Annual Report 2017–18

Australian Digital Health Agency

Australian Government

Australian Digital Health Agency

Harry Iles-Mann

Front Cover: Kathy Rainbird and Donelle Gibbs
Back Cover: Lionel "Tiger" Corrigan

Guide to this report

This annual report describes the operations and performance of the Australian Digital Health Agency (the Agency) during 2017–18. The report was prepared in accordance with legislated reporting requirements under the *Public Governance, Performance and Accountability Act 2013* and other Commonwealth legislation including the *My Health Records Act 2012*.

Part 1 – Introduction and overview

Introduces the Agency, and provides an overview of its operations, its achievements in 2017–18, and priorities for 2018–19.

Part 2 – Performance

Details the Agency's performance against work plan priorities captured in its 2017–18 Corporate Plan and against ministerial targets published in the Health Portfolio Budget Statements 2017–18. It also addresses reporting obligations under the My Health Records Act.

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 2017–18.

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.

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Feedback and inquiries

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Annual Report 2017–18

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Letter of transmittal

Australian Government
Australian Digital Health Agency

15 October 2018

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 2017 to 30 June 2018.

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 second year of operations and addresses the requirements of section 46 of the *Public Governance, Performance and Accountability Act 2013,* including annual performance statements under paragraph 39(1)(b) and audited financial statements as required by subsection 43(4) of that Act.

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

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

Jim Birch AM
Chair
Australian Digital Health Agency

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Chair's message

On behalf of the Board of the Australian Digital Health Agency it is my pleasure to present to you the Agency's annual report for its second year of operations.

The Agency's work for the past year has been guided by *Australia's National Digital Health Strategy – Safe, Seamless and Secure: evolving health and care to meet the needs of modern Australia*, which was developed through extensive national consultation, and approved by COAG health ministers in August 2017. A comparable process of national consultation has guided the development of the implementation guide to the strategy, the *Framework for Action*.

Both the strategy and its accompanying implementation framework identify seven strategic priority outcomes, which collectively encompass every major aspect of the design, delivery and operations of a national digital healthcare system. The articulation of these priorities and their national agreement helps to ensure that digital health activities across Australia are coordinated around a shared guiding vision.

This past year has been one of steady growth and consolidation, in preparation for more widespread changes in years to come. The expansion of the My Health Record system to all Australians, except those who choose not to have one, has been announced. Pathology laboratories, diagnostic imaging services, public and private hospitals, and community pharmacies are connecting to My Health Record to contribute and utilise patient health information. Progress towards a national secure clinical messaging system is well underway.

The health sector is just beginning to embark on a digital transformation. Digital health promises not just improvements in efficiency and convenience, but more importantly, significantly improved safety and patient outcomes. Moreover, it is anticipated that the widespread implementation of digital health will give consumers more control of their health and care, connecting and empowering healthcare providers and promoting Australia's global leadership in digital health and innovation.

The Agency's vision of collaborative digital health system does not stop at our national borders. Australia is not alone in these endeavours. To take advantage of shared international perspectives, the Agency has founded the Global Digital Health Partnership to bring together nations and health agencies to benefit from a shared understanding of the challenges faced in each country, and the solutions and lessons that have emerged.

Australia's health system is already a world leader in several respects, and our pioneering work in digital health will further enhance this status. I invite you to join us on this journey.

Jim Birch AM
Chair

Australian Digital Health Agency

Chief Executive Officer's review

In the first year of operations, the Agency helped rebuild new momentum in digital health services and in our second, we have been focused on delivery with a clear resolve to work collaboratively and in partnership with consumers, clinicians, industry and governments.

A strategy for all Australians

The vision guiding this digital evolution is laid out in the National Digital Health Strategy[1], which was approved by the Council of Australian Governments (COAG) Health Council in August 2017. In the communiqué that followed their meeting, the health ministers noted:

> *This Strategy will build on Australia's existing leadership in digital health care and support consumers and clinicians to put the consumer at the centre of their health care and provide choice, control and transparency.*[2]

The strategy has been welcomed by Australia's digital health community following its release, a testimony to the open and thorough consultation process that led to its development. It truly is a digital health strategy for Australia, not just for the Agency.

Guiding the implementation of the strategy

The process of engagement and co-design that governed the development of the strategy has also shaped the *Framework for Action*[3], which sets out how the Agency, governments, the healthcare industry, technology industry and research community will all play a part in achieving the vision laid out in the National Digital Health Strategy. This framework aligns to strategic national health reform priorities and investments across Australia, highlights current and planned activities, and can be used to identify role gaps that will need to be addressed.

Agency milestones and achievements

Other milestones and achievements of the Agency during this year are as follows.

- **Delivering our annual Agency work plan**, securing a four-year intergovernmental agreement (2018–22) to support implementation of the National Digital Health Strategy, and operating national infrastructure (the Healthcare Identifiers Service, National Authentication Service for Health, Clinical Terminology) to a very high standard of reliability.
- **Delivering a program** to ensure readiness for the consumer communications campaign for the opt out process for the My Health Record system. This involved upgrading the system, raising awareness of healthcare providers, and significant security programs. Digital health could deliver tangible health care improvements and save the health system up to $7 billion a year by avoiding diagnosis, treatment and prescription errors.

1. Australia's National Digital Health Strategy, https://conversation.digitalhealth.gov.au/australias-national-digital-health-strategy
2. Health Ministers approve Australia's National Digital Health strategy, https://www.digitalhealth.gov.au/news-and-events/news/health-ministers-approve-australia-s-national-digital-health-strategy
3. Framework for Action, https://conversation.digitalhealth.gov.au/framework-for-action

Sussan Ley MP, Agency CEO Tim Kelsey, Agency Chief Medical Adviser Meredith Makeham, MPHN Director Clinical Services Julie Redway, MPHN staff, and local community members

Case study: **Berrigan, the first My Health Record connected town in Australia**

The community of Berrigan in NSW is the first town in Australia where all key healthcare providers are connected and using My Health Record. The Australian Digital Health Agency and the Murrumbidgee Primary Health Network (MPHN) identified Berrigan, a town in the Riverina region of New South Wales, as the first town in Australia where the local general practice, pharmacy, aged care centres, and the local hospital are all connected to the system. Additionally, over 50% of the town's population, and every resident in the aged care facility has an active My Health Record.

MPHN Acting CEO Melissa Neal said she is not surprised a rural community of around 950 people is leading the way with My Health Record.

"*In my experience, small rural communities have an inspiring sense of community spirit and connectedness. This achievement for Berrigan demonstrates the town's community strength, the foresight of the local health professionals and the town's willingness to uptake digital health technology*," Ms Neal said.

The Hon Sussan Ley MP, Member for Farrer, representing Minister for Health, the Hon Greg Hunt MP, and the Minister for Rural Health, Senator the Hon Bridget McKenzie, said people in rural and remote areas of Australia need to be able to have their important health information when they receive care.

"*My Health Record allows Australians and their health professionals to securely access their health information to improve their care, whether at home or in a metropolitan hospital.*"

- **The Agency's Board continued to take advice from six advisory committees,** whose members include many of the country's most distinguished clinical and digital health leaders. The Agency also continued to take direction from a number of steering groups, drawing on clinical, industry and consumer expertise, to oversee design and delivery of key services.
- **Achieving a milestone agreement with industry, jurisdiction and clinical partners** to a national secure messaging scheme which will mean that all registered health practitioners will have access to reliable digital tools to share clinical correspondence – and end their dependency on the fax machine.

Case study: **Helping community pharmacies become leaders in digital health**

The Agency and the Pharmacy Guild of Australia are working together to help build the digital health capabilities of community pharmacies and advance the efficiency, quality, and delivery of healthcare to improve health outcomes for all Australians.

The Agency and Guild are working on optimising connectivity to the My Health Record system through community pharmacy support including continuing professional development, and pursuing meaningful use facilitators in areas such as shared care planning, transitional care, telehealth, and interoperability with pharmacy clinical service IT platforms.

Guild Executive Director David Quilty said that the Guild supports optimised integration of community pharmacies into the My Health Record system. Community pharmacists have long been early adopters and innovators in digital health, and this partnership has helped spur the sector on to make a bigger contribution.

Pharmaceutical Society of Australia (PSA) National President Dr Shane Jackson said uptake of the My Health Record in community pharmacies is allowing dispensing information to be shared and used by other health professionals, and to deliver better care to consumers.

- **Reaching agreement with the main public and private providers** of key clinical information to upload into the My Health Record. The two largest private pathology services are now connected and actively uploading; more than 50% of community pharmacists are registered; all states and territories are either connected, or will be by 2019.
- **Delivering partnerships with consumer and clinical leaders** – including the Royal Australian College of General Practitioners, the Australian Medical Association, the Pharmacy Guild, the Pharmaceutical Society of Australia and the Consumer Health Forum – to support My Health Record education and training nationwide, and mobilising 31 Primary Health Networks and numerous community organisations to support the expansion program and public communications.
- **Establishing a comprehensive digital health benefits measurement program** which will capture data on the impact of national investment over the coming years.
- **Releasing the National Requirements** for Electronic Prescriptions.
- **Successful deployment** of Releases 9.1 to 9.4 of the My Health Record including operational improvements for providers and consumers.
- **Launching a developer program** that supports innovators to safely and securely connect to the My Health Record.
- **Supporting a diverse, high performing team** to deliver, while continuing to develop professionally.

> *Until now, pharmacists have been dispensing, counselling, providing advice, and conducting medication reconciliation partially blindfolded. My Health Record helps to lift the veil and our contributions will further cement pharmacists as an integral member of the primary healthcare team.*
>
> **Chris Campbell**
> Pharmacist and Chair of the
> Pharmaceutical Society of Australia and
> My Health Record Project
> Working Group Queensland

Global Digital Health Partnership

GLOBAL DIGITAL HEALTH
PARTNERSHIP

Australia is by no means alone in its exploration of the benefits of digital health technologies. Other nations and healthcare organisations are turning to digital health technologies to address ageing populations and other challenges, while improving safety, convenience and overall efficiency. In recognition of these shared challenges, the Agency took the initiative to establish the Global Digital Health Partnership[4] (GDHP), a forum that brings together the US, UK, Canada, Austria, Italy, South Korea, Saudi Arabia, Hong Kong, Singapore, India, Indonesia, Sweden, Argentina, Australia, Brazil, New Zealand, Ukraine

4. Global Digital Health Partnership (GDHP), https://gdhp.org

and the World Health Organization to develop international collaborations on digital health to improve health and care around the world.

Five work streams have been established, in cyber security, interoperability, evidence and evaluation, policy environments, and clinical and consumer engagement. The inaugural meeting of the GDHP took place in Canberra in February, followed by a second in Washington DC in April. More meetings are planned, and other countries have expressed interest in joining, in recognition of the value of this ground breaking work.

My Health Record

At the time of writing, almost one quarter of all Australians have registered for a My Health Record. That figure is expected to change dramatically with the transition to an "opt out" system early in the 2018–19 financial year.

Once this resource becomes almost ubiquitous across the Australian health system, clinical workflows and consumer behaviours will gradually and irrevocably change to take advantage of its many benefits. Moreover, the digitally transformed healthcare landscape will provide a platform for ongoing innovation, further enhancing Australia's already enviable healthcare system.

Berrigan: a glimpse of the future

A small glimpse of the near future of Australian healthcare was afforded to us when we visited the town of Berrigan, in the Riverina region of NSW. Berrigan has the distinction of being the first town in Australia to connect all of its medical services to My Health Record.

For many people the benefits of digital health will be realised gradually, as health and medical data gradually accumulates to form a comprehensive medical history. Others are seeing more immediate benefits, such as Damien Taylor, a local teacher in Berrigan, and his family.

Not long ago, Damien's baby daughter was diagnosed with two holes in her heart. "That was the worst day of my life," he said.

He said My Health Record was critical for his family – it is the one safe place he keeps all his daughter's complex and lengthy clinical notes so that he can share it with her clinicians.

Damien's daughter has now had successful surgery and is doing well. My Health Record, he says, is "invaluable, a key part of our lives."

Another year of digital health milestones

As we approach the end of the Agency's second year of operations, it is timely to reflect on how much we have achieved in our formative years. Not only has the Agency forged strong relationships with stakeholders, we have delivered an ambitious program of work, set by the strategy to 2022, achieved major milestones with industry on seemingly intractable problems, and embarked upon the expansion of the My Health Record system.

It has been a privilege to lead this organisation and to work with such an enthusiastic set of stakeholders. I look forward to continuing to deliver outcomes with stakeholders and to achieve the 2022 vision in the strategy.

Tim Kelsey
Chief Executive Officer
Australian Digital Health Agency

1 Introduction and overview

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

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

Focus

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

Foundations

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

> *"Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy-to-use tools for both patients and providers."* [5]

Enabling legislation

The Agency Rule created the Agency and governs its operations. The Rule was made by the Commonwealth Minister for Finance under Section 87 of the *Public Governance, Performance and Accountability Act 2013*[6] (PGPA Act) which allows for the creation of Commonwealth corporate entities. The Agency is the first in the Commonwealth to be established by this new mechanism.

Governance structure

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

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

Delivery priorities for 2017–18

The Agency's 2017–18 Operational Plan, produced in accordance with the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016*[7] (Agency Rule) requirements, prioritised the following programs of work:

- My Health Record;
- Secure messaging and interoperability;
- Medicines safety;
- Pathology and diagnostic imaging;
- Strategy, research and development; and
- Organisational excellence.

These priorities were published in the Agency's *Corporate Plan 2017–18*[8], and performance against each priority is captured in Part 2 of this report.

Board as an accountable authority

A 10-member Board, chaired by Jim Birch AM, is the accountable authority of the Agency. As accountable authority, the Board sets the strategic direction for the Agency and is responsible for its operations.

5. Health Portfolio Budget Statements, http://www.health.gov.au/internet/budget/publishing.nsf/content/2018-2019_Health_PBS
6. Public Governance, Performance and Accountability Act 2013, https://www.legislation.gov.au/Details/C2017C00269
7. Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016, https://www.legislation.gov.au/Details/F2016L00070
8. Corporate Plan, https://www.digitalhealth.gov.au/about-the-agency/corporate-plan

Our people and their location

At 30 June 2018, the Agency had 245 staff (permanent and temporary) working from offices in Brisbane, Sydney and Canberra.

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:

- My Health Record system;
- Healthcare Identifiers (HI) Service;
- National Authentication Service for Health NASH);
- Secure messaging delivery;
- Supply chain;
- Australian Medicines Terminology (AMT) and SNOMED CT-AU; and
- Clinical document specifications.

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

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

Another is compulsory under the PGPA Act:

- Audit and Risk Committee

Intergovernmental agreement

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 2017–18

The Agency is jointly funded by the Commonwealth ($250.526 million) and the states and territories ($32.250 million) reflecting the commitment at all levels of government to the delivery of digital health reform.

Inherited functions – My Health Record System Operator

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

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 COAG Health Council (CHC).

Financial outcome

- Operating loss: $20.494 million
- Operating revenue: $235.561 million
- Operating expenses: $256.055 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 Our role

The Agency's functions, as defined in Section 9 of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016*[9] (Agency Rule), 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 for all national digital health operations, functions and activities includes the role of the My Health Record System Operator (the System Operator), which transitioned from the Department of Health to the Agency 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, Department of Human Services.

1.2.2 National Digital Health Strategy

The National Digital Health Strategy was approved by Australia's health ministers on 4 August 2017, and made publicly available on the same day. Its subtitle, *Safe, Seamless and Secure: evolving health and care to meet the needs of modern Australia*, highlights its focus and purpose.

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

The seven strategic priorities described in the National Digital Health Strategy were formulated from the inputs of the extensive "Your health.

9. Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016, https://www.legislation.gov.au/Details/F2016L00070

Your say" consultation process, and are as follows:

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

1.2.3 Our principles

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

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

> *I have already had the experience, in an earlier form of the My Health Record, of one of my patients' lives being saved, because the hospital was able to access the information that was in that electronic record and not give a diabetic in a coma the usual antibiotic that would be used in that situation for sepsis.*
>
> *This person had a severe anaphylactic allergy to that antibiotic and, if it had been given, would have been killed. That's just a single example of how important My Health Record is.*
>
> **GP Dr Richard Kidd**
> AMA Council of General Practice

1

Introduction and overview

- **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 – we are building a culture to "think like a patient, act like a taxpayer".

> *The My Health Record will result in doctors having access to better information, in a more timely fashion, via secure means. Less time chasing up paperwork means more time can be spent treating our patients.*
>
> *The current [paper record] system meant many patient records were incomplete especially if the patient has seen multiple clinicians or been discharged from a hospital.*
>
> **Dr Michael Gannon**
> President
> Australian Medical Association (AMA)

1.2.4 Our values

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

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

To strengthen our values-based culture, the Agency has its own set of complementary values that are embedded in both policy and practice.

Working together

We get our best results working collaboratively.

We set challenging but realistic goals and pursue them together.

We value the open and robust exchange of opinions, views and ideas.

We approach our work with balance, enjoyment and passion.

Respect and trust

All our intentions are based on trust, support and open feedback.

We show consideration and support for one another and for our customers.

We embrace diversity in people, opinions and skills.

Transparency

We take stewardship of public resources seriously.

We are open in the way we do our work. We are open to scrutiny.

We operate ethically and with professionalism.

Leading through learning

We learn from others.

We seek new information and find bold ways to apply that learning to digital health.

We continuously evaluate and improve the way we do our work.

We support innovative health solutions that have a positive impact.

Customer focus

We never lose sight of the impact our work will have on patient care and the safety and efficiency of the Australian healthcare system.

Understanding customer needs is our first priority.

We maintain effective internal and external customer relations.

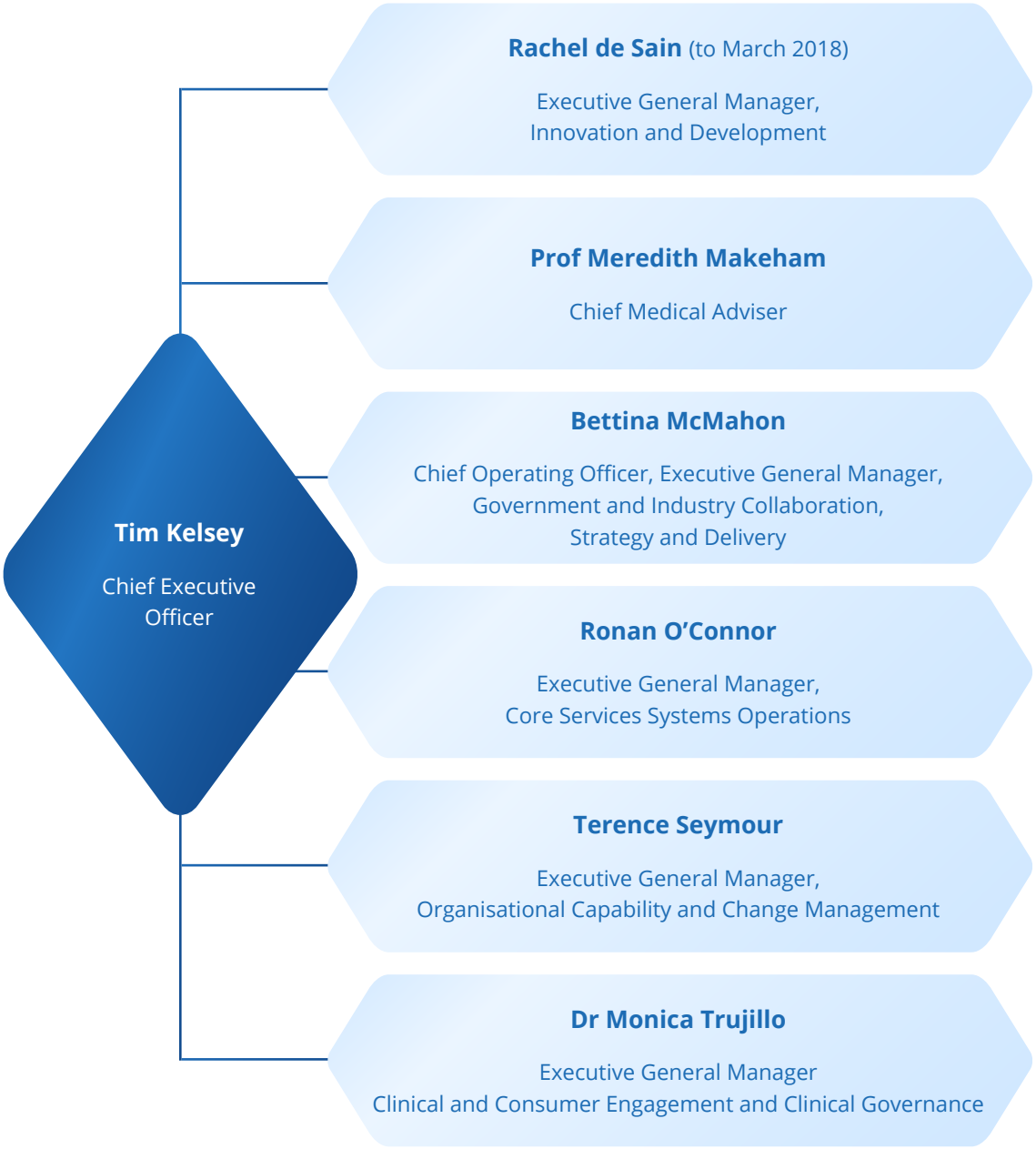
We listen to understand.

In late 2017–18 the Agency started work to renew these values, and to embed them in a behaviours framework to support the values in action, in both policies and practice.

1.2.5 Our structure

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

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



These executive general managers lead the following divisions.

- **Innovation and Development Division**
  Coordinates the innovative and technical aspects of the digital health program. It focuses on open innovation, specifications and standards, and product development. It provides overall design integration for all of the services developed to ensure that the national digital health systems and services provide the best user experience and deliver measurable improvements that are derived from evidence of user needs and deliver tangible benefits across the health ecosystem.
- The **Chief Medical Adviser** is responsible for leading the approach to research and evaluation at the Australian Digital Health Agency coordinated by the Research Programs team, and provides advice and support to the Executive across all Agency divisions. This includes the current domestic and international evidence to guide our policy, project and program delivery, and the application of digital health services and technologies to clinical practice settings. In addition, the Chief Medical Adviser quality assures our clinical governance approaches relating to the clinical safety processes applied to the development of our digital health systems and services.
- **Government and Industry Collaboration Strategy and Delivery Division**
  Responsible for leading and driving collaboration and education, and the non-clinical input to the strategy, design, implementation of national digital health systems and non-clinical adoption approaches. The division has a key role in the management of strategic relationships with consumers, states and territories, the federal government, health non-government organisations, software organisations and professional association stakeholders. Additionally, it oversees the Agency's Privacy Management Framework and the coordination of the National Digital Health Strategy and associated work program, and is responsible for the Digital Program Office which guides the successful delivery of the organisation's annual program of work.
- **Core Services Systems Operations Division**
  Operates the core national digital health systems and services providing technical support and leadership. These include the My Health Record and other foundation systems and services such as the Healthcare Identifiers (HI) Service, National Authentication Service for Health (NASH), eHealth Reference Platform, National Clinical Terminology Service (NCTS) and Clinical Informatics. The division provides the Cyber Security Centre function and is responsible for the development, operation and risk management of the security, fraud compliance conformance, release management and testing functions for Agency and core digital health systems.
- **Organisational Capability and Change Management Division**
  Responsible for the provision of quality delivery of a significant program of organisational capability and change management. This includes financial services, people and capability management, knowledge management and information and communications technology support, Agency performance reporting and Board and Advisory Committee secretariat and legal services. The division also leads and collaborates with internal and external stakeholders to manage the day-to-day operations of the Agency.
- **Clinical and Consumer Engagement and Clinical Governance Division**
  Leads the engagement of the healthcare provider community and members of the public to raise awareness of the value of digital health in both clinical practice and the

Agency CEO Tim Kelsey and Chief Medical Adviser Meredith Makeham with participants at the second GDHP Summit 2018 in Washington DC

Case study: **What's next for the Global Digital Health Partnership?**

Clinical Professor Meredith Makeham, the Agency's Chief Medical Adviser, tells us what's on the horizon for the GDHP.

"When international participants from thirteen countries, Hong Kong SAR, and the World Health Organization (WHO) met for the inaugural GDHP summit, we identified five key priorities to work on: cyber security, interoperability, evidence and evaluation, policy environments, and clinical and consumer engagement.

A work plan has been developed for each of the five key work stream priorities, and we have held a number of teleconferences and progressed work in Washington ahead of our next meeting in London in August 2018. For example, in the evidence and evaluation work stream we are looking at the development of a framework that will enable all the GDHP participants to work in ways that let them compare results with each other in a meaningful fashion.

These kinds of frameworks will help to create a common ground that will enable each participant to collaborate in a meaningful way and thereby establish a solid foundation for future learning and growth in digital health.

We're really proud of the way Australia has led the establishment of the GDHP. It's an incredibly valuable initiative for all of our participants and a fantastic opportunity for us to learn from international best practice and ensure we're using cutting edge evidence to develop the digital health services of the future."

broader community, and to build knowledge and ability to use the My Health Record system effectively and appropriately. It also manages the clinical and clinical informatics input to the design of digital health systems, as well as the development, implementation, operation and monitoring of a clinical governance framework, clinical functional assurance, clinical incident management and safety review programs. The division is also responsible for the oversight, management and coordination of clinical programs, including the Medicines Safety, Pathology and Diagnostic Imaging programs.

These divisions are supported by the **Office of the CEO**, which supports the CEO's internal and external activities, as well as stakeholder management. It includes the Office of the Chief Medical Adviser, the research functions of that office, the Agency's Chief of Staff, and other senior support roles. The Agency's communications and media team reports to this office via the Chief of Staff.

1.2.6 Our engagement approach

The Agency's accountability extends beyond the Commonwealth and state and territory health departments, to diverse groups who have a stake in digital health improving the reach, impact and efficiency of modern healthcare.

These include:

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

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

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

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

Our products and services

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

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

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

Bringing it all together

My Health Record

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

Co-producing outcomes with the community

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

Offers strategic advice directly to the My Health Record Expansion Program Board and to the Agency to ensure the program delivers tangible benefits to healthcare providers and patients.

Membership includes: Jim Birch AM (Chairman), Dr Steve Hambleton (Deputy Chair), Cathy Baynie (Australian Association of Practice Management 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 (Australian College of Nursing), Dr Rohan vanden Driesen (The Royal Australian and New Zealand College of Radiologists), Philipp Herrmann (Allied Health Professions Australia), Emma Hossack (Medical Software Industry Association), 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 (Australian Medical Association), 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

Expert panel of stakeholders providing strategic advice to the Agency on the approaches it is using to measure benefits for the expansion of the My Health Record system.

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

Works with the healthcare ecosystem that represents clinical and community views to shape, guide and assure the delivery of My Health Record that will meet the needs of all that interact with the product now and in the future.

Membership includes: Dr Chris Pearce (clinical co-sponsor), Jamila Rizvi (consumer co-sponsor), Nicolle Marchant (AMSANT - Aboriginal Medical Services), 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), Martin Seneviratne (Junior Medical Officer), 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

Provides advice and makes recommendations that support interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers and consumers.

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

Medicines Safety Program Steering Group

Provides program guidance and oversight to support outcomes that improve clinical safety and identifies opportunities for enhancing the safety and efficiency of medicines management through standard approaches to electronic medicines identification and supply chain management.

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).

Pathology Program Steering Group

Offers strategic direction and advice in terms of pathology projects and initiatives and engages with the health sector to ensure the program delivers meaningful outcomes that address sector needs.

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

Diagnostic Imaging Program Steering Group

Provides strategic input and acts as a link between program activities and the health sector to ensure alignment with sector expectations and to deliver outcomes that improve quality, safety and access to diagnostic information.

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

National Clinical Terminology Service Steering Committee

Supports and promotes initiatives that drive the adoption of clinical terminology in the Australian healthcare community and guides the future direction of the National Clinical Terminology Service.

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 (Medical Software Industry Association), Prof Meredith Makeham, Ronan O'Connor, Dion McMurtrie, Elizabeth Donohoo and Kerri Burden (the Agency), Jenny Hargreaves (Australian Institute of Health and Welfare), Jolanta Samoc (Therapeutic Goods Association), Michael Walsh (Queensland Health), Shane Porter (Department of Health).

Research Programs Reference Group	Identifies ways to foster collaborative approaches to research with academics, healthcare providers, consumers and industry partners to build the evidence base that supports the delivery of the Agency's work plan and the National Digital Health Strategy.

Membership includes: Prof Meredith Makeham (the Agency), David Bunker (Queensland Genomics Health Alliance), Prof Enrico Coiera (Australian Institute of Health Innovation), Dr Louise Schaper (Health Informatics Society of Australia), 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).

Joint Committee on Digital Health and Genomics	Provides advice to the Agency and to the Australian Genomic Health Alliance regarding the future development of Australia's digital health foundations (including the My Health Record system) to support the advancement of precision medicine and other activities relating to the public good which are enabled by the integration of genomic information with health and related data.

Membership includes: Prof Kathryn North (Australian Genomics and Murdoch Children's Research Institute), Prof Meredith Makeham, Ronan O'Connor, Garth McDonald and Dr Janice Biggs (the Agency), John Cannings (Australian Genomics Community Advisory Group Representative), Prof John Christodoulou (Australian Genomics Program One Co-Lead, Clinical Flagship Representative), A/Prof Marcel Dinger (Australian Genomics Program Two Co-Lead), Tiffany Boughtwood (Australian Genomics), Shane Porter (Department of Health), Dr David Hansen (CSIRO), Marcel Dinger, CEO, Genome.One.

Case study: **My Health Record empowers carers and their loved ones**

Donna Sedgman is primary carer to her 20-year-old daughter Marnie Clapham. At the age of 16, Marnie – a healthy and typical teen – suffered a brain haemorrhage. She was lucky to survive and her prospects for eating, walking, and even speaking were slim when she first presented at the hospital.

Marnie achieved all milestones during her 15-month stay, and even returned to riding horses; however, she will need personal, assisted care for the rest of her life.

"*Marnie is a young person with complex care needs and is supported by multiple healthcare providers. My Health Record helps all of us work together to improve her future*," said Donna.

Carers Australia Chief Executive Officer Ara Cresswell believes a fully integrated digital health approach should include easy portability of client history from one provider to another, where the client is truly the owner of his or her own health data.

"*Through My Health Record, important details carers need to remember are digitally recorded and easily retrieved*," Ms Cresswell said.

The My Health Record connects key parts of the health system, such as general practices, pharmacies, private and public hospitals. Almost one quarter of all Australians have registered for a My Health Record as of 27 July 2018. Connected healthcare providers are able to contribute to and use health information in the My Health Record on behalf of their patients to make more informed decisions about their health and care.

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

The My Health Record system operates in accordance with Australian Government security standards and undergoes regular independent security compliance and vulnerability assessments. These standards are regularly updated to address emerging security threats.

Access to the system is monitored in order to detect suspicious or inappropriate behaviour. Regular privacy risk assessments are conducted to identify privacy risks and implement measures to mitigate those risks.

Securely connecting people and organisations

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.

National Authentication Service for Health (NASH)

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.

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.

Standardising clinical communications

Clinical Terminologies

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

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

The NCTS publishes monthly updates of SNOMED CT-AU (the Australian localisation of SNOMED CT), which now includes the Australian Medicines Terminology (AMT) and other code systems.

These updates ensure that medicines content remains current with the Therapeutic Goods Administration and the Pharmaceutical Benefits Schedule, as well as continually enhancing clinical descriptions such as diagnosis, allergies, diagnostic order and results, supporting a shared meaning among the creators and users of health data.

Achievements 2017–18

Health ministers approve
National Digital Health Strategy
Establishing vision for 2018–2022

Framework for Action
developed through
nationwide consultation
Guiding implementation of digital health strategy

Commencement of expansion of
My Health Record system
Transition to “opt out”

Global Digital Health Partnership
Ground-breaking international collaboration

Intergovernmental agreement to 2022
for implementing digital health strategy and
operating national infrastructure

Accelerated uploading of clinical content
to My Health Record

Partnerships with consumer and clinical peak bodies
supporting My Health Record education

Agreement on
national secure messaging scheme

Developer program
to foster innovation

National requirements for
electronic prescriptions

Digital health benefits measurement program

Clinical Informatics Specifications

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

Digitally identifying physical goods

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.

Digital health services

Research and Evaluation

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

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

- Embed an organisational focus on research and benefits evaluation across all Agency programs;
- Establish capability and capacity to create and apply evidence at the Agency, and an environment where best practice evidence can easily be applied to future work programs;
- Establish partnerships and collaborations with researchers, jurisdictions, and industry that drive evidence building both domestically and internationally on the benefits of digital health services;

> *Becoming a digital hospital was a proven way to reduce prescribing errors, improve efficiency and safety of medication management, and reduce duplicate orders for pathology and radiology tests.*
>
> **Dr Stephen Ayre**
> Chief Executive
> Metro South Health

- Prioritise and promote research funding to support evidence creation for ongoing digital health investment; and
- Support the capacity building of the digital health research and development workforce in academia and industry.

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

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

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

Digital Health Cyber Security Centre

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

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

With the aim of maximising available resources and reducing duplication of effort, the Digital Health CSC has established, and is continuing to grow, partnerships with a range of national and international cyber security organisations across government and the private sector. These partnerships facilitate ongoing improvements to the Agency's knowledge of evolving cyber threats, and provide opportunities to leverage shared expertise and materials across organisations. Information gained through these partnerships is used to support the development of guidance materials and threat intelligence information for the digital health sector. In addition to ongoing security operations activities, the Digital Health CSC has worked to implement and enhance tools which support real time monitoring of the My Health Record system, provide improved alert capabilities and facilitate ongoing security management for the Agency. A continuous improvement program has been established to deliver enhancements to these tools over time.

Test Bed 15

Lead organisation

precedence healthcare

Partners

IPN Medical Centres

Supporters

phn Adelaide — An Australian Government Initiative

Capital Health Network

TRUENTH

Movember Foundation

WA Primary Health Alliance — Better health, together

phn — Perth North, Perth South, Country WA

Region

Health priority areas

- ✔ Empowerment
- ✔ Chronic disease management

Duration

FY18/19	FY19/20	FY20/21	FY21/22

Case study: **Improving patient healthcare through digital trials**

Patients from around Australia will benefit from 15 new projects that will utilise information from a consenting patient's My Health Record to improve the delivery of their healthcare.

The $8.5 million Digital Health Test Beds program will trial new approaches in chronic health, palliative care, and post hospital support.

Precedence Health Care are leading a test bed project that uses an app and patient portal named MediTracker, which is the first patient-centred app to connect patients to their GP and their selected care team. It links directly to patients' GP medical records and to My Health Record, as well as digital monitoring devices and wearables used by patients, and shares this data with patients and their care teams.

Precedence Health Care will work with Primary Health Networks across five states and territories (Western Australia, South Australia, Victoria, Tasmania, and the ACT) to recruit over 10,000 chronically ill patients into the trial. IPN Medical Centres will provide free access to MediTracker for all their patients, and Movember will use MediTracker as part of their integrated care initiatives supporting men with prostate cancer.

The project will also include patients involved in the Commonwealth Department of Health's Health Care Homes trial, for which Precedence is already supplying the core risk stratification and patient assessment technology.

Privacy

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

The Agency has an established Privacy team to embed privacy within the functions and culture of the Agency. The functions of the Privacy team include corporate privacy risk management, project assurance, engagement and awareness.

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

Digital Health Developer Program

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

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

1.2.7 Our purpose, outcome and program structure

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

The Agency has a single purpose and outcome, with one contributing program. The Health Minister's Portfolio Budget Statements 2017–18[10], released in the 2017 Budget, provide an overarching statement on the Agency's purpose, and articulate the intended outcome for the Agency for the reporting year, and the program through which that outcome will be delivered:

Purpose	To improve health outcomes for Australians through the delivery of digital health services and systems, and to support digital innovation across Australia to give people more control of their health and healthcare
Outcome	To deliver national digital healthcare systems to enable and support improvement in health outcomes for Australians
Program	Digital Health

10. Australian Government 2017–18 Health Portfolio Budget Statements, http://www.health.gov.au/internet/budget/publishing.nsf/content/2017-2018_Health_PBS

1.2.8 The path ahead — outlook for 2018–19

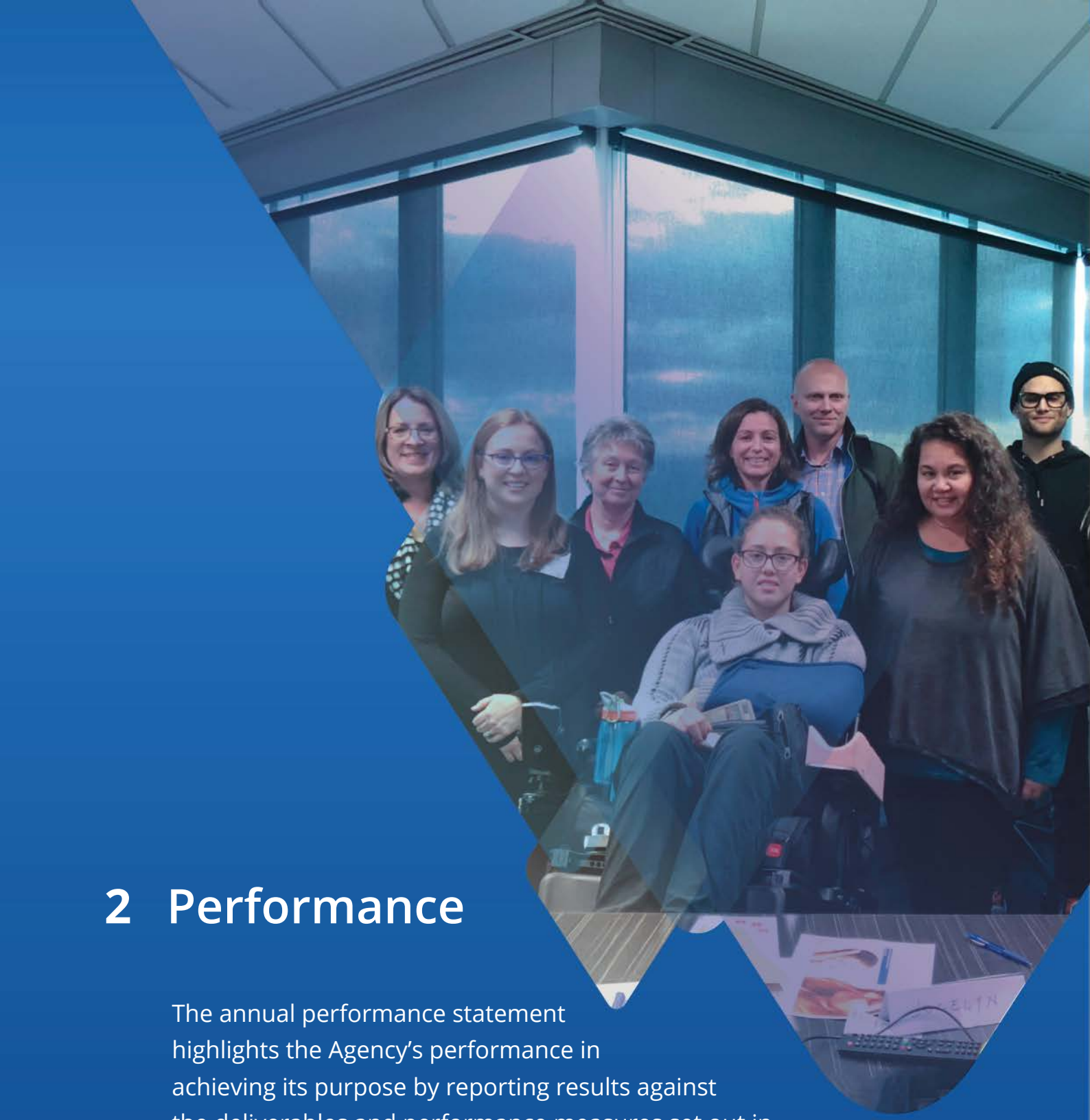
The National Digital Health Strategy was officially launched early in July 2018, alongside its companion implementation guide, the Framework for Action. These documents set out a clear vision for digitally enabled healthcare in 2022, and a plan on how to get there.

Later in the year the My Health Record system will be expanded to include all Australians, except those who choose not to have one. The combined effect of these milestones will be to set the direction for Australian digital health through to 2022 and to achieve measurable improvements to the healthcare system and consumer outcomes.

The Agency's *Corporate Plan 2018-19* describes a number of flagship deliverables that build on these foundations.

- My Health Record content will grow in relevance and utility for daily clinical practice, as more hospitals, community pharmacies, pathology laboratories and diagnostic imaging providers connect to it. Clinicians will also benefit from ongoing improvements in the usability of the data held by the system.
- The design of the My Health Record will continue to evolve, enabling new business models, supporting improved outcomes in aged care, and increasing utilisation by specialists.

- A blueprint and roadmap will be developed for My Health Record that leverages the national digital health infrastructure. Market engagement will commence with a view to re-platforming the system to further improve functionality.
- Interoperable secure clinical messaging will be implemented nationally, making communications between clinicians much simpler and more reliable. A directory of endpoint locations will be scaled nationally, allowing healthcare providers to find secure endpoints for any other provider.
- More broadly, an interoperability strategy and roadmap will be developed, which will lead towards safer, more consistent interactions between disparate clinical systems, especially in the transfer of care.
- A national technology strategy will be developed, which will support ongoing digital health innovation, and new models of care will be trialled, bringing digitally enabled clinical workflows closer to everyday reality in Australian healthcare.
- Proof of concept trials for a Child Digital Health Record and a digital pregnancy health record will be completed, followed by national implementations of each.



2 Performance

The annual performance statement highlights the Agency's performance in achieving its purpose by reporting results against the deliverables and performance measures set out in the Agency's Corporate Plan 2017–18[11] and in the Health Minister's Portfolio Budget Statements 2017–18[12]. It also addresses My Health Record System Operator reporting requirements under the *My Health Records Act 2012*.

11. Corporate Plan, https://www.digitalhealth.gov.au/about-the-agency/corporate-plan
12. Health Portfolio Budget Statements, http://www.health.gov.au/internet/budget/publishing.nsf/Content/2017-2018_Health_PBS

2.1 Annual performance statement

Statement of preparation by accountable authority

On behalf of the Board, I present the 2017–18 annual performance statements of the Australian Digital Health Agency, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

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

Jim Birch AM
Chair
15 October 2018

2.2 Performance against our purpose

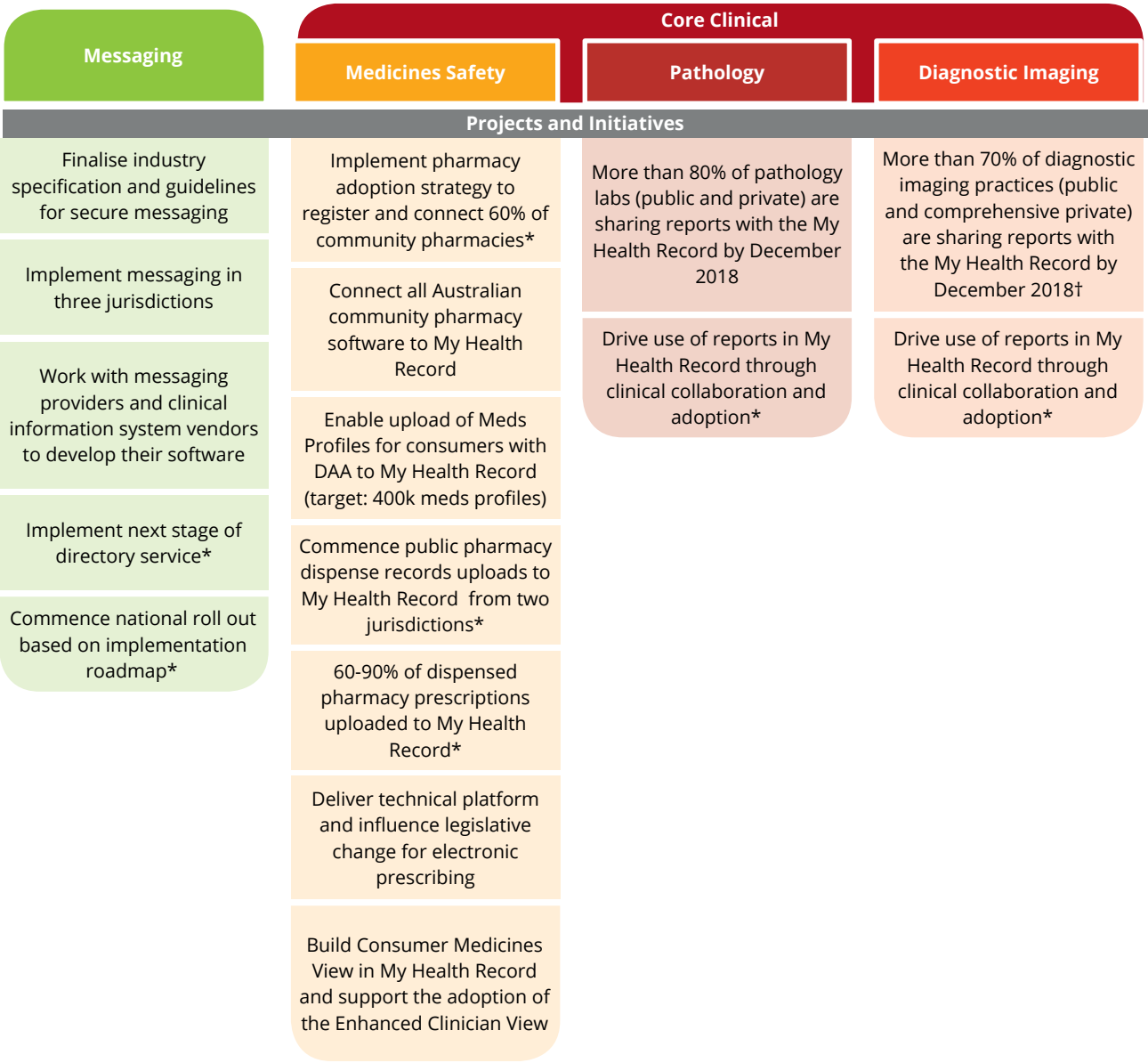
The annual performance statement provides an assessment of the Agency's performance during the year, and how it supported the Agency in achieving its purpose of improving health outcomes through the delivery of digital innovation, health systems and services.

It presents the annual work plan priorities published in the Agency's *Corporate Plan 2017–18*, clarifies their contribution to the Agency's purpose, and reports on the results produced from the Agency's second 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 2017–18.

2.3 Annual work plan priorities from the Corporate Plan 2017–18

The following diagrams show the Agency's work plan priorities for the 2017–18 financial year.

2.3.1 High level COAG work plan – funded through contributions from all Australian governments



*Multi-year initiative that will continue beyond June 2018

†A "comprehensive practice" is a medical practice, or a radiology department of a hospital, that provides X ray, ultrasound and computed tomography services (whether or not it provides other services). https://www.legislation.gov.au/Details/F2016C00951

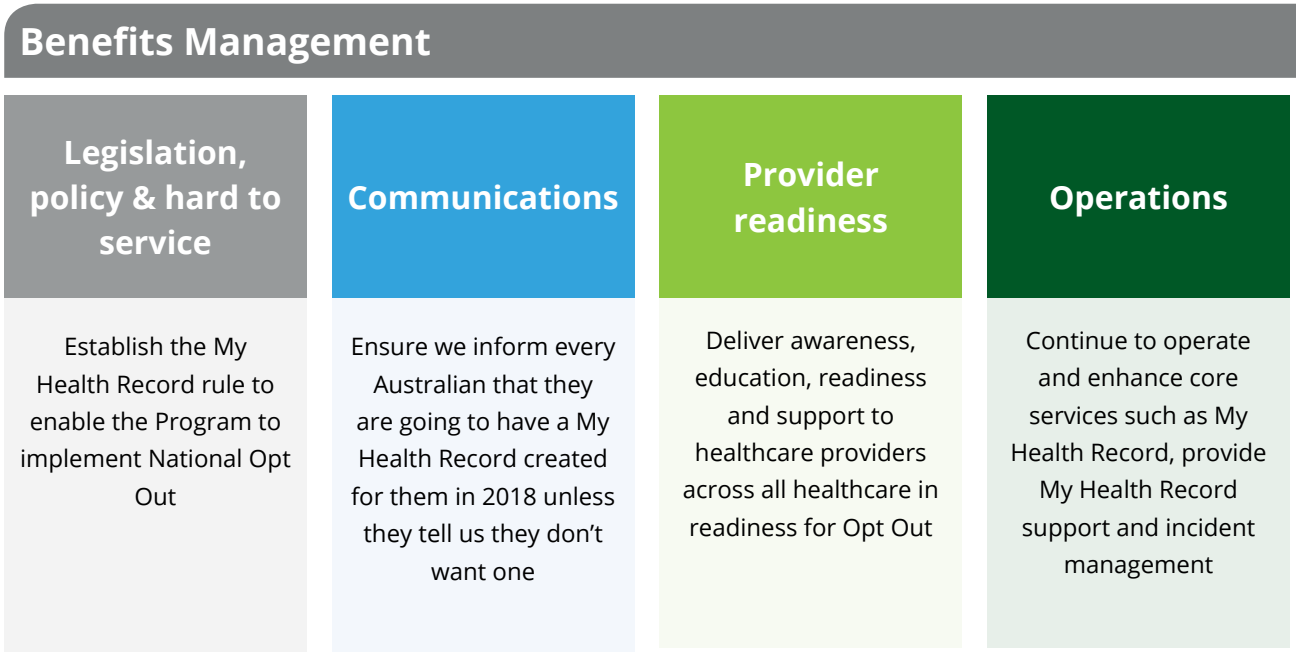
Ongoing Operational Functions

- Strategy, benefits, evidence based research and horizon scanning
- Clinical, consumer, government and industry collaboration, education and adoption
- Core service systems, operations and improvement
- Cyber security

Improve My Health Record	Strategy Research and Development	Interoperability	Organisational Excellence
Establish a developer program supporting the software industry	Implement projects through Children's Collaborative Network for Innovation	Deliver package of standards, roadmap and approach to implementation	Drive cultural change*
Connect more private hospitals to My Health Record*	Support future delivery of the Health Care Homes program	Maximise impact of terminology service and products	Implement the risk management framework, including risk systems
Complete public hospital connections	Scope care handover in remote communities	Scope and trial implementation of Master Drug Catalogue and Ontoserver	Assess the requirement for rebranding the Agency
Roadmap and new releases for HIPS, establish as national infrastructure	Implement two projects to embed telehealth in clinical consultations		Establish an internal operating model that recognises Agency as a matrix organisation
Clinical authentication*	Finalise strategy with AHMAC and CHC		Replace IT legacy systems and create an integrated technical environment
Draft scope for releases ♦ Flags and notifications Phase 1 ♦ Mobile capability ♦ Consumer improvements to Med View ♦ Customer authentication ♦ Flags and notifications phase 2 ♦ Mental health gateway ♦ Aged care gateway ♦ Mobile enhancements ♦ Clinical authentication ♦ Shared care plans	Scope urgent and emergency care program – in two jurisdictions		Excellence in program delivery and financial management*
	Scoping study in two areas to support end of life care		

- Co-design
- Clinical governance, quality and safety
- Corporate services and organisational change management

2.3.2 My Health Record Expansion Work Program – funded by the Commonwealth Government



Consistent with the Agency's commitment to open dialogue with the health system, the priorities for 2017–18 were determined following consultation with a variety of healthcare providers, jurisdictional representatives, industry participants and consumer advocates.

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

Improvements	Technology	Cyber security	DHS Transition
Enhancement to the My Health Record portal to improve the usability for consumers, service providers and clinicians	Continue to operate and enhance the technical infrastructure required to support National Opt Out	Ensure the security of the My Health Record system	Establish a National Contact Centre and migrate all services from the Department of Human Services to the Agency including implementation of Face to Face services

2.3.3 Secure messaging

Purpose

The experience of modern day healthcare for many patients and carers involves interacting with a variety of different healthcare providers.[13,14] 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.[15,16]

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

Moreover, research shows that general practitioners waste 10% of their time daily in searching for paper records.[22] 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.[23] However, these different methods are generally not compatible – meaning that these proprietary secure messaging approaches do not work with each other.[24] Despite significant effort, there is no nationally consistent, standards-based approach to secure messaging, which limits the ability of healthcare providers to communicate effectively.

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

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.

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Case study: **Industry collaborates to end the era of the fax machine**

Out of date and insecure fax machines are being used to share patient information between healthcare providers, despite other sectors discarding them over a decade ago. Not only do fax machines cause frustration for healthcare providers trying to communicate with each other, they can also result in patient harm.

In May 2018, a coroner's report revealed that Hodgkin's lymphoma patient Mettaloka Halwala died alone following chemotherapy complications. His medical test results were faxed to the wrong number, which meant his treating haematologist did not receive information that could have saved his life.

Coroner Rosemary Carlin called for the hospital involved to phase out fax transmission of imaging results as a matter of urgency. She said it was difficult to understand why such an antiquated and unreliable means of communication exists at all in the medical profession.

On 6 June 2018, key industry participants at a secure messaging industry collaboration workshop agreed to adopt the tools, processes, and standards that have been demonstrated to solve the interoperability problems across secure messaging and clinical information systems.

Through this collaboration, Australia is on track to end the use of fax machines in healthcare, with key industry players agreeing to the next steps to improve secure messaging of patient records between healthcare providers using clinical software.

The work program involves a number of streams, including:

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

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

Results

1. **Finalise industry specifications and guidelines for secure messaging**

   An industry-based technical working group was formed to facilitate collaborative development of specifications that software suppliers can adopt in their solutions to enable consistent secure messaging across care providers. The group produced two specifications to support consistent use of an HL7™ messaging profile, as well as an application interface that allows the sharing of provider address information across different secure messaging and clinical practice systems used by care providers.

2. **Implement messaging in three jurisdictions**

   The Agency released a request for tender in 2017 seeking responses from suppliers who were able to establish and work within a consortium-based collaborative model to deliver secure messaging capabilities across different areas of the health sector. Two consortiums made up of secure messaging suppliers, clinical information system vendors and users were established. These consortiums will deliver discharge summaries from acute hospital care to general practitioners, referrals from general practice to specialists and allied health practitioners, and reports from allied health back to the referrer in two jurisdictions. Both consortiums have commenced delivering electronic messaging. In addition, end users will be able to search not only their own provider directory for electronic addresses to send to, but also directories used by other practices using different software.

3. **Work with messaging providers and clinical information system vendors to develop their software**

   The Secure Messaging program continues to actively co-design products with software vendors to progress the ability to send electronic messages safely and securely across the sector. The technical working group meets regularly with active participation from software suppliers, and the program engages heavily via the Medical Software Industry Association and conducts industry workshops to ensure that software suppliers and stakeholders can participate in determining priorities and direction.

> *[My Health Record] will enable our health professionals to make informed decisions through improved access to relevant and timely health information, assisting our patients to enjoy better health outcomes, and allowing our pharmacies to offer new and innovative services.*
>
> **Mark Finocchiaro**
> Managing Partner and Director
> Chemist Warehouse

4. **Implement the next stage of directory services**

   The Agency's industry consultation made it clear that priority should be given to the establishment of provider identity and addressing services, which enable providers to easily find the details and electronic

address for the care provider they want to send information to. In response, options to improve provider directory services have been developed and design work is progressing, in collaboration with the technical working group and in consultation with jurisdictional representatives.

The first stage of more accessible directory services is being implemented through the proof of concept projects, delivering a search capability that allows care providers to search the directories of providers using different software solutions. The next stage will be in partnership with a jurisdiction or private hospital to validate scaling at a national level.

5. **Commence national delivery based on an implementation roadmap**

   Implementation activities have progressed through the proof of concept projects. The next phases of implementation will continue through 2018–19 and will deliver enhanced messaging capabilities that support clinical workflows, will advance the use of message acknowledgements and smarter forms, and will deliver the next phase of the provider directory and addressing service.

2.3.4 Medicines safety

Purpose

In any two-week period, around 7 in 10 Australians and around 9 in 10 older Australians will have taken at least one medicine.[28] Those medicines keep Australians out of hospitals, prevent disease and play a pivotal role in ensuring a productive and healthy community.

However, with the growth in use of medicines comes an increase in the risk of adverse drug events. Medication-related hospital admissions have been estimated to comprise 2% to 3% of all Australian hospital admissions, with an estimated annual cost of $1.2 billion.[29] These problems are particularly acute in the elderly and those with chronic disease. Great care needs to be taken to ensure that the right drug is given to the right patient, at the right time, in the right dose and form, through the right channel.

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

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

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

Results

1. **Implement pharmacy adoption strategy to register and connect 60% of community pharmacies**

   The Agency has collaborated with the Department of Human Services to streamline the registration process for community pharmacies. 1,935 pharmacies were registered to the My Health Record system between 1 July 2017 and 30 June 2018.

28. Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety – Improving Medication Safety. July 2002. https://www.safetyandquality.gov.au/wp-content/uploads/2012/12/Second-National-Report-on-Patient-Safety-Improving-Medication-Safety.pdf
29. Australian Council for Safety and Quality in Health Care. Literature Review: Medication Safety in Australia. Aug 2013. https://safetyandquality.gov.au/wp-content/uploads/2014/02/Literature-Review-Medication-Safety-in-Australia-2013.pdf

Case study: **Steve Renouf**

"In 1993, I was diagnosed with Type 1 diabetes, and it turned out that my four sons have it too, so we all have ongoing treatment for it. Eventually I got involved with Diabetes Australia and the Juvenile Diabetes Research Foundation as their ambassador, which led to advocacy work with the diabetic community. For the last six years, I've worked for the Institute of Urban Indigenous Health, which is based in the South East Corner. We started off with four Aboriginal Medical Services and have grown to 18 services. I see myself as a bridge between consumers and the medicos.

I'm also working as co-chair of the Agency's Medicine Safety Program. It's a vital program with the potential to save many lives. Every year, thousands of mistakes are made with medicine prescriptions, leading to hospitalisations and even deaths. These mistakes can happen when a patient is seeing more than one doctor for different ailments and getting prescriptions from each of them. The patient ends up being over-prescribed or taking dangerous medication combinations. It can get complicated and hard to track."

This figure, in addition to previously registered community pharmacies, will result in more than 60% of community pharmacies registered to the My Health Record system.

2. **Connect all Australian community pharmacy software to My Health Record**

   Fred Dispense and Aquarius continue to be connected to the My Health Record system. In 2018, three out of eight software vendors (Minfos, RxOne and Pos Dispense) connected to the My Health Record. The remaining vendors (Corum, Z Dispense, Mountaintop Dispense, MyScript and ScriptPro Dispense) are on track to connect by September 2018. By the end of 2018 all major pharmacy dispensing vendors will have connections to the My Health Record system.

3. **Enable upload of medicines profiles for consumers with dose administration aids to My Health Record**

   The Agency continues to work with the National Infrastructure Operator (NIO) to progress Stage 1 of the Pharmacist Curated Medicines Lists (PCML) project, which will enable upload of PCMLs in PDF format. Stage 2 is being progressed concurrently with the establishment and engagement of the Clinical Design Team and Technical Design Team underway to design a structured data format for PCML.

4. **Commence public pharmacy dispense record uploads to the My Health Record system from two jurisdictions**

   Public pharmacy dispense records are being uploaded from two jurisdictions. Northern Territory commenced uploading public pharmacy dispense records in August 2017, followed by New South Wales in December 2017.

5. **60–90% of dispensed pharmacy prescriptions uploaded to the My Health Record system**

   51% of community pharmacies registered for My Health Record by 30 June 2018, with 75% anticipated by December 2018. This figure will include most of the large retail pharmacy chains and will enable at least 60% of all retail dispensed messages to be uploaded.

   Dispense records are also being uploaded to My Health Record from multiple jurisdictions including Northern Territory, Tasmania and New South Wales.

6. **Deliver technical platform and influence legislative change for electronic prescribing**

   The Agency is working with the Department of Health to define the partnership and resourcing required to deliver the Electronic Prescriptions Project within the 2018–19 FY. The Agency has been tasked with developing conformance profiles to support software developers building electronic prescribing functionality into their products, and initial conversations have commenced to determine the scope of the work.

7. **Build a Consumer Medicines View in the My Health Record system and support the adoption of the Enhanced Clinician View**

   The Consumer Medicines View has been built in the My Health Record system. Enhancements to Clinician Medicines View was placed on hold due to increased activity and scope around My Health Record releases in 2017–18, and the Agency is reviewing this outcome to determine next steps.

2.3.5 Pathology

Purpose

Having pathology 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.[30] [31]

This work program includes a number of streams:

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

30. Westbrook JI, Georgiou A, Dimos A, Germanos T. Computerised pathology test order entry reduces laboratory turnaround times and influences tests ordered by hospital clinicians: a controlled before and after study. Journal of Clinical Pathology. 2006;59(5):533-6.
31. Georgiou A, Prgomet M, Lymer S, Hordern A, Ridley L, Westbrook J. The impact of a health IT changeover on Medical Imaging Department work processes and turnaround times. A mixed method study. Applied Clinical Informatics. 2015;6(3):443-53.

Results

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

1. **More than 80% of pathology labs (public and private) will be sharing reports with the My Health Record system by December 2018**

   30% of pathology labs (totalling 134: 39 public, 95 private) were uploading reports to the My Health Record system by 30 June 2018. The Northern Territory and New South Wales have commenced uploading pathology reports to My Health Record. Projects are underway with market leading private pathology providers and other state health jurisdictions to go live state-wide by December 2018.

2. **Drive use of pathology reports in My Health Record through clinical collaboration and adoption**

   To drive the use of reports in My Health Record through clinical collaboration and adoption, the Agency has delivered targeted education material, forums and seminars to increase awareness among health practitioners.

2.3.6 Diagnostic imaging

Purpose

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

This work program includes the upload of diagnostic imaging reports to the My Health Record from public hospitals and private providers.

Results

1. **More than 70% of diagnostic imaging practices (public and comprehensive private) will be sharing reports with the My Health Record system by December 2018**

   4% of diagnostic imaging practices (totalling 60: 28 public, 32 private) were uploading reports to the My Health Record system by 30 June 2018. The Northern Territory and New South Wales have commenced uploading diagnostic reports to My Health Record. Projects are underway with market leading software vendors, private diagnostic imaging providers and other state health jurisdictions to go live state-wide by December 2018.

2. **Drive use of diagnostic imaging reports in My Health Record through clinical collaboration and adoption**

   The Agency has created awareness of the capability and benefits of using diagnostic imaging reports in My Health Record across the healthcare community through the delivery of targeted education material, forums and seminars.

2.3.7 My Health Record

Purpose

The objective of the My Health Record program is to identify important opportunities that support the realisation of the full potential of the My Health Record. This will allow clinicians to experience benefits from the system in their day-to-day work, and consumers to experience

> *These enhancements mean that Australians can now be confident that healthcare advice provided by Healthdirect GPs will be available to their regular GP in a more timely, secure and streamlined manner, with the additional benefit of having the information uploaded to the My Health Record for care situations where the patient does not have a regular GP. Sharing healthcare information via secure electronic communications supports clinical handover and continuity of care which leads to better healthcare outcomes.*

Dr Nathan Pinskier
Chair of RACGP Expert Committee on eHealth

improvements in the quality and convenience of healthcare services through better sharing of information supporting their care.

The program will work collaboratively with users to co-produce improvements to the My Health Record that have a significant impact upon patient care. It will improve the value of the My Health Record for a range of users, including those in hospital emergency departments, who are a key group that could benefit from better information about a patient's current medications and medical history at the point of care.

Results

The latest version of the My Health Record (Release 9) delivers user interface improvements, highlights health and wellbeing information, improves mobile access and supports the opt out participation model. Enhancements and improvements are developed in line with our service delivery model that drives the improvement changes through robust discovery, co-design and usability testing with the user groups.

A key factor in the continued growth and adoption of the My Health Record is increasing the volume of valuable clinical documents in the system and increasing consumer participation through the national transition to an opt out approach. In the first half of the 2018–19 financial year the Agency will be working closely with governments, Primary Health Networks, consumer and clinical peaks and public communication channels including the media to ensure all Australians can make an informed choice about having a My Health Record created for them by the end of 2018 or opting out.

1. **Establish a developer program supporting the software industry**

   The Developer Partner Program was launched on 4 July 2017, with the aim of fostering a vibrant, productive community of developers, innovators and implementers who are engaged with the digital health agenda and are contributing to it in a spirit of co-design and co-production, producing applications that support safe, seamless and secure outcomes for patients, carers and healthcare providers.

The program has delivered a new digital space for the development community[32] which brings together all the digital assets including specifications, product guides, implementation resources and supporting materials and also allows registered users to interact through the introduction of commenting functionality on certain pages. We have engaged with the developer community through support for Agency and third-party events, as well as the release of Agency code libraries using world-class open source approaches.

2. **Connect more private hospitals to the My Health Record**

> *While further work is required to fully integrate with hospital clinical information systems, My Health Record now offers a 'medicines view' showing patient medications and related information, and an increasing number of clinical documents such as referrals, shared health summaries and pathology and diagnostic imaging reports. This information will empower clinicians to make timely decisions in consultation with their patients.*
>
> **Alison Verhoeven**
> Chief Executive
> Australian Healthcare & Hospitals Association

In 2017–18, an additional 17 private hospitals and health services connected to the My Health Record, increasing the proportion from 79% in July 2017 to 86% in June 2018. New private hospitals connected include Cabrini, St Vincent's Australia, and St. John of God Hospital Group. In Australia, as of June 2018 there are a total of 208 candidate private hospitals and clinics, with 178 (86%) of these connected to the My Health Record. Of these, 176 can view the My Health Record, and 167 are able to upload.

3. **Complete public hospital connections**

In 2017–18, an additional 55 public hospitals and health services were connected to the My Health Record, increasing the proportion of healthcare services connected from 67% in July 2017 to 74% in June 2018.
A range of connectivity projects were undertaken in 2017–18, delivering an increase of coverage of the My Health Record in Victoria through the continued commissioning state-wide of My Health Record infrastructure that will allow district health services to quickly connect to the My Health Record.

In Australia, there are a total of 1,108 public hospitals and health services, with 815 (74%) of these connected to the My Health Record as of June 2018. Of these, 815 can view the My Health Record and 609 are able to upload.

4. **Roadmap and new releases for HIPS establishing it as part of the national infrastructure**

The HIPS product ("Health Identifier and PCEHR System") enables the seamless integration of digital health systems with national digital health infrastructure services,

32. https://developer.digitalhealth.gov.au

Increasing document volume in the My Health Record system

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

The number of shared health summaries uploaded to the My Health Record system doubled, 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 2017–18 reporting period.

Document category/name	At 2 July 2017	At 1 July 2018	Percentage growth
Clinical documents	**2,418,635**	**6,372,433**	**163%**
Shared Health Summary	910,840	1,871,039	105%
Discharge Summary	1,042,414	1,975,119	89%
Event Summary	280,506	602,592	115%
Specialist Letter	50,139	85,418	70%
eReferral Note	29	78	169%
Pathology Report	81,498	1,686,495	1969%
Diagnostic Imaging Report	53,209	151,692	185%
Prescription and Dispense Documents	**10,857,987**	**20,908,168**	**93%**
Prescription	8,451,581	16,285,116	93%
Dispense	2,406,406	4,623,052	92%
Consumer Documents	**139,596**	**177,949**	**27%**
Consumer Entered Health Summary	87,249	113,043	30%
Consumer Entered Notes	37,478	45,221	21%
Advance Care Directive Custodian Report	13,707	17,467	27%
Advance Care Planning Document	1,162	2,218	91%
Medicare Documents	**513,053,858**	**720,590,275**	**40%**
Australian Immunisation Register	1,406,057	2,385,976	70%
Australian Organ Donor Register	484,416	628,538	30%
Medicare/DVA Benefits Report	302,215,367	424,379,845	40%
Pharmaceutical Benefits Report	208,948,018	293,195,916	40%
Child My Health Record Documents	**14,809**	**16,990**	**15%**
Personal Health Observation	6,934	7,964	15%
Personal Health Achievement	986	1,169	19%
Child Parent Questionnaire	6,889	7,857	14%

Case study: **Townsville resident Rebecca Vella believes My Health Record is an essential tool to keep track of all of her important health information**

Rebecca's fiancé is a proud member of the Australian Defence Force, which means the couple are packing up their entire lives and moving to a new city every two to three years on average.

My Health Record does not replace the need for Rebecca to have clinical conversations with her doctor, but it is a good source of details to complement the clinical conversation.

"*I am currently accessing services in various facilities, and having a My Health Record to refer to means that I thankfully don't have to repeat my story to every new provider I see*," she said.

Rebecca suffers from a serious anaphylactic reaction to penicillin and believes that the most valuable data on her record is her allergy information.

"*I recently went to hospital, and the Emergency Department staff were able to use previous uploads on my record to assist them with my diagnosis*," she told us.

During her hospital visit, Rebecca's healthcare providers were able to access the results of tests she had previously done and medications she had been recently prescribed.

"*The Emergency Department staff were able to access all of my test results, even though I didn't have any of the physical paper work with me*," she noted.

Rebecca has strong confidence in using My Health Record to assist and contribute to the quality of the care that she receives.

She loves the idea of staying in control of her important health information, and does so conveniently and securely by accessing her My Health Record at least once a week on her mobile phone.

such as the Healthcare Identifiers Service, the My Health Record system, and Secure Message Delivery systems. It is a middleware product offering standards-based interfaces for seamless integration with systems like patient administration systems, clinical information systems, and laboratory and radiology information systems. It is aimed primarily at supporting large-scale digital health environments typically found in organisations such as hospitals and diagnostic service providers; however, it is also suitable for direct integration with digital health products. In 2017–18 a HIPS roadmap was delivered, as well as releases to:

- Improve pathology and diagnostic imaging report documents to support diagnostic service providers to upload their reports to the My Health Record system;
- Introduce stability improvements to prepare HIPS for the very high document upload volumes expected to result from My Health Record Expansion; and
- Support the Pharmacist Curated Medicines List to allow pharmacies to share such documents via the My Health Record system, thereby enhancing consumers' medicines safety.

5. **Clinical authentication**

A number of improvements have been made to the healthcare provider registration and authentication processes:

- The seed organisation registration process was reduced from a number of weeks to hours, via an online process available in the Health Professionals Online Service (HPOS) system;
- The National Provider Portal is accessible via the Provider Digital Access (PRODA) system, removing the need for individual National Authentication Service for Health certificates in the Provider Portal;
- Certificates for healthcare organisations will be available to request, re-issue and revoke, via HPOS; and
- The HI Service and NASH certificate policies have been updated to the SHA-2 Gatekeeper PKI Framework, as mandated by the Digital Transformation Agency.

6. **Draft scope for releases**

Over 2017–18, the priority was to improve the user experience for consumers and providers. This has been delivered through:

- Enhanced usability when accessing via mobile devices;
- Enriched Medicines View to prioritise vital health and wellbeing information at a glance, such as allergies and adverse reactions;
- Better experience when reviewing pathology and diagnostic imaging, including improved search, grouping and presentation of reports;
- Clearer navigation, labelling and descriptions; and
- Increased accessibility for the visually impaired.

The national infrastructure has been scaled to effectively handle the increased traffic to the My Health Record system (both during the opt out period and beyond the bulk registration) to ensure site performance and up-time, encouraging ongoing engagement and reducing demand on the support centres.

Increased security capacity has also been delivered to uphold the security posture of My Health Record system and services, and to proactively manage emerging cyber security threats, risks and vulnerabilities.

My Health Record system reporting obligations

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

The Agency takes the security of patients' health and other personal information very seriously. Many of the protections provided by the My Health Records 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 Act requires the Agency to include statistics in its annual report on My Health Record system registration, usage, security, and complaints, and the outcomes of those complaints in terms of investigations, enforceable undertakings or court proceedings seeking injunctive relief. These statistics are outlined in the following table.

Reporting requirement	Statistics
Registrations, cancellations, suspensions of registrations	♦ In 2017–18 the Agency, as System Operator, registered 935,206 people for a My Health Record. There were a total of 42,877 cancelled registrations during the year. ♦ In 2017–18 the System Operator registered an additional 2,676 healthcare provider organisations. 88 registrations were cancelled or suspended for reasons such as a provider organisation discontinuing operations or where transfer of ownership has occurred.
Use of the My Health Record system by healthcare providers and healthcare recipients	♦ A total of 797,539 people accessed their My Health Record via the consumer portal in 2017–18. ♦ An average of 1,379 unique healthcare provider organisations, via their clinical information systems, viewed records in the My Health Record system each week during 2017–18. ♦ An average of 4,807 unique healthcare provider organisations uploaded records to the My Health Record system each week during 2017–18. ♦ A total of 221,580,930 documents were uploaded to the My Health Record system in 2017–18.

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. **42** data breaches (in 28 notifications) were reported to the Office of the Australian Information Commissioner as required under Section 75 of the *My Health Records Act 2012* (the Act) concerning potential data security or integrity breaches. The Agency, in its capacity as the My Health Record System Operator, reported three **(3)** breaches to the Office of the Australian Information Commissioner. These included: ♦ 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; and ♦ 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. The remaining **39** data breaches were reported by the Chief Executive Medicare as a registered repository operator under Section 38 of the Act. These included: ♦ **17** breaches resulting from data integrity activity initiated by the Department of Human Services to identify intertwined Medicare records (that is, where a single Medicare record has been used interchangeably between two or more individuals); and ♦ **22** breaches resulting from suspected fraud against the Medicare program involving unauthorised Medicare claims being submitted, and the incorrect records appearing in the My Health Record of the affected customers. In all instances, the Department of Human Services took action to correct the affected My Health Records.
Complaints received, investigations undertaken, enforceable undertakings accepted, injunctions granted	In 2017–2018, a total of **57** complaints were made in relation to the My Health Record. Complaints are initially registered and actioned by the Department of Human Services or Call Centre service officers and escalated to the Agency if the issue is complex or relates to a potential privacy, clinical or cyber security breach. 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.

Australia's National Digital Health Strategy

Framework For Action

How Australia will deliver the benefits of digitally enabled health and care

1

Health information that is available whenever and wherever it is needed

2

Health information that can be exchanged securely

National Digital Health Strategy

Priority activities 2018–2022

3

High-quality data with a commonly understood meaning that can be used with confidence

4

Better availability and access to prescriptions and medicines information

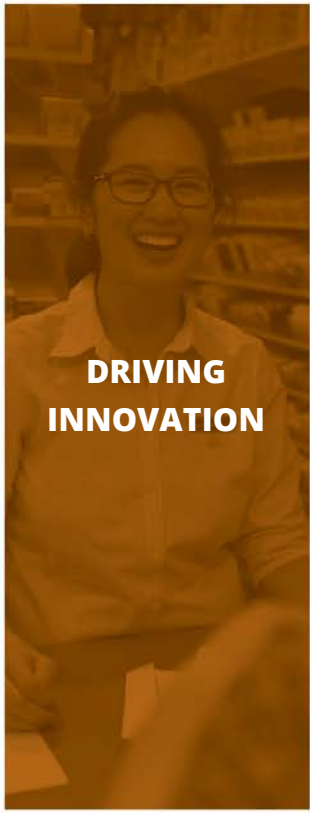
5

Digitally enabled models of care that improve accessibility, quality, safety and efficiency

6

A workforce confidently using digital health technologies to deliver health and care

7

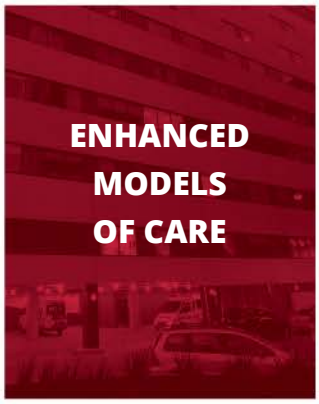


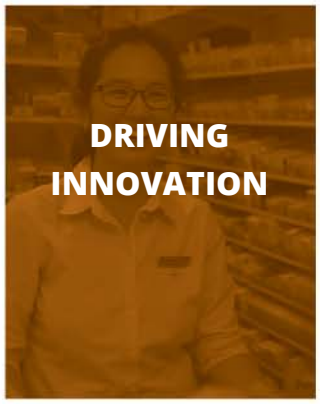
A thriving digital health industry delivering world-class innovation

National Digital Health Strategy

Priority activities 2018–2022

1.1 Realising the benefits of the My Health Record system	2.1 Enable secure exchange of clinical information	3.1. Clinical information exchange through interoperability
1.1.1 My Health Record Expansion Program	2.1.1 National provider addressing service	3.1.1. National interoperability strategy
1.1.2 Future use of the My Health Record	2.1.2 Standards-based secure messaging capability	3.1.2 Co-design standards and specifications
1.1.3 Medical devices in the My Health Record	2.1.3 Nationally coordinated programs	3.1.3 Conformance, compliance and accreditation framework
1.2 Enable the safe and secure use of My Health Record system data	2.1.4 Improving experience by leveraging national infrastructure	3.1.4 Increasing digital maturity
1.2.1 Secure use of My Health Record data	2.2 Make it easy for providers to participate	3.2 National health technology strategy
	2.2.1 National authentication and identification services	3.2.1 National health technology strategy
		3.3 Promote data quality
		3.3.1 Enhance national data services
		3.3.2 National health data governance





4.1 Nationally coordinated digital medicines program	5.1 Test bed and scaling up environments	6.1 Develop capabilities to deliver better health and care outcomes	7.1 Promote inclusiveness and equality of experience
4.1.1 Digital medicines program blueprint	5.1.1 Digital health test bed framework	6.1.1 Supporting adoption by the health workforce	7.1.1 Addressing barriers to digital inclusion
4.1.2 Electronic prescriptions	5.1.2 Embedding telehealth	6.1.2 Digital health embedded in training	7.1.2 Reliable and affordable connectivity for all Australians
4.1.3 Best possible medicines list	5.1.3 End-of-life care	6.1.3 Digital health in national standards and accreditation	7.2 Fuel and accelerate healthcare innovation
4.1.4 National medicines data service	5.1.4 Chronic disease management		7.2.1 Innovation showcase
4.1.5 Medicines information for consumers	5.1.5 Residential aged care		7.2.2 Developer partner program
4.1.6 Medicines decision support tools	5.1.6 Children's Health Record		7.2.3 Digital health services endorsement framework
4.1.7 Enhance incident reporting capabilities	5.1.7 Emergency care		7.2.4 Health innovation exchange
4.1.8 National allergy strategy			7.2.5 Partnerships with accelerators and incubators
4.1.9 Real-time prescription monitoring			7.2.6 Development of design principles
			7.2.7 Support for app enablement

2.3.8 Strategy, research and development

Purpose

During the 2017–18 financial year, the Agency developed the National Digital Health Strategy, defining strategic priority outcomes to be achieved by 2022.

The seven priority areas were derived from the consultation process and associated research. They articulate a set of shared outcomes for all stakeholders that complement existing investments in digital health initiatives and will enable health innovation and improved health and care experiences to be delivered. This will result in measurable benefits for patients, carers, healthcare providers and the broader health system.

Achievement of the outcomes in the strategy will depend on continued co-production with patients, consumers and carers – and the governments, healthcare professionals, organisations and industry innovators who serve them.

As custodians of the strategy, the Australian Digital Health Agency co-designed the strategy's implementation plan – the Framework for Action – with its many partners in the community, building on the findings of the strategy's national consultation.[39] This document articulates the activities required to deliver on the strategy's outcomes, promotes collaboration and information sharing, and provides a guide for organisations to help them to align to national strategic priorities in digital health.

Results

1. **Implement projects through Children's Collaborative Network for Innovation**

   During this financial year, the next phase of the National Children's Digital Health Collaborative was commenced. This work including planning and design for several work streams of this multi-year initiative. A broad program governance framework was established across key clinical, community, jurisdiction and Commonwealth stakeholders to oversee the development of the first of the initiatives including the Child Digital Health record. The project team of this national initiative, led by eHealth NSW, produced key engagement and communication strategies and plans as well as technical and functional requirements for the national solution and benefits and evaluation strategies.

2. **Support future delivery of the Health Care Homes program**

   Under this program of work the Agency has supported the Health Care Homes trials run by the Department of Health. The trials aim to reduce the barriers that patients face across fragmented health services, with the aim of keeping them well, at home and out of hospital through the ongoing coordination, management and support of their care. The Agency and the Department of Health are working together to make better use of existing functionality in the My Health Record to support this program. This has included facilitating additional training for providers on use and benefits of the My Health Record as well as identification of other Agency programs such as the Advance Care Planning work with jurisdictions to support Health Care Homes.

3. **Scope care handover in remote communities**

   A decision was made to pause this work in 2017–18 and to review as a candidate for the 2018–19 work plan.

4. **Implement two projects to embed telehealth in clinical consultations**

   A decision was made to pause this work in 2017–18 and to review as a candidate for the 2018–19 work plan.

5. **Finalise strategy with Australian Health Minister's Advisory Council (AHMAC) and COAG Health Council**

   In August 2017, the National Digital Health Strategy was approved by the COAG Health Council. The Agency then led the co-production of the Framework for Action, which calls out the projects, innovations, investments and new ways of working that will progress the seven strategic priorities in the strategy. The launch of the strategy and the Framework for Action is a significant milestone for digital health in Australia and the result of an authentic collaboration with patients, consumers and carers – and the governments, healthcare professionals, organisations and industry innovators who serve them.

6. **Scope urgent and emergency care program in two jurisdictions**

   In July 2017, a two-year project commenced to establish routine use of the My Health Record system by clinicians in hospital emergency departments. The project is being undertaken by the Agency, in partnership with the ACSQHC. The project team is led by a senior emergency department and retrieval physician. The outcome of the project is to develop a framework that will increase the uptake and improve the clinical use of the My Health Record in emergency departments.

   Since the project commenced, robust project governance has been established with the formation of a national oversight committee. The first phase of the My Health Record in Emergency Departments Project was under way in 2017–18.

Project milestones achieved in 2017–18 include:

- A literature review and environmental scan;[33]
- Workshops with emergency department clinical staff at Townsville, Cairns and Nepean hospitals and telephone interviews with emergency department directors and health IT experts across Australian states and territories, US, UK, Israel and Denmark;
- A report on critical success factors identified for the pilot framework; and
- A survey distributed to emergency department staff in all five health services involved in the My Health Record opt out trial study.

Findings from the literature review and stakeholder consultation activities have informed the development of the framework.

> *My Health Record will provide access to verifiable clinical information such as a shared health summary, which is really useful when you're sitting down with a patient for a MedsCheck or Home Medication Review. The benefit to patients is safer and more effective care.*
>
> **Dr Shane Jackson**
> National President
> Pharmacy Society of Australia

33. "Factors and Effects of Electronic Health Records in Emergency Departments", https://www.safetyandquality.gov.au/publications/my-health-record-in-emergency-departments-literature-review-and-environment-scan

7. **Scoping study in two areas to support end of life care**

   Over 2017–18, the Agency commenced planning of an initiative in Victoria on the use of My Health Record to support a person's wishes for end of life care prior to entering a clinical pathway. This project will leverage Victoria's recent policy change to ensure a person's wishes and values need to be considered before medical treatment decisions are made on their behalf.

2.3.9 Interoperability

Purpose

The future success of digital health in Australia is strongly predicated on the capability of the health sector to share and use information. The Interoperability program will determine the right path to strengthen and improve the tools for digital interoperability in the Australian health sector and deliver products and an approach that gives the market and governments clarity on Australia's path to digital health interoperability.

Results

1. **Deliver a package of standards, roadmap and approach to implementation**

   A review of interoperability within Australian healthcare, with comparison to other jurisdictions and industries, has been undertaken by the Interoperability program. Clinical and community consultation has been conducted to identify the priorities for the broader public and industry consultation that will inform development of an implementation roadmap in 2018–19.

2. **Maximise impact of terminology service and products**

   A terminology server contains and provides access to clinical terminology. The main purpose of a clinical terminology server is to allow the consistent and comparable entry of clinical data, such as patient observations, findings and events.

   In 2017–18 the Agency released monthly updates of the SNOMED CT-AU and AMT terminologies, incorporating new medicines and clinical content including a large number of customer requests from clinicians and vendors within general practice, pharmacy, health jurisdictions, allied health, surgery and pathology.

   In this period the Agency also delivered new reference sets for the identification of all reportable drugs to support Electronic Recording and Reporting of Controlled Drugs in Tasmania and Victoria with a process in place to support all states and territories when they go live. In addition, the Agency has also incorporated reference sets from the Royal Australasian College of Surgeons, and the Royal College of Pathologists Australasia into SNOMED CT-AU to ease implementation efforts by vendors.

3. **Scope and trial implementation of Master Drug Catalogue and Ontoserver**

   Ontoserver® is a terminology server that supports multiple versions and formats of SNOMED CT (and extensions), as well as the ability to host other classifications, reference sets, mappings, and so on.

   In 2017–18 the Agency released Ontoserver 5 and upgrades to the terminology mapping tool. Nearly 50 affiliate organisations or individuals within Australia have chosen to license their own instance of Ontoserver.

The My Health Record in Emergency Departments project team.
L to R: Chris Leahy, Dr Andrew Hugman, Angela Ryan, Paul Miles, Neville Board

Case study: **My Health Record in Emergency Departments project**

The My Health Record in Emergency Departments Project sets out to research, pilot and establish routine use of the My Health Record system in hospital emergency departments. This is a two-year project being undertaken by the Australian Commission on Safety and Quality in Health Care in conjunction with the Australian Digital Health Agency.

Dr Andrew Hugman, the clinical lead on this project said:

"This is a huge and exciting project that will ensure that emergency departments' clinical staff have access to the ever-increasing amount of data stored in the My Health Record system. The My Health Record system is rapidly accumulating a massive amount of clinical information, as a result of the expansion of the My Health Record system and enhanced connections of public and private healthcare providers within it.

This project is going to help ensure that ED clinicians are able to maximise the benefits of all of this data to improve their patients' care. It won't matter whether someone is treated in a tertiary or remote hospital, or whether it's private or public. The aim of the project is to unify the access to the My Health Record information to enhance the delivery of care regardless of which ED they might be in."

2.3.10 Organisational excellence

Purpose

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

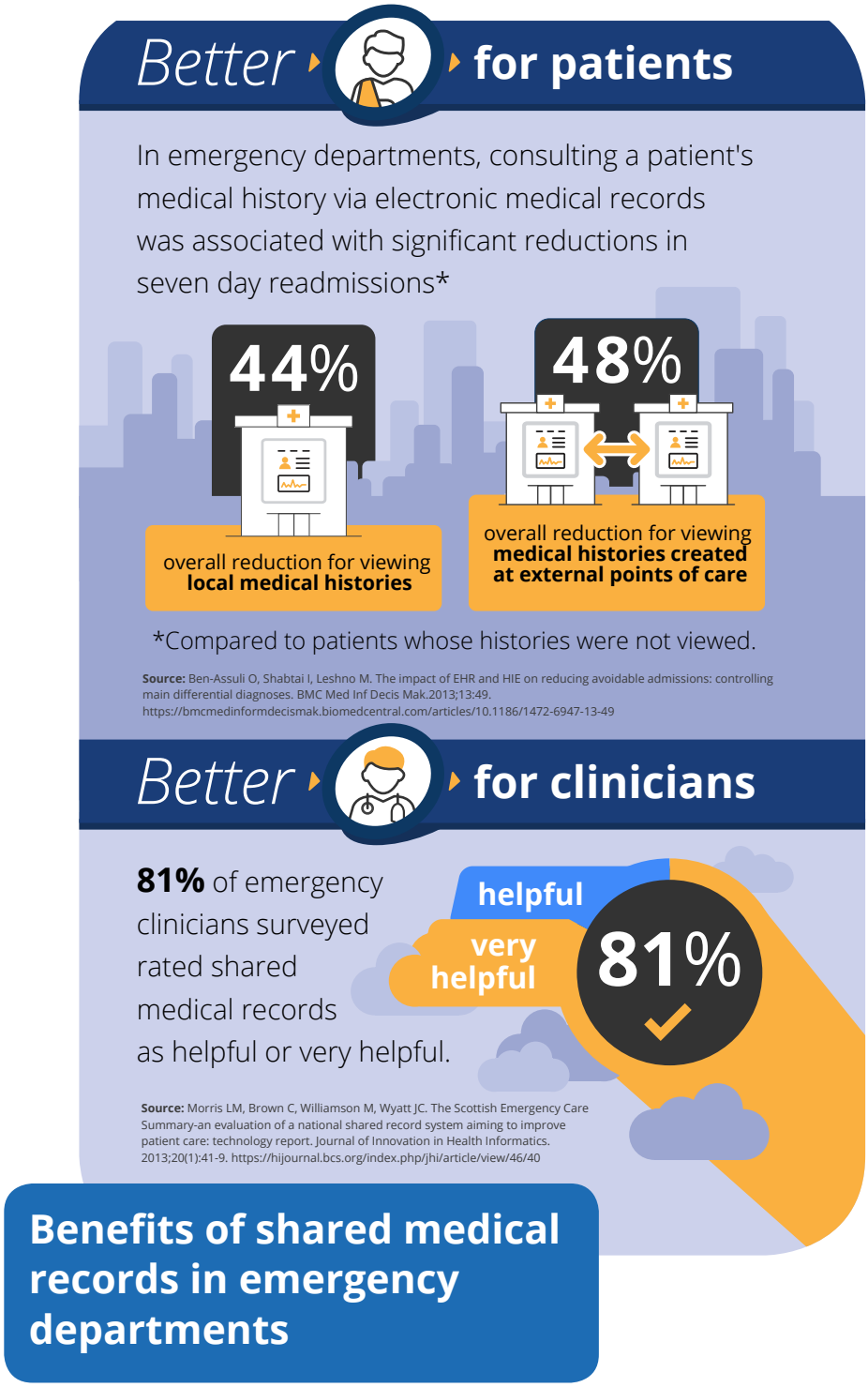
Driving improved health outcomes through the use of digital health technologies requires an engaged staff and an organisation committed to excellence in delivery. The Organisational Excellence program of work will seek to instil an organisational culture of passion and commitment to improved healthcare through the use of digital health.

The program will embed into Agency operations the principles of accountability, meaningful engagement and collaboration, and a focus on benefits realisation, as well as providing assurance to funders that funds are being applied to the right priorities and used prudently.

Results

1. **Drive cultural change**

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



Benefits of shared medical records in emergency departments

The Agency's focus on building organisational capability extends to fostering a culture of cohesion and collegiality, to ensure that the Agency's values (working together, respect and trust, transparency, leading through learning and customer focus) guide decision-making and make the Agency a great place to work. In late 2017–2018 the Agency commenced work to refresh its organisational values to ensure alignment with our strategic direction and desired culture, and to build a behaviours framework to support those values in action.

2. **Implement the risk management framework, including risk systems**

   The Agency is committed to an embedded risk management environment where risk consideration forms an intrinsic part of "business as usual" culture, promoting risk-informed decision-making. The Agency's risk management strategy, framework and policy (RMSFP) provides comprehensive guidance and information on the Agency's risk management processes and structures, to help staff recognise and engage with risks on a daily basis. The risk management strategy, framework and policy complies with the Commonwealth Risk Management Policy, supports the requirements of Section 16 of the PGPA Act, and includes the 11 principles set out in AS/NZS ISO 31000 to effectively manage risk.

   The Agency's strategic risks recognise the effect of uncertainty on our ability to achieve our purpose, high level activities and intended results. The strategic risks are identified and managed by the Agency's Executive Leadership Team and endorsed by the Board. The Executive Leadership Team monitors the risks and associated treatments on a monthly basis, with the Audit and Risk Committee and Board receiving quarterly updates.

3. **Assess the requirement for rebranding the Agency**

   It was determined that Agency rebranding was not required for 2017–18 and accordingly this project was removed from the work program following Board approval.

4. **Establish an internal operating model that recognises the Agency as a matrix organisation**

   To meet the demands of an ambitious work program, the Agency is shifting from a traditional hierarchy to a matrix organisational structure whereby teams are assembled from various functional disciplines and have multiple reporting lines – not simply to their functional manager, but also to multiple project managers for the finite life of the task at hand. This new approach to organisational management, characterised by a number of functional ("solid line") and project ("dotted line") reporting relationships is inherently flexible and dynamic, and encourages efficiency as experts and resources are shared across projects.

   This approach also allows for greater communication across the organisation – not just from the top down, but also a horizontal flow of information across branches and divisions. The creation of these multidisciplinary teams with considerable autonomy allows the Agency to draw on diverse skill sets, well equipped to respond to emerging needs and changing and uncertain environments. It has the added advantage of fostering a deeper sense of collaboration and cooperation, strengthening the spirit of partnership across the Agency.

5. **Replace IT legacy systems and create an integrated technical environment.**

   Under the banner of IT enterprise analysis, the team working on the technology that binds the Agency together made progress in delivering a flexible IT capability that implements the "One Agency" integration vision and supports future commitments, providing the agility and scalability required for the imminent nationwide expansion of the My Health Record.

Case study: **Nudging digital health**

David Halpern is a British psychologist who has specialised in recent years in advising governments on how the findings of behavioural science can be formulated as policy "nudges". His Grand Rounds presentation at the Agency explored some of the way that these ideas could be of value in digital health.

"Digital health is at the intersection of two big areas of focus. More than half of healthy years of life lost are estimated to be a result of behavioural or lifestyle factors. In other words, smoking, diet, exercise, but also less obvious factors such as social isolation, unsafe sex, and not completing medication.

At the same time, digital opens the door to new and affordable solutions. More subtly, digital makes possible much more rapid identification, testing and scaling of new and evolving solutions.

Put them together, and you can see why digital health is a very exciting space. Of course, its very power means that we also need to be sure to bring the public with us on this journey: it's their lives, their data, and it should be for them to set the parameters of the space in which we work."

During 2017–18, this business-led enterprise analysis initiative has:

- Engaged with business areas to model how the Agency produces value for its stakeholders and the capabilities required to produce this value;
- Produced a holistic and integrated view of the Agency's business capability requirements;
- Visualised areas of duplication or inefficiency that may be candidates for rationalisation and optimisation;
- Conducted a current to target state gap analysis of the Agency's ability to meet these requirements;
- Developed a sourcing strategy to bridge the gap required to achieve target state, including an evaluation of the services available from our shared service provider, Department of Health Shared Services; and
- Upgraded the ageing IT Infrastructure hardware and stabilised the core IT platform in order to mitigate high priority risks around out-of-service data storage solutions and unsupportable physical and virtual servers.

Collectively, these information and communication technology projects are helping the Agency to make headway in delivering core operational and business excellence.

6. **Excellence in program delivery and financial management**

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

   Significant activity has been directed at compliance with the PGPA Act and associated instruments and policies. These set the standard for the use and management of public resources, with a particular emphasis on planning, performance and reporting.

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

2.3.11 My Health Record system expansion

Benefits management

As part of the My Health Record Expansion Program the Agency has established multiple benefit evaluation workstreams – including market research, data analytics, impact evaluation, behavioural economics, digital health test beds, and health economic modelling – to generate robust evidence of health and economic benefits attributable to My Health Record.

To evaluate the impact of the My Health Record system, the Agency has partnered with a range of institutions, including the University of Melbourne, Flinders University, University of Wollongong, Western Sydney University, the Australian Institute of Health and Welfare, NPS MedicineWise, NSW Ministry of Health, PenCS, MedCast, McNair yellowSquares, the Behavioural Insights Team, Taylor Fry, and PwC Australia. This work has produced qualitative and quantitative evidence that expected benefits are being realised, and that there is strong agreement among healthcare providers that My Health Record has potential to deliver a range of benefits. The Agency has also supported 15 new digital health test beds to evaluate the impact of enhanced models of care. The test beds will utilise the My Health Record system and national infrastructure services as a platform to foster sustainable, scalable innovation by entrepreneurs, industry, and health services.

Program management

An assurance framework exists to ensure the My Health Record Expansion Program delivers on time, remains on budget, realises benefits and is delivered to quality standards. Assurance gateway reviews are conducted by the Department of Finance at the completion of each gate. Since inception, the program has completed two assurance reviews by 30 June 2018, conducted by the Department of Finance's Assurance Reviews Unit, with the findings that the program is green/amber with a likely successful delivery of My Health Record Expansion.

The Program has a robust three-tier governance structure (strategic, program, operational) in place, consisting of:

- **Tier 1** – Agency Board and Program Board to oversee My Health Record Expansion; also responsible for setting the overall strategic design, direction and alignment to strategy, overseeing all strategic investment decisions and responsible for the realisation of benefits.
- **Tier 2** – Program Management Office and Program Delivery Committee to oversee execution and provide decision and execution guidance at program level.
- **Tier 3** – Program Management Working Groups to manage delivery of projects within the program and manage day-to-day operational delivery of My Health Record Expansion.

Delivery by December 2018, to cost, quality standards and benefits realisation is highly likely as there are no major risk or issues threatening delivery to the agreed timeframe. The Agency has adopted an industry-recognised program management framework based on Managing Successful Programs (MSP) and PRINCE2 which provides a consistent approach and governance model for delivery of large-scale programs like My Health Record Expansion. In alignment with the PRINCE2 methodology, the Agency Program Delivery Framework consists of four stage gates (Initiation, Plan, Delivery and Closure) and defines the:

- Specification of required programs and project artefacts;
- Required entry and exit criteria for each program stage; and
- Stage gate and stage review compliances for each program stage.

Stakeholder engagement management

The My Health Record Expansion Program supports collaboration with a wide variety of stakeholders across the health and non-health sector including jurisdictions, Primary Health Networks, clinical and consumer peaks, other government departments/agencies and corporate partners. Oversight is provided by a steering group made up of senior representatives from 30 of the key stakeholder organisations.

> *Nine months ago, we said anything over 50% would be a spectacular job, given the degree of difficulty faced by the agency. (The Agency) has as good as achieved 50%, which says this is an organisation that is moving on its target and goals, probably in a much better way than the predecessor agencies.*
>
> **Jeremy Knibbs**
> Medical Republic Publisher

Case study: **Pharmacists have worked in the dark for way too long**

Associate Professor Mark Naunton is Head of Pharmacy at the University of Canberra. He believes that thanks to My Health Record, pharmacists will be able to practice what they preach – they will have secure access to a patient's health information.

"For too long pharmacists have worked in the dark with patients. Having a My Health Record will mean important health information such as allergies, current conditions, medicine details, pathology reports or diagnostic imaging scan reports can be digitally stored in one place and will allow access by health professionals with the patient's consent.

I believe a key benefit of My Health Record for patients and, in fact, the whole healthcare system is that pharmacists are finally linked and integrated more into the healthcare team.

For pharmacists, it will allow them to provide better informed patient-centred care.

One area of great concern for me is in the post-discharge period and confusion around medication changes particularly for people with multiple chronic diseases. According to Australia's Health 2016 (published by the Australian Institute of Health and Welfare) 23% of Australians, or 5.3 million people, had two or more of eight selected chronic diseases.

Having access to information about a patient's hospitalisation and medication management – through discharge summaries and the Medicines View features of My Health Record – will enhance the care pharmacists can provide patients and minimise the risk of medication misadventure."

2.4 Performance targets from the Portfolio Budget Statements 2017–18

The Agency's performance measures are sourced from the annual work program published in its Corporate Plan 2017–18 and others are determined by the Health Minister ahead of publication of the Portfolio Budget Statements (PBS). While these two documents usually align, in the case of 2017–18, with the Government's announcement of the national opt out program, the Agency co-produced a program implementation plan with industry, healthcare providers, jurisdictions and supporting organisations such as Primary Health Networks to deliver the two year program over 2017–19. This led to targets being set at December 2018 to line up with national opt out, and the Agency's work program aligned accordingly.

The table below highlights the attainment of the Agency's purpose by outcomes achieved across the seven 2017–18 performance targets set by the Minister in the Health PBS, published in the 2017–18 Budget. They do not take into account December 2018 targets which are the focus for much of the Agency's work.

PBS-stated objective	Performance criteria	2017–18 target	Outcome
Delivering core clinical programs (medicines safety, pathology, diagnostic imaging)	Better medicines safety through improved accuracy, timeliness, visibility and accessibility of medicines information in the My Health Record system.	Commence public pharmacy dispense records upload to the My Health Record from two jurisdictions and upload a minimum of 60% of dispensed pharmacy prescriptions supplied to consumers registered with the My Health Record by 30 June 2018.	Commenced uploading public hospital pharmacy dispense records to the My Health Record system from the Northern Territory and New South Wales. 51% of community pharmacies were registered for the My Health Record by 30 June 2018.
	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.	All states and territories, two private diagnostic imaging providers and two private pathology providers are sharing diagnostic imaging and pathology reports with the My Health Record.	Four states and territories, three private diagnostic imaging providers and four private pathology providers connected and sharing diagnostics reports with the My Health Record.

PBS-stated objective	Performance criteria	2017–18 target	Outcome
Improving the My Health Record system	Enhance the My Health Record system to improve participation, usage, content and engagement with the service.	Release an upgrade to the My Health Record system to improve the medicines view, end user experience and mobile access, complete public hospital connections, and connect an additional 20 private hospitals to the My Health Record system between 1 July 2017 and 30 June 2018.	Released two upgrades to the My Health Record system to support the opt out participation model and to improve the end user experience and mobile access, and connected 55 additional public hospitals and health services (out of a total of 1,107) and 17 private hospitals (out of a total of 208) to the My Health Record system, taking the total public hospital connections to 74% and private hospital connections to 86%.
	Availability of the My Health Record system.	99% of the time (excluding planned outages).	The My Health Record system availability rate exceeded 99% during 2017–18 (excluding scheduled outages). Access by people to registration and view system functions achieved 99.68% availability in 2017–18.
Achieving secure messaging and interoperability	Establish secure message interoperability by developing and deploying a process for a message to flow securely from one health service provider to another.	Finalise industry specification and guidelines for secure messaging and implement messaging in three jurisdictions.	Finalised industry specification and guidelines for secure messaging implemented across messaging proof of concept projects in Victoria and New South Wales.
Conducting strategy research and driving development of digital health	Development and delivery of the National Digital Health Strategy.	Finalise National Digital Health Strategy with the COAG Health Council.	The COAG Health Council approved the National Digital Health Strategy 2018–2022 on 4 August 2017, and the Framework for Action was co-produced with industry, governments, and the broader sector by 30 June 2018.
Delivering national opt out for My Health Record	Deliver national opt out participation for My Health Record.	Finalise a program delivery, outline key milestones and decision points for successful implementation.	Finalised program delivery, identified key milestones and decision points for national expansion of the My Health Record system.

Case study: **The importance of interoperability: a conversation with Dr Nathan Pinskier**

"There are two fundamental levels of interoperability in clinical messaging. The most basic is ***interconnectivity*** *– we have to "standardise the rail gauge", so to speak. So a train travelling from Melbourne to Sydney can actually cross the border at Albury Wodonga without the need for a different train. Similarly, we first need to get the interconnectivity between clinical messaging vendors working.*

Once we start moving the trains, then we can start focusing on the content of the messaging. You've got to get the trains rolling – standardise the stocks, standardise the gauge – and then focus on the messaging so we can start to actually understand the content of the message, which we talk about as ***semantic interoperability****. That is, the computers can understand the information contained in the message, not just the humans. That's moving from human readable to machine readable.*

That's when clinical terminologies become critical. So that's about having standardised clinical terminology, and obviously the one we've chosen for Australia is SNOMED CT-AU, which is also used internationally. It's about linking the clinical terminology coding to recognised clinical vocabularies. So it doesn't matter what vocabulary you use, so long as it links in to a back-end coding system.

I think this is a critical point that most people don't quite get. They talk about getting clinicians to code. What I say is that they don't need to code – the code is in the background, it's a machine number. What we need to focus on is to have clinicians use drop-down boxes to record critical information as opposed to merely recording free text."

3 Management and accountability

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

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 Council of Australian Governments Health Council (CHC).

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

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

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

Other key governance features include:

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

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

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 direction to achieve the Agency's purpose, and oversees performance, governance and resource

allocation as custodian of Commonwealth, state and territory funding.

The Board maintains a watching brief over internal and external environments, and ensures that Agency operations and outcomes are fit for purpose and align with government priorities.

Its efforts are balanced across creating the future and delivering the present. In fulfilling its statutory obligation to produce an annual work program it gives a clear picture of operational priorities, actions and planned outcomes for each financial year.

Board members

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

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

The composition and history of the Agency's Board membership is as follows:

Chair

- Jim Birch AM

SES officer in the Commonwealth Department of Health:

- Paul Madden (to 31 March 2017)
- Martin Bowles PSM (to 31 August 2017)
- Glenys Beauchamp PSM (from 28 May 2018)

Nominated Australian Health Ministers' Advisory Council members:

- Stephen Moo (to 18 September 2017)
- Michael Walsh

Other members:

- Robert Bransby
- Dr Eleanor Chew
- Dr Elizabeth Deveny
- Lyn McGrath
- Stephanie Newell
- Dr Bennie Ng
- Prof Johanna Westbrook

Jim Birch AM

Chair

Mr Jim Birch AM, Chair, is also 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. He has a Bachelor of Health Administration from the University of New South Wales.

Martin Bowles PSM

(to 31 August 2017)

Martin Bowles PSM is currently the National CEO of Calvary Health Care. He was the Secretary, Department of Health until 1 September 2017, a position he was appointed to in October 2014. In that role, he led reforms in primary health care and mental health service arrangements, access to medical and pharmaceutical benefits, aged care, hospital funding and digital health.

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

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

Mr Bowles has previously held senior executive positions in the education and health portfolios in the state government public sector, prior to joining the Commonwealth Public Service.

Glenys Beauchamp PSM

(from 28 May 2018)

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 has an economics degree from the Australian National University and an MBA from the University of Canberra.

Stephen Moo

(to 18 September 2017)

Stephen Moo is an executive consultant for digital health with PB Consulting and was the Chief Information Officer for the Northern Territory Department of Health until September 2017. Mr Moo has been employed in the health sector for over 34 years, with the last 16 years having direct responsibility for the design, development, implementation and ongoing systems management for major corporate client and clinical information systems, and information communications and infrastructure. He has overseen the Northern Territory's eHealth program for the past 11 years and is the principal architect and sponsor for the development and implementation of a comprehensive eHealth program that is widely regarded as one of the most advanced of its kind in Australia.

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

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

3

Management and accountability

Michael Walsh

Michael Walsh is the Director-General Queensland Health where he leads a public health and hospital system for a population of nearly 5 million people. Prior to this role, 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.

Rob Bransby

Rob Bransby has more than 35 years' experience in business, financial services and the health sector. Mr Bransby stepped down from his full-time 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.

Dr Eleanor Chew

Dr Eleanor Chew is a specialist general practitioner and medical educator, with extensive experience representing the role of primary care in the health services profession. 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 holds a Bachelor's Degree in Medicine and Surgery and a Masters of Medicine (General Practice) from the University of Queensland. She is a Fellow of the Royal Australian College of General Practitioners and a Fellow of the Australian Institute of Company Directors.

Dr Elizabeth Deveny

Dr Elizabeth Deveny is currently the CEO of South Eastern Melbourne Primary Health Network (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. Dr Deveny is also currently Chair of the Australian Digital Health Agency Board's Privacy and Security Advisory Committee.

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.

Stephanie Newell

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.

Dr Bennie Ng

Dr Bennie Ng is a specialist hospital administrator and general practitioner, with senior management and policy experience in Australia and abroad. He is currently the General Manager, Partnerships and Strategy at Healthscope, a leading healthcare provider which operates 45 private hospitals across Australia. Dr Ng commenced his career as a General Practitioner in Western Australia before becoming the Managing Director of General Practice Registrars Australia, a national body advocating for better primary care workforce, education and training policies. He has extensive experience in providing advice to the Australian Government. As an adviser to the Minister for Health, he oversaw the expansion of chronic disease management and mental health services in primary care and Medicare. As Head of Social Policy at the Office of the Prime Minister his responsibilities included health and hospitals, aged care, disabilities/NDIS and indigenous affairs.

Dr Ng has held other senior positions including the Head of Clinical Services Planning at the Hong Kong Hospital Authority and the General Manager, Cancer Medicine at the Peter MacCallum Cancer Centre in Melbourne. He holds a Bachelor's Degree in Medicine and Surgery and a Masters of Business Administration and is a Fellow of the Royal Australasian College of Medical Administrators and of the Royal Australian College of General Practitioners. Dr Ng is currently a part-time member of the Administrative Appeals Tribunal.

Professor Johanna Westbrook

Professor Johanna Westbrook is Professor of Health Informatics and Director, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, at Macquarie University. She is internationally recognised for her research evaluating the effects of 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 Australasian College of Health Informatics.

Management and accountability

Board meetings

The Board meets regularly in accordance with a formally approved timetable and agenda. The Board convened on nine occasions throughout 2017–18, five of which were via teleconference. In accordance with PGPA Act requirements, details of the number of Board meetings attended by each member during the financial year are outlined below.

Board Member	Term of appointment	Meetings held and eligible to attend	Meetings attended
Jim Birch AM, Chair	20 April 2016 to 20 April 2019	9	9
Martin Bowles (to 31 August 2017) replaced Paul Madden)	01 April 2017 to 01 April 2020	2	1
Robert Bransby	20 April 2016 to 20 April 2019	9	7
Dr Eleanor Chew	20 April 2016 to 20 April 2019	9	9
Dr Elizabeth Deveny	20 April 2016 to 20 April 2019	9	9
Glenys Beauchamp PSM (from 28 May 2018)	28 May 2018 to 28 May 2021	1	0
Lyn McGrath	20 April 2016 to 20 April 2019	9	7
Stephen Moo (to 18 September 2017)	20 April 2016 to 20 April 2017 20 April 2017 to 20 April 2018	2	2
Stephanie Newell	20 April 2016 to 20 April 2019	9	9
Dr Bennie Ng	20 April 2016 to 20 April 2019	9	9
Michael Walsh	20 April 2016 to 20 April 2017 20 April 2017 to 20 April 2018 01 Aug 2018 to 01 Aug 2021	9	9
Professor Johanna Westbrook	20 April 2016 to 20 April 2019	9	9

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: ♦ The efficient and effective delivery of clinical care using digital health; ♦ The architectural integration of digital health systems; ♦ Proposed innovations and measures to improve the efficiency and effectiveness of digital health systems for clinicians and users of the system; ♦ Changes to digital health system design to improve clinical usability and usefulness based on experience with the use of digital systems; and ♦ Recommendations in relation to priorities of investment in, and development and implementation of, national digital health systems.
Consumer Advisory Committee	The Consumer Advisory Committee advises on: ♦ How to ensure key messages about digital health are communicated effectively to relevant stakeholders and health consumer groups; ♦ Recognising the interests of minority and special interest groups so as to ensure that their interests are taken into account in the design and implementation of digital health systems; and ♦ Establishing and maintaining collaboration with health consumers and providers in relation to digital health systems.
Privacy and Security Advisory Committee	The Privacy and Security Advisory Committee advises on: ♦ Legal issues in relation to digital health systems, including copyright, data privacy issues, confidentiality issues, data security and legal liability; ♦ The long-term legal framework of digital health systems; ♦ Privacy and security issues encountered by users of digital health systems, and the resolution of any problems arising from monitoring these issues; and ♦ Standards (including compliance with standards) relating to privacy and security in relation to digital health systems.

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

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

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

Audit and Risk Committee	The Audit and Risk Committee was established to 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: ♦ Financial reporting: activities such as advising on the entity's preparation and review of its annual financial statements, the adequacy of the entity's internal budgeting and reporting, and the entity's obligations under the PGPA Act and other relevant Acts. ♦ Performance reporting: reviewing the framework of key performance indicators and other performance measures, or the entity's annual performance statement; or making recommendations on concerns or opportunities identified by internal or external audits.

Audit and Risk Committee	♦ System of risk oversight and management: advising the entity about internal audit plans; advising about professional standards to be used by internal auditors in the course of carrying out audits; reviewing the entity's response to internal and external audits and reviewing the entities risk management framework which may include review of the entity's risk management plan and business continuity plan. ♦ System of internal control: reviewing the entity's compliance framework, governance arrangements and internal control environment.

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 accountable to the Agency 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 Board of the Agency's My Health Record Expansion Program is chaired by the Agency CEO, Tim Kelsey. Its membership includes the Agency's Executive General Manager for Core Services Systems Operations, Ronan O'Connor, as well as Caroline Edwards and Maria Jolly (Department of Health), Amanda Cattermole and Paul Creech (Department of Human Services), Dr Lesley Seebeck (Digital Transformation Agency), Daniel Hunter (jurisdictional representative) and Lizz Reay (Primary Health Network representative).

3.1.3 Internal governance

CEO

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

Executive Leadership Team

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

Management and accountability

Senior Leadership Team

The Senior Leadership Team also has a role in overseeing operational activities and in guiding the ongoing development of the Agency's governance policies and processes. The Senior Leadership Team, comprising general managers (branch heads) meets with the Executive Leadership Team 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 (Section heads) through the Directors' Forum, which meets fortnightly with a representative of the Executive and Senior Leadership Teams. This forum has a dual purpose: as a communication channel to cascade key messaging from the Executive, and as a critical feedback loop. It allows upward communication of staff insights on emerging challenges, resourcing priorities, performance progress, and the operation of policies and processes in practice, leading to their continuous improvement.

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

Internal committees

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

Internal committee	Purpose
Portfolio Management Committee	Oversees the planning and delivery of the Agency's annual work program.
Information Governance Steering Committee	Guides the implementation of the Agency's information management programs.
Clinical Programs Management Committee	Manages operational aspects of the Agency's clinical programs: Medicines Safety, Pathology and Diagnostic Imaging programs, and any new programs identified by the Agency's Board.
Digital Health Safety and Quality Management Committee	Establishes a forum where clinical governance mechanisms are in place and effective across the Agency.

Case study: **Bringing digital health to Central Australia**

Australia's digital health system is currently developing and evolving to best serve the community's needs and arguably, people living in the most remote areas of the continent stand to benefit the most.

Dr Sam Goodwin is the Executive Director of Medical and Clinical Services with the Central Australian Health Service, which covers a two million square kilometre expanse in the Northern Territory and parts of Western Australia, Queensland and South Australia. Between 60,000-80,000 residents come under its jurisdiction, a high percentage of whom identify as Indigenous Australians.

Having lived and worked in the area for 11 years, Dr Goodwin gives first-hand insights into the challenges faced by remote communities and how digital services can make a significant, positive difference.

Diabetes, kidney disease and other chronic illnesses are prevalent in remote indigenous communities. Dr Goodwin points out these health issues are impacted by lower socio-economic standards of living and long travelling distances for face-to-face medical treatment.

For many, a trip to a specialist entails a 1,000 kilometre round trip. He believes that digital health has the power to address some of these problems. For example, video conferencing between patient and healthcare provider – telehealth – can eliminate the need for a patient to travel those great distances. It will save time and money, providing a virtual consulting office without the patient having to leave their families and miss work.

And what about the challenges of bringing a digital health system to areas so remote that people don't have access to computers? Dr Goodwin pointed out that the Aboriginal and Torres Strait Islander peoples are actually "comparably familiar" with the digital world. If they use mobile phones (and they do) they can take advantage of the digital health services and other mobile health applications. It's just a matter of putting the infrastructure in place and supplying communities with the right network and broadband capabilities.

Digital health has the ability to put the patient's needs at the centre of health care, creating equity of access to treatment within complex and disparate health systems.

3

Management and accountability

Risk management

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

In its first year of operations, the Agency designed and implemented a system of internal controls for the oversight and management of risk, including policy guidelines, tools and templates.

The framework is aimed at building a positive and transparent risk culture by embedding risk management principles and processes into business-as-usual activities.

The risk management framework is modelled on better practice methodologies, and aligned with the international standard on risk management (AS/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 appointed Axiom Associates as its internal auditors in February 2017, who prepared a Strategic Internal Audit Plan extending through June 2019. The audit program was informed by a consultative and collaborative risk assessment process to target areas of highest risk and those of high value warranting independent appraisal of financial and operational controls.

Audits covering assurance mapping, financial reporting, shared services arrangements, procurement and project management were completed during the reporting period. All findings are presented to the Audit and Risk Committee, with an accompanying plan to action any recommendations as part of ongoing efforts to improve Agency processes and performance.

Priority areas for 2018–19 activity include internal budgeting and the Agency's privacy management framework. The Agency will continue to focus audit resources on identified areas of significant or financial risk while being flexible enough to respond to emerging risks and changing demands. The audit program will be reviewed and revised to account for significant changes in the internal and external environment, and also to reflect the continued growth in the Agency's maturity and capability.

External audit

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

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

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

3.1.4 Fraud control

The Agency has developed an integrity framework aimed at ensuring standards of professionalism, individual accountability and ethical behaviour are valued and shared across the organisation.

The framework is underpinned by polices, plans and procedures such as accountable authority instructions that encourage responsible public administration and minimise the risk of misappropriation of Agency resources.

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

During 2017–18, the Agency conducted a risk assessment of its possible exposure to fraud, corrupt or improper conduct. That assessment allowed for the preparation of a fraud control plan tailored to Agency requirements. The plan documents the Agency's fraud governance arrangements, risk mitigation measures and reporting responsibilities. It also provides for training and awareness activities to assist Agency staff to identify suspected fraud and understand their disclosure obligations. The plan is supported by appropriate fraud prevention, detection and response strategies to minimise the incidence and impact of fraud.

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

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

3.1.5 Business continuity management

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

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

Over 2017–18 the Agency commenced a Business Continuity Management Improvement Project culminating in a business impact assessment, improvements to the quality of business continuity documentation and a formal exercise program being established. The Agency also focused on testing and validating business continuity arrangements and incorporating any lessons learned from recovery exercises. Training also took priority to make staff aware of their roles and responsibilities during a crisis and understand Agency measures to centralise and coordinate its response and prioritise and restore system and workforce availability.

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 2017–18 financial statements of the Agency, which is presented in Part 4 of this report. The Agency was not the subject of any performance audits by the Auditor-General during the reporting period.

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

The Agency appeared before the Senate Estimates (Community Affairs Legislation) Committee to answer questions about Agency operations in October 2017, but no reports on the Agency were released by a parliamentary committee or the Commonwealth Ombudsman.

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

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 2017–18 the Agency received nine 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 – www.digitalhealth.gov.au.

Case study: **Enhanced clinical leadership at the Australian Digital Health Agency**

The Agency has tripled the number of clinical reference leads – from 15 to 45 members. Each one is an experienced, well-regarded healthcare professional who is able to represent the perspectives of their profession in designing digital health products and services. Collectively, they provide an invaluable conduit between the Agency's product and service development teams and Australian healthcare professionals.

This expansion will promote greater engagement across healthcare sectors, and enable more diverse and nuanced clinical advice in the development and assurance of the Agency's products and services.

The expanded group met in Sydney on 29 March for an induction workshop covering the role and structure of the Agency, the 2017–18 work program, international research in digital health, My Health Record fundamentals, case studies and more.

Feedback from the workshop was overwhelmingly positive.

Dr Michael Araco, Medical Advisor at Healthdirect, said that "*Dr Chris Moy had great insight as did hearing from the senior clinical reference leads*."

Specialist nurse and researcher Helen Almond valued "*the diversity and fullness of the program and the networking opportunity*", and ICT Manager at NSW Health Pathology Juliana Iles-Mann appreciated "*gaining a deeper understanding of how the Agency works, its program of works and where my expertise might fit in*."

3.3 Additional reporting requirements under the PGPA Rule 2014

3.3.1 Ministerial directions and policy orders

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

No ministerial directions or notifications were given during the 2017–18 reporting period.

3.3.2 Compliance with finance law

The PGPA Rule requires that the Agency report on any significant non-compliance during 2017–18 with finance law (encompassing the PGPA Act, any delegated legislation under that Act, or an Appropriation Act).

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

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 2017–18.

However, it is noted that a material change to the Agency's portfolio of work is underway following the Federal Government announcement in the May 2017 Budget of the My Health Record – continuation and expansion Budget Measure which will see the national expansion of the My Health Record to every Australian unless they choose not to have one. Australia is now the first country in the world to commit to the provision of a digital health record to every citizen. As the System Operator for the My Health Record, the Agency is responsible for implementing this historic work and is 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 – Martin Bowles PSM until 1 September 2017, and Glenys Beauchamp PSM from 18 September 2017 – was both the accountable authority for one body (the Department of Health), and a member of the accountable authority of another (a member of the Agency Board) during the reporting year.

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

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

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

There were 9 transactions in 2017–18 and their value in aggregate was $2.456 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 2017–18 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 2017–18 was $24,448.58 (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.

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 2018, the Agency employed 245 staff under both those arrangements (235 permanent and 10 temporary) across offices in Brisbane, Sydney and Canberra.

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.

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

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; and
- Staff and family access to an Employee Assistance Program – an independent, confidential and free professional counselling service provided by external, registered psychologists to address vocational or personal issues (52 employees, or their families, utilised this service in 2017–18).

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.

Case study: **How to design an award winning health app**

The secret? Real co-design and co-production, says Cheryl McCullagh, Director of Clinical Integration at the Sydney Children's Hospitals Network.

"About six years ago we wanted to address a gap in information sharing, particularly for patients with complex conditions who were seeing multiple providers.

So we started talking to patients and families about what they really wanted from us. They told us that their main issues were about communications between their providers, understanding what their condition was, where their treatment was up to, and keeping everyone up to date when those things changed.

This feedback and other patient-centred considerations led us down a more visionary path where patients and families would be the centre of their healthcare communications and decision-making. We called this the "Memory Strategy" – it's a shared memory of care for life, for providers and for patients.

We came up with a model for communicating in real time in business hours through encrypted SMS that would streamline communications that the patients and parents were already attempting to make. We wanted the communications to happen in real time, be secure and easy to track and refer back to, and those requirements became the foundations of the communications module of the app.

And then the other major part was keeping track of events to keep their life organised, making sure that they had all the right appointments at the right time, with the right preparation instructions, and even mechanisms to change those if they needed to.

I think there's a groundswell of recognition across the world that patients are more important in care outcomes than we first thought. Their condition, their capability, their leadership, their advocacy, their self-knowledge – all those things are just as important to long term health or a successful health experience than many of the things that we might intermittently provide."

3.5.2 Advertising and market research

Under Section 311A of the *Commonwealth Electoral Act 1918* the Agency is required to disclose payments exceeding $13,500 (inclusive of GST) to advertising, market research, polling, direct mail or media advertising organisations. Sums less than $13,500 are not required to be reported.

During 2017–18 the Agency's total expenditure for advertising and market research over the reporting threshold was $1,043,528.20 (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	Purpose	Expenditure (GST inclusive)
Ogilvy & Mather	Creative design in support of My Health Record expansion	$28,292.00 $69,889.60 $116,483.40 $17,070.55 $13,749.95 $116,483.13 $93,186.50
Market research organisation	**Purpose**	**Expenditure (GST inclusive)**
ORC International	Market research in support of My Health Record expansion	$378,519.46 $107,250.04 $28,053.57 $74,550.00
Total		**$1,043,528.20**

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 tele-conferencing 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; and
- Energy-efficient practices in air-conditioning, computer and lighting, such as lighting control systems that activate by motion sensors.

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

4 Financial statements

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

4.1 Financial summary

The Agency is jointly funded by the Commonwealth ($250.526 million)[34] and the states and territories ($32.250 million).

The corporate focus through 2017–18 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.

4.1.1 Financial outcome

The Agency had a total operating revenue of $235.561 million in 2017–18. The Agency incurred total expenses of $256.055 million. As a result, the Agency recorded an operating loss of $20.494 million in 2017–18 relating to the carry forward of 2016–17 COAG funding under the intergovernmental agreement 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 2017–18 with carry forward expenditure covered through funding received in 2016–17, which was recorded as revenue for accounting purposes in that year. Depreciation/amortisation has no impact on underlying cash.

4.1.2 Audited financial statements

The Australian National Audit Office (ANAO) inspected the Agency's financial records and provided an unqualified audit opinion on the financial statements and accompanying explanatory notes on 24 September 2018. The ANAO's report and the Agency's financial statements are presented on pages 107 to 131 of Part 4.

The Agency will continue to focus on its budget management in 2018–19 to maintain its financial sustainability and to deliver strongly against its statutory priorities.

34. Australian Digital Health Agency chapter in Health Portfolio Budget Statements 2017–18, page 190, http://www.health.gov.au/internet/budget/publishing.nsf/Content/2017-2018_Health_PBS_sup2/$File/2017-18_Health_PBS_4.03_Digital%20Health.pdf

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Digital Health Agency for the year ended 30 June 2018:

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

(b) present fairly the financial position of the Australian Digital Health Agency as at 30 June 2018 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian Digital Health Agency, which I have audited, comprise the following statements as at 30 June 2018 and for the year then ended:

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

Basis for Opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Australian Digital Health Agency in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (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 Australian Digital Health Agency the Board of the Australian Digital Health Agency (the Board) is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under that Act. The Board is also responsible for such internal control as the Board determines is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the Australian Digital Health Agency's ability to continue as a going concern, taking into account whether the entity's operations will cease as a result of an administrative restructure or for any other reason. The Board is also responsible for disclosing, 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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Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

Australian National Audit Office

Sean Benfield
Executive Director
Delegate of the Auditor-General

Canberra
24 September 2018

Australian Government
Australian Digital Health Agency

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SYDNEY NSW 2000
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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 2018 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.

.....	.....	.....
Rob Bransby	Tim Kelsey	Steven Momcilovic
Acting Board Chair	Chief Executive Officer	Chief Financial Officer
Accountable Authority		
DATE 21/09/2018	DATE 21/09/2018	DATE 21/09/2018

Australian Digital Health Agency

Statement of Comprehensive Income

for the period ended 30 June 2018

		ACTUAL		BUDGET ESTIMATE	
		2018	2017	Original Budget	Variance
	Notes	**$'000**	$'000	$'000	$'000
NET COST OF SERVICES					
Expenses					
Employee Benefits	2.1A	**34,195**	33,958	40,414	6,219
Suppliers	2.1B	**205,347**	115,764	180,333	(25,014)
Depreciation and Amortisation	3.2A	**15,931**	29,893	10,365	(5,566)
Write-Down and Impairment of Assets	2.1C	**582**	1,746	-	(582)
Total expenses		**256,055**	181,361	231,112	(24,943)
Own-Source Income					
Own-source revenue					
Contributions from Jurisdictions	2.2A	**32,250**	32,250	32,250	-
Interest	2.2B	**3,224**	1,546	1,800	1,424
Other Revenue	2.2C	**3,025**	-	-	3,025
Total own-source revenue		**38,499**	33,796	34,050	4,449
Gains					
Other Gains	2.2D	**-**	56,699	-	-
Total gains		**-**	56,699	-	-
Total own-source income		**38,499**	90,495	34,050	4,449
Net cost of services		**(217,556)**	(90,866)	(197,062)	(20,494)
Revenue from Government	2.2E	**197,062**	110,303	197,062	-
(Deficit) / Surplus attributable to the Australian Government		**(20,494)**	19,437	-	(20,494)
OTHER COMPREHENSIVE INCOME					
Items not subject to subsequent reclassification to net cost of services					
Changes in asset revaluation surplus		**-**	776	-	-
Total other comprehensive income		**-**	776	-	-
Total comprehensive income attributable to the Australian Government		**(20,494)**	20,213	-	(20,494)

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

Budget Variances Commentary

Statement of Comprehensive Income

The deficit in 2017-18 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 2017-18 with carry forward expenditure covered through funding received in 2016-17, 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 2018

	Notes	ACTUAL 2018 $'000	ACTUAL 2017 $'000	BUDGET ESTIMATE Original Budget $'000	BUDGET ESTIMATE Variance $'000
ASSETS					
Financial assets					
Cash and Cash Equivalents	3.1A	**81,531**	40,548	20,075	61,456
Trade and Other Receivables	3.1B	**5,962**	8,825	78	5,884
Other Investments	3.1C	**-**	6,001	-	-
Total financial assets		**87,493**	55,374	20,153	67,340
Non-financial assets					
Leasehold Improvements	3.2A	**1,681**	521	-	1,681
Plant and Equipment	3.2A	**3,027**	1,192	1,647	1,380
Computer Software	3.2A	**16,854**	854	-	16,854
Other Intangibles	3.2A	**60,897**	38,789	103,825	(42,928)
Other Non-Financial Assets	3.2B	**5,117**	1,127	395	4,722
Total non-financial assets		**87,575**	42,483	105,867	(18,292)
Total assets		**175,069**	97,857	126,020	49,049
LIABILITIES					
Payables					
Suppliers	3.3A	**51,417**	11,521	5,874	(45,543)
Other Payables	3.3B	**3,600**	588	-	(3,600)
Total payables		**55,017**	12,109	5,874	(49,143)
Provisions					
Employee Provisions	4.1A	**6,838**	5,802	4,503	(2,335)
Other Provisions	4.1B	**637**	338	-	(637)
Total provisions		**7,475**	6,140	4,503	(2,972)
Total liabilities		**62,492**	18,249	10,377	(52,115)
Net assets		**112,577**	79,608	115,643	(3,066)
EQUITY					
Contributed Equity		**112,877**	59,413	103,825	9,052
Reserves		**15,776**	776	-	15,776
Retained Surplus / (Accumulated Deficit)		**(16,075)**	19,419	11,818	(27,893)
Total equity		**112,577**	79,608	115,643	(3,066)

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. Computer software and other intangibles are lower than budget due to lower capitalisation, higher amortisation and lower opening balance than budgeted.

Liabilities

Total liabilities were higher than budgeted due to two factors. Firstly, 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. Secondly, the Agency has increased the employee provisions due to an increase in staff numbers and increased entitlements from a further year of operation.

Equity

Equity is in line with expectations and the variance is due to the net effect of the variances in assets and liabilities above.

Australian Digital Health Agency

Statement of Changes in Equity

for the period ended 30 June 2018

	Notes	ACTUAL 2018 $'000	ACTUAL 2017 $'000	BUDGET ESTIMATE Original Budget $'000	BUDGET ESTIMATE Variance $'000
CONTRIBUTED EQUITY					
Opening balance					
Balance carried forward from previous period		**59,413**	-	50,362	9,051
Adjusted opening balance		**59,413**	-	50,362	9,051
Comprehensive income					
Total comprehensive income		**-**	-	-	-
Transactions with owners					
Contributions by owners					
Equity injection - Appropriations		**53,464**	10,589	53,464	-
Restructuring	6.1A	**-**	48,824	-	-
Total transactions with owners		**53,464**	59,413	53,464	-
Transfers between equity components		**-**	-	-	-
Closing balance as at 30 June		**112,877**	59,413	103,826	9,051
RETAINED EARNINGS					
Opening balance					
Balance carried forward from previous period		**19,419**	(18)	11,818	7,601
Adjusted opening balance		**19,419**	(18)	11,818	7,601
Comprehensive income					
Surplus/(Deficit) for the period		**(20,494)**	19,437	-	(20,494)
Total comprehensive income		**(20,494)**	19,437	-	(20,494)
Transfers between equity components		**(15,000)**	-	-	(15,000)
Closing balance as at 30 June		**(16,075)**	19,419	11,818	(27,893)
ASSET REVALUATION RESERVE					
Opening balance					
Balance carried forward from previous period		**776**	-	-	776
Adjusted opening balance		**776**	-	-	776
CASH RESERVE					
Opening balance					
Balance carried forward from previous period		**-**	-	-	-
Adjusted opening balance		**-**	-	-	-
Comprehensive income					
Changes in asset revaluation surplus		**-**	776	-	-
Total comprehensive income		**-**	776	-	-
Transfers between equity components		**15,000**	-	-	15,000
Closing balance as at 30 June		**15,776**	776	-	15,776

Australian Digital Health Agency

Statement of Changes in Equity

for the period ended 30 June 2018

		ACTUAL		BUDGET ESTIMATE	
		2018	2017	Original Budget	Variance
	Notes	**$'000**	$'000	$'000	$'000
TOTAL EQUITY					
Opening balance					
Balance carried forward from previous period		**79,608**	(18)	62,180	17,428
Adjusted opening balance		**79,608**	(18)	62,180	17,428
Comprehensive income					
Surplus/(Deficit) for the period		**(20,494)**	19,437	-	(20,494)
Capital commitments		**-**	776	-	-
Total comprehensive income		**(20,494)**	20,213	-	(20,494)
Transactions with owners					
Contributions by owners					
Equity injection - Appropriations		**53,464**	10,589	53,464	-
Restructuring		**-**	48,824	-	-
Total transactions with owners		**53,464**	59,413	53,464	-
Closing balance as at 30 June		**112,577**	79,608	115,644	(3,067)

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

Accounting Policy

Equity Injections

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

Restructuring of Administrative Arrangements

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

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

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

Contributed gains

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

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. This movement is recognised directly in equity for the year.

Budget Variances Commentary

Statement of Changes in Equity

Equity is largely in line with expectations. The total equity position of the Agency has increased due to budgeted equity injections. The strong performance last year, provided a higher than budgeted opening balance for the year, offset by the operating deficit for this year. No other items have directly impacted equity.

Australian Digital Health Agency

Cash Flow Statement

for the period ended 30 June 2018

	Notes	ACTUAL 2018 $'000	ACTUAL 2017 $'000	BUDGET ESTIMATE Original Budget $'000	BUDGET ESTIMATE Variance $'000
OPERATING ACTIVITIES					
Cash received					
Appropriations		**197,062**	110,303	197,062	-
Interest		**3,223**	1,454	1,800	1,423
Net GST received		**16,123**	8,478	9,500	6,623
Contributions from jurisdictions		**37,860**	29,922	32,250	5,610
Other		**3,150**	48,351	-	3,150
Total cash received		**257,418**	198,508	240,612	16,806
Cash used					
Employees		**33,409**	30,331	40,235	6,826
Suppliers		**185,456**	114,866	189,848	4,392
Total cash used		**218,865**	145,197	230,083	11,218
Net cash from/(used by) operating activities		**38,553**	53,311	10,529	28,024
INVESTING ACTIVITIES					
Cash received					
Investments		**308,065**	58,999	-	308,065
Total cash received		**308,065**	58,999	-	308,065
Cash used					
Purchase of property, plant and equipment		**57,034**	17,351	64,536	7,502
Investments		**302,064**	65,000	-	(302,064)
Total cash used		**359,098**	82,351	64,536	(294,562)
Net cash from/(used by) investing activities		**(51,033)**	(23,352)	(64,536)	13,503
FINANCING ACTIVITIES					
Cash received					
Other (Contributed Equity)		**53,464**	10,589	53,464	-
Total cash received		**53,464**	10,589	53,464	-
Cash used					
Total cash used		**-**	-	-	-
Net cash from/(used by) financing activities		**53,464**	10,589	53,464	-
					-
Net increase/(decrease) in cash held		**40,983**	40,548	(543)	41,526
Cash and cash equivalents at the beginning of the reporting period		**40,548**	-	20,619	19,929
Cash and cash equivalents at the end of the reporting period	3.1A	**81,531**	40,548	20,076	61,455

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). An additional $15.20 million has been approved by the Minister for Finance to be expensed in 2018-19 as part of an operating loss. Activity late in 2017-18, has resulted in higher than budgeted payables balances, with payments to be made in the first months of 2018-19.

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 NEHTA 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, including delivery of 'opt-out'.
- Funding from the Australian Government, states and territories received pursuant to the Inter-Governmental Agreement signed on 8 April 2016 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 rounded to the nearest $'000 unless otherwise specified.

Australian Digital Health Agency

Notes to and forming part of the financial statements

1. Overview

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 may have a material effect on the Agency's financial statements.

AASB 9 Financial Instruments

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. AASB 9 applies for reporting periods beginning on or after 1 January 2018 and replaces AASB 139 *Financial statements: Recognition and Measurement.* AASB 9 applies, with some exceptions, to all types of financial instruments and introduces a new classification model for financial assets that is more principles-based than the previous requirements in AASB 139. The Agency's date of initial application is 1 July 2018 and does not require restatement of the prior periods. This new standard will not have a material effect on the Agency's financial statements.

AASB 9 requires the Agency to apply a simplified approach to trade and lease receivables and contract assets without a significant financing component. The Agency shall always measure the loss allowance at an amount equal to lifetime expected credit losses.

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 not have a material effect on the financial statements when applied retrospectively.

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

The Australian Government has announced it will extend the opt-out period for My Health Record by one month to give Australians more time to consider their options and amend the My Health Record legislation to allow records to be permanently deleted from the system. The announcement has no impact on the Agency's financial performance or financial position in the reporting period, but will result in some additional costs in 2018-19.

Other than the events above, 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.

Australian Digital Health Agency

Notes to and forming part of the financial statements

2.1 Expenses

	2018 $'000	2017 $'000
2.1A: Employee Benefits		
Wages and salaries	**26,793**	25,413
Superannuation		
Defined contribution plans	**2,709**	2,529
Defined benefit plans	**516**	347
Leave and other entitlements	**4,044**	4,922
Separation and redundancies	**133**	747
Total employee benefits	**34,195**	33,958

Accounting Policy

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

2.1B: Suppliers		
Goods and services supplied or rendered		
Consultants	**3,839**	9,053
Contract for services	**149,837**	72,325
Contractors	**24,224**	9,142
Travel	**2,573**	1,875
IT services	**6,687**	5,078
Other	**14,804**	15,437
Total goods and services supplied or rendered	**201,964**	112,910
Other suppliers		
Minimum lease payments	**3,152**	2,600
Workers compensation expenses	**231**	254
Total other suppliers	**3,383**	2,854
Total suppliers	**205,347**	115,764

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	**3,221**	1,312
Between 1 to 5 years	**14,553**	188
More than 5 years	**2,234**	-
Total operating lease commitments	**20,008**	1,500

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**	1,746
Total write-down and impairment of assets	**582**	1,746

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

Australian Digital Health Agency

Notes to and forming part of the financial statements

2.2 Own-Source Revenue and Gains

	2018	2017
	$'000	$'000
Own-Source Revenue		
2.2A: Contributions from Jurisdictions		
New South Wales	**10,326**	10,326
Victoria	**7,998**	7,998
Queensland	**6,515**	6,515
Western Australia	**3,509**	3,509
South Australia	**2,328**	2,328
Tasmania	**710**	710
Australian Capital Territory	**529**	529
Northern Territory	**335**	335
Total contributions from Jurisdictions	**32,250**	**32,250**

Accounting Policy

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

2.2B: Interest		
Deposits	**3,224**	1,546
Total interest	**3,224**	1,546

Accounting Policy

Interest revenue is recognised using the effective interest method.

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

Currently the Agency does not derive revenue from the sale of goods and services. Funding for the Digital Health and Hard to Service Strategy was agreed in this financial year with the Department of Health and relates to the improvement of My Health Record and the three months of national My Health Record opt-out period. This is outside from the IGA agreed contribution. From time to time the Agency may receive other irregular or intermittent revenue.

Australian Digital Health Agency

Notes to and forming part of the financial statements

2.2 Own-Source Revenue and Gains

	2018	2017
	$'000	$'000
2.2D: Other Gains		
Resources received free of charge		
Net transfer of NEHTA assets and liabilities as at 1 July 2016	-	52,355
Additional net assets transferred from NEHTA arising from a change in fair value at 30 June 2016	-	4,298
Other	-	46
Total other gains	-	56,699

Accounting Policy

Resources Received Free of Charge

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

2.2E: Revenue from Government		
Department of Health		
Corporate Commonwealth entity payment item	**197,062**	110,303
Total revenue from Government	**197,062**	110,303

Accounting Policy

Revenue from Government

Funding received or receivable from non-corporate Commonwealth entities (appropriated to the non-corporate Commonwealth entity as a corporate Commonwealth entity payment item for payment to this entity) is recognised as revenue from 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

	2018	2017
	$'000	$'000
3.1A: Cash and Cash Equivalents		
Cash on hand or on deposit	**81,531**	40,548
Total cash and cash equivalents	**81,531**	40,548

Accounting Policy

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

3.1B: Trade and Other Receivables		
Goods and services receivables		
Goods and services	**2,693**	8,082
GST receivable from the ATO	**5,504**	2,397
Interest Receivable	**93**	92
Total goods and services receivables	**8,290**	10,571
Total trade and other receivables (gross)	**8,290**	10,571
Less impairment allowance (receivables)	**(2,328)**	(1,746)
Total trade and other receivables (net)	**5,962**	8,825

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

Loans and Receivables

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

3.1C: Other Investments		
Deposits	**-**	6,001
Total other investments	**-**	6,001
Other investments expected to be recovered		
No more than 12 months	**-**	6,001
More than 12 months	**-**	-
Total other investments	**-**	6,001

Accounting Policy

ADHA's Investment policy

A term deposit with an original maturity date of 9 months was held at 30 June 2017. Investment activities were undertaken in accordance with the requirements of section 58 of the PGPA Act. Investments take the form of term deposits with various approved institutions for a term of 3 to 6 Months. No term deposits were held at 30 June 2018.

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 2018

	Leasehold Improvements	Plant and Equipment	Computer Software[1]	Other Intangibles	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2017					
Gross book value	881	1,883	2,503	64,954	71,249
Accumulated depreciation, amortisation	(360)	(691)	(1,649)	(26,165)	(29,893)
Total as at 1 July 2017	521	1,192	854	38,789	41,356
Additions					
Purchase	2,250	2,410	18,999	-	23,659
Internally developed	-	-	-	33,375	33,375
Depreciation and amortisation	(1,090)	(575)	(2,999)	(11,267)	(15,931)
Total as at 30 June 2018	1,681	3,027	16,854	60,897	82,459
Total as at 30 June 2018 represented by					
Gross book value	3,131	4,293	21,502	98,329	127,255
Accumulated depreciation, amortisation and impairment	(1,450)	(1,266)	(4,648)	(37,432)	(44,796)
Total as at 30 June 2018	1,681	3,027	16,854	60,897	82,459

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

No impairment was recognised for Buildings, Plant and Equipment, Computer Software and Other Intangibles at 30 June 2018, nor were any expected to be sold or otherwise disposed of at 30 June 2018.

Capital commitments

The Agency has a $40 million contractual obligation for two more years during the 2018-2019 and 2019-2020 financial years 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, except for purchases costing less than $2,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

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

During the 2017-18 financial year the asset capitalisation policy was reviewed. As a result of changing policies the asset capitalisation threshold was reduced from $5,000 with an effective date of 1 July 2017 as shown below. The comparatives have not been updated to reflect the assets which were previously expensed under the old accounting policy as the impact is immaterial.

Category	Capitalisation Threshold
Purchased IT hardware and IT software	$500
Leasehold improvements	$50,000
Internally developed IT software and internally developed IT	$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 stated at Note 3.2A. An internal assessment was made at 30 June 2018 and no fair value movements were identified from the independent valuation that was undertaken as at 30 June 2017.

Australian Digital Health Agency

Notes to and forming part of the financial statements

3.2 Non-Financial Assets

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

Impairment

All assets were assessed for impairment at 30 June 2018. 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.

Australian Digital Health Agency

Notes to and forming part of the financial statements

3.2 Non-Financial Assets

	2018 $'000	2017 $'000
3.2B: Other non-financial assets		
Prepayments	**2,473**	1,127
Right of use assets	**266**	-
Lease incentive asset	**2,378**	-
Total other non-financial assets	**5,117**	1,127
Other non-financial assets expected to be recovered		
No more than 12 months	**2,829**	1,127
More than 12 months	**2,288**	-
Total other non-financial assets	**5,117**	1,127

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

	2018 $'000	2017 $'000
3.3A: Suppliers		
Trade creditors and accruals	**51,417**	11,521
Total suppliers	**51,417**	11,521
3.3B: Other Payables		
Salaries and wages	**314**	329
Lease incentive	**3,137**	-
Superannuation	**24**	24
Separations and redundancies	**-**	235
Unearned income	**125**	-
Total other payables	**3,600**	588

Accounting Policy

Trade creditors and accruals

Trade creditors and accruals are recognised at their nominal amounts.

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

	2018 $'000	2017 $'000
4.1A: Employee Provisions		
Leave	**6,838**	5,802
Total employee provisions	**6,838**	5,802
Employee provisions expected to be settled		
No more than 12 months	**5,070**	2,427
More than 12 months	**1,768**	3,375
Total employee provisions	**6,838**	5,802

Accounting policy

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

Leave

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

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

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

Separation and Redundancy

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

Superannuation

The Agency's staff comprise both 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

	2018	2017
	$'000	$'000
4.1B: Other Provisions		
Provision for restoration	**637**	338
Total other provisions	**637**	338
Provision for restoration		
As at 1 July	**338**	-
Additional provisions made	**299**	338
Total as at 30 June	**637**	338

The Agency currently has five agreements for the leasing of premises and three 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.

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.

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 General Managers and board members. Key management personnel remuneration is reported in the table below:

	2018	2017
	$'000	$'000
Key management personnel remuneration expenses		
Short-term employee benefits	**3,209**	2,618
Post-employment benefits	**293**	229
Other long-term employee benefits	**245**	174
Termination benefits	**44**	-
Total key management personnel remuneration expenses[1]	**3,791**	3,021

The total number of key management personnel that are included in the above table are 16 (2017: 17).

[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 2017-18.

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 General Managers (EGMs) 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 EGMs constitute KMP for the purposes of *AASB 124* .

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

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

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

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

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

4.4 Remuneration of Auditors

Amounts paid or payable for audit of the financial statements 2017-18 is $120,000. (2017: $160,000).

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

	2018 $'000	2017 $'000
5.2A: Categories of Financial Instruments		
Financial Assets		
Held-to-maturity investments		
Other Investments	-	6,001
Total held-to-maturity investments	-	6,001
Loans and receivables		
Cash and Cash Equivalents	**81,531**	40,548
Trade and Other Receivables	**5,962**	8,825
Total loans and receivables	**87,493**	49,373
Total financial assets	**87,493**	55,374
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	**51,417**	11,521
Total financial liabilities measured at amortised cost	**51,417**	11,521
Total financial liabilities	**51,417**	11,521

Accounting Policy

Financial Assets

The Agency classifies its financial assets in the following categories:
1. Held-to-maturity investments; and
2. Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon 'trade date'.
Interest revenue from Held to maturity investments and loans and receivables for 2017-18 was $3.224 million (2017: $1.546mil).

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

5.2B: Credit Risk

The Agency was exposed to minimal credit risk as loans and receivables are cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. The amount was equal to the total amount of the trade receivables of $5.7 million in 2018 (2017: $8.8mil). 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 2018 (2017: 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 entity 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	
	2018	2017
	$'000	$'000
Non-financial assets		
Leasehold Improvements	**1,681**	521
Plant and equipment	**3,027**	1,192
Total fair value measurements in the statement of financial position	**4,709**	1,713
Total assets not measured at fair value in the statement of financial position	**82,867**	40,770

Accounting Policy

All revaluations were conducted in accordance with the revaluation policy stated at Note 3.2. An internal assessment was made at 30 June 2018 and no fair value movements were identified from the independent valuation that was undertaken as at 30 June 2017.

Australian Digital Health Agency

Notes to and forming part of the financial statements

6.1 Restructuring

6.1A: Restructuring

There was no restructuring event during the year ended 30 June 2018. The fair value of the My Health Record intangible asset that was transferred from the Department of Health to the Agency on 1 July 2016 was $48.8 million and the net assets / (liabilities) assumed from all entities was equal to this amount.

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.

5.1 Annual Report compliance index

Public Governance, Performance and Accountability Act 2013

Requirement	Reference	Pages
Annual Report for Commonwealth entities	Section 46	Throughout
Annual Performance Statements	Paragraph 39(1)(b)	41
Audited Annual Financial Statements	Subsection 43(4)	107
Auditor-General's audit report	Subsection 43(4)	105

Public Governance, Performance and Accountability Rule 2014

Requirement	Reference	Pages
Approval of report by Accountable Authority (Agency Board)	Section 17BB	Throughout
Parliamentary standards of presentation	Section 17BC	Throughout
Plain English and clear design	Section 17BD	Throughout
Enabling legislation	Paragraph 17BE(a)	16
Legislated objects and functions	Paragraph 17BE(b)(i)	16
Purpose	Paragraph 17BE(b)(ii)	16
Responsible minister	Paragraph 17BE(c)	17
Ministerial directions	Paragraph 17BE(d), (f)	97
Policy orders	Paragraphs 17BE(e), (f)	97
Annual performance statements	Paragraph 17BE(g)	41
Significant issues related to financial compliance	Paragraph 17BE(h), (i)	97
Details and attendance of board members	Paragraph 17BE(j)	86
Organisational structure	Paragraph 17BE(k)	22
Location	Paragraph 17BE(l)	17
Governance	Paragraph 17BE(m)	78
Related entity transactions	Paragraphs 17BE(n), (o)	97

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Navigation aids

Requirement	Reference	Pages
Significant activities and changes	Paragraph 17BE(p)	97
Judicial decisions or decisions of administrative tribunals	Paragraph 17BE(q)	94
Reports by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	Paragraph 17BE(r)	94
Information from subsidiaries	Paragraph 17BE(s)	N/A
Insurance and indemnities	Paragraph 17BE(t)	98
Compliance index	Paragraph 17BE(u)	133
Work Health and Safety Act 2011	Schedule 2, Part 4	99
Commonwealth Electoral Act 1918	Section 311A	101
Environment Protection and Biodiversity Conservation Act 1999	Section 516A	102
My Health Records Act 2012	Section 107	58

5.2 Index of images

Every image used in this report is of someone who works in digital health, or is being helped by it.

Location	Story
Front cover	Visiting Martu country https://www.myhealthrecord.gov.au/news-and-media/my-health-record-stories/visiting-martu-country
Inside front cover	Harry Iles Mann https://youtu.be/FBtxQyZxiDs
p. 11 Case study	Berrigan NSW takes the lead in connecting to My Health Record https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/berrigan-nsw-takes-the-lead-in-connecting-to-my-health-record
p. 12 Case study	Helping community pharmacies become leaders in digital health https://www.digitalhealth.gov.au/news-and-events/news/the-australian-digital-health-agency-and-pharmacy-guild-join-forces-to-help-community-pharmacies-become-leaders-in-digital-health
Part 1 splash page	Sydney North PHN facilitates a smooth transition to My Health Record https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/sydney-north-phn-facilitates-a-smooth-transition-to-my-health-record
p. 24 Case study	What's next for the Global Digital Health Partnership? https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/what-s-next-for-the-global-digital-health-partnership
p. 30 Case study	Donna & Marnie's My Health Record for carers https://www.youtube.com/watch?v=OSOKLwKLor8
pp. 38-39	Visiting Martu country https://www.myhealthrecord.gov.au/news-and-media/my-health-record-stories/visiting-martu-country
Part 2 splash page	Mums and dads help to shape National Children's Digital Health Collaborative https://www.digitalhealth.gov.au/news-and-events/news/mums-and-dads-help-to-shape-national-children-s-digital-health-collaborative
p. 47 Case study	Media release - Industry collaborates to end the era of the fax machine https://www.digitalhealth.gov.au/news-and-events/news/media-release-industry-collaborates-to-end-the-era-of-the-fax-machine
p. 50 Case study	My Health Record and the Medicines Safety Program https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/my-health-record-and-the-medicines-safety-program-by-steve-renouf
p. 56 Case study	My Health Record will allow consumers to take greater ownership of their health needs https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/my-health-record-will-allow-consumers-to-take-greater-ownership-of-their-health-needs

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Navigation aids

Location	Story
p. 67 Case study	When every second counts: Q&A with Dr Andrew Hugman, Emergency Physician https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/when-every-second-counts-q-and-a-with-dr-andrew-hugman-emergency-physician
p. 70 Case study	Nudging digital health with David Halpern https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/q-and-a-with-david-halpern
p. 73 Case study	"Pharmacists have worked in the dark for way too long" https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/pharmacists-have-worked-in-the-dark-for-way-too-long
p. 76 Case study	The importance of interoperability: a conversation with Dr Nathan Pinskier https://www.digitalhealth.gov.au/news-and-events/news/blog-the-importance-of-interoperability-a-conversation-with-dr-nathan-pinskier
Part 3 splash page	Morto's My Health Record Story https://www.youtube.com/watch?v=BaSldbW1zhQ
pp. 78-79	PHNs build My Health Record expansion readiness https://www.digitalhealth.gov.au/news-and-events/news/phns-build-my-health-record-expansion-readiness
p. 91 Case study	Bringing Digital Health to Central Australia — introducing Dr Sam Goodwin https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/13-bringing-digital-health-to-central-australia-introducing-dr-sam-goodwin
p. 96 Case study	Enhanced clinical leadership at the Australian Digital Health Agency https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/enhanced-clinical-leadership-at-the-australian-digital-health-agency
p. 100 Case study	How to design an award-winning health app https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/how-to-design-an-award-winning-health-app
Part 4 splash page	A platform for empowerment https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/a-platform-for-empowerment
Part 5 splash page	On the road, in the air – talking about My Health Record in Western Australia https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/on-the-road-in-the-air-talking-about-my-health-record-in-western-australia
Back cover	Tiger's My Health Record Story https://www.youtube.com/watch?v=4ynC-GQjwR4

5.3 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
RACS	Royal Australasian College of Surgeons
RCPA	Royal College of Pathologists Australasia
SMD	Secure Message Delivery
WHO	World Health Organization

Australian Government

Australian Digital Health Agency