Australian Government
Australian Digital Health Agency

# Annual Report 2018 – 19

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Australian Digital Health Agency
Annual Report 2018–19

**Acknowledgements**

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# Guide to this report

This annual report describes the operations and performance of the Australian Digital Health Agency (the Agency) during 2018 – 19. The report was prepared in accordance with legislated reporting requirements under the *Public Governance, Performance and Accountability Act 2013 (PGPA Act)* 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 2018–19, and priorities for 2019 – 20.

### Part 2 – Performance

Details the Agency's performance against work plan priorities captured in its ***Corporate Plan 2018 –19*** and against ministerial targets published in the Health Portfolio Budget Statements (PBS) 2018–19. 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 2018 –19.

### Part 5 – Navigation aids

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

# Letter of transmittal

Australian Government
Australian Digital Health Agency

30 September 2019

The Hon Greg Hunt MP
Minister for Health
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Digital Health Agency, I am pleased to present our annual report for the period 1 July 2018 to 30 June 2019.

The Agency was established on 30 January 2016, following registration of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2017, and commenced operations on 1 July 2016. The report reflects on our third 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), audited financial statements as required by subsection 43(4) of that Act and new reporting requirements introduced in 2019 concerning executive remuneration and the management of human resources.

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.*

In accordance with sections 68 and 69 of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2017, the Agency will notify each state and territory health minister of the availability of the report, and provide a copy on request.

Yours sincerely

Dr Elizabeth Deveny
Chair
Australian Digital Health Agency

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# Contents

# Chair's message

On behalf of the Australian Digital Health Agency Board I would like to recognise the immense efforts of everyone who has worked with us over the past year and extend our thanks to all of the Agency's staff for their achievements, dedication, and resilience.  I am especially honoured to Chair the Agency's Board and would like to acknowledge the work of the previous Chair, Jim Birch, and our outgoing Board members [Robert Bransby, Dr Eleanor Chew, Stephanie Newell, Michael Walsh, Professor Johanna Westbrook] all of whom were pivotal to the achievement of the Agency's goals over the past year. Australia's health system is consistently ranked among the best in the world in international studies, something that we should be both proud of and greatly reassured by. Moreover, our digital health initiatives lead the world in many respects.

My Health Record is now a fundamental feature of Australia's health infrastructure, a resource that clinicians and consumers will increasingly rely on in clinical workflows and personal health management. The expansion and transition of My Health Record is but the start of the journey for the Agency, there are a number of foundational steps outlined in the National Digital Health Strategy yet to be realised. We will need continued focus as we build the next pieces of national infrastructure and further strengthen our partnerships. Technology has the capacity to improve safety and convenience, while at the same time reducing health inequalities by extending these capabilities to communities that have been hard to service by conventional methods. Our challenge is to ensure that in building these technical foundations, the consumer's experience of care remains the touchstone for all our collective efforts.

A collaborative and open approach has always characterised the Agency's major endeavours, and this would be an appropriate time to reaffirm that commitment. Quality and safety are cornerstones of effective healthcare, and these traits are fostered and sustained by open, honest conversations and transparent environments. We will continue to be open to conversations, open to new challenges, open to opportunities and open to new ways of thinking.

It would be a disservice to this spirit of openness to not acknowledge that this transition has been accompanied by far more controversy than anticipated, but we have listened. The community has spoken and said that it wants better health outcomes enabled by technology. A raft of digital enablers will follow from these initial steps towards the digital enhancement of health and care, further enhancing the benefits for all Australians. Once again, I wish to extend my heartfelt gratitude to all our staff and stakeholders who have supported us so far, and welcome new voices to the ever-developing national conversation on digital health. We are still in the early days of transformation, but the broad outlines of an equitable, accessible and better future are coming into view.

**Dr Elizabeth Deveny**
Chair

# Chief Executive Officer's review

*Earlier this year a patient presented at the Emergency Department of the Royal Perth Hospital and collapsed at the Triage desk. 'The patient had a fluctuating conscious state, was profoundly hypotensive with a sporadic heart beat and was not able to give any medical information,' said Tiffany Graham, clinical nurse in the ED. 'Staff were able to view the patient's My Health Record and found a discharge summary from another hospital, as well as access the patient's most recent Pharmaceutical Benefits Scheme (PBS), which showed he had recently been dispensed quite a large volume of one particular drug. Staff suspected the patient may have overdosed on this medicine and after consultation with on-call toxicologists were able to commence treatment based on this information. We wouldn't have been able to access that information without My Health Record. It's such an important resource to us.'*

**2018 - 19 is the third year of the Agency's operations. Our first year focussed on rebuilding momentum in digital health, and our second on design and delivery in collaboration with partners across the community. Our third year has seen successful implementation of key national digital health strategy priorities to support improvement in health outcomes for all Australians.**

**Strategic Priority 1:
My Health Record**

## National Expansion to 90% of Australians

On 22 February 2019, My Health Records were created for 90% of Australians – providing people and their care professionals with online access to key health information. Leanne Wells, chief executive of the Consumers Health Forum of Australia, commented:

> *"The Consumers Health Forum has for some years strongly supported a secure national health records system because of the potentially great benefits it offers consumers and health providers."*

Dr Chris Moy, President of the Australian Medical Association in South Australia, said

> *"My Health Record is a game changer in providing a health provider with immediate access to key information about the individual's medical history. It will reduce harm caused by medicine errors because people and their healthcare providers will have access to important information about medicines and allergies. This could save your life in an emergency."*

In July 2018, the Agency and its delivery partners – including state and territory governments, primary health networks. Aboriginal and Torres Strait Island health and medical services and clinical and consumer peak bodies – launched a major national communications initiative to make Australians aware of their right to opt out of My Health Record, if they wished to. This prompted an important national debate which raised concerns about the privacy and security of My Health Record. The government listened to those concerns and introduced new legislation to strengthen protections.

## Supporting effective clinical use

Alongside public communications, the Agency and its partners continued to support clinical professionals to use My Health Record most effectively. All general practices, pharmacies and Aboriginal Medical Services were provided with training during the course of the year while jurisdictional health and hospital services accelerated programs of education for their clinical staff. Specific programs have been launched to support effective use in public hospital emergency departments in partnership with the Australian Commission in Health Care. A key priority for the Agency and its partners in the next financial year is to finalise a comprehensive strategy for ongoing clinical education and its extension to support professionals in specialist medicine, aged care, end of life care and mental health. We have also launched a Communities of Excellence initiative with a particular focus on remote and rural Australia to support clinical providers in all the facilities make best use of My Health Record – for example, in Palm Island.

## Improving access to key clinical information

A major focus has been to improve access to clinical information in My Health Record. By June 2019, more than 1 billion documents had been uploaded. There has been a significant increase in the number of providers uploading documents. More than 75% of public hospital beds are connected and uploading; 60% of pathology services are connected with almost all public providers uploading; and the imperative of medicine safety has led community pharmacy to be the largest adopter in the last 12 months with over 80% of community pharmacies registered and more than 60% connected to view and contribute to My Health Record.

**Strategic Priority 2:
Secure messaging**

In 2018 - 19 we developed national standards to address gaps in existing interoperability standards for secure messaging. Industry agreement on solution architecture for interoperable messaging and distributed directory has enabled the delivery of two proof-of-concept projects initiated with vendor-led consortiums to refine and implement standards.

Dr Nathan Pinskier, past chair of the Royal Australian College of General Practitioners (RACGP) Expert Committee on eHealth, said:

> *When I call someone on my mobile phone, I don't need to know which service provider or which handset or which operating system they are using. Secure clinical messaging must have a comparable level of ease, transparency and interconnectivity. The new community agreed and developed interoperable solutions architecture is a major step forward in resolving these issues. The focus now needs to shift to broad health sector implementation, adoption and usage".*

The Agency has launched the National Out of Hospital Care Collaborative, led by South Australia, to deliver the first region in Australia using secure messaging that implements the interoperability standards, with a view to a national model for Australia in 2020.

### Strategic Priority 3: Interoperability

In 2018 - 19, the Agency launched a national consultation to develop an Interoperability Roadmap for Australia. The National Interoperability Program has been established to bring forward to COAG Health Council a roadmap to interoperability in 2019 – 20. Since January 2019, the Agency has held 15 co-design workshops across Australia, 33 community meetings and multiple jurisdictional working groups with every jurisdiction and facilitated online contributions through the *Better Connections: Your health, your say* website.

Interoperability has been defined by the Global Digital Health Partnership[1] as:

> *The ability of a system or product to transfer meaning of information within and between systems or products without special effort on the part of the user. Interoperability is made possible by the implementation of standards.*

Graham Grieve, a leading Australian health technologist, said:

> *We know that the health system is fragmented. That means that there's gaps between the fragments. And those gaps become chasms that people fall into, and can't get out of.*

### Strategic Priority 4: Medicines Safety

In 2017 the Medicines View document was made available in the My Health Record. It aggregates all relevant medicines and allergy data in a single view in real time and is now the most viewed document type in the system. Following this success, the Pharmacist Shared Medicines List (PSML) document type was released in 2019 to further improve curation of medicines information in My Health Record.

Dr Chris Freeman, President, Pharmaceutical Society of Australia said:

> *We know that you're almost four times more likely to be admitted to hospital from a medicine related problem than you are a road traffic accident. Tools like the Pharmacist Shared Medicine List will allow pharmacists to engage with other health professionals to ensure that we have up to date and accurate information around the person's medicines to make better decisions."*

1. The Global Digital Health Partnership is a collaboration of 25 countries, together with the World Health Organisation. Australia was inaugural chair until February 2019. More information is available at www.gdhp.org



### Strategic Priority 5: Enhanced Models of Care

The National Children's Digital Health Collaborative, which was launched last year, is continuing to co-design the Child Digital Health Record. The first proof of concepts for a national digital baby book will go live in NSW in 2019 – 20.

Dr Michael Brydon, a paediatrician and advocate for the Collaborative, said:

> *The Collaborative is exploring how every child in Australia can have the option of a comprehensive digital health record from the time they are conceived, through those critical first years and adolescence; readily accessible by parents and healthcare providers and ultimately for that individual throughout their life. This will be of enormous value – not only to healthcare professionals providing care to those children – but to the children themselves as they become young adults and start making decisions about their own health and care."*

### Strategic Priority 6: Workforce and Education

The Agency has continued to support the new CXIO network with more than 200 clinicians actively engaged. The Australasian Health Informatics Fellowship Program (AHIFP) has again seen the Agency sponsor its own fellow and offer opportunities to progress careers in health informatics and CPD-accredited digital health modules for GPs and pharmacists.

Dr Louise Schaper, CEO of the Health Informatics Society of Australia, said

> *"The CXIO Network is a welcome opportunity to not only contribute from the digital health experiences I have gained but also broaden those experiences from connecting and working with an expert team of other clinicians who work in the digital health space."*

In 2019 - 20, the Agency will deliver a workforce roadmap, bringing together the workforce education activities occurring across jurisdictions, tertiary and secondary education, and health services education to support better coordination and collaboration to support a health workforce confidently and safely using technology to deliver better care.

# Case study: **My Health Record lends a hand in Townsville floods**

Townsville, in Far North Queensland, is no stranger to cyclones, but the flood that struck in February 2019 was in some respects harder to manage because of its prolonged effects. Paul Willis, a Townsville-based pharmacist, told ABC Radio that during this extended period, his pharmacy relied on My Health Record to provide care to many displaced people who were cut off from their usual healthcare providers and therefore unable to access their prescriptions via familiar channels.

> *"[This was] a new experience for us, absolutely, patients that we've never seen before that we had no record of on our normal dispense systems and so we leant very heavily on My Health Record to understand their medication profiles and determine what we could actually give them safely as normal doses are or as emergency doses until they could get to a doctor in the next day or two."*

By fortunate coincidence, Townsville residents already have high rates of My Health Record usage as a result of participating in "opt out" trials in 2016.

> *"All of the patients had medicine profiles established we had I think at the time, nearly two years' worth of data that had been uploaded to My Health Record. All of the pharmacies, their [major] software providers and even some of the smaller software providers had already completed integration of My Health Record into our dispense software, so the businesses were well prepared. The data was available and we're in a very fortunate position because we were in that initial trial we were one of the two trial regions for My Health Record."*

This access to medicines information became a significant source of comfort to many displaced people who lacked access not only to their medicines, but to information about them.

> *"It was I think it was quite reassuring for many patients, we had bus loads of patients turning up from evacuation centres who hadn't slept … We set up a brew point for tea and coffee, but many of these patients weren't waiting two to five minutes for a script anymore at the pharmacy they were curling up in a quiet corner of the pharmacy and resting or getting some sleep waiting their turn. And when it was their turn we got patients presenting that didn't know what medicines they were on.*
>
> *We were able to trace [their medications] and then confirm it against a My Health Record profile that was available to us. And then when you see us work it out with a very high level of confidence, you can imagine those patients who were still in damp clothes, in a state close to shock or actual shock. And that is a very reassuring thing to be able to do, [to say] 'No don't worry we know exactly what you're on we can sort it all out for you'."*
>
> *"My Health Record was certainly a very valuable part of the health system that minimised distress, minimised discomfort, and it minimised harm that could have occurred through medicine error or their absence of access to medicine so it turned out to be a very important part of the health system during our flood crisis."*

Credit: This case study uses content derived from ABC Radio North Queensland interview on 7 Aug 2019. https://www.youtube.com/watch?v=UeWWXXsUJJ0

### Strategic Priority 7: Driving Innovation

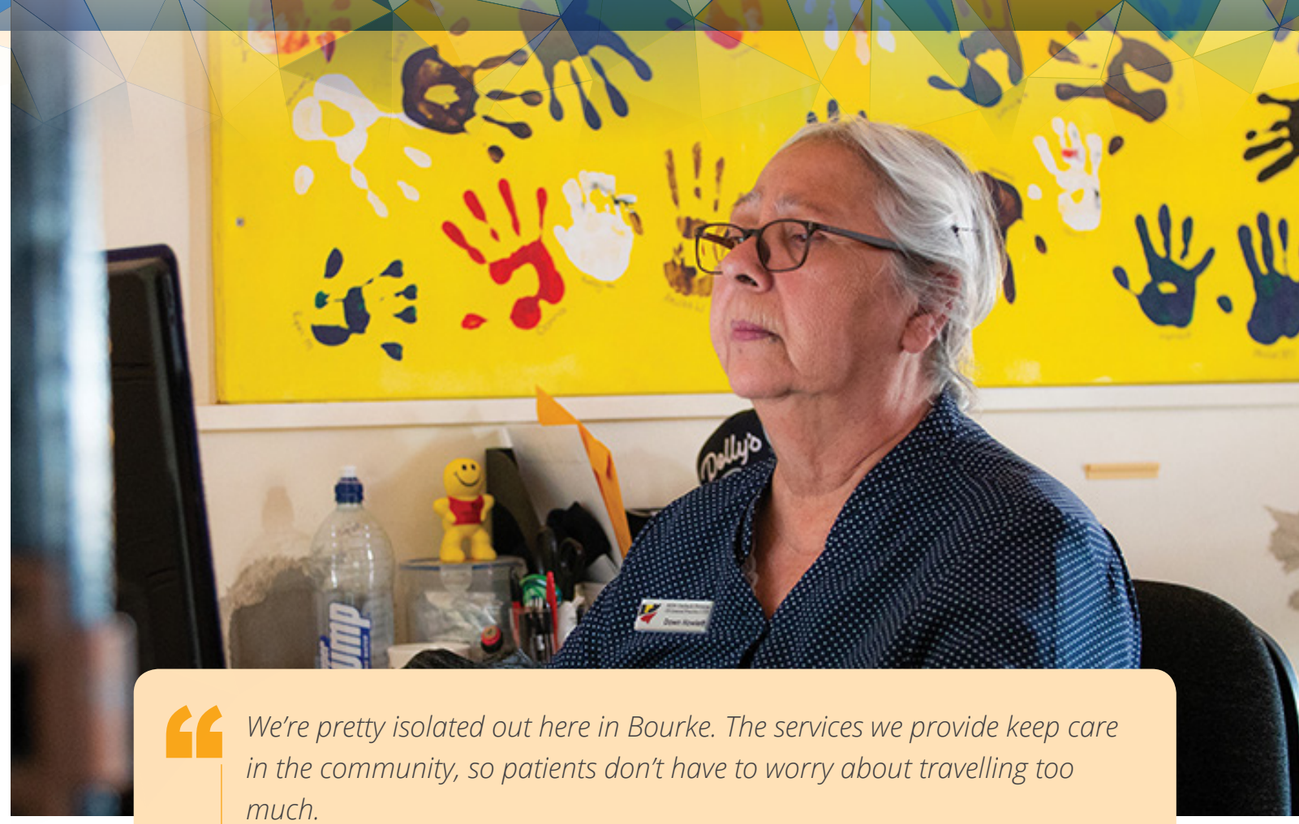
Fifteen new digital health test beds focused on using national infrastructure such as My Health Record, coupled with research, to deliver new innovative models of care, have been commissioned. In 2018 - 19, the Agency has continued development of its developer program, supported through an online developer portal and industry software roadmap. The Agency has also continued work on the My Health Record mobile program supporting a national review of mHealth initiatives and a national approach to safe and efficacious mHealth apps.

### The Australian Digital Health Agency: a collaborative, open culture

Since the Agency was established, the first priority has been to support our high-performing team to develop a collaborative, open culture focussed on our outcomes and on managing our resources as effectively and efficiently as possible, regularly reassessing our values and reflecting on how we can best contribute to the improvement of health outcomes for Australians. We conducted an organisational review this year and instituted new approaches to engaging all members of the team in improving the ways we work together and with our partners in the community.

I would like to thank the governments of Australia, our partners in the community and, most importantly, the Agency's own staff for their dedication, hard work and passion in improving ways in which data and digital technology can support the health and wellbeing of all Australians.

**Tim Kelsey**
Chief Executive Officer



*We're pretty isolated out here in Bourke. The services we provide keep care in the community, so patients don't have to worry about travelling too much.*

*Through all the years that I've worked in Aboriginal health and in nursing, we were always told that our lifespan was shorter than the average Australian. So keeping on top of chronic disease management is important. That's why I like My Health Record – it's ideal for chronic disease management.*

*My Health Record is vitally important to me so I like to get that across to my patients. I use it myself and explain why I'd like them to consider it.*

*We're a pretty transient mob of people – we're a family of extended families. We could be living in Canberra next week or we could be up on the Gold Coast because we have relatives all over the place. To have My Health Record follow us around would be great.*

*If someone collapsed somewhere and was rushed to hospital where nobody knew them, it could be looked up on My Health Record. The help will be much quicker. It could save lives."*

**Dawn Howlett -** Aboriginal Health Practitioner
Bourke New South Wales

https://www.myhealthrecord.gov.au/news-and-media/my-health-record-stories/healthcare-vital-for-remote-community

This part provides a view of the Agency at a glance, an overview of the Agency's purpose, role, strategy and functions, and an outline of the path ahead.

# 1 Introduction and overview

## 1.1 The Agency at a glance

### Purpose

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.

### Focus

The Agency's focus is on engagement, innovation, quality and clinical 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 improving health outcomes for Australians through the delivery of digital innovation, health systems and services.

### Enabling legislation

The *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* (Agency Rule)[2] created the Agency and governs its operations. The Rule was made by the Commonwealth Minister for Finance under Section 87 of PGPA Act[3] which allows for the creation of Commonwealth corporate entities. The Agency is the first in the Commonwealth to be established by this new mechanism.

### Delivery priorities for 2018 – 19

The Agency's 2018 – 19 Operational Plan, produced in accordance with requirements of the Agency Rule, prioritised the following programs of work:

- Medicines safety
- My Health Record — expansion and enhancements
- My Health Record — connections
- Interoperability and data quality
- Secure messaging
- Digitally enabled new models of care
- Corporate projects

These priorities were published in the Agency's Corporate Plan 2019 – 20,[4] and performance against each priority is captured in **Part 2** of this report.

### Inherited functions – My Health Record System Operator

The Agency became the My Health Record System Operator on 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.

### 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 identity from the Commonwealth.

Information about our governance, management and accountability frameworks is covered in **Part 3** of this report.

2. https://www.legislation.gov.au/Details/F2016L00070
3. https://www.legislation.gov.au/Details/C2017C00269
4. Corporate Plan, https://www.digitalhealth.gov.au/about-the-agency/corporate-plan

### Board as an accountable authority

An 11-member Board, chaired by Dr Elizabeth Deveny, is the accountable authority of the Agency. As accountable authority, the Board sets the objectives, strategies and policies[5] for the Agency and is responsible for the proper and efficient performance of the Agency's functions[6].

### 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 Agency Rule:

- Digital Health Safety and Quality Governance Committee[7]

Another is compulsory under the PGPA Act:

- Audit and Risk Committee

### Inter-jurisdictional

The Agency operates under an intergovernmental agreement between members of 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.

### Funding 2018–19

The Agency is jointly funded by the Commonwealth ($256.812 million) and the states and territories ($30.220 million) reflecting the commitment at all levels of government to the delivery of digital health reform.

5. Section 14(a) of the Agency Rule.
6. Section 14(b) of the Agency Rule.
7. Disbanded on 11 April 2019.

### 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
- National Clinical Terminology Service (NCTS) including Australian Medicines Terminology (AMT) and SNOMED CT–AU
- 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.

### Portfolio and ministerial oversight

The Agency sits within the Health portfolio and is accountable to the Commonwealth Minister for Health, the Hon. Greg Hunt MP. The Agency also reports to state and territory health ministers through the Council of Australian Governments (COAG) Health Council.

### Our people and their location

At 30 June 2019, the Agency had 242 staff (permanent and temporary) working from offices in Brisbane, Sydney and Canberra.

### Financial outcome

- Operating loss: $22.712 million
- Operating revenue: $259.760 million
- Operating expenses: $282.472 million

The Agency's financial performance, and Australian National Audit Office (ANAO) audited financial statements are presented in **Part 4** of this report.

## 1.2 Overview of the Agency

### 1.2.1 Role

The Agency is the accountable organisation for progressing 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[8], are:

1. to coordinate, and provide input into, the ongoing development of the National Digital Health Strategy;
2. to implement those aspects of the National Digital Health Strategy that are directed by the Ministerial Council;
3. 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;
4. 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;
5. to develop, monitor and manage specifications and standards to maximise effective interoperability of public and private sector digital health systems;
6. to develop and implement compliance approaches in relation to the adoption of agreed specifications and standards relating to digital health;
7. to liaise and cooperate with overseas and international bodies on matters relating to digital health;
8. such other functions as are conferred on the Agency by the Agency Rule or by any other law of the Commonwealth; and
9. to do anything incidental to or conducive to the performance of any of the above functions.

The Agency's responsibility includes the role of the My Health Record System Operator (the System Operator), which transitioned from the Department of Health to the Agency on 1 July 2016.

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, and the Chief Executive Medicare, Services Australia.

### 1.2.2 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 take into consideration 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 consumers 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.
- **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 use of taxis for official purposes, a policy of economy fares for all domestic travel and high compliance with best fare of the day flights – we are building a culture to "think like a patient, act like a taxpayer".

8. See https://www.legislation.gov.au/Details/F2016L00070

> ***"Please do not send letters, documents or messages via fax"***
>
> *This Adelaide-based based GP, academic, and recent long serving member of the RACGP Expert Committee on eHealth and Practice Systems has taken a stand against the use of archaic paper records and fax machines by requesting that other clinicians only use secure clinical messaging or telephone to reach him.*
>
> **Q: How long have you been refusing faxes at your practice, and what motivated you to take this stand?**
>
> *"My letterhead has featured a request to use secure messaging for at least a couple of years. Over time, I've gradually made that request stronger and stronger each time I update my letterhead."*
>
> *"Our clinic already runs a fully electronic clinical and administrative records system, so we don't write on paper except when other people require us to. We don't keep any paper records, and we don't want anyone else sending us paper documents or faxes."*
>
> *"Faxed images are particularly crazy. The image quality is already degraded by the fax, and then it gets scanned into a digital system for storage, further degrading the quality. And the irony is that these images are often produced by digital systems in the first place! The whole exercise is a terrible waste of time and effort, as well as giving you poor quality legibility."*
>
> **Dr Oliver Frank**
> MBBS PhD FRACGP FACHI

### 1.2.3 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 its own set of complementary values. In 2018–19 the Agency refreshed its values and worked to embed them in a behaviours framework, in both policies and practice, to support the Agency's strategic direction:

**Working together**

We get our best results working collaboratively – this is how we excel.

**Respect and trust**

We care about each other and we treat everyone in a way that we would want to be treated. We know with conviction that we can rely on each other because it is only together that we can achieve greatness.

**Transparent**

We share our knowledge and our skills because, when we work in an open and frank way, we demonstrate that we trust and respect each other.

**Accountable**

We are all accountable for living our values and taking responsibility for our actions. When we think this way, we will always be focusing on doing things that are right and good.

**Innovative**

We seek to understand new and different ways to improve delivery and performance for digital health.

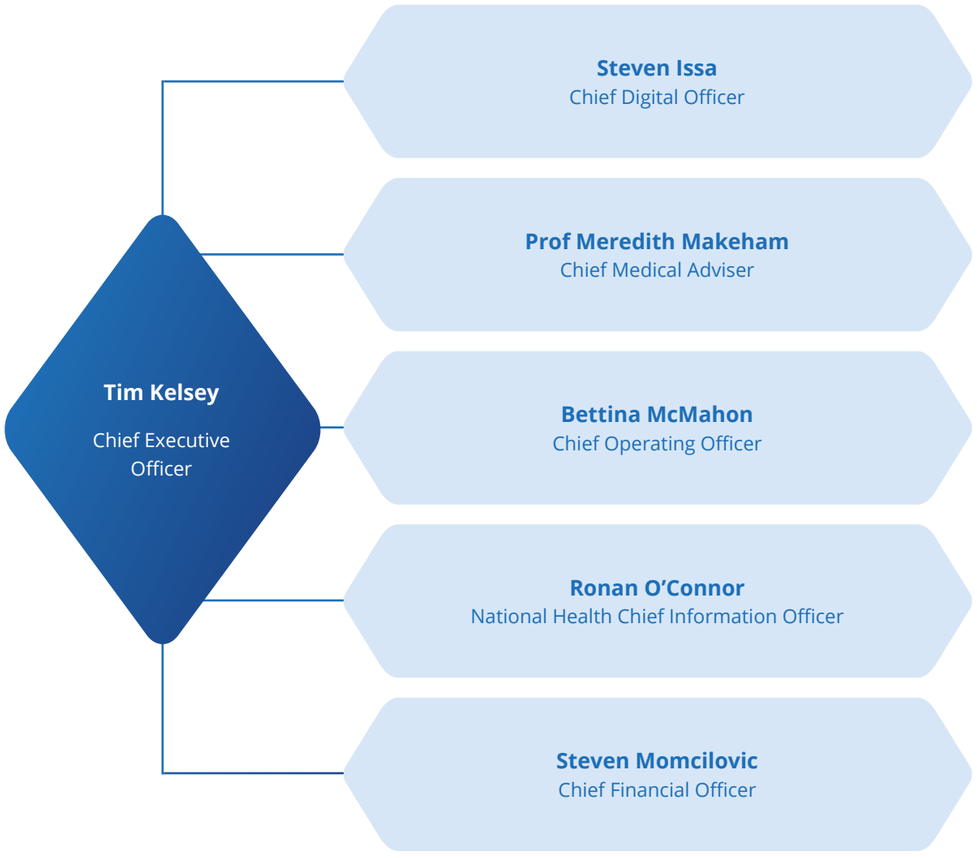
### 1.2.4 Structure

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.

In September 2018, two years into operations, the Agency revisited its organisational design – consolidating senior positions and integrating and prioritising disparate functions – in anticipation of scaling back operations at the conclusion of the national opt out period, and shifting to an operating model that put a greater focus on service delivery.

**Management team**

The Chief Executive Officer (CEO) of the Agency, Tim Kelsey, is responsible for the overall management of the Agency. He is assisted by an Executive Leadership Team as depicted in the following figure:




**The Executive Leadership Team lead the following divisions:**

**Architecture, Design and Strategy Division**
***Core functions***

- Digital strategy and planning
- Architecture and user experience
- Policy and privacy
- Benefits and research
- Data catalogue and governance
- Terminology and tooling

**Clinical Advisory, Safety and Quality Division**
***Core functions***

- Clinical governance
- Research advisory
- Clinician and consumer safety and quality
- International relations and horizon scanning

**Office of the Chief Operating Officer**
***Core functions***

- Programs and work plan development
- Promoting use in clinical practice
- Corporate services minus Information and Communications Technology (ICT)
- Developer program

**Finance Division**
***Core functions***

- Statutory Chief Financial Officer duties
- Financial transaction and reporting services
- Budget and planning including workplan

**Infrastructure Operations Division**
***Core functions***

- Strategic Service Design and Delivery
- Communications and Community Engagement
- Technology Delivery and Projects
- Operations
- Information Technology and Cyber Security

These divisions are supported by the **Office of the CEO**, which also supports the CEO's internal and external activities, and stakeholder management.

# Case study: **Mums and dads help to shape National Children's Digital Health Collaborative**

My Health Record, along with other existing national digital health infrastructure such as healthcare identifiers and clinical terminology, will be utilised in a bid to make Australia the best place in the world to raise healthy children and young people, and to be raised. This is the vision of the National Children's Digital Health Collaborative, a partnership between eHealth NSW, the Sydney Children's Hospitals Network, and the Australian Digital Health Agency.

Patients, carers and families are at the heart of the Collaborative's exploration of how digital health technology can improve the health and wellbeing of children and young people living in Australia. Their involvement is helping to ensure that the voice of the consumer is central in the design of all of the Collaborative's digital health initiatives, alongside the voice of clinicians and other key stakeholders.

> *"This is such an exciting initiative, and I'm thrilled to be able to contribute my thoughts and ideas to the design of digital solutions and tools that will ultimately impact on my child's development throughout his life," said Shantelle Rennie, a first-time mother of three-month-old Harrison, from East Gosford in NSW. "I am all for anything that makes it easier to keep track of this important information about my child's health and wellbeing."*

https://www.digitalhealth.gov.au/news-and-events/news/mums-and-dads-help-to-shape-national-children-s-digital-health-collaborative

## 1.2.5 Products and services

Upon its establishment, the Agency inherited a range of products and services from those entities who previously performed some of the Agency's functions, which have been added to and enhanced through a range of new initiatives.

These products and services are referred to collectively as the national infrastructure and constitute Australia's digital health foundations. Operating and maintaining this infrastructure is a core activity for the Agency.

In 2018–19, the national infrastructure consisted of the following initiatives:

### My Health Record

My Health Record is a secure digital summary of an individual's health information, stored in one place. It's available when and where it's needed and can be accessed by individuals and their healthcare providers, offering seamless sharing of information.

The secure sharing of digital health information has many benefits, including reducing hospital admissions and the duplication of pathology tests. It can also improve overall medicine safety and even save lives.

Seven health system benefits and two economic benefits are summarised in the figure below.





### My Health Record benefits

**Benefits for the health system**

**Quality use of medicines –** The MHR will support a reduction in hospital admissions that result from ADEs caused by medicine errors. The MHR will also facilitate de-prescribing of medicines.

**Reducing unnecessary testing duplication –** The MHR will promote efficiency in pathology and diagnostic test requests that are required, resulting in a reduction in duplicative testing.

**Enhanced integrated and coordinated care –** The MHR supports the integration of care across a patient's care pathway as a piece of information infrastructure.

**Empowering patient self-management –** The MHR will support patient self-management post-discharge and will reduce the risk of readmission.

**Facilitating end of life care preferences –** This benefit highlights the MHR potential to facilitate appropriate advanced care support for those who need it.

**Promoting efficient information use and data creation –** Clinical cohorts have adopted, or are adopting, MHR as information support. Depending on maturity of each cohort, the MHR will support a reduction in administrative burden resulting in time savings, and future data and information creation.

**Emerging healthcare benefits –** over the next 10 years, health sectors including genomics, medical devices and registries will improve the ways in which care is delivered and treatment provided from the use of MHR.

**Economic benefits**

**Productivity benefits –** The MHR will increase the productivity of an individual through reducing the time spent in care and in poor health, and increasing the ability to work and spend time with family and friends.

**Digital health market creation –** There is economic value in leveraging MHR to stimulate the digital market place to create new technology, applications and supporting interfaces.

Source: PwC. MHR benefits modelling results. Final. March 2019

Australia is one of the first countries to implement a personally controlled electronic health system of this kind.

In 2018 every Australian aged over 14 years was given the choice to have a My Health Record or to opt out.

### 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.

### 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 and 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.

### National Authentication Service for Health

The NASH is a service to support healthcare providers and organisations in securely accessing and sharing health information. The 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.

### 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 over 413,000 products from more than 500 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.

### Australian Medicines Terminology and SNOMED CT-AU

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

The NCTS publishes monthly updates of SNOMED CT-AU (the Australian extension of SNOMED CT), which incorporates the AMT. These updates ensure that medicines content remains current with the Therapeutic Goods Administration and the Pharmaceutical Benefits Schedule, as well as continually enhancing clinical content such as diagnoses, allergies, adverse reactions, procedures and results, supporting a shared meaning among the creators and users of health data.

The NCTS now also hosts FHIR code systems and FHIR value sets on the National Terminology Server to support the Agency clinical information specifications and FHIR profiles developed in the community.

### Clinical document 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.

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 Clinical Terminology program supports the ability to use a standard mechanism for describing data shared between healthcare providers.

### 1.2.6 The path ahead — outlook for 2019 – 20

- Co-design a national technology alignment program to place Australia at the forefront of digital health innovation.
- Launch the national goals of care collaborative to facilitate uploading of advance care planning documentation to My Health Record supporting end of life care.
- Trial and evaluate proofs-of-concept for the Child Digital Health Record, Digital Pregnancy Record and Child Digital Health Checks.
- Develop architecture and implement the National Provider Addressing Service and service registration assistant to enable seamless, safe and secure addressing.
- Deliver a roadmap for digital health interoperability in Australia and operationalise a community standards development model to enhance data interchange between disparate clinical information systems.
- Deliver a National Digital Health Workforce and Education Roadmap which will set out a pathway to achieve our goals in the National Digital Health Strategy.

**The diagram below outlines the areas of focus for 2019–20.**

| My Health Record | Secure Messaging | Interoperability and Data Quality | Medicines Safety | Enhanced Models of Care | Workforce and Education | Driving Innovation |
|---|---|---|---|---|---|---|
| Product Development (e.g. Path viewer) | Provider Addressing Service | National Interoperability Roadmap | Pharmacist Shared Medicines List | National Children's Digital Health Collaborative | Workforce and Education Roadmap | Developer Portal Refresh |
| Strategy, Research and Development | Industry Alliance, Participation and Adoption | Community Standards Development Model | Electronic Prescribing of Medicines | National Goals of Care Collaborative | Digital Health Curriculum - Maturity Model | National Infrastructure Integration Toolkit |
| Policy and Legislation | User Awareness, Education and Adoption | Privacy Framework and Security Protocols | Digital Medicines Program Blueprint | Specialist MHR Connection and Use | Undergrad/Vocational/ CPD Programs | Developer Partner Consultation and Survey |
| | National Messaging Strategy - Inter Gov Exchange | National Minimum Content Development | Meds Decision Support in Transition of Care | Out of Hospital Care | Targeted Projects to Support Education and Use | Innovation Spotlight Series |
| | | Mobile Health Framework | | Ongoing MHR Connection and Use | | |

| Business Improvement Activities | | | | | | |
|---|---|---|---|---|---|---|
| Organisational Excellence | Integrated People Management | Recruitment and Onboarding Improvements | Financial Management Enhancements | | ICT Improvements | Electronic Records Management |
| | PMF Adoption and Project Online Implementation | Agency-wide Training, Development and Leadership | | | CRM Improvements | People and Culture |

| National Health Infrastructure Support Costs | |
|---|---|
| Business Streams | Foundation Systems and Support |
| | Data Management, Informatics, Benefits and Research |
| | Clinical, Engagement and Education (Including Communication and Awareness) |
| | Business Enabling |

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 2018 – 19 and in the Health Minister's Portfolio Budget Statements 2018–19. It also addresses My Health Record System Operator reporting requirements under the My Health Records Act 2012.

# 2 Performance

## 2.1 Annual performance statement

### Statement of preparation by accountable authority

On behalf of the Board, I present the 2018–19 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.

**Dr Elizabeth Deveny**

Chair

14 October 2019

## 2.2 Performance against our purpose

The annual performance statement provides an assessment of the Agency's performance against its purpose. It presents the annual **work plan** priorities published in the Agency's **Corporate Plan 2018–19**, clarifies their contribution to the Agency's purpose, and reports on the results produced from the Agency's third 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 (PBS) 2018–19**.

## 2.3 Performance targets from the Portfolio Budget Statements 2018–19

The Agency's performance targets for 2018–19 are first articulated in the Minister for Health's PBS, published in the 2018–19 Budget and restated in the Agency's ***Corporate Plan 2018 – 19***, published in August 2018. Both documents tie performance targets to the seven (7) priority outcomes of the National Digital Health Strategy[9] aimed at delivering the benefits of digitally enabled innovation to patients, carers and healthcare professionals.

They capture *planned performance* by the Agency. *Actual performance* is reported in the table below, including the location of the targets in the PBS and Corporate Plan (CP) to allow line of sight between what was intended, and what was in fact delivered. Where the Agency has fallen short of full delivery of targets, an explanation is provided in support.

| Pillar of National Digital Health Strategy | Performance criteria | 2018 – 19 target | Achieved | OUTCOME by 30 June 2019 |
|---|---|---|---|---|
| **Health information that is available whenever and wherever it is needed** | Deliver a national opt out model for the My Health Record and enhance the system to improve participation, usage, content and engagement with the service. | Deliver a national opt out model for the My Health Record by 31 December 2018 (extended until 31 January 2019), and release a minimum of two upgrades to the system to increase content, improve the end user experience, mobile access, management of family records, allergies, medicines view, and access controls.<br>Source: PBS p202 CP p17 | Target met | Delivered a national opt out model for the My Health Record system by 31 January 2019, including:<br>♦ multiple releases in support of opt out initiatives and<br>♦ legislative changes in December 2018 to strengthen the safety and privacy protections of the system. |
| | Increase My Health Record system adoption by public and private hospitals. | Connect an additional 30 public hospitals and 15 private hospitals to the My Health Record.<br>Source: PBS p202 CP p17 | Target met | A total of 32 additional public hospitals and health services and 18 additional private hospitals were connected. |

9. National Digital Health Strategy – Safe, seamless and secure: evolving health and care to meet the needs of modern Australia: https://conversation.digitalhealth.gov.au/australias-national-digital-health-strategy

| Pillar of National Digital Health Strategy | Performance criteria | 2018 – 19 target | Achieved | OUTCOME by 30 June 2019 |
|---|---|---|---|---|
| **Health information that is available whenever and wherever it is needed** | Establish foundation sources of pathology and diagnostic imaging reports in the My Health Record with key implementation partners from public hospital networks and the private sector. | Six States and Territories, and more than 60% of private pathology labs and 10% of private diagnostic imaging practices connected and sharing reports with the My Health Record.<br>Source:<br>PBS p202 CP p19 | Target partially met | All states and territories were connected and sharing reports with My Health Record from inpatient settings.<br>Nationally 41% of private pathology labs (not 60% as targeted) were connected to the My Health Record.<br>20% of private diagnostic imaging practices connected and shared reports with the My Health Record – exceeding the 2018–19 target.<br>Extensive engagement with private sector pathology and diagnostic imaging providers continued throughout 2018–19, supporting providers with their connection and software upgrade challenges, as well as negotiating with several larger organisations regarding their willingness to participate, which accounted for the shortfall in private pathology participation. |
| | Maintain availability of the My Health Record system. | Maintained availability 99% of the time (excluding planned outages).<br>Source:<br>PBS p203 CP p19 | Target met | Maintained availability 99.65% of the time. |
| **Health information that can be exchanged securely** | Establish a trustworthy, seamless process for a message to flow securely from one provider to another and over time to consumers. | Establish a federated provider directory and information exchange trust framework to support information exchange and implement specifications and guidelines and extend use of interoperable messaging from initial sites.<br>Source:<br>PBS p203CP p20 | Target partially met | The Agency secure messaging program coordinated activities across industry, government and clinical peak stakeholders to design and implement a range of interoperable solutions that support widespread improvements for consumer and clinical communications. Key deliverables through industry working group forums included agreement on specifications supporting federated provider directory services, a national trust framework and standardisation of message payloads.<br>The result of these co-developed innovations allows healthcare providers to find each other and exchange clinical information in real time.<br>This foundational work has been the result of sustained engagement with industry. While the ongoing discussions have meant the development of an appropriate solution has been prolonged, meaningful progress towards delivering a federated provider directory service has been achieved – providing the platform for improved continuity of care through increased information exchange across care settings.<br>In March 2019, the Agency launched an industry engagement and enablement strategy to the software community to implement agreed standards that support wide-scale consistent approaches to secure messaging. Over 42 secure messaging vendors are developing this enhanced functionality to be delivered in 2019 - 20. |

| Pillar of National Digital Health Strategy | Performance criteria | 2018 – 19 target | Achieved | OUTCOME by 30 June 2019 |
|---|---|---|---|---|
| **High-quality data with a commonly understood meaning that can be used with confidence** | Strengthen and improve the tools for digital interoperability in the Australia health sector. | Broaden consultation on interoperability Roadmap and agree timeframes and targets for implementation. Develop an interoperability Roadmap for Australia.<br>Source:<br>PBS p203 CP p20 | Target met | The Agency commenced an extensive co-design process with wide-ranging stakeholder engagement, which resulted in the development of a draft national health interoperability roadmap. |
| **Better availability and access to prescriptions and medicines information** | Improve the accuracy, timeliness, visibility and accessibility of medicines information in the My Health Record system. | 80% of community pharmacies connect and upload dispensed prescription records to the My Health Record. Support Department of Health on digital signatures policy development.<br>Source:<br>PBS p204 CP p21 | Target partially met | 66% of community pharmacies were connected and uploading (not 80% as projected) dispensed prescription records to the My Health Record as at 30 June 2019.<br>All major community pharmacist software products are My Health Record conformant, enabling access to the majority of pharmacists.<br>The lower than expected connection and usage rates (66% instead of 80%) reflected industry sentiment at the time, and the subsequent need for further ongoing education and consultation with industry to translate registrations into connections and use.<br>Supported the Department of Health on digital signatures policy development by examining solutions to ensure only healthcare professionals with the legal right to prescribe medicines can use the electronic prescribing system to generate electronic prescriptions. |
| **A workforce confidently using digital health technologies to deliver health and care** | Support healthcare professionals to trust in, and capitalise on, the benefits of digital technologies. | Support governments and educational institutions to develop curricular to build digital workforce capability.<br>Source:<br>PBS p205 CP p22 | Target met | The Agency has continued its partnership with the Australasian College of Health Informatics (ACHI) and Macquarie University to sponsor PhD candidates with an industry placement, as a pathway to ACHI Fellowship. It is the first program of its kind in Australasia and will prepare individuals for leadership roles in the health informatics workforce and address demands for experienced and qualified health informatics specialists from various disciplines.<br>In addition, the Agency is working closely with the Health Informatics Society of Australia (HISA) and ACHI to establish and grow the CXIO Network. This network brings together health informatics professionals working in leadership roles (Chief Clinical, Nursing, Medical and Pharmacy Information Officers) to provide supporting workforce and educational materials and resources as well as a peer support network for new and existing CXIOs.<br>In support of Continuing Professional Development, the Agency has engaged with over 30 clinical peak organisations including the Australian Medical Association (AMA), The Royal Australian College of General Practitioners (RACGP), Allied Health Professions Australia (AHPA), Australian Association of Practice Management (AAPM), the Pharmacy Guild and Pharmaceutical Society of Australia (PSA), with 1,443 education events delivered and participation of 40,329 stakeholders. |

| Pillar of National Digital Health Strategy | Performance criteria | 2018 – 19 target | Achieved | OUTCOME by 30 June 2019 |
|---|---|---|---|---|
| **Digitally-enabled models of care that improve accessibility, quality, safety and efficiency** | Trial new models of health care to test their effectiveness in real-world environments to accelerate national uptake of initiatives with greatest benefit. | Proceed with at least two pioneering initiatives to test evidence-based digital empowerment of key health priorities.<br><br>Source:<br>PBS p204 CP p21 | Target met | Target exceeded, delivering 15 initiatives to test evidence-based digital empowerment of key health priorities including Reducing Hospital Admissions, Cardiology Care and Closing Aged Care Integration Gaps. |
| **A thriving digital health industry delivering world-class innovation** | Drive innovation by working with industry, healthcare consumers and the research sector to expand existing digital tools and create new ones that meet the changing needs of patients and providers. | Support the Mobile Gateway Program and implement a secondary use framework for the My Health Record.<br><br>Source:<br>PBS p205 CP p22 | Target met | Supported the Mobile Gateway to the My Health Record by working with the National Infrastructure Operator (Accenture), Services Australia, and the MyGov teams to release a new authentication pattern to verify user identity. Assisted with internal reviews to ensure that the Agency has a robust conformance framework for app developers and provided input into developing an approach for a mobile health (mHealth) regulatory framework for Australia that supports innovation, protects patient privacy and avoids unnecessary and duplicative regulation.<br><br>Coordinated and undertook preparatory work for the implementation of the Framework to guide the secondary use of My Health Record data by outlining key principles that will be used to establish the governance mechanisms and processes to guide decisions about releasing data. |


# Case study: **International engagement in Digital Health**

The Agency, in its remit to liaise and cooperate with overseas and international bodies on matters relating to digital health, has been working closely with governments from around the world through the Global Digital Health Partnership (GDHP). The GDHP is in a unique position to support the adoption of digital health services globally that can improve health and care outcomes, transform access to services, and support people to take more control of their health information.

The GDHP work plan addresses the key themes of interoperability, clinical and consumer engagement, evidence and evaluation, policy environments, and cyber security. Through collaboration on these key areas, the Agency's strategic and operational alignment has been achieved between the National Digital Health Strategy (the strategy) and the Framework for Action and the deliverables of the GDHP work streams. For example the interoperability work stream has been supporting Australia with our own domestic digital transformational challenges and the Agency's development of the interoperability roadmap, as part of our Better Connections: Your health, your say consultation. International relationships developed through the GDHP have been leveraged to support the development of the roadmap and ensure the effective implementation of this consultation.

The GDHP was initiated in February 2018. During the 2018 – 19 year, Australia was Chair of the partnership which grew to 25 participating countries and the WHO. As Secretariat, the Agency supported the development of white papers published in February 2019 from the five key theme work stream areas. In March 2019, India took over as Chair and Secretariat of the partnership.

The GDHP positions Australia as a global leader through the creation of a global platform for improving health outcomes for citizens internationally and for achieving the Sustainable Development Goals (SDGs), specifically number 3: *Ensure healthy lives and promote wellbeing for all at all ages.*

## 2.4 Annual work plan priorities from the Corporate Plan 2018 – 19

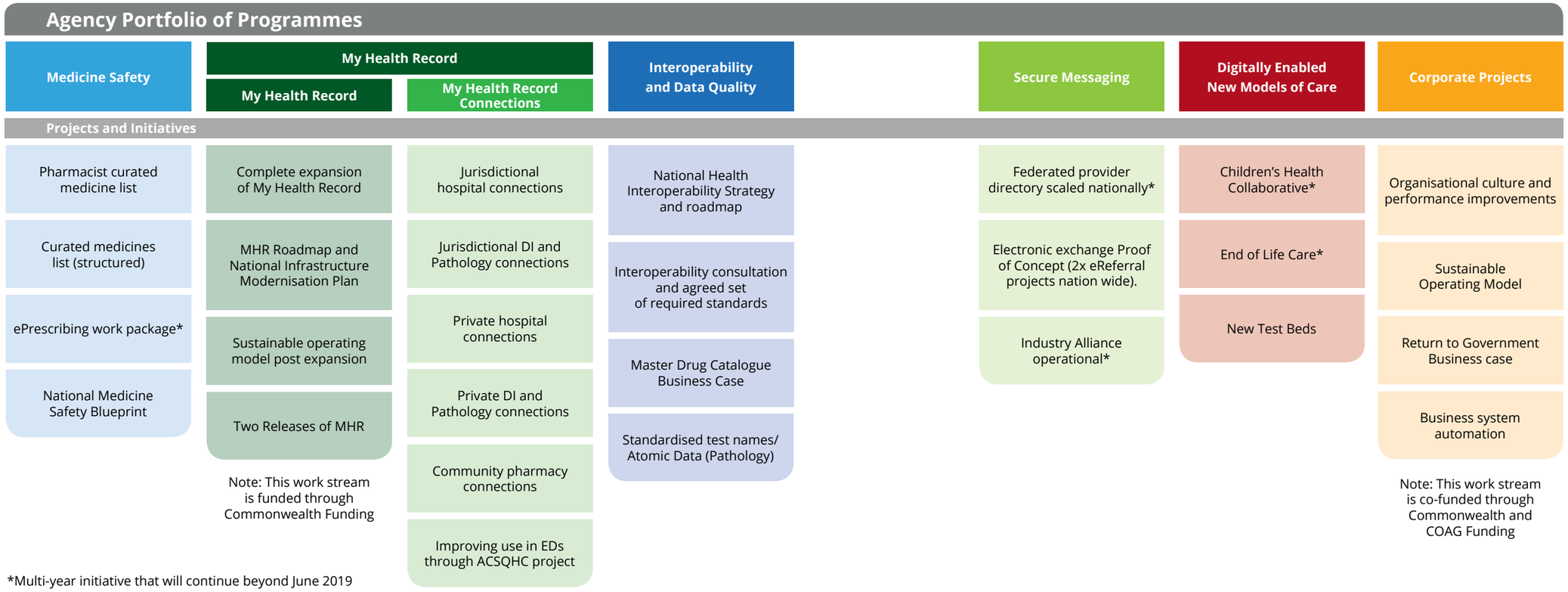
The targets in the PBS and Corporate Plan, covering all the critical activities within our digital health remit, give a broad perspective of the Agency's proposed performance. But they do not complete the performance story.
The Agency is one of only a handful of Commonwealth entities with a statutory obligation to produce an annual work plan[10].
The effect is to put that work plan at the centre of any performance discussion.

### 2.4.1 Agency annual work plan

The diagram below presents the Agency's annual work plan priorities for the 2018 – 19 financial year. It consists of a series of programs with projects that sit under each program banner. These programs closely align with the priority outcomes of the National Digital Health Strategy.

Consistent with the Agency's obligations under the PGPA Rule,[11] and in support of measuring the Agency's performance over 2018 – 19, each program is assessed in terms of its purpose, the results produced, followed by a synoptic analysis of factors contributing to results across all programs.

In this way we can see how each priority area of work within the Agency furthers the Agency's overall purpose of delivering the benefits of digitally enabled health and care.




*Multi-year initiative that will continue beyond June 2019

10. Under Section 70 of the Agency Rule, the Agency's Board 'must prepare a national digital health work program for each financial year'.
11. Section 16F PGPA Rule.

## 2.4.2 Medicines safety

### Overview

The Medicines Safety strategic priority in the National Digital Health Strategy recognises that the use of medicines is the most common intervention made in health care – in any two-week period, around seven in ten Australians (and nine in ten older Australians) will have taken at least one medicine[12]. Unfortunately, this also means that problems with medicine use are also common. The PSA's Medicine Safety: Take care report[13] released in February 2019 demonstrated that 250,000 hospital admissions annually are a result of medicines-related problems and incur an annual cost of $1.4 billion. But 50 per cent of this harm is potentially preventable. Medicines errors have a disproportionate impact on older Australians, and 98 per cent of residential aged care residents have at least one medicines-related problem.

The Agency's Medicines Safety Program is focused on improving access to information about medicines, allergies and adverse reactions, to support safe and efficient medicines use and reduce adverse events by implementing a nationally coordinated digital medicines safety program to increase the safety and quality of medicines use across health and care.

### Results

The Agency's major activities in this area included:

- Co-designing a Digital Medicines Blueprint to implement digital services to increase the safety, quality and efficiency of medicines use across health and care. This blueprint document describes the Agency's operational response to the National Digital Health Strategy in relation to medicines. It takes the Framework for Action as a starting point, and through a national conversation with industry, clinicians, consumers, and government has identified specific priorities and ways of working together to deliver the nationally coordinated Medicines Safety Program to the year 2022.
- Releasing the Pharmacist Shared Medicines List (PSML)[14] in My Health Record 10.1. This is a new document type in My Health Record that provides a snapshot of consolidated medicines information at a particular point in time, including over-the-counter and other non-prescription medicines rather than just what has been prescribed or dispensed.
- Providing technical support to the Commonwealth Department of Health Electronic Prescriptions Project, to facilitate the co-design of an over-arching systems architecture (how it all works), conformance requirements (what each system must do in order to participate) and conformance scheme (how systems will be determined to be conformant). As a result of this project, prescribers and their subjects of care will have the option to use fully electronic prescriptions as an alternative to paper-based alternatives.

12. Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety – Improving Medication Safety. July 2002.
13. Pharmaceutical Society of Australia 2019.Medicine Safety: Take Care. Canberra: PSA.
14. Described as "The Pharmacist Curated Medicines List" in the 2018–19 Work Plan.



## Case study: **Getting community pharmacies onboard**

The PSA reports that medicine-related problems result in 250,000 hospital admissions annually, costing $1.4 billion. Adoption of My Health Record medicines information at the point of care may help to reduce these figures by allowing community pharmacists to see discharge summaries, shared health summaries, and pathology/diagnostic imaging reports, all of which save time and enhance the pharmacist's ability to gain a more complete picture of the patient to provide safer, better care.

However, sector adoption was lagging in early 2018, with only 29 per cent of community pharmacists registered for My Health Record. In response, the Agency re-engineered its sector engagement to create a value proposition to register the majority of community pharmacies, to educate on use, to work with industry to develop conformant software, and to ensure that community pharmacies were connected and using My Health Record by June 2019.

As a result of this program, more than 85 per cent of community pharmacies registered for My Health Record by June 2019. This outcome, which exceeded KPIs, was made possible through collaboration between the Agency and the PSA, the Pharmacy Guild, the SHPA, pharmacy banner groups, clinical software developers, Primary Health Networks, and Services Australia. A quality solution was delivered that was informed by all key stakeholders, reflected business needs of the sector as well as the value proposition established by prior engagement, and meshed with clinical workflows in community pharmacies.

## 2.4.3 My Health Record – expansion and enhancements

The My Health Record system was implemented on 1 July 2012. It was initially called the Personally Controlled Electronic Health Record. It was designed around privacy, security and consumer choice and control, rather than as a model of registration.

In 2016, opt out trials were held in two locations, resulting in 971,000 people being registered for a My Health Record.

The trials were independently evaluated, with the results showing a high level of support among healthcare consumers and providers for the automatic creation of My Health Record for people.

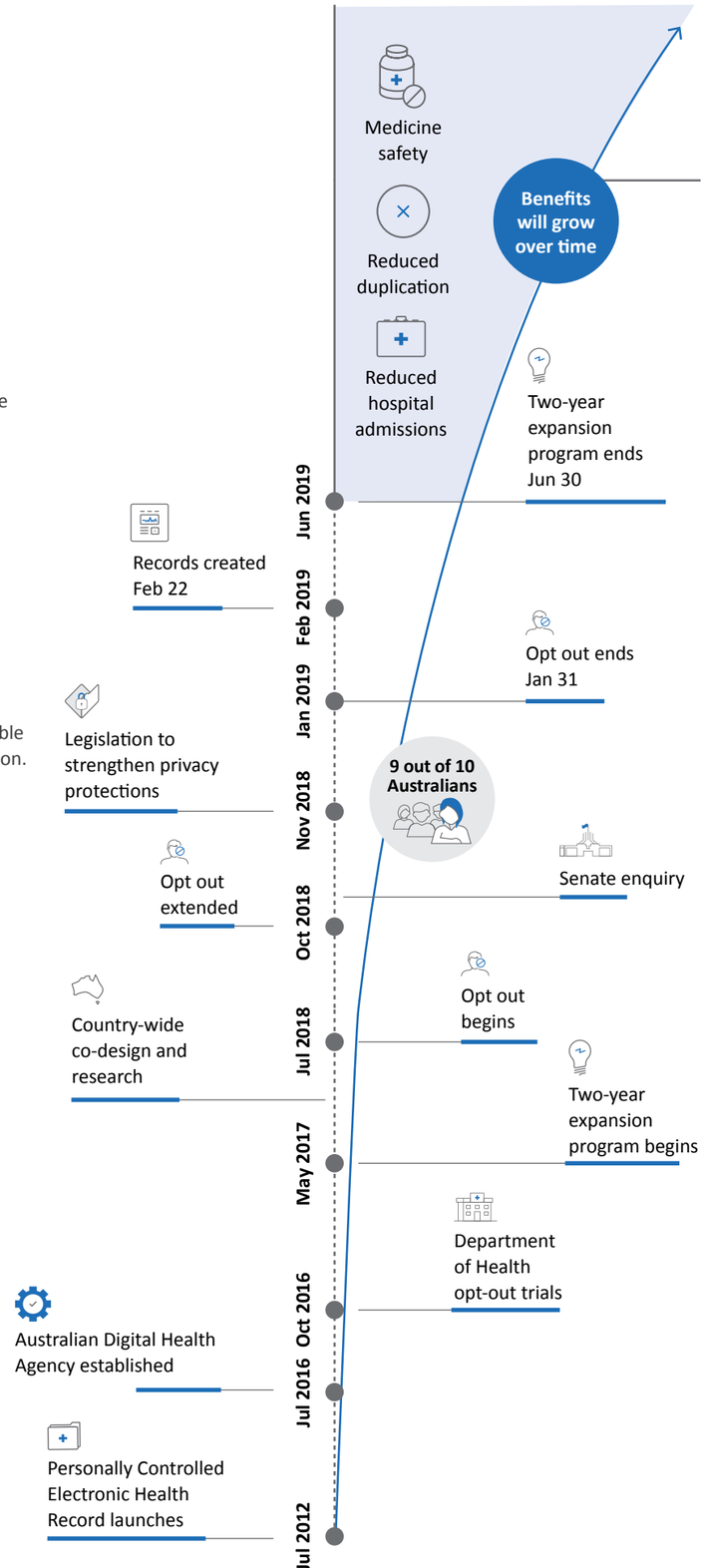
As a result of the recommendations from the opt out trials, the Australian Government agreed to give all Australians a My Health Record unless they chose not to have one.

To ensure every Australian was given that choice, the Australian Digital Health Agency designed a national opt out model which would be implemented during a two-year nationwide expansion program to transform the healthcare system for all Australians.The Agency established a formal governance model to address the specific needs of the Expansion Program, give the senior executive appropriate strategic guidance, and oversee delivery of the program.

## Outcome:
Transformation of the Australian My Health Record System

**The expansion program had six key areas of focus:**

1. Inform all Australians that they are going to have a My Health Record unless they opt out.
2. Support all Australians to opt out.
3. Connect healthcare providers to My Health Record and train them to use the system.
4. Protect the rights of Australians.
5. Deliver a modern, robust and stable digital system to support the nation.
6. Ensure the My Health Record system is safe and secure.




The Program Board and Program Delivery Committee were responsible for guiding and directing delivery of the Program. The My Health Record Expansion Steering Group provided access to expert advisors to provide guidance on key issues, risks and overall program direction.

A Program Management office coordinated and gave guidance to the program to plan, track and control the progress and delivery of outputs and outcomes. This included setting up governance and management structures, coordinating the workstreams, developing regular reporting and tracking and managing issues, risks and changes.

To deliver the opt out model for the whole of Australia and achieve the outcomes of the program, the Agency identified six focus areas delivered through multiple workstreams. The individual workstreams had their own responsibilities and activities but they frequently combined their skills to target key planned outcomes:

1. **Inform all Australians that they are going to have a My Health Record created for them unless they opt out.**
2. **Support all Australians to opt out.**
3. **Connect healthcare providers to the My Health Record system and train them to use the system to support their patients.**
4. **Ensure Australians' rights and privacy are protected.**
5. **Create a modern, robust and stable digital system to support the nation.**
6. **Ensure the My Health Record system is safe and secure.**

The implementation stage involved numerous projects and activities in the lead-up to and during the six-month opt out period, which began on 16 July 2018. During the opt out period, Australians made their choice: to have a My Health Record, or – as was their right – to opt out of the system.

A wide range of evidence-based and tested content was produced for every kind of audience. This spanned six communication activity areas where people could learn about their choice to have a My Health Record – Advertising, Community, Health, Digital, Publicity and Advocacy.

Ultimately it meant every Australian had the choice to see or hear about My Health Record and their right to opt out. It also gave every Australian the chance to learn more about My Health Record via face-to face conversations at events across Australia, from their doctor or pharmacist, or via the Help line.

Over 200 tailored pieces of communication were developed for both consumers and healthcare providers. These focused on benefits, privacy and security, how to opt out and where to go for help. Materials were available in 17 ethnic languages, 15 indigenous languages and there were easy-to-read and low-literacy versions.

Some of the main communication activities and their outcomes:

## Health

Posters and brochures were displayed in more than 15,000 healthcare locations including general practices, pharmacies, public and private hospitals and Aboriginal health services.

My Health Record brochures were sent out with over 3 million Medicare letters.

## Advocacy

30 national consumer advocacy organisations and over 200 regional and local consumer organisations communicated to their members about My Health Record.

Parliamentary briefing letters and packs were sent to all 76 Senators and 150 sitting federal members, to help inform their electorate offices and constituents.

Since the commencement of opt out, Ministerial requests received by the Agency for response (16 July 2018 to 29 January 2019):

650 Ministerial briefs and correspondence (including ministerial and Agency responses)

7 Parliamentary Questions

30 Senate Estimates Questions on Notice

## Publicity

During the opt out period, over 10,000 media articles were published or appeared on TV or radio in mainstream media. In social media over 30,000 unique authors contributed to the social conversation about whether to get a My Health Record or to opt out.

The Agency had a dedicated media team to support all media enquiries and respond with factual information 24/7.

## Advertising

An advertising campaign reached 97% of Australians. It ran on outdoor advertising, radio, newspapers, digital media and TV reaching people in metropolitan, regional, rural and remote areas. This included advertising in ethnic and Aboriginal and Torres Strait Islander languages.

## Community

People had face-to-face conversations at over 3,889 community events across Australia. At least 373 of these were in very remote communities.

Posters and brochures were available in over 4,500 Australia Post retail outlets and 1,400 libraries around Australia.

Mobile outreach vans visited 75 remote towns across Australia.

## Digital

Over 4.5 million people visited the My Health Record website, which included information in 17 languages.

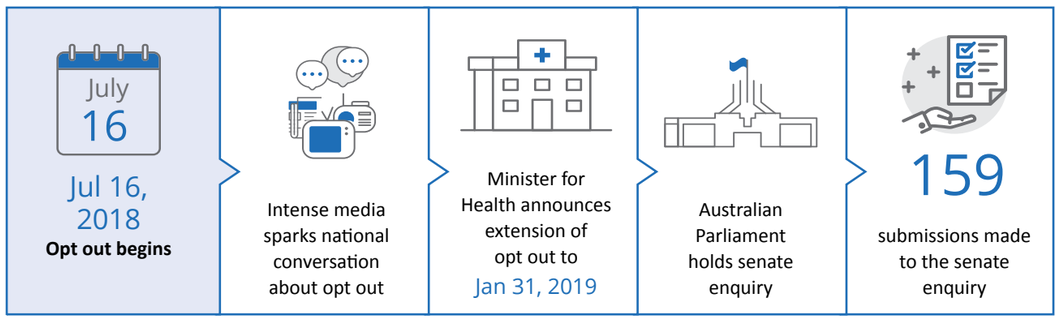
A social media campaign resulted in more than 1.5 billion opportunities to see social media content.

30 video case studies featuring consumers and clinicians were released on www.myhealthrecord.gov.au and social media channels such as YouTube.

Emails to more than 800,000 registered health practitioners were sent via the Australian Health Practitioners Registration Authority (AHPRA).

On 26 November 2018, Parliament passed the My Health Records Amendment (Strengthening Privacy) Bill 2018 in response to the Australian community's calls for even stronger privacy and security protections for people using My Health Record.

Outcome:
Ensure Australians' rights and privacy are protected



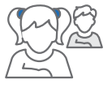

## Strengthened privacy protections

Legislation changes made to My Health Records Act on November 28, 2018

No access for employment or insurance purposes

No access by law enforcement or government agencies without a court order

Permanent deletion of a cancelled My Health Record



Once a teenager turns 14, Authorised Representatives will be automatically removed

Harsher fines and penalties will apply for inappropriate or unauthorised use of information

Stronger privacy protections for people at risk of family violence

Operation of the My Health Record system cannot be delegated*

The principles contained within the framework to guide the secondary uses of data will become law

No commercial use of My Health Record data

* Other than to the Chief Executive of Medicare or to an employee of the Department of Health

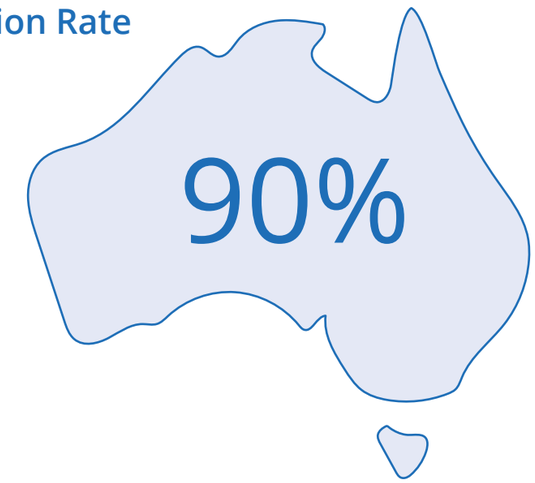
### Results

- On 31 January 2019, the My Health Record system was expanded to include all Australians except those who chose to opt out. As a result of this program over 90 per cent of Australians have a My Health Record.
- To ensure that the Agency is prepared to operate effectively and efficiently beyond closure of the My Health Record Expansion Program, a sustainable post-expansion operating model has been developed. It included an organisational restructure (completed in September 2018) and updated governance arrangements to ensure key learnings and best practice processes are embedded in the operating model going forward.
- Seven releases were delivered for the My Health Record during the reporting period and included multiple enhancements and improvements that met new legislative requirements, improved scalability of the national infrastructure, enhanced security, and provided additional benefits to users.
- A My Health Record roadmap and national infrastructure modernisation has been developed for the delivery of new and enhanced capabilities to My Health Record. Business requirements and use cases have been developed, and a review of the current-state infrastructure, architecture and business requirements will inform the need and direction for the future.

**22.55M** Total **My Health Records**

## National Consumer Participation Rate

| | |
|---|---|
| Australian Capital Territory | **87%** |
| New South Wales | **90%** |
| Northern Territory | **94%** |
| Queensland | **91%** |
| South Australia | **89%** |
| Tasmania | **90%** |
| Victoria | **89%** |
| Western Australia | **90%** |




## Consumer Participation by age

| Age Range | Female | Male |
|---|---|---|
| **0 – 9** | **13%** | **13%** |
| **20 – 40** | **15%** | **15%** |
| **41 – 64** | **14%** | **15%** |
| **65 and Older** | **8%** | **7%** |
| **Total** | **50%** | **50%** |

### 2.4.4 My Health Record connections

#### Overview

The Agency ran a nationwide readiness program to connect healthcare providers to the system and educate them on how to use it to benefit their patients.

This involved introducing healthcare providers to My Health Record and its benefits and explaining that the opt out model would mean most of their patients would have a My Health Record.

Many healthcare providers including community pharmacy, pathology labs and public and hospital pharmacists were connected for the first time to the My Health Record system during the opt out period. This greatly increased the amount of healthcare locations across Australia connected to the system.

The provider readiness program also collaborated with a range of delivery partners across Australia to reach all healthcare professionals. This included the 31 Primary Health Networks, State and Territory governments, private hospital organisations, clinical and regulatory peak bodies and Aboriginal health services (National Aboriginal Community Controlled Health Organisation and Affiliates).

The 2018 – 19 workplan focused on connections with jurisdictions, private hospitals, pathology and diagnostic imaging services, and community pharmacies.

#### Results

- All eight jurisdictions are connected to My Health Record, (including pathology and diagnostic imaging connections). An additional 32 public hospitals were connected to the My Health Record in 2018 – 19 – exceeding the target of 30.
- Eighteen private hospitals connected to My Health Record during the reporting period, including major chains Mater, Ramsay, St Vincent's Australia, Healthscope, and UnitingCare Queensland. This result surpassed the target of 15 sites.
- Eleven of 14 dispensing software products (used by over 90 per cent of community pharmacies) are conformant with, and connected to, My Health Record. The Agency continues to work with pharmacies to translate registrations into connections and active usage.
- The Australian Commission on Safety and Quality in Health Care (the Commission), in partnership with the Agency, has conducted a pilot tranche of My Health Record awareness sessions in emergency departments in metropolitan and regional Western Australia, with over 100 emergency department doctors, nurses and allied health staff attending.

# Increasing document volume in the My Health Record system

The number of documents uploaded to the My Health Record system has more than doubled in the past financial year. Significant increases to Pathology, Diagnostic Imaging and Dispense documents followed the connection of clinical software that supported the new document types and the registrations and connections of healthcare organisations contributing these documents to the system. Having these 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. ,

This has been supported by the practice incentive requirements for general practice organisations and My Health Record expansion activities, including partnering with Primary Health Networks and clinical peak organisations.

The following table shows the number of documents uploaded to the My Health Record (by category) during the 2018 – 19 reporting period:

| Document category/name | At 1 July 2018 | At 30 June 2019 | Percentage growth |
|---|---|---|---|
| **Clinical documents** | **6.4 million** | **23 million** | **259%** |
| Shared Health Summary | 1.9 million | 2.9 million | 53% |
| Discharge Summary | 2 million | 3.6 million | 80% |
| Event Summary | 600,000 | 1 million | 67% |
| Specialist Letter | 85,000 | 140,000 | 65% |
| eReferral Note | 78 | 160 | 105% |
| Pathology Report | 1.7 million | 13 million | 665% |
| Diagnostic Imaging Report | 150,000 | 2.6 million | 1633% |
| **Prescription and Dispense Documents** | **21 million** | **56 million** | **167%** |
| Prescription | 16 million | 29 million | 81% |
| Dispense | 4.6 million | 27 million | 487% |
| **Consumer Documents** | **180,000** | **230,000** | **28%** |
| Consumer Entered Health Summary | 110,000 | 150,000 | 26% |
| Consumer Entered Notes | 45,000 | 52,000 | 16% |
| Advance Care Directive Custodian Report | 17,000 | 22,000 | 29% |
| Advance Care Planning Document | 2,200 | 4,700 | 114% |
| **Medicare Documents** | **720 million** | **1.2 billion** | **67%** |
| Australian Immunisation Register | 2.4 million | 4.8 million | 100% |
| Australian Organ Donor Register | 630,000 | 1 million | 59% |
| Medicare/DVA Benefits Report | 420 million | 680 million | 62% |
| Pharmaceutical Benefits Report | 290 million | 470 million | 62% |
| **Child My Health Record Documents** | **15,000** | **17,000** | **13%** |
| Personal Health Observation | 6,900 | 8,000 | 16% |
| Personal Health Achievement | 990 | 1,200 | 21% |
| Child Parent Questionnaire | 6,900 | 8,100 | 17% |
| Total active documents in My Health Record | 750 million | 1.3 billion | 60% |





- In addition, an Emergency Department-Clinician's Guide to My Health Record has been has been developed in collaboration with the Australasian College for Emergency Medicine (ACEM), the College of Emergency Nurses Australia, the Australian College of Nursing (ACN), and the Society of Hospital Pharmacists Australia (SHPA). The guide has been endorsed by ACEM's Council of Advocacy, Practice and Partnerships, and will officially be launched in late 2019.

## 2.4.5 Interoperability and data quality

### Overview

The future success of digital health in Australia rests strongly on the ability of the health sector to share and use information. Around the world, governments are recognising the importance – sometimes describing this as a right – for people to be able to have their records move seamlessly across organisational, state and even national boundaries. Interoperability between clinical systems is both the greatest challenge of digital health and its greatest promise. A connected health system gives clinicians access to the most complete information available: a patient's medical history, including allergies, medicines and pre-existing conditions, maximising the opportunities for optimal outcomes.

### Results

Over 2018 – 19, the interoperability program took significant foundational steps in making interoperability a reality. Noteworthy achievements included:

- Undertaking an extensive co-design process with wide-ranging stakeholder engagement, which resulted in the development of a national health interoperability roadmap. A community standards development model is in development to support collaborative standards development across industry – recommending a working structure, development processes, organisation roles and responsibilities, governance and ongoing operational support.
- Partnering with the CSIRO to deliver the Master Drug Catalogue review paper that outlines the problem statement, high-level requirements and scope for master medicines data management.
- The development of a maturity model for interoperability and associated assessment tools to support stakeholder self-assessment and implementation planning is being progressed.

### 2.4.6 Secure messaging

#### Overview

The experience of modern day healthcare for many patients and carers involves interacting with a variety of different healthcare providers. 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. It is also a key driver of health service efficiency, as well as patient engagement and satisfaction.

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. Moreover, research shows that general practitioners waste 10 per cent of their time daily in searching for paper records.[15] A national clinical messaging system would greatly reduce this wasted time and effort.

Secure clinical messaging is already in place in Australia, albeit in a piecemeal form. Existing implementations include diagnostic requesting and reporting, as well as sending discharge summaries from hospitals to general practice.[16] However, these different methods are generally not compatible – meaning that these proprietary secure messaging approaches do not work with each other. 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,[17] As a result, patients often have disjointed healthcare experiences, and feel that they need to repeat information all too often.[18]

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.

#### Results

Notable achievements for 2018 – 19 include:

- A FHIR™-based API has been developed to enable shared access and searching of multiple provider directories, irrespective of customer platform.
- The Agency released an industry offer to drive adoption of enhanced secure messaging capabilities in clinical information system software.
- An education, awareness and implementation support plan for primary, specialists and allied health to drive accelerated adoption across users has been developed.
- A vendor agreement has been established for collaboration in the design of the federated provider addressing solution.
- The Agency facilitated the release of two national communiques from industry working groups, one of which confirmed agreement with industry on a conceptual model for an Industry Alliance to help drive secure messaging capabilities across sector.
- A service registration assistant has been co-designed and the validation phase has commenced.

15. Smith PC, Araya-Guerra R, Bublitz C, Parnes B, Dickinson LM, Van Vorst R, et al. Missing clinical information during primary care visits. Jama.
16. Govtech review. Replacing fax machines with secure messaging. [Internet].
17. Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2015–16. 4839.0 Canberra: Australian Bureau of Statistics; 2016.
18. Australian Digital Health Agency Secure Messaging.



### 2.4.7 Digitally enabled new models of care

#### Overview

The Enhanced Models of Care Program is focused on enabling digitally enhanced models of care that improve accessibility, quality, safety and efficiency through the better use of information and technology, including the My Health Record and other national systems and services.

During the national consultation on the Digital Health Strategy, state and territory governments identified priority health reform areas which highlighted the need for digitally enabled models of care that improved coordination of care, access for disadvantaged groups, factoring in individuals' needs.

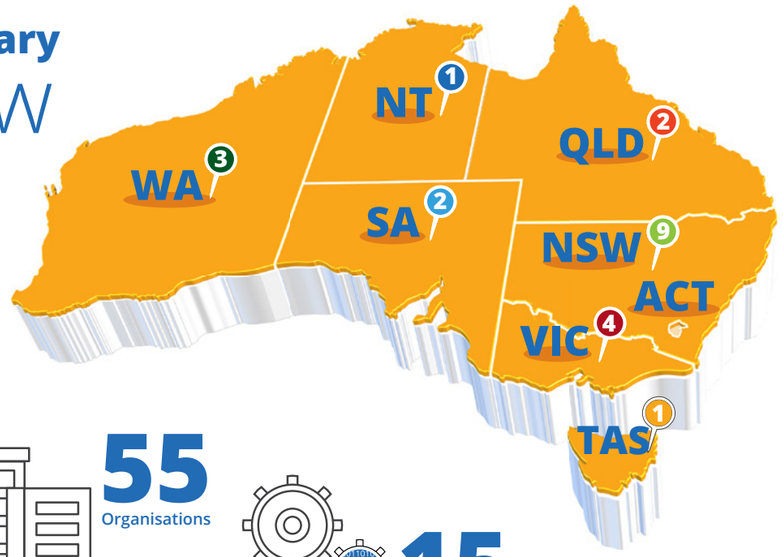
Digitally enhanced models of care projects are scheduled throughout the life of the National Digital Health Strategy, with each having a formal evaluation, examining the degree to which target benefits have been achieved and lessons learned to support national scaling.

#### Results

- Children's Health Collaborative – The Agency has partnered with eHealth NSW and the Sydney Children's Hospitals Network to establish the Collaborative. The Collaborative consists of over 400 individuals including consumers, clinicians, health and social care provider organisations, researchers, jurisdictions and ICT industry partners who are focused on improving the health and wellbeing of Australian children and young people through the use of digital technologies. NSW Health is providing overall leadership and program management for the Collaborative which is co-designing, implementing and evaluating proof of concepts for three national initiatives in support of children's health and wellbeing: a Child Digital Health Record, a Digital Pregnancy Health Record, and Child Digital Health Checks.
- End of Life Care – South Eastern Melbourne Primary Health Network (SEMPHN) delivered a report for the Agency to identify and analyse the barriers and enablers to uploading advance care planning documents to My Health Record within general practices, and subsequently made recommendations to improve the current functionality of processes. Following on from the recommendations provided in this report the Western Australian Department of Health have been commissioned to lead a national collaborative on goals of care. In 2018–19 the project has been scoped and the governance established, and the collaborative will officially commence in July 2019.
- New Test Beds – The purpose of this strategic priority is to trial new models of health care to test their effectiveness in real-world environments to accelerate national uptake of initiatives with greatest benefit. The 2018 – 19 target was to proceed with at least two pioneering initiatives to test evidence-based digital empowerment of key health priorities. This target was comprehensively exceeded, with 15 test beds initiated in the reporting period. The test beds have actively focused on building their partnership relationships, governance models, recruitment strategies and developing functional specifications. Many have successfully engaged sites across the country. Key highlights include establishing technical capabilities to enable new models of care, recognising potential solutions to accelerate benefits realisation, and demonstrating leadership in digital health innovation.

## Test Bed Summary

# Overview




**26** Locations

**55** Organisations

**15** Test beds

### NSW/ACT

Pancreatic Cancer Companion App

Medicines Safety at Transitions of Care

Health Data Interchange

Diversion Machine Learning Tool

Enhancing My Health Record View

Private Specialist Connections

Closing Aged Care Integration Gaps

Cardiology Care

Medi Tracker Mobile App

### VIC

Reducing Hospital Admissions

Medicines Safety at Transitions of Care

Diversion Machine Learning Tool

Enhancing My Health Record View

### WA

Kabisa Pathology Display in Clinical Setting

Improving Self-Management

Medi Tracker Mobile App

### SA

Digitally-Enabled Palliative Shared Care

Medi Tracker Mobile App

### QLD

Actionable Cancer Patient Perspectives

Continuity of Care for Prisoners

### NT

Digitally-Enabled Palliative Shared Care

### TAS

Medi Tracker Mobile App



## 2.4.8 Corporate projects

### Overview

Driving improved health outcomes through the use of digital health technologies requires an engaged staff and an organisation committed to excellence in delivery. The Corporate Projects program of work will seek to instil an organisational culture of passion and commitment to improved delivery of health and care. The focus on building organisational capability extends to fostering a culture of cohesion and collegiality and building disciplined and robust organisational processes and infrastructure that support business functions and our staff.

### Results

- Restructure and business automation – the Agency introduced a number of changes both to internal structures – consolidating positions, merging discrete functions – as well as to internal systems. New automated processes were rolled out in relation to procurement, My Health Record reporting statistics and internal travel and an ICT Business Continuity Plan was introduced to automate failover and recovery processes. The changes were built to seamlessly integrate with existing processes, and with sufficient flexibility to incorporate potential changes down the track. The immediate benefit was to improve the resilience of the environment, which in turn improved stability for business operations. It also liberated time for more creative and complex responsibilities requiring a greater degree of staff intuition and engagement. The new environment coupled with improvements to security tracking and monitoring, have delivered greater accountability, better visibility of business operations and compliance and procedural checks, ensuring process outcomes that are timely, consistent, reliable and support good governance.
- Clinical Reference Leads (CRLs) – clinical leadership and co-design are critical clinical governance principles underpinning the digital health agenda to ensure solutions and approaches meet the needs of the target end-user. The Agency has formally engaged with 41 CRLs to ensure continued clinical engagement with healthcare professionals with contemporary clinical practice experience and digital health subject matter experts from varying fields across the healthcare sector – and from across the country. The Agency's CRLs are embedded in the governance arrangements supporting the Agency's product development lifecycle, including clinical risk management. The CRLs actively support the Agency's work program through a range of activities including, clinical input and governance to programs and products (co-design), digital health advocacy at external events, change and adoption and peer to peer education and awareness raising activities and supporting operational activities.

### 2.4.9 Analysis of Factors contributing to results

| Positive factors | Negative factors |
|---|---|
| Increased number of system releases improve usability | Heightened sensitivity to data security resulted in intensified media coverage |
| Legislative changes to improve engagement and sentiment were implemented end to end efficiently | Need for software upgrades in industry delayed pharmacy uploading |
| Strong collaboration and co-development with key stakeholders realised improved healthcare provider adoption | Negative community sentiment also impacted industry and required additional engagement and education |
| Events integration drove clinical peak engagement | |

## 2.5 My Health Record system reporting obligations

The My Health Record system operates under the *My Health Records Act 2012* (MHR Act). The MHR 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 MHR Act are about ensuring that Australians have strong protection of their digital records. These protections are underpinned by rigorous reporting obligations.

Section 107 of the MHR 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 | ♦ As at 30 June 2019, there were 22.55 million active records in the My Health Record system.<br>♦ In 2018 – 19 the System Operator registered an additional 3,711 healthcare provider organisations. 96 registrations were cancelled or suspended for reasons such as a provider organisation discontinuing operations or transferring ownership. |
| Use of the My Health Record system by healthcare providers and healthcare recipients | ♦ A total of 1,741,602 people accessed their Record via the national consumer portal in 2018 – 19.<br>♦ An average of 2,306 unique healthcare provider organisations, via their clinical information systems, viewed Records each week during 2018 – 19.<br>♦ An average of 6,497 unique healthcare provider organisations uploaded documents to Records each week during 2018–19.<br>♦ A total of 493,388,445 documents were uploaded to the My Health Record system in 2018 – 19. |

| Reporting requirement | Statistics |
|---|---|
| Occurrences compromising the integrity or security of the My Health Record system | There have been no purposeful or malicious attacks compromising the integrity or security of the My Health Record system.<br>38 matters (in 35 notifications) were reported to the Office of the Australian Information Commissioner as required under Section 75 of the MHR Act concerning potential unauthorised access, security or integrity breaches.<br>37 of the 38 matters were breaches, and most were attributable to administrative errors (such as cases of intertwined Medicare records, or processing errors when creating records for infants), with three (3) cases involving unauthorised access to an individual's My Health Record.<br>The Agency, in its capacity as the My Health Record System Operator, reported four (4) matters to the Office of the Australian Information Commissioner. These included:<br>♦ One (1) breach resulting from unauthorised access to a My Health Record as a result of an incorrect Parental Authorised Representative being assigned to a child;<br>♦ Two (2) breaches resulting from suspected fraud against the Medicare program where the incorrect records appearing in the My Health Record of the affected individual were also viewed without authority by the individual undertaking the suspected fraudulent activity; and<br>♦ One (1) suspected breach resulting from incorrect registration and unauthorised access to the My Health Record of a minor by a Services Australia officer acting as a delegate of the System Operator. This notification was subsequently revoked as it was later confirmed that the access had been requested by the consumer's parent and was therefore authorised (consequently it did not constitute a breach).<br>Services Australia, in its capacity as a Registered Repository Operator reported 34 data breaches (in 31 notifications) to the Office of the Australian Information Commissioner. These included:<br>♦ 27 breaches resulting from data integrity activity initiated by Services Australia to identify intertwined Medicare records (that is, where a single Medicare record has been used interchangeably between two or more individuals); and<br>♦ Seven (7) breaches resulting from suspected fraud against the Medicare program involving unauthorised Medicare claims being submitted, with the incorrect Medicare data subsequently appearing in the My Health Record of the affected customers. In all instances, Services Australia took action to correct the affected My Health Records. |

| Reporting requirement | Statistics |
|---|---|
| Complaints received, investigations undertaken, enforceable undertakings accepted, injunctions granted | ♦ Complaints to the Agency about My Health Record are made to the call centre, in email, through the website form or in writing. Complaints are escalated through the Agency for investigation and response if the issue is complex or relates to a potential privacy, clinical or cyber security breach.<br>♦ In 2018 – 2019, during the My Health Record Expansion Program, the Agency received over 10,000 incoming requests through the My Health Record inbox from 1 July 2018 to 21 February 2019.<br>♦ In addition, 304 formal complaints were made to the Agency in 2018 – 19 in relation to the My Health Record through the call centre, other email channels, in writing, and for the period 22 February to 30 June 2019 through the My Health Record inbox.<br>♦ 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. |

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.

# 3 Management and accountability


## 3.1 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 COAG Health Council.

The Agency's governance framework has its legislative foundation in the 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
- 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.

### 3.1.1 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 and policy 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 10 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.

The composition and history of the Agency's Board membership follows:[19]

**Chair**

- Dr Elizabeth Deveny
- Jim Birch AM (until 20 April 2019)

**Senior Executive Service (SES) officer in the Commonwealth Department of Health:**

- Ms Glenys Beauchamp PSM
- Martin Bowles PSM (until 31 August 2017)
- Paul Madden (until 31 March 2017)

**Nominated Australian Health Ministers' Advisory Council members:**

- Dr Zoran Bolevich
- Michael Walsh
- Stephen Moo (until September 2017)

**Other members:**

- Lyn McGrath
- Dr Bennie Ng
- A/Professor Learne Durrington
- Dr Samuel Heard
- Ms Emma Hossack
- Adjunct Professor Kylie Ward
- Professor Michael Woods
- Robert Bransby (until 20 April 2019)
- Dr Eleanor Chew (until 20 April 2019)
- Stephanie Newell (until 20 April 2019)
- Professor Johanna Westbrook (until 20 April 2019)

19. The final service dates for past Board members are indicated in parentheses.

## Dr Elizabeth Deveny

Chair from 20 April 2019

Dr Elizabeth Deveny is currently the CEO of SEMPHN. Her emphasis on mutual respect and accountability of each and every staff member was a key factor in the nationally-recognised success of Bayside Medicare Local. 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.

Dr Deveny 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.

## Jim Birch AM

Chair until 20 April 2019

Jim Birch AM is Chair of the Australian Red Cross Blood Service, Deputy Chair of the Independent Hospital Pricing Authority, Chair of Clevertar Pty Ltd 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 (EY) having been the Global Health Leader.

He has also been the EY Government and Public Sector Leader from 2012 until the end of 2014. Formerly Mr Birch was also the EY Lead Partner in Health and Human Services for Asia Pacific. He has over 35 years' experience in planning, leading and implementing change in complex organisations transcending such areas as healthcare, justice and human services.

Mr Birch 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. Mr Birch has previously been Chair of the Australian Health Ministers' Advisory Council, a member of the ACSQHC and was a Board Member of NEHTA and Chair of Rural Health Workforce Australia.

## Dr Zoran Bolevich

From 1 August 2018

Dr Zoran Bolevich is Chief Executive of eHealth NSW and Chief Information Officer of NSW Health. With a background in medicine and business administration, Dr Bolevich has worked in a number of senior health system management, health IT and data analytics leadership roles in Australia and New Zealand.

Leading a team of more than 1,250 staff, Dr Bolevich is focusing on implementing the eHealth Strategy for NSW Health, streamlining governance of eHealth NSW's key programs and activities, and developing a highly effective, customer-focused Health IT organisation. Dr Bolevich is passionate about improving the health system through meaningful and effective use of digital technologies, data analytics, research and innovation in partnership with patients, clinicians, health organisations, government and industry partners.

Dr Bolevich holds a medical degree, a Master's of Business Administration and is a Fellow of the Royal Australasian College of Medical Administrators.

## Dr Eleanor Chew

Until 20 April 2019

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

Dr Chew is on the Board of General Practice Training Queensland and is a past Vice President and Chair of the Royal Australian College of General Practitioners. She is an experienced leader with strategic vision and a solid understanding of governance responsibilities. Dr Chew serves on a range of committees and working groups focused on the advancement of quality primary care, in both the private and government sectors.

Dr Chew is a Fellow of the Royal Australian College of General Practitioners and a Fellow of the Australian Institute of Company Directors. In January 2019, Dr Chew was awarded an Order of Australia Medal for her service to medicine.

## Robert Bransby

Until 20 April 2019

Rob Bransby has more than 35 years' experience in business, financial services and the health sector. Mr Bransby stepped down from his fulltime role as Managing Director of HBF Health Limited in 2017. During his 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.

Mr Bransby has long held a leadership position within the health insurance sector and is the immediate past president of the industry association, Private Healthcare Australia. Mr Bransby 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, he enjoyed a successful 25-year career in banking with National Australia Bank. Mr Bransby is currently a director of Synergy, Craig Mostyn Group and Chair of Commonwealth Financial Planning Limited, BW Financial Advice Limited, Count Financial Limited, Financial Wisdom Limited, Commonwealth Private Bank Limited and the Australian Health Insurance Alliance. He is also a Commissioner of the Insurance Commission of Western Australia. Mr Bransby holds an SF Fin FAIM.

## Ms Glenys Beauchamp PSM

Glenys Beauchamp PSM was appointed Secretary of the Department of Health on 18 September 2017. Ms Beauchamp has had an extensive career in the Australian Public Service at senior levels with responsibility for a number of significant government programs covering economic and social policy areas.

She has more than 25 years' experience in the public sector and began her career as a graduate in the Industry Commission. Prior to her current role, Ms Beauchamp was Secretary, Department of Industry, Innovation and Science (2013–2017) and Secretary of the Department of Regional Australia, Local Government, Arts and Sport (2010–2013). She has served as Deputy Secretary in the Department of the Prime Minister and Cabinet (2009–2010) and the Department of Families, Housing, Community Services and Indigenous Affairs (2002–2009).

Ms Beauchamp has held a number of executive positions in the ACT Government including Deputy Chief Executive, Department of Disability, Housing and Community Services and Deputy CEO, Department of Health. She also held senior positions in housing, energy and utilities functions with the ACT Government. Ms Beauchamp was awarded a Public Service Medal in 2010 for coordinating Australian Government support during the 2009 Victorian bushfires. Ms Beauchamp holds an economics degree from the Australian National University and an MBA from the University of Canberra.



## Dr Samuel Heard OAM

From 20 April 2019

Dr Samuel Heard OAM is primarily a rural general practitioner. He is currently the Medical Director of the Central Australian Aboriginal Congress, a 45 year old community controlled health service with 400 staff and 11 clinics across Central Australia. He is also the Medical Director of the Flinders University Regional Training Hub in Central Australia, where he is an Associate Professor. Dr Heard grew up in Naracoorte, South Australia, and studied medicine at Adelaide University, graduating in 1978. He completed his general practice training in London and was a part-time academic with London University. He returned to Darwin in 1992 working with Menzies School of Health Research but staying involved with European eHealth research projects. He developed the openEHR methodology with Thomas Beale, an engineer in the late 1990s. Key elements of this work have been adopted as an international (CEN and ISO) standard. Dr Heard has been a founding Fellow of the Australian College of Health Informatics and a founding director of the openEHR Foundation, with appointment as a Senior Visiting Research Fellow at University College London. He continues to be a director of Ocean Informatics, an Australian company that first implemented the openEHR methodology and provided the NT My eHealth Record software. He has worked extensively in education and standardisation, representing Australia in international eHealth standards development. He has been a delegate to CEN (European), ISO (International) and HL7 (International) standards organisations. Dr Heard worked on technical committees at IHTSDO (International terminology) as a UK nominee. Dr Heard holds an MBBS, DRCOG, MRCGP, FRACGP, FACH.

## Lyn McGrath

Lyn McGrath is the Group Executive Retail Banking at the Bank of Queensland. She was recently the Executive General Manager, Wealth Advice at the Commonwealth Bank of Australia (CBA). Prior to this role Ms McGrath was Executive General Manager, Retail Sales leading the largest financial services distribution business in Australia for six years.

Before joining the CBA in 2007, Ms McGrath held roles with St George in Retail Banking. She has extensive senior management experience in strategic and operational roles within the utilities and media industries and over 20 years' experience in financial services.

Ms McGrath is highly regarded for her transformational leadership, financial management experience and customer experience strategy thought leadership. She holds an MBA and BA from Macquarie University as well as a Dip PR (Hons) and is a graduate of the Australian Institute of Company Directors.

Ms McGrath is a Senior Fellow with FINSIA, a Fellow with the Australian Institute of Managers and Leaders 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. Ms McGrath holds an MBA and BA from Macquarie University as well as a Dip PR (Hons).

## Adjunct Professor Kylie Ward

From 20 April 2019

Adjunct Professor Kylie Ward is the CEO of the ACN and is a renowned nursing workforce leader and a passionate CEO who has shaped ACN to become a prominent and influential professional organisation. Ms Ward leads ACN's strong collective voice for the nursing profession, promoting nursing involvement in advocacy and policy development at the state and federal levels. She continues to drive nursing influence in broader professional issues to the next level, both locally and internationally.

Ms Ward's distinguished career spans almost three decades, during which time she has been awarded honorary Professorships from Monash University, Deakin University, University of Technology Sydney and Western Sydney University, as well as holding Executive Director of Nursing and Midwifery positions in the largest health services in NSW and Victoria.

Ms Ward currently sits on the Aged Services Industry Reform Committee (IRC) and the Health Translation Advisory Committee (HTAC) of the National Health and Medical Research Council (NHMRC). A highly accomplished CEO, Ms Ward has had responsibility for multi-million dollar budgets throughout her career. Her commitment and professionalism have been recognised through the multiple awards she has won throughout her career, including the 2017 ACT Telstra Business Woman of the Year Award for Social Purpose and Enterprise and 2018 Western Sydney University Prestigious Alumni's Award for Professional Excellence. Ms Ward holds a M.Mgt, Dip.App.Sci (Nursing), Acute Care Cert., FACN, Wharton Fellow, MAICD.

## Professor Michael Woods

From 20 April 2019

Professor Michael Woods is a Professor of Health Economics at the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and Visiting Scholar at the Australian National University. He is a member of the Aged Care Financing Authority.

Professor Woods' research focus is on aged care reform, the delivery of palliative care, improving the efficiency and effectiveness of the health workforce and the economics and financing of health systems. He draws on current and developing sources of health information and on novel data linkages to undertake health research and develop policy. In 2016 he was appointed as the Independent Reviewer for COAG Health Council Commissioned Review of the Workforce Education Accreditation System under National Registration and Accreditation Scheme.

Professor Woods was previously Deputy Chairman of the Productivity Commission and Presiding Commissioner on over 20 national Inquiries. He led several landmark reports including Caring for Older Australians, Science and Innovation and Australia's Health Workforce. Since 2001 he has held senior research and policy advisory roles in East and South East Asia, including as a Senior Expert to assist the OECD's outreach to ASEAN (2016-17) and as a Staff Consultant to the World Bank, advising Vietnam on re-setting its Growth Strategy (2018–19).

Previously Professor Woods was the Under Treasurer for the Australian Capital Territory, guiding the development of the ACT's economic policy and fiscal management. Professor Woods holds a Bachelor of Arts (Hons), Australian National University and a Graduate Diploma in Education, Canberra College of Advanced Education 1974.



## Emma Hossack

From 20 April 2019

Emma Hossack is the CEO of the Medical Software Industry Association (MSIA). MSIA represents over 90 per cent of the providers of all the providers of health software in Australia. Over 91 per cent of all MBS/PBS transactions involve MSIA member software. Prior to this appointment in December 2018, Ms Hossack was the CEO of Extensia, a leading Australian supplier of software solutions and technologies for the health care sector. Additionally, Ms Hossack was the CEO of Binder, an information logistics platform used across all industry sectors. Extensia deployed a number of implementations of privacy by design shared electronic health record systems across Australia over the past decade. Extensia responded to the global need for systems to more effectively exchange information in aged care, chronic disease, indigenous care and disability sectors. Extensia achieved this through the deployment of interoperable flexible software. Extensia's platform enables individual autonomy and dignity as well as improved health outcomes and efficiencies.

Before acquiring Extensia, Ms Hossack practiced as a commercial lawyer as a Senior Associate with a national law firm based in Melbourne and in 2007 she completed a Master of Laws at Queensland University of Technology, majoring in consent models and privacy compliant sharing of health information.

Now based in Brisbane, her other interests and positions include membership of HISA, Past President and current member of iappANZ (Australian and New Zealand International Association of Privacy Professionals) and representative on many jurisdictional and Commonwealth Government reference groups and boards. Ms Hossack holds a Bachelor of Arts (Hons) and Bachelor of Laws from the University of Melbourne and a Masters of Laws from the Queensland University of Technology.

## Stephanie Newell

Until 20 April 2019

Stephanie Newell is a consultant facilitator, educator and healthcare consumer advocate leader who works in partnership across all levels of healthcare so that health services and health systems are safe, consumer focused and are designed with health care consumers for health care consumers.

Prior to her work in health, Ms Newell's career was in banking and finance with the National Australia Bank. Ms Newell's roles within health care have included Consumer and Community Engagement Coordinator of the Health Consumers' Council of Western Australia and consultant educator for The Australian Council on Health Care Standards.

Ms Newell is also a foundation member and a designated "Patients for Patient Safety Champion" of the World Health Organization's Patients for Patient Safety program and a founding member of the Global Patient and Family Advisory Group of the Beryl Institute (USA) for Patient Experience. She also contributes to a number of Australian and international health care policy and research groups and initiatives, is a past Board member of Consumer Health Forum of Australia and was the inaugural Chair of the South Australian Department of Health Safety and Quality Consumer and Community Advisory Committee.

Ms Newell holds postgraduate qualifications in Entrepreneurship, Commercialisation and Innovation from the University of Adelaide and is a Graduate member of the Australian Institute of Company Directors.

## A/Professor Learne Durrington

From 20 April 2019

A/Professor Learne Durrington is Chief Executive Officer, WA Primary Health Alliance which operates the three Primary Health Networks in Western Australia. Learne is known as a strategic leader and has a strong blend of skills and knowledge in both government and not for profit sectors. Key areas of executive leadership and responsibility include: Health, mental health and primary care – child protection and family services; and – disability and ageing. Her leadership has developed throughout her career in roles where the dynamic environment and changing policy environment contributed to her tenacity, resilience and ongoing learning. The notion of curiosity and collaboration have been vital to her achievements.

A/Professor Durrington holds a Masters Degree in Public Policy, Bachelor Social Work (Hons), GAICD, FAIM and FACHSM.

## Michael Walsh

Until 6 September 2019

Michael Walsh was the Director-General Queensland Health until 6 September 2019, where he led a public health and hospital system for a population of nearly 5 million people. Prior to this role, he was the inaugural Chief Executive/ CIO of eHealth NSW, providing eHealth and ICT services to the NSW Health System. He has also worked as Chief Executive of HealthShare NSW, the NSW Health shared service provider.

Mr Walsh 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. He 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.

Mr Walsh 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. Mr Walsh holds a Master of Business Administration, Bachelor of Arts (Hons) in psychology, Bachelor of Science in human movement and Bachelor of Education.

## Dr Bennie Ng

Dr Bennie Ng is the Chief Executive Officer of the Australian Medical Association Western Australia (AMA WA). He commenced his career as a General Practitioner before becoming immersed in health policy and management.

Dr Ng has extensive experience in providing advice to the Australian Government having been an adviser to the Minister of Health and later appointed as Head of Social Policy at the Office of the Prime Minister and had responsibilities across health and hospitals, aged care, disabilities/NDIS and indigenous affairs. He has held senior positions in strategy, services planning and general management across public and private hospital sectors including the Peter MacCallum Cancer Centre, Healthscope Limited as well as the Hong Kong public hospital authority.

Dr Ng 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, and is a Council member of the National Library of Australia.

## Professor Johanna Westbrook

Until 20 April 2019

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 ICT in health care and has published over 350 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 Professor Westbrook 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 Australian College of Health Informatics (ACHI).

### Board meetings

The Board meets regularly in accordance with a formally approved timetable and agenda. The Board convened on seven occasions throughout 2018 – 19, two) of which were via teleconference.

In accordance with PGPA Act requirements, Board member terms of appointment and details of the number of Board meetings attended during the financial year are outlined below.

| **Board Member** (all non-executive) | Term of appointment | Meetings attended |
|---|---|---|
| **Dr Elizabeth Deveny** | 20 April 2019 to 19 April 2022 | 6 |
| **Jim Birch AM** | 20 April 2016 to 20 April 2019 | 6 |
| **Glenys Beauchamp PSM** | 28 May 2018 to 27 May 2021 | 6 |
| **Dr Zoran Bolevich** | 01 August 2018 to 31 July 2021 | 6 |
| **Robert Bransby** | 20 April 2016 to 20 April 2019 | 6 |
| **Dr Eleanor Chew OAM** | 20 April 2016 to 20 April 2019 | 6 |
| **A/Professor Learne Durrington** | 20 April 2019 to 19 April 2022 | - |
| **Dr Samuel Heard OAM** | 20 April 2019 to 19 April 2021 | 1 |
| **Emma Hossack** | 20 April 2019 to 19 April 2022 | 1 |
| **Lyn McGrath** | 20 April 2019 to 19 April 2021 | 6 |
| **Stephanie Newell** | 20 April 2016 to 20 April 2019 | 6 |
| **Dr Bennie Ng** | 20 April 2016 to 20 April 2019 | 5 |
| **Michael Walsh** | 20 April 2016 to 20 April 2017<br>20 April 2017 to 20 April 2018<br>20 April 2019 to 6 September 2019 | 7 |
| **Adjunct Professor Kylie Ward** | 20 April 2019 to 19 April 2022 | 1 |
| **Professor Johanna Westbrook** | 20 April 2016 to 20 April 2019 | 6 |
| **Professor Michael Woods** | 20 April 2019 to 19 April 2022 | 1 |

## 3.1.2 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:<br>♦ the efficient and effective delivery of clinical care using digital health;<br>♦ the architectural integration of digital health systems;<br>♦ changes to digital health system design to improve clinical usability and usefulness based on experience with the use of digital systems;<br>♦ proposed innovations and measures to improve the efficiency and effectiveness of digital health systems for clinicians and users of the system; and<br>♦ recommendations in relation to priorities of investment in, and development and implementation of, national digital health systems. |
| **Jurisdictional Advisory Committee** | The Jurisdictional Advisory Committee gives guidance on all matters for consideration by the Board in order to facilitate nationals coordination and consistency across geographic and health sector boundaries. Its members are senior representatives of Commonwealth, state and territory health departments. |
| **Consumer Advisory Committee** | The Consumer Advisory Committee advises on:<br>♦ how to ensure key messages about digital health are communicated effectively to relevant stakeholders and health consumer groups;<br>♦ 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<br>♦ 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 advises on:<br>♦ Legal issues in relation to digital health systems, including copyright, data privacy issues, confidentiality issues, data security and legal liability;<br>♦ The long-term legal framework of digital health systems;<br>♦ Privacy and security issues encountered by users of digital health systems, and the resolution of any problems arising from monitoring these issues; and<br>♦ Standards (including compliance with standards) relating to privacy and security in relation to digital health systems. |

The PGPA 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**[21] | The Digital Health Safety and Quality Governance Committee advises on:<br>♦ All safety, quality and clinical governance aspects of services and contracts undertaken or managed by Australian Digital Health Agency;<br>♦ 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;<br>♦ Safety, quality and clinical governance matters, including policies, that are referred to the Digital Health Safety and Quality Governance Committee;<br>♦ Committee by the Agency Board, the Australian Commission on Safety and Quality, Advisory Committees or the Australian Department of Health; and<br>♦ Approving and recommending the Agency Clinical Quality Plan which will include consideration of the outcomes and recommendations provided by the ACSQHC based upon the conduct of audits and reviews of Agency clinical approaches. |

20. Disbanded on 11 April 2019.

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 help 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. This includes:<br>♦ 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.<br>♦ 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.<br>♦ 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.<br>♦ System of internal control: reviewing the entity's compliance framework, governance arrangements and internal control environment. |

### 3.1.3 My Health Record Expansion Program Board

In addition to advisory committees mandated under the Agency's enabling Rule and governance legislation, the Agency has established the My Health Record Expansion Program Board. Its purpose is to drive the program forward and to provide direction and strategic oversight to ensure the program delivers its intended outcomes and realises expected benefits. The Program Board is chaired by the Agency CEO. Its membership includes the Agency's Executive General Manager for Infrastructure Operations, as well as representatives from the Department of Health, Services Australia, the Digital Transformation Agency, and jurisdictional and Primary Health Network representatives.

This Board was disbanded at the conclusion of the My Record expansion program.

### 3.1.4 Data Governance Board

The *My Health Records (Strengthening Privacy) Act 2018*, introduced protections around the secondary use of My Health Record data. The new law enshrined the principles contained within the Framework to guide the secondary uses of My Health Record system data and established a Data Governance Board to approve the release of any data in line with these rules. The Board, when constituted, will contain members from the Agency, the Australian Institute of Health and Welfare, the Aboriginal and Torres Strait Islander Peoples' Advisory Panel, as well as independent experts.

### 3.1.5 Specialist committees

All major Agency initiatives are led by steering groups with representatives across the health sector and user spectrum – clinicians, consumers, jurisdictions – so that all voices are heard in the design process.

**My Health Record Expansion Program Steering Group***

Membership includes: Jim Birch AM (Chair), Dr Steve Hambleton (Deputy Chair), Cathy Baynie (AAPM Ltd), Jane Bollen (Australian Primary Health Care Nurses Association), Ms Melissa Cadzow (consumer representative), Dr James Cameron (The Royal Australasian College of Physicians), Karen Carey (Independent Consumer Representative), Rowena Clift (Western Victoria Primary Health Network), Sean Mutchmor (Australian College of Rural and Remote Medicine), Adjunct Professor Naomi Dobroff MACN (ACN), Dr Rohan vanden Driesen (The Royal Australian and New Zealand College of Radiologists), Philipp Herrmann (AHPA), Emma Hossack (MSIA), Paul Jones (The Pharmacy Guild of Australia), Karen Kinmont (Australian Private Hospital CIO Forum), Dr Edwin Kruys (Royal Australian College of General Practitioners), Matt Malone (Australian Private Hospital CIO Forum), Nigel McGothigan (Leading Age Services Australia Ltd), Prof John McNeil AM (Monash University), Dr Chris Moy (AMA), Peter O'Halloran (jurisdictional nominee), Professor Moira Paterson (Monash University), Mr Bruce Pedersen (Australian Information Industry Association), Frank Quinlan (Mental Health Australia), A/Prof Vitali Sintchenko (The Royal College of Pathologists of Australasia), Sharon Sweeney (Brisbane South Primary Health Network), Leanne Wells (Consumers Health Forum of Australia).

**My Health Record Expansion Program Benefits Measurement Steering Group***

Membership includes: Peter Alexander (Digital Transformation Agency), Dr Richard Ashby (eHealth Queensland), Dr Zoran Bolevich (eHealth NSW), Associate Professor Douglas IR Boyle (Melbourne Medical School), Shane Porter (Department of Health), James Downie (Independent Hospital Pricing Authority), David Fredericks and Martin Graham (Department of Finance), Louisa Jorm (University of NSW), Professor Libby Roughead (University of South Australia), Barry Sandison (Director Australian Institute of Health and Welfare), Leanne Wells (CEO Consumer Health Forum).

**My Health Record Product Improvement Group**

Membership includes: Peter Alexander (Digital Transformation Agency), Dr Richard Ashby (eHealth Queensland), Dr Zoran Bolevich (eHealth NSW), Associate Professor Douglas IR Boyle (Melbourne Medical School), Shane Porter (Department of Health), James Downie (Independent Hospital Pricing Authority), David Fredericks and Martin Graham (Department of Finance), Louisa Jorm (University of NSW), Professor Libby Roughead (University of South Australia), Barry Sandison (Director Australian Institute of Health and Welfare), Leanne Wells (CEO Consumer Health Forum).

* Disbanded at the conclusion of the My Record expansion program

## My Health Record Product Improvement Group

Membership includes: Dr Chris Pearce (clinical co-sponsor), Jamila Rizvi (consumer co-sponsor), Geoff Rohrsheim (Chamonix and Chamonix Health), Dr Jill Tomlinson (Melbourne Hand Surgery), Dr Daniel Byrne (Chandler Hill Surgery), Professor Tim Shaw (University of Sydney), Vaughan Badawy (Ramsay Health Care The Avenue & Glenferrie Private Hospitals), Dr Kathy Brotchie (GP), Aaron Jones (Sydney Local Health District – Royal Prince Alfred Hospital), Harry Iles-Mann (Acting Consumer Co-Sponsor), Learne Durrington (WA Primary Health Alliance), Dianne Zalitis (The Infertility Question), Dr Shannon Nott (Founder of Future Health Leaders), Penny Mills (Leichhardt General Practice), Dr Steve Leicester (Headspace).

## Secure Messaging Program Steering Committee

The Secure Messaging Program Steering Committee is chaired by Dr Nathan Pinskier and cosponsored by Dr Pinskier (clinical representative), Dr Zoran Bolevich (jurisdictional representative) and Fiona Panagoulias (community representative).

## Medicines Safety Program Steering Group

The Medicines Safety Program Steering Group is co-chaired and co-sponsored by Dr Steve Hambleton (clinical representative), Steve Renouf (consumer representative) and Christopher Leahy (representing the Australian Commission on Safety and Quality in Health Care).

## National Clinical Terminology Service Steering Committee

The National Clinical Terminology Service Steering Committee is co-chaired by Tim Kelsey (Agency CEO) and Dr David Hansen (CSIRO). Membership includes: Christopher Leahy (Australian Commission on Safety and Quality in Health Care), Dr Clair Sullivan (Queensland Health), Dinah Graham (MSIA), Prof Meredith Makeham, Steven Issa, Dion McMurtrie and Elizabeth Donohoo (the Agency), Jenny Hargreaves (Australian Institute of Health and Welfare), Jolanta Samoc (Therapeutic Goods Association), Tanya Harch (Queensland Health), Barbara Whitlock (Department of Health).

## Research Programs Reference Group

Membership includes: Prof Meredith Makeham (the Agency), David Bunker (Queensland Genomics Health Alliance), Prof Enrico Coiera (Australian Institute of Health Innovation), Dr Louise Schaper (HISA), Maureen Robinson (Healthdirect Australia), Prof Michael Kidd (Flinders University), Nadia Levin (Research Australia), Prof Sallie Pearson (University of NSW), Prof Sally Redman (Sax Institute), Dr Shane Jackson (University of Tasmania), Prof Tim Shaw (University of Sydney), Dr Janice Biggs, Dr Andrea Willcocks and Emily Bogue (the Agency).

Steve Otto, a 59 year old Electrical Instrument Technician was referred by his local GP to Sutherland Hospital (Sydney) after a chest X-ray confirmed pneumonia. The hospital discharged Steve after administering IV antibiotics and advised him that the Hospital Community Clinical Nurse Specialist would continue antibiotic treatment via home visits for the following two days.

When Steve arrived home, his wife was concerned as he still seemed so unwell and she had questions as to why he had not been admitted, whether he was infectious, what he was being tested for and what was the appropriate care. Steve accessed his My Health Record on his iPad using the Healthi app. He was able to read the Discharge Summary written by the Senior Medical Officer which listed the diagnosis, treatment, and, most helpfully, the plan. Due to My Health Record access Steve and his family had a much clearer understanding of the diagnosis and follow-up treatment.

*"We could see what tests were carried out, when the results were expected and that the nurse would attend the following day for my follow-up treatment. We felt like we better understood why I was discharged and what the plan was."*

The Community Health Nurse then attended the following day and put her laptop on Steve's kitchen bench and promptly accessed the 'Discharge Referral Baseline' documentation via her laptop. Steve was impressed by the fact she did not need any paper at all. The nurse administered IV antibiotics, and documented her observations directly into the electronic medical record.

*"I told her the doctor's summary I'd accessed on My Health Record had been very detailed and helpful and she said they were always like that and that helps her with continuity of care for patients."*

The nurse then explained the details she was entering into her laptop would go straight back into the hospital electronic medical record. Steve was not only impressed with the wonderful care from the nurse and hospital doctor, he was impressed with how easily the nurse could remotely access this same information and enter information into his file that could be accessed by the doctor.

*"It's important to me that my information is all in the same place and the doctors and nurses can have real time access to each other's input and results. After seeing how all this works I am really impressed with My Health Record as this is the first time in my life I've had such easy access to my own health information."*

**Steve Otto**

## 3.1.6 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. 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 meets with the Executive Leadership Team once a month. This 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 through the Directors' Forum, which meets fortnightly with a representative of the Executive and Senior Leadership Team. 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 |
|---|---|
| **Financial Portfolio and Delivery 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. (Disbanded March 2019.) |
| **Clinical Governance Committee** | Peak operational committee for Clinical Governance with responsibility for ensuring clinical governance is observed in action, is measurable and contributes to organisational performance. |

## 3.1.7 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/NZS ISO 31000) 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 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's internal audit services were provided by Axiom Associates during 2018 – 19. The risk-based internal audit program is informed by a consultative and collaborative process involving key Agency officials. Audits covering ICT corporate security maturity, workforce planning, legislative compliance and travel expenditure were completed during the reporting period, with audits nearing completion on the privacy framework and risk management system. All audit reports are presented to the Audit and Risk Committee, with accompanying plans to action any recommendations as part of ongoing efforts to improve Agency processes and performance.

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 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.

## 3.1.8 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. In 2018 – 19 the Agency undertook significant improvements to its Public Interest Disclosure (PID) arrangements, including a new policy, delegations and authorisations, publicising reporting and support information on its intranet and external website, and instituting an ongoing PID training and awareness program for staff.

During 2018 – 19, the Agency commenced a fraud risk assessment refreshment, to review potential exposure to fraud, corruption or improper conduct and assess the effectiveness of existing control measures. When complete, the assessment will underpin a review of the Agency's fraud control plan. No material instances of fraud were reported during 2018 – 19.

## 3.1.9 Business continuity management

The Agency has developed a business continuity plan that builds 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 business continuity planning focuses on testing and validating business continuity arrangements and incorporating any lessons learned from recovery exercises.

## 3.2 External scrutiny

The Agency is accountable to the Australian Government through the Commonwealth Minister for Health and to state and territory health ministers through the COAG Health Council.

It reports quarterly to AHMAC which is responsible 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.

### 3.2.1 Auditor-General reports

The Auditor-General issued an unqualified audit opinion for the 2018–19 financial statements of the Agency, which is presented in **Part 4** of this report. In January 2019, the Auditor-General commenced a performance audit of the effectiveness of the Agency's implementation of the My Health Record system, including an examination of whether the system promotes the achievement of its purposes, system risks are appropriately assessed, managed and monitored, and whether monitoring and evaluation arrangements are effective. The report is due for release in the next reporting period.

### 3.2.2 Judicial decisions or administrative reviews

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

### 3.2.3 Parliamentary, Ombudsman, Australian Information Commissioner reports

Both a Senate Committee and the Office of the Australian Information Commissioner published reports in late 2018 concerning the operation of My Health Record system. In August 2018, the Senate referred the My Health Record system to the Community Affairs Reference Committee for inquiry and report on the benefits of the system, the decision to transition to national participation and the Agency's administration of that transition, as well as measures to strengthen the system's privacy controls. The Committee concluded that the My Health Record system is a 'significant healthcare reform' with the potential to 'revolutionise the quality and continuity of healthcare' and 'improve…health outcomes for many Australians.[22] The Committee supported a number of measures to boost public and medical community confidence in the integrity of the system. These led to the December 2018 introduction of the My Health Records (Strengthening Privacy) Act 2018 to safeguard the security and privacy of health information in the My Health Record system, with provisions to protect against domestic violence and tougher penalties for those that misuse the system.

In addition to the Senate review, every year the Australian Information Commissioner produces a report which touches directly on the work of the Agency as the My Health Record System Operator. The Information 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. That 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.

21. My Health Record System: Final Report, Chapter 5 Chapter 5, Conclusion and Recommendations.

### 3.2.4 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.

### 3.2.5 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 2018 – 19 the Agency received 54 requests pursuant to the FOI Act. Information released in response to the FOI Act requests is published in accordance with IPS requirements and accessible in the FOI Disclosure log page on the Agency website, see www.digitalhealth.gov.au


# Case study: **Residential aged care gets connected through My Health Record**

Transitions of care always carry the risk of losing vital patient information, which could lead to suboptimal care and adverse outcomes. These transitions are especially problematic for elderly patients, who are relatively likely to have multiple conditions and less likely to remember their medical history and medicine regimes.

Paige Martinez, the Health System Improvement Manager at the Central Queensland, Wide Bay, Sunshine Coast PHN wanted to know if My Health Record could improve outcomes for patients in residential aged care by linking their health information between GPs, allied health, and hospitals. So she reached out to Geoff Briggs at the Australian Digital Health Agency and Melissa Galvin at Benevolent Aged Care in Rockhampton to develop a pilot study.

Preliminary results have been encouraging. The study is finding that My Health Record can be embedded into clinical workflows such as admission processes and medicine reviews, and that having a dedicated resource for facilitating necessary registration, developing policies and educating staff is cost effective. Early engagement with clinicians, residents and family is proving to be of value in gaining greater awareness and support.





## 3.3 Additional reporting requirements under the PGPA Rule

### 3.3.1 Ministerial directions and policy orders

The PGPA 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 2018–19 reporting period.

### 3.3.2 Compliance with finance law

The PGPA Rule requires that the Agency report on any significant non-compliance during 2018–19 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 2018–19 reporting period.

### 3.3.3 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 PGPA 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 2018–19 though the national expansion of the My Health Record to every Australian who chose to have one represented a significant undertaking for the Agency in the last financial year. Australia is one of the first countries 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 partnering with key stakeholders to ensure its successful implementation.

### 3.3.4 Related entity transactions

The Agency is related to the Department of Health under the PGPA Rule because the Secretary of the Department of Health (Glenys Beauchamp 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) for 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 subleases 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 four transactions in 2018–19 and their value in aggregate was $3.09 million (GST inclusive).

### 3.3.5 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 2018–19 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 2018–19 was $24,243.07 (GST inclusive).

## 3.4 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 information technology, and a range of other disciplines. The Agency recognises the strength in their diversity.

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.

### 3.4.1 Staff statistics

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 2019, the Agency employed 242 staff under both those arrangements across offices in in Brisbane, Sydney and Canberra.

The table below gives a breakdown of staff across offices in the form mandated by a 2019 amendment to the PGPA Rule 2014.[23] The tables record the numbers of ongoing (permanent) and non-ongoing (temporary) staff, full-time or part-time status, gender, and location, with data for both current and previous year. It highlights the balance in our employment profile across male (118) and female (124) staff.

22. Inclusion of a new Section 17BE(ka) to the Public Governance, Performance and Accountability Rule 2014

Emma Hossack, MSIA CEO, and Robert Best, MSIA President

## Case study: **What's on the horizon for digital health?**

Emma Hossack and Robert Best from the Medical Software Industry Association share their insights with us.

**Q: What are the hot topics in digital health for the year ahead? We hear a lot about technologies like artificial intelligence and blockchain, but what are the less obvious themes that you're expecting to emerge?**

> **Emma:** *Interoperability will definitely be a major theme. Getting interoperability working will create a fluidity of data that will lay the foundations for a lot of other capabilities. Once we have fluidity of health data – with appropriate privacy safeguards of course – a lot of clinical benefits and efficiencies are inevitable. Our industry vision is for a better, more efficient and accessible health system so interoperability is a key goal for our industry.*

*Other projects that the Agency is working on will have a big impact, such as e-prescribing. GPs can already create electronic prescriptions, but it's not a fully digital end-to-end process. Having the option to go fully digital will have advantages of security, consumer convenience, and save clinicians time. It can be done with a lot of existing infrastructure already provided by our members which is a big plus.*

> **Robert:** *I think we'll see significant growth in the "internet of things" in healthcare this year. Wearable devices are already taking off among consumers. We'll start to see a greater movement towards these kinds of devices talking seamlessly to clinical systems (with the patient's permission of course), to improve health monitoring, medicine management, and a range of other issues.*

## All Ongoing Employees Current Report Period (2018–19)

| | Male | | | Female | | | Indeterminate | Total |
|---|---|---|---|---|---|---|---|---|
| | Fulltime | Part-Time | Total Male | Fulltime | Part-Time | Total Female | Total Indeterminate | |
| **NSW** | 22 | 3 | 25 | 37 | 7 | 44 | - | 69 |
| **QLD** | 57 | 1 | 58 | 30 | 6 | 36 | - | 94 |
| **SA** | - | - | - | - | - | - | - | - |
| **TAS** | - | - | - | - | - | - | - | - |
| **VIC** | - | - | - | - | - | - | - | - |
| **WA** | - | - | - | - | 1 | 1 | - | 1 |
| **ACT** | 25 | 2 | 27 | 29 | 4 | 33 | - | 60 |
| **NT** | - | - | - | - | - | - | - | - |
| **Overseas** | - | - | - | - | - | - | - | - |
| ***Total*** | 104 | 6 | 110 | 96 | 18 | 114 | - | 224 |

## All Ongoing Employees Previous Report Period (2017–18)

| | Male | | | Female | | | Indeterminate | Total |
|---|---|---|---|---|---|---|---|---|
| | Fulltime | Part-Time | Total Male | Fulltime | Part-Time | Total Female | Total Indeterminate | |
| **NSW** | 20 | 1 | 21 | 52 | 7 | 59 | - | 80 |
| **QLD** | 59 | 2 | 61 | 36 | 1 | 37 | - | 98 |
| **SA** | - | - | - | - | - | - | - | - |
| **TAS** | - | - | - | - | - | - | - | - |
| **VIC** | - | - | - | - | - | - | - | - |
| **WA** | - | - | - | - | 1 | 1 | - | 1 |
| **ACT** | 18 | - | 18 | 35 | 4 | 39 | - | 57 |
| **NT** | - | - | - | - | - | - | - | - |
| **Overseas** | - | - | - | - | - | - | - | - |
| ***Total*** | 97 | 3 | 100 | 123 | 12 | 136 | - | 236 |

## All Non-Ongoing Employees Current Report Period (2018–19)

| | Male | | | Female | | | Indeterminate | Total |
|---|---|---|---|---|---|---|---|---|
| | Fulltime | Part-Time | Total Male | Fulltime | Part-Time | Total Female | Total Indeterminate | |
| **NSW** | 5 | - | 5 | 4 | 1 | 5 | - | 10 |
| **QLD** | 2 | - | 2 | 4 | - | 4 | - | 6 |
| **ACT** | 1 | - | 1 | 1 | - | 1 | - | 2 |
| ***Total*** | 8 | - | 8 | 9 | 1 | 10 | - | 18 |

## All Non-Ongoing Employees Previous Report Period (2017–18)

| | Male | | | Female | | | Indeterminate | Total |
|---|---|---|---|---|---|---|---|---|
| | Fulltime | Part-Time | Total Male | Fulltime | Part-Time | Total Female | Total Indeterminate | |
| **NSW** | 3 | - | 3 | 1 | 1 | 2 | - | 5 |
| **QLD** | 1 | - | 1 | - | 1 | 1 | - | 2 |
| **ACT** | - | - | - | - | - | - | - | - |
| ***Total*** | 4 | - | 4 | 1 | 2 | 3 | - | 7 |

### 3.4.2 Executive remuneration

In April 2019, the PGPA Rule was amended to provide greater clarity over Commonwealth executive remuneration arrangements and to standardise annual report disclosure of the remuneration of key management personnel, senior executives and other highly paid staff. These new requirements recognise the heightened interest from Parliament and the public for transparency over executive remuneration.

They are to replace online reporting of executive remuneration on the Agency's website introduced in 2016–17, and supplement aggregate reporting for key management personnel in its Financial Statements.

The new disclosures cover key management personnel, senior executives and other highly paid staff:

| | |
|---|---|
| **Key Management Personnel (KMP)** | Under accounting standards, KMP are defined as having authority and responsibility for planning, directing and controlling the activities the Agency. The Agency has determined KMP to be its Board members, its CEO and Executive Leadership Team. This is consistent with the reporting of the Agency's KMP in its Financial Statements (in Part 4).<br><br>Under the new arrangements KMP, their positions, and total remuneration package are identified, reflecting the shift to individual (rather than aggregate) reporting for the Agency's Board and leadership team. |
| **Senior executives** | Senior executives encompass the Agency's General Managers and anyone (who does not qualify as a KMP) who is responsible for decision-making or having substantial input to decisions affecting the operations of the Agency. |
| **Other highly paid staff** | Whereas the above two categories are determined by role or classification, this final category, other highly paid staff, is decided solely on the basis of remuneration. It captures any staff who are neither KMP nor senior executives whose total remuneration exceeds an annual reporting threshold of $220,000 for the 2018–19 reporting period (this figure that will be indexed yearly). |



## Remuneration policies and practices

The Agency employs both public servants and common law employees. For all non-SES officers, including both public servants and common law employees, the Agency utilises the remuneration bands set out in the section 24 Determination made under section 24(1) of the Public Service Act 1999. It manages remuneration within these bands. SES officer remuneration is aligned with the Department of Health SES remuneration bands. Any requests for remuneration outside these bands must be supported by a business case to the CEO for consideration.

The Agency sourced an external Remuneration Review by Deloitte to:

- Analyse employee salary bands
- Deliver a breakdown of Agency and comparable Commonwealth agencies remuneration for different positions, and how their employees and current salary fits into these ranges
- Analyse market rates for key technical roles in the Agency
- Determine techniques used by comparable agencies to attract and retain staff
- Provide options for consideration to enable the Agency to retain and attract quality staff to deliver on its strategic priorities.

The recommendations of this report will be utilised in making decisions on Agency remuneration and benefits.

## Remuneration Governance arrangements

Remuneration for the CEO is managed through the Remuneration Tribunal which is an independent statutory authority that handles remuneration of key Commonwealth offices.

As a small Agency the CEO is responsible for the annual remuneration review for all SES officers. The Agency applies the Department of Health remuneration bands for SES and increases are considered for those SES who are within the remuneration bands. The review is undertaken in August each year to align with the end-cycle performance ratings which are completed in July. Any requests for remuneration outside these bands must be supported by a business case to the CEO for consideration.

For all non-SES officers, including both public servants and common law employees any requests for remuneration outside the section 24 Determination remuneration bands also requires a business case to the CEO for consideration.

## 3.4.3 Key management personnel

Under new requirements introduced for the 2018–19 reporting year, each of the Agency's KMP names, positions and remuneration packages are identified:

### Remuneration tables

The remuneration information in the tables below is presented in accordance with 2019 amendments to the PGPA Rule.[23]

| | | Short-term benefits | | | Post-employment benefits | Other long-term benefits | | Termination benefits ($) | Total remuneration |
|---|---|---|---|---|---|---|---|---|---|
| Name | Position Title | Base Salary ($) | Bonuses ($) | Other benefits and allowances ($) | Superannuation contributions ($) | Long service leave ($) | Other long-term benefits ($) | | |
| Timothy Kelsey | Chief Executive Officer | 538,454 | - | 4,429 | 27,921 | 5,709 | - | - | 576,513 |
| Ronan O'Connor | Executive General Manager | 346,293 | 18,265 | - | 37,782 | 8,617 | - | - | 410,958 |
| Bettina McMahon | Executive General Manager | 309,907 | 18,265 | 26,914 | 36,888 | 7,878 | - | - | 399,852 |
| Terence Seymour | Executive General Manager (outgoing) | 225,225 | - | 29,046 | 24,454 | 6,629 | - | 107,688 | 393,042 |
| Meredith Makeham | Executive General Manager | 338,816 | - | - | 30,957 | 8,523 | - | - | 378,295 |
| Monica Trujillo | Executive General Manager (outgoing) | 61,398 | - | 5,693 | 8,267 | 1,875 | - | - | 77,234 |
| Steven Momcilovic | Chief Finance Officer (incoming) | 177,511 | - | 1,539 | 30,390 | 3,991 | - | - | 213,431 |
| David Delaporte | Chief Finance Officer (outgoing) | 48,189 | - | - | 4,421 | 1,532 | - | 32,578 | 163,266 |
| Steven Issa | Chief Digital Officer (incoming) | 134,595 | - | 12,126 | 13,374 | 3,171 | - | - | 163,266 |
| Elizabeth Deveny | Board Chair (incoming) | 87,368 | - | - | 8,300 | - | - | - | 95,668 |
| Michael Woods | Board Member (incoming) | 10,879 | - | - | 1,033 | - | - | - | 11,912 |
| Emma Hossack | Board Member (incoming) | 10,879 | - | - | 1,033 | - | - | - | 11,912 |
| Samuel Heard | Board Member (incoming) | 10,879 | - | - | 1,033 | - | - | - | 11,912 |
| Learne Durrington | Board Member (incoming) | 10,879 | - | - | 1,033 | - | - | - | 11,912 |
| Kylie Ward | Board Member (incoming) | 10,879 | - | - | 1,033 | - | - | - | 11,912 |
| Bennie Ng | Board Member | 58,224 | - | - | 8,966 | - | - | - | 67,190 |
| Lyn McGrath | Board Member | 67,754 | - | - | 6,437 | - | - | - | 74,190 |
| James Birch | Board Chair (outgoing) | 95,555 | - | - | 9,078 | - | - | - | 104,633 |
| Robert Bransby | Board Member (outgoing) | 62,133 | - | 6,722 | 6,507 | - | - | - | 75,632 |
| Eleanor Chew | Board Member (outgoing) | 54,872 | - | - | 5,161 | - | - | - | 60,032 |
| Stephanie Newell | Board Member (outgoing) | 54,872 | - | - | 5,161 | - | - | - | 60,032 |
| Johanna Westbrook | Board Member (outgoing) | 54,872 | - | - | 5,161 | - | - | - | 60,032 |
| Rodney Ecclestone | Acting Executive General Manager | 35,696 | - | 3,045 | 3,563 | 1,322 | - | - | 43,626 |
| Kerri Burden | Acting Executive General Manager | 14,478 | - | 3,713 | 2,714 | 502 | - | - | 21,407 |

23. Sections 17BE(ta), 17CA-CC and Schedule 3 of the Public Governance, Performance and Accountability Rule 2014.

### Senior executives

Senior executive disclosures are at aggregate level, reporting on averaged remuneration packages within dollar ranges ($25,000 bands), and show the number of executives within each band:

| Total remuneration bands | $0-$220,000 | $220,001-$245,000 | $245,001-$270,000 | $270,001-$295,000 |
|---|---|---|---|---|
| Number of senior executives | 7 | 4 | 2 | 3 |
| Average base salary ($) | 118,236 | 178,003 | 199,386 | 226,992 |
| Average bonuses ($) | - | - | - | - |
| Average other benefits and allowances ($) | 3,790 | 7,758 | 2,520 | 8,915 |
| Average superannuation contributions ($) | 15,089 | 22,005 | 20,746 | 31,603 |
| Average long service leave ($) | 3,583 | 6,196 | 4,765 | 6,185 |
| Average other long term benefits ($) | - | - | - | - |
| Average termination benefits ($) | 20,249 | 27,241 | 41,918 | - |
| Average total remuneration ($) | 160,948 | 241,202 | 269,334 | 273,695 |

### Other highly paid staff

Under the new statutory requirements, the Agency is also obliged to produce a table showing the value of remuneration packages for other highly paid staff, defined as those employees who do not fall into the categories above but whose average reportable remuneration was $220,000 or more for the financial period. No staff fell in that category for the reporting period 2018–19.

## 3.5 Mandatory reporting requirements under various Commonwealth legislation

### 3.5.1 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).

The Agency's National Work Health and Safety 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 WHS policies and promotion of safe work practices. Committee representatives worked closely with state-based health and safety committees and 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 work life balance.

Under the WHS Act, the Agency must provide statistics of any notifiable incidents (serious work-related injuries or illness) and details of any investigations conducted during the reporting period. In accordance with Schedule 2, Part 4 of that Act, the Agency is also required to report on initiatives taken during the year to ensure workplace health and safety and the outcomes of those initiatives.

These initiatives included the following:

#### Workplace health and safety

- Encouraging staff to report accidents, incidents 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 70%)
- Presence of first aid facilities and supplies 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 support staff and
- ICT remote working capabilities to cover all staff, enabling flexible delivery from outside the office or at home, with manager approval.

#### Wellbeing

- Resilience training to support staff to manage the challenges of organisational change
- 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 (42 employees, or their families, utilised this service in 2018–19).

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.

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.

### 3.5.2 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 agencies, market research, polling, direct mail or media advertising organisations. Sums less than $13,000 are not required to be reported.

During 2018 – 19 the Agency's total expenditure for advertising and market research over the reporting threshold was $6,661,629.05 (GST inclusive).

The following table shows the breakdown of payments by category. Agency payments for creative advertising and market research services supplied within the reporting period but processed outside it will be reported in next year's annual report.

| **Advertising agency** | **Expenditure** (GST inclusive) |
|---|---|
| Ogilvy & Mather (Sydney) Pty Limited | $1,119,482.76 |
| Ten Alphas Pty Ltd | $79,200.00 |
| 2M Communications Pty Ltd | 29,172.00 |
| **Market research organisation** | **Expenditure** (GST inclusive) |
| Engine Asia Pacific Pty Ltd | 1,062,372.69 |
| Fifty-Five Five Pty. Ltd | 762,300.00 |
| **Media organisation** | **Expenditure** (GST inclusive) |
| Mediabrands Australia Pty Ltd | 2,859,153.00 |
| Carat Australia Media Services Pty | 749,948.61 |
| **Total** | **6,661,629.05** |

### 3.5.3 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 teleconferencing facilities as an alternative to travel, wherever possible
- Initiatives to reduce paper consumption, such as introduction of paperless processes and follow-me printing 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
- 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.

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

# 4 Financial statements

## 4.1 Financial summary

The Agency is jointly funded by the Commonwealth ($256.812 million) and the states and territories ($30.220 million).

The corporate focus through 2018 – 19 was to maintain 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.

## 4.2 Financial outcome

The Agency had a total operating revenue of $259.760 million in 2018 – 19, and incurred total expenses of $282.472 million. As a result, the Agency recorded an operating loss of $22.712 million in 2018 – 19.

The deficit in 2018 – 19 relates to the carry forward of 2016 – 17 Council of Australian Governments (COAG) funding under the Inter-Governmental Agreement (IGA) for the delivery of the agreed work plan and also an allowance for depreciation/amortisation. There is no impact on the financial sustainability of the Agency resulting from the operating loss in 2018 - 19 with carry forward expenditure covered through funding received in 2017 - 18, which was recorded as revenue for accounting purposes in that year. Approval for this deficit has been obtained from the Minister for Finance.

## 4.3 Audited financial statements

The ANAO inspected the Agency's financial records and provided an unqualified audit opinion on the financial statements and accompanying explanatory notes on 1 October 2019. The ANAO's report and the Agency's financial statements are presented on pages 90 to 115 of **Part 4**.

The Agency will continue to focus on its budget management in 2019 – 20 to maintain its financial sustainability and to deliver strongly against its statutory priorities.

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 ('the Entity') for the year ended 30 June 2019:

(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 Entity as at 30 June 2019 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following statements as at 30 June 2019 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, comprising a summary of 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* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. 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.

**Accountable Authority's responsibility for the financial statements**

As the Accountable Authority of the Entity, the Board of the Australian Digital Health Agency (the Board) is responsible under the *Public Governance, Performance and Accountability Act 2013* (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under the Act. The Board is also responsible for such internal control as the Board determines is necessary to enable the preparation 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 ability of the Entity 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, as applicable, matters related to going concern and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

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19 National Circuit BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

### 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 the Accountable Authority 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

Sean Benfield

Executive Director

Delegate of the Auditor-General

Canberra

1 October 2019



Australian Government
Australian Digital Health Agency

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

In our opinion, the attached financial statements for the period ended 30 June 2019 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.

Elizabeth Deveny
Board Chair
Accountable Authority

DATE 27 September 2019

Tim Kelsey
Chief Executive Officer

DATE 27 September 2019

Steven Momcilovic
Chief Financial Officer

DATE 27 September 2019

## Australian Digital Health Agency

**Statement of Comprehensive Income**

*for the period ended 30 June 2019*

| | Notes | ACTUAL 2019 $'000 | ACTUAL 2018 $'000 | BUDGET ESTIMATE Original Budget $'000 | BUDGET ESTIMATE Variance $'000 |
|---|---|---|---|---|---|
| **NET COST OF SERVICES** | | | | | |
| **Expenses** | | | | | |
| Employee Benefits | 2.1A | **33,551** | 34,195 | 42,120 | 8,569 |
| Suppliers | 2.1B | **224,507** | 205,347 | 225,239 | 732 |
| Depreciation and Amortisation | 3.2A | **23,277** | 15,931 | 25,950 | 2,673 |
| Write-Down and Impairment of Assets | 2.1C | **1,137** | 582 | - | (1,137) |
| **Total expenses** | | **282,472** | 256,055 | 293,309 | 10,837 |
| **Own-Source Income** | | | | | |
| **Own-source revenue** | | | | | |
| Contributions from Jurisdictions | 2.2A | **30,220** | 32,250 | 32,250 | (2,030) |
| Interest | 2.2B | **1,479** | 3,224 | 639 | 840 |
| Other Revenue | 2.2C | **8,791** | 3,025 | - | 8,791 |
| **Total own-source revenue** | | **40,490** | 38,499 | 32,889 | 7,601 |
| **Net cost of services** | | **(241,982)** | (217,556) | (260,420) | 18,438 |
| Revenue from Government | 2.2D | **219,270** | 197,062 | 219,270 | - |
| **(Deficit) / Surplus attributable to the Australian Government** | | **(22,712)** | (20,494) | (41,150) | 18,438 |
| **Total comprehensive income / (loss) attributable to the Australian Government** | | **(22,712)** | (20,494) | (41,150) | 18,438 |

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

**Budget Variances Commentary**

**Statement of Comprehensive Income**

The deficit in 2018-19 relates to the carry forward of 2016-17 Council of Australian Governments (COAG) funding under the Inter-Governmental Agreement (IGA) for the delivery of the agreed work plan and also an allowance for depreciation/amortisation. There is no impact on the financial sustainability of the Australian Digital Health Agency (the Agency) resulting from the operating loss in 2018-19 with carry forward expenditure covered through funding received in 2017-18, which was recorded as revenue for accounting purposes in that year. Approval for this deficit has been obtained from the Minister for Finance.

## Australian Digital Health Agency

**Statement of Financial Position**

*as at 30 June 2019*

| | Notes | ACTUAL 2019 $'000 | ACTUAL 2018 $'000 | BUDGET ESTIMATE Original Budget $'000 | BUDGET ESTIMATE Variance $'000 |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| **Financial assets** | | | | | |
| Cash and Cash Equivalents | 3.1A | **83,411** | 81,531 | 35,610 | 47,801 |
| Trade and Other Receivables | 3.1B | **6,405** | 5,962 | 2,475 | 3,930 |
| **Total financial assets** | | **89,816** | 87,493 | 38,085 | 51,731 |
| **Non-financial assets** | | | | | |
| Leasehold Improvements | 3.2A | **4,666** | 1,681 | 1,140 | 3,526 |
| Plant and Equipment | 3.2A | **2,771** | 3,027 | 41 | 2,730 |
| Intangibles | 3.2A | **89,912** | 77,751 | 91,300 | (1,388) |
| Other Non-Financial Assets | 3.2B | **5,730** | 5,117 | 395 | 5,335 |
| **Total non-financial assets** | | **103,079** | 87,576 | 92,876 | 10,203 |
| **Total assets** | | **192,894** | 175,069 | 130,961 | 61,933 |
| **LIABILITIES** | | | | | |
| **Payables** | | | | | |
| Suppliers | 3.3A | **51,609** | 51,417 | 14,590 | (37,019) |
| Other Payables | 3.3B | **4,910** | 3,600 | 588 | (4,322) |
| **Total payables** | | **56,519** | 55,017 | 15,178 | (41,341) |
| **Provisions** | | | | | |
| Employee Provisions | 4.1A | **7,141** | 6,838 | 6,674 | (467) |
| Other Provisions | 4.1B | **1,826** | 637 | 338 | (1,488) |
| **Total provisions** | | **8,967** | 7,475 | 7,012 | (1,955) |
| **Total liabilities** | | **65,486** | 62,492 | 22,190 | (43,296) |
| **Net assets** | | **127,408** | 112,577 | 108,771 | 18,637 |
| **EQUITY** | | | | | |
| Contributed Equity | | **150,419** | 112,877 | 150,419 | - |
| Reserves | | **15,776** | 15,776 | 776 | 15,000 |
| Retained Surplus / (Accumulated Deficit) | | **(38,787)** | (16,075) | (42,424) | 3,637 |
| **Total equity** | | **127,408** | 112,577 | 108,771 | 18,637 |

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

**Budget Variances Commentary**

**Statement of Financial Position**

The Agency recorded the following significant movements in its assets, liabilities and equity:

*Assets*

Total assets were higher than budgeted mainly due to increases in the amount of cash held at 30 June. This favourable cash position is mainly due to accrued expenses on the statement of financial position with payments to suppliers to be made in the first months of the next reporting period.

*Liabilities*

Total liabilities were higher than budgeted due to a higher payables balance at 30 June than anticipated. These payables are within normal terms and sufficient cash is available to pay them when they fall due in the next reporting period.

*Equity*

Equity is in line with expectations and the variance is due to the net effect of the variances in assets and liabilities above. Cash reserve of $15 million is carried forward from 2017-18 as approved by the Board.

## Australian Digital Health Agency

**Statement of Changes in Equity**

*for the period ended 30 June 2019*

| | Notes | ACTUAL 2019 $'000 | ACTUAL 2018 $'000 | BUDGET ESTIMATE Original Budget $'000 | BUDGET ESTIMATE Variance $'000 |
|---|---|---|---|---|---|
| **CONTRIBUTED EQUITY** | | | | | |
| **Opening balance** | | | | | |
| Balance carried forward from previous period | | **112,877** | 59,413 | 112,877 | - |
| **Adjusted opening balance** | | **112,877** | 59,413 | 112,877 | - |
| **Transactions with owners** | | | | | |
| **Contributions by owners** | | | | | |
| Equity injection - Appropriations | | **37,542** | 53,464 | 37,542 | - |
| **Total transactions with owners** | | **37,542** | 53,464 | 37,542 | - |
| **Closing balance as at 30 June** | | **150,419** | 112,877 | 150,419 | - |
| **RETAINED EARNINGS** | | | | | |
| **Opening balance** | | | | | |
| Balance carried forward from previous period | | **(16,075)** | 19,419 | (1,274) | (14,801) |
| **Adjusted opening balance** | | **(16,075)** | 19,419 | (1,274) | (14,801) |
| **Comprehensive income** | | | | | |
| Surplus/(Deficit) for the period | | **(22,712)** | (20,494) | (41,150) | 18,438 |
| **Total comprehensive income** | | **(22,712)** | (20,494) | (41,150) | 18,438 |
| Transfers between equity components | | - | (15,000) | - | - |
| **Closing balance as at 30 June** | | **(38,787)** | (16,075) | (42,424) | 3,637 |
| **ASSET REVALUATION RESERVE** | | | | | |
| **Opening balance** | | | | | |
| Balance carried forward from previous period | | **776** | 776 | 776 | - |
| **Closing balance as at 30 June** | | **776** | 776 | 776 | - |
| **CASH RESERVE** | | | | | |
| **Opening balance** | | | | | |
| Balance carried forward from previous period | | **15,000** | - | - | 15,000 |
| **Adjusted opening balance** | | **15,000** | - | - | 15,000 |
| Transfers between equity components | | - | 15,000 | - | - |
| **Closing balance as at 30 June** | | **15,000** | 15,000 | - | 15,000 |



## Australian Digital Health Agency

**Statement of Changes in Equity**

*for the period ended 30 June 2019*

| | Notes | ACTUAL 2019 $'000 | ACTUAL 2018 $'000 | BUDGET ESTIMATE Original Budget $'000 | BUDGET ESTIMATE Variance $'000 |
|---|---|---|---|---|---|
| **TOTAL EQUITY** | | | | | |
| **Opening balance** | | | | | |
| Balance carried forward from previous period | | **112,577** | 79,608 | 112,379 | 198 |
| **Adjusted opening balance** | | **112,577** | 79,608 | 112,379 | 198 |
| **Comprehensive income** | | | | | |
| Surplus/(Deficit) for the period | | **(22,712)** | (20,494) | (41,150) | 18,438 |
| **Total comprehensive income** | | **(22,712)** | (20,494) | (41,150) | 18,438 |
| **Transactions with owners** | | | | | |
| **Contributions by owners** | | | | | |
| Equity injection - Appropriations | | **37,542** | 53,464 | 37,542 | - |
| **Total transactions with owners** | | **37,542** | 53,464 | 37,542 | - |
| **Closing balance as at 30 June** | | **127,408** | 112,577 | 108,771 | 18,637 |

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.

*Cash Reserve*

The purpose of this reserve is to recognise the potential costs of winding up the Agency should funding not be approved for future years. The creation of this reserve account has been approved by the Board.

**Budget Variances Commentary**

**Statement of Changes in Equity**

Equity is largely in line with expectations. The total equity position of the Agency has stayed at the simliar level as last year.

## Australian Digital Health Agency

**Cash Flow Statement**

*for the period ended 30 June 2019*

| | Notes | ACTUAL 2019 $'000 | ACTUAL 2018 $'000 | BUDGET ESTIMATE Original Budget $'000 | BUDGET ESTIMATE Variance $'000 |
|---|---|---|---|---|---|
| **OPERATING ACTIVITIES** | | | | | |
| **Cash received** | | | | | |
| Appropriations | | **219,270** | 197,062 | 219,270 | - |
| Interest | | **1,509** | 3,223 | 639 | 870 |
| Net GST received | | **26,493** | 16,123 | 16,597 | 9,896 |
| Contributions from jurisdictions | | **30,220** | 37,860 | 32,250 | (2,030) |
| Other | | **10,696** | 3,150 | - | 10,696 |
| **Total cash received** | | **288,188** | 257,418 | 268,756 | 19,432 |
| **Cash used** | | | | | |
| Employees | | **33,301** | 33,409 | 41,827 | 8,526 |
| Suppliers | | **250,814** | 185,456 | 242,129 | (8,685) |
| **Total cash used** | | **284,115** | 218,865 | 283,956 | (159) |
| **Net cash from/(used by) operating activities** | | **4,073** | 38,553 | (15,200) | 19,273 |
| **INVESTING ACTIVITIES** | | | | | |
| **Cash received** | | | | | |
| Investments | | **187,000** | 308,065 | - | 187,000 |
| **Total cash received** | | **187,000** | 308,065 | - | 187,000 |
| **Cash used** | | | | | |
| Purchase of property, plant and equipment | | **38,166** | 57,034 | 37,542 | (624) |
| Investments | | **187,000** | 302,064 | - | (187,000) |
| **Total cash used** | | **225,166** | 359,098 | 37,542 | (187,624) |
| **Net cash from/(used by) investing activities** | | **(38,166)** | (51,033) | (37,542) | (624) |
| **FINANCING ACTIVITIES** | | | | | |
| **Cash received** | | | | | |
| Other (Contributed Equity) | | **35,972** | 53,464 | 37,542 | (1,570) |
| **Total cash received** | | **35,972** | 53,464 | 37,542 | (1,570) |
| **Cash used** | | | | | |
| **Total cash used** | | - | - | - | - |
| **Net cash from/(used by) financing activities** | | **35,972** | 53,464 | 37,542 | (1,570) |
| **Net increase/(decrease) in cash held** | | **1,879** | 40,983 | (15,200) | 17,079 |
| Cash and cash equivalents at the beginning of the reporting period | | **81,531** | 40,548 | 50,810 | 30,721 |
| **Cash and cash equivalents at the end of the reporting period** | 3.1A | **83,411** | 81,531 | 35,610 | 47,801 |

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

**Budget Variances Commentary**

**Cash Flow Statement**

The higher than budgeted closing cash balance is the result of higher than budgeted opening cash balance, part of which has been approved by the Board to be held as a Cash Reserve ($15.00 million), and the timing of supplier payments.



## Australian Digital Health Agency

**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 National E-Health Transition Authority and My Health Record system operation activities managed by the Department of Health transferred to the Agency on that date.

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 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, extending the 2017-18 Budget measure titled *My Health Record — continuation and expansion.*
- Funding from the Australian Government, states and territories received pursuant to the Inter-Governmental Agreement signed in October 2018 and on any future such agreements.

**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 values are 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.

The following standards and/or interpretations that have been issued and are applicable to the future reporting periods will not have a material effect on the Agency's financial statements.

*AASB 15 Revenue from Contracts with Customers*

AASB 15 applies to all revenue arising from contracts unless the contracts are in scope of other standards and replaces all existing revenue requirements in Australian Accounting standards. This standard provides a single framework for revenue recognition using a five-step model. This standard will be effective for the Agency for the 2019-20 financial year and will not have a material effect on the financial statements.

*AASB 16 Leases*

The AASB has introduced AASB 16 *Leases* removing the distinction between operating and finance leases for lessees and requiring the recognition of a right-of-use (RoU) asset and lease liability on the balance sheet for most leasing arrangements. AASB 16 is the Australian equivalent to the IASB's IFRS 16. The Agency's initial application of AASB 16 will be for the 2019-20 financial year and will increase the lease liability and RoU by $20.431 million simultaneously resulting in nil impact on the net assets.

**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**

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

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **2.1A: Employee Benefits** | | |
| Wages and salaries | **25,013** | 26,793 |
| Superannuation | | |
| Defined contribution plans | **2,561** | 2,709 |
| Defined benefit plans | **667** | 516 |
| Leave and other entitlements | **4,259** | 4,044 |
| Separation and redundancies | **1,051** | 133 |
| **Total employee benefits** | **33,551** | 34,195 |

**Accounting Policy**

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

| | | |
|---|---|---|
| **2.1B: Suppliers** | | |
| **Goods and services supplied or rendered** | | |
| Consultants | **5,258** | 3,839 |
| Contract for services | **154,442** | 149,837 |
| Contractors | **28,697** | 24,224 |
| Travel | **2,988** | 2,573 |
| IT services | **7,726** | 6,687 |
| Communications | **13,193** | 1,044 |
| Other | **8,015** | 13,760 |
| **Total goods and services supplied or rendered** | **220,319** | 201,964 |
| **Other suppliers** | | |
| Minimum lease payments | **4,037** | 3,152 |
| Workers compensation expenses | **151** | 231 |
| **Total other suppliers** | **4,188** | 3,383 |
| **Total suppliers** | **224,507** | 205,347 |

**Leasing commitments**

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

| | | |
|---|---|---|
| **Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:** | | |
| Within 1 year | **3,397** | 3,221 |
| Between 1 to 5 years | **13,025** | 14,553 |
| More than 5 years | **364** | 2,234 |
| **Total operating lease commitments** | **16,786** | 20,008 |

**Accounting Policy**

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

| | | |
|---|---|---|
| **2.1C: Write-Down and Impairment of Assets** | | |
| Impairment on financial instruments[1] | - | 582 |
| Impairment of property, plant and equipment[2] | **12** | - |
| Impairment on intangible assets[3] | **1,125** | |
| **Total write-down and impairment of assets** | **1,137** | 582 |

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

[2] The impairment relates to IT hardware disposed in 2018-19.

[3] The impairment relates to the reclassification of intangible assets at 30 June 2019.

Australian Digital Health Agency

Notes to and forming part of the financial statements

## 2.2 Own-Source Revenue and Gains

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **Own-Source Revenue** | | |
| **2.2A: Contributions from Jurisdictions** | | |
| New South Wales | **9,676** | 10,326 |
| Victoria | **7,603** | 7,998 |
| Queensland | **6,068** | 6,515 |
| Western Australia | **3,276** | 3,509 |
| South Australia | **2,140** | 2,328 |
| Tasmania | **653** | 710 |
| Australian Capital Territory | **496** | 529 |
| Northern Territory | **308** | 335 |
| **Total contributions from Jurisdictions** | **30,220** | **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 October 2018). The above contributions from states and territories of $30.220 million represents half of the total contributions made under the Intergovernmental Agreement after adjustment for unearned revenue, 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.

| | | |
|---|---|---|
| **2.2B: Interest** | | |
| Deposits | **1,479** | 3,224 |
| **Total interest** | **1,479** | 3,224 |

**Accounting Policy**

Interest revenue is recognised using the effective interest method.

| | | |
|---|---|---|
| **2.2C: Other Revenue** | | |
| Other revenue | **8,791** | 3,025 |
| **Total other revenue** | **8,791** | 3,025 |

Currently the Agency does not derive revenue from the sale of goods and services. Funding for the Electronic Prescribing Project and Opt-out extension – Additional Communication expenditure was agreed in this financial year with the Department of Health.

| | | |
|---|---|---|
| **2.2D: Revenue from Government** | | |
| Department of Health | | |
| Corporate Commonwealth entity payment item | **219,270** | 197,062 |
| **Total revenue from Government** | **219,270** | 197,062 |

**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 the Australian Government by the corporate Commonwealth entity unless the funding is in the nature of an equity injection or a loan. The Agency's revenue from the Australian Government includes $32.25 million paid pursuant to the Intergovernmental Agreement (refer also Note 2.2A).



Australian Digital Health Agency

Notes to and forming part of the financial statements

## 3.1 Financial Assets

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **3.1A: Cash and Cash Equivalents** | | |
| Cash on hand or on deposit | **83,411** | 81,531 |
| **Total cash and cash equivalents** | **83,411** | 81,531 |

**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 | **3,948** | 2,693 |
| Receivable from Department of Health - equity | **1,570** | - |
| Other receivables | **50** | - |
| GST receivable from the ATO | **3,102** | 5,504 |
| Interest Receivable | **63** | 93 |
| **Total goods and services receivables** | **8,733** | 8,290 |
| **Total trade and other receivables (gross)** | **8,733** | 8,290 |
| **Less impairment allowance (receivables)** | **(2,328)** | (2,328) |
| **Total trade and other receivables (net)** | **6,405** | 5,962 |

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

All trade and other receivables are expected to be recovered within 12 months.

**Accounting Policy**

*Financial Assets*

"The Agency classifies its financial assets at the time of initial recognition depending on the nature and purpose of the asset. All receivables are classified as trade and other receivables and are expected to be recovered within 12 moths unless other indicated."
The collectability of debts are reviewed at the end of the reporting period and an impairment allowance is recognized.

Australian Digital Health Agency

Notes to and forming part of the financial statements

## 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 2019**

| | Leasehold Improvements | Plant and Equipment | Computer Software[1] | Other Intangibles | Total |
|---|---|---|---|---|---|
| | $'000 | $'000 | $'000 | $'000 | $'000 |
| **As at 1 July 2018** | | | | | |
| Gross book value | 3,131 | 4,293 | 21,502 | 98,329 | 127,255 |
| Accumulated depreciation, amortisation | (1,450) | (1,266) | (4,648) | (37,432) | (44,796) |
| **Total as at 1 July 2018** | 1,681 | 3,027 | 16,854 | 60,897 | 82,459 |
| Additions | | | | | |
| Purchase | 3,833 | 908 | - | - | 4,741 |
| Internally developed | - | - | - | 34,563 | 34,563 |
| Depreciation and amortisation | (848) | (1,152) | (4,003) | (17,273) | (23,277) |
| Impairment[2] | - | (12) | - | (1,125) | (1,137) |
| Other movements | | | | | |
| Reclassification | - | - | (1,604) | 1,604 | - |
| **Total as at 30 June 2019** | 4,666 | 2,771 | 11,247 | 78,666 | 97,349 |
| **Total as at 30 June 2019 represented by** | | | | | |
| Gross book value | 6,964 | 5,201 | 19,898 | 134,496 | 166,558 |
| Accumulated depreciation, amortisation and impairment | (2,298) | (2,430) | (8,651) | (55,830) | (69,210) |
| **Total as at 30 June 2019** | 4,666 | 2,771 | 11,247 | 78,666 | 97,349 |

[1] The carrying amount of computer software includes all purchased software. Internally generated assets are disclosed as other intangibles.

[2] $1.137 million was recognised for the impairment to Property, Plant and Equipment, Computer Software and Other Intangibles at 30 June 2019.

**Capital commitments**

The Agency has a $20 million contractual obligation in the financial year 2019-2020 for the system improvements for MHR.



Australian Digital Health Agency

Notes to and forming part of the financial statements

## 3.2 Non-Financial Assets

**Asset 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. Purchases costing less than $2,000 are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total) except for IT hardware a lower capitalisation threshold of $500 is applicable.

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 make good. These costs are included in the value of the Agency's provisions.

| Category | Capitalisation Threshold |
|---|---|
| Purchased IT hardware and IT software | $500 |
| Leasehold improvements | $50,000 |
| Internally developed IT software and hardware | $100,000 |
| IT projects (software and hardware integration) | $100,000 |
| All other property, plant and equipment | $2,000 |

*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.

All revaluations were conducted in accordance with the revaluation policy. An independent valuation was performed at 30 June 2019 and no material fair value movements were identified.

**Asset Accounting Policy**

*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 subject to update to specific older MHR releases |

*Impairment*

All assets were assessed for impairment at 30 June 2019. 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.





**3.2 Non-Financial Assets**

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **3.2B: Other non-financial assets** | | |
| Prepayments | **3,549** | 2,473 |
| Right of use assets | **224** | 266 |
| Lease incentive asset | **1,957** | 2,378 |
| **Total other non-financial assets** | **5,730** | 5,117 |
| **Other non-financial assets expected to be recovered** | | |
| No more than 12 months | **3,619** | 2,829 |
| More than 12 months | **2,111** | 2,288 |
| **Total other non-financial assets** | **5,730** | 5,117 |

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

Australian Digital Health Agency

Notes to and forming part of the financial statements

## 3.3 Payables

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **3.3A: Suppliers** | | |
| Trade creditors and accruals | **51,609** | 51,417 |
| **Total suppliers** | **51,609** | 51,417 |
| **3.3B: Other Payables** | | |
| Salaries and wages | **261** | 314 |
| Lease incentive | **2,595** | 3,137 |
| Superannuation | **24** | 24 |
| Unearned income | **2,030** | 125 |
| **Total other payables** | **4,910** | 3,600 |

**Accounting Policy**

*Trade creditors and accruals*

Trade creditors and accruals are recognised at amortised costs.

Liabilities are recognised to the extent that goods and services have been received.

*Lease incentives*

Lease incentives taking the form of 'free' leasehold improvements and rent holidays are recognised as liabilities.

These liabilities are reduced on a straight-line basis by allocating lease payments between rental expense and reduction of the lease incentive liability.



Australian Digital Health Agency

Notes to and forming part of the financial statements

## 4.1 Provisions

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **4.1A: Employee Provisions** | | |
| Leave | **7,141** | 6,838 |
| **Total employee provisions** | **7,141** | 6,838 |
| **Employee provisions expected to be settled** | | |
| No more than 12 months | **5,763** | 5,070 |
| More than 12 months | **1,378** | 1,768 |
| **Total employee provisions** | **7,141** | 6,838 |

**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 Australian Public Service (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 Australian 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.

Australian Digital Health Agency

Notes to and forming part of the financial statements

## 4.1 Provisions

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **4.1B: Other Provisions** | | |
| Provision for restoration | **494** | 637 |
| Provision for onerous lease | **1,332** | - |
| **Total other provisions** | **1,826** | 637 |
| | | |
| **Provision for restoration** | | |
| As at 1 July | **637** | 338 |
| Additional provision made | **(143)** | 299 |
| **Total as at 30 June** | **494** | 637 |
| | | |
| **Provision for onerous lease** | | |
| As at 1 July | - | - |
| Additional provision made | **1,332** | - |
| **Total as at 30 June** | **1,332** | - |
| | | |
| **Other provisions expected to be settled** | | |
| No more than 12 months | **335** | **494** |
| More than 12 months | **1,491** | **143** |
| **Total other provisions** | **1,826** | **637** |

The Agency currently has three agreements for the leasing of premises and one of those agreements requires the Agency 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.

An onerous lease provision of $1.33million was recognised at 30 June 2019, reflecting the present value of lease expense, net of estimated sub-lease revenue, for a non-cancellable contract for office space.

**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.

*Provision for Restoration Obligation*

Where the Agency has a contractual obligation to undertake remedial work upon vacating leased properties, the estimated cost of that work is recognised as a liability. An equal value asset is created at the same time and amortised over the life of the lease of the underlying leasehold property.

*Provision for Onerous Lease*

An onerous contract is a contract in which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it. The entity has a contract that is onerous, the present obligation under the contract is recognised and measured as a provision.



Australian Digital Health Agency

Notes to and forming part of the financial statements

## 4.2 Key Management Personnel Remuneration

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 board member (whether executive or otherwise) of that agency. The Agency has determined the key management personnel to be Chief Executive Officer, Executive Leadership Team members and Board members. Key management personnel remuneration is reported in the table below:

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **Key management personnel remuneration expenses** | | |
| Short-term employee benefits | **2,950** | 3,209 |
| Post-employment benefits | **281** | 293 |
| Other long-term employee benefits | **50** | 245 |
| Termination benefits | **140** | 44 |
| **Total key management personnel remuneration expenses**[1] | **3,421** | 3,791 |

The total number of key management personnel that are included in the above table are 24 due to the change in Board membership in April 2019 (2018: 16). Decrease in remuneration is due to change in the Senior Leadership Team in October 2018.

[1] 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. The head count only includes key management personnel who received remuneration from the Agency in 2018-19.

Australian Digital Health Agency

Notes to and forming part of the financial statements

## 4.3 Related Party Disclosures

**Related party relationships:**

The Agency is an Australian Government controlled corporate Commonwealth entity. It has a governing board of members, a Chief Executive Officer (CEO) and Executive Leadership Team (ELT) members and a Portfolio Minister.

Pursuant to *AASB 124 Related Party Disclosures,* the 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 ELT members constitute KMP.

Officers acting into the CEO, or an ELT 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.

Giving consideration to relationships with related entities, and transactions entered into during the reporting period by the Agency, 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 2018-19 is $120,000. (2018: $120,000).



Australian Digital Health Agency

Notes to and forming part of the financial statements

## 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.

**Accounting Policy**

Contingent assets and liabilities may arise from uncertainty as to the existence of an asset or liability, or where the amount cannot be reliably measured.

Contingent assets are disclosed when settlement is probable but not virtually certain.

Contingent liabilities are disclosed when settlement is greater than remote.

**Australian Digital Health Agency**

**Notes to and forming part of the financial statements**

## 5.2 Financial Instruments

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| **5.2A: Categories of Financial Instruments** | | |
| **Financial Assets under AASB 139** | | |
| Cash | - | 81,531 |
| Trade and Other Receivables | - | 5,962 |
| **Financial Assets under AASB 9** | | |
| **Financial assets at amortised cost** | | |
| Cash | 83,411 | - |
| Trade and Other Receivables | 6,405 | - |
| **Total financial assets** | 89,816 | 87,493 |
| **Financial Liabilities** | | |
| **Financial liabilities measured at amortised cost** | | |
| Trade creditors and accruals | 51,609 | 51,417 |
| **Total financial liabilities measured at amortised cost** | 51,609 | 51,417 |
| **Total financial liabilities** | 51,609 | 51,417 |

**Classification of financial assets on the date of initial application of AASB 9.**

| Financial assets class | Note | AASB 139 original classification | AASB 9 new classification | AASB 139 carrying amount at 1 July 2018 $'000 | AASB 9 carrying amount at 1 July 2018 $'000 |
|---|---|---|---|---|---|
| Cash | 3.1A | Loans and receivables | Amortised Cost | 81,531 | 81,531 |
| Trade and Other Receivables | 3.1B | Loans and receivables | Amortised Cost | 5,962 | 5,962 |
| **Total financial assets** | | | | 87,493 | 87,493 |

**Accounting Policy**

*Financial Assets*

With the implementation of AASB 9 Financial Instruments for the first time in 2019, the Agency classifies its financial assets in the following categories:

a. financial assets at fair value through profit or loss;
b. financial assets at fair value through other comprehensive income; and
c. financial assets measured at amortised cost.

The classification depends on both the Agency's business model for managing the financial assets and contractual cash flow characteristics at the time of initial recognition. Financial assets are recognised when the Agency becomes a party to the contract and, as a consequence, has a legal right to receive or a legal obligation to pay cash and derecognised when the contractual rights to the cash flows from the financial asset expire or are transferred upon trade date.

Interest revenue from financial assets for 2018-19 was $1.479 million (2017: $3.224 million).

*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'.

**5.2B: Credit Risk**

The Agency is 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 $7.6 million in 2018 (2018: $5.9 million). The Agency managed its credit risk by establishing policies and procedures for debt management.

The Agency had no financial assets that were past due but not impaired at 30 June 2019 (2018: None)



**Australian Digital Health Agency**

**Notes to and forming part of the financial statements**

## 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.

The different levels of the fair value hierarchy are defined below:

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Agency can access at measurement date.

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.

Level 3: Unobservable inputs for the asset or liability.

Leasehold improvements are categorised as Level 3.

Plant and equipment are categorised as Level 2.

**5.3A: Fair Value Measurement**

| | Fair value measurements at the end of the reporting 2019 $'000 | 2018 $'000 |
|---|---|---|
| **Non-financial assets** | | |
| Leasehold Improvements | 4,666 | 1,681 |
| Plant and equipment | 2,771 | 3,027 |
| **Total fair value measurements in the statement of financial position** | 7,437 | 4,709 |
| **Total assets not measured at fair value in the statement of financial position** | 95,642 | 82,867 |

**Accounting Policy**

All revaluations were conducted in accordance with the revaluation policy stated at Note 3.2. An independent valuation was performed at 30 June 2019 and no material fair value movements were identified.

## 5.4 Aggregate Assets and Liabilities

| | 2019 $'000 | 2018 $'000 |
|---|---|---|
| Assets expected to be recovered in: | | |
| No more than 12 months after reporting period | 93,253 | 87,994 |
| More than 12 months after the reporting period | 99,641 | 87,075 |
| | 192,894 | 175,069 |
| Liabilities expected to be recovered in: | | |
| No more than 12 months after reporting period | 60,614 | 57,492 |
| More than 12 months after the reporting period | 4,872 | 5,000 |
| | 65,486 | 62,492 |

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

The compliance table below, identifying the location of compulsory content in the Agency's annual report, is presented in form required by amendments to the PGPA Act in 2019.

# 5 Navigation aids

## Case study:
# International review puts Australia ahead in consumer control of digital health records

An international comparison review of digital health record systems shows My Health Record consumers in Australia have more ability to personally control their digital health information than in similar countries worldwide.

The Digital Health Evidence Review, released by the Australian Digital Health Agency, brings together studies comparing My Health Record with similar systems across the world, including those in France, the UK, the USA and New Zealand.

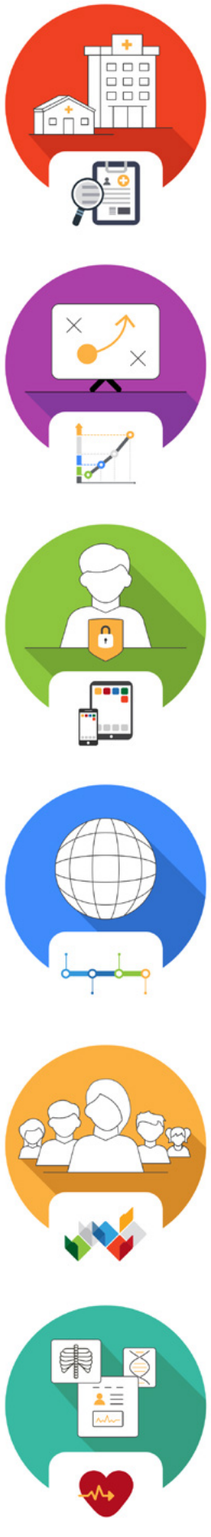
> *"Although many countries have laws that allow users to view their health information, only Australia and a handful of other countries have laws that allow citizens to control who sees their information and request corrections to their own health data," says Agency Chief Medical Adviser, Professor Meredith Makeham.*

It is worth noting that this review took place before the Australian Government introduced additional consumer safeguards in November 2018, which further strengthened Australia's position as an international leader in consumer control of digital health information.

Research Australia CEO Nadia Levin has welcomed the review.

> *"There is great value in sharing information about the My Health Record system and similar digital platforms around the world. This information can support researchers, policy makers and the community in understanding the way personal health records can support better health outcomes and health system improvements, while considering the necessary controls required to build trust in such a system" Ms Levin says.*

The Digital Health Evidence Review drew on a variety of research sources, including academic peer-reviewed literature, government reports and white papers, World Health Organization (WHO) data, and other information sourced from international governments and agencies responsible for the delivery of digital health services. It can be accessed at www.digitalhealth.gov.au/evidence-review.



## 5.1 Index of annual report content requirement

| PGPA Rule Reference | Part of Report | Description | Requirement |
|---|---|---|---|
| 17BE | Contents of annual report | | |
| 17BE(a) | 20 | Details of the legislation establishing the body | Mandatory |
| 17BE(b)(i) | 22 | A summary of the objects and functions of the entity as set out in legislation | Mandatory |
| 17BE(b)(ii) | 20 | The purposes of the entity as included in the entity's corporate plan for the reporting period | Mandatory |
| 17BE(c) | 21 | The names of the persons holding the position of responsible Minister or responsible Ministers during the reporting period, and the titles of those responsible Ministers | Mandatory |
| 17BE(d) | N/A | Directions given to the entity by the Minister under an Act or instrument during the reporting period | If applicable, mandatory |
| 17BE(e) | N/A | Any government policy order that applied in relation to the entity during the reporting period under section 22 of the Act | If applicable, mandatory |
| 17BE(f) | N/A | Particulars of non compliance with:<br>(a) a direction given to the entity by the Minister under an Act or instrument during the reporting period; or<br>(b) a government policy order that applied in relation to the entity during the reporting period under section 22 of the Act | If applicable, mandatory |
| 17BE(g) | 36 | Annual performance statements in accordance with paragraph 39(1)(b) of the Act and section 16F of the Rule | Mandatory |

| PGPA Rule Reference | Part of Report | Description | Requirement |
|---|---|---|---|
| 17BE(h), 17BE(i) | N/A | A statement of significant issues reported to the Minister under paragraph 19(1)(e) of the Act that relates to non compliance with finance law and action taken to remedy non compliance | If applicable, mandatory |
| 17BE(j) | 66 | Information on the accountable authority, or each member of the accountable authority, of the entity during the reporting period | Mandatory |
| 17BE(k) | 26 | Outline of the organisational structure of the entity (including any subsidiaries of the entity) | Mandatory |
| 17BE(ka) | 92 | Statistics on the entity's employees on an ongoing and non ongoing basis, including the following:<br>(a) statistics on full time employees;<br>(b) statistics on part time employees;<br>(c) statistics on gender;<br>(d) statistics on staff location | Mandatory |
| 17BE(l) | 21 | Outline of the location (whether or not in Australia) of major activities or facilities of the entity | Mandatory |
| 17BE(m) | 66 | Information relating to the main corporate governance practices used by the entity during the reporting period | Mandatory |
| 17BE(n), 17BE(o) | 91 | For transactions with a related Commonwealth entity or related company where the value of the transaction, or if there is more than one transaction, the aggregate of those transactions, is more than $10,000 (inclusive of GST):<br>(a) the decision making process undertaken by the accountable authority to approve the entity paying for a good or service from, or providing a grant to, the related Commonwealth entity or related company; and<br>(b) the value of the transaction, or if there is more than one transaction, the number of transactions and the aggregate of value of the transactions | If applicable, mandatory |

| PGPA Rule Reference | Part of Report | Description | Requirement |
|---|---|---|---|
| 17BE(p) | 91 | Any significant activities and changes that affected the operation or structure of the entity during the reporting period | If applicable, mandatory |
| 17BE(q) | 88 | Particulars of judicial decisions or decisions of administrative tribunals that may have a significant effect on the operations of the entity | If applicable, mandatory |
| 17BE(r) | 88 | Particulars of any reports on the entity given by:<br>(a) the Auditor General (other than a report under section 43 of the Act); or<br>(b) a Parliamentary Committee; or<br>(c) the Commonwealth Ombudsman; or<br>(d) the Office of the Australian Information Commissioner | If applicable, mandatory |
| 17BE(s) | N/A | An explanation of information not obtained from a subsidiary of the entity and the effect of not having the information on the annual report | If applicable, mandatory |
| 17BE(t) | 92 | Details of any indemnity that applied during the reporting period to the accountable authority, any member of the accountable authority or officer of the entity against a liability (including premiums paid, or agreed to be paid, for insurance against the authority, member or officer's liability for legal costs) | If applicable, mandatory |
| 17BE(ta) | 96 | Information about executive remuneration | Mandatory |
| *17BF* | Disclosure requirements for government business enterprises | | |
| *17BF(1)(a)(i)* | N/A | An assessment of significant changes in the entity's overall financial structure and financial conditions | If applicable, mandatory |
| *17BF(1)(a)(ii)* | N/A | An assessment of any events or risks that could cause financial information that is reported not to be indicative of future operations or financial conditions | If applicable, mandatory |
| *17BF(1)(b)* | N/A | Information on dividends paid or recommended | If applicable, mandatory |

| PGPA Rule Reference | Part of Report | Description | Requirement |
|---|---|---|---|
| *17BF(1)(c)* | N/A | Details of any community service obligations the government business enterprise has including:<br>(a) an outline of actions taken to fulfil those obligations; and<br>(b) an assessment of the cost of fulfilling those obligations | If applicable, mandatory |
| *17BF(2)* | N/A | A statement regarding the exclusion of information on the grounds that the information is commercially sensitive and would be likely to result in unreasonable commercial prejudice to the government business enterprise | If applicable, mandatory |

## 5.2 Acronyms and abbreviations

| Acronym | Term |
|---|---|
| **ACSQHC** | Australian Commission on Safety and Quality in Health Care |
| **AHMAC** | Australian Health Minister's Advisory Council |
| **AMT** | Australian Medicines Terminology |
| **ANAO** | Australian National Audit Office |
| **CBA** | Commonwealth Bank of Australia |
| **COAG** | Council of Australian Governments |
| **DHS** | Department of Human Services |
| **EY** | Ernst and Young |
| **GDHP** | Global Digital Health Partnership |
| **HI** | Healthcare Identifiers |
| **HPOS** | Health Professionals Online Service |
| **ICT** | Information and communication technology |
| **IHTSDO** | International Health Terminology Standards Development Organisation |
| **IPS** | Information Publication Scheme |
| **NASH** | National Authentication Service for Health |
| **NCTS** | National Clinical Terminology Service |
| **NEHTA** | National E-Health Transition Authority |
| **NGO** | Non-Government Organisations |
| **NPC** | National Product Catalogue |
| **PBS** | Portfolio Budget Statements |
| **PCML** | Pharmacist Curated Medicines Lists |
| **PGPA** | Public Governance, Performance and Accountability |
| **RACS** | Royal Australasian College of Surgeons |
| **RCPA** | Royal College of Pathologists Australasia |
| **SMD** | Secure Message Delivery |
| **WHO** | World Health Organization |

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