Truck**

Mobile connectivity will greatly improve access to the My Health Record, especially for those patients with limited mobility or who have difficulty accessing traditional health and care providers. One notable example is Awabakal's Medical Service, an Aboriginal community controlled health service in Hamilton NSW.

This service aims to deliver culturally appropriate primary health care services, advocacy and social and emotional support to Aboriginal people and their families. The popular service features a unique GP outreach truck that has serviced over 16,000 people in the surrounding remote and rural areas. Since 'going electronic' the outreach truck no longer has to cart around heavy patient files whilst out on the road. Having a digital system with real-time access to patient data reduces the time that the GP needs to spend verifying patient details.

The Agency's 2016-17 work program includes a number of initiatives designed to improve innovation in mobile connection to My Health Record, so we can expect to see more innovation in this space in the near future.

Electronic medical records are a key enabler for Awabakal Medical Service's innovative GP outreach truck.

The Agency is committed to an ongoing open and transparent dialogue with these stakeholders, ensuring that work remains informed and guided by the key issues facing its stakeholders in the short and longer term.

The Agency also continues to work closely with the Commonwealth Department of Health which has retained responsibility for digital health policy, and with state and territory governments, which share the goal of delivering a digital health capability that will improve health outcomes and quality and efficiency in healthcare.

This mutual interest across jurisdictions is reflected in the Council of Australian Governments (COAG) Intergovernmental Agreement on National Digital Health, with Commonwealth, state and territory health ministers as signatories. The Agreement reflects a commitment to the work of the Agency and a recognition of the benefits of a coordinated and collaborative approach across jurisdictions.

Our products and services

Upon its establishment, the Agency inherited a range of products and services from its predecessor organisations, which have been added to and enhanced through a range of new initiatives. These products and services are referred to collectively as "national infrastructure", and constitute Australia's digital health foundations. Operating and maintaining this infrastructure is a core activity for the Agency.

The major functions of the national infrastructure are to securely connect people and organisations, standardise clinical communications, and to digitally identify physical goods. The My Health Record sits at the apex of these activities, bringing these functions together into a cohesive service for all Australians.

These core activities are supported and supplemented by a number of digital health services, namely, the Research and Evaluation Program; the Digital Health Cyber Security Centre; and the Digital Health Developer Program.

Bringing it all together

1. My Health Record

Since 2012, the national My Health Record system has provided a secure online summary of Australian patients' health information. When the Agency was established, it became the System Operator for the My Health Record system (previously the Commonwealth Department of Health).

The My Health record connects key parts of the health system, such as general practices, pharmacies, private and public hospitals. Five million Australians are participating as of 12 July 2017. Connected healthcare providers are able to contribute to and use health information in the My Health Record on behalf of their patients to make more informed decisions about their health and care.

The system provides potentially lifesaving access to reports on an individual's medications, allergies, laboratory tests and chronic conditions. The system supports significant improvements in the safety, quality and efficiency of healthcare for the benefit of individuals, the healthcare system and the economy.

The My Health Record system operates in accordance with Australian Government security standards and undergoes regular independent security compliance and vulnerability assessments. These standards are regularly updated to address emerging security threats. Access to the system is monitored in order to detect suspicious or inappropriate behaviour. Regular privacy risk assessments are conducted to identify privacy risks and implement measures to mitigate those risks.

Securely connecting people and organisations

2. Healthcare Identifiers Service

The Healthcare Identifiers Service (HI Service) is a national service for uniquely identifying healthcare providers and individuals, ensuring that the right health information is associated with the right individual as patients move through the health system. A healthcare identifier is a unique 16-digit number that identifies an individual, healthcare provider or healthcare organisation.

3. National Authentication Service for Health

The National Authentication Service for Health (NASH) is a service to support healthcare providers and organisations in securely accessing and sharing health information. NASH builds on the HI Service to provide healthcare providers and organisations with authentication credentials that assert their Healthcare Identifier, which means that the parties they transact with will be able to have trust in their identity.

4. Secure Messaging

Reliable, secure provider-to-provider communication is a key component of digitally enabled integrated and coordinated care across the Australian health sector. Secure Messaging is a foundational capability enabling interoperability and safe, seamless, secure information sharing between healthcare providers.

While there are significant pockets of secure messaging already in use, there has historically been an inconsistent approach to secure messaging and information exchange across Australian healthcare. This has exacerbated information sharing challenges across the sector.

The Agency's Secure Messaging program is working collaboratively with industry, suppliers of secure messaging solutions and clinical software vendors to reduce existing barriers to adoption and provide pragmatic and implementable solutions.

Standardising clinical communications

5. Clinical Terminologies

Clinical Terminologies for clinical concepts and medicines are a key part of national infrastructure, supporting the sharing of high-quality data with a commonly understood meaning that can be used with confidence, driving greater safety, quality and efficiency. The Terminology program supports the ability to use a standard mechanism for describing data shared between healthcare providers.

The Agency manages and contributes to the ongoing refinement of clinical terminologies via the National Clinical Terminology Service (NCTS), Australia's National Release Centre for SNOMED CT®.

The NCTS publishes monthly updates of SNOMED CT-AU (the Australian localisation of SNOMED CT), which now includes the Australian Medicines Terminology (AMT) and other code systems. These updates ensure that medicines content remains current with the Therapeutic Goods Administration and the Pharmaceutical Benefits Schedule, as well as continually enhancing clinical descriptions such as diagnosis, allergies, diagnostic order and results, supporting a shared meaning among the creators and users of health data.

6. Clinical Informatics Specifications

The Clinical Informatics Specifications program produces specifications with consistent underlying data models, enabling common and consistent structures for information exchange and supporting appropriate use of clinical terminologies.

Digitally identifying physical goods

7. Supply Chain

The national infrastructure supports the ability to digitally identify the physical goods used in healthcare to greatly improve the capability to track and manage these goods, improving clinical safety while delivering savings through the ability to ensure that the right products are received in the right location, at the right time.

The centrepiece of the Supply Chain program is the National Product Catalogue (NPC), a central repository of accurate, standardised information about products, ranging from large medical devices to consumables and medicines. The NPC currently boasts 413,650 products from 504 healthcare suppliers.

In addition, an eProcurement solution has been developed, which streamlines the electronic purchasing process. With the standardised data provided by the NPC, the eProcurement solution improves the efficiency of the purchasing process and reduces costs. Buyers and suppliers both benefit from eProcurement through reduced order errors, standardised catalogues, better product identification and greater traceability throughout the supply chain.

Digital Health Services

1. Research and Evaluation Program

The Research and Evaluation Program aims to facilitate and coordinate the creation of evidence to support our ongoing national investment in digital health services and technology, and position the Agency as lead partners with key stakeholders in this field. It is applied across the organisation using a structured and integrated approach. Its focus is upon priority areas within the National Digital Health Strategy and our Agency work plan deliverables, and supporting the national My Health Record expansion. The delivery of this approach requires an ongoing organisational capability and capacity to create, consider, and apply research evidence.

The key objectives of the Research and Evaluation program are to:

- Embed an organisational focus on research and benefits evaluation across all Agency programs;
- Establish capability and capacity to create and apply evidence at the Agency, and an environment where best practice evidence can easily be applied to future work programs;
- Establish partnerships and collaborations with researchers, jurisdictions, and industry that drive evidence building both domestically and internationally on the benefits of digital health services;
- Prioritise and promote research funding to support evidence creation for ongoing digital health investment; and
- Support the capacity building of the digital health research and development workforce in academia and industry.

A key desired outcome is to successfully embed a culture across the Agency that draws upon research principles. This will be achieved by focusing program delivery on evidence-based outcomes, supporting the development of benefits measurement for our work programs with knowledge drawn from the current digital health evidence base, and to ensure cohesion and leverage investment across a broad range of projects occurring simultaneously within the Agency.

Highlight achievements of the Research and Evaluation program this year include:

- Quality assuring the evidence base that supports the National Digital Health Strategy;
- Ongoing domestic and international research and evaluation horizon scanning and collaborations;
- Supporting organisational excellence through initiatives such as the 'Grand Rounds' speaker series;
- Leading the matrix approach to the benefits evaluation of the My Health Record expansion;
- Establishing an evidence collection for the Agency which informs project and program evidence queries and evaluation approaches across the organisation; and
- Developing the Global Digital Health Partnerships project.

2. Digital Health Cyber Security Centre

The Digital Health Cyber Security Centre (Digital Health CSC) has been established to support secure operation of national digital health systems and protection for Australian personal health information that is stored and transacted through the Agency. In addition, the Digital Health CSC also aims to raise the security awareness and maturity across the Australian digital healthcare ecosystem.

Within the four themes of 'Partner, Secure, Inform and Respond', the Digital Health CSC provides a range of cyber-security capabilities to support secure national digital health operations across Australia. This enables the Agency to monitor and assess emerging and evolving cyber threats.

3. Digital Health Developer Program

The Agency's Digital Health Developer Program seeks to engage with the developer community to support the evolution and improvement of third-party products and services, leveraging the functionality of the My Health Record system and supporting national infrastructure.

This program endeavours to provide a single place to connect, remove ambiguity from technical information, facilitate innovation and co-design and make connecting to the My Health Record as easy as possible.

Our purpose, outcome and program structure

The Agency operates within the Commonwealth performance framework which focuses on an entity's purpose, outcomes and programs of work supporting that purpose.

The Agency has a single purpose and outcome, with one contributing program. The Health Minister's Portfolio Budget Statements 2016-17, released in the 2016 Budget, provide an overarching statement on the Agency's purpose, and articulate the intended outcome for the Agency for the reporting year, and the program through which that outcome will be delivered:

Purpose	To improve health outcomes for Australians through the delivery of digital healthcare systems
Outcome	To deliver national digital healthcare systems to enable and support improvement in health outcomes for Australians
Program	Digital Health

The path ahead – outlook for 2017-18

With a clearly articulated purpose and strategy, focus is now firmly on delivery of the seven strategic priorities outlined in the National Digital Health Strategy. A more detailed view of the year ahead is presented in the Agency's Corporate Plan 2017-18.[7]

Although there is much to be achieved in this coming year, a significant focus will be the expansion of the My Health Record system.

My Health Record expansion

The transition to 'opt-out' is the fastest way to realise the significant health and economic benefits of My Health Record for all Australians including through avoided hospital admissions, fewer adverse drug events, reduced duplication of tests, better coordination of care for people seeing multiple healthcare providers, and better informed treatment decisions. The Agency has established a measurement program to track and evaluate the realisation of these benefits.

National 'opt-out' model announced

In May 2017, the Australian Government announced its commitment for continued and improved operation of the My Health Record system, including a transition to an 'opt out' model in 2018. This followed unanimous support at the Council of Australian Governments (COAG) for a national rollout, with a My Health Record to be created for every Australian by the end of 2018, unless they tell us they don't want one.

Opt-out participation is supported by an independent evaluation of two opt-out trials which showed a high level of support from both healthcare providers and individuals. The opt-out rate was just 1.9% across the two trial areas.[8]

The Agency has established robust governance arrangements for the expansion program including an implementation working group, with representation from the Executive General Managers for each work stream. The working group meets weekly and reports to the My Health Record Expansion Program Board, which in turn reports into the Agency Board.

Additionally, the My Health Record Expansion Program Steering Group provides advice and guidance to the Program Board. This group is chaired by Jim Birch AM, with Dr Steve Hambleton as the Deputy Chair, and consists of over 30 stakeholder groups including national clinical peaks, academia and consumer groups.

My Health Record

"Prioritise making the My Health Record shareable and used by all health professionals and in all health settings. This fundamental step will have massive benefits to consumers who will be able to trust that their information is being adequately communicated."

Consumers Health Forum of Australia

7. *Australian Digital Health Agency Corporate Plan 2017-18, https://www.digitalhealth.gov.au/about-the-agency/corporate-plan , 2017.*
8. *http://www.health.gov.au/internet/main/publishing.nsf/Content/ehealth-evaluation-trials*

2.0

Performance

The annual performance statement highlights the Agency's performance in achieving its purpose by reporting results against the deliverables and performance measures set out in the Agency's Corporate Plan 2016-17 and in the Health Minister's Portfolio Budget Statements 2016-17. It also addresses My Health Record System Operator reporting requirements under the *My Health Records Act 2012*.

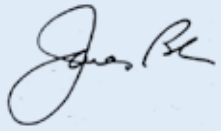
Garden City Medical Centre, Brisbane QLD

Annual performance statement

Statement of Preparation by Accountable Authority

On behalf of the Board I present the 2016-17 annual performance statements of the Australian Digital Health Agency, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

In my opinion, these annual performance statements are based on properly maintained records, accurately reflect the performance of the Agency, and comply with subsection 39(2) of the PGPA Act.



Jim Birch AM
Chair
16 October 2017

Performance against our purpose

The Annual Performance Statement provides an assessment of the Agency's performance during the year, and how it supported the Agency in achieving its purpose of improving health outcomes through the delivery of digital innovation, health systems and services.

It presents the annual work plan priorities published in the Agency's Corporate Plan 2016-17, clarifies their contribution to the Agency's purpose, and reports on the results produced from the Agency's first year of operations. It also reports on the Agency's success in meeting the performance targets set by the Health Minister in the Health Portfolio Budget Statements 2016-17.

Annual work plan priorities from the corporate plan 2016-17

The following diagram shows the Agency's work plan priorities for the 2016-17 financial year.

AGENCY STRATEGIC PRIORITIES		
MESSAGING	**MEDICINES SAFETY**	**PATHOLOGY & DIAGNOSTIC IMAGING**
PROGRAMS/PROJECTS		
1. Working with industry to improve user experience	**1.** Design better medicines information for healthcare providers through My Health Record	**1.** Addressing concerns of private pathology industry
2. Develop robust national directory service and meet service levels requirements	**2.** Co-produce a robust, integrated and safe 'medicines at your fingertips' national program	**2.** Co-design final end to end design and adoption requirements for private pathology
3. Simplify the renewal process for authentication certificates	**3.** Increasing use of electronic prescriptions, electronic medications management, and terminology	**3.** Upload pathology and diagnostic imaging reports to My Health Record from public hospitals
4. Increase uptake of clinicians using electronic messages		**4.** Upload pathology and diagnostic imaging reports to My Health Record in private hospitals
5. Implement new end to end solution		

Figure 2 – The Agency's work plan priorities for financial year 2016-17

AGENCY STRATEGIC PRIORITIES			
MY HEALTH RECORD	**STRATEGY**	**CORE CLINICAL**	**ORGANISATIONAL EXCELLENCE**
PROGRAMS/PROJECTS			
1. Working with the software industry to improve user experience and connect GP, pharmacy, aged care providers	**1.** Finalise the National Digital Health Strategy, and forward work program	**1.** Establish Children's Collaborative Network for Innovation	**1.** Committing to the prudent use of resources
2. Connecting more hospitals to My Health Record		**2.** Support delivery of the Healthcare Homes Strategy	**2.** Optimising opportunities as the national digital health agency
3. Innovation in mobile connection for providers to My Health Record		**3.** Embed telehealth in clinical consultations	**3.** Earning trust as a reliable operator of national data systems
4. Release 8.0 – improved user experience, implementing outcomes from medicines and pathology and diagnostic imaging streams			**4.** Leading the world in digital health cyber security
			5. Making the organisation hum
5. Return to Government on My Health Record consumer participation options			**6.** Exemplifying openness and transparency

Performance

Consistent with the Agency's commitment to open dialogue with the health system, the priorities for 2016-17 were determined following consultation with a variety of healthcare providers, jurisdictional representatives, industry participants and consumer advocates.

Each work plan priority has a governance structure that puts system users – clinicians, consumers, jurisdictions – at the forefront as co-producers. The clinical community, jurisdictions, vendors and consumer representatives have all indicated their willingness to participate in the governance of these programs, and the Jurisdictional Advisory Committee also advised that these activities would provide value to jurisdictions.

Secure messaging

Purpose: Many patients' and carers' experience of modern day healthcare involves interacting with numerous different healthcare providers.[9,10] The ability of healthcare providers to easily, reliably and securely exchange health information – both directly with one another and with their patients – is a key enabler of coordination of care and integration of care.[11,12,13,14]

Program Governance

The Agency's **Pathology Program** is co-chaired and co-sponsored by Dr Steve Hambleton (clinical representative), Matthew Ames (consumer representative) and Dr Anne Duggan (representing the Australian Commission for Safety and Quality in Health Care).

The Agency's **Diagnostic Imaging Program** is co-chaired and co-sponsored by Dr Steve Hambleton (clinical representative), Associate Professor Nick Ferris, Matthew Ames (consumer representative) and Dr Robert Herkes (representing the Australian Commission for Safety and Quality in Health Care).

The Agency's **Medicines Safety Program** is co-chaired and co-sponsored by Dr Steve Hambleton (clinical representative), Steve Renouf (consumer representative) and Neville Board (representing the Australian Commission for Safety and Quality in Health Care).

The Agency's **Secure Messaging Program** is chaired by Dr Nathan Pinskier and co-sponsored by Dr Pinskier (clinical representative), Dr Zoran Bolevich (jurisdictional representative) and Fiona Panagoulias (community representative).

9. *National Health Performance Authority. Healthy Communities: Frequent GP attenders and their use of health services in 2012–13. Sydney: National Health Performance Authority; 2015.*
10. *Royal Australian College of Practitioners. RACGP position statement: The use of secure electronic communication within the health care system. Sydney: Royal Australian College of Practitioners; 2016.*
11. *Georgiou A, Marks A, Braithwaite J, Westbrook JI. Gaps, disconnections, and discontinuities--the role of information exchange in the delivery of quality long-term care. The Gerontologist. 2013;53(5):770-9.*
12. *Banfield M, Gardner K, McRae I, Gillespie J, Wells R, Yen L. Unlocking information for coordination of care in Australia: a qualitative study of information continuity in four primary health care models. BMC Family Practice. 2013;14(34):1-11.*
13. *Fontaine P, Ross SE, Zink T, Schilling LM. Systematic review of health information exchange in primary care practices. Journal of the American Board of Family Medicine : JABFM. 2010;23(5):655-70.*
14. *Shapiro JS, Mostashari F, Hripcsak G, Soulakis N, Kuperman G. Using health information exchange to improve public health. American journal of public health. 2011;101(4):616-23..*

It is also a key driver of health service efficiency,[15,16,17,18] as well as patient engagement and satisfaction.[19,20,21] An economic analysis, undertaken as part of the development of the National Digital Health Strategy, has estimated that the gross economic benefit of ubiquitous secure messaging could be around $2 billion over 4 years and more than $9 billion over 10 years.

Research shows that General Practitioners waste 10% of their time daily in searching for paper records.[22]

In Australia, there is established use of secure messaging using a range of different electronic communication methods; for example, diagnostic requesting and reporting, and sending discharge summaries from hospitals to general practice.[23] However, these different methods are generally not compatible – meaning that these proprietary secure messaging approaches do not work with each other.[24] Despite significant effort, there is no nationally consistent, standards-based approach to secure messaging, which limits the ability of healthcare providers to communicate effectively.

The inability of healthcare providers to share health information easily and safely can lead to communication breakdowns, which contribute to poor health outcomes, duplication and inefficiency.[25,26,27] As a result, patients often have disjointed healthcare experiences, and feel that they need to repeat information all too often.[28]

"[There is] no common standard for secure messaging between providers – we are like nineteenth 19th century colonies each with their own rail gauge."

Health service IT manager

"One of the most pressing priorities is to improve interoperability, integration and secure messaging capability of the various systems (with appropriate privacy parameters) of public and private organisations to share data, which is critical for providing coordinated and connected patient care."

Queensland Government, eHealth Queensland submission

15. *Fontaine P, Ross SE, Zink T, Schilling LM. Systematic review of health information exchange in primary care practices. Journal of the American Board of Family Medicine : JABFM. 2010;23(5):655-70.*
16. *Vest JR. Health information exchange and healthcare utilization. Journal of medical systems. 2009;33(3):223-31.*
17. *Frisse ME, Johnson KB, Nian H, Davison CL, Gadd CS, Unertl KM, et al. The Financial impact of health information exchange on emergency department care. J Am Med Inform Assoc. 2012;3(3):328-33.*
18. *HealthLink. Case Study General Practice: Henderson Medical Centre - Enhancing delivery of medical services. Auckland; 2004.*
19. *Goldzweig CL, Tow gh AA, Paige NM, Orshansky G, Haggstrom DA, Beroes JM, et al. Systematic Review: Secure Messaging Between Providers and Patients, and Patients' Access to Their Own Medical Record: Evidence on Health Outcomes, Satisfaction, E ciency and Attitudes [Internet]. Washington D.C.: Department of Veterans A airs (US); 2012.*
20. *Baer D. Patient-Physician E-Mail Communication: The Kaiser Permanente Experience. J Oncol Pract. 2011;7(4):230-3.*
21. *Jenssen BP, Mitra N, Shah A, Wan F, Grande D. Using Digital Technology to Engage and Communicate with Patients: A Survey of Patient Attitudes. J Gen Intern Med. 2016;31(1):85-92.*
22. *Smith PC, Araya-Guerra R, Bublitz C, Parnes B, Dickinson LM, Van Vorst R, et al. Missing clinical information during primary care visits. Jama. 2005;293(5):565-71.*
23. *Deloitte. Secure Messaging Market Analysis. Sydney; 2014.*
24. *See note 22.*
25. *Georgiou A, Marks A, Braithwaite J, Westbrook JI. Gaps, disconnections, and discontinuities--the role of information exchange in the delivery of quality long-term care. The Gerontologist. 2013;53(5):770-9.*
26. *Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2015-16. 4839.0 Canberra: Australian Bureau of Statistics; 2016 [Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0].*
27. *Health Care Complaints Commission. Case Studies, Volume 1. Sydney: Health Care Complaints Commission; 2003.*
28. *Australian Digital Health Agency. Secure Messaging Problem Statement. Sydney: Australian Digital Health Agency; 2016.*

The secure messaging program focuses on improving the messaging and information exchange experience for healthcare providers by providing a reliable, easy-to-use service that will give them the ability and the confidence to stop using fax machines.

The work program involves a number of streams, including:

1. Working with industry to improve the experience of users sending secure messages;
2. Improving national directory infrastructure and service levels to bring them in line with the level of service demanded by clinical users;
3. Simplifying the experience for clinical practices to renew authentication certificates;
4. Increasing the number of clinicians who send and receive electronic messages by developing a strategy to increase take-up and address barriers to use; and
5. Supporting a number of targeted implementations to validate the approach and scalability of secure messaging capabilities to support broader national adoption.

The outcome of this program will ultimately be the end of fax machine usage in practices, as confidence is built in the usability and reliability of secure messaging services.

Results:

1. **Working with industry to improve the experience of users sending secure messages**

   The project has been underpinned by industry collaboration with a key focus on engagement with clinical system users, healthcare providers and vendors. Industry has been consulted throughout the project to identify key barriers and obstacles to adoption, an agreed approach and technical direction and 'quick win' projects, including specific sites and participating vendors.

   Initial implementations have been tailored to specific use cases, in order to validate the chosen approach. The secure messaging program is split into three core streams of activity covering industry adoption and business models, technical and solution implementation; and future architecture and roadmap.

2. **Improving national directory infrastructure and service levels to bring them in line with the level of service demanded by clinical users**

   The Secure Messaging Technical Working Group (TWG) was established in January 2017, to support the development of a national secure messaging capability that enables seamless and cost-effective electronic communication between healthcare provider organisations of all sizes and sectors across Australia. The group is achieving this by identifying, analysing and proposing resolutions to technical issues and barriers that restrict or inhibit a seamless national secure messaging capability.

   One of the key priorities of the TWG is improving accessibility and usability of directory information from federated sources, underpinned by an appropriate architecture.

   This industry-led working group is responsible for developing the Fast Healthcare Interoperability Resources (FHIR®) based Application Programming Interface (API) for healthcare provider directory access and search, and significant progress has been

made towards this goal. Due to the complexity of this work, the number of industry participants and the collaboration with HL7 Australia, this component will continue into 2017-18.

3. **Simplifying the experience for clinical practices to renew authentication certificates**

   The use of appropriate identifiers and certificates to support short-term projects and solutions, as well as longer-term national directives (such as Individual Healthcare Identifier, Healthcare Provider Identifier, and NASH) have been considered as part of the secure messaging program.

   Guidelines for the use of commercial certificates and proprietary identifiers to industry were drafted in June 2017. Assessment and documentation of the current processes was undertaken and the independent risk assessment completed by a third party, who delivered their report and recommendations in June 2017. The use of commercial certificates as an interim approach will simplify the user experience of renewing certificates. The guidelines will continue to be enhanced and refreshed through 2017-18.

4. **Increasing the number of clinicians who send and receive electronic messages by developing a strategy to increase take-up and address barriers to use**

   A sustainable commercial model is required to support the continued adoption of secure messaging across the health sector. Secure messaging requires the involvement of different vendor and user participants, and so needs to be supported in a consistent and manageable way to ensure ongoing adoption and use.

   The consideration of sustainable economic and commercial models will continue into 2017-18.

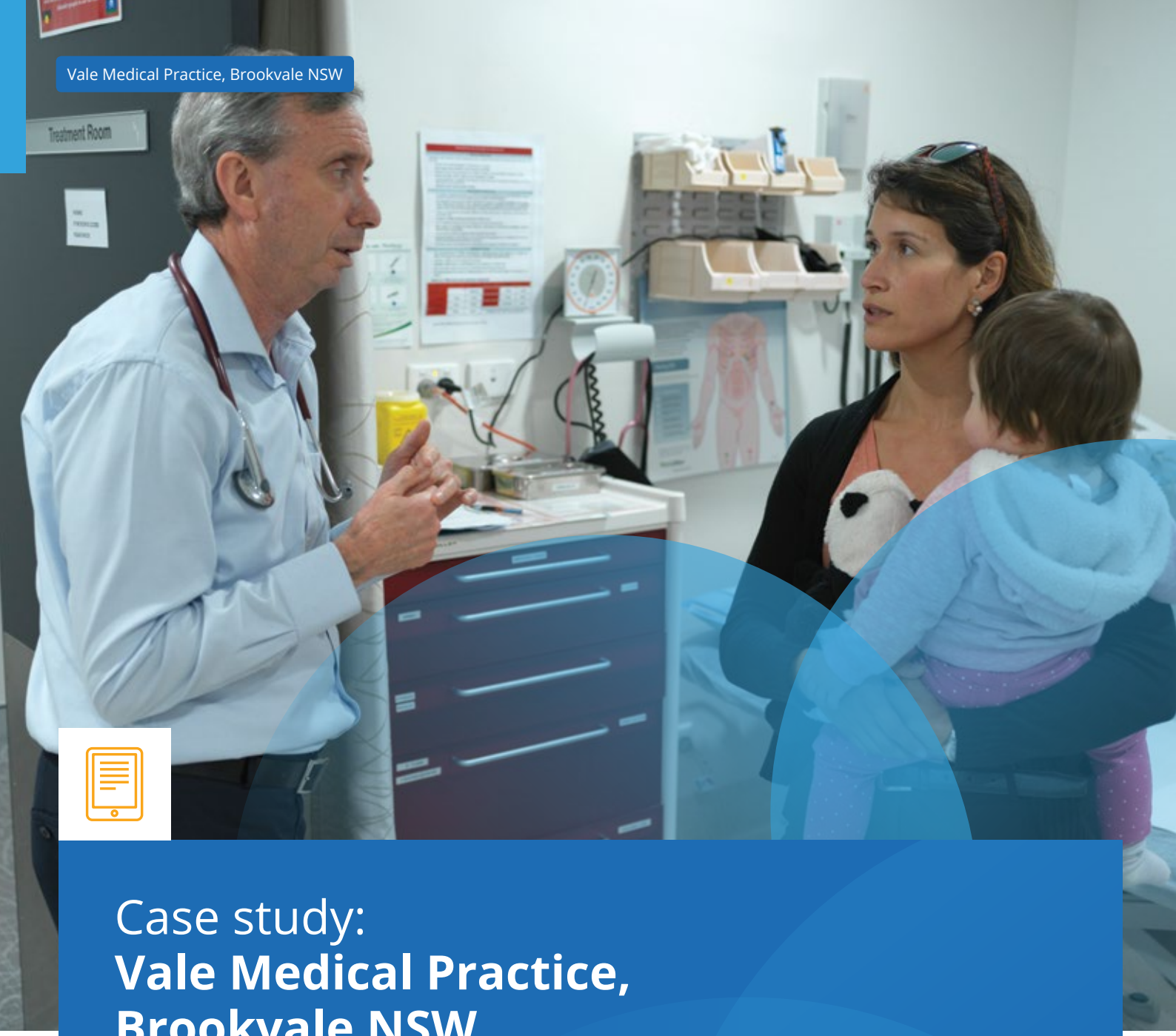
5. **Supporting a number of targeted implementations to validate the approach and scalability of secure messaging capabilities to support broader national adoption**

   In February 2017 the Agency released a request for tender, seeking partners from industry to establish and implement secure messaging capabilities as 'proof of concept' projects addressing specific use cases. The goal of these projects is to improve 'point-to-point' messaging between healthcare providers and the clinical information systems in use across Australia by bringing together the various components of the Agency's secure messaging program into end-to-end implemented projects.

   The preferred vendors for the implementation projects have been identified, informed and the projects established.

   These implementation projects have been established to validate the solution approach, improve interoperability between vendors, and drive scalability to support a broader national deployment. The initial implementation projects will be underpinned by use cases that cover discharge summaries from hospital to general practitioners (GPs) or other providers, referrals from GPs to specialists or allied health professionals, and reports or referrals from allied health to GPs, specialists or other providers.

   These 'proof of concept' projects will continue into 2017-18.



Case study: **Vale Medical Practice, Brookvale NSW**

The Agency's 2016-17 work program includes an initiative to work with the software industry to improve user experience and connect GPs and pharmacies. Large multi-disciplinary clinics like Vale Medical Practice in Brookvale will be amongst the first to benefit. This practice offers services ranging from family medicine to GP-managed care plans, WorkCover consultations and exercise physiology.

The centre's patients come from a range of backgrounds including those with chronic illnesses, which may involve multiple clinicians in the delivery of care to the same patient in the one location. GPs, pharmacists and nurses can have confidence that they have accurate patient information and history from a single source of truth in the My Health Record. This enables the team to provide the best care in this collaborative setting as information can flow within the practice easily, safely and securely.

Other benefits include reduced time in clinician meetings and less paperwork administration.

Clinicians can manage their regular customers with care and be confident in the information they have with new customers.

"When patients move between care settings, the absence of complete and up-to-date medication data can contribute to instances of care becoming high risk, resulting in medication misadventures and unnecessary hospital re-admissions."

Pharmacy Guild of Australia submission

Medicines safety

Purpose: In any two-week period around 7 in 10 Australians and around 9 in 10 older Australians will have taken at least one medicine.[29] Those medicines keep Australians out of hospitals, prevent disease and play a pivotal role in ensuring a productive and healthy community.

However, with the growth in use of medicines comes an increase in the risk of adverse drug events. Medication-related hospital admissions have been estimated to comprise 2% to 3% of all Australian hospital admissions, with an estimated annual cost of $1.2 billion.[30] These problems are particularly acute in the elderly and those with chronic disease. Great care needs to be taken to ensure that the right drug is given to the right patient, at the right time, in the right dose and form, through the right channel.

In addition, those prescribing, dispensing and administering medicines need to be aware of an accurate picture of other medicines currently being taken by a patient, and any allergies that they might have.

The medicines safety program aims to increase medicines awareness, reduce hospital admissions due to adverse drug events, reduce harm due to medicines misadventure, and improve quality of life through the safe and effective use of medicines.

Although work will be a multi-year national program, important progress was made during the 2016-17 financial year, including:

- Providing better medicines information for healthcare providers through the My Health Record by improving the quality, timeliness and access to the medicines information in the various documents in the My Health Record, and making this more readily available to patients, carers and healthcare providers;
- Co-producing a robust, integrated and safe 'medicines at your fingertips' national program, utilising the community conversation about the National Digital Health Strategy; and
- Accepting that while healthcare provider systems are primarily geared to meet the needs of the individual clinician or practice, those systems can have broader benefits for patients if the information could be more easily be shared and used.

The medicines safety program of work has been run in partnership with the Australian Commission on Safety and Quality in Health Care (ACSQHC), supporting national objectives to improve medicines safety, and avoid preventable hospital admissions that occur due to adverse drug events.

29. Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety – Improving Medication Safety. July 2002. https://www.safetyandquality.gov.au/wp-content/uploads/2012/12/Second-National-Report-on-Patient-Safety-Improving-Medication-Safety.pdf

30. Australian Council for Safety and Quality in Health Care. Literature Review: Medication Safety in Australia. Aug 2013. https://safetyandquality.gov.au/wp-content/uploads/2014/02/Literature-Review-Medication-Safety-in-Australia-2013.pdf

Results:

1. **Design better medicines information for healthcare providers through My Health Record**

   An extensive co-design process was undertaken to develop a new approach to displaying medicines information in the My Health Record system. The design for the new Medicines View has been improved through user feedback received from a range of healthcare providers, e.g. general practitioners, hospital specialists, community and hospital pharmacists, peak health care industry and professional bodies, including the ACSQHC. The new Medicines View, made available in the My Health Record system in June 2017, will form a platform for future enhancements to the display of medicines information.

2. **Coproducing a robust integrated and safe national program**

   The Agency established the Medicines Safety Program Governance Framework with the steering group as its key stakeholder, representing more than 20 peak industry bodies and professional organisations.

   Progress by the steering group so far includes:

   - Conducting and validating an environmental scan of all the current and planned digital activities that support access to safer medicines, and identifying opportunities for improved coordination, collaboration, and investment;
   - Identifying new priority projects or activities, through consultation with the healthcare sector, which should be delivered directly by the Agency or through partnerships with other organisations. This will include the investigation of any short-term opportunities for improvement identified through the National Digital Health Strategy consultation, which will be included in the Agency's work plan; and
   - Developing an evidence-based, sector-wide digital Medicines Safety Program roadmap, including a benefits realisation plan to monitor progress of both adoption and outcomes.

3. **Increase use of electronic prescriptions, electronic medications management and terminology**

   Clinical terminologies are critical to the quality of shared data, and support the standardisation of medicines information by facilitating medicines information sharing between local and national systems; supporting greater data accuracy during transfer of care using medicines information in electronic discharge summaries, shared health summaries, and referral records; and enhancing the medicine information exchange capabilities of the existing electronic medication management systems (hospitals).

   Good progress has been made in 2016-17 with regard to increased use of clinical terminologies, with SNOMED CT-AU and the AMT having been implemented and deployed in a variety of sites and clinical applications, including public and private hospitals within Victoria, Northern Territory (NT), New South Wales (NSW), Queensland, Tasmania and Western Australia (WA).

   In recognition of this work, the Agency won a Queensland iAward in collaboration with the AEHRC and the CSIRO for providing "state-of-the-art terminology services that promote adoption of national clinical terminologies in electronic health and medical records in Australia".[31]

31. https://www.iawards.com.au/history/2017-iawards/state-winners-and-merit-recipients

Harry Iles-Mann, Sydney NSW

Case study: **Harry Iles Mann, Sydney NSW**

Harry is 22 years old, currently studying at Macquarie University in Sydney. At 3 years old, he was diagnosed with Inflammatory Bowel Disease (Ulcerative Colitis) and Liver Disease (Primary Schlerosing Cholangitis) and in 2013, he was diagnosed with severe depression and anxiety.

He has spent essentially his whole life interacting with various facets of the healthcare system, and found to his disappointment and frustration that clinicians were sometimes unwilling to share information with each other, let alone with him directly, which impacted on the quality of his care, his health and ultimately his wellbeing.

As a result, he has developed an interest in how clinical information and access to that information can be used to make the system more user friendly and patient-centric. He sees the My Health Record as a valuable tool for managing his health information, and in the process taking control of his healthcare.

The Agency's 2016-17 work program includes a number of initiatives designed to improve user experience in medicines, pathology and diagnostic imaging. Early adopters like Harry Iles-Mann will immediately appreciate these benefits, as will many others soon after.

Increase the volume of 'dispense' data sent to the My Health Record system from community pharmacies

The Agency launched the Community Pharmacy Dispensing Software Providers Partnership offer, to enable all pharmacists in Australia to utilise national digital health services, and to ensure that healthcare providers and consumers have access to important medicines information.

The offer invited software developers to apply for funding to build capability to support direct upload of AMT-coded Clinical Document Architecture (CDA) dispense records; to support viewing of the My Health Record; and to support their users to connect and begin using the My Health Record. The offer supports the execution of required technical development to connect all community pharmacy dispensing software providers to the My Health Record system.

The Agency also entered into an agreement with the Pharmacy Guild of Australia, aimed at driving adoption and use of the My Health Record system by community pharmacies (supported by education and training) and maximising medicines safety benefits.

Pathology and diagnostic imaging

Purpose: Having pathology and diagnostic imaging results available in a single location and accessible by all healthcare providers will enhance clinical management and care by reducing wasted clinical time locating results, and avoiding unnecessary repeat tests.[32,33]

This work program includes a number of streams:

- Addressing the interests and concerns of private pathology laboratories to gain their support in making results available through the My Health Record;
- Co-design final end-to-end design and adoption requirements for private pathology;
- Upload pathology and diagnostic imaging reports to the My Health Record from public hospitals; and
- Upload pathology and diagnostic imaging reports to the My Health Record from private providers.

Results: These projects were developed to connect data feeds from public and private pathology and diagnostic imaging providers to the My Health Record system. Design and development of the required My Health Record capabilities has been completed and the system is now accepting data from pathology laboratories and radiology practices.

1. **Addressing the interests and concerns of the private pathology industry**

   Engagement with private pathology laboratories is ongoing, both directly and through representation on the Pathology Program Steering Group.

   In April 2017, the Agency announced that it had reached its first agreement with Australia's largest provider of diagnostic services, Sonic Healthcare, to share pathology reports with the My Health Record. Under the agreement, Sonic Healthcare will progress the upload of pathology reports to the My Health Record in North Queensland, Nepean in New South Wales and Tasmania, commencing in the second half of 2017.

32. Westbrook JI, Georgiou A, Dimos A, Germanos T. Computerised pathology test order entry reduces laboratory turnaround times and influences tests ordered by hospital clinicians: a controlled before and after study. Journal of Clinical Pathology. 2006;59(5):533-6.

33. Georgiou A, Prgomet M, Lymer S, Hordern A, Ridley L, Westbrook J. The impact of a health IT changeover on Medical Imaging Department work processes and turnaround times. A mixed method study. Applied Clinical Informatics. 2015;6(3):443-53.

A significant number of private pathology laboratories have also expressed interest in connecting with the My Health Record by submitting expressions of interest to participate via the diagnostic software industry partnership offer released in June 2017.

2. **Co-design final end-to-end design and adoption requirements for private pathology**

   The Agency has convened a Technical Working Group with sector representatives and is working with the largest private pathology providers on the approach to participation and upload, to inform the early deployments by private laboratories.

3. **Upload pathology and diagnostic imaging reports to My Health Record from public hospitals**

   At the end of the reporting year, 77,893 pathology reports had been uploaded to the My Health Record from 12 laboratories, and 52,859 diagnostic imaging reports had been uploaded to the My Health Record from five public hospitals.

   The Agency has agreements with five jurisdictions to progress upload of pathology and diagnostic imaging reports to the My Health Record. The Northern Territory Health Department has completed its implementation and is uploading both pathology and diagnostic imaging reports. NSW Health commenced upload of pathology reports from the South Eastern Sydney and Illawarra Shoalhaven Local Health Districts in April 2017 and will be adding more laboratories over the next year. Pathology and diagnostic imaging reports from other NSW local districts will be rolling out in 2017-18, as will those of other state jurisdictions.

4. **Upload pathology and diagnostic imaging reports to My Health Record from private providers**

   Upload of pathology and diagnostic imaging reports by the private sector was not commenced by June 2017. At 30 June 2017, Australia's largest pathology provider, Sonic Healthcare was connected to the My Health Record test system ahead of planned upload of pathology and diagnostic imaging reports later in 2017. The Agency released a diagnostic software industry offer on 2 June 2017 to organisations that develop or maintain software systems for private sector pathology laboratories and diagnostic imaging providers.

   The Agency is offering sector-wide funding to enable pathology laboratories and diagnostic imaging practices to access upgraded software to enable their participation in the My Health Record. By 30 June 2017 there had been strong interest from the market and contracts with industry will be offered from July 2017.

2.0

Performance

My Health Record

Purpose: The objective of the My Health Record program is to identify important opportunities that support the realisation of the full potential of the My Health Record. This will allow clinicians to experience benefits from the system in their day-to-day work, and consumers to experience improvements in the quality and convenience of healthcare services through better sharing of information supporting their care.

The program will work collaboratively with users to co-produce improvements to the My Health Record that have a significant impact upon patient care.

This program will improve the value of the My Health Record for a range of users, including those in hospital emergency departments who are a key group that could benefit from better information about a patient's current medications and medical history at the point of care.

Results: The latest version of the My Health Record (Release 8) delivers user interface improvements and improves support for pathology and diagnostic imaging information. Over 140 clinicians and 220 consumers contributed to the development of this release.

A key factor in the continued growth and adoption of the My Health Record is the connection of more hospitals, and the national transition to an 'opt-out' approach. Trial data suggests that approximately 2% of users are likely to opt out; applying this figure to the current population suggests that the consumer base will grow from 5 million Australians (as at 12 July 2017) to approximately 24 million. As a result, Australia will have the highest participation rate in a national health record system in the world by the end of 2018.

"My Health Record is the future of medicine."

Dr Michael Gannon, President, Australian Medical Association

Case study: **Increasing document volume in the My Health Record system**

The number of documents uploaded to the My Health Record has increased substantially during the past financial year.

The number of Shared Health Summaries uploaded to the My Health Record system increased fourfold, supported by the new practice incentive requirements for general practices and the My Health Record participation trials.

The following table shows the number of documents uploaded to the My Health Record (by category) during the 2016-17 reporting period.

Document Category	At 26 June 2016	At 25 June 2017	Percentage growth
Clinical Documents	675,651	2,374,059	**351%**
Shared Health Summary	144,605	893,530	**617%**
Discharge Summary	422,312	1,029,024	**243%**
Event Summary	73,928	275,216	**372%**
Specialist Letter	19,094	49,490	**259%**
eReferral Note	26	29	**111%**
Pathology Report	0	74,423	**N/A**
Diagnostic Imaging Report	15,686	52,347	**333%**
Prescription and Dispense Documents	3,995,189	10,689,086	**267%**
Prescription	2,902,677	8,315,955	**286%**
Dispense	1,092,512	2,373,131	**217%**
Consumer Documents	97,503	138,675	**142%**
Consumer Entered Health Summary	59,247	86,637	**146%**
Consumer Entered Notes	28,005	37,289	**133%**
Advance Care Directive Custodian Report	10,060	13,625	**135%**
Advance Care Planning Document	191	1,124	**588%**
Medicare Documents	298,887,197	508,892,673	**170%**
Australian Immunisation Register	709,675	1,389,099	**195%**
Australian Organ Donor Register	351,895	481,272	**136%**
Medicare/DVA Benefits Report	179,231,336	299,939,038	**167%**
Pharmaceutical Benefits Report	118,594,291	207,083,264	**174%**
Child My Health Record (CeHR) Documents	12,785	14,772	**115%**
Personal Health Observation	5,902	6,915	**117%**
Personal Health Achievement	847	982	**115%**
Child Parent Questionnaire	6,036	6,875	**113%**
Total Active Documents in My Health Record	303,668,325	522,109,265	**171%**

Performance

1. **Working with the software industry to improve user experience and connect GP, pharmacy and aged care providers**

   This project was designed to increase the volume of content being uploaded to the My Health Record, by working with software developers and vendors of clinical information systems to improve the user experience and connect GP, pharmacy, and aged care providers to the My Health Record.

   Projects were completed with seven vendors to enhance software to interact with the My Health Record.

2. **Connecting hospitals to the My Health Record**

   A large number of public and private hospitals in NSW, Queensland, Victoria and WA were connected to the My Health Record system during the 2016-17 financial year. Details of the participation of public and private institutions are provided below.

   ### Public hospitals and health services

   Connection of public health services to the My Health Record system has made significant progress during the past financial year. In 2016-17, an additional 231 public hospitals and health services were connected to the My Health Record, increasing the proportion of healthcare services connected from 52% in July 2016 to 67% in June 2017.

   A range of connectivity projects were undertaken in 2016-17, delivering state-wide coverage of the My Health Record in WA health services, while Victoria is commissioning state-wide My Health Record infrastructure that will allow district health services to quickly connect to the My Health Record. The following services are already connected in Victoria: Austin Health, Eastern Health, Peninsular Health, Royal Children's Hospital, and Monash Health.

   In Australia, there are a total of 1,129 public hospitals and health services, with 760 (67%) of these connected to the My Health Record, as of June 2017. 748 of these can view the My Health Record, and 549 are able to upload.

   ### Private hospitals and health services

   In 2016-17, an additional 95 private hospitals and health services connected to the My Health Record, increasing the proportion from 38% in July 2016 to 79% in June 2017.

   Private hospitals connected include Ramsay Healthcare Group – all 77 hospitals (and mobile app for staff), Mater Central Queensland and Cura Day Clinics in nine sites.

   In Australia, there are a total of 204 candidate private hospitals and clinics, with 161 (79%) of these connected to the My Health Record, as of June 2017. 161 of these can view the My Health Record, and 154 are able to upload.

Dr Liz Jackson, Cairns QLD

Case study: **Dr Liz Jackson, Cairns QLD**

The Agency's 2016-17 work program includes a number of initiatives designed to improve medicines safety and improve medicines information for healthcare providers. These benefits are already being experienced by Dr Liz Jackson and her patients in Cairns, North Queensland.

Liz is an Obstetrician Gynaecologist practicing in one of the areas where the opt-out trials took place recently. As a result, individuals in that region had the opportunity to have a My Health Record automatically created for them – and roughly 98% took up the offer.

"It's been the game changer for me in this region because everyone is in it," says Liz.

"When a patient calls the hospital, the midwife looks at their most recent updated pregnancy information on the My Health Record and we can plan what health services they require when they are coming in to have their baby. If it's a potential emergency, we can plan theatre and staffing. With the paper pregnancy handheld record, we would not see that information until the patient walks in the door."

One of Liz's patients had the most complex pregnancy that she had dealt with for some years. The patient's GP was using the My Health Record and they both were able to share information that the patient could see – using Shared Health Summaries and Discharge Summaries from Cairns hospital. Together they kept the patient at home, rather in hospital and had multidisciplinary input using the My Health Record as the mode through which information was communicated.

"You would not operate not knowing how your medical systems work – a computer is now a tool in medicine," says Liz.

My Health Record is now the main tool that Liz uses for managing pregnancy records between her rooms, the hospital and the patient's GP; she has not used paper-based pregnancy records for over a year. At her urging, all her patients now use the 'Healthi' smartphone app, which makes possible new levels of convenience and control in managing their health information.

3. **An innovative mobile interface to the My Health Record**

   This project created a developer interface which enables mobile apps to connect to patient information stored in the My Health Record, with informed patient consent. Mobile apps that implement this interface thus allow consumers to interact with their My Health Record using smartphones or other portable devices. Four mobile apps achieved production access to the My Health Record by 30 June 2017.

4. **Release 8 of My Health Record – improved user experience, implementing outcomes from medicines and pathology and diagnostic imaging streams**

   The Medicines Information view, introduced in Release 8, enables users to quickly sort and display medicines information held in a patient's My Health Record documents by date or in alphabetical order. The medicines information is gathered from:

   - The patient's most recent (and up to two years') prescription and dispense records and other Pharmaceutical Benefits Scheme claims information;
   - The patient's most recent Shared Health Summary and Discharge Summary;
   - Recent Event summaries, Specialist Letters and e-Referral Notes uploaded to the patient's record since their latest Shared Health Summary, and
   - The patient's Personal Health Summary that may include any Allergies or Adverse Reactions and other key information.

   Early reviews suggest that this new feature is a welcome development.

Release 8 also improved access to relevant pathology and diagnostic imaging information by providing a new search function and an enhanced user interface. New user interface features in the pathology and diagnostic imaging views include column sorting, reordering and renaming, and group by filters.

"I just found this new document on a patient's My Health Record called Medicines View. A single document with everything I need about a patient's medications, easy to read, easy to download and incredibly useful. Absolutely brilliant – too good to be true but it is! Along with pathology and radiology this will be a game changer."

Dr Daniel Byrne, RACGP Chair SA&NT and GP in Adelaide

Phone access makes health care easier

Sandra Motteram and her daughter Eliza Leake access health record on a phone with Digital Health Agency chief executive officer Tim Kelsey and chief medical adviser Meredith Makeham. Picture: Jon Gellweiler

Case study: **Sandra Motteram, Bunbury WA**

By Chloerissa Eadie
Bunbury Herald, 3 January 2017

BECAUSE Bunbury woman Sandra Motteram could access her daughter Eli's health records on a phone, the four -year-old went through with a scheduled vaccination instead of having to make another appointment.

Ms Motteram visited the Bunbury Community Health Centre to find that the computer system was down, which meant medical staff could not access Eliza's health records requiring the pair to come back at a later date. However, because Ms Motteram was registered for My Health Record she pulled up her daughter's records on her phone, allowing her to receive the vaccination on the spot.

"It was really convenient at that time and everyone pretty much has a phone on them these days," she said.

Community health nurse manager Marie O'Donoghue said it was "a particular glitch" which prevented the centre from accessing the records.

"It saved a lot of time, because children are often apprehensive when they come in for an immunisation at that age and Sandra had prepared her well, so it was important that we followed through on that." she said.

Digital Health Agency chief executive officer Tim Kelsey said it was a good example of how the experience of health care was improved with vital information accessible on a mobile device.

"If you have your mobile phone with your information on it and you had an emergency, the treating clinician and the paramedic could know what your allergies were and medications you had," he said.

"There are lots of reasons why we need to encourage people to participate in the My Health Record because it is better for them."

In the South West, 57 organisations have registered for My Health Record and about 1400 Shared Health Summaries have been uploaded this year. To register, speak to your GP at your next appointment or visit www.myhealthrecord.gov.au.

5. Return to Government on My Health Record consumer participation options

This program was aimed at implementing a national opt-out arrangement for the My Health Record. An opt-out rate of 2% is expected based on the outcome of trials undertaken in Northern Queensland and the Nepean Blue Mountains Primary Health Networks in 2016. Extending this figure to the entire population suggests that 98% of the population could have a My Health Record by the end of 2018.

To deliver on national opt-out arrangements, there are a range of systems and services (NASH, HI and the Contact Centre) currently provided by the Department of Human Services which need to be enhanced and scaled up to support the ongoing operation of the My Health Record system when it supports all Australians. These systems and services will be transitioned to the Agency as part of the program.

Achievements to the end of the reporting period include:

- Supported the Department of Health in preparing submission to government on expanding My Health Record consumer participation;
- Mobilisation of the program team and establishment of program governance arrangements after decision made by federal government;
- Engagement of Primary Health Networks as key delivery partners;
- Agreement of the National Infrastructure Operator sourcing strategy;
- Delivery of clinical improvements, including enhancements to the Medicines Information view, pathology and diagnostic imaging; and
- Completion of exploratory research to inform the communications strategy and activities required to achieve the required level of consumer awareness.

Garden City Medical Centre, Brisbane QLD

My Health Record system reporting obligations

The My Health Record system operates under the *My Health Records Act 2012*. The Act establishes the role and functions of the Agency as System Operator; a registration framework for individuals, and entities such as healthcare provider organisations, to participate in the system; and a privacy framework (aligned with the *Privacy Act 1988*) specifying which entities can access and use information in the system, and the penalties that can be imposed on improper use of this information.

The Agency takes the security of patient's health and other personal information very seriously. Many of the protections provided by the *My Health Records Act 2012* are about ensuring that Australians have strong protection of their digital records. These protections are underpinned by rigorous reporting obligations.

Section 107 of the Act requires the Agency to include statistics in its Annual Report on My Health Record system registration, usage, security, and complaints, and the outcomes of those complaints in terms of investigations, enforceable undertakings or court proceedings seeking injunctive relief. These statistics are outlined in the following table:

Reporting requirement	Statistics
Registrations, cancellations, suspensions of registrations	In 2016-17 the Agency, as System Operator, registered 1,120,817 people for a My Health Record. There were a total of 20,151 cancelled registrations during the year. In 2016-17 the System Operator registered an additional 1,320 healthcare provider organisations. 89 registrations were cancelled or suspended.
Use of the My Health Record system by healthcare providers and healthcare recipients	A total of 664,278 people accessed their My Health Record via the consumer portal in 2016-17. A total of 2,217 unique healthcare provider organisations, via their clinical information systems, viewed records in the My Health Record system during 2016-17. A total of 4,538 unique healthcare provider organisations uploaded records to the My Health Record system during 2016-17. A total of 218,776,890 documents were uploaded to the My Health Record system in 2016-17.

Performance

Reporting requirement	Statistics
Occurrences compromising the integrity or security of the My Health Record system	35 data breach notifications were reported to the Office of the Australian Information Commissioner as required under Section 75 of the *My Health Records Act 2012* (concerning potential data security or integrity breaches). Twenty-nine of these were reported by the Chief Executive Medicare as a registered repository operator under Section 38 of the Act. These included: • Nine notifications resulting from data integrity activity initiated by Department of Human Services (DHS) to identify intertwined Medicare records. An intertwined Medicare record exists where a single Medicare record has been used interchangeably between two or more individuals; and • Twenty notifications resulting from suspected fraud against the Medicare program involving unauthorised Medicare claims being submitted, and the incorrect records appearing in the My Health Record of the affected customers. In all instances the DHS took action to correct the affected My Health Records. The remaining six incidents were reported by the My Health Record System Operator. These included: • Two notifications resulting from unauthorised access to a My Health Record as a result of an incorrect Parental Authorised Representative being assigned to a child; and • Four notifications resulting from suspected fraud against the Medicare program where the incorrect records appearing in the My Health Record of the affected individual was also viewed without authority, by the individual undertaking the suspected fraudulent activity. There have been no purposeful or malicious attacks compromising the integrity or security of the My Health Record system.
Complaints received, investigations undertaken, enforceable undertakings accepted, injunctions granted	In 2016-17 a total of 64 complaints were made in relation to the My Health Record system and, as of as of 24 July 2017, one remained open. Complaints are initially registered and actioned by DHS customer service officers. If the matter is complex or relates to a potential privacy or clinical safety issue, the complaint is referred to Agency staff for resolution. No enforceable undertakings were accepted by the System Operator and no proceedings were initiated by the System Operator in relation to enforceable undertakings or injunctions.

National Digital Health Strategy

Purpose: During the 2016-17 financial year, the Agency developed the National Digital Health Strategy, outlining the seven strategic priorities for digital health in Australia. The Strategy will guide a coordinated approach to the delivery of digital health in Australia through 2022.

Results: In developing the National Digital Health Strategy, the Australian Digital Health Agency led the extensive 'Your health. Your say' consultation process to ensure that the Strategy was informed by Australian consumers, carers, healthcare providers, community groups, professional bodies and many other key health stakeholders. 3000 people attended over 100 forums, workshops, webcasts and town hall meetings held across Australia.[34]

Desire for Digital Health

94% of people want to use digital technology to access general health information.

93% of healthcare professionals want to use digital technologies to share health records with patients

Source: *'Your Health. Your Say.' survey, Australian Digital Health Agency, Nov 2016 - Jan 2017*

Four key themes emerged from the consultation process, forming the foundation of the National Digital Health Strategy:

- Support me in making the right healthcare choices, and provide me with options;
- Help all the people who care for me to understand me, and together, provide safe and personalised care;
- Create an environment where my healthcare providers and I can use and benefit from innovative technologies; and
- Preserve my trust in the healthcare system and protect my rights.

The consultation has:

- Enabled the Agency to build an understanding of what a broad and diverse set of Australian communities want and expect from a modern healthcare system;
- Generated a positive and constructive discussion about how data and technology can be used to create healthier lives, including resetting the relationship between the Agency and key stakeholder groups; and
- Established a new, collaborative way of working in partnership with stakeholders and end users that can be sustained across Agency programs.

AHMAC endorsed the National Digital Health Strategy at the 2 June 2017 meeting, as well as the Agency's Forward Work Plan 2018-22 and supporting budget, which are aligned to the Strategy.

34. See note 1.

Strategic Priorities

The National Digital Health Strategy defines strategic priority outcomes to be achieved by 2022. The seven priority areas were derived from the consultation process and associated research.

They articulate a set of shared outcomes for all stakeholders that complement existing investments in digital health initiatives and will enable health innovation and improved health and care experiences to be delivered. This will result in measurable benefits for patients, carers, healthcare providers and the broader health system. The following diagram shows the vision, key themes and strategic priorities.

Clare, SA

Vision

Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy to use tools for both patients and providers.

key Themes

1. Support me in making the right healthcare choices, and provide me with options

2. Help all the people who care for me to understand me, and together, provide safe and personalised care

3. Create an environment where my healthcare providers and I can use and benefit from innovative technologies

4. Preserve my trust in the healthcare system and protect my rights

Strategic Priorities

1. Health information that is available whenever and wherever it is needed
2. Health information that can be exchanged securely
3. High-quality data with a commonly understood meaning that can be used with confidence
4. Better availability and access to prescriptions and medicines information
5. Digitally-enabled models of care that improve, accessibility, quality, safety and efficiency
6. A workforce confidently using digital health technologies to deliver health and care
7. A thriving digital health industry delivering world class innovation

By 2022, the National Digital Health Strategy will deliver the essential, foundational elements of health information that can be safely accessed and easily utilised and shared. Innovators, entrepreneurs and developers will be able to use these foundational elements to develop tools that patients and health professionals can use every day to measurably improve healthcare and health outcomes.

TO

1 in 10 people lose their child's health and development book

25%

Only **25% of youth** facing **mental health** problems seek care

3-6 days

Average wait of **3-6 days** to see a GP

15-20 visits

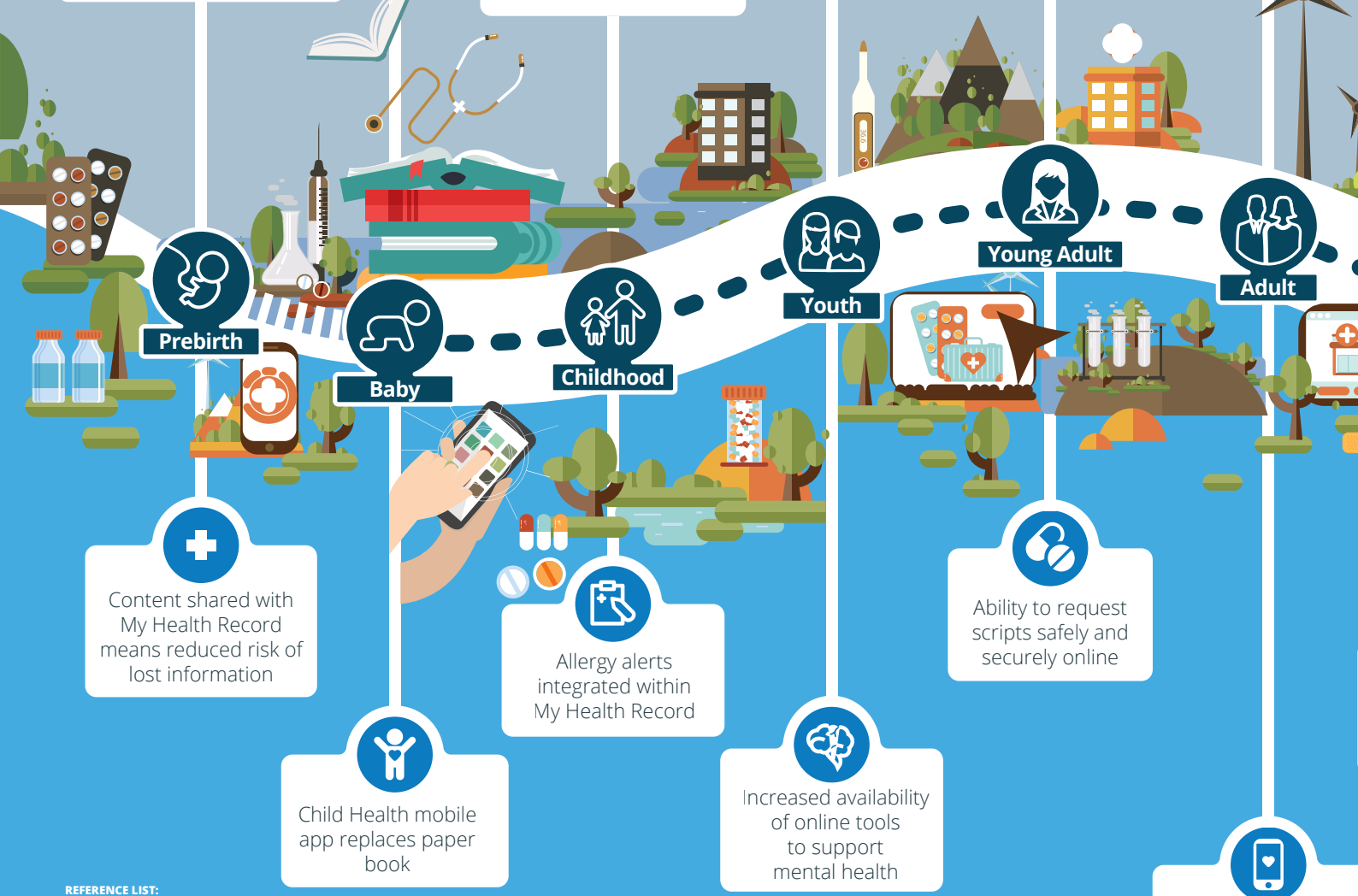
A healthy pregnancy usually includes **15-20** separate encounters with health care services

x5

Hospital admission for **anaphylaxis** has **increased 5X** in last decade in **1-4yr olds**

11%

11% of women missed contraceptive pills due to difficulty accessing GP for repeat



Content shared with My Health Record means reduced risk of lost information

Child Health mobile app replaces paper book

Allergy alerts integrated within My Health Record

Increased availability of online tools to support mental health

Ability to request scripts safely and securely online

Same day online consultation with chosen provider

REFERENCE LIST:

Prebirth – Today

http://www.materonline.org.au/getattachment/Services/Maternity/Health-Professional-Information/Guidelines-and-Policies/MMH_AntenatalAppointmentSchedule.pdf

Baby

http://www.abs.gov.au/ausstats%5Cabs@.nsf/0/8668A9A0D4B0156CCA25792F0016186A?Opendocument

https://www.medicalsearch.com.au/nsw-health-seeks-opinions-for-its-latest-blue-book-review/f/19016y

Childhood

http://www.jacionline.org/article/S0091-6749(15)00702-2/fulltext

Youth

http://www.mindframe-media.info/for-media/reporting-mental-illness/facts-and-stats#C&Y

Young Adult

http://onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2005.01.011/abstract

Adult

http://www.ruralhealth.org.au/infographics

Senior

Early cost and safety benefits of an inpatient electronic health record

Zlabek et al

J Am Med Inform Assoc (2011) 18 (2): 169-172

Aged Care

Does facilitated Advance Care Planning reduce the costs of care near the end of life?

Systematic review and ethical considerations

Corinna Klingler1, Jürgen in der Schmitten2 and Georg Marckmann1

End of Life / Palliative

https://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf

FU

ODAY

$1.2B

223,000 admitted to hospital due to **adverse drug event** costing **$1.2billion**

18%

18% of aged care residents experienced a missed or **significantly delayed dose of their medicine** within 24 hours of discharge from Hospital

40%

Death rates for remote Australians are **40% higher** for **coronary heart disease**

70%

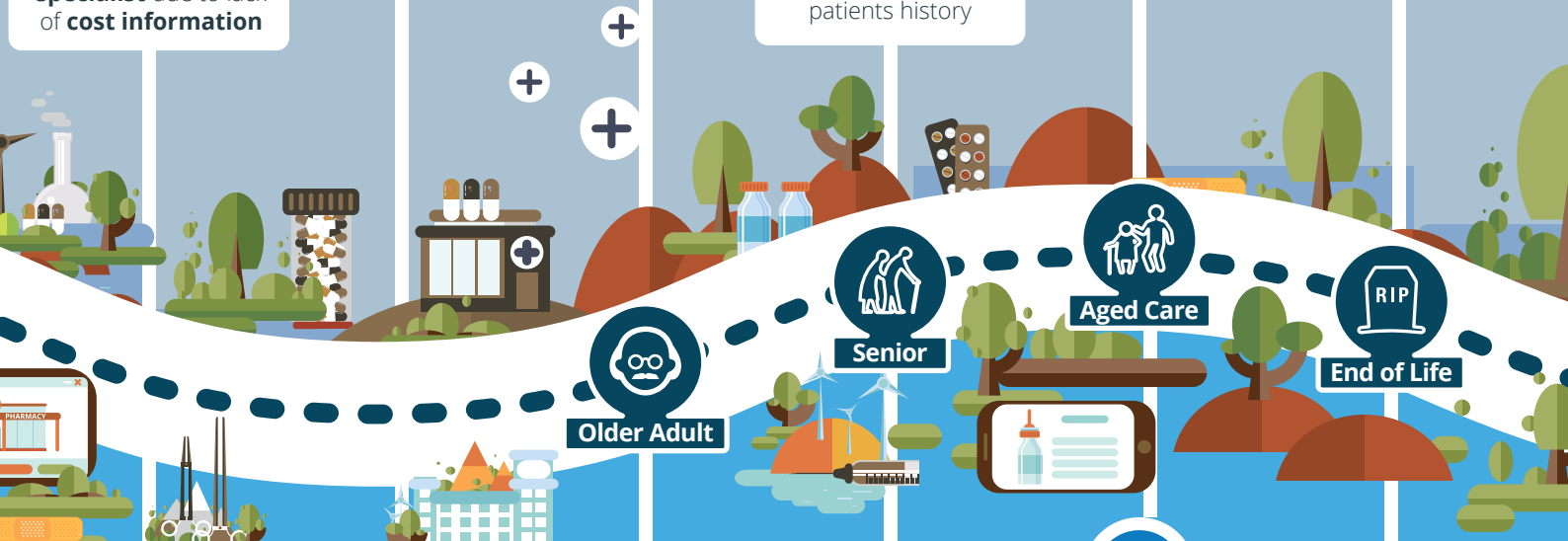
70% of people want to die at home, yet only about **14% do so**

8%

8% do not see specialist due to lack of **cost information**

14%

14% of pathology tests are ordered due to lack of access to patients history



Ability to compare costs and availability of specialists online

Medicines information available via My Health Record reduces safety risk

Notifications, alerts, discharge and transfer summaries integrated into the system to ensure consistent information

Digital tools make it easier to access services remotely

People and their clinicians will be able to see results of previous tests

Access to Advance Care Directive means less invasive unwanted procedures and average **$5,400 saving** per patient

Australian Government
Australian Digital Health Agency

UTURE

In addition, AHMAC agreed to recommend submission of the National Digital Health Strategy and Australian Digital Health Agency forward work plan for approval by the COAG Health Council (CHC) at its first meeting in the next reporting period (4 August 2017). The Strategy was subsequently approved by the CHC at this meeting.

Core clinical

1. **National Collaborative Network for Child Health Informatics**

   Purpose: This program of work is targeted with establishing a National Collaborative Network for Child Health Informatics that will bring together centres of excellence in children's health innovation across the country. The network will create a forum in which to leverage the work in NSW and collaborate with groups across the country who are pursuing similar goals.

   The network will also provide a link into the technology industry, the research community and health policy departments. This initiative aims to accelerate improvements to the practice of children's health by supporting collaboration across organisational and jurisdictional boundaries.

   Results: In 2017, the Agency partnered with eHealth NSW and the Sydney Children's Hospitals Network to establish the National Collaborative Network for Child Health Informatics (the Network). The Network's objective is to identify and scope 4–5 strategic national projects and initiatives, aimed at achieving positive health and wellbeing outcomes for Australian children and young people, made possible through patient-centred and clinician-friendly digital systems and capabilities.[35]

   The Network has brought together stakeholders from all levels of government, consumers, clinicians, peak bodies, Non-Government Organisations, researchers and ICT industry partners to identify and scope a number of potential initiatives for investment that will have a positive impact on the health and social outcomes and experiences of children and their families, through leveraging existing national digital technologies and platforms.

   Through a number of collaborative workshops held in June, themed around the key priorities of the National Strategic Framework for Child and Youth Health (*Healthy, Safe and Thriving*), and utilising the feedback received through the National Digital Health Strategy consultation process, the Network identified 41 potential digital health initiatives to support children's health and wellbeing.

   In the next reporting period, the Network's Expert Reference Group, totalling 60 members of the Network split across three workstreams of Community and Clinical, ICT and Digital and Research, will meet to validate and prioritise these initiatives based on whether they will positively impact the health and social outcomes of children, whilst being safe, efficient, feasible and affordable.

2. **Health Care Homes Strategy**

   Purpose: This program of work will provide Agency support for the Health Care Homes trials run by the Department of Health. The trials aim to reduce the barriers patients face across fragmented health services, with the aim of keeping them well, at home and out of hospital through the ongoing co-ordination, management and support of a patient's care. This work priority will identify opportunities for data and technology to support the trials to achieve the desired healthcare outcomes for the people involved.

35. https://www.pulseitmagazine.com.au/news/australian-ehealth/3711-adha-to-fund-national-collaboration-for-children-s-digital-health

Results: The Agency has identified a range of resources and support tools available to support the successful rollout of the Health Care Home trial. This support includes:

- Training resources to support the in-scope PHNs;
- Training packages for hospitals located near Health Care Homes practices;
- Collaboration with the Department of Health on clear communication resources, with the Agency focusing on ensuring that Health Care Homes patients can access and use the information available in their My Health Record; and
- Identification of other program areas where work can be aligned to enhance the implementation of the Health Care Homes trial, including within the Pathology, Diagnostic Imaging and Telehealth programs.

The Agency has conducted an analysis to identify and assess a range of options for supporting the visibility of shared care plans that are generated for Health Care Homes patients. The Agency is working with the Department of Health on evaluation of the trial.

3. **Embedding telehealth in clinical consultations**

Purpose: Telehealth presents a huge opportunity to help prevent disease and provide more convenient and accessible healthcare services. It offers solutions to some significant challenges facing the healthcare system today, such as finding better ways to provide care to elderly Australians in an ageing population, helping people with chronic diseases to more effectively manage their conditions, and providing more accessible care to many Australians living in regional and remote locations who today need to travel significant distances to access healthcare.

Discussions with remote healthcare providers have uncovered significant usability problems with existing video-conferencing technology and workflows that create a burden for providers and consumers currently using telehealth services, and a barrier to broader take up across the country. This program of work will focus on improving the experience of telehealth for users of those services, and extending the reach of these technologies into new geographies and health settings.

Results: The Agency commissioned NT Health to lead development of a national steering group tasked with completing this baseline of telehealth status and developing a roadmap and work plan to embed telehealth into clinical practice and as a core part of the National Digital Health Strategy. This work is delivering the following key outputs in 2017–18:

- Defining the scope of telehealth to best align to the national digital health agenda;
- Establishing a baseline of telehealth status and known issues; and
- Delivering a national engagement plan and set of initiatives to embed telehealth into clinical consultations.

The program of work is part of a longer term strategy to deliver telehealth to benefit all Australians.

Hermannsburg (Ntaria) Community Health Centre, NT

Case study: **Northern Territory telehealth project**

The provision of telehealth services to deliver outpatient appointments was assessed at three Northern Territory sites between 2014 and 2015: Alice Springs, Katherine and Tennant Creek.

The evaluation demonstrated that increasing telehealth use in these locations (more than seven- fold in Tennant Creek, four-fold in Alice Springs and a doubling in Katherine) led to reductions in travel, with patients in Tennant Creek more likely to use telehealth than to travel. The 'Did Not Attend' (DNA) rate for appointments lowered significantly. The estimated cost savings for the project for participants was on the order of $1.189 million.

Surveys indicated high levels of support for telehealth from participating patients and a strong desire to use telehealth in the future. Clinicians had similar attitudes in their endorsement of telehealth, reporting an improvement in continuity of care for their patients, and that they would be likely to use telehealth in the future and recommend it to their colleagues.

The Agency's 2016-17 work program includes an initiative to embed telehealth in clinical consultations, so many more people will soon experience these benefits first hand, with ongoing cost savings scaling with implementation.

Organisational excellence

Purpose: The Agency has an opportunity to deliver meaningful improvement to Australia's health system – to patients, carers and healthcare providers, translating digital health technologies into improved health outcomes. By building on established national digital health foundations, significant progress is possible in a short timeframe.

Driving improved health outcomes through the use of digital health technologies requires an engaged staff and an organisation committed to excellence in delivery. The Organisational Excellence program of work will seek to instil an organisational culture of passion and commitment to improved healthcare through the use of digital health. The program will embed into Agency operations the principles of accountability, meaningful engagement and collaboration, and a focus on benefits realisation, as well as providing assurance to funders that funds are being applied to the right priorities and used prudently.

Results:

1. **Committing to the prudent use of resources**

   The creation of the Agency represents a new chapter in the growth of digital health development, with a renewed focus on pursuing initiatives that have immediate, tangible benefits for the health sector and the community. The Agency's challenge is to deliver these benefits at the greatest efficiency.

   The first step in responding to this challenge is to build disciplined and robust organisational processes and infrastructure that support its business functions and aspire to the highest standards of governance. Discharging the Agency's obligations under various regulatory frameworks that apply to Commonwealth corporate entities is a priority.

   Significant activity has been directed at compliance with the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and associated instruments and policies. These set the standard for the use and management of public resources, with a particular emphasis on planning, performance and reporting. This activity has led to the introduction of a number of compliance initiatives, including: a risk management framework, fraud control arrangements, a business continuity plan, the appointment of an independent Audit and Risk Committee, an Internal Audit Charter, Accountable Authority instructions; and financial delegations.

   Efforts are also focused on meeting Commonwealth financial reporting obligations under the PGPA Act and adapting the Agency's financial systems to adhere to the public sector governance structure. Important work has also begun on implementing a Budgetary Control Framework that will allow greater clarity surrounding business decisions, drive efficiency in developing budget positions and forecasts, improve capability to deal with externally imposed savings measures (such as efficiency dividends) and strengthen protocols in dealing with the Agency's key governmental stakeholders.

2. **Optimising opportunities as the national digital health agency**

   As part of improving the performance of the Agency, the Board approved the development and implementation of two key frameworks: the *Agency Wide Quality Framework* and the *Agency Clinical Governance Framework*. These frameworks are designed to drive quality improvements and safeguard high standards of patient care.

   The frameworks were completed on schedule by the end of the 2016-17 reporting period, and implementation will commence in 2017-18.

Performance

Agency Wide Quality Framework

The Agency Wide Quality Framework describes how quality is embedded in all aspects of the Agency's work, and ultimately how the delivery of the National Digital Health Strategy will be supported. It provides a foundation of specific quality principles and elements for the Agency to implement appropriate measures and initiatives, in alignment with the framework. It also offers transparency to external stakeholders, acting to instil confidence in the quality of internal Agency processes and the products and services delivered.

Clinical Governance Framework

The Australian Commission on Safety and Quality in Health Care (ACSQHC) defines clinical governance as:

> "A system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish."

This definition is used by the Agency as the foundation for its Clinical Governance Framework, recognising that the Agency's products and services can directly impact the delivery of care by healthcare providers.

The Agency's Clinical Governance Framework has ten Agency-tailored guiding principles, each focused on the digital health consumer experience:

1. Alignment with the Agency's strategic priorities;
2. Culture of safety and quality improvement;
3. Effective leadership and accountability;
4. Transparent external assurance;
5. Integrated and responsive risk and incident management;
6. Governance embedded into core business processes;
7. Evidence-based models of care;
8. Supporting high quality data security and privacy;
9. Frameworks, policies and processes are fit for purpose and are built to last; and
10. Co-production with consumers and clinicians.

Note: Items 3 and 4 in this stream are treated separately for a more cohesive narrative. **See Privacy and Security** below.

5. Making the organisation hum

The Agency is founded with a clear sense of purpose: the potential for digital health technology to transform healthcare delivery. The Agency recognises that a strong network of staff who share this sense of purpose will better position us for success. The Agency needs staff to be highly capable, committed and sufficiently agile to meet the Agency's evolving commitments to government and the community. Consequently, the Agency is striving to create a workplace that offers staff challenging and meaningful work. The goal is to create a vibrant and nurturing work environment that promotes professional and personal development.

The Agency's focus on building organisational capability extends to fostering a culture of cohesion and collegiality, to ensure that the Agency's values – working together, respect and trust, transparency, leading through learning and customer focus – guide decision making and make the Agency a great place

to work. One initiative, *Grand Rounds: Lunch and Learn*, introduced primarily as a learning opportunity, has also strengthened group cohesion. Grand Rounds, which has a storied tradition in medicine, has promoted a sense of camaraderie across the Agency as networks of like-minded individuals with shared interests listen to leaders and innovators give their insights on emerging technologies in digital health.

6. Exemplifying openness and transparency

The Agency recognises that instilling and promoting transparency matters both for its culture and for its accountability to the outside world. Parliament and the public, just like shareholders in a listed company, have a right to know what the Agency has achieved with the funds provided. The Agency discloses intended and actual performance in a number of external reports, and also in internal reports made publicly available.

The Agency's work plan priorities for each financial year and related measures of success are disclosed in its corporate plan, published on the website by 31 August every year (other than the Agency's inaugural year). The Agency acquits actual performance against those work plan forecasts in Part 2 of this report.

The Agency also makes internal board papers available on its website.[36] These describe progress against the work plan and other commitments, and reflect the candour and accountability expected from the CEO, management and Agency Board. They report on progress, as well as systemic, process and cultural factors that may be hampering progress.

The Agency also welcomes open dialogue and transparency for the other benefits they bring: sharing insights with stakeholders and authentic engagement will drive improvements in Australia's digital health capabilities. The value of collaboration, listening and learning from a diverse stakeholder community was most evident in the development of the National Digital Health Strategy, which in turn reflected the spirit of partnership across the stakeholder spectrum.

Privacy and security

Note: These two topics represent items 3 and 4 respectively within the Organisational Excellence stream.

Privacy

Purpose: To earn and maintain the community's trust as a reliable operator of national data systems, the Agency is focusing on ensuring its privacy compliance obligations are met and that privacy governance accountabilities and processes have been documented. Protecting the privacy and confidentiality of every citizen's personal information is considered a critical success factor in managing national data systems.

Results: The Agency has established a Privacy team to embed privacy within the functions and culture of the Agency. The functions of the Privacy team include corporate privacy, assurance, engagement and advice.

While there is strong support for the value of the My Health Record system and the potential benefits to the Australian community, there is general community concern about the security of data and the extent to which individual privacy is appropriately protected. Maintaining community trust in the privacy and security of the My Health Record system is imperative to the success of the program. Therefore, the Privacy team will take a proactive, privacy design approach to managing the development and operation of the My Health Record system.

36. https://www.digitalhealth.gov.au/about-the-agency/australian-digital-health-agency-board/board-papers

The Agency has reviewed its operations as a Commonwealth government agency and as the System Operator of the My Health Records system, as well as compliance with the *Privacy Act 1988* and privacy-related provisions of the *My Health Records Act 2012* and *Healthcare Identifiers Act 2010*. Resulting actions have seen the Privacy team deliver a privacy vision for the Agency, a privacy governance framework setting out roles and accountabilities, development of key processes (which are now being operationalised) and planning of a 2017-18 training and awareness program.

Security

Purpose: The Digital Health Cyber Security Centre (Digital Health CSC) was established to support secure operation of national digital health systems, and protection for Australian personal health information that is stored and transacted through the Australian Digital Health Agency. The Digital Health CSC will also raise security awareness and maturity across the Australian digital healthcare ecosystem.

Following the themes 'Partner. Secure. Inform. Respond.' The Digital Health CSC provides a range of cyber security capabilities to support national digital health operations across Australia. This enables ongoing monitoring and assessment of evolving cyber threats, and facilitates continuous improvement to the approach to cyber security.

With the aim of maximising available resources and reducing duplication of effort, the Digital Health CSC has established, and is continuing to grow, partnerships with a range of national and international cyber security organisations across government and the private sector. These partnerships facilitate ongoing improvements to the Agency's knowledge of evolving cyber threats, and provide opportunities to leverage shared expertise and materials across organisations. Information gained through these partnerships is used to support the development of guidance materials and threat intelligence information for the digital health sector.

In addition to ongoing security operations activities, the Digital Health CSC has worked to implement and enhance tools which support real time monitoring of the My Health Record system, provide improved alert capabilities and facilitate ongoing security management for the Agency. A continuous improvement program has been established to deliver enhancements to these tools over time.

Performance targets from the Portfolio Budget Statements 2016-17

Whilst the majority of the Agency's performance measures are sourced from the annual work program published in its 2016-17 Corporate Plan, others are determined by the Health Minister. The table below highlights the attainment of the Agency's purpose by outcomes achieved across the six 2016-17 performance targets set by the Minister in the Health Portfolio Budget Statements (PBS), published in the 2016 Budget.

Attainment of PBS-stated objectives

PBS-stated objective	Performance criteria	2016-17 target	Achieved	Outcome
Building foundations for better health outcomes through improved governance, and management and delivery of national digital health services.	Development of, and delivery on, the National Digital Health Strategy.	Development of, and delivery on, the COAG Health Council (CHC) agreed National Digital Health Work Program for 2016-17 and 2017-18.	✓	The **2016-17** work program was approved by the CHC on 7 October 2016, and the **2017-18** work program was approved on 24 March 2017. AHMAC endorsed the National Digital Health Strategy at its 2 June 2017 meeting. AHMAC also endorsed the Australian Digital Health Agency Forward Work Plan 2018-22 and supporting budget which are aligned to the National Digital Health Strategy. AHMAC also agreed to recommend submission of the National Digital Health Strategy and Australian Digital Health Agency Forward Work Plan **2018-22** for approval by the CHC at its first meeting in the **2017-18** reporting period (4 August 2017). The Strategy was subsequently approved by the CHC at this meeting.
Promoting and facilitating user communication, engagement and collaboration through open innovation.	Active communication, consultation, engagement, and collaboration with consumers, health care providers and the health industry in relation to digital health.	Undertake an independently administered targeted survey of consumers, health care providers and the health industry by 30 June 2017 to provide baseline data for future comparison.	✓	From October 2016 to February 2017, the Agency led the extensive 'Your health. Your say' consultation process. More than 3,000 people attended over 100 forums, workshops, webcasts and town hall meetings held across Australia, and over 1,000 submissions and survey responses were provided by Australian consumers, carers, healthcare providers, community groups, professional bodies and many other key health stakeholders. Of the survey responses received, 54% came from members of the general public, 31% from healthcare providers, and 15% from the industry, science, and technology sector. These inputs have been used to inform all elements of the National Digital Health Strategy.
	Acceptance and use of the national digital healthcare system by consumers, health care providers and health industry.	Undertake an independently administered targeted survey of consumers, health care providers and the health industry by 30 June 2017 to provide baseline data for future comparison.	✓	As above.

Performance

PBS-stated objective	Performance criteria	2016-17 target	Achieved	Outcome
	Delivery of communication and education campaigns for consumers and health care providers about the national digital healthcare system to increase uptake and use, including information about security and privacy.	Educational program data used to establish a baseline to measure an increase in use of national digital healthcare systems.	✓	The Agency, with the support of Clinical Reference Leads, has provided regular education and training to healthcare providers and consumers, often in collaboration with the Primary Health Networks, peak bodies and professional groups. From January to June 2017, the Agency provided face-to-face training to approximately: • 1200 healthcare providers, • 100 Primary Health Network staff, and • 100 consumers. This face-to-face contact was complemented with a series of webinars and a range of eLearning programs.
Operating an effective and secure digital healthcare system.	Operation of a secure national digital healthcare system.	The national digital healthcare system complies with Australian Government cyber security policies, practices and legislation, with intelligence about cyber threats used to continually refine security approaches.	✓	The Digital Health Cyber Security Centre provides a range of capabilities which support secure operation of national digital health systems, provide protection for Australian personal health information that is stored and transacted through the Australian Digital Health Agency, and facilitate improved cyber security awareness and maturity across the health ecosystem. Information security policies and practices are implemented to improve alignment of national digital health systems and Agency processes with the Australian Government Information Security Manual.
	Availability of the national digital healthcare system.	99% of the time (excluding planned outages).	✓	The My Health Record system availability rate exceeded 99% during 2016-17 (excluding scheduled outages). Access by people to registration and view system functions achieved 99.63% availability in 2016-17.

3.0

Management and accountability

This part provides information about the Agency's governance framework, fraud and risk management arrangements, external scrutiny, freedom of information and human resources and addresses annual reporting obligations in relation to advertising and market research, work health and safety, as well as ecologically sustainable development and environmental performance processes.

Princess Alexandra Hospital, Brisbane QLD

3.0

Management and accountability

Corporate governance

The Agency is governed by a skills-based Board, supported by advisory committees, and reports to Commonwealth, state and territory health ministers through the Council of Australian Governments' Health Council (CHC).

The Agency's governance framework has its legislative foundation in the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* (Agency Rule). The PGPA Act sets out requirements for the governance, reporting and accountability of Commonwealth entities and for their use and management of public resources. It vests many of the powers and responsibilities for the financial management of a Commonwealth entity in the hands of the Accountable Authority, which is the Board of the Agency. The Agency Rule established the Board, Advisory Committees and the position of CEO, and defined their roles and responsibilities.

The accountability and governance practices in place to support this legislative regime promote strong performance and careful stewardship of public resources. They are designed to assure the Agency's ability to deliver on the expectations of government, the health sector, and the community.

Fundamental to the Agency's governance arrangements is establishing an appropriate controls environment to ensure probity and transparency. Roles, lines of authority and delegations for decision-making are all clearly defined. They are reinforced through training and awareness initiatives so that staff have a common understanding of their obligations, and their purpose in providing a system of checks and balances to safeguard the integrity of the Agency's work.

Other key governance features include:

- A focus on audit, risk management and fraud control strategies;
- A mechanism for stakeholder participation through representation on specialist committees;
- Internal and external scrutiny through a robust planning and reporting framework; and
- Embedding ethics and integrity in the values and culture of the Agency.

A number of governance bodies form a key part of the Agency's assurance processes.

The Board

The Agency Board sits at the apex of the governance structure and is the Accountable Authority of the Agency under the PGPA Act. The Board is accountable to Parliament through the Minister for Health. In accordance with section 14 of the Agency Rule, the Board sets the strategic direction to achieve the Agency's purpose, and oversees performance, governance and resource allocation as custodian of Commonwealth, state and territory funding.

The Board maintains a watching brief over internal and external environments, and ensures that Agency operations and outcomes are fit for purpose and align with government priorities. Its efforts are balanced across creating the future and delivering the present. In fulfilling its statutory obligation to produce an annual work program it gives a clear picture of operational priorities, actions and planned outcomes for each financial year.

Board Members

The Board brings a range of skills and perspectives to the Agency. The Agency Rule prescribes the eligibility requirements for Board members so that, collectively, the Board has expertise and experience in the fields of health informatics, leading digital healthcare delivery, policies and services, consumer health advocacy, clinical safety, law, financial management and Board and business leadership.

Board appointments, functions, powers and procedures are also conferred by the Agency Rule and further clarified in the Board's Charter. The Board consists of the Board Chair and up to ten other members, all of whom are non-executive members, appointed by the Minister for Health for a term (in aggregate) of up to three years.

3.0

Management and accountability

Jim Birch AM
Chair

Jim Birch AM is Chair of the Australian Red Cross Blood Service, Deputy Chair of the Independent Hospital Pricing Authority, Chair of Mary MacKillop Care SA and a board member of the Australian Red Cross Society, the Little Company of Mary Health Care and Cancer SA. He was formally a Partner in Ernst and Young having been the Global Health Leader. He has also been the Government and Public Sector Leader from 2012 until the end of 2014.

Formerly Jim was also the Lead Partner in Health and Human Services for Asia Pacific. He has over thirty five years' experience in planning, leading and implementing change in complex organisations transcending such areas as healthcare, justice and human services.

Jim has been a Chief Executive of a Human Services and Health Department (South Australia), Deputy Chief Executive of Justice and Chief Executive of major health service delivery organisations, including teaching hospitals.

Jim has previously been Chair of the Australian Health Ministers' Advisory Council, a member of the Australian Commission on Safety and Quality in Health Care and was a Board Member of the National E-Health Transition Authority and Chair of Rural Health Workforce Australia. He has a Bachelor of Health Administration from the University of New South Wales.

Martin Bowles PSM
Term commenced on 01 April 2017, replacing Paul Madden

Martin Bowles PSM was the Secretary Department of Health, a position he was appointed to in October 2014. He is currently leading reforms in primary health care and mental health service arrangements, access to medical and pharmaceutical benefits, aged care, hospital funding and digital health.

Previously, Martin was the Secretary of the Department of Immigration and Border Protection, overseeing the management of migration, humanitarian, citizenship and visa policy and programs. Prior to this role, Martin held the positions of Deputy Secretary in the Department of Climate Change and Energy Efficiency, and the Department of Defence, respectively.

In 2012, Martin was awarded a Public Service Medal for delivering highly successful energy efficiency policies and remediation programs for the Home Insulation and Green Loans programs.

Martin has previously held senior executive positions in the education and health portfolios in the state government public sector, prior to joining the Commonwealth Public Service. Martin has a Bachelor of Business degree, a Graduate Certificate of Public Sector Management and is a Fellow of the Australian Society of Certified Practising Accountants.

Rob Bransby

Rob Bransby has more than 35 years' experience in business, financial services and the health sector. Rob recently stepped down from his full time role as Managing Director of HBF Health Limited, a position he had held since 2008. During Rob's 12 years at HBF, the organisation consolidated its position as Western Australia's leading health fund, reaffirming its focus on member health and embarking on an ambitious strategy to become a valued health partner to HBF members.

Rob has long held a leadership position within the health insurance sector and continues in his role as Chairman of the industry association, Private Healthcare Australia (PHA). Rob is well known for championing the interests of health fund members and as an advocate for not-for-profit health insurers.

Prior to working at HBF, Rob enjoyed a successful 25 year career in banking with NAB holding positions including Corporate Finance Manager – Corporate Banking Western Australia, Head of Business Financial Services – New South Wales and CEO – Medfin Finance. Rob is currently President of Private Healthcare Australia (PHA) and Director of the Australian Digital Health Agency, Synergy, Commonwealth Financial Planning Limited, BW Financial Advice Limited, Count Financial Limited, Financial Wisdom Limited and the Craig Mostyn Group. He is also a Commissioner of the Insurance Commission of Western Australia.

Dr Eleanor Chew

Dr Eleanor Chew is a specialist general practitioner and medical educator, with extensive experience representing the role of primary care in the health services profession. Eleanor has worked as a GP in Brisbane, Darwin, Perth and Canberra in a variety of practice settings including solo, small practices, and corporate practice.

Eleanor is on the board of General Practice Training Queensland and is a past Vice President and Chair of the RACGP. Eleanor is an experienced leader with strategic vision and a solid understanding of governance responsibilities.

Eleanor serves on a range of committees and working groups focused on the advancement of quality primary care, in both the private and government sectors.

Eleanor holds a Bachelor's Degree in Medicine and Surgery and a Masters of Medicine (General Practice) from the University of Queensland. She is a Fellow of the RACGP and a Fellow of the Australian Institute of Company Directors.

Dr Elizabeth Deveny

Dr Elizabeth Deveny is currently the CEO of South Eastern Melbourne Primary Health Network. Before her appointment at SEMPHN, Elizabeth was Chief Executive of Bayside Medicare Local (BML) from its formation in 2012. Her emphasis on mutual respect and accountability of each and every staff member was a key factor in the nationally-recognised success of BML. Amongst her other current appointments she chairs the Southern Metropolitan Partnership which brings community, industry and local government together to provide the Victorian Government advice about regional priorities.

Elizabeth is an experienced and well-respected senior executive with a strong commitment to providing sustainable health outcomes for all Australians, and a demonstrated ability to build and maintain positive, productive partnerships with key stakeholders and the broader community. She holds a Masters degree in vocational health education and a PhD in Medicine (clinical decision making), both from Melbourne University.

Paul Madden

Term ended on 31 March 2017

Paul Madden holds the position of Deputy Secretary/Special Adviser, Strategic Health Systems and Information Management. Paul provides advice and leadership on a range of technical and strategic issues in Health, including Digital Health and My Health Record.

During the 2016-17 year, he supported the Australian Government in leading the national rollout of digital health initiatives including foundation technologies and related services across Australia, the continued and improved operation of the My Health Record system, and the trials of opt-out participation arrangements.

Paul is a member of the Department of Health Executive Committee.

Lyn McGrath

Lyn McGrath is the Executive General Manager, Wealth Advice at the Commonwealth Bank of Australia. Prior to her current role Lyn was Executive General Manager, Retail Sales leading the largest financial services distribution business in Australia for 6 years. She has been with Commonwealth Bank of Australia since 2007 leading large distribution businesses. Prior to this, she held roles with St George in Retail Banking.

Lyn has extensive senior management experience in strategic and operational roles within the utilities and media industries and over 20 years' experience in Financial Services. Lyn is highly regarded for her transformational leadership, financial management experience and customer experience strategy thought leadership.

Lyn holds an MBA and BA from Macquarie University as well as a Dip PR (Hons). She is a Graduate of the Australian Institute of Company Directors and currently holds Board positions at Commonwealth Financial Planning, Commonwealth Private and the Evidence for Learning Board, a joint initiative with Social Ventures Australia and Commonwealth Bank.

Lyn is a Senior Fellow with FINSIA, a Fellow with the Australian Institute of Managers and Leaders, Advisory Board member of Financial Services Council and a member of Chief Executive Women Ltd. In 2012, she was named as one of the 100 Most Influential Women in Australia by the Australian Financial Review.

Stephen Moo

Stephen Moo is the Chief Information Officer for the Northern Territory Department of Health. Stephen has been employed in the health sector for over 34 years, with the last 16 years having direct responsibility for the design, development, implementation and on-going systems management for major corporate client and clinical information systems, and information communications and infrastructure. Stephen has overseen the Northern Territory's eHealth program for the past 11 years and is the principal architect and sponsor for the development and implementation of a comprehensive eHealth program that is widely regarded as one of the most advanced of its kind in Australia.

As Chair of the National Health Chief Information Officer Forum for the past 8 years, Stephen has played a key role in the development of the National eHealth Strategy and national eHealth foundation services and standards with the previous National E-Health Transitional Authority.

Stephen was appointed by the Australian Health Ministers' Advisory Council as the Jurisdictional ICT representative on the eHealth Implementation Taskforce Steering Committee, which assisted to establish the Australian Digital Health Agency.

Stephanie Newell

Ms Stephanie Newell is a consultant facilitator, educator and healthcare consumer advocate leader.

Stephanie has extensive experience within the health care sector contributing as a member of a number of Australian and international health care policy and research groups and initiatives in areas which include consumer engagement, patient experience, patient safety, quality improvement, accreditation and standards development. Prior to her roles within the health care sector, Stephanie's career was in banking and finance with the National Australia Bank.

Stephanie's roles have included Consumer and Community Engagement Coordinator of the Health Consumers' Council WA and consultant educator developing and facilitating workshops on partnering with consumers and patient-centred care across Australia for The Australian Council on Health Care Standards.

Stephanie is a foundation member and a designated 'Patients for Patient Safety Champion' of the World Health Organization's Patients for Patient Safety program, a past board member of Consumer Health Forum and was the inaugural Chair of the South Australian Department of Health's Safety and Quality Consumer and Community Advisory Committee. Stephanie holds post-graduate qualifications in Entrepreneurship, Commercialisation and Innovation from the University of Adelaide and is a Graduate member of the Australian Institute of Company Directors.

Dr Bennie Ng

Dr Bennie Ng is a specialist hospital administrator and general practitioner, with senior management and policy experience in Australia and abroad. He is currently the General Manager, Partnerships and Strategy at Healthscope, a leading healthcare provider that operates 45 private hospitals across Australia.

Since commencing his career as a General Practitioner, Bennie has gained extensive experience in providing advice to the Australian Government. As an adviser to the Minister of Health, he was responsible for the introduction of measures to expand chronic disease management and mental health services in primary care and Medicare. As Head of Social Policy in the Office of the Prime Minister his responsibilities included health and hospitals, aged care, disabilities/NDIS and indigenous affairs. He has held other senior positions including the Head of Clinical Services Planning at the Hong Kong Hospital Authority and the General Manager, Cancer Medicine at the Peter MacCallum Cancer Centre in Melbourne.

Bennie has a Bachelor's Degree in Medicine and Surgery and a Masters of Business Administration. He is a Fellow of the Royal Australasian College of Medical Administrators and of the Royal Australian College of General Practitioners. Bennie is currently a part-time member of the Administrative Appeals Tribunal.

Michael Walsh

Michael Walsh is the Director-General Queensland Health where he leads a public health and hospital system for a population of nearly 5 million people. Prior to this role, Michael was the inaugural Chief Executive / CIO of eHealth NSW, providing eHealth and ICT services to the NSW Health System. Michael has also worked as Chief Executive of HealthShare NSW, the NSW Health shared service provider.

Michael has extensive experience at the government senior executive level in both NSW and Queensland and has worked in the private sector including for a leading consulting firm. Michael has led large organisational strategy and change programs including major departmental integrations; significant ICT programs; and, large hospital infrastructure programs such as the $10 billion Queensland Hospital rebuilding program including the Gold Coast University Hospital, Sunshine Coast University Hospital and Queensland Children's Hospital.

Michael has a strong background in public sector governance and leadership. He also has strong experience in portfolio, program and project management, business case development and implementation of major government initiatives.

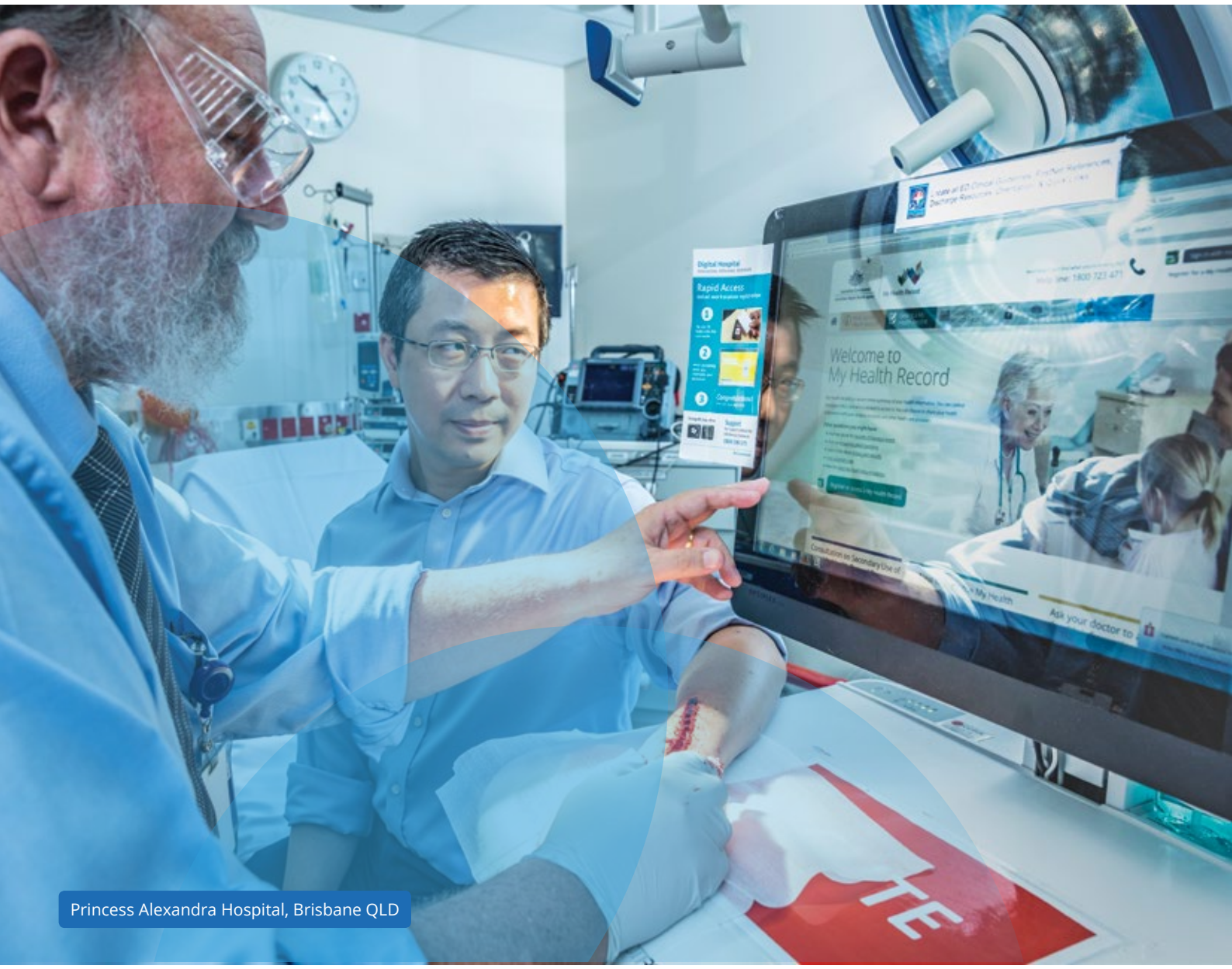
Professor Johanna Westbrook

Professor Johanna Westbrook is Professor of Health Informatics and Director, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, at Macquarie University. She is internationally recognised for her research evaluating the effects of information and communication technology (ICT) in health care and has published over 300 papers. This research has led to significant advances in our understanding of how clinical information systems deliver (or fail to deliver) expected benefits and supported translation of this evidence into policy, practice, and IT system changes.

In 2014 Johanna was awarded Australian ICT Professional of the Year by the Australian Information Industry Association. She has a PhD in Epidemiology from the University of Sydney, a Masters in Health Administration from the University of New South Wales, and a Bachelor of Applied Science (with Distinction) from the University of Sydney. She is a Fellow of the American College of Medical Informatics and the Australasian College of Health Informatics.

3.0

Management and accountability



Princess Alexandra Hospital, Brisbane QLD

Board Meetings

The Board meets regularly in accordance with a formally approved timetable and agenda. The Board convened on 15 occasions throughout 2016-17, five of which were via teleconference. In accordance with PGPA Act requirements, details of the number of Board meetings attended by each member during the financial year are outlined below:

Board member	Term of appointment	Meetings held and eligible to attend	Achieved
Jim Birch AM, Chair	20 April 2016 to 20 April 2019	**15**	**14**
Martin Bowles (replaced Paul Madden)	01 April 2017 to 01 April 2020	**2**	**2**
Robert Bransby	20 April 2016 to 20 April 2019	**15**	**15**
Dr Eleanor Chew	20 April 2016 to 20 April 2019	**15**	**14**
Dr Elizabeth Deveny	20 April 2016 to 20 April 2019	**15**	**14**
Paul Madden (to 31-03-2017)	20 April 2016 to 20 April 2019	**13**	**12**
Lyn McGrath	20 April 2016 to 20 April 2019	**15**	**11**
Stephen Moo	20 April 2016 to 20 April 2017 20 April 2017 to 20 April 2018	**15**	**13**
Stephanie Newell	20 April 2016 to 20 April 2019	**15**	**14**
Dr Bennie Ng	20 April 2016 to 20 April 2019	**15**	**15**
Michael Walsh	20 April 2016 to 20 April 2017 20 April 2017 to 20 April 2018	**15**	**11**
Professor Johanna Westbrook	20 April 2016 to 20 April 2019	**15**	**10**

Advisory committees

The Board utilises expert advisory committees to provide strategic thought leadership in their areas of specialist remit, and to assist the Board more broadly in the performance of its functions.

A number of committees are created expressly by the Agency Rule, which prescribes the eligibility requirements for membership (such as relevant expertise) and gives an overview of functions:

Jurisdictional Advisory Committee	The Jurisdictional Advisory Committee gives guidance on all matters for consideration by the Board in order to facilitate national coordination and consistency across geographic and health sector boundaries. Its members are senior representatives of Commonwealth, state and territory health departments.
Clinical and Technical Advisory Committee	The Clinical and Technical Advisory Committee advises on: • The efficient and effective delivery of clinical care using digital health; • The architectural integration of digital health systems; • Changes to digital health system design to improve clinical usability and usefulness based on experience with the use of digital systems; • Proposed innovations and measures to improve the efficiency and effectiveness of digital health systems for clinicians and users of the system; and • Recommendations in relation to priorities of investment in, and development and implementation of, national digital health systems.
Consumer Advisory Committee	The Consumer Advisory Committee advises on: • How to ensure key messages about digital health are communicated effectively to relevant stakeholders and health consumer groups; • Recognising the interests of minority and special interest groups so as to ensure that their interests are taken into account in the design and implementation of digital health systems; and • Establishing and maintaining collaboration with health consumers and providers in relation to digital health systems.

Privacy and Security Advisory Committee

The Privacy and Security Advisory Committee focuses on:

- Legal issues in relation to digital health systems, including copyright, data privacy issues, confidentiality issues, data security and legal liability;
- The long-term legal framework of digital health systems;
- Privacy and security issues encountered by users of digital health systems, and the resolution of any problems arising from monitoring these issues; and
- Standards (including compliance with standards) relating to privacy and security in relation to digital health systems.

The Agency Rule also allows the Board to establish additional committees as it considers appropriate. In that context, the Digital Health Safety and Quality Governance Committee was formed:

Digital Health Safety and Quality Governance Committee

The Digital Health Safety and Quality Governance Committee advises on:

- All safety, quality and clinical governance aspects of services and contracts undertaken or managed by Australian Digital Health Agency;
- Oversight of the development, implementation and monitoring of all safety, quality and clinical governance approaches and mechanisms, inclusive of continuous quality improvement and clinical risk management undertaken by the Agency;
- Safety, quality and clinical governance matters, including policies, that are referred to the Digital Health Safety and Quality Governance Committee by the Agency Board, the Australian Commission on Safety and Quality, Advisory Committees or the Australian Department of Health; and
- Approving and recommending the Agency Clinical Quality Plan which will include consideration of the outcomes and recommendations provided by the Australian Commission on Safety and Quality in Health Care based upon the conduct of audits and reviews of Agency clinical approaches.

The final advisory body, an audit committee, is mandated by section 45 of the PGPA Act, and section 17 of the *Public Governance, Performance and Accountability Rule 2014* (PGPA Rule) sets out its powers of review:

Audit and Risk Committee

The Audit and Risk Committee was established to assist the Board discharge its responsibilities under the PGPA Act and PGPA Rule through review of the Agency's financial reporting, performance monitoring, risk oversight and management, internal control and legislative and policy compliance:

- Financial reporting: activities such as advising on the entity's preparation and review of its annual financial statements, the adequacy of the entity's internal budgeting and reporting, and the entity's obligations under the PGPA Act and other relevant Acts.
- Performance reporting: reviewing the framework of key performance indicators and other performance measures, or the entity's annual performance statement; or making recommendations on concerns or opportunities identified by internal or external audits.
- System of risk oversight and management: advising the entity about internal audit plans; advising about professional standards to be used by internal auditors in the course of carrying out audits; reviewing the entity's response to internal and external audits and reviewing the entities risk management framework which may include review of the entity's risk management plan and business continuity plan.
- System of internal control: reviewing the entity's compliance framework, governance arrangements and internal control environment.

Internal governance

CEO

The CEO, Tim Kelsey, leads the Agency in implementing a portfolio of work that supports the Board's vision. Under section 53 of the Agency Rule, Tim manages the day-to-day administration of the Agency and does so in accordance with the strategy, plans and policies approved by the Agency Board. He is the primary point of liaison between the Board and senior management.

Executive leadership team

The CEO is supported by the Executive Leadership Team, comprised of five Executive General Managers (Division heads) and a Chief Medical Adviser. The team meets weekly with the CEO and is active in the implementation of the governance framework through strategic and financial planning, consideration of ongoing and emerging risks, review of controls, and monitoring the delivery of performance outcomes. It is the primary forum for operational decision-making in the Agency.

Senior leadership team

The Senior Leadership Team also has a role in overseeing operational activities and in guiding the ongoing development of the Agency's governance policies and processes. The Senior Leadership Team, comprising General Managers (Branch heads) meets with the Executive Leadership Team every three weeks. It provides a mechanism for information sharing, cooperation and collaboration across the leadership group to drive organisational capability and performance.

Directors' forum

Opportunities to provide input on strategic issues and resolve operational issues are extended to Directors (Section heads) through the Directors' Forum, which meets fortnightly with a representative of the Executive and Senior Leadership Teams. This forum has a dual purpose: as a communication channel to cascade key messaging from the Executive, and as critical feedback loop. It allows upward communication of staff insights on emerging challenges, resourcing priorities, performance progress, and the operation of policies and processes in practice, leading to their continuous improvement.

Together, these forums set the cultural and ethical tone for the Agency and enrich Agency-wide strategic thinking.

Internal Committees

A range of internal committees also support the Agency's leadership and its ability to deliver on its strategic priorities.

Internal committee	Purpose
Portfolio Management Committee	Oversees the planning and delivery of the Agency's annual work program.
Clinical Programs Management Committee	Manages operational aspects of the Agency's Clinical Programs: Medicines Safety, Pathology and Diagnostic Imaging programs, and any new programs identified by the Agency's Board.
Digital Health Safety and Quality Management Committee	Establishes a forum where clinical governance mechanisms are in place and effective across the Agency.
Workplace Health and Safety Steering Committee	Brings together staff and management to develop and review health and safety policies and procedures across the Agency.

3.0

Management and accountability

Risk management

The Agency is committed to a comprehensive and coordinated approach to managing risk at the enterprise, program and project levels.

In its first year of operations, the Agency designed and implemented a system of internal controls for the oversight and management of risk, including policy guidelines, tools and templates. The framework is aimed at building a positive and transparent risk culture by embedding risk management principles and processes into 'business as usual' activities.

The risk management framework is modelled on better practice methodologies, and aligned with the international standard on risk management (AS/NSW ISO 310000) and the *Commonwealth Risk Management Policy 2014*.

It is designed to support the delivery of the strategic objectives determined by the Board by ensuring that potential adverse events, threats and uncertainties are identified, measured, managed and mitigated. An equal focus is placed on the active and ongoing reporting of risks to ensure they are captured and escalated, where appropriate, to allow visibility by senior management.

Enterprise-wide or strategic risks that could materially impact on the success of the Agency, are owned and reviewed by the Agency board. The Board determines the nature and extent of risk it is prepared to accept to achieve the Agency's purpose, consistent with the Agency's risk appetite and prudent use of public funds.

Audit and risk committee

The Audit and Risk Committee is independent of the Agency and provides assurance and advice to the Board on the Agency's risk, governance and control framework, and the integrity of its performance and financial reporting.

Its efforts are aimed at championing a risk-aware culture that encourages robust risk assessment, risk-informed decision-making, and anticipation of risk in the pursuit of Agency objectives. A primary responsibility of the Committee under its charter is to oversee the preparation and implementation of the Agency's key risk management initiatives, including audit, fraud control, and business continuity activities.

The risk framework is complemented by an assurance framework designed to confirm the operation and effectiveness of key controls. It is developed to industry standards and scaled to Agency requirements. Consistent with annual obligations in its charter, during the reporting period the Committee commissioned an Agency-wide assurance map to identify the Agency's key assurance arrangements. This yearly exercise will allow for early detection and correction of any gaps or duplications in assurance coverage, thereby strengthening the Agency's compliance and review processes and freeing up resources for other use.

Risk management forum

Given that responsibility for risk management rests with all of the Agency's staff, a Risk Management Forum was established with membership across business, product and program areas, to build and nurture a risk management capability and a broader understanding of risk exposures across the Agency.

Portfolio management committee

The Agency's Portfolio Management Committee, which monitors delivery of the annual work program and derivative projects, also maintains a broad entity-wide perspective of risks which facilitates a consistent approach to their identification, treatment and monitoring on an ongoing basis.

Audit arrangements

The Agency relies on audit activities as an essential tool to identify opportunities to deliver better practices that will drive performance and greater transparency of the Agency's governance and decision-making arrangements.

Internal audit

The Agency appointed Axiom Associates as its internal auditors in February 2017, and they prepared a Strategic Internal Audit Plan extending through June 2019. The audit program was informed by a consultative and collaborative risk assessment process to target areas of highest risk and those of high value warranting independent appraisal of financial and operational controls.

Financial reporting and shared services audits were underway during the reporting period. The findings will be presented to the Audit and Risk Committee, with an accompanying plan to action any recommendations as part of ongoing efforts to improve Agency processes and performance.

Priority areas for 2017-18 activity include security controls, business continuity and contract management. The Agency will continue to focus audit resources on identified areas of significant or financial risk while being flexible enough to respond to emerging risks and changing demands. The audit program will be reviewed and revised to account for significant changes in the internal and external environment, and also to reflect the continued growth in the Agency's maturity and capability.

External audit

The Auditor-General is the external auditor for the Agency, as required by the PGPA Act. The Auditor-General, through the Australian National Audit Office (ANAO), has audited the Agency's financial statements to ensure they have been prepared in accordance with the Australian Accounting Standards and other requirements prescribed by the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*. The Agency's financial statements are presented in Part 4 of this report.

Under its Charter, the Audit and Risk Committee is empowered to act as the liaison point between Agency management and the ANAO, and to review both the financial accounts and the processes in place that support the integrity of financial information published in the Annual Report.

The Audit and Risk Committee also oversees the Agency's fraud control arrangements.

Fraud control

The Agency has developed an integrity framework aimed at ensuring standards of professionalism, individual accountability and ethical behaviour are valued and shared across the organisation. The framework is underpinned by polices, plans and procedures such as Accountable Authority Instructions that encourage responsible public administration and minimise the risk of misappropriation of Agency resources.

The Agency recognises that all staff must do their part to safeguard Agency assets against loss through fraud, negligence or other misconduct and promote a positive workplace culture by supporting fraud control efforts. The Agency also recognises its responsibility to support individuals who report suspected wrongdoing.

During 2016-17, the Agency conducted a risk assessment of its possible exposure to fraud, corrupt or improper conduct. That assessment allowed for the preparation of a Fraud Control Plan tailored to Agency requirements. The plan documents the Agency's fraud governance arrangements, risk mitigation measures and reporting responsibilities. It also provides for training and awareness activities to assist Agency staff to identify suspected fraud and understand their disclosure obligations. The plan is supported by appropriate fraud prevention, detection and response strategies to minimise the incidence and impact of fraud.

The fraud control plan accords with the Commonwealth Fraud Control Framework and with the ANAO Better Practice Guide, Fraud Control in Australian Government entities, and gives effect to the fraud control provisions of the *Public Governance, Performance and Accountability Act 2013 (PGPA Act*) and Rule 10 of the *Public Governance, Performance and Accountability Rule 2014*.

No material instances of fraud were reported during the financial year.

Business continuity management

The Agency has developed a Business Continuity Plan aimed at building operational resilience by ensuring that critical services continue in the aftermath of a major business disruption, and ordinary functions resume within acceptable recovery timeframes.

The plan is mapped to the Agency's risk profile and details contingencies and related controls to reduce the likelihood and effect of a business interruption. Disaster recovery plans are also in place to safeguard ICT systems that are intrinsic to the Agency's operations.

The Agency's second year of operations will focus on testing and validating business continuity arrangements and incorporating any lessons learned from disaster recovery exercises. Training will also take priority so staff are aware of their roles and responsibilities during a crisis and understand Agency measures to centralise and coordinate its response and prioritise and restore system and workforce availability.

External scrutiny

The Agency is accountable to the Australian Parliament through the Commonwealth Minister for Health and to state and territory health ministers through the COAG Health Council. It reports quarterly to the Australian Health Minister's Advisory Council (AHMAC) which has responsibility for providing strategic and operational support to the COAG Health Council.

The Agency's operations are also open to scrutiny from the Auditor-General, the courts, administrative tribunals, parliamentary committees, the Commonwealth Ombudsman, the Australian Information Commissioner and the community under the Freedom of Information regime.

Auditor-General reports

The Auditor-General issued an unqualified audit opinion for the 2016-17 financial statements of the Agency, which is presented in Part 4 of this report. The Agency was not the subject of any performance audits by the Auditor-General during the reporting period.

Judicial decisions or administrative reviews

There were no judicial or administrative tribunal decisions impacting on the operations of the Agency.

Parliamentary, Ombudsman, Australian Information Commissioner reports

The Agency appeared at Senate Estimates (Finance and Public Administration Legislation) Committee to answer questions about Agency operations in October 2016 and in February 2017, but no reports on the Agency were released by a parliamentary committee or the Commonwealth Ombudsman.

The Australian Information Commissioner produces a yearly report which touches directly on the work of the Agency as the My Health Record System Operator. The Commissioner has a statutory obligation to produce an annual report on digital health compliance and enforcement activity in accordance with Section 106 of the *My Health Records Act 2012* (the Act). The Act contains provisions that protect and restrict the collection, use and disclosure of personal information. The Australian Information Commissioner monitors and enforces compliance with those provisions as the independent regulator of the privacy aspects of the My Health Record system.

Capability reviews

The Australian Public Service Commission oversees a program of external reviews of public sector agencies to assess their ability to meet future objectives and challenges. No capability reviews of the Agency were conducted during the reporting period.

Freedom of information regime

Part 2 of the *Freedom of Information Act 1982* (FOI Act) established the Information Publication Scheme (IPS), effective from 1 May 2011. It reflected a shift to a pro-disclosure culture for government, with the expectation that agencies take the lead in anticipating and publishing material for public accessibility, rather than react to ad hoc requests.

The scheme compels the Agency to publish certain categories of information online. These include the Agency's structure, functions and decision-making powers, as well as operational information supporting the exercise of those functions and powers. The Agency is also required to publish a plan detailing the information that will be made available as part of the IPS, and the steps it will take to ensure compliance with IPS obligations.

The Agency has met the regulatory requirements by website publication of the broad range of information required, as well as by preparing a plan explaining how it will administer the IPS. It undertakes to keep the online content accurate, current and complete.

The Agency recognises that public sector information – information that is generated, collected or funded by government – is a valuable national resource that should be available for community access and use.

Consistent with the objects of the FOI Act and the Agency's commitment to transparency and open government, the Agency favours disclosure in the absence of competing public interest considerations such as the protection of personal information.

During 2016-17 the Agency received one request pursuant to the *Freedom of Information Act 1982* (FOI Act). Information released in response to FOI Act requests is published in accordance with IPS requirements and accessible in the FOI Disclosure log page on the Agency website – www.digitalhealth.gov.au.

Additional reporting requirements under the PGPA Rule 2014

Ministerial directions and policy orders

The *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* provides that the Minister for Health may give directions to the Agency about the performance of its functions or the exercise of its powers. In addition, the Minister for Finance, under the PGPA Act, may notify the Board of any general Australian Government policies that apply to the Agency.

No ministerial directions or notifications were given during the 2016-17 reporting period.

Compliance with finance law

The PGPA Rule requires that the Agency report on any significant non-compliance during 2016-17 with finance law (encompassing the PGPA Act, any delegated legislation under that Act, or an Appropriation Act).

The Agency has not identified any significant non-compliance issues during the reporting period.

Significant activities and changes

The PGPA Rule also requires the Agency to provide details of significant activities and changes that affected the operations or structure of the entity during the reporting year. The Rule requires the Agency to notify the Minister for Health of events such as proposals to form a company, partnership or trust, to acquire or dispose of a significant shareholding in a company or commence or cease business activities or to make other significant changes. No significant events in that context arose during 2016-17.

However, it is noted that a material change to the Agency's portfolio of work is underway following the Federal Government announcement in the May 2017 Budget of the My Health Record – continuation and expansion Budget Measure which will see the national expansion of the My Health Record to every Australian unless they choose not to have one. Australia is now the first country in the world to commit to the provision of a digital health record to every citizen. As the System Operator for the My Health Record, the Agency is responsible for implementing this historic work and will be partnering with key stakeholders to ensure its successful implementation.

Related entity transactions

The Agency is related to the Department of Health under the PGPA Rule because the Secretary of the Department of Health, Martin Bowles PSM, was both the Accountable Authority for one body (the Department of Health), and a member of the Accountable Authority of another (a member of the Agency Board) during the reporting year.

The PGPA rule requires the Agency to disclose any related-entity transactions between those two bodies where a minimum financial threshold is met (the aggregate value of transactions exceeds $10,000) during the reporting period and to describe the process supporting the procurement decision. The Agency is also to provide the number and aggregate value of those transactions. The purpose of the provision is to ensure transparency around any perceived or potential conflicts of interest.

The reporting obligation arises as the Agency has shared service arrangements with its portfolio entity, the Department of Health, to minimise the resource cost associated with various corporate service functions, such as payroll and financial processing and recording services. The Agency also sub-leases its premises in Canberra from the Department of Health.

All related entity procurements were operational in nature and authorised by Agency management in accordance with the Commonwealth Procurement Rules and relevant Board delegations. The arrangements are independent of, and separated from, Board decision-making processes. The relationship is managed under a Memorandum of Understanding and appropriate contractual arrangements.

There were 9 transactions in 2016-17 and their value in aggregate was $1.671 million (GST inclusive).

Insurance and indemnities

The PGPA Rule requires the Agency to provide details of any indemnity that applied to the Agency Board, any member of the Board or officer of the Agency against a liability (including premiums paid, or agreed to be paid, for insurance against the Agency Board, member or officer's liability for legal costs). In 2016-17 the Agency maintained directors' and officers' liability insurance as part of its overall insurance arrangements with the Commonwealth's self-managed insurance fund, Comcover. The premium paid for Board members' and officers' coverage for 2016-17 was $24,474.73 (GST inclusive).

Human resources management

The Agency's people are its most valuable asset. They are at the heart of its ability to deliver on the performance expectations of ministerial, health sector and community stakeholders. They have backgrounds and skills in healthcare, health informatics and IT, and a range of other disciplines. The Agency recognises the strength in their diversity.

As a dual staffing body, the Agency is empowered to employ staff under the *Public Service Act 1999* as well as under its own enabling legislation, the Agency Rule. At 30 June 2017, the Agency employed 247 staff across both those arrangements (199 permanent and 48 temporary). Those staff were based in Brisbane, Sydney and Canberra, with a small Melbourne office concluding operations before the end of 2016-17 reporting period.

The Agency is committed to investing in staff development both formally, through targeted external training opportunities and informally, through in-house learning initiatives supported by knowledge management and information sharing systems and processes. Development needs are identified through the Agency's performance management framework which links individual behaviours and performance to Agency objectives.

Workforce planning is underway to ensure that the Agency's capability and resources are coordinated and leveraged, both now and in the future. This planning includes an environmental analysis and risk assessment to identify any gaps between current and future workforce needs, with a particular focus on building a team that is appropriately skilled to support the opt-out initiative for My Health Record participation.

Mandatory reporting requirements under various Commonwealth legislation

Workplace health and safety

Valuing the Agency's people extends to recognising the responsibility to promote their health and wellbeing and to meet employer obligations under the *Work Health and Safety Act 2011* (WHS Act). In accordance with Schedule 2, Part 4 of the WHS Act, the Agency is required to report on initiatives taken during the year to ensure workplace health and safety and the outcomes of those initiatives. It is also required to provide statistics of any notifiable incidents (serious work-related injuries or illness) and details of any investigations conducted during the reporting period.

The Workplace Health and Safety Steering Committee is the key forum that supports the Agency's health and safety culture. It oversees and coordinates the Agency's compliance with the WHS Act and its implementation, including the development of policies and promotion of safe work practices.

Committee representatives worked closely with senior managers and supervisors to deliver a number of prevention and early intervention initiatives to minimise the risk of workplace injuries and enable staff to work in a happy and healthy environment, and maintain a balance with home life.

These initiatives included the following.

Workplace health and safety

- Workplace hazard inspections where staff were encouraged to report accidents or dangers;
- Workstation assessments with the provision of tailored ergonomic equipment as required;
- The availability of sit-to-stand desks to promote movement and active working;
- An Agency-funded influenza vaccination program (participation rate was 44%);
- Presence of first aid facilities and supplies including automatic external defibrillators, and offer of training for first aid officers, floor wardens responsible for emergency evacuation procedures and staff with specific WHS-related responsibilities; and
- Work health and safety procedural guidance for all workers.

Work-life balance

- Flexible work arrangements to manage and avoid staff working excessive hours; and
- ICT remote working capabilities to cover all staff, enabling them to work periodically from outside the office or at home, with manager approval.

Wellbeing

- Resilience training to support staff to manage the challenges of organisational change; and
- Staff and family access to an Employee Assistance Program – an independent, confidential and free professional counselling service provided by external, registered psychologists to address vocational or personal issues (15 employees, or their families, utilised this service in 2016-17).

These initiatives have assisted employees in adopting healthy work and lifestyle practices, and reflect the Agency's commitment to fostering a strong health and safety culture.

Consistent with this culture, no accidents or injuries occurred that were reportable under Section 38 of the WHS Act, and no investigations were conducted under Part 10 of that Act.

Advertising and market research

Under Section 311A of the *Commonwealth Electoral Act 1918* the Agency is required to disclose payments exceeding $13,000 (inclusive of GST) to advertising, market research, polling, direct mail or media advertising organisations. Sums less than $13,000 are not required to be reported.

During 2016-17 the Agency's total expenditure for advertising and market research over the reporting threshold was $140,238.93 (GST inclusive).

The following table shows the breakdown of payments by category.

Media Advertising Organisation	Purpose	Expenditure (GST Inclusive)
Dentsu Mitchell Media Australia Pty	Advertisements for Tender in Newspapers	$109,898.48
Allegis Group Australia Pty Ltd	Placement of Jobs Ads in Newspapers	$30,230.45
Total		**$140,238.93**

Ecologically sustainable development and environmental performance

Under Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999*, the Agency is obliged to report on:

- Ecologically sustainable development – how its activities accord with, and contribute to, environmental sustainability; and
- Environmental performance – how its activities impact on the environment, and measures taken to minimise their impact.

Digital health's contribution to ecological sustainability

Discussion of the benefits of digital health rightly tends to focus on improved patient outcomes and the delivery of high quality, safe and cost-effective care. However, one impact that is often overlooked is the potential benefit to the environment.

At a macro level, the Agency is helping to build a digital health future that promotes environmental sustainability. In this future, online health records will replace paper files, electronic diagnostic imaging reports will lower plastic waste from x-rays, and telehealth will reduce reliance on patient transportation by lessening the need for face-to-face consultations.

Agency strategies to minimise environmental footprint

From an operational perspective, the Agency is mindful of its environmental responsibility and has taken steps to ensure both the efficient use of resources and effective waste management through the use of:

- Video and tele-conferencing faculties as an alternative to travel, wherever possible;
- Initiatives to reduce paper consumption, such as introduction of paperless processes in business areas, the use of dual monitors at workstations, large screen displays in group settings, and web-based sharing tools across teams;
- Recycling programs for paper, communal and co-mingled waste, to minimise disposal to landfill; and
- Energy-efficient practices in air-conditioning, computer and lighting, such as lighting control systems that activate by motion sensors.

As the Agency grows as an organisation it will continue to manage corporate activities in a manner that minimises the impact on the environment.

Corrections to previous annual report

1. The 2015-16 Annual Report of the Agency[37] reported on Agency start-up activities before it commenced operations on 1 July 2016. It covered the period from 30 January 2016, when the Agency was established, until 30 June 2016. The report was included in the 2015-16 Annual Report of the Department of Health as Appendix 5. The Financial Statements on page 434 of Appendix 5 reported the monetary unit as '$,000' when it should have been expressed as '$'.

2. The 2015-16 Annual Report of the My Health Record System Operator[38] reported annual Security and System Usage statistics on pages 9–10. My Health Record system healthcare provider organisation participation was determined by multiplying monthly average figures without removing duplicate information, resulting in an over-statement of the figures provided.

   Current Agency processes provide an average of each of the 12 months in the reporting period ensuring an accurate record of My Health Record participation over the 12-month reporting period.

37. Department of Health. Department of Health Annual Report 2015-16 (Appendix 5). http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16-cnt2/$File/appendix-5-australian-digital-health-agency-2015-16-annual-report.pdf

38. Department of Health. My Health Record System Operator Annual Report 1 July 2015 to 30 June 2016. https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/0F2F30876A95E7D4CA257F8A0008E337/$File/MyHealthRecordSystemOperatorAnnualReport-2015-16.PDF

4.0

Financial statements

This part reports on the Agency's financial performance, and includes financial statements audited by the Auditor-General.

Garden City Medical Centre, Brisbane QLD

Financial summary

The Agency is jointly funded by the Commonwealth ($120.892 million) and the states and territories ($32.25 million)[39].

The corporate focus through 2016-17 was to establish a strong system of financial management and accountability to fulfil our obligations under the PGPA Act and to support the Agency's operational performance, strategic direction and leadership.

The Agency's financial results for the reporting year confirm its strong and sound financial position, and its ability to operate within its budget.

Financial Outcome

The Agency had a total operating revenue of $144.099 million in 2016-17. Gains of $57.475 million were also recorded, reflecting the net assets and liabilities transferred from NEHTA free of charge, and revaluations of property, plant and equipment. The Agency incurred total expenses of $181.361 million. As a result, the Agency recorded a comprehensive income (a surplus) of $20.213 million in 2016-17.

Audited financial statements

The Australian National Audit Office (ANAO) inspected the Agency's financial records and provided an unqualified audit opinion on the financial statements and accompanying explanatory notes on 16 October 2017. The ANAO's report and the Agency's financial statements are presented on pages 97 to 131 of Part 4.

The Agency will continue to focus on its budget management in 2017–18 to maintain its financial sustainability and to deliver strongly against its statutory priorities.

39. Budget Other Income was published in the 2016-17 Portfolio Budget Statements (PBS) as $34.40m. The Commonwealth and jurisdictions agreed to reduce their contributions to $32.25m for 2016-17, however this was not included in the PBS. In compliance with AASB1055: Budgetary Reporting, the financial statements recorded in this Annual Report show the original published 2016-17 PBS of $34.40m and actual Other Income reflects the agreed amount of $32.25m.

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Digital Health Agency for the year ended 30 June 2017:

(a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian Digital Health Agency as at 30 June 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian Digital Health Agency, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

- Statement by the Accountable Authority, Chief Executive Officer and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Notes to and forming part of the financial statements including significant accounting policies and other explanatory information.

Basis for Opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Australian Digital Health Agency in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* to the extent that they are not in conflict with the *Auditor-General Act 1997* (the Code). I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other Information

The Accountable Authority is responsible for the other information. The other information comprises the information included in the annual report for the year ended 30 June 2017 but does not include the financial statements and my auditor's report thereon.

My opinion on the financial statements does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Australian Digital Health Agency, the Board of Australian Digital Health Agency (the Board) is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under that Act. The Board is also responsible for such

GPO Box 707 CANBERRA ACT 2601
19 National Circuit BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

internal control as the Board determines is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the Australian Digital Health Agency's ability to continue as a going concern, taking into account whether the entity's operations will cease as a result of an administrative restructure or for any other reason. The Board is also responsible for disclosing matters related to going concern as applicable and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

Auditor's Responsibilities for the Audit of the Financial Statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office

Muhammad Qureshi
Acting Executive Director

Delegate of the Auditor-General

Canberra
16 October 2017

Financial statements 2016-17

Australian Government
Australian Digital Health Agency

Level 25, 56 Pitt Street
SYDNEY NSW 2000
Telephone: (02) 8298 2600
Facsimile: (02) 8298 2666
www.digitalhealth.gov.au

Statement by the Accountable Authority, Chief Executive Officer and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2017 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Australian Digital Health Agency will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Australian Digital Health Agency Board Members.

Board Chair
Accountable Authority

16 October 2017

Tim Kelsey
Chief Executive Officer

16 October 2017

David Delaporte
General Manager, Finance, Procurement & Facilities (assuming responsibility of the Chief Financial Officer)

16 October 2017

Australian Digital Health Agency
Statement of Comprehensive Income
for the period ended 30 June 2017

	Notes	**2017 $'000**	2016 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Employee Benefits	2.1A	**33,958**	199	39,082
Suppliers	2.1B	**115,764**	22	119,142
Depreciation and amortisation	3.2A	**29,893**	-	10,132
Write-Down and Impairment of Assets	2.1C	**1,746**	-	-
Total expenses		**181,361**	221	168,356
Own-Source Income				
Own-source revenue				
Contributions from Jurisdictions	2.2A	**32,250**	-	34,400
Interest	2.2B	**1,546**	-	1,200
Total own-source revenue		**33,796**	-	35,600
Gains				
Other Gains	2.2C	**56,699**	203	41,183
Total gains		**56,699**	203	41,183
Total own-source income		**90,495**	203	76,783
Net cost of services		**(90,866)**	(18)	(91,573)
Revenue from Government	2.2D	**110,303**	-	110,303
Surplus attributable to the Australian Government		**19,437**	(18)	18,730
OTHER COMPREHENSIVE INCOME				
Items not subject to subsequent reclassification to net cost of services				
Changes in asset revaluation surplus		**776**	-	-
Total other comprehensive income		**776**	-	-
Total comprehensive income attributable to the Australian Government		**20,213**	(18)	18,730

The above statement should be read in conjunction with the accompanying notes.

Australian Digital Health Agency
Statement of Comprehensive Income
for the period ended 30 June 2017

Budget Variances Commentary

Statement of Comprehensive Income

The Agency recorded a higher than budgeted surplus for 2016-17 due primarily to the following factors:

i. Higher 'Gains' pertaining to the transfer of net assets from the National Electronic Health Transition Authority (NEHTA) to the Agency on 1 July 2016. The budget figures (reported May 2016) preceded the final audited financial statements for NEHTA (which were not finalised until September 2016) and the estimate used significantly understated the 'Other Gains' in net assets transferred.

ii. Total expenses were higher than budgeted due to complex nature of the Agency's program delivery and the impacts associated with transitioning operations to a corporate Commonwealth entity. This was further impacted by uncertainties inherent in the Agency's level of investing expenditure, which is predominantly on intangible assets.

Australian Digital Health Agency
Statement of Financial Position
as at 30 June 2017

	Notes	**2017 $'000**	2016 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and Cash Equivalents	3.1A	**40,548**	-	27,531
Trade and Other Receivables	3.1B	**8,825**	-	78
Other Investments	3.1C	**6,001**	-	-
Total financial assets		**55,374**	-	27,609
Non-financial assets				
Leasehold Improvements	3.2A	**521**	-	-
Plant and equipment	3.2A	**1,192**	-	940
Computer software	3.2A	**854**	-	-
Own-Source Income	3.2A	**38,789**	-	50,361
Other Non-Financial Assets	3.2B	**1,127**	-	379
Total non-financial assets		**42,483**	-	51,680
Total assets		**97,857**	-	79,289
LIABILITIES				
Payables				
Suppliers	3.3A	**11,521**	10	5,874
Other Payables	3.3B	**588**	8	-
Total payables		**12,109**	18	5,874
Provisions				
Employee Provisions	4.1A	**5,802**	-	4,324
Other Provisions	4.1B	**338**	-	-
Total provisions		**6,140**	-	4,324
Total liabilities		**18,249**	18	10,198
Net assets		**79,608**	(18)	69,091
EQUITY				
Contributed equity		**59,413**	-	50,361
Reserves		**776**	-	-
Retained surplus		**19,419**	(18)	18,730
Total equity		**79,608**	(18)	69,091

The above statement should be read in conjunction with the accompanying notes.

Australian Digital Health Agency
Statement of Financial Position
as at 30 June 2017

Budget Variances Commentary
Statement of Financial Position

Assets

Total assets were higher than budgeted mainly due to:

a. Higher than budgeted 'Other Gains' (refer comments Statement of Comprehensive Income) which were substantively represented by Cash or Cash equivalents and Other Investments.

b. An increase in receivables reflecting current invoices due in respect of fourth quarter billing of states and territories for their contributions pursuant to the Intergovernmental Agreement on National Digital Health (IGA).

c. An offset by a decrease in Other Intangibles and Computer Software capitalisation.

Liabilities

Total liabilities were higher than budgeted due to the delays encountered with certain projects and the movement in employee provisions.

Equity

The increase in Equity is attributable to:

a. The higher than budgeted surplus for 2016-17, primarily driven by the transfer of NEHTA assets to the Agency on 1 July 2016

b. Transfer of the My Health Record from the Department of Health accounted for as a restructuring of administrative arrangements.

Australian Digital Health Agency
Statement of Changes in Equity
for the period ended 30 June 2017

	Notes	**2017 $'000**	2016 $'000	Original Budget $'000
CONTRIBUTED EQUITY				
Opening balance				
Balance carried forward from previous period		**-**	-	-
Adjusted opening balance		**-**	-	-
Comprehensive income				
Other comprehensive income		**-**	-	-
Total comprehensive income		**-**	-	-
Transactions with owners				
Contributions by owners				
Equity injection - Appropriations		**10,589**	-	10,589
Restructuring	6.1	**48,824**	-	39,772
Total transactions with owners		**59,413**	-	50,361
Transfers between equity components		**-**	-	-
Closing balance as at 30 June		**59,413**	-	50,361
RETAINED EARNINGS				
Opening balance				
Balance carried forward from previous period		**(18)**	-	-
Adjusted opening balance		**(18)**	-	-
Comprehensive income				
Surplus/(Deficit) for the period		**19,437**	(18)	18,730
Total comprehensive income		**19,437**	(18)	18,730
Closing balance as at 30 June		**19,419**	(18)	18,730
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		**-**	-	-
Adjusted opening balance		**-**	-	-
Comprehensive income				
Changes in asset revaluation surplus		**776**	-	-
Total comprehensive income		**776**	-	-
Closing balance as at 30 June		**776**	-	-
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		**(18)**	-	-
Adjusted opening balance		**(18)**	-	-

Australian Digital Health Agency
Statement of Changes in Equity
for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
TOTAL EQUITY (continued)				
Comprehensive income				
Surplus/(Deficit) for the period		**19,437**	(18)	18,730
Changes in asset revaluation surplus		**776**	-	-
Total comprehensive income		**20,213**	(18)	18,730
Transactions with owners				
Contributions by owners				
Equity injection - Appropriations		**10,589**	-	10,589
Restructuring		**48,824**	-	39,772
Total transactions with owners		**59,413**	-	50,361
Closing balance as at 30 June		**79,608**	(18)	69,091

The above statement should be read in conjunction with the accompanying notes.

Accounting Policy

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) and Departmental Capital Budgets (DCBs) are recognised directly in contributed equity in that year.

Restructuring of Administrative Arrangements

Net assets received from, or relinquished, to another Government entity under a restructuring of administrative arrangements are adjusted at their book value directly against Contributed equity.

Prior to 1 July 2016, the Australian government's investment in the My Health Record (MHR) was administered by the Department of Health and reported in its accounts as an administered intangible asset. A Cabinet decision (April 2015) provided the relevant authority in terms of section 26(2) of the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 to account for the subsequent transfer of the asset to the Agency as a restructure of administrative arrangement.

On this basis, the asset was recognised by the Department of Health at its net book value immediately prior to transfer. This amount, $48.8 million was taken up by the Agency on 1 July 2016 as the opening balance of the MHR.

Contributed gains

In contrast to the transfer of the MHR asset, the transfer of NEHTA net assets to the Agency on 1 July 2016 are accounted for as Other Gains in the Statement of Comprehensive Income consistent with the requirements of AASB 1004 Contributions. The net assets of NEHTA were previously controlled by the Commonwealth, states and territories through a separate company structure established under the Corporations Act 2001.

Budget Variances Commentary

Statement of Changes in Equity

The increase in Equity is attributed to:

a. The higher than budgeted surplus for 2016-17, primarily driven by the transfer of NEHTA assets to the Agency on 1 July 2016

b. Transfer of the My Health Record from the Department of Health accounted for as a restructuring of administrative arrangements

c. A capital contribution from the Australian Government but was partly offset by the higher than budgeted depreciation and amortisation expenses.

Australian Digital Health Agency
Cash Flow Statement
for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Appropriations		**110,303**	-	110,303
Interest		**1,454**	-	1,285
Net GST received		**8,478**	-	11,000
Other		**78,273**	-	84,390
Total cash received		**198,508**	-	206,978
Cash used				
Employees		**30,331**	-	38,976
Own-Source Income		**114,866**	-	118,399
Net GST paid		**-**	-	11,000
Total cash used		**145,197**	-	168,375
Net cash from/(used by) operating activities		**53,311**	-	38,603
INVESTING ACTIVITIES				
Cash received				
Investments		**-**	-	-
Total cash received		**-**	-	-
Cash used				
Purchase of property, plant and equipment		**17,351**	-	21,661
Investments		**6,001**	-	-
Total cash used		**23,352**	-	21,661
Net cash from/(used by) investing activities		**(23,352)**	-	(21,661)
FINANCING ACTIVITIES				
Cash received				
Other (Contributed Equity)		**10,589**	-	10,589
Total cash received		**10,589**	-	10,589
Total cash used		**-**	-	-
Net cash from/(used by) financing activities		**10,589**	-	10,589
Net increase/(decrease) in cash held		**40,548**	-	27,531
Cash and cash equivalents at the beginning of the reporting period		**-**	-	-
Cash and cash equivalents at the end of the reporting period	3.1A	**40,548**	-	27,531

The above statement should be read in conjunction with the accompanying notes.

Australian Digital Health Agency
Cash Flow Statement
for the period ended 30 June 2017

Budget Variances Commentary

Cash Flow Statement

The main variances relate to:

a. Net increase in cash held at 30 June 2017 due primarily to the higher Other contributions which relate to the transfer of net assets from NEHTA at 1 July 2016, constituted by cash and cash equivalents.

b. Higher than budgeted movements in investing activities, both cash received and cash used, due to the Agency actively managing its cash funds position progressively throughout the financial year to derive higher interest revenues.

c. Lower than budgeted expenditure on employee related expenses and suppliers, tied back to the lower than budgeted program expenditure.

Notes to and forming part of the financial statements

1. Overview

Objective of the Agency

The Australian Digital Health Agency (the Agency) is an Australian Government controlled corporate Commonwealth entity established by the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* (the Rule).

The Agency was established as a Corporate Commonwealth entity on 30 January 2016 following registration of the Rule on 29 January 2016, and commenced operations on 1 July 2016.

All assets and liabilities of NEHTA and My Health Record system operation activities managed by the Department of Health transferred to the Agency on that date. Prior to 1 July 2016, the Department of Health was primarily responsible for the establishment of the Agency, and as a result there was no funding allocated to, or expenditure by, the Agency for 2015-16.

The Agency had no cash flows during 2015-16 and the Agency held no assets during 2015-16.

The Agency has responsibility for the strategic management and governance for the National Digital Health Strategy and the design, delivery and operations of the national digital healthcare system including the My Health Record (MHR) system. It provides the leadership, coordination and delivery of a collaborative and innovative approach to utilising technology to support and enhance a clinically safe and connected national health system.

The Agency is structured to meet the following outcome:

Outcome 1: *To deliver national digital healthcare systems to enable and support improvement in health outcomes for Australians.*

The continued existence of the Agency in its present form and with its present programs is dependent on:

- Government policy and on continued funding by the Australian Government for the Agency's administration and programs relating to the My Health Record functions, including delivery of 'opt-out'.
- Funding from the Australian Government, states and territories received pursuant to the IGA signed on 8 April 2016 and on any future such agreements.

1. Overview (continued)

The Basis of Preparation

The financial statements are general purpose financial statements and are required by Section 42 of the *Public Governance, Performance and Accountability Act 2013*.

The financial statements have been prepared in accordance with:

a. *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015* (FRR) for reporting periods ending on or after 1 July 2015 and

b. Australian Accounting Standards and Interpretations – Reduced Disclosure Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian dollars and rounded to the nearest $'000 unless otherwise specified.

New Accounting Standards

All new, revised, amending standards and/or interpretations that were issued prior to the sign-off date and are applicable to the current reporting period did not have a material effect on the Agency's financial statements.

Taxation

The Agency is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Events After the Reporting Period

Opt-out funding

Subsequent to 30 June 2017, the Agency received $181.6 million additional funding from the Australian Government for delivering national opt-out for My Health Record due by 31 December 2018. Following unanimous support by the Council of Australian Governments (COAG), the Australian Government agreed to invest significant additional funding over two years to ensure every Australian has a My Health Record, unless they prefer not to. The expansion of the My Health Record marked a major upscaling in the delivery of the Agency's programs.

New lease

The Agency also entered into a 7 year lease for its Brisbane office.

Other than these two events, there were no matters or circumstances which have arisen since the end of the financial year which significantly affected, or alternatively may affect the operations of the Agency, the results of these operations or state of affairs of the Agency in subsequent years.

2.1 Expenses	Notes	2017 $'000	2016 $'000
2.1A: Employee Benefits			
Wages and salaries		**25,413**	179
Superannuation			
Defined contribution plans		**2,529**	-
Defined benefit plans		**347**	12
Leave and other entitlements		**4,922**	8
Separation and redundancies		**747**	-
Total employee benefits		**33,958**	199

Accounting Policy

Accounting policy for employee related expenses is contained in Note 4.1.

2.1B: Suppliers			
Goods and services supplied or rendered			
Consultants		**81,378**	-
Contractors		**9,142**	-
Travel		**1,875**	-
IT services		**5,078**	-
Other		**15,437**	22
Total goods and services supplied or rendered		**112,910**	22
Other suppliers			
Minimum lease payments		**2,600**	-
Workers compensation expenses		**254**	-
Total other suppliers		**2,854**	-
Total suppliers		**115,764**	22

Leasing commitments

The Agency in its capacity as a lessee holds non-cancellable property leases in Canberra, Sydney and Brisbane.

Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:			
Within 1 year		**1,312**	1,787
Between 1 to 5 years		**188**	1,330
Total operating lease commitments		**1,500**	3,117

2.1 Expenses (continued)	2017 $'000	2016 $'000
2.1C: Write-Down and Impairment of Assets		
Impairment on financial instruments[40]	**1,746**	-
Impairment of property, plant and equipment	**-**	-
Impairment on intangible assets	**-**	-
Total write-down and impairment of assets	**1,746**	-

40. The impairment relates to accounts receivable representing non-payment of contributions during 2016-17 by the state of South Australia.

2.2 Own-Source Revenue and gains	2017 $'000	2016 $'000
Own-Source Revenue		
2.2A: Contributions from Jurisdictions		
New South Wales	**10,326**	-
Victoria	**7,998**	-
Queensland	**6,515**	-
Western Australia	**3,509**	-
South Australia	**2,328**	-
Tasmania	**710**	-
Australian Capital Territory	**529**	-
Northern Territory	**335**	-
Total contributions from Jurisdictions	**32,250**	-

Accounting Policy

The Agency receives contributions from jurisdictions based on an agreed formula as set out in Schedule A to the Intergovernmental Agreement on National Digital Health (signed April 2016). The above contributions from states and territories of $32.25 million represents half of the total contributions made under the Intergovernmental Agreement, with a further $32.25 million being contributed by the Australian Government. The latter contribution is included in Revenue from Government and is shown in Note 2.2D.

2.2 Own-Source Revenue and gains (continued)	2017 $'000	2016 $'000
2.2B: Interest		
Deposits	**1,546**	-
Total interest	**1,546**	-

Accounting Policy

Interest revenue is recognised using the effective interest method.

2.2C: Other Gains		
Resources received free of charge		
Net transfer of NEHTA assets and liabilities as at 1 July 2016	**52,355**	-
Additional net assets transferred from NEHTA arising from a change in fair value at 30 June 2016[41]	**4,298**	-
Other	**46**	203
Total other gains	**56,699**	203

Accounting Policy

Resources Received Free of Charge

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government entity as a consequence of a restructuring of administrative arrangements (refer to Note 6.1).

41. Relates to additional non-current assets (including Leasehold improvements, Plant and equipment and Computer Software) revalued subsequent to the net transfer of NEHTA assets on 30 June 2016 following an independent assessment of fair values performed by RHAS.

2.2D: Revenue from Government		
Appropriations		
Departmental appropriations	**110,303**	-
Total revenue from Government	**110,303**	-

Accounting Policy

Revenue from Government

Funding received or receivable from non-corporate Commonwealth entities (appropriated to the non-corporate Commonwealth entity as a corporate Commonwealth entity payment item for payment to this entity) is recognised as Revenue from Government by the corporate Commonwealth entity unless the funding is in the nature of an equity injection or a loan. In addition to these payments made by the Department of Health, there was a further $32.25 million paid to the Agency from the Australian Government pursuant to the Intergovernmental Agreement (refer also Note 2.2A).

3.1 Financial Assets	2017 $'000	2016 $'000
3.1A: Cash and Cash Equivalents		
Cash on hand or on deposit	**40,548**	-
Total cash and cash equivalents	**40,548**	-

Accounting Policy

Cash is recognised at its nominal amount. Cash and cash equivalents include cash on hand and deposits in bank accounts with an original maturity of 3 months or less that are convertible to known amounts of cash and subject to insignificant risk of changes in value.

3.1B: Trade and Other Receivables		
Goods and services receivables		
Goods and services	**8,082**	-
GST receivable from the ATO	**2,397**	-
Interest Receivable	**92**	-
Total goods and services receivables	**10,571**	-
Total trade and other receivables (gross)	**10,571**	-
Less impairment allowance (receivables)	**(1,746)**	-
Total trade and other receivables (net)	**8,825**	-
Trade and other receivables (net) expected to be recovered		
No more than 12 months	**8,825**	-
More than 12 months	**-**	-
Total trade and other receivables (net)	**8,825**	-
Trade and other receivables (net) aged as follows		
Not overdue	**8,238**	-
Overdue by		
0 to 30 days	**-**	-
31 to 60 days	**36**	-
61 to 90 days	**-**	-
More than 90 days	**551**	-
Total trade and other receivables (net)	**8,825**	-

3.1 Financial Assets (continued)	2017 $'000	2016 $'000
Impairment allowance aged as follows		
Not overdue	-	-
Overdue by		
0 to 30 days	-	-
31 to 60 days	-	-
61 to 90 days	-	-
More than 90 days	1,746	-
Total impairment allowance	1,746	-

Credit terms for goods and services were within 30 days. The Agency has not provided any loans.

Accounting Policy

Loans and Receivables

Trade receivables and other receivables that have fixed or determinable payments and that are not quoted in an active market are classified as 'loans and receivables'. Receivables for goods and services, which have 30 day terms, are reviewed at the end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

Reconciliation of the Impairment Allowance

Movements in relation to 2017	Goods and services $'000	Other receivables $'000	Total $'000
As at 1 July 2016			
Amounts written off	-	-	-
Amounts recovered and reversed	-	-	-
Increase/(Decrease) recognised in net cost of services	1,746	-	1,746
Total as at 30 June 2017	1,746	-	1,746

Accounting Policy

Financial assets are assessed for impairment at the end of each reporting period. If there is an indication that receivables may be impaired the Agency makes an estimation of the receivables recoverable amount. When the carrying amount of the receivable exceeds the recoverable amount, it is considered impaired and a provision for impairment is made so the net value equals the recoverable amount.

3.1 Financial Assets (continued)	2017 $'000	2016 $'000
3.1C: Other Investments[42]		
Deposits	**6,001**	-
Total other investments	**6,001**	-
Other investments expected to be recovered		
No more than 12 months	**6,001**	-
More than 12 months	**-**	-
Total other investments	**6,001**	-

42. A term deposit with an original maturity of more than 3 months was held at 30 June 2017.

3.2 Non-Financial Assets

3.2A: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment and Intangibles

Reconciliation of the opening and closing balances of property, plant and equipment, computer software and other intangibles for 2017

	Leasehold Improvements $'000	Plant and equipment $'000	Computer Software[43] $'000	Other Intangibles[44] $'000	Total $'000
As at 1 July 2016					
Gross book value	-	-	-	-	-
Accumulated depreciation, amortisation	-	-	-	-	-
Total as at 1 July 2016	-	-	-	-	-
Additions					
Purchase	**8**	**424**	**789**	-	**1,221**
Internally developed	-	-	-	**16,130**	**16,130**
Acquisition of entities or operations (including restructuring)[45]	**505**	**2,079**	**1,714**	**48,824**	**53,122**
Revaluations and impairments recognised in other comprehensive income	**515**	**261**	-	-	**776**
Depreciation and amortisation	**(507)**	**(1,572)**	**(1,649)**	**(26,165)**	**(29,893)**
Total as at 30 June 2017	**521**	**1,192**	**854**	**38,789**	**41,356**
Total as at 30 June 2017 represented by					
Gross book value	**1,028**	**2,764**	**2,503**	**64,954**	**71,249**
Accumulated depreciation, amortisation and impairment	**(507)**	**(1,572)**	**(1,649)**	**(26,165)**	**(29,893)**
Total as at 30 June 2017	**521**	**1,192**	**854**	**38,789**	**41,356**

43. The carrying amount of computer software included $1.5 million of purchased software and $0.2 million of internally generated assets.
44. Other intangibles constitute the MHR asset transferred from the Department of Health on 1 July 2016 and further commentary on this is found within the Accounting Policy notes to the Statement of Changes in Equity in the paragraph 'Restructuring of Administrative Arrangements'.
45. Plant and equipment and Buildings (i.e. leasehold assets) were transferred from NEHTA at 1 July 2016.

No impairment was recognised for Buildings, Plant and equipment at 30 June 2017.
No impairment was recognised in respect of Computer Software and Other Intangibles at 30 June 2017.
No Buildings, Plant and equipment, Computer Software and Other Intangibles were expected to be sold or otherwise disposed of at 30 June 2017.
The prior year compative balances were nil.

Revaluations of non-financial assets

All revaluations were conducted in accordance with the revaluation policy stated at Note 3.2. On 30 June 2017, an independent valuer, Jones Lang Lasalle Incorporated, conducted a revaluation on leasehold improvements and plant and equipment. The revaluation report identified a total increment of net fair value of the Agency's assets held on the asset register of $776,000.

Accounting Policy

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor's accounts immediately prior to the restructuring.

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases costing less than $5,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in leases taken up by the Agency where there exists an obligation to makegood. These costs are included in the value of the Agency's provisions.

The asset capitalisation threshold for computer software and other intangible assets is $5,000.

Revaluations

Following initial recognition at cost, property, plant and equipment are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets did not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations depend upon the volatility of movements in values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of Asset Revaluation Reserve except to the extent that it reverses a previous revaluation decrement of the same asset class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that asset class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

Depreciation

Depreciable property, plant and equipment are written-off to their estimated residual values over their estimated useful lives, in all cases using the straight-line method of depreciation.

Depreciation rates, residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

Asset Class	Useful life (years)
Leasehold improvements	length of lease
Plant and equipment	3 - 10
Computer software	2 - 5
Other Intangibles	1 - 5

Impairment

All assets were assessed for impairment at 30 June 2017. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs of disposal and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the Agency were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

Intangibles

The Agency's intangibles comprises software licences, data sets, internally developed software for internal use and the MHR asset. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the Agency's software is shown in the table appearing under Depreciation.

All software assets were assessed for indications of impairment as at 30 June 2017.

3.2 Non-Financial Assets (continued)	2017 $'000	2016 $'000
3.2B: Other Non-Financial Assets		
Prepayments	**1,127**	-
Total other non-financial assets	**1,127**	-
Other non-financial assets expected to be recovered		
No more than 12 months	**1,127**	-
More than 12 months	**-**	-
Total other non-financial assets	**1,127**	-

No indicators of impairment were found for other non-financial assets.

3.3 Payables	2017 $'000	2016 $'000
3.3A: Suppliers		
Trade creditors and accruals	**11,521**	10
Total suppliers	**11,521**	10
Suppliers expected to be settled		
No more than 12 months	**11,521**	10
More than 12 months	**-**	-
Total suppliers	**11,521**	10

Settlement terms are 30 days.

3.3B: Other Payables		
Salaries and wages	**329**	8
Superannuation	**24**	-
Separations and redundancies	**235**	-
Total other payables	**588**	8
Other payables to be settled		
No more than 12 months	**588**	8
More than 12 months	**-**	-
Total other payables	**588**	8

Accounting Policy

Trade creditors and accruals are recognised at their nominal amounts. Liabilities are recognised to the extent that goods and services have been received.

4.1 Provisions	2017 $'000	2016 $'000
4.1A: Employee Provisions		
Leave	**5,802**	-
Total employee provisions	**5,802**	-
Employee provisions expected to be settled		
No more than 12 months	**2,427**	-
More than 12 months	**3,375**	-
Total employee provisions	**5,802**	-

Accounting policy

Liabilities for short-term employee benefits and termination benefits expected within twelve months of the end of reporting period are measured at their nominal amounts.

Leave

The liability for employee benefits includes provision for annual leave and long service leave.

No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years is estimated to be less than the annual entitlement for sick leave.

The liability for long service leave has been determined by reference to the shorthand method prescribed by the Government Actuary as per the FRR and Commonwealth Entity Financial Statement Guide. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Separation and Redundancy

Provision is made for separation and redundancy benefit payments. The Agency recognises a provision for termination when it has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

Superannuation

The Agency's staff comprise both APS employees and staff whose employment is subject to contracts under Common Law. Both groups of employees are reflected in the Agency's Average Staffing Level (ASL) numbers.

APS staff are either members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), or the PSS accumulation plan (PSSap), or other superannuation funds held outside the Australian Government.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

The Agency makes employer contributions to the employees' defined benefit superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government. The Agency accounts for these contributions as if they were contributions to defined benefit plans.

In respect of the other more prominent group of Common Law contract employees, the Agency makes employer contributions to funds held outside of the Australian Government.

The liability for superannuation recognised as at 30 June represents outstanding contributions, if any.

4.1 Provisions (continued)	2017 $'000	2016 $'000

4.1B Other Provisions	Provision for restoration $'000	Provision for restoration $'000
As at 1 July 2016		
Additional provisions made	**338**	-
Amounts used	**-**	-
Amounts reversed	**-**	-
Unwinding of discount or change in discount rate	**-**	-
Total as at 30 June 2017	**338**	-
Other provisions expected to be settled		
No more than 12 months	**67**	-
More than 12 months	**271**	-
Total other provisions	**338**	-

The Agency currently has 5 agreements for the leasing of premises which have provisions requiring the entity to restore the premises to their original condition at the conclusion of the lease. The Agency has made a provision to reflect the present value of this obligation.

Accounting Policy

Classification of Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and rewards incidental to ownership of leased assets. An operating lease is a lease that is not a finance lease.

Finance Leases

Where an asset is acquired by means of a finance lease, the asset is capitalised at either the fair value of the lease property or, if lower, the present value of minimum lease payments at the inception of the contract and a liability is recognised at the same time and for the same amount. The discount rate used is the interest rate implicit in the lease. Leased assets are amortised over the period of the lease. Lease payments are allocated between the principal component and the interest expense.

Operating leases

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

4.2 Key Management Personnel Remuneration	2017 $'000
Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Agency, directly or indirectly, including any director (whether executive or otherwise) of that Agency. The Agency has determined the key management personnel to be Chief Executive Officer, Executive General Managers and board members. Key management personnel remuneration is reported in the table below:	
Short-term employee benefits	**2,618**
Post-employment benefits	**229**
Other long-term employee benefits	**174**
Total key management personnel remuneration expenses[46]	**3,021**

The total number of key management personnel that are included in the above table are 17.

46. The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Minister. The Portfolio Minister's remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the Agency.

4.3 Related Party Disclosures

Related party relationships:

The Agency is an Australian Government controlled corporate Commonwealth entity. It has a governing board of directors, a Chief Executive Officer (CEO) and Executive General Managers (EGMs) and a Portfolio Minister.

Pursuant to AASB 124 Related Party Disclosures Agency key management personnel (KMP) are asked to provide details of where any of their close family members, or a controlled entity (entities) has (have) transacted with the Agency. Where any doubt exists, the information is to be recorded and collected in any event.

AASB 124 requires disclosure of related party relationships that include transactions where significant influence exists between the Agency and other parties. The Standard identifies that 'key management personnel (KMP)' have the capacity to influence the operations of the Agency, and therefore parties related to KMP become related parties to the Agency and require disclosure in the annual financial statements.

The Agency has determined that all board members, the CEO and EGMs constitute KMP for the purposes of AASB 124.

Officers acting into the CEO, or an EGM role, have been assessed against the criteria of whether their acting role allowed them to plan, direct and control the activities of the Agency.

Given the breadth of Government activities, related parties may transact with the government sector in the same capacity of 'common citizens'. Common citizen or 'open contest' transactions are not requested or recorded as they reflect those transactions that may be undertaken with the Agency under the same terms and conditions as any other citizen.

The Agency transacts with other Australian Government controlled entities consistent with normal day-to-day business operations provided under normal terms and conditions, including the payment of workers compensation and insurance premiums. These are not considered individually significant to warrant separate disclosure as related party transactions.

Refer to Note 4.1 Employee Provisions for details on superannuation arrangements with the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), and the PSS accumulation plan (PSSap).

Giving consideration to relationships with related entities, and transactions entered into during the reporting period by the entity, it has been determined that there are no related party transactions to be separately disclosed.

4.4 Remuneration of Auditors

Amounts paid or payable for audit of the financial statements 2016-17 is $160,000. (2016: $10,000).

5.1 Contingent Assets and Liabilities

Quantifiable Contingencies

The Agency had no quantifiable contingencies at reporting date.

Unquantifiable Contingencies

The Agency had no unquantifiable contingencies at reporting date.

5.2 Financial Instruments	2017 $'000	2016 $'000
5.2A: Categories of Financial Instruments		
Financial Assets		
Held-to-maturity investments		
Other Investments	**6,001**	-
Total held-to-maturity investments	**6,001**	-
Loans and receivables		
Cash and Cash Equivalents	**40,548**	-
Trade and Other Receivables	**8,825**	-
Total loans and receivables	**49,373**	-
Total financial assets	**55,374**	-
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	**11,521**	10
Total financial liabilities measured at amortised cost	**11,521**	10
Total financial liabilities	**11,521**	10

Accounting Policy

Financial assets

The Agency classifies its financial assets in the following categories:

a. financial assets at fair value through profit or loss;

b. held-to-maturity investments;

c. available-for-sale financial assets; and

d. loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon trade date.

Effective Interest Method

Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

Financial Assets at Fair Value Through Profit or Loss

Financial assets are classified as financial assets at fair value through profit or loss where the financial assets:

a. have been acquired principally for the purpose of selling in the near future;

b. are derivatives that are not designated and effective as a hedging instrument; or

c. are parts of an identified portfolio of financial instruments that the entity manages together and has a recent actualpattern of short-term profit-taking.

Assets in this category are classified as current assets.

Financial assets at fair value through profit or loss are stated at fair value, with any resultant gain or loss recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any interest earned on the financial asset.

Available-for-Sale Financial Assets

Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories.

Available-for-sale financial assets are recorded at fair value. Gains and losses arising from changes in fair value are recognised directly in reserves (equity) with the exception of impairment losses. Interest is calculated using the effective interest method and foreign exchange gains and losses on monetary assets are recognised directly in profit or loss. Where the asset is disposed of or is determined to be impaired, part (or all) of the cumulative gain or loss previously recognised in the reserve is included in surplus and deficit for the period.

Impairment of Financial Assets

Financial assets are assessed for impairment at the end of each reporting period.

Financial assets held at amortised cost-if there is objective evidence that an impairment loss has been incurred for loans and receivables or held to maturity investments held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Statement of Comprehensive Income.

Available for sale financial assets-if there is objective evidence that an impairment loss on an available-for-sale financial asset has been incurred, the amount of the difference between its cost, less principal repayments and amortisation, and its current fair value, less any impairment loss previously recognised in expenses, is transferred from equity to the Statement of Comprehensive Income.

Financial assets held at cost -if there is objective evidence that an impairment loss has been incurred, the amount of the impairment loss is the difference between the carrying amount of the asset and the present value of the estimated future cash flows discounted at the current market rate for similar assets.

Financial liabilities

Financial liabilities are classified as either financial liabilities 'at fair value through profit or loss' or other financial liabilities. Financial liabilities are recognised and derecognised upon 'trade date'.

Financial Liabilities at Fair Value Through Profit or Loss

Financial liabilities at fair value through profit or loss are initially measured at fair value. Subsequent fair value adjustments are recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any interest paid on the financial liability.

Other Financial Liabilities

Other financial liabilities, including borrowings, are initially measured at fair value, net of transaction costs. These liabilities are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective interest basis.

Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

5.2 Financial Instruments (continued)	2017 $'000	2016 $'000
5.2B: Net Gains or Losses on Financial Assets		
Held-to-maturity investments		
Interest revenue	**1,546**	-
Net gains/(losses) on held-to-maturity investments	**1,546**	-
Net gains on financial assets	**1,546**	-

5.2C: Fair Value of Financial Instruments	Carrying amount 2017 $'000	Fair value 2017 $'000	Carrying amount 2016 $'000	Fair value 2016 $'000
Financial Assets				
Other Investments	**6,001**	**6,001**	-	-
Cash and Cash Equivalents	**40,548**	**40,548**	-	-
Trade and Other Receivables	**8,825**	**8,825**	-	-
	-	**-**	-	-
Total financial assets	**55,374**	**55,374**	-	-
Financial Liabilities				
Trade creditors and accruals	**11,521**	**11,521**	-	-
Total financial liabilities	**11,521**	**11,521**	-	-

5.2 Financial Instruments (continued)	2017 $'000	2016 $'000

5.2D: Credit Risk

The Agency was exposed to minimal credit risk as loans and receivables are cash and trade receivables

The maximum exposure to credit risk was the risk that arises from potential default of a debtor.

The amount was equal to the total amount of the trade receivables of $8.8 million in 2017.

The Agency managed its credit risk by establishing policies and procedures for debt management.

Credit quality of financial assets not past due or individually determined as impaired

	Not past due nor impaired 2017 $'000	Past due or impaired 2017 $'000	Past due or impaired 2016 $'000
5.2E: Net Gains or Losses on Financial Assets			
Trade and Other Receivables	**8,238**	**587**	-
Total	**8,238**	**587**	-

Receivables relate to State and Territory contributions invoiced at 30 June 2017 but not yet paid.

Ageing of financial assets that were past due but not impaired in 2017

	0 to 30 days $'000	31 to 60 days $'000	61 to 90 days $'000	90+ days $'000	Total $'000
Trade and Other Receivables	**-**	**36**	**-**		**36**
Total	**-**	**36**	**-**	**-**	**36**

5.3 Fair Value Measurement

The following tables provide an analysis of assets and liabilities that are measured at fair value. The remaining assets and liabilities disclosed in the statement of financial position do not apply the fair value hierarchy.

5.3A: Fair Value Measurement	Fair value measurements at the end of the reporting period	
	2017 $'000	2016 $'000
Non-financial assets		
Leasehold Improvements	**521**	-
Plant and equipment	**1,192**	-
Total fair value measurements in the statement of financial position	**1,713**	-
Total assets not measured at fair value in the statement of financial position	**40,770**	-

Accounting Policy

Non-financial assets were revalued at 30 June 2017 by an independent valuer.

6.1 Restructuring

6.1A: Restructuring	2017 Transfer of the My Health Record[47] $'000
FUNCTIONS ASSUMED	
Assets recognised	
Cash	-
Trade and Other Receivables	-
Buildings	-
Plant and equipment	-
Computer software	-
Other intangibles	**48,824**
Other Non-Financial Assets	-
Total assets recognised	**48,824**
Liabilities recognised	
Suppliers	-
Employee Provisions	-
Other Payables	-
Total liabilities recognised	-
Net assets/(liabilities) recognised[48]	**48,824**
Income assumed	
Recognised by the receiving entity	-
Recognised by the losing entity	-
Total income assumed	-
Expenses assumed	
Recognised by the receiving entity	-
Recognised by the losing entity	-
Total expenses assumed	-

The purpose of the Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016 (the Rule) is to establish the Agency. The Agency will be a corporate Commonwealth entity which will be legally separate from the Commonwealth.

47. The fair value of the My Health Record intangible asset was transfered from the Department of Health to The Agency on 1 July 2016.

48. The net assets/(liabilities) assumed from all entities were $48.8 million.

4.0

Financial Statements

Garden City Medical Centre, Brisbane QLD

5.0

Navigation aids

This part assists readers to locate information in the report. It includes an index of annual report content requirements, and a list of acronyms and abbreviations.

Garden City Medical Centre, Brisbane QLD

Annual Report compliance index

Public Governance, Performance and Accountability Act 2013

Requirement	Reference	Pages
Annual Report for Commonwealth entities	Section 46	Throughout
Annual Performance Statements	Paragraph 39(1)(b)	34
Audited Annual Financial Statements	Subsection 43(4)	99
Auditor-General's audit report	Subsection 43(4)	97

Public Governance, Performance and Accountability Rule 2014

Requirement	Reference	Pages
Approval of report by Accountable Authority (Agency Board)	Section 17BB	Letter of transmittal
Parliamentary standards of presentation	Section 17BC	Throughout
Plain English and clear design	Section 17BD	Throughout
Enabling legislation	Paragraph 17BE(a)	18
Legislated objects and functions	Paragraph 17BE(b)(i)	20
Purpose	Paragraph 17BE(b)(ii)	18
Responsible minister	Paragraph 17BE(c)	19
Ministerial directions	Paragraph 17BE(d), (f)	90
Policy orders	Paragraphs 17BE(e), (f)	90
Annual performance statements	Paragraph 17BE(g)	34
Significant issues related to financial compliance	Paragraph 17BE(h), (i)	90
Details and attendance of board members	Paragraph 17BE(j)	74
Organisational structure	Paragraph 17BE(k)	25

Requirement	Reference	Pages
Location	Paragraph 17BE(l)	19
Governance	Paragraph 17BE(m)	71
Related entity transactions	Paragraphs 17BE(n), (o)	90
Significant activities and changes	Paragraph 17BE(p)	90
Judicial decisions or decisions of administrative tribunals	Paragraph 17BE(q)	88
Reports by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	Paragraph 17BE(r)	88
Information from subsidiaries	Paragraph 17BE(s)	Not applicable
Insurance and indemnities	Paragraph 17BE(t)	91
Compliance index	Paragraph 17BE(u)	134
Work Health and Safety Act 2011	Schedule 2, Part 4	92
Commonwealth Electoral Act 1918	Section 311A	93
Environment Protection and Biodiversity Conservation Act 1999	Section 516A	93
My Health Records Act 2012	Section 107	55

Acronyms and abbreviations

Acronym/ Abbreviation	Term
ACSQHC	Australian Commission on Safety and Quality in Health Care
AEHRC	Australian e-Health Research Centre
AMT	Australian Medicines Terminology
CDA™	Clinical Document Architecture
CIS	Clinical Information System
DI	Diagnostic imaging
DVA	Department of Veterans' Affairs
HI Act	*Healthcare Identifiers Act 2010*
HI Service	Healthcare Identifiers Service
HPI-I	Healthcare Provider Identifier – Individual
HPI-O	Healthcare Provider Identifier – Organisation
HPO	Healthcare Provider Organisation
IHI	Individual Healthcare Identifier
MBS	Medicare Benefits Schedule
NASH	National Authentication Service for Health
NEHTA	National E-Health Transition Authority
NIO	National Infrastructure Operator
PBS	Portfolio Budget Statements
PKI	Public Key Infrastructure
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners

5.0

Navigation aids

Australian Government

Australian Digital Health Agency