Australian Government
Australian Digital Health Agency

CELEBRATING 10 YEARS

Australian Digital Health Agency

ANNUAL REPORT

2025–26

Our work means so much to so many

Publication details

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If you have any questions or feedback regarding this report, please direct them to:
Performance Reporting Australian Digital Health Agency
GPO Box 9942, Canberra ACT 2601
Phone: 1300 901 001
Email: help@digitalhealth.gov.au

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Preface

Guide to this report

This annual report describes the operations and performance of the Australian Digital Health Agency during 2025–26. The report was prepared in accordance with legislated reporting requirements under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and other Commonwealth legislation including the *My Health Records Act 2012*.

The Agency is jointly funded by the Australian Government and all state and territory governments.

Part 1. Introduction and overview

Introduces the Agency and provides an overview of its operations, priorities for 2025–26 and outlook for 2026–27.

Part 2. Performance

Details the Agency's performance against work plan priorities captured in its *Corporate Plan 2025–26* and against targets published in the Health Portfolio Budget Statements (PBS) 2025–26. It also addresses reporting obligations under the *My Health Records Act 2012*.

Part 3. Management and accountability

Discusses the Agency's governance arrangements, external scrutiny, human resources, executive remuneration and audit committee disclosures. It also includes 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 2025–26.

Part 5. Navigation aids

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

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Letter of transmittal

Australian Government
Australian Digital Health Agency

21 September 2026

The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme
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 2025 to 30 June 2026.

The Agency was established on 30 January 2016, following registration of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016*, and commenced operations on 1 July 2016. The report reflects on our tenth year of operations, marking an important milestone as the Agency enters its second decade.

The report 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. It 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* encompassing a new requirement to publish a Climate Disclosure Report.

The annual report was approved for presentation to you in accordance with a resolution of the Board on 21 September 2026.

In accordance with sections 68 and 69 of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2016, the Agency will notify each state and territory health minister of the availability of the report, and provide a copy on request.

Yours sincerely

Lyn McGrath
Chair
Australian Digital Health Agency

Australian Digital Health Agency ABN 84 425 496 912
GPO Box 9942, Canberra ACT 2601
Phone 1300 901 001
www.digitalhealth.gov.au
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Chair's message

The Agency's 10-year anniversary is a moment to look beyond any single year and recognise how far Australia's digital health system has come. Over a decade, capabilities that were once emerging have become part of the nation's health infrastructure, giving Australians and healthcare providers more secure and convenient ways to access and share health information.

Having been part of the Board since the Agency's inception, first as a Board member and now as Chair, I have had the privilege of overseeing this work develop, from early national foundations to the trusted capabilities that now support healthcare across the country. For me, that makes this anniversary particularly meaningful and reinforces my appreciation of the sustained effort, collaboration and discipline required to build national digital health capability over time.

The milestones of the past 10 years tell a story of growing national reach and ambition. Two National Digital Health Strategies have established a shared direction for connected healthcare, while My Health Record has grown to more than 25 million records. Electronic prescribing, launched nationally in 2020, has now supported more than 525 million electronic prescriptions. More recently, the 1800MEDICARE app has put access to key health information into people's hands, with more than one million downloads. Collectively, they mark a fundamental shift in how health information can be accessed and used to support care across Australia.

Australia is now entering the next phase of its digital health evolution. The opportunity is to use these foundations at greater scale so that relevant health information is available when needed, shared appropriately across care settings and protected by strong privacy and security safeguards. Continued investment in My Health Record and the 1800MEDICARE app, alongside Sharing by Default, a National Medicines Record and a National Digital Child Health Record, will help make care safer, more connected and more responsive throughout people's lives. The Board's role will be to ensure this next phase is pursued with clear strategic direction, effective oversight to maintain the trust of Australians and continued clear focus on the public value derived from digital health initiatives.

Our ambition must extend well beyond technology. Realising the full benefits of digital health will require deeper integration into clinical workflows and broader participation across the health system. It will also require enduring partnerships with governments, healthcare providers, software vendors, consumers and communities, with a clear focus on equitable access. This offers the opportunity to support broader health sector reforms, including contemporary models of care and improved outcomes for Australians. As responsible use of artificial intelligence advances, privacy, safety, transparency and ethics remain central to maintaining public trust.

The Board looks to the Agency's next decade with confidence in its people, its partnerships and the foundations now in place. On behalf of the Board, I thank everyone who has contributed to this progress. Together, we can build on the achievements of the past 10 years and shape a more connected, resilient and equitable health system that delivers lasting value, now and for the future.

Lyn McGrath
Chair

Chief Executive Officer's review

The Agency's 10th year marked both a significant milestone and a year of substantial delivery. As we celebrate this important anniversary, we also pay tribute to our departing Chair, **Lyn McGrath**. With a decade of service to the Board, including her tenure as Chair, Lyn's valued leadership has made an enduring contribution to the Agency and to Australia's digital health transformation.

This legacy is reflected in the progress we made throughout the year to advance a more connected health system. We translated national policy and investment into trusted services that serve Australians and healthcare professionals at the point of care, while enabling health information to move safely, securely and with purpose to support better decisions and better care.

The reach and value of these services continued to grow. Over 2025–26, consumer use of My Health Record increased by 94%, healthcare providers viewed information more than 207 million times during episodes of care, and electronic prescriptions accounted for nearly 27% of Pharmaceutical Benefits Scheme prescriptions dispensed. These results demonstrate that digital health is becoming integral to the delivery of modern healthcare in Australia.

Our priorities were clear: to improve the performance and usability of national services, make health information more complete and timelier and connect more of the health system. We advanced services and platforms such as My Health Record, Provider Connect Australia, the National Authentication Service for Health and Health Connect Australia, alongside work on medicines information, standards, workforce capability and infrastructure modernisation. Together, this work is improving national digital health services today while establishing the capabilities Australia will require for the future.

Sharing by default was a defining priority. We enabled pathology and diagnostic imaging reports to be shared to My Health Record by default from 1 July 2026. Since the reform was announced in May 2023, views of pathology reports have risen by 589% and diagnostic imaging reports by 738%, making clinically important information more readily available when and where it is needed.

We also made substantial progress against the *National Digital Health Strategy*. Of the 32 initiatives led or co-led by the Agency, 16 are complete and the remainder are underway. This reflects strong partnerships across government, healthcare providers, industry, consumers and communities, and the collective effort needed to build a modern, connected and digitally enabled health system. Continued Budget investment provides a strong platform for the next phase: strengthening secure information sharing, lifting standards and conformance, and embedding digital health more deeply and effectively in everyday care. Maintaining public confidence throughout this work requires a continued focus on clinical safety, privacy and cyber security.

I thank the Agency's people and our partners for their expertise, commitment and unwavering sense of public purpose. Their contribution has made this progress possible. Together, we are carrying forward the momentum of the past 10 years and shaping a safer, more connected and person-centred future for healthcare in Australia.

Amanda Cattermole PSM
Chief Executive Officer

Part 1. Introduction and overview

Information about this Part

Part 1 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.

The Agency at a glance

Foundations

The Agency was established on 30 January 2016 and began operations on 1 July 2016, with a vision of improving health outcomes for Australians through the delivery of digital innovation, health systems and services.

Enabling legislation

The Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016 (Agency Rule) established the Agency and governs its operations. The Rule was made by the

Minister for Finance under Section 87 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) that allows for the establishment of corporate Commonwealth entities. The Agency was the first Commonwealth entity established through this legislative mechanism.

National Digital Health Strategy

Internationally recognised[1] in a study of 9 OECD countries' eHealth strategies for its clarity and action orientation, Australia's *National Digital Health Strategy 2023–2028* (the Strategy) continues to guide Agency priorities and ensure our work puts people at the centre of a modern, connected and digitally enabled healthcare system.

The Agency plays a central role in implementing the Strategy and its Delivery Roadmap, leading or co-leading 32 of the roadmap's 80 initiatives. Reflecting this progress, the Agency published the *National Digital Health Strategy Action & Impact Report 2023–2025* (Action and Impact Report) in November 2025, demonstrating strong momentum across the Delivery Roadmap, with 50% of Agency-led initiatives completed by the end of the reporting period. The Action and Impact Report highlighted progress in interoperability, information sharing, workforce capability, consumer access to health information and digital inclusion, reflecting the broad range of activity underway across the Delivery Roadmap. While significant progress has been made, delivering the full vision of the Strategy will continue to rely on strong partnerships across governments, healthcare providers, technology partners and the broader health and care sector.

> 'Embracing the possibilities of the ***National Digital Health Strategy 2023–2028*** can transform the industry into a leader of modern healthcare – and with the right support, pharmacists are ready to take the leap.'
>
> Siena Barry, Pharmacy Guild of Australia
> Published in *Australasian Pharmacy*, 1 August 2025

Products and services

The Agency supports connected care across Australia through its stewardship of key national digital health infrastructure, including:

- My Health Record
- 1800MEDICARE app
- Healthcare Identifiers Service
- National Authentication Service for Health (NASH)
- Health Information Provider Service (HIPS)
- Provider Connect Australia (PCA)
- SNOMED CT-AU (including Australian Medicines Terminology)
- Digital health standards
- Clinical content specifications
- Real Time Prescription Monitoring (RTPM)
- Clinical Learning Australia
- Health Connect Australia.

[1] K Palm, A Brantnell, M Peolsson, N Özbek and G Hedström (2025) 'National eHealth strategies: a comparative study of nine OECD health systems', *BMC Health Services Research* 25, 269.

Further information on each of these products and services, and their contribution to connected care, is provided at Core national digital health capabilities supporting connected care.

Delivery priorities for 2025–26

Over the course of 2025–26, the Agency led the way in advancing and expediting digital innovation as part of the broader national health agenda. The Agency's Corporate Plan 2025–26 championed 3 strategic areas of focus:

- drive information sharing
- accelerate digitally connected healthcare
- deliver national digital health infrastructure.

Performance against each priority area can be found in Part 2 of this report.

Governance structure

The Agency is a corporate Commonwealth entity, established by a rule under the PGPA Act. Information about our governance, management and accountability framework is covered in Part 3 of the report.

Board as the accountable authority

The Agency Board, chaired by Ms Lyn McGrath, is the Agency's accountable authority. As the accountable authority, the Board sets the objectives, strategies and policies[2] for the Agency and is responsible for the proper and efficient performance of the Agency's functions.[3]

Advisory committees

The Board is supported by an Audit and Risk Committee, composed of independent members, as required under the Public Governance, Performance and Accountability Rule 2014.

The Board is also supported in the performance of its functions by advisory committees. Four standing advisory committees are established under the Agency Rule:

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

Intergovernmental Agreement

The Agency operates under an Intergovernmental Agreement between the federal and state and territory governments. Under this agreement, the Agency works closely with the states and territories to transform how health information is used to deliver better healthcare and implement a world-class digital health capability in Australia.

[2] Section 14(a) of the Agency Rule.
[3] Section 14(b) of the Agency Rule.

Portfolio and Ministerial oversight

The Agency sits in the Health, Disability and Ageing portfolio and is accountable to the Ministers of the portfolio. At 30 June 2026 the Ministry was as follows:

- The Hon Mark Butler MP, Minister for Health and Ageing, Minister for Disability and the National Disability Insurance Scheme
- Senator the Hon Jenny McAllister, Minister for the National Disability Insurance Scheme
- The Hon Sam Rae MP, Minister for Aged Care and Seniors
- The Hon Emma McBride MP, Assistant Minister for Mental Health and Suicide Prevention, for Rural and Regional Health, for Health and Aged Care, and for Indigenous Health.

Our people and their location

At 30 June 2026, the Agency had 737 permanent staff with offices in Brisbane, Canberra and Sydney.

Funding

The Agency is jointly funded by the Commonwealth ($323.85 million) and the states and territories ($32.25 million), reflecting the commitment at all levels of government to the delivery of digital health reform.

Financial outcome

- Operating deficit: $41 million
- Operating revenue: $346 million
- Operating expenses: $387 million

The Agency's financial statements and the Australian National Audit Office's (ANAO) independent auditor's report are presented in Part 4 of this report.

Overview of the Agency

Role

The Australian Digital Health Agency is the steward for digital enablement of Australia's health system, working to make health information easier and safer to access, share and use.

The Agency leads and coordinates the National Digital Health Strategy, in partnership with governments, healthcare providers, industry and consumers. This includes strengthening Australia's digital health infrastructure, helping different systems work together and supporting the secure sharing of health information. Together, this work supports safer, more connected care and better health outcomes for Australians.

Central to this work is My Health Record, a key part of Australia's digital health infrastructure. As its System Operator, the Agency is responsible for maintaining its security, privacy and integrity. Strong clinical governance supports all aspects of the Agency's work, helping ensure digital health initiatives are safe, effective and fit for purpose.

The Agency carries out these responsibilities under the Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016, with its functions set out in section 9 of the Rule.

'One of the best things any federal government has implemented in recent years, I think, is the **My Health Record**, where your health records are in one central place so that any practitioner can have a look at them before they treat you. I recently saw the benefits of it. I couldn't get in to see my GP and I needed to get the results for some blood tests. And I was chatting to my pharmacist about some medication that I'd been prescribed. He said, "Well, I can look at your blood tests here if they're on My Health Record." And he looked it up ... and Bob's your uncle.'

Stephen Cenatiempo, 2CC Breakfast presenter
Aired on 29 January 2026

Values

The Agency's values and culture are fundamental to the successful delivery of our work program. They reflect our reputation, who we are, what drives us, what we stand for, how we work together and with others and our ethics. As a Commonwealth public sector organisation, the Agency embraces the Australian Public Service ICARES values:

I	Impartial
C	Committed to service
A	Accountable
R	Respectful
E	Ethical
S	Stewardship

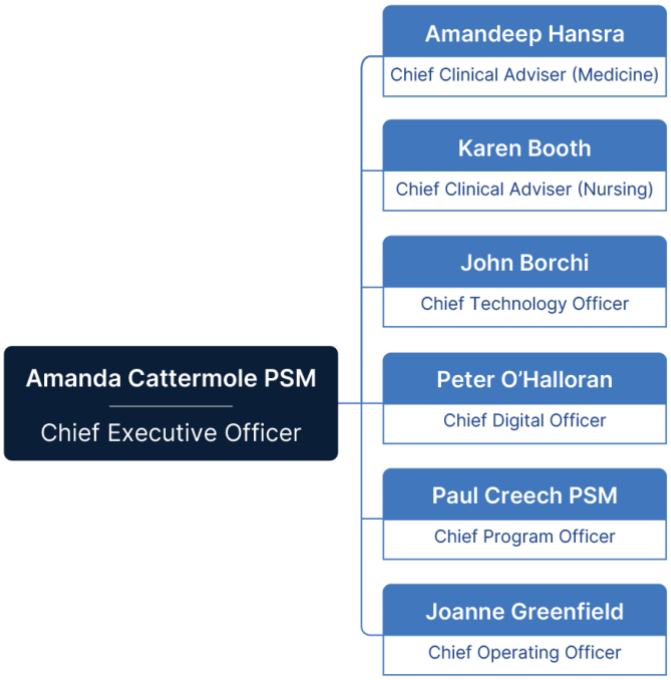
These values are embedded in the 2026–2028 People Strategy, which sets out how we will build, develop and sustain the capabilities required to deliver the Agency's mandate now and into the future.

Structure

The Agency's organisational structure is designed 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.

Management team

Chief Executive Officer (CEO) Amanda Cattermole PSM is responsible for the overall management of the Agency. She is assisted by a Senior Executive Committee:



Divisions

The Agency has the following divisions:

Technology Services	Operating high quality, trusted, reliable and secure national digital health infrastructure and health support systems, including My Health Record.
Digital Solutions	Stewarding the national digital health ecosystem and products through analysis, data, architecture, standards, connections, service and user design.
Policy Programs and Engagement	Informing policies, managing external stakeholder relationships, and being the place of excellence for driving program delivery, reporting and outcomes.
Corporate Services	Bringing together corporate services that work in partnership across the Agency to support the effective delivery of the Agency's operations.

The Agency's committee structure and decision-making processes are further detailed in Part 3.

Case study: How digital health is empowering people when it matters most

For Allyson Hickey, a 34-year-old Adelaide mother of 2, being able to easily access her own health records in a way that works for her has been nothing short of life-changing.

Born with Stickler syndrome, a rare genetic condition that affects hearing, vision and joints, Allyson has a sight impairment and moderate hearing loss. ‘My daily life is affected in pretty much every aspect, from cooking, cleaning and getting ready for the day to caring for my children, leisure activities, friendships, communication and work,’ she says. ‘Everything is affected by my vision and hearing loss, given the significance of both the losses.’

Along with learning strategies to adapt and manage on a day-to-day basis, she relies on support workers, assistive technology and the help of her husband to juggle the demands of life.

Allyson also relies on digital tools such as the 1800MEDICARE app (formerly **my health** app).

‘For a person with disabilities, I find the app especially easy and accessible to use,’ Allyson says. ‘The interface is easily readable and the whole app is very accessible, particularly for someone with a vision impairment.’

Access all areas

Before Covid, Allyson attended all her medical appointments in person, but when mask wearing and telehealth became the norm during the pandemic, she found it increasingly difficult to follow verbal explanations from doctors. ‘I can struggle to understand accents, and lip-reading was no longer possible with masks,’ she says. ‘Being able to read my results instead of relying on my hearing has made a huge difference.’

With the 1800MEDICARE app, Allyson can check blood test results, referrals and appointment notes in her own time, using the app’s accessibility features to make reading easier. ‘I use dark mode and I increase the text size,’ she says. ‘I also really appreciate the colour coding. It’s quite user friendly and very readable.’

During her recent pregnancy, Allyson had to manage unusually high iron levels and the possibility of haemochromatosis. ‘Having a multidisciplinary care team means having to share information between providers, and having one platform where those results and that information is available makes it really helpful,’ she says.

‘It means we don’t have to rely on things like documents being faxed to other providers or, worse, having to get repeated tests. I can just get the results up and show the particular care provider I’m with, so that’s made it a lot easier.’

Allyson uses the system to keep track of her children’s immunisations and her own pathology results and plans to use it to store prescriptions. As an education midwife, she also sees the wider potential.

‘I provide education to healthcare professionals about supporting women with disabilities and their families through pregnancy and parenthood,’ she says.

‘Being able to access their own records is going to make a huge difference. It will definitely benefit people with disabilities and provide them with a sense of confidence that they can play a bigger part of their health journey in partnership with their healthcare professionals.’

This article first appeared in The Guardian on 13 October 2025 and has been adjusted slightly for the annual report.

Core national digital health capabilities supporting connected care

Digital health is increasingly embedded in the way Australians access healthcare and manage their health information. As demand for secure, connected and easy-to-use digital services continues to grow, the Agency remains focused on strengthening the foundations of Australia's digital health ecosystem and supporting more connected models of care.

The products, services and programs described below are at the core of the Agency's work, underpinning many of the performance measures and performance highlights reported in Part 2 of this report.

Core capability	Purpose	Contribution to digital health outcomes
My Health Record	Brings together key health information in a secure online summary, including medicines, immunisations, pathology and diagnostic imaging reports, and hospital discharge summaries.	Improves information sharing by giving people and healthcare providers access to important information when it is needed. This supports diagnosis and treatment, continuity of care and fewer unnecessary tests.
1800MEDICARE app (formerly **my health** app)	Provides Australia's digital front door to healthcare, with secure access to My Health Record information, electronic prescriptions, health services and Medicare links.	Makes health information and services easier to access and manage. This helps people stay informed, take greater control of their health and connect with care.
Healthcare Identifiers Service	Assigns unique identifiers to individuals, healthcare providers and healthcare organisations.	Helps ensure the right information is matched to the right person and provider. This supports safe, accurate information sharing across connected digital health services.
National Authentication Service for Health	Issues digital credentials that healthcare organisations use to securely access national digital health services and exchange information.	Protects health information while enabling trusted connections between healthcare providers and national services.
Health Information Provider Service	Connects hospital and diagnostic systems with national services such as My Health Record and the Healthcare Identifiers Service.	Brings secure information sharing into existing workflows, making it easier for healthcare providers to upload and view information while delivering care.
Provider Connect Australia	Enables healthcare provider organisations to update service and practitioner information once and share it with business partners.	Improves the accuracy of provider information, reduces repeated administration and supports more reliable connections across the health system.
SNOMED CT-AU (including Australian Medicines Terminology)	Provides standard terms for recording health conditions, procedures and medicines in digital systems.	Gives different systems a common language. This helps information retain the same meaning when it is shared, supporting safer care and medicines use.
Privacy	Develops and implements privacy plans and ensures products and services meet legislative requirements and community expectations for the privacy of their information.	Protects personal health information and gives Australians control over access, supporting safe and secure digital health services.

Core capability	Purpose	Contribution to digital health outcomes
Security	Protects the Agency's digital services, people, information and physical assets, and strengthens cyber resilience across the healthcare sector.	Builds trust in digital health through secure, resilient and reliable services, supporting the safe delivery of Agency operations and the sharing of information across the healthcare sector.
Digital health standards	Supports the development, adoption and implementation of standards – common rules for sharing and understanding health information.	Enables systems to connect and exchange information consistently and securely, supporting safer care. It is the foundation for modern national digital health infrastructure.
Clinical content specifications	Defines common formats for exchanging clinical information.	Makes shared information consistent, structured and easier to understand and use. This supports safety, quality, efficiency and interoperability.
Medicines safety	Uses connected services such as electronic prescribing, real-time prescription monitoring and My Health Record to improve access to medicines information.	Supports safer prescribing, dispensing and medicines management by making accurate information available across care settings, especially during transitions of care.
Clinical governance	Provides the frameworks, oversight and advice used to support safe, effective and person-centred digital health services.	Ensures digital health products and services are designed and operated with safety, quality and continuous improvement at their core.
Building workforce capability	Through **Clinical Learning Australia** and **Embedding digital health education into higher degrees**, delivers nationally consistent digital health training and assessment for pre-vocational doctors and education for university health degree students.	Builds a workforce that can confidently and safely use digital health technologies, supports workforce mobility across states and territories, and enables better connected, higher quality care.
Health Connect Australia	Designed to enable health information to be shared quickly and securely between healthcare participants through a national health information exchange.	Will modernise national infrastructure so information can follow people across care settings. This supports connected teams, better access, greater efficiency and improved care quality.

'I personally think everybody should be registered with **My Health Record**. It gives you lots of useful information. A lot of it [is] what your GP uploads or your doctors upload to the system, but you can find out lots of things there. It's getting better all the time.'

Dr Normal Swan, ABC Health Report presenter
Aired on ABC Radio *Perth Mornings*, 20 October 2025

10 years of digital health transformation

JULY 2016
Australian Digital Health Agency operational and becomes My Health Record System Operator

JAN 2019
My Health Record opt-out → now more than 25M records

AUG 2017
1st National Digital Health Strategy

OCT 2022
Capability Action Plan → lifting digital capability across the healthcare workforce

DEC 2022
API Gateway → Received and processed 10.2B service requests

MAY 2020
Electronic prescribing launches nationally → now more than 518.8M electronic prescriptions issued

FEB 2023
First Agency-led Clinical Governance Summit → 700 attendees

MAR 2023
Provider Connect Australia → 6,847 organisations now registered

MAR 2023
my health app launched to help people access key health information in My Health Record in the palm of their hands

JUL 2023
National Healthcare Interoperability Plan 2023–2028 → completed 80% of actions to drive connected healthcare

NOV 2023
2nd National Digital Health Strategy → ranked #1 in global study

DEC 2024
Aged Care Support Plans in My Health Record → connected care for older Australians

JUN 2025
Health Connect Australia → laying the foundation to transform and better connect the healthcare ecosystem

AUG 2025
My Health Record on FHIR® → national transformation program launched

DEC 2025
National Allied Health Digital Uplift Plan → co-designed with 220+ professionals and 60 peak bodies

MAR 2026
National Clinical Governance Committee for Digital Health → national oversight for virtual care, AI and Better and Faster Access

JAN 2026
1800MEDICARE app rebrand → 15,000 average daily active users and 1M+ downloads

JUN 2026
Ahead of Sharing by Default mandate → 836M pathology and 76M diagnostic imaging reports already uploaded

MAY 2026
National Framework for Digital Health Standards → supporting a more consistent, connected and clinically safe digital health system

Outlook for 2026–27 and beyond

Looking ahead, the modernisation of national digital health capabilities will continue at pace, with the intent to remain trusted, secure and useful for Australians. In 2026–27 and beyond, the focus will be on making health information more complete, timely and useful at the point of care; reducing duplication and administrative burden; and supporting safer, more connected experiences for Australians, carers and healthcare providers.

This work will be delivered through 3 interconnected focus areas that reflect the Agency's role in enabling digitally connected healthcare:

- drive information sharing
- accelerate digitally connected, safe and secure healthcare
- deliver national digital health infrastructure.

Drive information sharing

Improving the availability, quality and usefulness of health information will remain central to supporting more informed decisions by consumers and healthcare providers. This includes supporting sharing by default reforms, enhancing consumer channels and helping priority sectors adopt national digital health products and services with practical guidance, education and connection support.

1800MEDICARE app: Work will continue to expand the 1800MEDICARE app as a trusted digital front door for health information and services. Planned enhancements include improved profile and preference management, timely notifications when new clinical documents are available, and expanded document upload functionality, beginning with Advance Care Planning. Work will also continue to align the app with the My Health Record national consumer portal and streamline access to medicines information, health advice and non-urgent clinical support.

Improving information in My Health Record: Following the commencement of sharing by default reforms on 1 July 2026, pathology and diagnostic imaging reports will be supported to be shared automatically to My Health Record, subject to exceptions. Reforms are expected to progressively extend to medicines information from prescription and dispensing data and GP chronic condition management plans. Advice, document specifications, technical support, stakeholder engagement and education will help healthcare providers connect and comply while maintaining privacy, consent and security safeguards.

> '[**Automated uploading** to My Health Record] is arguably one of the most important enhancements in NHW's program of continuous improvement. It enables information sharing between clinicians operating on different platforms. My Health Record ties it all together, and that's good for both patients and clinicians alike.'
>
> Justin Otto, Northeast Health Wangaratta clinical application specialist
> Published in *Pulse+IT*, 11 February 2026

National Digital Child Health Record: Foundational work will begin on a National Digital Child Health Record to support the Thriving Kids initiative. The initial phase will focus on collecting and presenting a 3-year-old health assessment within My Health Record using SMART on FHIR® technology, giving families secure access to developmental information they can choose to share with healthcare professionals.

Support for uptake of national digital health products: Targeted support will be provided for sectors where digital health adoption can deliver the greatest benefit, including general practice, specialists, pharmacy, pathology, diagnostic imaging, aged care and allied health. This will include finalising the Allied Health Industry

Offer, supporting vendors to complete conformance and connect to My Health Record and electronic prescribing, progressing the National Allied Health Digital Uplift Plan, and delivering education and enablement activities with sector partners.

Workforce engagement: Digital health capability across the workforce will be strengthened through Clinical Learning Australia and the Workforce Capability Action Plan. Clinical Learning Australia will be embedded into routine Agency operations and prepared for inclusion in the next intergovernmental agreement. The Digital Health Workforce Hub will support nationally aligned capability frameworks, maturity assessments, adoption tools, shared learning resources and career pathways, alongside culturally safe and inclusive digital health education for Aboriginal and Torres Strait Islander health workers and expanded learning resources for VET-trained healthcare providers.

Accelerate digitally connected, safe and secure healthcare

A stronger digital backbone will help health information move safely and securely across settings. In 2026–27, this will include progressing national interoperability actions, improving provider and identity services, strengthening medicines safety and supporting consistent adoption of digital health standards.

Interoperability: Implementation of the *Connecting Australian Healthcare – National Healthcare Interoperability Plan* will continue, including governance through the Council for Connected Care, quarterly progress reporting, shared implementation resources, the Online Interoperability Toolkit and Implementer Hub, and online forums to support collaboration. Key work will include progressing the Healthcare Identifiers Roadmap, harmonising interoperability requirements in procurement, developing an information-sharing model that includes active consent management, supporting FHIR® capability through the Standards Academy and related initiatives, and measuring and publicly reporting digital maturity.

Provider Connect Australia: PCA uptake will continue to increase across healthcare organisation locations, with a focus on general practices, their business partners and high-referral allied health providers where possible. PCA will also support the rollout of the Health Connect Australia Provider Directory and integrations with Google, jurisdictional systems and clinical software products. Enhancements will improve the user experience, expand allied health capability and support more accurate national health directories.

Medicines safety: Digital technologies will continue to support safe, simple, personalised and connected medicines management. Work will progress the National Medicines Record by onboarding the National Prescription Delivery Service as a conformant My Health Record registered repository operator, establishing FHIR® as the foundation standard, and designing and piloting core technical infrastructure, clinical alerts and a minimum viable product prototype. National electronic prescribing standards will be strengthened and electronic prescribing in public hospitals supported, with further enhancements to the national real-time prescription monitoring system to improve user experience and expand access for healthcare providers.

System enhancement: The Healthcare Identifiers Roadmap will progress to support a national health information exchange through Health Connect Australia, including promoting healthcare identifier use, improving matching and enabling identifiers for information exchange. Coordinated efforts across government, industry and healthcare providers will support modernisation of the National Authentication Service for Health Public Key Infrastructure, while the Healthcare Information Provider Service will be modernised to strengthen alignment with FHIR®-based data exchange, structured data capability and emerging information-sharing models.

Digital health standards: A nationally coordinated program will strengthen the adoption, implementation and ongoing development of digital health standards. This will include improving the use of procurement

guidelines; maintaining and expanding core minimum system requirements; supporting Australia's role in the Global Digital Health Partnership; delivering standards training through the Standards Academy; supporting Connectathons and implementation forums; and continuing to enhance the Standards Catalogue, National Clinical Terminology Service and priority terminology content for medicines, allied health and aged care use cases.

Improving workflow: The Agency will continue to simplify and accelerate industry connections to national infrastructure. In 2026–27, this will include implementing conformance pathways in ServiceNow for the Provider Directory and registered repository operators, SMART on FHIR® applications and share by default conformance, as well as embedding automated test tools into the conformance lifecycle and completing the Implementer Hub redevelopment.

Deliver national digital health infrastructure

Modernising national digital health infrastructure will remain a priority so information can be accessed, exchanged and used safely in real time. This work will strengthen the reliability, security and scalability of national systems while laying the foundations for a learning health system that uses trusted data to improve care, planning and outcomes.

My Health Record on FHIR®: A new FHIR®-based repository will be progressed to support the National Repositories Service under the *My Health Records Act 2012*. FHIR®-based APIs will support more granular, searchable health information and reduce reliance on PDF-based documents. Over time, this capability is expected to support device integrations, remote monitoring and a more holistic view of health information, while maintaining strong access management, secure connections and authentication controls.

Health Connect Australia: Delivery will continue on the foundations for a national health information exchange, including the Health Connect Provider Directory and Authorisation Service. In 2026–27, an early adopter pilot of the provider directory will progress before broader access is enabled for healthcare organisations in early 2027. This will establish consistent national standards and connections so clinical information can be shared more easily and safely across jurisdictions and systems.

Service delivery and platform uplift: Operational visibility, service reliability and integration capability will be strengthened across critical digital health services. This includes uplifting the Health API Gateway to improve security, reliability, scalability and developer efficiency; consolidating legacy data analytics platforms into the Unified Data Analytics Platform; improving the Configuration Management Database as a foundation for service integration and management; and expanding end-to-end monitoring to support faster issue detection and resolution across a multi-vendor, multi-product environment.

Part 2. Performance

Information about this part

This part highlights the Australian Digital Health Agency's performance in achieving its purpose and is divided into 3 sections:

1. the Agency's 2025–26 **annual performance statements** as required by the PGPA Act
2. a report on the Agency's delivery of its annual national digital work program
3. My Health Record System Operator reporting requirements under the *My Health Records Act 2012*.

Annual performance statements 2025–26

Statement of preparation by accountable authority

On behalf of the Board, I present the 2025–26 annual performance statements of the Australian Digital Health Agency, as required under paragraph 39(1)(a) of the 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.

Lyn McGrath
Chair
21 September 2026

Performance targets from the Portfolio Budget Statements 2025–26

This section reports on the Agency's 2025–26 results against the performance measures and supporting annual targets published in the Health, Disability and Ageing Portfolio Budget Statements 2025–26 (PBS) in March 2025, and in the Agency's Corporate Plan 2025–26 in August 2025. The targets tie performance to 3 strategic areas of focus:

- drive information sharing
- accelerate digitally connected healthcare
- deliver national digital health infrastructure.

An analysis of performance is provided below for each 2025–26 target. All 9 targets were met or exceeded.

In addition to these specific performance outcomes, the Agency has also successfully delivered a range of other initiatives outlined in the Agency Work Plan (an attachment to the Corporate Plan). Performance against the Work Plan is provided in Section 2.

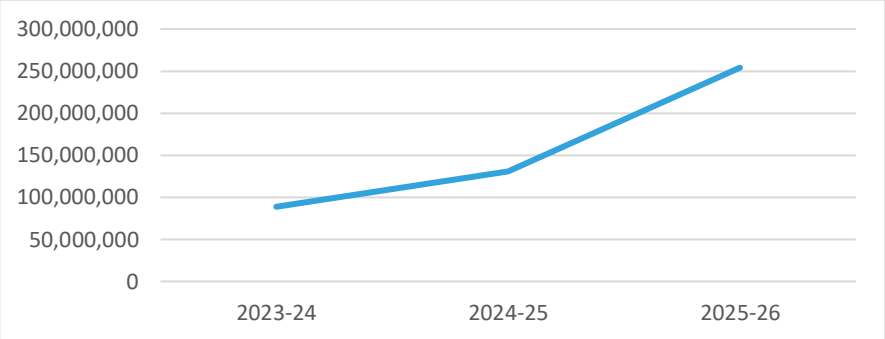
Drive information sharing

<table>
<tr><th colspan="3">Digital health products and services are adopted and used</th></tr>
<tr><th>2025–26 target and source</th><th>Performance result</th><th>Analysis</th></tr>
<tr><td>20% increase in pathology and diagnostic imaging reports shared with My Health Record.

Source:
PBS p. 181
Corporate Plan p. 37</td><td>Target met</td><td>The Agency exceeded the annual target, achieving 235.5 million pathology and diagnostic imaging uploads in 2025–26. The result demonstrates continued growth in the availability of pathology and diagnostic imaging information in My Health Record.

<table><tr><th></th><th>2024–25</th><th>2025–26</th></tr><tr><td>Uploads</td><td>175.1 million</td><td>235.5 million</td></tr><tr><td>% annual increase</td><td>Baseline</td><td>35%</td></tr></table>
The results were supported by the increased awareness in the lead up to the implementation of the Share by Default initiative on 1 July 2026. As more pathology and diagnostic imaging results become available through My Health Record, healthcare providers are better able to access important clinical information when and where it is needed.</td></tr>
<tr><td>Increased use of key digital services:

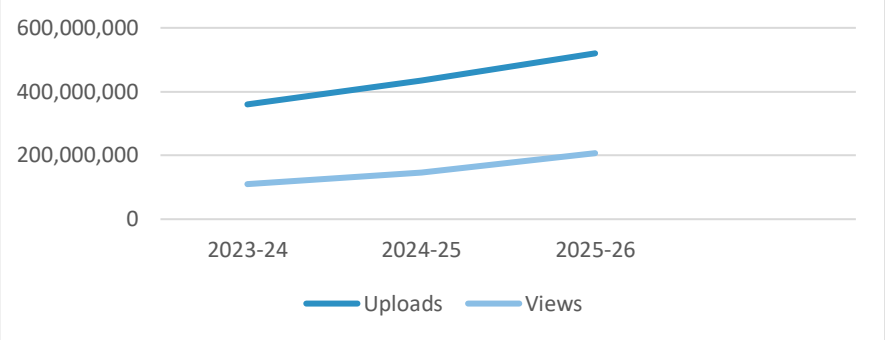
Source:
PBS p. 181
Corporate Plan p. 37</td><td>Target met</td><td>This target comprised 4 sub-targets:
20% annual increase in consumer use of My Health Record
15% annual increase in provider use of My Health Record
25% annual increase of my health app[4] downloads
25% of total PBS prescriptions are electronically prescribed[5]</td></tr>
<tr><td>20% annual increase in consumer use of My Health Record</td><td>Sub-target met</td><td>Consumer participation results over 2025–26 demonstrated continued growth in engagement with My Health Record.



<table><tr><th>Use*</th><th>2023–24</th><th>2024–25</th><th>2025–26</th></tr><tr><td>Uploads</td><td>31,581</td><td>33,163</td><td>33,023</td></tr><tr><td>Views</td><td>88.7 million</td><td>130.9 million</td><td>254 million</td></tr><tr><td>Total</td><td>88.7 million</td><td>130.9 million</td><td>254 million</td></tr><tr><td>% annual increase</td><td>26%</td><td>48%</td><td>94%</td></tr></table>
*Use is defined as a consumer uploading to or viewing their My Health Record in the last 12 months.</td></tr>
</table>

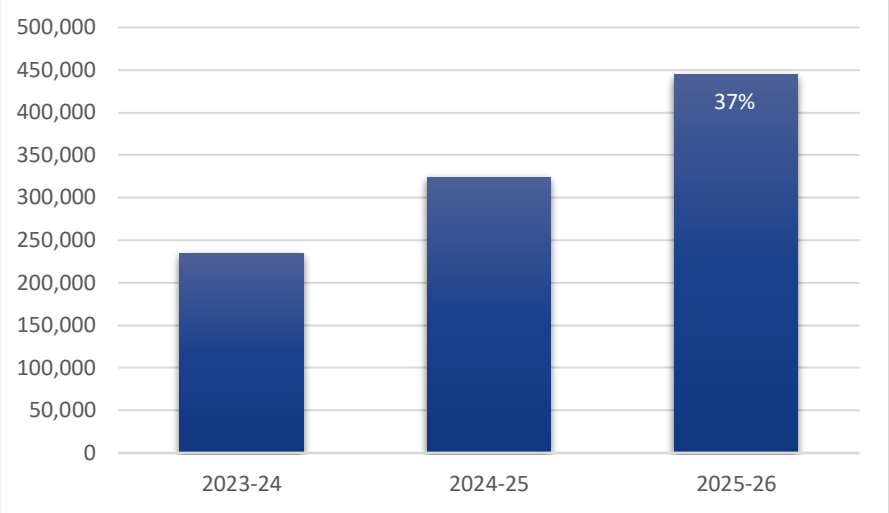
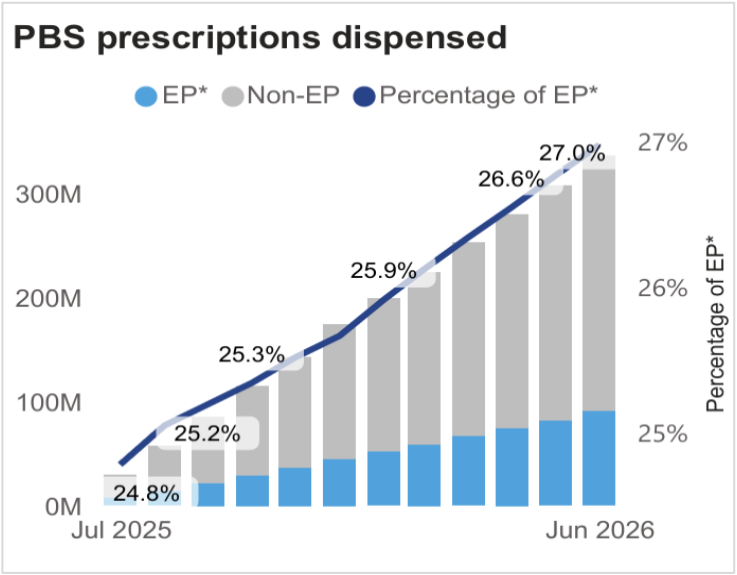
[4] Note that the **my health** app was rebranded to 1800MEDICARE app from 1 January 2026.

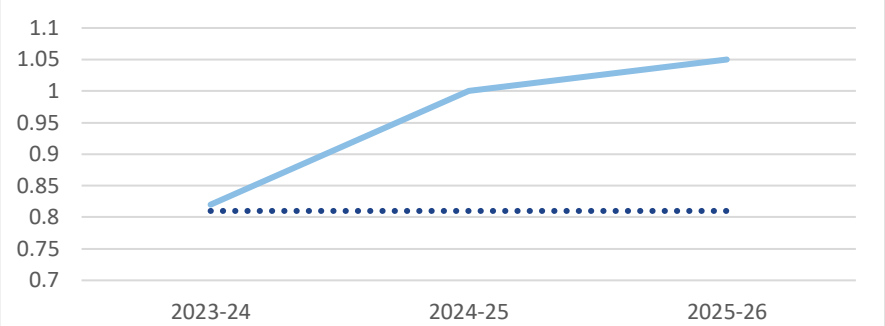
[5] Total reflects dispensed and not prescribed.

<table>
<tr><th colspan="3">Digital health products and services are adopted and used</th></tr>
<tr><th>2025–26 target and source</th><th>Performance result</th><th>Analysis</th></tr>
<tr><td></td><td></td><td>The growth achieved this year was largely driven by a substantial increase in consumers accessing and viewing their health information through My Health Record. This trend demonstrates a growing expectation among Australians for convenient, secure digital access to their health information and services.</td></tr>
<tr><td>15% annual increase in provider use of My Health Record</td><td>Sub-target met</td><td>Total provider interactions with My Health Record continued to increase in 2025–26 demonstrating a sustained upward trend in provider use.


<table>
<tr><th>Use*</th><th>2023–24</th><th>2024–25</th><th>2025–26</th></tr>
<tr><td>Uploads</td><td>360 million</td><td>435 million</td><td>520 million</td></tr>
<tr><td>Views</td><td>110 million</td><td>147 million</td><td>207 million</td></tr>
<tr><td>Total</td><td>470 million</td><td>582 million</td><td>728 million</td></tr>
<tr><td>% annual increase</td><td>23%</td><td>24%</td><td>25%</td></tr>
</table>
*Use is defined as a provider uploading to or viewing My Health Record in the last 12 months.
By enabling faster access to pathology and diagnostic imaging reports, the program has strengthened the value of My Health Record as a trusted source of clinical information.
Greater provider participation supports more informed and connected care by giving clinicians timely access to important patient information. This helps improve continuity of care, enhances coordination between healthcare providers, reduces unnecessary duplication of tests and procedures and ultimately supports safer and more efficient healthcare outcomes for Australians. </td></tr>
<tr><td>25% annual increase of my health app (1800MEDICARE app) downloads*

* The my health app was rebranded to the 1800MEDICARE app from 1 January 2026.</td><td>Sub-target met</td><td>The my health app (1800MEDICARE app) continued its growth in 2025–26, demonstrating sustained consumer adoption over the past 2 years. The rebranding of the app to 1800MEDICARE on 1 January 2026, together with associated push notifications, may have contributed to increased downloads.</td></tr>
</table>

Digital health products and services are adopted and used		
2025–26 target and source	**Performance result**	**Analysis**
		 **2023–24** | **2024–25** | **2025–26** Downloads | 234,275 | 324,030 | 444,623 **% annual increase** | Baseline | 38% | **37%** The continued uptake of the app is providing more Australians with convenient and secure access to their health information and digital health services. By making it easier for consumers to access and manage their health information, the app supports greater participation in healthcare decisions and contributes to a more connected, person-centred healthcare system.
25% of total PBS prescriptions are electronically prescribed* *Total reflects dispensed and not prescribed.	Sub-target met	The proportion of prescriptions dispensed electronically increased steadily over 2025–26, from 24.8% in July 2025 to 27.0% in June 2026, demonstrating growing integration of digital prescribing into routine clinical practice.  **Note:** Monthly PBS and RPBS prescriptions dispensed by pharmacies as electronic prescriptions, including claimable, under co-payment and rejected claims processed through the PBS Online system with an associated electronic prescribing unique identifier.

Digital health products and services are adopted and used		
2025–26 target and source	**Performance result**	**Analysis**
		Greater use of electronic prescribing supports safer, more efficient access to medicines by enabling prescriptions to be issued, transmitted and dispensed securely online. This reduces reliance on paper, improves convenience for consumers and healthcare providers and supports a more connected healthcare system.
Achieve a 'positive' evaluation (>0.8) of user experience of **my health** app. Source: *PBS p. 181* *Corporate Plan p. 37*	**Target met**	User experience ratings have increased year-on-year over the past 3 years, demonstrating continued improvements in consumers' experience of the **my health** app.  **My health app** / **2023–24** / **2024–25** / **2025–26** **>0.8 positive evaluation** / 0.82 / 1.0 / **1.05** Throughout 2025–26, the app was enhanced through the release of features designed to respond to consumer needs, including improvements to the Share by Default program for pathology and diagnostic results and strengthened privacy and access controls. The app was also rebranded to 1800MEDICARE on 1 January 2026, increasing consumer awareness and reinforcing its role as a key digital entry point to health information and services.

Accelerate digitally connected healthcare

Digital health products and services are safe, secure and connected		
2025–26 target and source	**Performance result**	**Analysis**
Publish an annual Clinical Governance Performance Report. Source: *PBS p. 182* *Corporate Plan p. 38*	**Target met**	The Agency delivered and published the annual Clinical Governance Performance Report, providing a comprehensive overview of the activities undertaken to monitor and improve clinical governance support for national digital health projects and programs. The 2024–25 Clinical Governance Performance Report demonstrates delivery against the requirement to publish an annual report, providing progress in

<table>
<tr><th colspan="3">Digital health products and services are safe, secure and connected</th></tr>
<tr><th>2025–26 target and source</th><th>Performance result</th><th>Analysis</th></tr>
<tr><td></td><td></td><td>embedding the Clinical Governance Framework for Digital Health across programs, partnerships and internal operations.

It highlights the influence of clinical governance on key national initiatives, including Sharing by Default implementation, My Health Record enhancements and culturally safe approaches for Aboriginal and Torres Strait Islander peoples. The report also reflects the strengthened contribution of clinical leadership and advisory groups, and the consistent application of the Framework across the organisation.

The report reinforces our commitment to transparency and accountability in digital health governance, sharing progress, insights and challenges to support broader sector adoption of the Framework.</td></tr>
<tr><td>Establish a standards microsite and online forum to support the uptake of global digital health standards across the health sector.

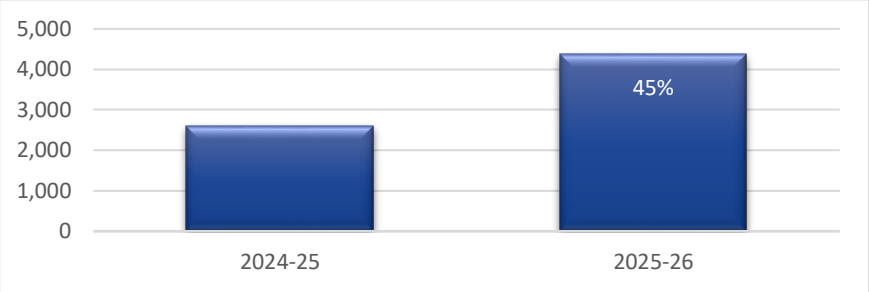
Source:
PBS p. 182
Corporate Plan p. 38</td><td>Target met</td><td>The standards microsite was successfully launched on 10 November 2025. The Digital Health Communities online discussion forum was successfully launched on 23 June 2026, initially to support the FHIRside community engagement activities.

Utilisation data for 10 November 2025 to 30 June 2026 shows the digital health community is increasingly using the standards materials being published. Regular updates to the Standards Catalogue, CIS Requirements, Procurement Guidelines and Standards Academy training courses have provided new content promoting continued engagement.

<table><tr><th colspan="2">Standards microsite usage</th></tr><tr><td>Active users</td><td>12.1K</td></tr><tr><td>Total users</td><td>12.4K</td></tr></table></td></tr>
<tr><td>Develop a case study through the refresh of 2 conformance assessment schemes to support health sector connection to national infrastructure.
Source:
PBS p. 182
Corporate Plan p. 38</td><td>Target met</td><td>To support Australia’s evolving electronic prescribing ecosystem and the implementation of Share by Default legislation, the Agency uplifted the Conformance Assessment Schemes (CAS) for both electronic prescribing and My Health Record. The CAS uplifts ensure alignment with current requirements and provide implementers with clear, up-to-date conformance guidance.

The case study found that across both CAS, conformance artefacts were reviewed and updated to improve clarity, accuracy and usability. This included:
aligning requirements with current legislative and policy settings
updating references to supporting standards, artefacts and documentation
improving consistency of language and terminology
clarifying conformance expectations for implementers and assessors
establishing a stronger foundation for ongoing maintenance and future enhancements.
The refresh provided a more contemporary and accessible conformance artefact capable of supporting current requirements and sets up the schemes for the next phase of conformance modernisation.

These refinements improve the usability and readability of the schemes, support more consistent interpretation and application of conformance requirements by implementers and assessors, and help maintain alignment with evolving legislative and policy requirements across the national digital health ecosystem.</td></tr>
</table>

Digital health products and services are safe, secure and connected		
2025–26 target and source	**Performance result**	**Analysis**
10% increase in participation in cyber security awareness activities conducted by the Agency across the health sector through and for Australian healthcare consumers. Source: *PBS p. 182* *Corporate Plan p. 38*	**Target met**	The Agency substantially exceeded the performance target for 2025–26. The increase demonstrates continued strong engagement with cyber awareness activities. The result confirms sustained momentum in building organisational cyber resilience, with validated year-end data showing performance above target for the full financial year.  **Digital health security awareness activity** / **2024–25** / **2025–26** Webinar participants — Baseline — 1,125 Enrolments in eLearning — 2,645 Total — 3,770 **% annual increase** — **45%** Through its cyber security awareness activities, the Agency is strengthening cyber resilience by improving cyber awareness, security behaviours and incident readiness of the health sector. This supports the secure delivery of digital health services, enhances the protection of sensitive health information, and helps build public confidence in the safety and reliability of Australia's digital health systems.

Deliver national digital health infrastructure

Digital health infrastructure supports healthcare		
2025–26 target and source	**Performance result**	**Analysis**
Agency products and services meet or exceed the planned availability target of 99.9%: • National Consumer Portal • National Provider Portal • **my health** app Source: *PBS p. 183* *Corporate Plan p. 38*	**Target met**	The National Consumer Portal, National Provider Portal and **my health** app all met or exceeded the target during 2025–26. **2023–24** / **2024–25** / **2025–26** National Consumer Portal — 99.82% — 99.9% — 99.92% National Provider Portal — 99.79% — Not available — 99.90% **my health** app — 99.75% — 99.9% — 99.93% **% annual total** — 99.78% — 99.9% — **99.91%** This outcome has been supported by the Agency's: • focus on improving coordination, visibility and operational resilience across its digital health environment • efforts to implement a Configuration Management Database (CMDB) and end-to-end observability tools • continued improvement and maturation of service integration and management processes.

Digital health infrastructure supports healthcare		
2025–26 target and source	**Performance result**	**Analysis**
Report on the Agency's National Infrastructure strategic partners contractual relationships through the Partner Value Index. Source: *PBS p. 183* *Corporate Plan p. 38*	**Target met**	The Partnership Value Index, established in 2022–23, uses standardised interview and survey questions to assess strategic partner performance across major contracts, driving value for money over a sustained period. Results have remained positive and stable since 2023–24, reflecting strong partner understanding of Agency objectives, contractual obligations and service quality. In 2025–26, all strategic partners received positive scores, with feedback stable or improving. This indicates increasing partner maturity, stronger alignment with Agency expectations and more collaborative relationship management. The Index demonstrates the effectiveness of the Agency's approach to support innovative, sustainable and cost-effective digital health solutions. The target will be phased out in 2026–27 and reviewed to determine the most valuable approach for future reporting.

Priorities from the Corporate Plan 2025–26

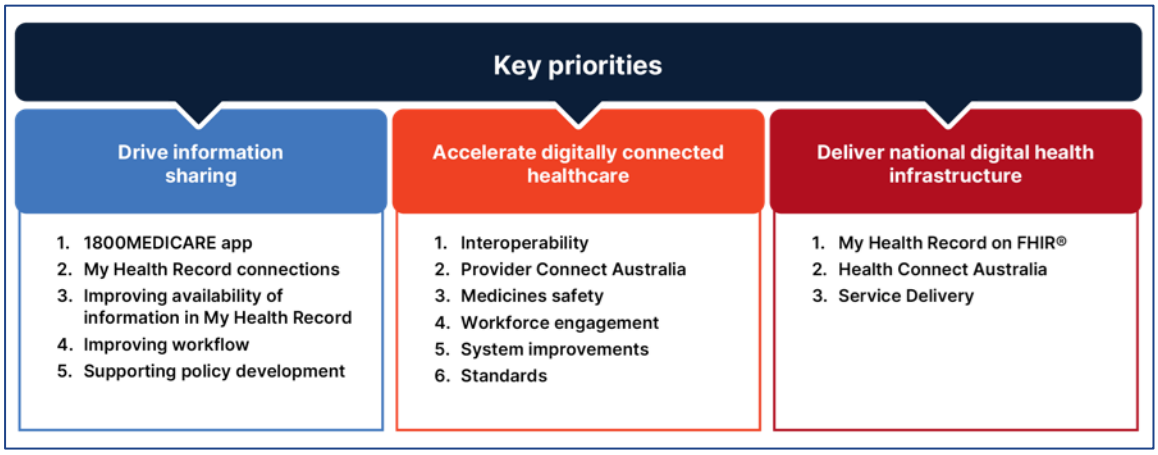
The targets in the 2025–26 Portfolio Budget Statements and Agency Corporate Plan cover core Agency activities. They provide a broad view of the Agency's performance, but not the full performance story. The Agency is one of only a handful of Commonwealth entities with a statutory obligation to also produce an annual work plan. The work plan translates the priorities in the Corporate Plan 2025–26 into a focused program of delivery and puts those priorities at the centre of any performance discussion.

This section reports on performance against those priorities.

Key priorities

Agency activities are organised around the same 3 priorities as the performance targets:

- drive information sharing
- accelerate digitally connected healthcare
- deliver national digital health infrastructure.



In support of measuring the Agency's performance in 2025–26, each program is assessed in terms of key areas of activity for the year and the results produced, followed by a synoptic analysis of factors contributing to those results. This approach shows how each work program priority area furthers the Agency's purpose.

Drive information sharing

The first focus was strengthening the flow of health information across the healthcare system. In 2025–26, high-quality information sharing remained fundamental to safe, connected and person-centred care, enabling healthcare providers to access the information they needed, when and where it was needed. This work supported better clinical decision-making, improved coordination across care settings and helped Australians play a more active role in managing their health. Across the year, the Agency advanced 4 priority areas that enhanced the completeness, timeliness and accessibility of health information across the health system.

1. **1800MEDICARE app** (formerly **my health** app)

In 2025–26, **my health** app was rebranded as the 1800MEDICARE app to align with the Australian Government's broader 1800MEDICARE initiative and reinforce its role as a central digital access point for trusted health information and services. The rebrand was supported by a program of enhancements that improved consumer access, information availability, notifications and user control. Key achievements during the year included:

- **Growing consumer reach:** Downloads of the 1800MEDICARE app exceeded one million during 2025–26, demonstrating strong consumer interest in accessing health information through a trusted government digital channel. This growth expanded the app's reach and strengthened its role as a practical entry point to My Health Record and related services like Find and Book a Health Service and the Symptom checker.

  Downloads during 2025–26: 444,623 downloads were recorded during the year.

  Cumulative downloads: as at 30 June 2026, total downloads stood at 1,110,961.
- **Improved access to health information:** The app supported implementation of the Sharing by Default reforms, giving consumers access to a broader and more timely set of pathology and diagnostic imaging information enabled by My Health Record. These improvements made the app more useful in everyday care by helping consumers stay informed, prepare for conversations with healthcare providers and access important information when needed. This contributed to increased ongoing engagement, with 700,398 onboarded users actively using the app as at 30 June 2026, compared with 417,969 in 2024–25, and approximately 14,785 active users each day, compared with 7,702 in 2024–25.
- **Timely in-app notifications:** From March 2026, the Agency implemented a scalable notification framework to alert users when new health documents became available. The feature improved the consumer experience by helping users identify new information sooner and reducing the risk of missed updates. Since launch, notifications were accessed 370,500 times by 159,700 unique users, demonstrating strong early use and providing a foundation for future targeted push notifications.
- **Greater consumer control:** The Agency introduced Privacy and Access Management, and Profile and Settings Management in the app, giving users more direct control over record access, personal details, Medicare settings and how their health information is shared. These changes reduced the need to rely on other channels and made more account and information-sharing tasks available within the app.

Analysis of factors contributing to results

Positive factors	Challenges
• **Improved user experience and accessibility**: The intuitive design and rebrand to **1800MEDICARE**, combined with seamless integration with My Health Record, have significantly increased app adoption, reduced barriers to use, and encouraged more frequent access and updates to personal health information. • **Enhanced functionality and control:** Features such as real-time notifications, removal of delays for results, and the ability to manage access to privacy, profile and Medicare settings has improved timely access to information, boosted engagement, and strengthened user control and convenience.	• **User expectations:** The rebrand to **1800MEDICARE** has led to user expectations that core Medicare services are available in the app, contributing to negative feedback, which accounts for approximately 40% of all app store feedback since 1 January 2026. • **Onboarding barriers:** Challenges with linking My Health Record with myGov are a commonly reported barrier in completing the 1800MEDICARE app onboarding.

Case study: Australia's fastest man needs fast access to health information

In April 2026, 22-year-old sprinter Lachie Kennedy made Australian athletics history, breaking the 10-second barrier twice. His 2 blistering 9.96-second performances cemented his place as Australia's fastest man and secured his selection for the 2026 Glasgow Commonwealth Games.

What spectators don't see is the challenge Lachie faces long before he steps onto the track.

Living with type 1 diabetes amplifies the complexity of an elite sporting career. When Lachie was diagnosed in 2018, his family worried there might be limitations.

'He will have an extra 100 or so more decisions a day than anyone else does,' says mum Rachel Kennedy. 'What to eat? What exercise am I doing? How will my blood sugar react to that? He's got all those decisions that he must make, every single day.'

In addition to talent and training, Lachie's success depends on an extensive healthcare team including endocrinologists, physiotherapists, exercise physiologists and dietitians – who all need timely access to accurate information to support his health and performance. But coordinating information across multiple providers takes time.

'It's sort of difficult to get the information to all the people on my team,' Lachie says.

Connected care became even more important after the Paris 2024 Olympic Games, when Lachie was diagnosed with a stress fracture in his lower back.

Having timely access to a complete picture of an athlete's health is critical, as information delays can slow treatment and rehabilitation decisions, explains exercise physiologist Matt Crear. 'We often work on time-sensitive timelines. We want to see stuff from medications through to results from scans, correspondence from specialists.'

Professor Margaret McGill, Assistant Director of the Royal Prince Alfred Hospital, agrees. 'We all need access to the same information. If we had it documented in a clear, safe place, that would make life easier for everyone.'

Lachie and his care team found the solution in My Health Record and the 1800MEDICARE app.

Diagnostic imaging and pathology reports, data generated through his diabetes management technologies and other key health information are uploaded and accessed in near real time. This provides his team with the most up-to-date picture of his health and gives Lachie a secure, permanent record of his health history.

'Yeah, I actually was quite surprised to see how much data and medical history was in the My Health Record and in the app and see all the history and years back it goes,' Lachie says.

His team also sees significant benefits. Matt Crear says, 'Access to that primary care information is going to really help us with our efficiency in doing our job. It's going to be a game changer for allied health professionals.'

So does Lachie's mum. 'My hopes for Lachie's health journey in the future would be that he continues to take care of himself. I'd like him to use things like My Health Record. I'd like him to have access to his data.'

As Lachie prepares for his next career milestone, he remains determined not to let diabetes or injury define what he can achieve. He sees access to his health information as more than convenience. It supports independence, confidence and informed care at every stage of his journey.

'For me, it just helps reach that level of autonomy that it wouldn't be possible to reach without technology.'

Scan the QR code to watch the full case study:

2. My Health Record connections

In 2025–26, the Agency improved the sharing and use of key health information by expanding My Health Record registrations across priority sectors. Work focused on connecting residential aged care homes and pathology and diagnostic imaging providers, registering private specialist practices, and commencing activities to support allied health sector connection through the Allied Health Industry Offer. Together, these activities broadened access to My Health Record and improved the flow of information across care settings, including through:

- **Specialist connection:** 1,091 specialists were registered with My Health Record during 2025–26, increasing access to key health information in specialist care. This supports a more complete clinical picture, reduces duplication and helps coordinate care for consumers moving between providers and settings.
- **Residential aged care connections:** supported residential aged care homes to connect to My Health Record, with 322 additional homes registered, bringing total registrations to 57%. Tailored assistance, training resources and software conformance support helped providers access key resident health information, including pathology, diagnostic imaging and hospital discharge information, during transitions between residential aged care and acute care settings.
- **Pathology and diagnostic imaging provider connections:** supported pathology and diagnostic imaging providers to connect to and share information through My Health Record, with 372 providers registered and 16 pathology providers and 356 diagnostic imaging clinics supported during the year. Through targeted implementation support, provider education and readiness activities, the sector was prepared for the commencement of the Sharing by Default reforms on 1 July 2026. This contributed to increased provider participation ahead of the legislative deadline, resulting in a growing volume of pathology and diagnostic imaging reports being uploaded to My Health Record, increasing the information available to consumers and healthcare providers.
- **Second Aged Care Industry Offer:** completed in May 2026. The industry offer supported 13 software vendors to integrate My Health Record with their software products and implement the Residential Care Transfer Summary functionality. Participating software vendors also released enhanced products to their aged care clients, supporting increased access to My Health Record throughout the sector.
- **Allied Health Industry Offer:** progressed the Allied Health Industry Offer to support software vendors to develop clinical information systems and mobile clinical information systems capable of connecting to the Healthcare Identifiers Service, My Health Record and electronic prescribing. In 2025–26, this work supported fit-for-purpose, conformant products for diverse allied health professions, with 16 vendors supported through the offer during the year. The first vendor achieved conformance to My Health Record in May 2026.
- **National Allied Health Digital Uplift Plan:** released the National Allied Health Digital Uplift Plan in December 2025. The plan was developed in partnership with the Department of Health, Disability and Ageing and Allied Health Professions Australia, following public consultation in June and July 2025. It provides a coordinated pathway to strengthen digital capability across the allied health workforce through improved infrastructure, training, support and connection pathways, including greater integration with My Health Record.

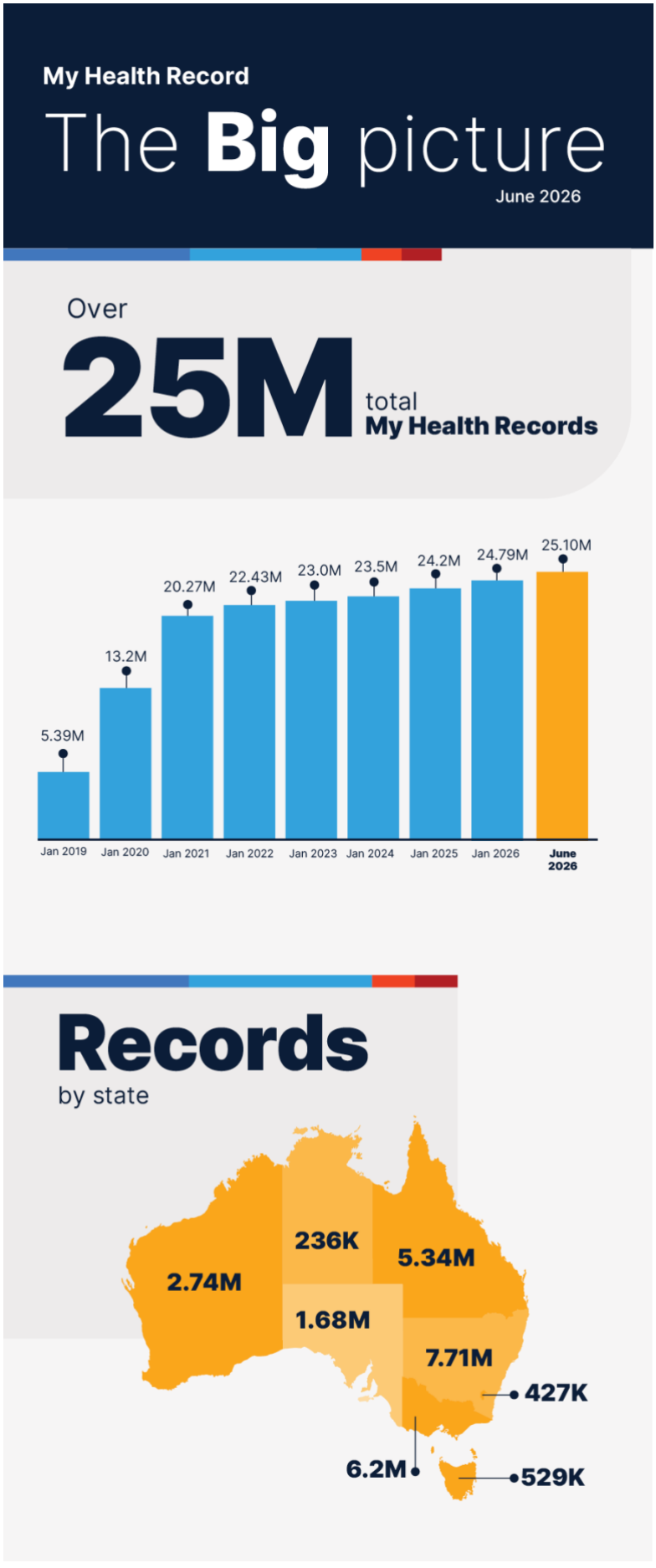
Analysis of factors contributing to results

Positive factors	Challenges
• **Expanded information sharing:** Implementation of Sharing by Default reforms and sector readiness activities increased participation in My Health Record, supporting broader sharing of pathology and diagnostic imaging information and more timely access to results for consumers and healthcare providers.	• **Complex allied health environment:** The allied health sector comprises more than 300,000 professionals across 55 distinct professions, with diverse service delivery models, levels of digital maturity and technology capability. This continued to influence the pace and scale of adoption of connected digital health solutions and integration with national digital health infrastructure.

Positive factors	Challenges
• **Allied health sector collaboration**: Engagement with the allied health software industry through the Allied Health Industry Offer and development of the National Allied Health Digital Uplift Plan accelerated the availability of connected, standards-based digital solutions and strengthened pathways for allied health participation in the national digital health ecosystem. The Agency also collaborated with Allied Health Professions Australia to support allied health professionals to engage with national digital tools and deliver targeted education and training. • **Aged care accessibility:** The Second Aged Care Industry Offer increased the aged care sector's ability to upload to My Health Record and share key health information, supporting safer transitions of care.	• **Sustaining digital transformation:** Delivering nationally connected healthcare requires ongoing investment and engagement across providers, software vendors and professional groups to implement interoperable solutions and meet evolving digital health standards and information-sharing requirements. • **Enabling transitions of care:** A lack of education means that awareness of the Residential Care Transfer Summary in acute care settings is low. Although residential care is contributing information, hospitals are not yet viewing the information at the same rate. This may discourage uploading by aged care in the future.

'Nurses and midwives can see more complete patient records, reducing uncertainty during clinical assessments. Accurate and timely diagnostic data helps us to understand what is happening for a patient at the point of care. It also helps avoid unnecessary repeat testing and enhances **continuity of care** when patients are admitted or transferred between facilities.'

Tanya, ED nurse in Melbourne
Published in *Australian Nursing and Midwifery Journal*, 9 December 2025


My Health Record
The Big picture
June 2026
Over
25M
total
My Health Records
5.39M
13.2M
20.27M
22.43M
23.0M
23.5M
24.2M
24.79M
25.10M
Jan 2019
Jan 2020
Jan 2021
Jan 2022
Jan 2023
Jan 2024
Jan 2025
Jan 2026
June 2026
Records
by state
236K
5.34M
2.74M
1.68M
7.71M
427K
6.2M
529K

What is **Inside**?

There are over

2.3 Billion

documents in the system that have been uploaded by **consumers** or **healthcare providers**.

Clinical Documents

1B

uploaded by a healthcare provider like hospitals, pathologists and increasingly specialists.

Medicine Documents

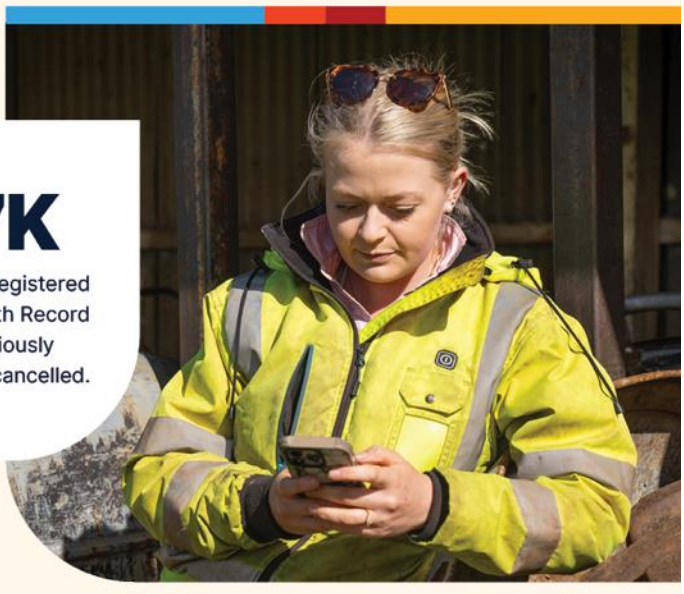
1.3B

uploaded by healthcare providers like pharmacists and GPs.

Consumer Documents

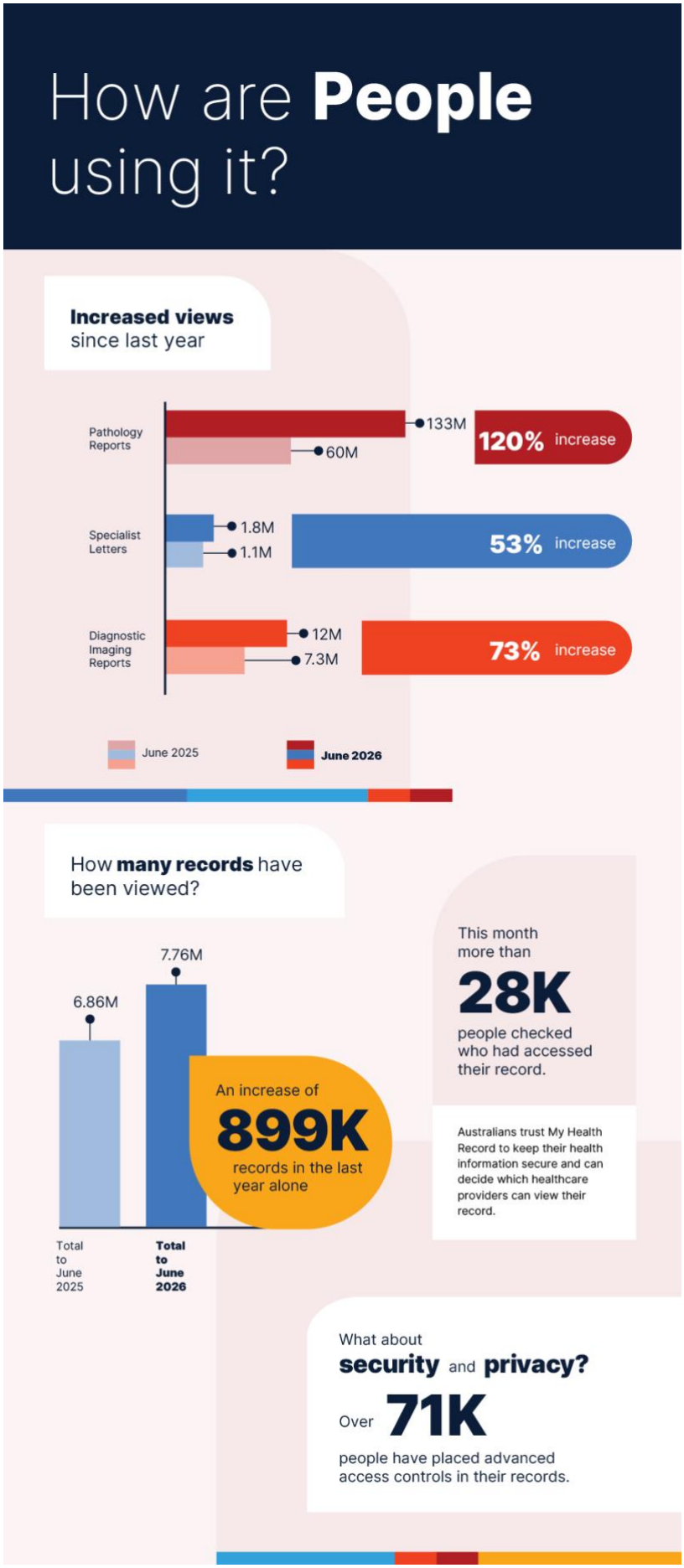
640K

uploaded by people.



527K

people have registered for a My Health Record who had previously opted out or cancelled.


How are People using it?
Increased views since last year
Pathology Reports
133M
60M
120% increase
Specialist Letters
1.8M
1.1M
53% increase
Diagnostic Imaging Reports
12M
7.3M
73% increase
June 2025
June 2026
How many records have been viewed?
7.76M
6.86M
An increase of 899K records in the last year alone
Total to June 2025
Total to June 2026
This month more than 28K people checked who had accessed their record.
Australians trust My Health Record to keep their health information secure and can decide which healthcare providers can view their record.
What about security and privacy?
Over 71K people have placed advanced access controls in their records.

How are **Healthcare providers** using it?

GP

99% of GPs are now registered

99% have used My Health Record

Pharmacy

99% of pharmacies are now registered

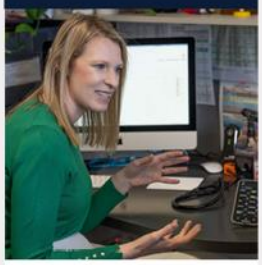
99% have used My Health Record

Public Hospital

97% of public hospitals are now registered

95% have used My Health Record

Specialist



75% of specialists are now registered

44% have used My Health Record

Aged Care

57% of aged care are now registered

21% have used My Health Record

My Health Record document volumes 2025–26

The following table shows the number of documents in My Health Record (by category) during 2025–26 and the change relative to 2024–25. It shows that the number of documents in My Health Record increased by 18% in 2025–26 and now totals more than 8.6 billion, with more than 258 million uploaded by either healthcare providers or consumers over the year.

Clinical document volumes exceeded 1 billion records for the first time, increasing by 34% over the year. This growth was driven in part by the government mandate to upload diagnostic imaging and pathology reports, with pathology reports rising by 35% to more than 855 million and diagnostic imaging reports growing by 37% to more than 78 million.

Prescription and dispense records also saw a 26% increase, rising from approximately 1.1 billion to more than 1.37 billion, reflecting the growing availability of medicines information through My Health Record. Specialist letters and eReferral notes recorded strong gains of 46% and 51% respectively, supporting more connected care and streamlined referral pathways.

On the consumer side, advance care documents rose by 47%, reflecting growing engagement in end-of-life planning. Medicare-sourced information remained the largest document category, increasing by 14% to more than 6.2 billion records and further enriching the information available through My Health Record.

Document category/name	At 30 June 2025 (rounded)	At 30 June 2026 (rounded)	Growth
Clinical	**754.798M**	**1.013B**	**34%**
Diagnostic Imaging Report	56.889M	78.221M	37%
Discharge Summary	32.464M	38.692M	19%
Event Summary	9.968M	13.385M	34%
Goals of Care	18.827K	32.300K	72%
Pathology Report	633.291M	855.118M	35%
Pharmacist Shared Medicines List	1.244M	1.607M	29%
Shared Health Summary	14.684M	16.906M	15%
Specialist Letter	6.237M	9.122M	46%
eReferral Note	1.291K	1.953K	51%
Consumer	**575.110K**	**640.219K**	**11%**
Advance Care Directive Custodian Report	51.081K	56.581K	11%
Advance Care Documents	28.769K	42.279K	47%
Child Parent Questionnaire	10.587K	10.586K	0%
Consumer Entered Health Summary	387.817K	430.013K	11%
Consumer Entered Notes	84.387K	88.063K	4%
Personal Health Achievement	1.787K	1.819K	2%
Personal Health Observation	10.682K	10.878K	2%

Document category/name	At 30 June 2025 (rounded)	At 30 June 2026 (rounded)	Growth
Medicare	**5.453B**	**6.232B**	**14%**
Australian Immunisation Register	20.919M	21.348M	2%
Australian Organ Donor Register	3.309M	3.459M	5%
Medicare DVA Benefits Report	3.221B	3.708B	15%
Pharmaceutical Benefits Report	2.207B	2.499B	13%
Prescription and Dispense Record	**1.088B**	**1.372B**	**26%**
Dispense Record	701.965M	895.815M	28%
Prescription Record	386.146M	476.339M	23%
All documents	**7.296B**	**8.618B**	**18%**

B = billion, M = million, K = thousand.

Document volumes include uploads from Medicare, healthcare providers and consumers. These figures may also be influenced by document amendments or removals, so changes in volume may not exactly match the number of uploads over the same period.

Healthcare provider views

The table below highlights the healthcare providers with the highest, second highest and third highest views by healthcare provider.

Healthcare provider views

View type	GPs	Pharmacies	Public hospitals	Private hospitals	Pathology & diagnostic imaging	Specialists	Allied health
Prescription & dispense View	6,365,309	1,274,115	11,716,973	497,581	24,964	3,871,751	30,821
Pathology report view	6,828,513	212,485	11,942,298	458,970	28,021	3,751,936	69,743
Diagnostic imaging view	5,899,801	11,783	11,013,433	441,218	272,408	3,488,697	29,834
Medicines view	1,855,317	268,737	22,380,875	482,495	30,680	722,229	20,103
Medicare overview	2,164,368	80,238	12,887,067	510,869	21,622	551,865	21,172
Australian Immunisation Register	4,667,960	1,370	1,057,979	122,131	6,921	3,038,419	19,839
Dispense record	1,637,877	117,923	9,243,707	51,275	11,479	911,726	13,731
Health record overview	575,837	441,194	11,769,772	399,988	17,653	796,686	20,990
Pathology report	6,162,813	339,486	7,758,209	119,048	100,252	1,403,488	50,162
Prescription record	990,293	60,073	5,872,992	67,772	8,210	499,923	6,691
Individual details view	425,587	153,811	8,594,308	198,645	708	321,014	16,788

Highest number of views
2nd highest
3rd highest

Healthcare provider use of My Health Record reflects the different roles providers play across the care continuum. Public hospitals generated the highest viewing activity across most record types, particularly for medicines, Medicare, pathology and health record information, highlighting the importance of timely access to comprehensive patient information in acute care settings.

GPs were also among the most active users, with strong engagement in pathology, diagnostic imaging, prescription and dispense, and immunisation information, reflecting their central role in coordinating care, managing preventive health and monitoring ongoing patient outcomes.

Usage patterns across other provider groups were similarly aligned to clinical need, demonstrating the broad integration of My Health Record information in clinical workflows across the healthcare system.

3. Improving availability of information in My Health Record

The Agency continued to enhance the information available through My Health Record in 2025–26 through 2 related but distinct initiatives. **Faster Access** focused on reducing the time Australians waited to view pathology and diagnostic imaging reports after they were uploaded to My Health Record. **Better Access** focused on preparing for Sharing by Default reforms commencing on 1 July 2026 that require pathology and diagnostic imaging reports prepared by, or on behalf of, pathologists and radiologists to be uploaded to My Health Record by default, subject to consumer choice and access controls. Key achievements during the year included:

- **Faster pathology access:** from October 2025, most pathology reports (including those listed in Faster Access – new test categories) became available for consumers to view in My Health Record as soon as they were uploaded. In addition, pathology report types that remained subject to a release delay (including anatomical pathology, cytopathology and genetic testing) became available after 5 days instead of the previous 7 days. These changes improved the timeliness of information available to consumers and their care teams and supported more informed clinical decision-making.
- **Faster diagnostic imaging access:** from March 2026, X-ray reports for limbs became available for consumers to view immediately after upload, while other diagnostic imaging reports, including CT, MRI, PET, mammograms and ultrasounds, became available after 5 days rather than the previous 7-day delay. This improved the availability of diagnostic information through My Health Record and strengthened access to key health information in time-sensitive and emergency situations.
- **Faster Access guidance and sector support:** supported awareness and implementation of the Faster Access changes through guidance and engagement with consumers, healthcare providers and the broader sector. By the time Faster Access to pathology reports commenced in October 2025, the Agency had provided guidance to more than 1,400 stakeholder groups, including peak bodies, colleges, jurisdictions, hospitals, Primary Health Networks, Aboriginal community-controlled health organisations, and pathology laboratories and diagnostic imaging providers, to help them prepare for and implement the changes.
- **Better Access readiness:** progressed preparatory work to support commencement of legislation on 1 July 2026, which requires pathology and diagnostic imaging reports prepared by, or on behalf of, a pathologist or radiologist to be shared to My Health Record by default. Guidance and implementation support helped sector participants prepare for the new requirements or seek an extension to comply, while preserving consumer choice and access controls.

Analysis of factors contributing to results

Positive factors	Challenges
• **Stronger visibility of health information:** Ongoing collaboration between the Agency and healthcare providers has established a defined set of pathology and diagnostic imaging tests eligible for faster availability. This has significantly increased the timeliness and availability of these reports within My Health Record. • **Greater stakeholder awareness:** Targeted education and stakeholder engagement have enhanced awareness and understanding of My Health Record, driving greater recognition of the expanded availability of pathology and diagnostic imaging reports.	• **Information release practices:** The practice of combining sensitive and non-sensitive test results into a single report by some pathology and diagnostic imaging providers delays faster access in My Health Record, restricting timely availability of results for consumers.

'The **sharing of results by default** will enable more consistent access to results and support safe handover when patients move between care teams or settings. It will allow for closer monitoring of complex patients who frequently access care from multiple providers.'

Grace, community care nurse in South Australia
Published in *Australian Nursing and Midwifery Journal*, 9 December 2025

Case study: The life-changing impact of sharing by default

In 2025, Christine was being treated in hospital for a stomach condition when she later logged in to view her reports in My Health Record. While reviewing a diagnostic imaging report, she noticed a finding that surprised her.

‘When I read the report on My Health Record, it said in bold text “suspicious slight lesion in the right breast”,’ Christine recalls. ‘And I thought, well, who wouldn’t be concerned?’

Had Christine not independently accessed her information, she may not have known to seek help.

‘That report wasn’t sent to my GP. If I hadn’t seen it myself in My Health Record, I wouldn’t have known to follow it up,’ she says.

Christine acted quickly, returning to her GP for further investigation. Tests confirmed early-stage breast cancer, measuring just 5–6 millimetres, about the size of a grain of rice. Because it was detected so early, Christine required only limited surgery.

‘I only needed one lymph node removed, the margins were clear, and I didn’t need chemotherapy.’

For Christine, the experience reinforced the importance of consumer access to health information. 'My Health Record was actually the hero in my story,' she says. 'It gave me the opportunity to act. Without it, I would have waited for someone else to tell me, and that didn't happen.'

Now back at work and continuing her recovery, Christine's message is clear: timely access to health information empowers people to be active participants in their own care, supporting earlier intervention and better outcomes when it matters most.

Christine is a busy health professional with a clinical nursing background and experience in cardiac rehabilitation, privacy and data protection. She lives in Brisbane with her husband and 3 children.

4. Improving workflow

The Agency modernised and simplified the software developer journey for connections and conformance in 2025–26, improving the way software developers connect to, and conform with, national digital health infrastructure. This work made implementation, conformance and connection pathways clearer, more efficient and easier to navigate, supporting safer, faster and more scalable uptake of digital health systems across Australia. Key initiatives included:

- **Implementer Hub launch:** launched the Digital Health Implementer Hub in February 2026, following the re-engineering of the Agency's Developer Portal. The re-engineered platform was designed to make it faster and easier for digital health organisations to connect to national digital health systems, with improved tools and clearer guidance for software developers, vendors and health services.
- **Improved developer experience:** introduced a more streamlined user experience through the Digital Health Implementer Hub, including a personalised case management system, dynamic smart forms and a dedicated dashboard to improve visibility of progress, upcoming requirements and stage-gate activity across connection and conformance journeys.
- **Tailored conformance pathways:** developed a built-in conformance engine within the Digital Health Implementer Hub that converts technical documentation into tailored requirements, use cases and test cases, guiding implementers through conformance activities in a way that is more specific to their implementation scope.
- **Expanded capability:** progressed broader capability uplift through the Digital Health Implementer Hub to support a more consolidated end-to-end implementation environment, with capability expected to extend further to areas such as electronic prescribing, re-conformance processes and the Healthcare Information Provider Service.
- **Security conformance rollout:** finalised the industry-wide implementation timeline for the My Health Record Connecting Systems Security Conformance Profile, supporting more consistent cyber security expectations for software systems connecting to My Health Record. New connecting systems are required to conform before production access is granted.

Analysis of factors contributing to results

Positive factors	Challenges
• **Improved efficiency and user experience:** Implementers reported that activities that previously took days could now be completed in	• **Change was required:** The project required the Agency to move away from traditional document-based and specification-led delivery approaches

Positive factors	Challenges
hours due to automation, consolidation of processes, dynamic forms and clearer onboarding pathways. • **Strong stakeholder adoption and confidence:** Industry participants, internal Agency staff and jurisdictions provided positive feedback, with over 100 implementers actively using the Hub. User involvement throughout design and testing helped create a solution that stakeholders felt ownership of and confidence in.	towards a product-led, iterative, data-driven model. This introduced complexity in changing established practices, processes and ways of working across multiple teams.

5. Supporting policy development

The Agency worked collaboratively with the Department of Health, Disability and Ageing and partners across government to shape policy, legislative and investment settings that enable digital health to support broader health system reform. This included providing strategic advice, participating in governance and whole-of-government forums, and considering and responding to consultations, reviews and reform processes that influence the national health and digital policy landscape.

- **Securing investment in critical national digital health infrastructure:** The Agency's engagement with the Department of Health, Disability and Ageing and partners across government helped reinforce My Health Record as critical national digital health infrastructure. Recognition of its increasing use, usability and value supported continued investment in My Health Record sustainment, Share by Default, the National Medicines Record and the National Digital Child Health Record, ensuring the platform can continue to support connected care and broader health reform as demand grows.
- **Developing a savings model for Share by Default**: The Agency developed a financial benefits model to demonstrate the expected reduction in duplicated pathology and diagnostic imaging tests and associated Medicare Benefits Schedule claims. The modelling identified indicative savings of $146.3 million in administered funding to the Health portfolio over 2 years from 2026–27, strengthening the evidence base for digital health investment and reform.
- **Contribution to legislative and cross-government reviews:** The Agency participated in several cross-government initiatives, including the review of My Health Records legislative instruments and Services Australia's Medical Information Ecosystem Review, which examined opportunities to improve medical information sharing and reduce administrative burden across government services.
- **Embedding digital health in broader reform:** Through strategic advice, evidence development, consultation responses and cross-government collaboration, the Agency helped ensure digital health is considered in policy design, legislative reform and investment.

Analysis of factors contributing to results

Positive factors	Challenges
• **Established relationships with policy partners:** Over time, the Agency has developed strong collaborative relationships with policy partners across the Health portfolio and central agencies.	• **Budgetary restraint:** Securing investment in large-scale infrastructure can prove difficult, especially in a tight fiscal environment. The Agency dedicated resources to demonstrate how digital health solutions

Positive factors	Challenges
• **Expansion of adoption and use of digital health products**: Increasing uptake and use of digital health products – including My Health Record, 1800MEDICARE app and Provider Connect Australia – continues to demonstrate the ongoing value of national digital health infrastructure and capabilities for the Australian public.	would leverage existing infrastructure and capabilities and how this approach benefits both government and stakeholders.

Accelerate digitally connected healthcare

The second focus is digital connectivity, enabling faster, more coordinated care and stronger collaboration across the healthcare system. By making it easier for Australians to engage with their healthcare and for healthcare professionals to access meaningful information, digital connectivity supports a more efficient and person-centred healthcare experience. In 2025–26, the Agency continued to make significant progress, with key initiatives including:

1. Interoperability

Interoperability is essential to a connected healthcare system because it allows health information to move securely, consistently and meaningfully between different systems, providers and care settings. When information can be shared and understood across the health system, consumers have better access to their health information and healthcare providers can make more informed decisions, reduce duplication and support safer, more coordinated care. In 2025–26, the Agency advanced interoperability and connected care through:

- **Interoperability Plan delivery:** by 30 June 2026, completed 35 actions under the *Connecting Australian Healthcare – National Healthcare Interoperability Plan 2023–2028*, representing 80% of the plan, with progress reports published on the Agency's website to support transparency, accountability and collaboration across the sector.
- **Interoperability Plan governance:** supported implementation of the Interoperability Plan through national governance forums, with the Council for Connected Care meeting 3 times to consider annual reporting and review, transitions of care, and data and design, and the Standards Advisory Group meeting twice to discuss national standards initiatives and the National Digital Health Standards.
- **National information sharing and legislative reform**: progressed nationally consistent settings for health information exchange by implementing legislative reforms to the *Healthcare Identifiers Act 2010*, strengthening the legal foundations for interoperable systems and enabling broader use of identifiers across health, aged care and disability sectors. The Agency also developed the information-sharing authorisation framework and Sharing by Default rules for pathology and diagnostic imaging, supporting more timely access to health information and improved care coordination, with commencement planned from 1 July 2026.
- **Standards governance uplift:** strengthened national coordination of standards through publication of the *National Framework for Digital Health Standards* in May 2026, which provides a nationally coordinated approach to the adoption, implementation, development and use of standards and identifies 5 key areas for action: governance, evidence and benefits, education and workforce development, communication and collaboration, and implementation support.
- **Healthcare identifiers adoption:** progressed implementation of the *National Healthcare Identifiers Roadmap 2023–2028* to increase adoption and use of national healthcare identifiers, with 17 Healthcare Identifier

Activities commenced, 4 completed and the remaining 3 scheduled to start in 2026–27. The Agency completed the legislative reform program, including passage of the Omnibus Bill 2025; released the My Health Record Conformance Profile v5.0; progressed HI Service improvements to strengthen data matching and accuracy; and delivered consolidated education materials and guidance to support greater adoption and integration of HI-enabled systems.

- **FHIR® implementation support:** strengthened FHIR® capability and standards implementation across the sector, with the Agency partnering with HL7 Australia to deliver FHIR® training that achieved over 450 course completions and more than 1,900 enrolments, while refreshing 4 courses to support the transition to more connected and interoperable systems.
- **Workforce capability and sector adoption:** strengthened workforce capability to support interoperability adoption through delivery of the Digital Health Train the Trainer Toolkit, new education resources and training programs to build FHIR® capability aligned to the National Digital Health Workforce and Education Roadmap, and continued development of implementation guides, terminology services and API frameworks to support secure, standards-based interoperability across the ecosystem.

Analysis of factors contributing to results

Positive factors	Challenges
• **Interoperability Plan implementation:** Delivery of the Interoperability Plan progressed steadily, with 80% of actions completed by 30 June 2026 and regular public reporting strengthening transparency and accountability. • **Stronger information-sharing foundations:** Legislative reforms to the Healthcare Identifiers Act and development of Share by Default rules strengthened the foundations for more consistent and timely information sharing, with the Agency mandating the use of standardised clinical terminology (SNOMED-CT) under the amendments to the My Health Record Rule. • **National Standards Leadership:** The National Framework for Digital Health Standards provides clearer national direction and coordination for standards adoption and implementation. • **Workforce capability uplift:** Workforce capability and the Healthcare Identifiers Roadmap support improved interoperability capability across the system. • **Greater implementation certainty:** Completion of the legislative reform program has provided greater certainty and a stable foundation for delivery of the HI Roadmap. • **Improved stakeholder guidance:** Strengthened education, standards and guidance materials have improved clarity for stakeholders and supported increased uptake and integration of healthcare identifiers.	• **Sustaining implementation momentum:** Maintaining delivery momentum and embedding completed actions into business-as-usual across jurisdictions and care settings. • **Balancing reform and readiness:** Implementing new legislative and information-sharing settings while balancing privacy, consent and system readiness requirements. • **Variable adoption of standards:** Driving consistent uptake of standards across diverse system environments and varying levels of digital maturity. • **Building system-wide capability:** Scaling workforce capability and increasing adoption of standards and identifiers across all sectors, including less digitally mature providers. • **Complex stakeholder coordination:** Coordinating delivery across multiple activities and stakeholders, which requires sustained effort to maintain momentum and alignment.

2. Provider Connect Australia

In 2025–26, the Agency enhanced Provider Connect Australia (PCA) to support more efficient information sharing, easier registration and publishing processes, stronger integration capability, and alignment with broader connected care priorities. This included ongoing user experience improvements, release enhancements, support for healthcare providers and business partners, and continued positioning of PCA as an important component of the evolving digital health ecosystem.

In 2025–26, the Agency strengthened PCA through:

- **User experience improvements:** delivered ongoing usability and process improvements through PCA release activity in 2025–26. These updates simplified publishing for healthcare providers, improved setup and navigation of organisation structures, improved experience when linking practitioners to an organisation and enhanced design, accessibility and dashboard experiences.
- **Health Connect Australia Provider Directory:** progressing important preparatory work to lay the foundations to support the provider directory in 2026–27.
- **Integration:** tighter integration with the Healthcare Identification (HI) Service and the National Health Services Directory to reduce duplication of information between systems as well as support interoperability between healthcare provider organisations and individuals.
- **Healthcare provider registration support:** supported healthcare provider organisations to register for PCA, including through one-on-one support and improved registration guidance, with 6,847 healthcare clinics registered, an increase of 2,836 during the 2025–26 year.
- **Business partner growth:** expanded engagement with business partners, with 48 business partner services participating, and 7 of these onboarded in the past year.
- **Sector engagement and adoption:** engaged healthcare providers, business partners and sector stakeholders to promote PCA uptake and identify insights for PCA's future roadmap. Engagement included holding 6 discovery workshops and 11 webinars, and attending 5 events.

'Australia reported some of the lowest rates of burnout due to administrative burden – half the rate in the U.S. Through the **Provider Connect Australia** system, the country has reduced the burden of administrative tasks like billing and communication for clinicians and practices. Unlike the US … which has a fragmented reporting system that is often unique to each payer and practice, Australia has a centralized platform for billing, documentation, and messaging, allowing seamless communication across providers, practices, and businesses.'

The Commonwealth Fund, *Causes and impacts of burnout among primary care physicians in 10 countries*
20 November 2025
doi: 10.26099/4p0p-hk02

Analysis of factors contributing to results

Positive factors	Challenges
• **Stakeholder-informed delivery:** The Agency maintained strong and consistent engagement with PCA users, business partners, primary health networks and allied health peak bodies throughout the year. This collaboration played a key role in shaping system enhancements, ensuring that updates were informed by real-world needs and sector feedback. These efforts also helped to build broader awareness and interest in PCA, supporting its continued growth. • **Tailored implementation support:** Direct support was provided to healthcare provider organisations throughout the PCA registration process when requested. This hands-on assistance reduced barriers to entry and supports sustained engagement and long-term use. • **Improving onboarding experience:** User experience improvements simplified publishing for healthcare providers, helping to ensure a smooth and efficient onboarding experience.	• **Expanding network participation:** Broader adoption remains a challenge, as the system delivers the greatest value when both healthcare providers and their business partners are actively engaged. This shared participation ensures timely updates, consistent information and improved efficiency across the healthcare network. • **Service differentiation:** The role of PCA compared with healthcare provider directories is unclear for some healthcare providers, highlighting the value of continued communication to clarify its distinct purpose and benefits.

3. Medicines safety

Safe medication practices help prevent adverse drug events, improve patient outcomes and support trust in the healthcare system. Medicines safety is a core component of the national digital health agenda, supporting safer, high-quality care through improved access to accurate and timely medicines information. The Agency is enhancing a digitally enabled medicines ecosystem across all care settings through the implementation of the following initiatives:

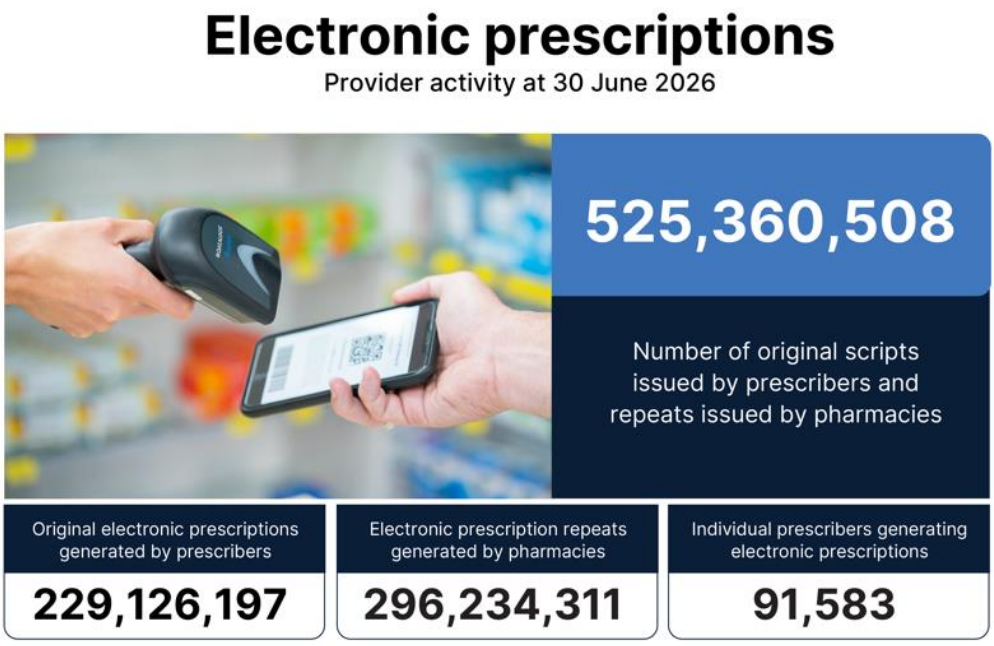
- **Electronic prescribing adoption:** ongoing collaboration with clinical peak organisations and other key stakeholders continued to support the uptake of electronic prescribing across both in-person and telehealth consultations. Electronic prescriptions provide a safe and convenient alternative to paper prescriptions, reducing the risk of transcription errors and supporting continuity of care. By 30 June 2026, more than 525 million electronic prescriptions had been issued nationally since its introduction in May 2020.
- **Provider implementation support:** supported prescribers and dispensers through updated guidance, fact sheets, webinars and online training on electronic prescribing and Active Script List workflows in clinical practice and community pharmacy settings.
- **Conformance and technical uplift:** made strong progress in uplifting software vendors to the latest electronic prescribing conformance standard during 2025–26, with approximately 80% of vendors uplifted to Conformance Profile v3.0.1. This work maintained a stable and current conformance environment through ongoing technical guidance and implementer support, enabling enhanced electronic prescribing functionality, stronger security and the staged removal of legacy exceptions. The remaining vendor uplift is expected to be completed in 2026–27, alongside continued retirement of outdated conformance profiles to ensure alignment with evolving digital health standards and maintain a safe, consistent experience for clinicians and consumers.

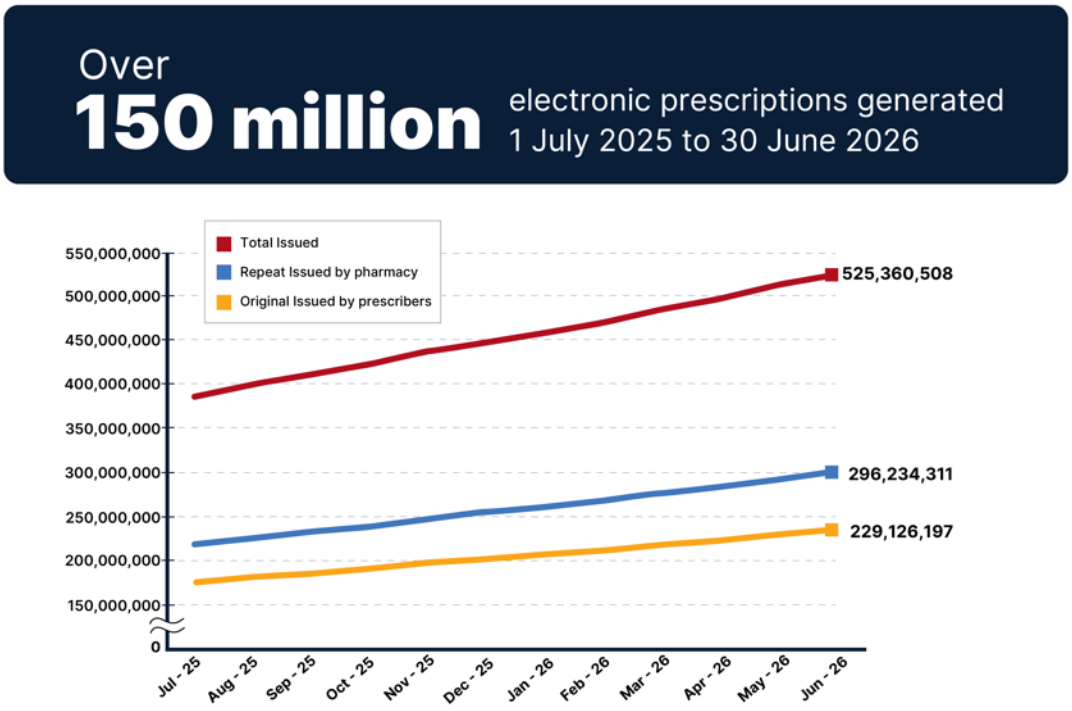
The Agency also oversaw conformance assessments for 10 electronic National Residential Medication Chart (eNRMC) systems, enabling real-time tracking and reducing medication-related risks for aged care residents. In parallel, the Agency progressed uplift of the electronic prescribing technical framework, addressing key risks and introducing new policy positions to strengthen clinical safety, interoperability and support for emerging models of care. This included updated conformance profiles, alongside a review and uplift of the conformance assessment scheme and solution architecture to enhance validation, auditability and overall system integrity.

- **Conformance registers:** maintained current conformance registers to provide transparency and visibility of software products conforming to electronic prescribing requirements. As at 30 June 2026, 112 products conformed to conformance profile v3.0.1 or v3.0.2 (the current conformance profiles for general prescribing systems and other connecting systems), compared with 69 products in June 2025. This represents an approximate 62% increase in products conforming to contemporary conformance standards over the past year.
- **Active Script List usability:** progressed work to strengthen the Active Script List (ASL), informed by research identifying priorities including improved functionality, enhanced education and support, and better access for non-English speakers and digitally excluded groups. Engagement with Primary Health Networks highlighted opportunities to increase awareness and integration to maximise ASL benefits for medicines management.
- **Electronic prescribing in public hospitals**: continued working closely with jurisdictions to support the expansion of electronic prescribing in public hospitals, recognising this as a complex, multi-year national initiative requiring coordinated delivery and strong oversight. A staged approach is being applied to reflect varying levels of digital maturity, balancing immediate implementation with longer term capability uplift. This includes establishing national technical and contractual foundations alongside tailored jurisdictional pathways, informed by early implementation insights and a focus on benefits realisation across clinical safety, workflow efficiency and consumer experience. Strong, clinically led governance underpins this work to ensure safe, consistent and sustainable outcomes, while establishing the foundational capabilities required for public hospital medicines information to contribute to a national, longitudinal medicines record.
- **Sharing medicines information:** targeted discovery work was undertaken to inform future government reforms to improve the sharing of medicines information across care settings. This included national consultation, a validated survey and gap analysis to assess current capabilities and identify priority use cases, technical requirements and implementation pathways, aligned with the Australian Government's announcement of a National Medicines Record. The Agency also progressed early design and assurance for a first phase of the National Medicines Record capability, strengthening the foundations for improved medicines reconciliation, safer transitions of care and a more connected, high-quality medicines ecosystem.
- **Consumer access by app:** supported ongoing consumer access to electronic prescriptions through the 1800MEDICARE app, which allows users to store electronic prescriptions and view their Active Script List in a single mobile platform, supporting improved medicines management, particularly for people with complex or ongoing needs.
- **Real-time prescription monitoring:** progressed enhancements to the real-time prescription monitoring system (RTPM) to enable access to new clinician cohorts, in line with scope of practice reforms. This included Designated Registered Nurse Prescribers, as well as a pilot group of paramedics in Victoria. A coordinated program of jurisdictional releases strengthened core functionality, including login and patient search, to improve clinician usability and support safer prescribing decisions. These enhancements also strengthened the system's security posture, with positive outcomes from the March 2026 Infosec Registered Assessors Program assessment, a key independent assurance mechanism confirming compliance with Australian Government security standards and reinforcing trust in the system's integrity and resilience.

Analysis of factors contributing to results

Positive factors	Challenges
• **Collaborative national delivery:** Strong collaboration across jurisdictions, industry, clinical peaks and government enabled co-design of national solutions and accelerated progress on electronic prescribing and shared medicines information initiatives. • **Stakeholder commitment:** High levels of stakeholder engagement across the electronic prescribing ecosystem supported successful uplift of the technical framework and alignment with evolving models of care. • **Growing adoption and confidence:** Increasing adoption of electronic prescribing and growing clinician confidence in digital workflows contributed to improved system maturity and consumer access to medicines.	• **Phased implementation approach:** Resource constraints required that some enhancement work on the RTPM system would need to be phased over a longer period and extend beyond 2025–26. • **Variable digital maturity:** Differences in digital capability, legacy systems and jurisdictional requirements continue to present challenges for consistent national implementation of electronic prescribing, particularly in hospital settings. • **Competing delivery priorities:** Vendor priorities and the complexity of evolving clinical workflows required sustained engagement and slowed some aspects of technical uplift and implementation.





4. Workforce engagement

In 2025–26, workforce capability uplift was delivered through a broad suite of programs and partnerships. The *National Digital Health Capability Action Plan* provides a structured national framework for longer term capability development across the health and education sectors, while a wider program of work responds to immediate workforce needs. Delivery is enabled through collaboration with clinical peak bodies, Primary Health Networks, Aboriginal community-controlled health organisations, jurisdictions, healthcare provider organisations, universities and software vendors, allowing the Agency to reach the workforce at scale and tailor delivery to different settings.

In 2025–26, workforce engagement activity focused on building digital capability across current and future health workers through education, training and practical support, including through:

- **Train-the-trainer series:** delivered a suite of train-the-trainer initiatives in 2025–26 to build digital health capability through trusted education and sector networks. The approach equipped educators, Primary Health Networks and allied health peak bodies with nationally aligned resources, structured learning content and practical support so they could embed digital health knowledge in their own courses, regions and professional communities. This supported more consistent digital health education and helped extend the reach of Agency capability-building activities across current and future health workforces.
- **Universities:** launched the Digital Health Train the Trainer Toolkit in February 2026 to support university educators to embed digital health into health degrees. Developed collaboratively with the Australian Council of Senior Academic Leaders in Digital Health and piloted with educators from 17 universities across Australia, the toolkit responded to a clear sector need, with Agency material noting that 60% of senior university educators consulted had never taught digital health. It provides 8 learning plans and 34 core topics spanning technical concepts, professionalism and ethics, sector influences and person-centred health outcomes. Since launch, more than 260 university educators have accessed the toolkit, helping build educator confidence, improve consistency across courses and strengthen the digital readiness of future health professionals.

- **Primary Health Networks:** delivered a structured PHN education program covering My Health Record, Provider Connect Australia, allied health digital uptake, electronic prescribing and Active Script List, and aged care digital health. The program included foundation webinars, train-the-trainer sessions, communities of practice and supporting resources to help PHNs deliver tailored digital health education within their regions.
- **Allied health peak bodies:** delivered a coordinated national allied health digital uplift education initiative across Allied Health Professions Australia peak bodies, focused on increasing My Health Record registration and use, Provider Connect Australia uptake and electronic prescribing adoption. Informed by sector research insights, the initiative included a 2-part train-the-trainer series for digital change leads in 15 allied health peak bodies, supporting them to deliver targeted education within their respective peaks.
- **Nursing and midwifery student capability:** launched the Digital Health Foundations for Nursing and Midwifery: Competency Preparation for Placement course in March 2026 in partnership with La Trobe University. Aligned to the National Nursing and Midwifery Digital Health Capability Framework, the free course was designed to support nursing and midwifery students to enter the workforce with stronger digital health capability, helping them deliver safer and more connected care from the beginning of professional practice.
- **Vocational and aged care workforce training:** launched 2 new eLearning courses in December 2025 with the Digital Health CRC to improve understanding and use of My Health Record across vocational healthcare students and aged care workers. The Digital Health in Healthcare: Understanding My Health Record course supports VET students, while Supporting Quality Aged Care with My Health Record supports aged care workers. These courses help current and future workers build digital literacy, strengthen continuity of care and integrate My Health Record more effectively into everyday practice. Pilot testing showed substantial improvements in participants' self-rated understanding of My Health Record, with 86% rating themselves as having a 'good' or 'excellent' understanding post-course compared with less than 10% pre-course.
- **Clinical safety capability uplift:** built workforce capability in clinical safety for digital health through national eLearning developed with the Australasian Institute of Digital Health. The introductory course, launched in August 2025, was informed by more than 30 health sector representatives and piloted across health, education, industry and government settings, with 95% of pilot participants saying they would recommend it. Since launch, it has attracted more than 1,910 participants from fields including general practice, nursing, pharmacy, IT and administration. In May 2026, the Agency released an intermediate course to build practical skills and confidence to embed clinical safety as digital technologies become increasingly central to care delivery.

'This [**National Allied Health Uplift**] **plan** is not just a technology shopping list, it's an enablement pathway. It sets out how there is a coordinated plan to uplift the allied health sector … It is upskilling allied health professionals around digital health security and privacy and it's also ensuring the allied health terminology is uploaded to the system.'

Anita Hobson Powell, Australian Government Chief Allied Health Officer
Published in *Community Care Review*, 21 May 2026

Analysis of factors contributing to results

Positive factors	Challenges
• **Strong sector partnerships:** Collaboration with universities, clinical peak bodies, Primary Health Networks, Aboriginal community-controlled health organisations, jurisdictions and professional associations enabled workforce capability initiatives to be delivered at scale and tailored to diverse workforce settings**.** • **Established education delivery channels:** Agreements with healthcare organisations and sector partners to host and deliver eLearning products, webinars and train-the-trainer programs extended the reach of workforce capability initiatives and improved access to digital health education across the health sector. • **High-quality education and training resources:** Nationally aligned learning products – including university teaching resources, workforce eLearning courses and clinical safety training – provided practical and relevant capability development opportunities that were well received by educators, students and health professionals.	• **Variable workforce digital readiness:** Levels of digital health capability continue to vary across professions, organisations and care settings, requiring tailored education approaches and ongoing investment to support consistent adoption of digital health tools and practices.

Case study: My Health Record enables connected care on Country

For Aboriginal and Torres Strait Islander peoples, good health means more than the absence of illness or disease. Connection to Country and culture are fundamental drivers of physical and mental wellbeing.

The remote Northern Territory township of Ltyentye Apurte, also known as Santa Teresa, is a place where gospel and red dust fill the air, and digital healthcare supports the community with another kind of healing. While most residents speak several Indigenous languages, in a medical emergency there's only one language that matters – connected care.

Receiving care on Country is a key challenge for the more than 150,000 Indigenous Australians living in remote communities like Santa Teresa. They often travel long distances for specialist appointments and receive treatment from a range of health services.

For the healthcare staff supporting Santa Teresa's 650 residents, the challenge is deeply personal.

'I could sometimes be the voice for those who don't know how to communicate, especially when it comes to appointments. For many in our community, English isn't their first language,' explains Courtney Forbes, Clinical Administration Coordinator at Mpwelarre Health Service.

It's why Mpwelarre Health Service has embedded My Health Record into its delivery of on-Country primary healthcare to the community.

The ability for clinicians to access a patient's health story instantly, regardless of language or location, is nothing short of transformative. If a Santa Teresa resident presents to the local clinic requiring urgent hospitalisation, staff at Alice Springs Hospital could be accessing the patient's My Health Record within minutes.

Health Centre Manager Donald Blackman says the system provides a more complete picture of a patient's health journey.

'They might have gone to a GP, they might have gone to hospital. We can see what was happening in those locations,' he says.

That single access point to a patient's history can help care teams avoid a potentially dangerous drug interaction and give clinicians like remote area nurse Susan Kenny the confidence to proceed with life-saving care.

'You're always worrying that your treatment might hurt someone if you don't know the specifics. My job would be impossibly hard without My Health Record.'

The benefits extend beyond the community of Santa Teresa.

'It allows us to provide comprehensive primary healthcare at any point, at any clinic, as needed, and when needed by the patient,' says Dr John Boffa, chief medical officer at Central Australian Aboriginal Congress. 'Without that information, there are things you just can't do. You might not know what tablets patients are on or what blood tests they've had. You might be forced to duplicate tests. Those days are gone. My Health Record is an integral part of the solution.'

From remote communities to major hospitals, My Health Record enables a more connected, equitable healthcare system that drives continuity of care regardless of language, distance or location.

Scan the QR code to watch the full case study:

5. System improvements

Strategic partnerships with government entities, the software industry and peak clinical bodies supported system improvements across Australia's digital health infrastructure in 2025–26. Work during the year focused on strengthening the core services and conformance pathways that underpin secure, reliable and interoperable access to national digital health systems, including:

- **Expanded healthcare identifier (HI) model:** the HI Service supports unique identification of individuals, healthcare providers and healthcare organisations, and from November 2025 also supports a fourth identifier

type, the Healthcare Support Service Provider – Organisation (HSP-O), for organisations providing services and support for older Australians and people with disability.

- **HI Service conformance uplift:** released HI Service Conformance Profile v5.0 in July 2025 and v5.1 in June 2026, with supporting conformance documents updated to support safer and more capable use of healthcare identifiers in software systems. The releases introduced new requirements and enhancements, including the ability to search for an Individual Healthcare Identifier using a mobile number or email address, update patient details held in the HI Service, support stronger search and validation using IHI, Medicare and DVA identifiers, and reflect legislative changes introducing HSP-O and Health Administration Entity organisation types.
- **Improved conformance pathways:** simplified and strengthened implementation pathways for software developers through the launch of the Digital Health Implementer Hub in February 2026. The new platform introduced tailored conformance pathways, dynamic smart forms, a case management system and a conformance engine to make it faster and easier to connect to national digital health infrastructure, including the HI Service and My Health Record.
- **Security conformance implementation:** strengthened cyber security requirements for systems connecting to My Health Record through the My Health Record Connecting Systems Security Conformance Profile v1.0.1, published in November 2025, and finalised the industry-wide implementation timeline in 2026. Existing connecting systems, including HIPS, commenced a 12-month conformance period from 23 February 2026, while new systems are required to conform before receiving production access.
- **Continuity of the National Authentication Service for Health (NASH):** NASH supports secure access to and exchange of health information across Australia's healthcare system through the provision of public key infrastructure (PKI) certificates. In March 2026, Services Australia executed a new managed services agreement to transition NASH PKI services from infrastructure that is approaching end of life. The Agency has worked closely with Services Australia to develop a transition approach that will be seamless for healthcare providers.
- **Healthcare Information Provider Service (HIPS) enhancements:** strengthened HIPS as a middleware solution connecting hospital, diagnostic and clinical information systems with the HI Service and My Health Record through the release of HIPS v9.0 in October 2025 and HIPS v9.1 in May 2026. The releases introduced major platform and integration improvements, including migration of core components to .NET 8; support for cloud-based database hosting; alignment with mandatory clinical information system security conformance requirements, mobile, email and single-name IHI searches in line with HI Service Profile v5; and enhanced clinical administration capability to support auditing, anomaly tracking and stronger management of integration issues.
- **Digitised Comprehensive Health Assessment Program (CHAP) solution:** completed a digitised CHAP solution based on SMART on FHIR® and Structured Data Capture 'smartform' standards to support GPs in identifying unmet health needs of people with intellectual disability. The CHAP smartform is now available for integration into GP clinical information systems and draft FHIR® Implementation Guides are available to early-adopting software vendors on request. Furthermore, the national infrastructure that has been stood up to host the CHAP smartform has the potential to be re-used to support other similar solutions and thereby achieve whole-of-government efficiencies.
- **SMART on FHIR® capability:** supported the underlying delivery model for projects such as CHAP by expanding SMART on FHIR® capability and education. In May 2026, the Agency published new Standards Academy training on SMART on FHIR® app development and implementation, helping build implementation capability for future smart form–based solutions and other interoperable applications.

Analysis of factors contributing to results

Positive factors	Challenges
• **Support for healthcare identifier reform:** The Agency collaborated with the Department of Health, Disability and Ageing and Services Australia to build support into the HI Service for the legislative changes that introduced HSP-O and Health Administration Entity organisation types. • **Clinician-centred smart form design:** The collaborative design approach used to develop the digitised CHAP smart form delivered strong usability outcomes, with testing confirming the solution aligned well with clinician needs and workflows.	• **Competing vendor priorities:** Vendors of GP clinical information systems continue to balance multiple development priorities, delaying confirmation of the first 'early adopter' implementer of the CHAP smart form.

6. Standards

In 2025–26, the Agency focused on strengthening the governance, adoption and practical application of digital health standards, while continuing to invest in workforce capability and national terminology infrastructure, including through:

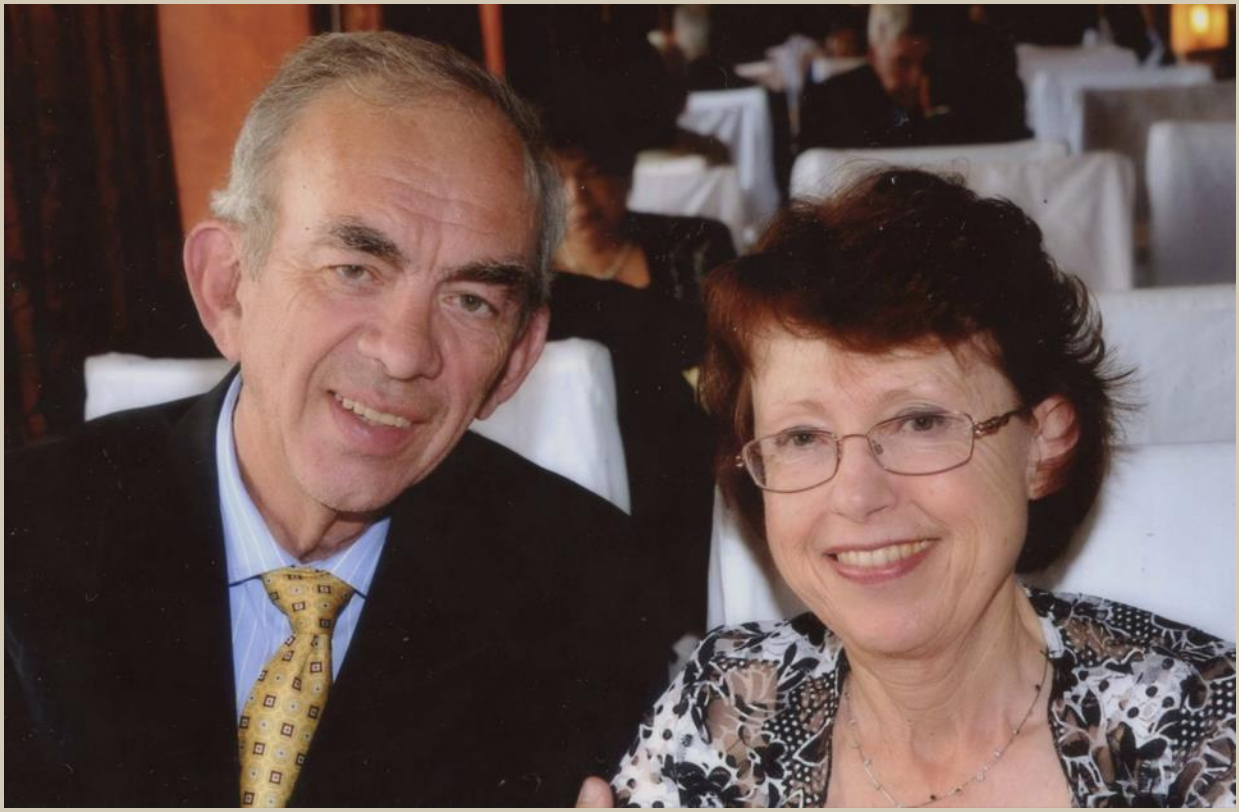
- **National standards framework:** published the *National Framework for Digital Health Standards* in May 2026, providing a nationally coordinated approach to the adoption, implementation, development and use of digital health standards. The framework identifies 5 key areas for action: governance, evidence and benefits, communication and collaboration, education and workforce development, and implementation support.
- **Digital Health Standards Catalogue:** further developed and maintained the Digital Health Standards Catalogue as a single source of truth for national and international standards relevant to digital health, with 150 additional digital health standard summaries published and 504 updated, with an average of 374 monthly visits (July 2025 – May 2026).
- **Standards for clinical systems:** supported implementation of clinical information system standards. The Aged Care Clinical Information System Standards remain available as recommended minimum software requirements for residential aged care home clinical information systems and electronic medication management systems, while subsequent work in 2025–26 extended this approach to developing broader clinical information system requirements and general practitioner clinical information software requirements.
- **Aged care standards:** Developed a Standards Harmonisation Report that analysed how the Australian Institute of Health and Welfare Aged Care National Minimum Data Set and the Aged Care National Best Practice Data Set align with FHIR® standards. It identified mapping gaps, required FHIR® profiles and extensions, and practical harmonisation options. Further work explored the current state of clinical information systems in the home care setting and the challenges associated with inconsistent label usage in residential aged care homes.
- **Procurement guidelines:** continued development and refinement of the Digital Health Procurement Guidelines to support a coordinated and consistent approach to purchasing healthcare technology in Australia. Consultation in 2025 received 137 responses, enabling the Procurement Guidelines to be officially launched for use. The consultation also identified key opportunities for improvement, including additional practical tools, content on emerging areas and uplift to navigation. This important tool is now in use within the sector and continues to evolve with ongoing feedback to meet the ever-changing requirements of Australian healthcare.

- **Standards Academy:** expanding the Agency role in capability-building, launched the Standards Academy in November 2025 as a learning hub providing practical training and resources to help clinicians, developers, policymakers, researchers and industry apply digital health standards in practice. During 2025–26 the Academy developed 6 new Standards courses as well as delivering a mixture of online, virtual workshops and face-to-face training to over 550 people, helping to ensure that all sectors of the workforce have access to training to meet their needs.
- **Partnering with industry for standards development and implementation support:** the Agency's standards program continues to mature through future-focused planning for governance, implementation support and workforce capability. Partnerships with standards development organisations (SDOs) such as HL7 Australia and Standards Australia, as well as initiatives such as Sparked, continue to ensure that the Agency is providing support and stewardship while working with the sector. Our partnership with HL7 Australia has ensured access to local Connectathons throughout 2025–26 to enable the necessary testing of new implementation guides and solutions. The first of the Agency FHIR® Implementation Guides, which will form building blocks for future Agency products, was successfully guided through industry collaboration in accordance with the Australian FHIR® Community Process (AFCP), and we contributed thousands of hours to the development and maintenance of digital health standards that will continue to support our national transformation.
- **National Clinical Terminology Service:** In partnership with CSIRO, the Agency:
    - delivered 12 monthly releases of SNOMED CT-AU
    - completed the Medicinal Cannabis in Australian Medicines Terminology (AMT) Phase 1 project on 30 April 2026, which included developing a novel terminology model for medicinal cannabis, tooling enhancements, training, editorial guidance and remediation of existing AMT medicinal cannabis content. Authoring of new AMT medicinal cannabis content commenced in the SNOMED CT-AU May 2026 release and will progressively be added into each monthly release into 2026–27.
    - completed the SNOMED International Implementation Maturity Assessment with individual health jurisdictions in March 2026, to form a baseline of clinical terminology implementation maturity across the jurisdictions and to inform future planning for outreach, education and implementation support to jurisdictions.

Analysis of factors contributing to results

Positive factors	Challenges
• **Stakeholder-informed design**: Engagement with key stakeholder groups has enabled high-quality consultation across projects, drawing on diverse expertise and sector perspectives to shape practical, evidence-informed standards products that deliver real benefit for Australians. • **Workforce capability uplift**: Investment in capability building and practical resources has strengthened workforce readiness and supported knowledge growth, improving overall program impact. • **Standards ecosystem suppor**t: Strong partnerships with SDOs and industry are ensuring continued progress towards the goals of implementing digital health standards.	• **Variable standards maturity**: Differences in readiness to adopt and implement standards have created challenges in aligning stakeholders and maintaining consistent progress across the sector.

Case study: Recording what matters most in My Health Record



Sydney-based dementia advocate Imelda Gilmore has come to rely on My Health Record, and the 76-year-old wishes she had accessed it earlier.

Her husband, Graham, was diagnosed with young onset Alzheimer's disease in his early 60s and died in 2016 after a rapid decline. 'We lived a great love story, and I did all I could to advocate for him,' she says. 'But the last 18 months of his life were traumatic.'

During that time, Graham was hospitalised 5 times following falls in the aged-care home where he'd lived since 2013. Each time, Imelda says access to critical information about his condition wasn't always available.

'Without that information during a medical emergency, they had no way of understanding that Graham had advanced dementia, was non-verbal, and couldn't understand why he was in the emergency department. And I wasn't always there to speak for him.'

Imelda says My Health Record could have made a huge difference to Graham's care. 'Now, I make sure mine is up to date with every bit of information that anyone could need to know about me in an emergency.'

Since Graham's passing, Imelda has become an advocate for people living with dementia, in particular drawing attention to their need for the best palliative and end-of-life care. 'I just have a passion for making a difference and I see that as my husband's legacy,' she says.

Imelda uses the personal health summary function in My Health Record to store her advance care planning documents. This ensures her healthcare teams will have reliable, real-time access to her wishes at the point of care, should she become seriously ill.

'It was confronting to write it all down,' she says. 'But it means my wishes are clear. And if I'm ever unconscious in an emergency, doctors won't have to guess.'

She also uses the personal health summary function to add details about the health supplements she takes, her prescriptions and allergies. Imelda documented her allergy to latex dressings, which she found out the hard way. 'My skin breaks out painfully if I have the wrong kind of bandage,' she says. 'That's not something you want people to find out during a crisis.'

Imelda sees My Health Record as a tool for dignity. 'Having your wishes known, having your history accessible; it helps ensure care is informed, appropriate and compassionate.'

This article first appeared in The Guardian on 13 October 2025 and has been adjusted slightly for the annual report.

Deliver national digital health infrastructure

The third focus is modernising national digital health infrastructure to enable real-time, secure access to health information. This includes progressing foundational work to introduce FHIR® capability into the My Health Record system and continued development of Health Connect Australia, the national health information exchange. These enhancements strengthen the systems that enable the exchange of health information across different settings and platforms.

1. My Health Record on FHIR®

In 2025–26, the Agency advanced the modernisation of My Health Record through work to introduce Fast Healthcare Interoperability Resources (FHIR®) capability, supporting the transition from a document-based architecture to a more contemporary, data-rich platform. This work is important because FHIR® provides a standards-based way to structure and exchange health information, making it easier for information to be integrated, used and shared securely across healthcare systems and settings. Key achievements during the year included:

- **Appointed delivery partner:** in August 2025, awarded Telstra Health the contract to lead the transformation of the My Health Record system, supported by Smile Digital Health and Leidos Australia. This was a major step in progressing the modernisation of national digital health infrastructure and establishing the delivery partnership needed to build a more real-time, interoperable and future-ready health data environment.
- **Expanded implementation guidance:** significantly expanded the available conformance artefacts through the publication of the My Health Record FHIR® Implementation Guide v1.4.0 in July 2025. This release introduced new profiles for advance care planning and personal health notes, retired older core profiles, and aligned the

implementation approach more closely with recent versions of AU Core and AU Base. These changes improve consistency for implementers and support broader use of standards-based information exchange.

- **Broader FHIR® record coverage:** expanded the published scope of My Health Record FHIR® artefacts across a broader range of information types, including Medical Conditions View, AIR information, AODR information, PBS/RPBS claims, MBS/DVA claims, MyMedicare registered practice information, patient emergency contact, advance care planning documents and personal health notes. This demonstrates more mature FHIR® enablement across key information domains in My Health Record.
- **Improved implementation support:** published FHIR® conformance artefacts in reusable packages, supported by validation forms and example resources for use in FHIR®-aware tools and implementation workflows. This strengthens implementation consistency, supports more reliable validation and testing and makes it easier for developers to build against My Health Record FHIR® artefacts.
- **Support for consumer-facing functionality:** evolved My Health Record FHIR® Gateway specifications to support consumer-facing products, including 1800MEDICARE app. Technical releases in October 2025 and March 2026 updated gateway specifications in response to changes to pathology and diagnostic imaging viewing delays, helping ensure FHIR®-based access pathways remained aligned with evolving consumer access settings and changes to the My Health Record experience.
- **Emergency contact capability supported:** enhanced consumer-facing API capability through the My Health Record FHIR® Gateway, including support for emergency contact information. API and data mapping artefacts were updated to support getting and updating emergency contact details, extending the practical use of FHIR®-based interactions in My Health Record.
- **Sector capability uplift:** supported sector readiness for the My Health Record transition to FHIR® through expanded training and implementation support. In partnership with HL7 Australia, the Agency delivered FHIR® training to more than 1,000 participants and launched 4 refreshed training courses, helping build the capability needed to support broader My Health Record and national FHIR® adoption.
- **Future delivery milestones:** progressed a range of supporting activities to prepare for subsequent phases of delivery under the My Health Record FHIR® repository and API program. This included onboarding of Telstra Health, Smile and Leidos, completing the Discovery and Design phase in February 2026 and transitioning into delivery in March 2026. The project built the first non-production development environment with a Smile instance in June 2026.

Analysis of factors contributing to results

Positive factors	Challenges
• **Rapid project mobilisation:** Development activities commenced promptly following completion of the negotiation period. • **Development environment established:** The first non-production development environment was successfully established, with a Smile instance downloaded to support the next phase of delivery.	• **Specialist workforce availability:** Limited availability of FHIR® expertise in the Australian market, relative to more established HL7 CDA capability, contributed to procurement delays and flow-on impacts to delivery timelines.

2. Health Connect Australia

Health Connect Australia made substantial progress in 2025–26, establishing strong strategic, technical and delivery foundations to support national interoperability. The release of core program artefacts, combined with advancement of the Provider Directory and Authorisation Service into build, and completion of Image Access discovery work, has positioned the program to transition from foundational design and build into scaled implementation. Progress was underpinned by key legislative reform, development of national standards, establishment of pilot sites and advancement of transition activities to bring core national infrastructure under Agency operations.

- The delivery of core program artefacts includes:
  - **Foundations Supplement:** outlines progress delivered through the Health Connect Australia Provider Directory, the National Digital Health Authorisation Service and the national approach to Image Access.
  - **Provider Directory FHIR® Implementation Guide:** the Health Connect Australia Provider Directory FHIR® Implementation Guide v26.0.0 was published, the first developed under the new FHIR® Framework and Australian FHIR® Community Process.
- The projects progressed into build include:
  - **Health Connect Australia Provider Directory:** the project progressed from design into build, supported by approved requirements, solution architecture and legislative reform. Key work included publishing the national FHIR® Implementation Guide, progressing pilot partnerships, integrating with Services Australia and preparing for the transition of the Healthcare Provider Directory to the Agency. These activities supported readiness for Agency operations and future national implementation.
  - **National Digital Health Authorisation Service:** progressed through design into build, with solution architecture approved and integration design finalised. Development has commenced and is tracking well, supported by endorsed requirements, positioning the service to enable secure, standardised access to health information as part of a national rollout.
- **National Medical Imaging Access (Image Access)**: During the reporting period, a sector-led discovery phase was completed in partnership with the Royal Australian and New Zealand College of Radiologists and Australian Diagnostic Imaging Association, identifying key barriers to accessing prior diagnostic images and establishing a nationally aligned vision for reform. The published *Image Access Strategy Report* outlines stakeholder-informed recommendations and has directly informed the conceptual architecture and future-state design for a federated, interoperable image access capability, aligned with Health Connect Australia foundations.

> ‘The release of the **Health Connect Australia Strategy** is a landmark moment, setting out a bold vision for a more connected, inclusive and modern healthcare system. At the heart of this transformation is a simple but powerful idea: information should follow the patient.’
>
> Kavin Arnasalon, Optus Head of Government, Enterprise and Business
> Published in *Pulse+IT*, 25 July 2025

Analysis of factors contributing to results

Positive factors	Challenges
• **Strong stakeholder engagement:** High levels of engagement across the sector, including clinical peak bodies, have strengthened alignment to real-world needs. • **Clinical and consumer input:** The Clinical Working Group continues to provide valuable insights, ensuring the program remains user-centred and fit for purpose. • **Standards validation and readiness:** Strong community participation in testing the Provider Directory FHIR® Implementation Guide has supported validation and adoption readiness. • **Collaborative delivery:** Ongoing jurisdictional support and committed pilot partners have enabled effective co-design, prioritisation and dependency management.	• **HPD transition costs:** Higher than expected transition costs required reprioritisation and de-scoping of some deliverables to remain within budget. • **Cross-program dependencies:** Dependencies across multiple national programs have impacted delivery sequencing, requiring active coordination and ongoing management. • **Legislative and policy dependencies:** Progress of key information-sharing use cases depends on future legislative and policy updates. These dependencies are being actively managed through phased delivery planning.

3. Service delivery

Service delivery remained an important enabler of the Agency's broader digital health priorities in 2025–26. This work focused on strengthening the Agency's ability to manage complex digital health environments, improve visibility across critical infrastructure and maintain reliable, responsive and resilient services that support national platforms and programs. Key initiatives included:

- **Service Integration and Management:** continued to mature Service Integration and Management (SIAM) ecosystem and processes. The SIAM framework was expanded to include additional service management disciplines, including Service Catalogue Management, Service Request Management, Availability Management and IT Service Continuity Management. Existing service providers were further integrated into the SIAM ecosystem, and one additional internal service provider was onboarded. These enhancements improved clarity of roles and responsibilities across providers, strengthened accountability, and supported the coordinated and effective delivery of critical ICT services.
- **End-to-end monitoring:** successfully completed End-to-end monitoring project phase 2 and phase 3. As part of the projects, Dynatrace was implemented for the My Health Record and Provider Connect Australia systems. Observability capability was uplifted across the digital health infrastructure. New dashboards and reports were developed to enhance visibility across the My Health Record and API Gateway systems to facilitate early identification and resolution of incidents. More than 350 staff attended the workshops organised to share knowledge about the Dynatrace platform to improve understanding and use of this platform across the organisation.
- **Configuration Management and Configuration Management Database:** continued to strengthen management of critical digital services by enhancing Configuration Management Database (CMDB), a central source of information that provides visibility of the systems, applications and technology infrastructure that support key services. Significant progress was made in maturing this capability, with critical services and all components of My Health Record and the API Gateway incorporated into the CMDB, enabling a clearer

understanding of service components and their interdependencies. Automated tools were introduced to improve the accuracy, completeness and timeliness of information, reducing reliance on manual processes and supporting more effective service management. Governance arrangements, including dedicated oversight forums, were established to promote data quality, accountability and consistent management practices. The CMDB was also integrated with core service management processes, helping teams to respond to incidents, manage changes and maintain service stability more effectively. Close collaboration with internal teams and major service providers further improved coordination across the Agency's multi-provider environment.

- **Service dependency visibility:** developed service mapping capabilities to create a clearer picture of how critical digital services are supported by underlying systems and technology infrastructure. This improved understanding of the relationships and dependencies between different components, enabling the Agency to better assess the potential impact of incidents, planned changes and service disruptions.

Analysis of factors contributing to results

Positive factors	Challenges
• **Collaborative governance:** Governance forums such as the Configuration Control Board introduced during the year enabled collaboration between key stakeholders and service providers. • **Consistent supplier management:** SIAM processes supported the effective and consistent management of service providers across the Agency. • **Continuous improvement:** SIAM forums and continuous improvement initiatives fostered a collaborative and engaging environment for service providers and the Agency. • **Proactive incident management:** The end-to-end monitoring platform supported the early identification and resolution of incidents, contributing to a significant reduction in incidents over the past 12 months. • **Enhanced infrastructure visibility:** End-to-end monitoring provided service providers and the Agency with greater visibility across the digital health infrastructure.	• **Embedding CMDB practices:** Use of the CMDB in core IT Service Management processes remains at an early stage. Further work is underway to improve adoption and visibility of critical components across national infrastructure and corporate environments. • **Evolving SIAM capability:** The Agency continues to strengthen SIAM practices across multiple suppliers and service processes to support greater consistency and integration. • **Expanding monitoring coverage:** Realising the full benefits of the end-to-end monitoring platform will require implementation across additional Agency products and systems in line with organisational priorities.

Case study: My Health Record and Royal Flying Doctor Service bringing connected emergency care to the bush

Leanne and Jeffrey Morris were living the dream of many grey nomads – caravaning between their NSW hometown of Euston and Uluru through some of Australia's most breathtaking landscapes and vast desert panoramas. Spirits were high as they headed towards a much-anticipated joy flight over Kati Thanda-Lake Eyre.

They were deep in the South Australian Outback when their plans were shattered.

While travelling the iconic Oodnadatta Track between Oodnadatta and William Creek, Leanne, 64, became critically ill. Her symptoms worsened as they travelled the unsealed road through one of Australia's most isolated regions. Unable to keep down food or water, Leanne's condition was rapidly deteriorating by the time they reached the William Creek caravan park. Heavy storms had set in, lashing the region.

'I don't remember too much, I was going in and out of consciousness,' Leanne said. 'My husband suggested we go into town to find a doctor. But I couldn't get out of the bed, I couldn't move.'

William Creek is a tiny tourist oasis with fewer than 20 permanent residents. It's more than 800 kilometres from Adelaide and 6 hours hard drive from the nearest major regional hospital, in Port Augusta.

With no doctor nearby and Leanne unable to leave the caravan without help, Jeffrey had to rely on the small remote community to help take Leanne to the town's Royal Flying Doctor Service (RFDS) William Creek community health clinic – Australia's first virtual emergency centre.

RFDS Critical Care Doctor Rose Skalicky assessed Leanne's condition via video call and determined she needed urgent hospital care in Adelaide. However, the extreme weather meant Leanne had to be stabilised and treated remotely until an aeromedical team could arrive safely.

The situation was made more challenging because, in their distressed state, neither Leanne nor Jeffrey could recall her medical history or medications. And when every second counted, waiting for information to be relayed by her regular GP after hours was precious time lost.

Dr Skalicky said having Leanne's My Health Record accessible at base prior to the flight to William Creek would have provided the care team with a more complete picture of Leanne's medical history.

'Understanding Leanne's medical history and current medications was key to understanding what would contribute to her deterioration,' Dr Skalicky said. 'Having access to Leanne's My Health Record would have expedited our ability to provide the best possible care and treatment.'

Leanne was eventually airlifted to the Royal Adelaide Hospital for urgent treatment.

Since Leanne's emergency, the RFDS has finalised the process of integrating its clinical information systems with My Health Record. Completed during the 2025–26 financial year, the integration project ensures that vital key health information can be accessed quickly by healthcare teams.

For Leanne, the experience showed how quickly a remote adventure can become a medical emergency. For the thousands of people who live in or travel through some of Australia's most isolated communities each year, the RFDS integration with My Health Record means vital key health information can now be available when and where it is needed most, helping clinicians make faster, better-informed decisions, even from hundreds of kilometres away.

'Australia continues to lead in rural and remote care innovation, supported by the **National Digital Health Strategy** and the **My Health Record** expansion.'

Black Book Market Research
Aired on ABC Radio *Perth Mornings*, 20 October 2025

My Health Record System Operator reporting requirements

The security of patient health and other personal information lies at the very heart of the My Health Record system. Many of the protections provided by the *My Health Records Act 2012* (the Act) are about ensuring that Australians' digital health records have strong protections. These protections are underpinned by rigorous reporting obligations.

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.

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 below.

My Health Record system registration, usage, security and complaints

Reporting requirement	Statistics
Registrations, cancellations, suspensions of registrations	• **Individuals:** In 2025–26 as the System Operator, the Agency registered 650,419 people for a My Health Record (a 9.4% increase from 2024–25). There are more than 24.9 million total active records in the My Health Record System. • **Healthcare provider organisations:** In 2025–26 the System Operator registered an additional 4,046 healthcare provider organisations, and 196 registrations were cancelled or suspended for reasons such as a provider organisation discontinuing operations or transferring ownership. • **Portal operators:** In 2025–26 no mobile portal operators were added or removed. Healthdirect Australia is the only portal operator as at 30 June 2026. • **Contracted service providers (CSPs)**: In 2025–26 the System Operator registered an additional 9 new CSPs. No CSPs were removed in 2025–26. There were 46 CSPs as at 30 June 2026.
Use of the My Health Record system by healthcare providers and healthcare recipients	• There were 3,282,745 unique My Health Records accessed in 2025–26, up from 2,542,398 in 2024–25 (29.1% increase), and total access of these records was 21,954,510 in 2025–26, up from 12,450,282 in 2024–25 (76.3% increase). • An average of 11,497 unique healthcare provider organisations viewed records each week during 2025–26 via their clinical information systems (15.4% increase on 2024–25). • An average of 15,404 unique healthcare provider organisations uploaded documents to the My Health Record system each week during 2025–26 (4.6% increase). • A total of 1,321,725,644 documents (including Medicare) were uploaded to the My Health Record system in 2025–26 (18.1% increase on 2024–25).
Occurrences relating to the integrity or security of the My Health Record system	• During 2025–26, 47 matters were reported to the System Operator by healthcare provider organisations under section 75 of the *My Health Records Act 2012*: ○ 21 matters involved inappropriate use of the Emergency Access function. These matters generally arose from a misunderstanding of the circumstances in which the function should be used. This includes

Reporting requirement	Statistics
	situations where no emergency circumstances existed and clinicians used the Emergency Access function (instead of the General Access function) to access a consumer's My Health Record for the purpose of providing healthcare. The majority (76%) of these matters involved access to a single individual's My Health Record. Organisations commonly responded by providing targeted education and refresher training, reviewing and updating My Health Record policies, strengthening onboarding processes, introducing additional monitoring and auditing of Emergency Access function use, and reviewing clinical information system workflows to reduce the likelihood of inadvertent access. In some matters, formal counselling and disciplinary action was undertaken. ○ 20 matters involved access to individuals' My Health Records that were not for the purpose of providing healthcare. These matters involved clinical staff accessing records without a clinical need or accessing records of individuals who were not current patients. Other matters involved incorrect patient identification resulting in access to the wrong record, and use of My Health Record information for quality assurance audits or studies. Again, the majority (75%) of these matters involved access to a single individual's My Health Record. Organisations responded by conducting investigations, counselling or disciplining staff, suspending or removing access privileges, and strengthening privacy and My Health Record training programs. One matter involved a staff member accessing My Health Records of multiple individuals without authorisation, resulting in the suspension of their professional registration and law enforcement involvement. ○ 2 matters involved documents being uploaded to My Health Record despite consumers requesting that documents not be uploaded. These matters arose from a staff error or software issues. Organisations responded by correcting technical issues and providing additional staff training. In all instances, the affected records were removed from My Health Record. ○ 4 of the reported matters were subsequently withdrawn after the organisation conducted further investigations and determined that they did not involve, or impact, the My Health Record system. Two of the matters related to cybersecurity events, one related to unauthorised access to business premises by a former employee, and one resulted from a technical issue that led to the inadvertent upload of documents to the My Health Record system. In addition, 4 matters were reported to the System Operator by consumers rather than participating healthcare provider organisations. These matters related to privacy, record access, or patient information handling concerns outside the My Health Record system. As a result, consumers were redirected to other appropriate reporting channels, and the matters were determined as not reportable to the System Operator under section 75 of the *My Health Records Act 2012*. *Note: Healthcare provider organisations are required to notify the System Operator and the Office of the Australian Information Commissioner (OAIC). However, where the entity is a state or territory authority, only the System Operator needs to be notified and notification to the OAIC is not required.*

Reporting requirement	Statistics
Complaints received, investigations undertaken, enforceable undertakings accepted, injunctions granted	• In 2025–26, 40 complaints were received in relation to My Health Record through the Contact us form, call centre, email or paper mail. No enforceable undertakings were sought by the System Operator, and no proceedings were initiated by the System Operator in relation to enforceable undertakings or injunctions.

Part 3. Management and accountability

Corporate governance

The Agency is governed by a skills-based Board supported by advisory committees and reports to Commonwealth, state and territory health ministers through the National Federation Reform Council.

The Agency's governance framework has its legislative foundation in the Agency Rule. The PGPA Act sets out requirements for the governance, reporting and accountability of Commonwealth entities and for their use and management of public resources. It vests many of the powers and responsibilities for the financial management of a Commonwealth entity in the hands of the accountable authority, which is the Board of the Agency. The Agency Rule established the Board, advisory committees and the position of CEO and defines 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 ensure the Agency's ability to deliver on the expectations of government, the health sector and the community.

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

Other key governance features include:

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

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

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, Disability and Ageing. In accordance with Section 14 of the Agency Rule, the Board sets the strategic and policy direction to achieve the Agency's purpose and oversees performance, governance and resource allocation as custodian of federal, 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.

The Board's efforts are balanced across creating the future and delivering the present. By fulfilling its statutory obligation to produce an annual work program, the Board provides 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 leaders.

Board appointments, functions, powers and procedures are also conferred by the Agency Rule and further clarified in the Board Charter. The Board consists of the Board Chair and at least 6, but not more than 10 other members (currently 10 members at 30 June 2026), all of whom are non-executive members, appointed by the Minister for Health, Disability and Ageing for a term (in aggregate) of up to 3 years. Members who have served on the Board during 2025–26 are listed below.

Ms Lyn McGrath (Chair)

Lyn McGrath is a chair and non-executive director with over 35 years experience at both board and senior executive levels in highly regulated and complex industries including financial services and healthcare. She brings to the Board significant governance and risk management experience.

Ms McGrath is Chair of Heartland Bank Australia Ltd, a subsidiary of Heartland Group (ASX/NZX: HGH); and a non-executive director at Credit Corp Ltd (ASX:CCP), a non-executive director of CIMB Group Holdings Berhad, a Malaysian listed Bank.

Ms McGrath's executive career includes her tenure as Group executive, Retail Banking at Bank of Queensland (ASX:BOQ) where she led a significant business turnaround and launched the Virgin Money Australia Digital Bank. She has also spearheaded large-scale data, digital and technology transformations as well as business turnarounds within ASX 100 organisations. Prior to joining BOQ Ms McGrath spent nearly 12 years at the Commonwealth Bank of Australia (ASX:CBA) where she held several senior positions, including Executive General Manager, Retail, with responsibility for nationwide retail distribution, and Executive General Manager, Wealth Advice, overseeing the bank's financial advice operations.

Ms McGrath has a Bachelor of Arts from Macquarie University and a Master of Business Administration from Macquarie Business School. She is a Graduate of the Australian Institute of Company Directors (AICD), Fellow of Institute of Company Directors Malaysia, Senior Fellow of FINSIA, a Vincent Fairfax Fellow in Ethical Leadership, and a member of Chief Executive Women.

Professor Christine Bennett AO

Emeritus Professor Christine Bennett AO is a company director, strategist and corporate advisor across the health and aged care sectors. She was formerly the Deputy Vice Chancellor, Enterprise and Partnerships (2020–2021) and the Dean, School of Medicine, Sydney (2011–2021) at The University of Notre Dame Australia. Professor Bennett is a specialist paediatrician and has over 40 years of health industry experience in clinical care and governance, strategic planning and health policy, commercial and investment advice, medical education and research and has held chief executive roles in the public, private and not-for-profit sectors. In 2008 Professor Bennett was appointed Chair of the National Health and Hospitals Reform Commission providing advice on a

long-term blueprint for the future of the Australian health system and aged care. She was awarded an Officer of the Order of Australia (AO) in 2014.

An experienced non-executive director in publicly listed, private and social enterprises, Professor Bennett's current roles include non-executive director of Sonic Healthcare (ASX-listed international healthcare company) and Regis Health Care Limited (an ASX-listed aged care provider), Patron of Research Australia, Independent Advisor for the Australian Council of Senior Academic Leaders in Digital Health and the Digital Health Co-operative Research Centre, and Co-convenor of the Champions of Change Coalition STEM and Health Group.

Through her varied career Professor Bennett has deep experience in leadership and governance; developing and implementing public policy; establishing clinical governance systems; advancing data science and digital technologies in health; facilitating research, development and commercialisation; and higher education and professional training. She has a developing interest in AI ethics and applied AI research, completing certification in AI Ethics and Board Oversight in May 2024. She also has a keen interest in consumer-empowered health care and the role of digital health in strengthening quality, efficiency and access in healthcare. Professor Bennett holds a Bachelor of Medicine, Bachelor of Surgery (MBBS) from the University of Sydney and a Master of Paediatrics from the University of New South Wales.

Ms Meegan Fitzharris

Ms Fitzharris has a unique and varied professional background and has worked as a senior government minister, member of parliament, public servant and consultant. She has worked extensively across a range of sectors.

Ms Fitzharris is currently the Director, Partnerships and Engagement at the University of Canberra and is a non-executive director of Dementia Australia and a member of the ACT Heart Foundation Advisory Board.

Ms Fitzharris was an elected member of the ACT Legislative Assembly and served as the Minister for Health, Medical Research, Transport, City Services and Higher and Vocational Education. As Health Minister, Ms Fitzharris also chaired the National Health Ministers Forum. Post politics she chaired the Reform Advisory Group for the Queensland Health Minister in 2020 that developed the *Unleashing the Potential* report, a foundational report for the HEALTHQ32: A vision for Queensland's health system.

She has worked in law enforcement, national security and as the Health Industry Lead at Australia's leading cyber security company, CyberCX. Ms Fitzharris holds a Bachelor of Commerce (First Class Honours) from the University of Otago and a Master of Arts in International Relations (First Class Honours) from the University of Auckland.

Ms Jodie Geissler PSM

Ms Jodie Geissler PSM is Chief Executive Officer, Austin Health, a major tertiary hospital in Melbourne, Victoria.

Prior to this role Ms Geissler held the position of Deputy Secretary, Hospitals and Health Services Division in the Department of Health Victoria. In that role she was responsible for managing hospital and health service commissioning and performance, encompassing both metropolitan and regional health services, along with Ambulance Victoria.

Ms Geissler previously held the role of Chief Executive Officer for the Royal Commission into Victoria's Mental Health System, and positions in the Department of Health Victoria leading the digital health program, and systems

transformation teams. In the Department of Premier and Cabinet Victoria, she led the Health and Human Services team with a focus on NDIS transition and health reform. Ms Geissler holds a Bachelor of Laws from The University of Queensland and a Master of Public Health (Health Systems Management) from Monash University.

Professor Warren Harding AM

Professor Warren Harding AM has a distinguished career in specialist health, strategy, technology and information systems and large complex project delivery experience in Government and Corporate roles across Asia Pacific. He has over 30 years at managing partner level with international consulting firms including Senior Adviser to McKinsey and Co. He was a former ministerial adviser to a Deputy Premier on technology and communications. He was appointed by Cabinet as the WA Minister for Health's Nominee on the WA Sustainable Health Review and was a strong advocate for digital health investment, creating a digital patient journey and closing the gap between health outcomes and costs. He has deep experience in Medtech, digital health innovation and commercialisation and is currently deploying AI-enabled use cases in personalised healthcare, precision medicine, remote patient monitoring and early digital detection of dementia.

Professor Harding is a leading global healthcare consultant; a member of the Department of Health, Disability and Ageing Dementia Expert Reference Group; and an advisory member of the National Institute for Lifespan Health and Wellbeing Research Centre. He is a former Board member of the WA Disability Services Commission and is currently Chair of Alzheimer's WA, leading their research and innovation program to support new models of care and care settings in aged care and for people living with dementia. He holds an appointment by the WA Cabinet as Chair of the Biosecurity Council of WA and is also a state-appointed independent reviewer of a major state-wide industry.

He has a BSc First Class Hons and a Graduate Diploma Media. He is a British Council Scholar, London School of Economics; Professor in the School of Medicine, Macquarie University; Adjunct Professor Faculty of Health Science Curtin University; and Graduate of the AICD. He was appointed a Member of the Order of Australia in 2023 for services to business, technology and community health.

The Hon Brad Hazzard

The Hon Brad Hazzard served for 32 years as the MP for Wakehurst in the NSW Parliament as a Shadow Minister in 17 portfolios and then as a Senior Government Minister in a range of portfolios, including Attorney General and later as Minister for Medical Research and Minister for Health including during the COVID-19 pandemic.

He has served on the Board of the Australian Digital Health Agency since November 2024.

He is also the non-executive Chair of CareFlight, a Board Member of the Sony Foundation, the Lead Reviewer of the Thoroughbred Racing legislation for the NSW Government, and holds a number of advisory roles, including to the Australian Government.

Mr Hazzard holds a Bachelor of Arts (Science) and a Diploma of Education from Macquarie University, a Bachelor of Laws from the University of New South Wales and a Master of Laws from the University of Sydney.

Dr Tanya Kelly

Dr Tanya Kelly is currently Deputy Director-General, Queensland Health, leading the eHealth Queensland Division. She leads the digital health strategic vision for Queensland's public health system in support of broader health system reforms. She is an experienced digital leader and active senior clinician, who has held senior digital health and clinical leadership roles throughout her career.

Dr Kelly recognises that digital health is not only critical to the day-to-day safe functioning of our health system, but also a key change driver. She is passionate about ensuring that digital health amplifies innovation into the future through whole-of-system foundations. Dr Kelly is also an advocate for the broader collaboration needed across the ecosystem, particularly alignment with the national digital health agenda in addressing system-wide challenges and opportunities.

Dr Kelly is a Fellow of the Australian and New Zealand College of Anaesthetists (FANZCA) and the immediate past chair of the Queensland Clinical Senate, a peak body that provides strategic clinician and consumer-led advice to Queensland Health. Beyond her clinical practice (MBBS, BMedSc), she has qualifications in clinical redesign and business and is a Certified Health Informatician (CHIA). Dr Kelly is also a member of the Australian E-Health Research Centre Board.

Mr Daniel McCabe

Mr Daniel McCabe is the First Assistant Secretary of Technology Assessment and Access Division of the Department of Health, Disability and Ageing. He is responsible for providing policy advice on access to medicines, devices and other medical technologies through the Pharmaceutical Benefits Scheme (PBS), Medicare Benefits Schedule (MBS), Life Saving Drugs Program and other targeted assistance programs. Mr McCabe previously had policy responsibility for digital health to connect consumers and healthcare providers with their health information across Australia's health system.

Mr McCabe holds a Bachelor of Information Technology.

Dr Danielle McMullen

Dr Danielle McMullen is an experienced health leader with a sound understanding of the health system across primary care and hospital systems, both public and private. She is a practising GP, with particular interest in women's and children's health.

Dr McMullen has extensive medical advocacy experience and is the current President of the Australian Medical Association. She has represented the medical profession on the Strengthening Medicare Taskforce and has experience providing advice to government through TGA committees and the Mental Health Reform Advisory Committee. She brings strong skills in leadership, governance, media, stakeholder engagement and teamwork.

Dr McMullen is passionate about building a better-connected healthcare system for the benefit of patients and healthcare providers. She holds a Bachelor of Medicine, Bachelor of Surgery (MBBS) from the University of New South Wales.

Professor Keith McNeil

Professor Keith McNeil has spent the last 44 years in the public health system both here in Australia (Queensland and South Australia) and overseas in the National Health Service (NHS) in the UK. He has held senior clinical specialist and leadership roles in heart and lung transplantation and pulmonary vascular disease and latterly moved into the corporate arena as a tertiary/quaternary hospital Chief Executive, health service CEO, and senior Health Department executive at state level, and at a national level in the NHS.

His journey of appointments includes CEO of Metro North Hospital and Health Service, CEO of Cambridge University (Addenbrookes) Hospitals, National Head of IT and Chief Clinical Information Officer (CCIO) for the NHS, and Deputy Director General, CCIO and Chief Medical Officer for Queensland Health. He is currently the Commissioner of the Commission on Excellence and Innovation in Health for the South Australian Government.

Professor McNeil brings a broad and deep experience across healthcare and is passionate about leveraging the digital agenda to transform patient outcomes and embed sustainability in the Australian healthcare system. He holds a Bachelor of Medicine, Bachelor of Surgery (MBBS) from the University of Queensland and is a Fellow of the Royal Australasian College of Physicians, Fellow of the Royal Australasian College of Medical Administrators, Fellow of the Australasian Institute of Digital Health, and previous Member of the Royal Society of Medicine.

Board meetings

The Board meets regularly in accordance with an annually approved timetable and agenda. The Board convened on 6 occasions throughout 2025–26. In accordance with PGPA Act requirements, Board member terms of appointment and details of the number of Board meetings attended during the financial year are outlined below.

Attendance at Board meetings

Board member (all non-executive)	Period as Board member during 2025–26	Meetings attended/ Eligible to attend
Ms Lyn McGrath, Chair	1 July 2025 to 30 June 2026	6/6
Professor Christine Bennett AO	1 July 2025 to 30 June 2026	6/6
Ms Meegan Fitzharris	1 July 2025 to 30 June 2026	6/6
Ms Jodie Geissler PSM	1 July 2025 to 30 June 2026	6/6
Professor Warren Harding AM	1 July 2025 to 30 June 2026	5/6
The Hon Brad Hazzard	1 July 2025 to 30 June 2026	6/6
Dr Tanya Kelly	1 July 2025 to 30 June 2026	5/6
Mr Daniel McCabe	1 July 2025 to 30 June 2026	6/6
Dr Danielle McMullen	1 July 2025 to 30 June 2026	6/6
Professor Keith McNeil	1 July 2025 to 22 May 2026, and 12 June 2026 to 30 June 2026	6/6

Advisory committees

The Board relies on 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.

Board advisory committees

Clinical and Technical Advisory Committee	The Clinical and Technical Advisory Committee advises on: • the efficient and effective delivery of clinical care using digital health • the architectural integration of digital health systems • changes to digital health system design to improve clinical usability and usefulness based on experience with the use of digital systems • proposed innovations and measures to improve the efficiency and effectiveness of digital health systems for clinicians and users of the system • recommendations in relation to priorities of investment in, and development and implementation of, national digital health systems.
Jurisdictional Advisory Committee	The Jurisdictional Advisory Committee gives guidance on all matters for consideration by the Board in order to facilitate national coordination and consistency across geographic and health sector boundaries. Its members are senior representatives of federal, state and territory health departments.
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 • 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 • standards (including compliance with standards) relating to privacy and security in relation to digital health systems.

Audit and Risk Committee

The final advisory body, an Audit and Risk Committee, was established to help the Board discharge its responsibilities mandated by Section 45 of the PGPA Act and Section 17 of the Public Governance, Performance and Accountability Rule 2014 (PGPA Rule) which sets out the committee's powers of review of financial reporting, performance monitoring, risk oversight and management, internal control and legislative and policy compliance.

The Audit and Risk Committee provides assurance and advice to the Board on the Agency's risk, governance, compliance and assurance frameworks and the integrity of its performance and financial reporting. Its efforts are aimed at championing a positive risk-aware culture that encourages a robust risk management framework and system of internal controls that support risk-informed decision-making, anticipation of risk and focus on effective assurance, internal audit, protective security, fraud control and business continuity activities.

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 supports 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.

Audit and Risk Committee	The Audit and Risk Committee responsibilities under the PGPA Act and PGPA Rule includes: • **financial reporting:** activities such as advising on the Agency's preparation and review of its annual financial statements, the adequacy of the internal budgeting and reporting and obligations under the PGPA Act and other relevant Acts • **performance reporting:** reviewing the framework of key performance indicators and other performance measures and the Agency's annual performance statements, including making recommendations on concerns or opportunities identified by internal or external audits • **system of risk oversight and management:** advising and approving the Agency's annual internal audit plan; advising about professional standards to be used by internal auditors in the course of carrying out audits; reviewing the Agency's response to internal and external audits; and reviewing the risk management framework, which includes the Agency's Resilience and Agility Program and Crisis Management Plan. • **system of internal control:** reviewing the Agency's system of internal controls, including compliance frameworks, governance arrangements and internal control environment in line with the Agency's strategic risk.

Audit committee disclosures

Amendments to the PGPA Rule 2014 in February 2020[6] give greater transparency over audit committee membership and remuneration. The disclosure requirements align the disclosure of Commonwealth public sector audit committee members' information in relation to names, qualifications, skills, attendance at meetings and remuneration with better practice in the corporate sector. The *ASX Corporate Governance Principles and Recommendations*[7] recommends that listed companies disclose much of the information included in these items. In accordance with the new statutory requirements, the electronic address of the Audit and Risk Committee's charter (the landing page on which a link to the charter is hosted) is https://www.digitalhealth.gov.au/about-us/organisational-structure/board-advisory-committees.

[6] Section 17BE (taa) of the Public Governance, Performance and Accountability Rule 2014.

[7] ASX Corporate Governance Council – Corporate Governance Principles and Recommendations, 4th edition, recommendation 4.1, pp. 19–20.

Member name	Qualifications, knowledge, skills or experience	Attendance at meetings / eligible to attend	Total remuneration GST inclusive	Additional information
Maria Storti	Ms Storti serves as an independent member of several Commonwealth audit committees and is a non-executive director. She is a former Ernst & Young advisory partner and has worked with professional services firms in the areas of audit, consultancy and risk. She has also held senior executive roles in various sectors, including government and education. *Qualifications*: MBA, Bachelor of Economics, Fellow of Chartered Accountants Australia & New Zealand, Fellow of the AICD, member of the Australian Institute of Internal Auditors.	6/6	$51,999.96	Chair
Prof Keith McNeil	Professor McNeil has spent the last 44 years in the public health system both here in Australia (Queensland and South Australia) and overseas in the National Health Service (NHS) in the UK. He has held senior clinical specialist and leadership roles in heart and lung transplantation and pulmonary vascular disease and latterly moved into the corporate arena as a tertiary/quaternary hospital Chief Executive, health service CEO, and senior Health Department executive at state level, and at a national level in the NHS. His journey of appointments includes CEO of Metro North Hospital and Health Service, CEO of Cambridge University (Addenbrookes) Hospitals, National Head of IT and Chief Clinical Information Officer (CCIO) for the NHS, and Deputy Director General, CCIO and Chief Medical Officer for Queensland Health. He is currently the Commissioner of the Commission on Excellence and Innovation in Health for the South Australian Government. Professor McNeil brings a broad and deep experience across healthcare and is passionate about leveraging the digital agenda to transform patient outcomes and embed sustainability in the Australian healthcare system. *Qualifications:* Bachelor of Medicine, Bachelor of Surgery (MBBS), University of Queensland; Fellow of the Royal Australasian College of Physicians; Fellow of the Royal Australasian College of Medical Administrators; Fellow of the Australasian Institute of Digital Health; previous Member of the Royal Society of Medicine.	5/6	$0	Agency Board member Reappointed to the ARC 12/06/2026

Member name	Qualifications, knowledge, skills or experience	Attendance at meetings / eligible to attend	Total remuneration GST inclusive	Additional information
Dr James Myerscough	Dr Myerscough has had a distinguished career as Chief Risk Officer in the financial services industry, consistently implementing a clear, practical approach to risk management. He has acted as a director of material subsidiary entities through times of significant change and challenge. He applies an exceptional background in numerous disciplines and a strong focus on business objectives to bind together the technical and the practical. He holds an outstanding track record of significantly improving the value of risk management activities to executives and boards through this approach. Dr Myerscough is currently engaged as the Chief Risk Officer of Lawcover Insurance, mentoring financial services Chief Risk Officers, and serves as a non-executive director for World Share Australia, a not-for-profit organisation supporting international aid projects. *Qualifications*: Doctor of Philosophy in Engineering Sciences, University of Oxford; Bachelor of Engineering (Electrical), University of Sydney; Bachelor of Science, Applied Mathematics, University of Sydney; Graduate of the AICD.	6/6	$29,805.14	
Mr Mark Ridley	Mr Ridley has served as an independent chair and member of audit and risk committees for several large and medium-sized Commonwealth agencies since 2011. This includes the Australian Signals Directorate, the departments of Foreign Affairs and Trade, Defence, Home Affairs, and Human Services, the Australian Federal Police and the Australian National University. He also advises entities on the governance and risk management of information and communications technology (ICT)–based programs. He was formerly a senior partner of PwC Australia and has held leadership roles in risk advisory work, internal audit and ICT project assurance. *Qualifications*: Bachelor degrees in Commerce and Accounting, Fellow of Chartered Accountants Australia and New Zealand (FCA), Graduate of the AICD.	6/6	$30,000.00	Appointed to the Audit and Risk Committee 16 July 2025

Internal governance

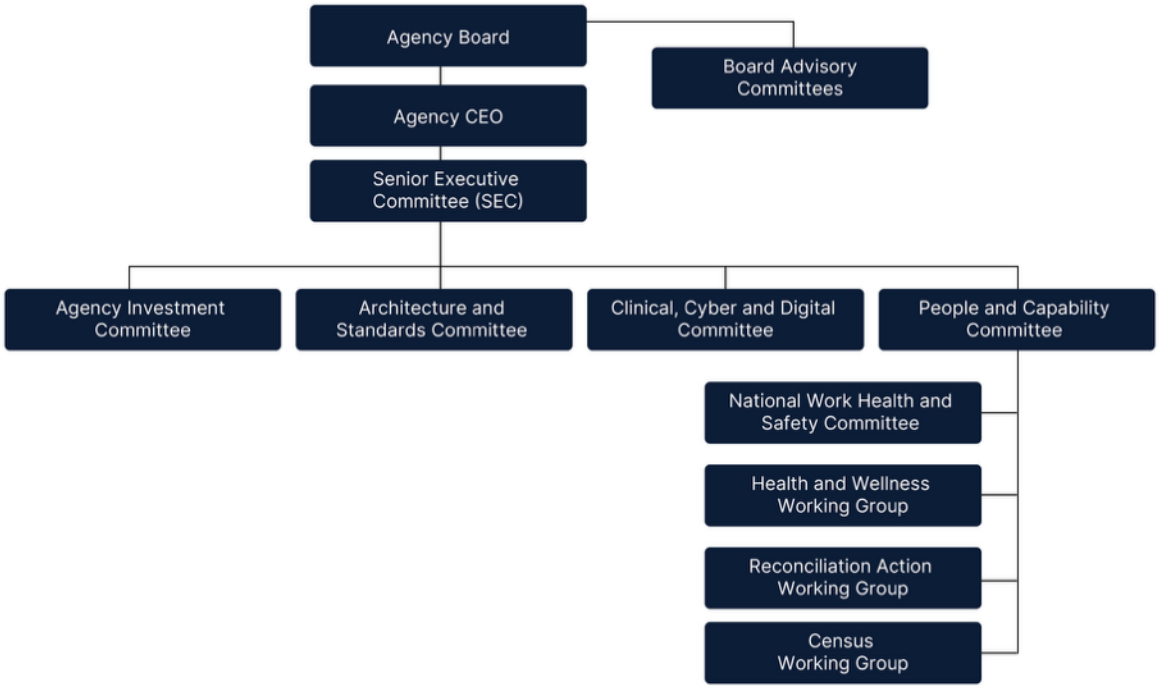
Chief Executive Officer

The CEO leads the Agency in implementing a portfolio of work that supports the Board's vision. Under Section 53 of the Agency Rule, the CEO 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. The CEO is the primary point of liaison between the Board and senior management.

Senior Executive Committee

The CEO is supported by the Senior Executive Committee. 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.

Internal committees



A range of internal committees also support the leadership and risk management that allow the Agency to deliver on its strategic priorities. The committees were formed after a comprehensive review of the Agency's governance framework with a particular focus on strengthening and streamlining effective, efficient, accountable and transparent decision-making. With a principles-based approach aligned to key activities, the risk management framework and system of internal controls, the Agency has implemented the following fit-for-purpose and streamlined governance committee structure.

The Agency's internal committees are:

Senior Executive Committee	Provides strategic oversight to all Agency committees and is the ultimate escalation point for both committee and other functional advisory and decision-making needs of the Agency.
Agency Investment Committee	Ensures the Agency effectively and appropriately plans and resources its work in line with the *Public Governance, Performance and Accountability (PGPA) Act 2013*, government priorities and the Intergovernmental Agreement (IGA) on Digital Health to support the delivery of improvements to the use, uptake and information sharing of national digital health products and services.
Architecture and Standards Committee	Ensures the Agency continues to deliver national digital health infrastructure that supports the transformation to a contemporary, connected, data-rich system. This enables real-time, accessible and user-centred products and services.
Clinical, Cyber and Digital Committee	Ensures accelerated digitally connected healthcare by embedding clinical considerations across all Agency work, facilitating interoperability across the health system and overseeing secure data use. This includes guiding consumer-centric digital service delivery and upholding trust, privacy and national interests in line with relevant laws and standards.
People and Capability Committee	Ensures the Agency continues to build a high-performing, high-integrity, accountable, adaptable, transparent and safe Agency culture with a focus on leadership and capability development and staff retention.

Risk management

The Agency is committed to comprehensive and coordinated risk management across its strategic, tactical and operational objectives. In June 2025 the Board approved the revised risk management framework, which includes the risk appetite statement and system of internal controls. The framework aligns to the international standard on risk management (AS/NZS ISO 31000) and the 2023 Commonwealth Risk Management Policy. The framework and the system of internal controls are designed to support the delivery of the Agency's strategic objectives by ensuring that potential adverse events, threats and uncertainties are identified, analysed, evaluated and treated. An equal focus is placed on a positive risk awareness culture, identifying emerging risk and capturing and escalating active and ongoing risks.

Audit arrangements

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

Internal audit

The Agency's 2025–26 Strategic Internal Audit Plan (Audit Plan) was delivered by Axiom Associates. The plan was informed by the Agency's risk environment and through collaboration with Agency Executive and was endorsed by the Audit and Risk Committee and approved by the Board. In 2025–26, the Audit Plan focused on high-risk high-value contract management process, the implementation of the *Auditor-General Report No. 36 2023–24 Procurement of My Health Record*, performance measures effectiveness and travel allowance process. All audit products are presented to the Audit and Risk Committee, and implementation of recommendations is actively monitored to improve Agency processes and performance. The Agency continues to focus audit resources on areas of high risk while being flexible enough to respond to emerging risks and changing demands. The 2026–27 Audit Plan is underway to further mature the Agency's capability to deliver its products and services.

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), audited the Agency's financial statements to ensure they were 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. The Auditor-General issued an unmodified audit report for the 2025–26 financial statements of the Agency.

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.

No performance audits were conducted by the ANAO on Agency operations in 2025–26.

Regulatory responsibilities

A Statement of Expectation for the Agency was issued by the Minister for Health, Disability and Ageing on 26 November 2025. The Statement of Expectation focused the Agency's role as a regulator of the *My Health Records Act 2012*, role as a steward of national digital health infrastructure and responsibilities in shaping the strategic direction of Australia's digital health ecosystem. In response, the Agency issued its Statement of Intent on 21 January 2026, outlining how it will meet the Minister's expectations, deliver its functions under its enabling legislation and discharge its responsibilities as a regulator of the *My Health Records Act 2012.* The Agency's activities and achievements in meeting the expectations set out in the Statement of Expectations are summarised throughout this Annual Report.

Procurement performance

The Agency has reviewed its internal procurement policies and practices and assessed its compliance against the Commonwealth Procurement Rules (CPRs). Further information on the Agency's procurement activities is available on AusTender.

During 2025–26, internal audit activities did not identify any material procurement or contract management non-compliance, with resulting recommendations focused on continuous improvement opportunities to further strengthen the Agency's procurement and contract management practices. The Agency was not subject to any audits by the ANAO audits regarding procurement or contract management, and there have been no findings against the Agency under the *Government Procurement (Judicial Review) Act 2018*.

The Agency has noted non-material instances of non-compliance with the CPRs with 15% of contract notices for approaches to market on or after 1 July 2025 being published late. The Agency is undertaking action to improve performance, including through policy reviews, process improvements and lessons learned from procurement activities.

For the period 1 July 2025 to 30 June 2026, the Agency executed 33 limited tenders. The Agency also completed 100 panel procurements and 2 open tender approaches. The Agency remains committed to maintaining effective procurement governance and continues to enhance its procurement policies, guidance, processes and capability to support compliance with the CPRs and the achievement of value-for-money outcomes.

Protective security

The Agency continued to strengthen its protective security arrangements in line with the Protective Security Policy Framework. Key activities included improving physical and personnel security, managing insider and foreign interference risks, strengthening oversight of third-party partners and delivering targeted security awareness initiatives.

Security risk assessments, monitoring and reviews supported continuous improvement and organisational resilience. No material protective security incidents, insider threat events or foreign interference matters were reported during 2025–26.

Fraud and corruption control

The Agency's 2024–26 Fraud and Corruption Control Plan and supporting policy set expectations for professional, accountable and ethical conduct. The plan is supported by policies and procedures, including the accountable authority instructions, that promote responsible public administration and safeguard Agency resources. It will be reviewed in 2026–27.

In 2025–26, the Integrity Unit strengthened the Agency's pro-integrity culture and reviewed its conflict of interest and gifts, benefits and hospitality frameworks to align with Australian Public Service Commission requirements and relevant ANAO recommendations. The Agency also reviewed its fraud and corruption controls following the introduction of the revised Commonwealth Fraud and Corruption Control Framework in July 2024.

The Agency will introduce its first Integrity Action Plan in 2026–27 to further strengthen culture, systems and accountability. No material instances of fraud were reported in 2025–26.

Business continuity

In 2025–26, the Agency led a coordinated Resilience and Agility Program to strengthen its ability to respond to and recover from crises and disruptive events in line with its Crisis Management Plan. This included confirming business continuity impacts and dependencies, recovery priorities and minimum operating requirements for critical Agency functions and services. These activities made business continuity plans more practical and consistent and helps the Agency sustain its essential operations during disruptions and restore services in a coordinated way. The activities also improved the function's ability to provide practical advice; guide preparedness, response and recovery activity; and support a more mature, informed and coordinated approach across the Agency.

Under this program, the Agency has undertaken collaborative exercises to strengthen crisis response and identify practical enhancements, including conducting post-event reviews to monitor and improve processes, to support accountability, visibility and closure.

External scrutiny

The Agency is accountable to the Australian Government through the Minister for Health, Disability and Ageing and to state and territory health ministers through the National Federation Reform Council. It reports quarterly to the Australian Health Ministers' Advisory Council, which is responsible for providing strategic and operational support to the National Federation Reform 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.

Judicial decisions or administrative reviews

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

Parliamentary, Ombudsman, Australian Information Commissioner reports

The Agency did not appear before the Senate Estimates (Community Affairs Legislation) Committee public hearings for 2025–26. The Agency was not called to appear at the October or December 2025 Supplementary Budget Estimates hearings; was scheduled to appear at the February 2026 Additional Estimates hearings but was released before appearing; and was not called to appear at the May–June 2026 Budget Estimates hearings.

No reports on the Agency were released by a parliamentary committee or the Commonwealth Ombudsman. Every year the Australian Information Commissioner produces a report that touches directly on the work of the Agency as My Health Record System Operator. The Information Commissioner has a statutory obligation to produce an annual report on digital health compliance and enforcement activity in accordance with Section 106 of the *My Health Records Act 2012*. That Act contains provisions that protect and restrict the collection, use and disclosure of personal information. The Australian Information Commissioner monitors and enforces compliance with those provisions as the independent regulator of the privacy aspects of the My Health Record system. A copy of the latest report can be found at Digital health annual reports | Office of the Australian Information Commissioner.

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 reacting 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 2025–26, the Agency received 124 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.

Additional reporting requirements under the PGPA Rule

Ministerial directions and policy orders

The PGPA Rule provides that the Minister for Health, Disability and Ageing 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 2025–26 reporting period.

Compliance with finance law

The PGPA Rule requires that the Agency report on any significant non-compliance during 2025–26 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 2025–26 reporting period.

Significant activities and changes

The PGPA Rule also requires the Agency to provide details of significant activities and changes that affected the operations or structure of the entity during the reporting year. The PGPA Rule requires the Agency to notify the Minister for Health, Disability and Ageing 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 of that nature arose during 2025–26.

Related entity transactions

The Agency is an Australian Government–controlled corporate Commonwealth entity. It has a governing Board of members, a CEO and SEC members and a Portfolio Minister.

Pursuant to AASB 124 Related Party Disclosures (AASB 124), Agency Key Management Personnel (KMP) are asked to provide details of where any of their close family members, or a controlled Agency/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 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 SEC members constitute KMP. This includes those acting in a role for 3 months or more continuously.

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.

During 2025–26, the Agency transacted for specific services with related parties including:

- the provision of My Health Record and other digital health services and contact centre services from Services Australia
- the provision of shared services from the Department of Health, Disability and Ageing
- accommodation sub-lease arrangements with the Department of Health, Disability and Ageing
- accommodation sub-lease arrangements with Intellectual Property Australia
- managed services from the Commonwealth Scientific and Industrial Research Organisation for the National Clinical Terminology Service
- the provision of services to support digital health initiatives to the Department of Health, Disability and Ageing
- the provision of services to support the Agency's digital health programs and outcomes with various state/territory government entities.

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

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 2025–26 the Agency maintained directors' and officers' liability insurance, which covers Board members as part of its overall insurance arrangements with the Commonwealth's self-managed insurance fund, Comcover. The premium paid for this coverage for 2025–26 was $243,763.36 (GST inclusive).

Human resources management

In April 2026, the Agency launched its People Strategy 2026–28, setting a vision for a future-ready, capable and innovative workforce with a high-performing, collaborative culture.

Building on the Workforce Strategy 2021–2026, the new strategy responds to rapid technological change, fiscal constraints, demographic shifts and the need to strengthen internal APS capability. Key achievements in 2025–26 included initiatives to strengthen leadership, career pathways, diversity and inclusion, flexible work, wellbeing and psychosocial safety, as well as a reduced gender pay gap.

The strategy identifies 5 workforce priorities:

- an AI-enabled workforce
- an innovative and continuously learning workforce
- a connected, collaborative and system-minded workforce
- a diverse, inclusive and purpose-driven workforce
- future-ready leaders who enable high performance and talent development.

Values-based and people-centred culture

The Agency has continued to build a values-based, inclusive and people-centred culture, consistent with the People Strategy's focus on a diverse, inclusive and purpose-driven workforce and a connected, collaborative and system-minded workforce. The Agency facilitated opportunities to:

- collaborate and connect through all-staff meetings, in-office events and corporate-giving campaigns
- engage to ensure staff understand how they contribute to the Agency's mission, recognised through executive messaging and the Agency's recognition program
- listen through a continuous feedback loop, including the APS Employee Census and internal surveys.

In 2025–26 the Agency took steps to bring core work in-house in line with the APS Strategic Commissioning Framework. Our targets aimed to bring $500,000 (GST excl.) of core work in-house in the job family Portfolio Program and Project Management. This target was partially achieved, with an actual reduction of $137,358 (GST excl.) in relevant supplier expenditure.

A key area of focus over 2025–26 was improving onboarding and induction processes, as this was recognised as a key contributor to employee experience, which contributes to stronger retention.

The Agency continued to mature recruitment, onboarding and induction processes, supported by the full implementation and optimisation of e-Recruit. The system provides an end-to-end recruitment solution integrated with ServiceNow and supports improved data accuracy, process efficiency and workforce reporting.

The Agency continued to embed the Essential Learning Program, which was developed in response to staff feedback and aligned to legislative, Enterprise Agreement and Agency requirements. The program supports consistent mandatory learning and reinforces the behaviours and positive culture the Agency seeks to maintain.

Workforce capability

The Agency continued to invest in workforce capability in line with the People Strategy 2026–2028, with a focus on AI, data and digital literacy, cyber awareness, continuous learning, APS capability and career pathways. Development opportunities included Agency workshops, leadership programs, external learning platforms, tailored training and study support.

The Agency's annual graduate program continued to build entry-level pathways and future digital health leaders through APS-wide and Agency-specific learning, mentoring and work rotations. The Agency also strengthened internal APS capability in core functions to support sustainable delivery and alignment with the APS Strategic Commissioning Framework.

Leadership development and empowerment

The Agency continued to build future-ready leadership capability, aligned with the People Strategy priority of enabling high performance, talent development, adaptive leadership and strong stewardship of national digital health transformation.

Since the launch of the APS SES Performance Leadership Framework in October 2023, the Agency has taken a range of actions to implement and embed the core elements of the Framework. This includes updated performance criteria to reinforce that behaviours are as important as outcomes when delivered for government and embedding continuous feedback via a 360-degree feedback cycle.

To extend and leverage implementation of the SES Framework, the Agency developed our DRIVE leadership development programs targeting APS6 to EL2 employees. These programs align to the APS Values and Secretaries Charter of Leadership Behaviours, aiming to increase our collective leadership impact. Participants benefit from

invaluable insights and practical strategies on crucial aspects of leadership, enabling safe, inclusive and trusted team cultures, while strengthening partnership and accountability for improved outcomes. This work supports leaders to navigate complexity, strengthen systems thinking, lead through change and create safe, inclusive and high-performing teams.

During 2025–26, the Agency also progressed work to strengthen talent management, including a more consistent and transparent approach to identifying, developing and retaining leadership and specialist capability. A new Talent Management Framework is scheduled to launch in late 2026. Leaders and managers within the Agency also benefit from additional development opportunities through the APS Academy, Growth Faculty and LinkedIn Learning.

Diversity and inclusion

The Agency continued to strengthen diversity, equity and inclusion, consistent with the People Strategy's focus on a diverse, inclusive and purpose-driven workforce that reflects the communities the Agency serves. Our 2026 Census results show that 35% of our staff identify as culturally and linguistically diverse and 87% of staff feel the Agency supports and actively promotes an inclusive workplace culture. This is 6% higher than similar-sized agencies and 5% higher than the APS overall.

The Agency's second Innovate Reconciliation Action Plan (RAP) will be launched in July 2026. This represents an important milestone in our ongoing reconciliation journey and our commitment to creating a more inclusive, culturally safe and equitable digital health system for Aboriginal and Torres Strait Islander peoples.

Since commencing our reconciliation journey in 2020 and launching our first Innovate RAP in 2023, the Agency has:

- strengthened partnerships with Aboriginal community-controlled health organisations (ACCHOs) and peak bodies
- increased procurement from Aboriginal and Torres Strait Islander businesses
- embedded Welcome to Country and Acknowledgement of Country practices across Agency events
- supported Aboriginal and Torres Strait Islander graduate pathways and workforce initiatives
- expanded engagement and education activities that improve digital health literacy and access.

The Agency recognises the significance of National Reconciliation Week, NAIDOC Week and National Close the Gap Day with all-staff events and activities.

In 2025, the Agency submitted our report to the Workplace Gender Equality Agency, covering the reporting period from 1 January 2024 to 31 December 2024. The results revealed that the Agency's gender pay gap stood at 3.4%, which is 3.8 percentage points lower than the comparison group. Due to size, the Agency had increased reporting requirements for the 2024 calendar year. The Agency continues to be compliant under the *Workplace Gender Equality Act 2012*, including in relation to these additional requirements.

On 4 December 2025, the Workplace Gender Equality Agency advised that from 2026 onwards, Commonwealth public sector employers of 100 or more employees must lodge their reports between 1 April and 31 May. This changed lodgement period reflects a merging of the public sector and private sector gender equality reporting programs. In 2026, the Agency submitted its report to the Workplace Gender Equality Agency, covering the reporting period from 1 January 2025 to 31 December 2025. The results revealed that the Agency's gender pay gap decreased and now stands at 2.7%. The Agency remains committed to gender equality and is actively working to strengthen efforts in this area. Our initiatives include the finalisation of the new People Strategy, the development of a Diversity and Inclusion Action Plan, and ongoing engagement with the Workplace Gender Equality Agency. These efforts will further reinforce our dedication to promoting gender equality within our workforce.

A diversity and inclusion action plan to be developed in 2026–27 will support delivery of the People Strategy by embedding diversity, equity and inclusion in recruitment, development and leadership practices, strengthening

accessibility and supporting progress against workforce representation goals. These goals will continue to strengthen the current sentiment from staff regarding respectful and inclusive culture.

Flexible work arrangements

The Agency continued to mature flexible working arrangements as part of its employee value proposition and its commitment to high-performing, inclusive, hybrid and dispersed teams. Flexible work arrangements support productivity, engagement, attraction, retention and wellbeing, as well as the Agency's diverse and inclusive workforce and digital operating model through arrangements such as part time, flexible hours, compressed work week and working away from the office or at home.

The 2026 Census results highlighted a high level of satisfaction with the Agency's arrangements, noting that:

- 89% of staff report that they are satisfied with their non-monetary employment conditions (e.g. leave, flexible working arrangements, other benefits)
- 95% of employees agreed that they were confident a flexible work request would be given reasonable consideration.

These approaches support the People Strategy's focus on building leadership, management and functional capability for hybrid, dispersed teams, while sustaining productivity, wellbeing, inclusion and engagement.

Staff statistics

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 2026, the Agency employed 737 staff under both those arrangements with offices located in Brisbane, Sydney and Canberra.

The tables below give a breakdown of staff across offices in the form mandated by a 2019 amendment to the PGPA Rule 2014.[8] The tables record the numbers of ongoing (permanent) and non-ongoing (temporary) staff, full-time or part-time status, gender and location, with data for both the current and previous year.

[8] Inclusion of a new Section 17BE(ka) in the Public Governance, Performance and Accountability Rule 2014.

All ongoing employees current report period (2025–26)

	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	
NSW	83	2	85	116	8	124	-	-	-	-	-	-	-	-	-	209
Qld	101	3	104	154	17	171	-	-	-	-	-	-	-	-	-	275
SA	2	-	2	7	1	8	-	-	-	-	-	-	-	-	-	10
Vic	9	-	9	19	1	20	-	-	-	-	-	-	-	-	-	29
WA	-	-	-	1	1	2	-	-	-	-	-	-	-	-	-	2
ACT	65	2	67	115	9	124	-	-	-	-	-	-	-	-	-	191
Total	260	7	267	412	37	449	-	-	-	-	-	-	-	-	-	716

All non-ongoing employees current report period (2025–26)*

	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total	
NSW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	3	-	-	17	-	-	-	-	-	-	-	-	-	21

* To avoid unintentional identification of employees who identified as non-binary, preferred not to indicate a gender or used a different term (other than male, female or non-binary) in the current reporting period, only aggregate totals for Man/Male, Woman/Female and the total of non-ongoing employees are reported.

All ongoing employees previous report period (2024–25)

	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full time	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	
NSW	92	2	94	102	10	112	-	-	-	-	-	-	-	-	-	206
Qld	104	3	107	146	10	156	-	-	-	-	-	-	-	-	-	263
SA	1	0	1	1	0	1	-	-	-	-	-	-	-	-	-	2
Tas	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	1
Vic	6	-	6	8	1	9	-	-	-	-	-	-	-	-	-	15
WA	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	1
ACT	67	1	68	112	7	119	-	-	-	-	-	-	-	-	-	187
Total	271	6	277	369	29	398	-	-	-	-	-	-	-	-	-	675

All non-ongoing employees previous report period (2024–25)*

	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full time	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	**Full time**	**Part time**	Total	
NSW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	15	-	-	45	-	-	-	-	-	-	-	-	-	61

* To avoid unintentional identification of employees who identified as non-binary, preferred not to indicate a gender or used a different term (other than male, female or non-binary) in the previous reporting period, only aggregate totals for Man/Male, Woman/Female and the total of non-ongoing employees are reported.

Executive remuneration

In April 2019, the PGPA Rule was amended to provide greater clarity over Commonwealth executive remuneration and to standardise annual report disclosure of the remuneration of KMP, senior executives and other highly paid staff. In 2020, the PGPA Rule was further amended to extend remuneration reporting to members of the Agency's Audit and Risk Committee. These new requirements recognise the heightened interest from Parliament and the public for transparency over remuneration arrangements. They are to replace online reporting of executive remuneration on the Agency's website introduced in 2016–17 and supplement aggregate reporting for KMP in financial statements. The disclosures include KMP, senior executives and other highly paid staff.

Key management personnel (KMP)	Under accounting standards, KMP are defined as having authority and responsibility for planning, directing and controlling the activities of the Agency. The Agency has determined KMP to be its Board members, its CEO and Senior Executive Committee. This is consistent with the reporting of the Agency's KMP in its financial statements (in Part 4). Under the new arrangements, KMP, their positions and total remuneration package are identified, reflecting the shift to individual (rather than aggregate) reporting for the Agency's Board and leadership team.
Senior executives	Senior executives encompass the Agency's branch managers and anyone (who does not qualify as a KMP) who is responsible for decision-making or having substantial input to decisions affecting the operations of the Agency.
Other highly paid staff	Whereas the above 2 categories are determined by role or classification, this final category, other highly paid staff, is decided solely on the basis of remuneration. It captures any staff who are neither KMP nor senior executives whose total remuneration exceeds an annual reporting threshold of $265,000 for the 2025–26 reporting period (this figure is indexed yearly).

Remuneration policies and practices

The Agency employs APS employees under the *Public Service Act 1999* and common law employees under the Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016.

Following APS-wide bargaining, the Agency completed agency-level bargaining consistent with the Public Sector Workplace Relations Policy 2023. The Australian Digital Health Agency Enterprise Agreement 2024–2027 was approved by the Fair Work Commission on 27 March 2024 and came into operation on 3 April 2024. Of eligible Agency staff, 81% voted with 90% voting in support of the new Agreement.

The new Agreement resulted in an 11.2% pay increase applied over 3 years to both APS and common law employees (if they were within the salary bands). When compared to previous entitlements, the APS common conditions provided Agency staff with:

- 30 improved conditions
- 13 conditions that remained the same or equal
- one condition was retained as it was better than the APS Common Condition.

The Enterprise Agreement resulted in greater consistency of conditions across the Agency. Common law employees are now able to access flex time for APS 1 to 6 employees, executive time off in lieu, an increase in personal leave entitlements from 15 to 18 days, eligibility for workplace responsibility allowance payments and alignment of superannuation entitlements to 15.4%.

Remuneration governance arrangements

During the reporting period the Agency's Remuneration Committee has remained active to systematically track, monitor and ensure compliance with legislative obligations. This committee also considers remuneration regarding attraction and retention, acknowledging the Agency has a high proportion of specialist roles that often attract higher salaries outside the public sector. The Remuneration Committee will also consider individual flexibility arrangements applications and reviews, along with SES remuneration.

Remuneration levels for SES employees are managed in accordance with the APS Executive Remuneration Policy and the Public Sector Workplace Relations Policy 2023. The CEO determines the appropriate level of pay for SES positions in line with SES remuneration policy. Remuneration levels are reviewed annually with consideration to individual performance, organisation performance and affordability, market competitiveness and the remuneration framework.

The CEO position is managed through the Remuneration Tribunal, an independent statutory authority that handles remuneration of key Commonwealth offices.

Remuneration tables

Under requirements introduced in the 2019–20 reporting year, each of the Agency's KMP names, positions and remuneration packages are identified.

Key management personnel

The remuneration information in the tables below is presented in accordance with 2019 amendments to the PGPA Rule.[9] The amounts presented reflect prescribed reporting requirements and include salary, employer superannuation contributions, and other reportable benefits, where applicable. Some year-on-year increases reflect a full year of service in 2025–26, compared with part-year service following appointment in 2024–25.

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

Remuneration of key management personnel

		Short-term benefits ($)			Post-employment benefits ($)	Other long-term benefits ($)		Termination benefits ($)	Total remuneration ($)
Name	**Position title**	**Base salary**	**Bonuses**	**Other benefits and allowances**	**Superannuation contributions**	**Long service leave**	**Other long-term benefits**		
Amanda Cattermole	Chief Executive Officer	512,532	-	3,616	81,940	14,450	-	-	612,537
Joanne Greenfield	Chief Operating Officer	336,432	-	13,479	54,811	16,285	-	-	421,007
Paul Creech	Chief Program Officer	360,312	-	3,660	67,097	15,298	-	-	446,367
Peter O'Halloran	Chief Digital Officer	383,815	-	3,679	59,922	10,828	-	-	458,245
John Borchi	Chief Technology Officer	360,038	-	10,503	58,152	10,193	-	-	438,885
Dr Amandeep Hansra	Chief Clinical Advisor (Medicine)	262,823	-	-	37,429	2,052	-	-	302,304
Karen Booth	Chief Clinical Advisor (Nursing)	210,617	-	-	31,925	1,610	-	-	244,153
Lyn McGrath	Board Chair	134,462	-	-	16,135	-	-	-	150,597
Danielle McMullen	Board Member	79,238	-	-	9,509	-	-	-	88,747
Brad Hazzard	Board Member	79,238	-	-	9,509	-	-	-	88,747
Warren Harding	Board Member	67,236	-	-	8,068	-	-	-	75,304
Meegan Fitzharris	Board Member	67,236	-	-	13,601	-	-	-	80,837
Christine Bennett	Board Member	67,236	-	-	8,068	-	-	-	75,304

Senior executives

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

Other highly paid staff

The final category to be reported is other highly paid staff – defined as employees who do not fall into the categories above (KMP or senior executives) but whose average reportable remuneration was $265,000 or more during the financial period.

The value of remuneration packages for senior executives and other highly paid staff is presented in the tables below.

Remuneration of senior executives

		Short-term benefits ($)			Post-employment benefits ($)	Other long-term benefits ($)		Termination benefits ($)	Total remuneration ($)
Total remuneration bands	Number of senior executives	Average base salary	Average bonuses	Average other benefits and allowances	Average superannuation contributions	Average long service leave	Average other long-term benefits	Average termination benefits	Average total remuneration
0–220,000	-	-	-	-	-	-	-	-	-
220,001–245,000	-	-	-	-	-	-	-	-	-
245,001–270,000	-	-	-	-	-	-	-	-	-
270,001–295,000	3	236,533	-	3,842	38,977	4,513	-	-	283,865
295,001–320,000	3	253,138	-	4,679	41,743	4,032	-	-	303,592
320,001–345,000	12	274,241	-	9,020	43,556	6,673	-	-	333,490
345,001–370,000	1	307,608	-	11,923	45,125	929	-	-	365,586
370,001–395,000	-	-	-	-	-	-	-	-	-
395,001–420,000	-	-	-	-	-	-	-	-	-

Remuneration of other highly paid staff

		Short-term benefits ($)			Post-employment benefits ($)	Other long-term benefits ($)		Termination benefits ($)	Total remuneration ($)
Total remuneration bands	Number of senior executives	Average base salary	Average bonuses	Average other benefits and allowances	Average superannuation contributions	Average long service leave	Average other long-term benefits	Average termination benefits	Average total remuneration
260,001–270,000	1	195,680	-	33,833	33,944	1,881	-	-	265,338
270,001–295,000	2	193,232	-	51,095	36,332	2,645	-	-	283,304
295,001–320,000	1	241,952	-	23,939	35,223	1,081	-	-	302,196

Mandatory reporting requirements under various Commonwealth legislation

Workplace health and safety

Valuing the Agency's people extends to recognising the responsibility to promote their health and wellbeing and to meet employer obligations under the *Work Health and Safety Act 2011* (WHS Act).

The Agency continued to strengthen its approach to workplace health and safety during 2025–26, with a focus on supporting a safe, healthy and inclusive working environment across office-based, hybrid and dispersed work settings.

The Agency's National Work Health and Safety Committee is the key forum that supports the Agency's health and safety culture. It oversees and coordinates the Agency's compliance with the WHS Act and its implementation, including the development of work, health and safety (WHS) policies and promotion of safe work practices. Committee representatives worked closely with senior managers and supervisors to deliver a number of prevention and early intervention initiatives to minimise the risk of workplace injuries and enable staff to work in a happy and healthy environment and maintain a work–life balance.

The Agency continued to support managers and employees through practical guidance, learning, consultation and reporting mechanisms that help identify risks early and strengthen prevention-focused controls. These activities complement the People Strategy 2026–2028 by supporting high-performing, inclusive and psychologically safe teams.

Workplace health and safety activities were informed by staff feedback, operational needs and the Agency's ongoing commitment to identify, assess and manage physical and psychosocial hazards. This included continued attention to wellbeing, workload, consultation, leadership capability and the safe management of flexible work arrangements. Throughout 2025–26, the Agency focused on initiatives to promote and increase the physical and psychological wellbeing of staff. The Agency:

- conducted a comprehensive review of its WHS committee structure to improve staff representation and ensure effective WHS support
- enhanced the capability of WHS networks through targeted development and support for Health and Safety Representatives, First Aid Officers, Mental Health First Aid Officers and Harassment Contact Officers
- underwent a proactive inspection from Comcare regarding its WHS consultation, coordination and cooperation arrangements, which affirmed the effectiveness of the Agency's practices
- continues to provide all staff, including contractors, with access to our Employee Assistance Program
- facilitates workstation assessments and workplace adjustments for staff
- provides dedicated case management support for both early intervention and cases requiring long-term support
- continues to mature its approach to early intervention to prevent and reduce the impact of injuries and illness and support employees to return to work as quickly as possible
- delivered an annual Agency-funded influenza vaccination program
- supports leaders to create and maintain a safe work environment with targeted engagement and interventions

- continued support for flexible working arrangements, supporting staff to balance personal and professional commitments
- delivered training focused on mental health, managing work demands and burnout, appropriate workplace behaviour, including details of the Respect@Work findings, the Respect@Work model for preventing and responding to sexual harassment, and positive duty requirements to create a safe workplace environment, support professional development and promote wellbeing.

All staff are assigned mandatory training obligations on commencement, with annual refresher training requirements, to ensure they are aware of their individual responsibility for maintaining a safe work environment.

In 2025–26, the Agency maintained its focus on continuous improvement in workplace health and safety governance, including incident reporting, risk management, consultation and wellbeing supports. This work supports the Agency's broader commitment to sustaining a safe, respectful and productive workplace for all staff.

The Agency has an active Health and Wellness Committee engaging staff in a broad range of initiatives to enhance the employee experience and engagement. Initiatives in 2025–26 included participation in the 10,000 Steps challenge, parkrun and a weekly virtual tabata workout. The committee created awareness about and engagement with relevant all-staff observances of events such as Men's Health Week and R U OK? Day and promoted a charity drive for Yipirinya School, a primary school for Aboriginal and Torres Strait Islander children in Alice Springs.

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.

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

No incidents occurred that were reportable under Section 38 of the WHS Act. There were no Comcare investigations, and no notices were issued under Part 10 of the WHS Act.

Advertising and market research

Under Section 311A of the *Commonwealth Electoral Act 1918* the Agency is required to disclose payments exceeding $17,300 (GST inclusive) to advertising agencies, market research, polling, direct mail or media advertising organisations.

During 2025–26 the Agency's total payments to advertising, market research and media services over the reporting threshold was $2,348,618.30 (GST incl.). The following table shows the breakdown of payments by category and the service provided. The Agency did not conduct any advertising campaigns during the reporting period.

Advertising, market research and media expenditure

Market research organisation	**Service provided**	**Expenditure** ($, GST incl.)
Lonergan Research Pty Ltd	Research participant recruitment services across key Agency digital health programs	$255,134.50
Stokes Mischewski Pty Ltd	My Health Record consumer research	$112,200.00
Whereto Research Based Consulting Pty Ltd	Consumer and healthcare provider research and polling studies	$590,411.80

Media advertising organisation	Service provided	Expenditure ($, GST inclusive)
Mediabrands Australia Pty Ltd	Advertising and search optimisation for Agency digital health products	$1,390,872.00
Total		$2,348,618.30

Climate disclosure statement

Under Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999* (EPBC Act), the Agency is obliged to report on ecologically sustainable development and environmental performance. The Agency meets these obligations through its Commonwealth Climate Disclosure (CCD) reporting.

The CCD is the government's policy for Commonwealth entities to publicly disclose their exposure to climate-related risks and opportunities, and the actions taken to manage them. As a Tranche 2 entity, the Agency is required to include climate-related disclosures in our annual reporting suite from 2025–26.

The Agency's Climate Disclosure Report addresses these requirements in accordance with the Year 1 reporting provisions and is available on our website and on the Transparency Portal.

Part 4. Financial statements

Information about this part

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

Financial summary

The Agency is jointly funded by Commonwealth appropriation ($323.85 million) and funding from the states and territories ($32.25 million).

Financial outcome

The Agency had a total operating revenue of $345.84 million and incurred total expenses of $387.24 million. As a result, the Agency recorded an operating deficit of $40.39 million in 2025–26.

Audited financial statements

The ANAO inspected the Agency's financial records and provided an unqualified audit opinion on the financial statements and accompanying explanatory notes on 21 September 2026. The ANAO's independent auditor's report and the Agency's financial statements are presented below.

Australian Digital Health Agency

Financial Statements

for the period ended 30 June 2026

Australian Digital Health Agency

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Australian Digital Health Agency
Independent Audit Report

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Opinion

In my opinion, the financial statements of the Australian Digital Health Agency (the Entity) for the year ended 30 June 2026:

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

(b) present fairly the financial position of the Entity as at 30 June 2026 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following as at 30 June 2026 and for the year then ended:

- Statement by the Chair of the Board, the Chief Executive and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Statement of Cash Flows; and
- Notes to and forming part of the financial statements, comprising a summary of material accounting policy information 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 Entity in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and their delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's responsibility for the financial statements

As the Accountable Authority of the Entity, the Board is responsible under the *Public Governance, Performance and Accountability Act 2013* (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Simplified Disclosures and the rules made under the Act. The Board is also responsible for such internal control as the Board determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result of an

GPO Box 707, Canberra ACT 2601
38 Sydney Avenue, Forrest ACT 2603
Phone (02) 6203 7300

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.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Australian National Audit Office

Jennifer Carter

Audit Principal

Delegate of the Auditor-General

Canberra

21 September 2026

Australian Digital Health Agency
STATEMENT BY THE CHAIR OF THE BOARD, THE CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2026 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.

Signed.....	Signed.....	Signed.....
Lyn McGrath	Amanda Cattermole	Tara Gould
Board Chair	Chief Executive Officer	Chief Financial Officer
Accountable Authority		
21 September 2026	21 September 2026	21 September 2026

Australian Digital Health Agency
Statement of Comprehensive Income
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Employee benefits	1.1A	**114,240**	93,796	92,845
Suppliers	1.1B	**236,093**	259,089	246,562
Depreciation and amortisation	2.2A	**36,268**	31,508	44,078
Finance costs	1.1C	**390**	298	356
Write-down and impairment of assets		**246**	36	-
Total expenses		**387,237**	384,727	383,841
Own-Source Income				
Own-Source Revenue				
Revenue from contracts with customers	1.2A	**2,280**	1,068	-
Contributions from jurisdictions	1.2B	**32,250**	32,250	32,250
Interest	1.2C	**5,709**	12,038	5,000
Other revenue		**-**	3	-
Total own-source revenue		**40,239**	45,359	37,250
Other gains		**-**	128	-
Total gains		**-**	128	-
Total own-source income		**40,239**	45,487	37,250
Net cost of services		**(346,998)**	(339,240)	(346,591)
Revenue from Government	1.2D	**305,605**	286,896	302,513
Surplus/(Deficit) on continued operations		**(41,393)**	(52,344)	(44,078)
OTHER COMPREHENSIVE INCOME				
Items not subject to subsequent reclassifications to net cost of services				
Changes in Asset Revaluation Reserve		**1,007**	275	-
Total other comprehensive income		**1,007**	275	-
Total comprehensive income/(loss) attributable to the Australian Government		**(40,386)**	(52,069)	(44,078)

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

Australian Digital Health Agency
Statement of Comprehensive Income
for the period ended 30 June 2026

Budget Variances Commentary

Expenses

Overall, 2025-26 expenses are $3.40 million (1%) higher than the 2025-26 Portfolio Budget Statement estimates (original budget), largely driven by:

- Employee benefits expenses are $21.4 million (23%) higher than the original budget, primarily driven by a higher average staffing level than budgeted which was actively managed to support key deliverables that arose throughout the year, a transition of contractors to APS to reduce overall costs to the Agency and the impact of a 3.4% pay increase implemented under the Agency's enterprise agreement.
- Supplier expenses are $10.5 million (4%) lower than the original budget, primarily due to reduced contractor expenditure following the conversion of contractor roles to APS employees which contributed to the increase in employee benefits expense. This was partially offset by higher information technology costs arising from increased cloud consumption and broader infrastructure cost pressures.
- Depreciation and amortisation expenses are $7.8 million (18%) lower than the original budget, primarily driven by the impact of lease-related adjustments not reflected in the original budget.

Own-Source Income

Own-source income is $3.0 million (8%) higher than the original budget, largely driven by revenue from contracts with customers, which was not budgeted due to the variability of these arrangements.

Australian Digital Health Agency
Statement of Financial Position
as at 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	**82,267**	125,507	115,379
Trade and other receivables	2.1B	**6,192**	6,686	7,823
Total financial assets		**88,459**	132,193	123,202
Non-financial assets				
Leasehold improvements	2.2A	**4,482**	4,516	2,010
Right of Use assets	2.2A	**7,639**	10,940	7,440
Plant and equipment	2.2A	**3,302**	4,447	5,829
Intangibles	2.2A	**73,447**	63,686	55,056
Prepayments		**14,215**	13,680	9,727
Total non-financial assets		**103,085**	97,269	80,062
Total assets		**191,544**	229,462	203,264
LIABILITIES				
Payables				
Suppliers	2.3A	**21,916**	38,759	34,183
Other payables	2.3B	**3,767**	3,459	4,938
Total payables		**25,683**	42,218	39,121
Interest Bearing Liabilities				
Leases	2.4A	**8,113**	10,907	7,864
Total interest bearing liabilities		**8,113**	10,907	7,864
Provisions				
Employee provisions	3.1A	**21,119**	17,578	12,991
Other provisions	3.1B	**475**	457	540
Total provisions		**21,594**	18,035	13,531
Total liabilities		**55,390**	71,160	60,516
Net assets		**136,154**	158,302	142,748
EQUITY				
Contributed Equity		**324,121**	305,881	324,121
Reserves		**17,094**	16,087	15,812
Accumulated Deficit		**(205,061)**	(163,666)	(197,185)
Total equity		**136,154**	158,302	142,748

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

Australian Digital Health Agency
Statement of Financial Position
as at 30 June 2026

Budget Variances Commentary

Assets

Total assets are $12.9 million (6%) lower than original budget largely driven by:

- Cash and cash equivalents are $33.1 million (29%) lower than the original budget, primarily due to higher expenditure during the year including increased employee benefits expenses resulting from higher staffing levels and the strategic conversion of contractor roles to APS employees and the loss of interest income related to a delay in the receipt of Agency's appropriation funding.
- Trade and other receivables are $1.6 million (21%) lower than the original budget, primarily driven by a lower GST receivable balance at year end as a result of lower accrued expenses than anticipated in the original budget. This was further supported by lower balances in other receivables, including leave transfer receivables, reflecting improved monitoring and timely settlement of outstanding balances.
- Leasehold improvements are $5.0 million (53%) lower than the original budget, primarily driven by the planned Canberra office fit out not proceeding and accelerated depreciation associated with the expiry of the Sydney premises.
- Plant and equipment are $2.5 million (43%) lower than the original budget, primarily due to reduced asset purchases during 2025-26 compared with budget assumptions. The original budget included a full laptop fleet replacement program; however, following a change in the associated business requirements, only a portion of the replacement program was required during the year.
- Intangible assets are $18.4 million (33%) higher than the original budget, mainly due to increased capitalisation of internally developed software, including projects deferred from prior periods into 2025–26.
- Right-of-use assets are $7.6 million (100%) higher than the original budget, primarily due to the recognition of lease assets not included in the original budget assumptions.
- Prepayments are $4.5 million (46%) higher than the original budget, driven by higher upfront payments for software licences, subscriptions and maintenance agreements.

Liabilities

Total liabilities are $6.3 million (10%) lower than original budget largely driven by:

- Supplier payables are $13.4 million (39%) lower than the original budget, primarily due to reduced labour hire contractor expenditure following the conversion of contractor roles to APS employees, together with timing differences in invoice processing and payments, with balances expected to fluctuate based on activity levels and payment cycles.
- Other payables are $1.2 million (24%) lower than the original budget, reflecting improved monitoring and control of accruals and the timing of payroll-related balances.
- Employee provisions are $8.1 million (63%) higher than the original budget, primarily driven by a higher average staffing level and associated increases in leave entitlements and salary-related on-costs.

Australian Digital Health Agency
Statement of Changes in Equity
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
CONTRIBUTED EQUITY				
Opening balance				
Balance carried forward from previous period		**305,881**	260,108	305,881
Adjusted opening balance		**305,881**	260,108	305,881
Contribution by owners				
Equity injection		**18,240**	45,773	18,240
Closing balance as at 30 June		**324,121**	305,881	324,121
RETAINED EARNINGS				
Opening balance				
Balance carried forward from previous period		**(163,666)**	(110,889)	(153,107)
Adjustment to property plant and equipment[1]		**(2)**	(433)	-
Adjusted opening balance		**(163,668)**	(111,322)	(153,107)
Comprehensive income				
Surplus/(Deficit) for the period		**(41,393)**	(52,344)	(44,078)
Total comprehensive income		**(41,393)**	(52,344)	(44,078)
Closing balance as at 30 June		**(205,061)**	(163,666)	(197,185)
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		**2,187**	1,912	1,912
Adjusted opening balance		**2,187**	1,912	1,912
Other comprehensive income[2]		**1,007**	275	-
Closing balance as at 30 June		**3,194**	2,187	1,912
CASH RESERVE				
Opening balance				
Balance carried forward from previous period		**13,900**	13,900	13,900
Closing balance as at 30 June		**13,900**	13,900	13,900

Australian Digital Health Agency
Statement of Changes in Equity
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		**158,302**	165,031	168,586
Adjustment to property plant and equipment		**(2)**	(433)	-
Adjusted opening balance		**158,300**	164,598	168,586
Comprehensive income				
Surplus/(Deficit) for the period		**(41,393)**	(52,344)	(44,078)
Other comprehensive income		**1,007**	275	-
Total comprehensive income		**(40,386)**	(52,069)	(44,078)
Transactions with owners				
Contributions by owners				
Equity injection		**18,240**	45,773	18,240
Total transactions with owners		**18,240**	45,773	18,240
Closing balance as at 30 June		**136,154**	158,302	142,748

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

[1]The comparative balance reflects a correction of a prior-period discrepancy between the asset module and the general ledger relating to property, plant and equipment. The current year balance relates to rounding adjustments.

[2] Other comprehensive income from changes in asset revaluation surplus consists of revaluation increments recognised on leasehold improvements and plant and equipment during the reporting period. Further information on these revaluation movements is provided in note 2.2A.

Accounting policy

Equity Injections

Amounts which are designated as 'equity injections' for a year (less any formal reductions) are recognised directly in contributed equity in that year.

Cash Reserve

The Agency has determined a cash reserve should be maintained to hold funds for contingency purposes. The creation and maintenance of this reserve account has been approved by the Board.

Australian Digital Health Agency
Statement of Cash Flows
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		**305,605**	286,896	302,513
Contributions from jurisdictions		**32,250**	32,250	32,250
Rendering of services		**3,373**	225	-
Net GST received		**29,262**	26,781	-
Interest		**5,845**	12,090	5,000
Other		**358**	-	-
Total cash received		**376,693**	358,242	339,763
Cash used				
Employees		**110,391**	88,600	92,845
Suppliers		**283,585**	285,121	246,562
Interest payments on lease liabilities		**373**	279	356
Total cash used		**394,349**	374,000	339,763
Net cash inflows/ (outflows) from operating activities		**(17,656)**	(15,758)	-
INVESTING ACTIVITIES				
Cash used				
Purchase of intangibles and property plant and equipment		**41,030**	31,190	29,025
Total cash used		**41,030**	31,190	29,025
Net cash (outflows) from investing activities		**(41,030)**	(31,190)	(29,025)
FINANCING ACTIVITIES				
Cash received				
Contributed equity		**18,240**	45,773	18,240
Total cash received		**18,240**	45,773	18,240
Cash used				
Principal payments of lease liabilities		**2,794**	3,665	2,876
Net cash used		**2,794**	3,665	2,876
Net cash inflows from financing activities		**15,446**	42,108	15,364
Net increase/(decrease) in cash held		**(43,240)**	(4,840)	(13,661)
Cash and cash equivalents at the beginning of the reporting period		**125,507**	130,347	129,040
Cash and cash equivalents at the end of period	2.1A	**82,267**	125,507	115,379

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

Budget Variances Commentary

The actual closing cash balance is $33.1 million (29%) lower than the budget. This variance is primarily attributable to higher expenditure incurred during the year, particularly capital investment in Internally Developed Software (IDS) and digital health assets. Cash used for the purchase of property, plant and equipment and intangible assets was $12.0 million (41%) higher than budget, reflecting increased capitalisation of IDS, including projects deferred from prior periods into 2025-26. Employee-related cash outflows were also higher than budget due to increased staffing levels and salary increases under the Agency's enterprise agreement. Higher prepayments at year end further reduced available cash. These impacts were partially offset by unbudgeted receipts from rendering of services and higher interest receipts.

Australian Digital Health Agency
Notes to and forming part of the financial statements

Overview

Objectives of the Agency

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

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

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

The Agency is structured to meet the following outcome:

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

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

- Government policy and on continued funding by the Australian Government for the Agency's administration and programs relating to the MHR functions.
- Funding from the Australian Government, states and territories received pursuant to the *Inter-Governmental Agreement* signed in August 2023, and on any such future agreements.

The Basis of Preparation

The financial statements are general purpose financial statements as 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); and
b) Australian Accounting Standards and Interpretations – including simplified disclosures for Tier 2 Entities under AASB 1060 issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The financial statements are presented in Australian dollars and values are rounded to the nearest $'000 unless otherwise specified.

Going Concern

The financial statements have been prepared on a going concern basis. This is supported by ongoing funding outlined in the 2026–27 Department of Health, Disability and Ageing Portfolio Budget Statements, continued Government endorsement of the Agency's objectives, and an active intergovernmental agreement on National Digital Health that remains in effect until 2027.

Significant Accounting Judgements and Estimates

Assumptions or estimates have been made in the following areas that have the most significant impact on the amounts recorded in the financial statements:

- The Agency's intangibles comprise software licences, data sets and Internally Developed Software (IDS). 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 which is reviewed as part of the annual impairment process.

Australian Digital Health Agency
Notes to and forming part of the financial statements

- Cloud computing arrangements (CCA) are first evaluated to determine whether they contain a lease. Non-lease components are further evaluated as a service contract or an intangible asset. CCA are an intangible asset if it is identifiable, controlled by the Agency and give the Agency the power to obtain future economic benefits. Configuration or customisation costs from CCAs are evaluated under the same principles. Useful life of intangible assets under CCA are determined by obsolescence, technology, economic factors and any rapid changes that may be occurring in the development of hosting arrangements or hosted software.
- Leave provisions involve assumptions based on the expected tenure of staff, patterns of leave claims and payouts, future salary movements and future discount rates.

No accounting assumptions or estimated give rise to a risk of material adjustment to carrying amounts of assets and liabilities within the next twelve months.

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

Events After the Reporting Period
There were no matters or circumstances which have arisen since the end of the financial year which significantly affected, or alternatively may affect the operations of the Agency, the results of these operations or state of affairs of the Agency in subsequent years.

Australian Digital Health Agency
Notes to and forming part of the financial statements

1. Financial Performance

This section analyses the financial performance of the Agency for the period ended 30 June 2026.

1.1: Expenses

	2026 $'000	2025 $'000
Note 1.1A: Employee benefits		
Wages and salaries	**82,656**	69,113
Superannuation		
Defined contribution plans	**12,848**	10,446
Defined benefit plans	**3,357**	1,795
Leave and other entitlements	**15,284**	12,352
Separation and redundancies	**95**	90
Total employee benefits	**114,240**	93,796

Accounting policy

Accounting policy for employee related expenses is contained in note 3.1.

Note 1.1B: Suppliers		
Goods and services supplied or rendered		
Contracts for services	**91,832**	122,113
Contractors	**49,595**	71,140
IT services	**85,878**	54,025
Other	**6,854**	8,776
Travel	**1,523**	2,248
Audit fees[1]	**120**	140
Consultants	**4**	-
Total goods and services supplied or rendered	**235,806**	258,442
Other suppliers		
Workers' compensation expenses	**287**	647
Total other suppliers	**287**	647
Total suppliers	**236,093**	259,089

[1] Amount paid or payable to the Australian National Audit Office for the audits of the financial statements.

Accounting Policy

Suppliers' expenses

The Agency applies a $5,000 threshold for recognition of prepayments and accrued expenses.

Short-term leases and leases of low-value assets

The Agency has elected not to recognise right-of-use assets and lease liabilities for short-term leases of assets that have a lease term of 12 months or less and leases of low value assets (less than $10,000 per asset). The Agency recognises the lease payments associated with these leases as an expense on a straight-line basis over the lease term.

Australian Digital Health Agency
Notes to and forming part of the financial statements

	2026 $'000	2025 $'000
Note 1.1C: Finance costs		
Interest on lease liabilities	**373**	279
Unwinding of discount on make good provision	**17**	19
Total finance costs	**390**	298

The above lease disclosures should be read in conjunction with the accompanying notes 2.2A and 2.4A.

1.2: Income

	2026 $'000	2025 $'000
Note 1.2A: Revenue from contracts with customers		
Rendering of services	**2,280**	1,068
Total revenue from contracts with customers	**2,280**	1,068

Revenue from rendering services is related to contracts with other Commonwealth entities for various projects and are recognised at a point in time.

Accounting Policy

The Agency has revenue from general contracts that are enforceable through legal or equivalent means and have specific performance obligations that transfer goods or services to a customer. Contracts are considered to be enforceable where there are specific rights specified in the agreement, and the parties can reasonably be expected to act on their obligations.

The Agency provides services to other entities and individuals, including undertaking functions or incurring costs on behalf of other Australian Government entities in accordance with contracts or other arrangements.

Revenue from rendering services is generally recognised over time as services are provided and recoverable costs are incurred. For arrangements that include milestone-based deliverables, revenue is recognised at a point in time when the relevant milestone has been completed and accepted by the customer, indicating that the associated performance obligation has been satisfied.

A contract liability for unearned revenue is recorded for obligations under contracts for which payment has been received in advance. Contract liabilities unwind as “revenue from contracts with customers” upon satisfaction of the performance obligations under the terms of the contract or other arrangements.

Note 1.2B: Contributions from jurisdictions		
New South Wales	**10,133**	10,133
Victoria	**8,211**	8,211
Queensland	**6,592**	6,592
Western Australia	**3,457**	3,457
South Australia	**2,264**	2,264
Tasmania	**716**	716
Australian Capital Territory	**568**	568
Northern Territory	**309**	309
Total contributions from jurisdictions	**32,250**	32,250

Accounting Policy

The Agency receives funding from jurisdictions in accordance with the financial contribution tables set out in the Intergovernmental Agreements on National Digital Health. Contributions from states and territories recognised during the reporting period totalled $32.25 million (2025: $32.25 million).

Australian Digital Health Agency
Notes to and forming part of the financial statements

	2026 $'000	2025 $'000
Note 1.2C: Interest		
Deposits	**5,709**	12,038
Total interest	**5,709**	12,038

Accounting Policy

Interest revenue is recognised using the effective interest rate.

Note 1.2D: Revenue from Government		
Department of Health, Disability and Ageing		
Corporate Commonwealth Entity payment item	**305,605**	286,896
Total revenue from Government	**305,605**	286,896

Accounting policy

Revenue from Government

Funding appropriated to the Department of Health, Disability and Ageing as a corporate Commonwealth Agency payment item for payment to the Agency is recognised as revenue from the Australian Government, unless the funding is in the nature of an equity injection or a loan, or goods and services revenue under AASB 15 *Revenue from Contracts with Customers*.

The Commonwealth contributed $32.25 million under the Intergovernmental Agreements on National Digital Health. Of this amount, $15.09 million (2025: $15.41 million) was received by the Agency and recognised as revenue from the Australian Government, with the balance appropriated directly to Services Australia for services provided in support of the Agency's operations.

Australian Digital Health Agency
Notes to and forming part of the financial statements

2. Financial Position

This section analyses the Agency's assets used to conduct its operations and the operating liabilities incurred as a result. Employee related information is disclosed in Section 3 People and Relationships.

2.1: Financial Assets

	2026 $'000	2025 $'000
Note 2.1A: Cash and cash equivalents		
Cash on hand or on deposit	**82,267**	125,507
Total cash and cash equivalents	**82,267**	125,507

Accounting Policy

Cash is recognised at its nominal amount.

Note 2.1B: Trade and other receivables		
Total goods and services receivables		
Goods and services	**2,551**	345
GST receivable from the ATO	**1,648**	3,159
Interest Receivable	**325**	461
Other receivables	**1,668**	2,721
Total goods and services receivables	**6,192**	6,686
Total trade and other receivables (gross)	**6,192**	6,686
Total trade and other receivables (net)	**6,192**	6,686

Credit terms for goods and services were within 20 days. The Agency has not provided any loans.

Accounting Policy

The Agency classifies its receivables at the time of initial recognition depending on the nature and purpose of the asset. All receivables are expected to be recovered within 12 months unless otherwise indicated.

The collectability of debts is reviewed at the end of the reporting period, and an impairment loss allowance is recognised if required.

Australian Digital Health Agency
Notes to and forming part of the financial statements

2.2: Non-Financial Assets

Note 2.2A: 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 2026

	Leasehold Improvements $'000	Right of Use (ROU) Assets $'000	Plant and Equipment $'000	Computer Software $'000	Other Intangibles[1] $'000	Total $'000
As at 1 July 2025						
Gross book value	6,338	25,835	6,723	17,840	260,097	316,833
Accumulated depreciation, amortisation and impairment	(1,822)	(14,895)	(2,276)	(17,840)	(196,411)	(233,244)
Total as at 1 July 2025	**4,516**	**10,940**	**4,447**	**-**	**63,686**	**83,589**
Additions						
Purchase	633	-	1,184	-	-	1,817
Internally developed	-	-	-	-	39,213	39,213
Revaluation increment/(decrement) recognised in other comprehensive income	1,152	-	(145)	-	-	1,007
Depreciation and amortisation	(1,816)	-	(2,118)	-	(29,272)	(33,206)
Depreciation on right-of-use assets	-	(3,062)	-	-	-	(3,062)
Other movements[2]	(3)	(239)	-	-	-	(242)
Disposals	-	-	(66)	-	(180)	(246)
Total as at 30 June 2026	**4,482**	**7,639**	**3,302**	**-**	**73,447**	**88,870**
Total as at 30 June 2026 represented by:						
Gross book value	4,682	12,374	3,602	17,840	291,977	330,475
Accumulated depreciation and amortisation	(200)	(4,735)	(300)	(17,840)	(218,530)	(241,605)
Total as at 30 June 2026	**4,482**	**7,639**	**3,302**	**-**	**73,447**	**88,870**

[1] The carrying amount of other intangibles includes assets under construction of $38.15 million, primarily relating to Healthcare Information Provider Service (HIPS), My Health Record (MHR), 1800Medicare, Health Connect, Fast Healthcare Interoperability Resources (FHIR) and Implementer Hub.

[2] Other movements of right-of-use assets primarily reflect the impact of updates to the lease model, including the identification and correction of prior lease data, and revisions to the discount rates applied to lease valuations to better align with the relevant lease terms.

Capital commitments
The Agency had contractual obligations of $2.55 million as at 30 June 2026 (2025: $11.5 million), primarily relating to capital commitments supporting infrastructure and operational needs.

Australian Digital Health Agency
Notes to and forming part of the financial statements

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. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

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

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position. Purchases costing less than $2,000 are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

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, refer note 3.1B.

Category	Capitalisation Threshold
Leasehold improvements	$50,000
Internally Developed Software	$100,000
IT projects (software and hardware integration)	$100,000
Property, plant and equipment	$2,000

Lease Right of Use (ROU) Assets

Leased ROU assets are capitalised at the commencement date of the lease unless they are short-term (less than 12 months) or of low value (less than $10,000), and comprise of the initial lease liability amount, initial direct costs incurred when entering into the lease less any lease incentives received. These assets are accounted for by the Agency as separate asset classes to corresponding assets owned outright.

Impairment reviews are undertaken for ROU assets, and an impairment loss is recognised against any ROU asset that shows indications of impairment. ROU assets continue to be measured at cost after initial recognition.

Revaluations

Following initial recognition at cost, property, plant and equipment (excluding ROU assets) are carried at fair value (or an amount not materially different from 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 depends 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 Statement of Comprehensive Income. Revaluation decrements for a class of assets are recognised directly in the Statement of Comprehensive Income 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.

Australian Digital Health Agency
Notes to and forming part of the financial statements

All revaluations were performed in accordance with the Agency's revaluation policy. The Agency considers a comprehensive valuation by an independent valuer at least every three years to be an appropriate frequency, having regard to the materiality and nature of the assets held. In the intervening years, desktop valuations are undertaken to ensure that carrying amounts do not materially differ from fair value.

A comprehensive independent valuation of property, plant and equipment was undertaken by CBRE during 2025-26. The valuation resulted in a net revaluation increment of $1.0 million, which has been recognised in the asset revaluation surplus. Assets identified for disposal were excluded from the valuation.

Depreciation and Amortisation

Depreciable property, plant and equipment and amortisable intangible assets are written-off to their estimated residual values over their estimated useful lives, in all cases using the straight-line method. Depreciation/amortisation 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/amortisation rates applying to each class of 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

The depreciation rates for ROU assets are based on the commencement date to the earlier of the end of the useful life of the ROU asset or the end of the lease term.

Impairment

All assets were assessed for impairment at 30 June 2026. 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 or an intangible asset is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

2.3: Payables

	2026 $'000	2025 $'000
Note 2.3A: Suppliers		
Trade creditors and accruals	**19,578**	37,514
Contract liabilities	**2,338**	1,245
Total suppliers	**21,916**	38,759

Accounting Policy

Trade creditors and accruals

Trade creditors and accruals are recognised at amortised cost.

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

Contract liabilities

The contract liabilities from contracts with customers are associated with performance obligations not yet met at 30 June.

Australian Digital Health Agency
Notes to and forming part of the financial statements

	2026 $'000	2025 $'000
Note 2.3B: Other payables		
Salaries and wages	**3,249**	3,026
Superannuation	**518**	433
Total other payables	**3,767**	3,459

2.4: Interest Bearing Liabilities

	2026 $'000	2025 $'000
Note 2.4A: Leases		
Lease liabilities	**8,113**	10,907
Total leases	**8,113**	10,907

Total cash outflow for leases for the year ended 30 June 2026 was $3.17 million (2025: $3.94 million)

Maturity analysis - contractual undiscounted cash flows		
Within 1 year	**2,780**	3,282
Between 1 and 5 years	**5,856**	8,616
Total leases	**8,636**	11,898

The Agency in its capacity as lessee occupies the following premises:

- Level 25, 175 Liverpool Street, Sydney.
- Level 17, 1 Eagle Street, Brisbane.
- Discovery House, West Wing Level 3, 47 Bowes Street, Canberra.

The above lease disclosures should be read in conjunction with the accompanying notes 1.1C and 2.2A.

Accounting Policy

For all new contracts entered into, the Agency considers whether the contract is, or contains, a lease. A lease is defined as 'a contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration'.

Once it has been determined that a contract is, or contains, a lease, the lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease, if that rate is readily determinable, or the Agency's incremental borrowing rate.

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification to the lease. When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset or profit and loss depending on the nature of the reassessment or modification.

Australian Digital Health Agency
Notes to and forming part of the financial statements

3. People and Relationships

This section describes a range of employment and post employment benefits provided to our people and our relationships with other key people.

3.1: Provisions

	2026 $'000	2025 $'000
Note 3.1A: Employee provisions		
Leave	**21,119**	17,578
Total employee provisions	**21,119**	17,578

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.

The liability for long service leave has been determined using the shorthand model provided by Department of Finance as per the FRR and Commonwealth Entities Financial Statements Guide. The estimate of the present value of the liability considers attrition rates and pay increases through promotion and inflation.

Separation and Redundancy

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 ASL numbers.

APS staff are either members of the Public Sector Superannuation Scheme (PSS), the PSS accumulation plan (PSSap), or other superannuation funds held outside the Australian Government. The PSS is a defined benefit scheme. 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 contribution plans.

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

	2026 $'000	2025 $'000
Note 3.1B: Other provisions		
Provision for restoration obligations		
As at 1 July	**457**	540
Revaluation	**1**	20
Unwinding of discount	**17**	19
Derecognition	**-**	(122)
Total as at 30 June	**475**	457

The Agency currently has two agreements for office leases in Sydney and Brisbane that require the Agency to restore the premises to their original condition at the conclusion of the lease. The Agency has made a provision for restoration to reflect the present value of these obligations.

Provision for Restoration Obligations

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

3.2: Key Management Personnel Remuneration

Key management personnel (KMP) 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). The Agency has determined the KMP to be Chief Executive Officer (CEO), Senior Executive Committee (SEC) members and Board members. KMP remuneration is reported in the table below:

	2026	2025
	$'000	$'000
Key management personnel remuneration expenses		
Short-term employee benefits	**2,956**	2,758
Post-employment benefits	**456**	415
Other long-term employee benefits	**71**	58
Total key management personnel remuneration expenses[1]	**3,483**	3,231

The total number of KMP that are included in the above table for 2026 is 17 (2025: 15).

[1] The above KMP 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 KMP who received remuneration from the Agency in 2025-26.

Australian Digital Health Agency
Notes to and forming part of the financial statements

3.3: Related Party Disclosures

The Agency is an Australian Government controlled Corporate Commonwealth Agency. It has a governing Board of members, a CEO and SEC members and a Portfolio Minister. Related parties to the Agency are KMP (refer Note 3.2), other Australian Government entities and certain state and territory government entities that participate in the governance and funding arrangements established under the Intergovernmental Agreements on National Digital Health.

Pursuant to *AASB 124 Related Party Disclosures*, the Agency's KMP are required to disclose any transactions between the Agency and their close family members, or entities controlled by them or their close family members. Where there is any uncertainty as to whether a relationship or transaction should be disclosed, the information is collected and assessed for disclosure.

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 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 SEC members constitute KMP, as they have the authority and responsibility for planning, directing and controlling the activities of the Agency. Individuals acting in these roles continuously for three months or more during the financial year are also included as KMP, as they exercise the same authority and responsibility during the acting period.

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 and on normal terms and conditions, including the payment of workers compensation and insurance premiums. Other than KMP remuneration disclosed in Note 3.2 and transactions with other Australian Government entities conducted on normal terms and conditions, there were no related party transactions requiring separate disclosure during the reporting period.

Australian Digital Health Agency
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4. Managing Uncertainties

This section analyses how the Agency manages financial risks within its operating environment.

4.1: 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 liabilities and contingent assets are not recognised in the statement of financial position but are reported in the notes.

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.

4.2: Financial Instruments

	2026 $'000	2025 $'000
Note 4.2A: Categories of financial instruments		
Financial Assets		
Financial assets at amortised cost		
Cash and cash equivalents	**82,267**	125,507
Trade and other receivables	**4,544**	3,527
Total financial assets at amortised cost	**86,811**	129,034
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	**21,916**	38,759
Total financial liabilities measured at amortised cost	**21,916**	38,759

The Agency is exposed to minimal credit risk as its financial assets primarily comprise cash and trade receivables. The maximum exposure to credit risk is the risk arising from the potential default of a debtor. At 30 June 2026, the maximum exposure to credit risk was equal to the total carrying amount of trade receivables, excluding GST receivable from the ATO, of $4.54 million (2025: $3.53 million).

The Agency had no financial assets that were past due but not impaired at 30 June 2026 (2025: Nil).

Accounting Policy

Financial Assets

The Agency's financial assets comprise cash and cash equivalents and trade and other receivables. Financial assets are recognised when the Agency becomes a party to a contract and, as a consequence, has a legal right to receive cash. Financial assets are derecognised when the contractual rights to the cash flows expire or are transferred. The Agency measures its financial assets at amortised cost.

Interest revenue from financial assets for 2026 was $5.71 million (2025: $12.04 million).

Financial Liabilities

Financial liabilities are recognised when the Agency becomes a party to a contract and has a legal obligation to pay cash. Financial liabilities are derecognised when the obligation is extinguished. Supplier and other payables are recognised at amortised cost.

Australian Digital Health Agency
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4.3: Fair Value Measurement

The Agency's Leasehold Improvements and Plant and Equipment are measured at fair value and categorised within the fair value hierarchy. The remaining assets and liabilities disclosed in the Statement of Financial Position are not measured at fair value.

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

- Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Agency can access at measurement date.
- Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3: Unobservable inputs for the asset or liability.

Leasehold improvements are categorised as Level 3.
Plant and equipment are categorised as Level 2 and Level 3.

Note 4.3A: Fair value measurement

	Fair Value measurements at the end of the reporting period	
	2026	2025
	$'000	$'000
Non-financial assets		
Leasehold Improvements	**4,482**	4,516
Plant and equipment	**3,302**	4,447
Total fair value measurements in the Statement of Financial Position	**7,784**	8,963
Total non-financial assets not measured at fair value in the Statement of Financial Position	**95,301**	88,306

Accounting Policy

All revaluations were conducted in accordance with the revaluation policy. A comprehensive valuation of Leasehold Improvements and Plant and Equipment was performed during the financial year by CBRE, an independent qualified valuer. The valuation was based on fair value principles, using market-based and depreciated replacement cost methodologies, as appropriate to the nature of the assets. The valuation resulted in a revaluation increment recognised in other comprehensive income, with adjustments made for all material movements.

Australian Digital Health Agency
Notes to and forming part of the financial statements

5. Other Information

5.1: Current/Non-Current Distinction for Assets and Liabilities

	2026 $'000	2025 $'000
Note 5.1A: Current/non-current distinction for assets and liabilities		
Assets expected to be recovered in:		
No more than 12 months		
Cash and cash equivalents	**82,267**	125,507
Trade and other receivables	**6,192**	6,686
Prepayments	**11,459**	10,757
Total no more than 12 months	**99,918**	142,950
More than 12 months		
Leasehold Improvements	**4,482**	4,516
Right of use Assets	**7,639**	10,940
Plant and equipment	**3,302**	4,447
Intangibles	**73,447**	63,686
Prepayments	**2,756**	2,923
Total more than 12 months	**91,626**	86,512
Total assets	**191,544**	229,462
Liabilities expected to be settled in:		
No more than 12 months		
Suppliers	**21,916**	38,759
Other payables	**3,767**	3,459
Leases	**2,519**	2,811
Employee provisions	**5,133**	6,460
Other provisions	**249**	174
Total no more than 12 months	**33,584**	51,663
More than 12 months		
Leases	**5,594**	8,096
Employee provisions	**15,986**	11,118
Other provisions	**226**	283
Total more than 12 months	**21,806**	19,497
Total liabilities	**55,390**	71,160

Part 5. Navigation aids

Information about this part

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

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

Index of annual report content requirements

Corporate Commonwealth entities

PGPA Rule reference	Part of report	Description	Requirement
17BE Contents of annual report			
17BE(a)	Enabling legislation page 3	Details of the legislation establishing the body	Mandatory
17BE(b)(i)	Role page 7	A summary of the objects and functions of the entity as set out in legislation	Mandatory
17BE(b)(ii)	Purpose page 3	The purposes of the entity as included in the entity's corporate plan for the reporting period	Mandatory
17BE(c)	Portfolio and Ministerial oversight page 6	The names of the persons holding the position of responsible Minister or responsible Ministers during the reporting period, and the titles of those responsible Ministers	Mandatory
17BE(d)	Ministerial directions and policy orders page 83	Directions given to the entity by the Minister under an Act or instrument during the reporting period	If applicable, mandatory
17BE(e)	Ministerial directions and policy orders page 83	Any government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	If applicable, mandatory

PGPA Rule reference	Part of report	Description	Requirement
17BE(f)	N/A	Particulars of non-compliance with: (a) a direction given to the entity by the Minister under an Act or instrument during the reporting period; or (b) a government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	If applicable, mandatory
17BE(g)	Annual performance statements 2025–26 page 17	Annual Performance Statements in accordance with paragraph 39(1)(b) of the Act and section 16F of the Rule	Mandatory
17BE(h), 17BE(i)	Compliance with finance law page 83	A statement of significant issues reported to the Minister under paragraph 19(1)(e) of the Act that relates to non-compliance with finance law and action taken to remedy non-compliance	If applicable, mandatory
17BE(j)	The Board page 67	Information on the accountable authority, or each member of the accountable authority, of the entity during the reporting period	Mandatory
17BE(k)	Structure page 8	Outline of the organisational structure of the entity (including any subsidiaries of the entity)	Mandatory
17BE(ka)	Staff statistics page 87	Statistics on the entity's employees on an ongoing and non-ongoing basis, including the following: (a) statistics on full-time employees (b) statistics on part-time employees (c) statistics on gender (d) statistics on staff location	Mandatory
17BE(l)	Our people and their location page 6	Outline of the location (whether or not in Australia) of major activities or facilities of the entity	Mandatory
17BE(m)	Corporate governance page 67	Information relating to the main corporate governance practices used by the entity during the reporting period	Mandatory

PGPA Rule reference	Part of report	Description	Requirement
17BE(n), 17BE(o)	Related entity transactions page 83	For transactions with a related Commonwealth entity or related company where the value of the transaction, or if there is more than one transaction, the aggregate of those transactions, is more than $10,000 (inclusive of GST): (a) The decision-making process undertaken by the accountable authority to approve the entity paying for a good or service from, or providing a grant to, the related Commonwealth entity or related company. (b) The value of the transaction, or if there is more than one transaction, the number of transactions and the aggregate of value of the transactions	If applicable, mandatory
17BE(p)	Significant activities and changes page 83	Any significant activities and changes that affected the operation or structure of the entity during the reporting period	If applicable, mandatory
17BE(q)	Judicial decisions or administrative reviews page 82	Particulars of judicial decisions or decisions of administrative tribunals that may have a significant effect on the operations of the entity	If applicable, mandatory
17BE(r)	External scrutiny page 82	Particulars of any reports on the entity given by: (a) the Auditor-General (other than a report under section 43 of the Act) or (b) a Parliamentary Committee or (c) the Commonwealth Ombudsman or (d) the Office of the Australian Information Commissioner.	If applicable, mandatory
17BE(s)	N/A	An explanation of information not obtained from a subsidiary of the entity and the effect of not having the information on the annual report	If applicable, mandatory
17BE(t)	Insurance and indemnities page 84	Details of any indemnity that applied during the reporting period to the accountable authority, any member of the accountable authority or officer of the entity against a liability (including premiums paid, or agreed to be paid, for insurance against the authority, member or officer's liability for legal costs)	If applicable, mandatory

PGPA Rule reference	Part of report	Description	Requirement
17BE(taa)	Audit committee disclosures page 75	The following information about the audit committee for the entity: (a) a direct electronic address of the charter determining the functions of the audit committee (b) the name of each member of the audit committee (c) the qualifications, knowledge, skills or experience of each member of the audit committee (d) information about each member's attendance at meetings of the audit committee (e) the remuneration of each member of the audit committee.	Mandatory
17BE(ta)	Executive remuneration page 91	Information about executive remuneration	Mandatory
17BF Disclosure requirements for government business enterprises			
17BF(1)(a)(i)	N/A	An assessment of significant changes in the entity's overall financial structure and financial conditions	If applicable, mandatory
17BF(1)(a)(ii)	N/A	An assessment of any events or risks that could cause financial information that is reported not to be indicative of future operations or financial conditions	If applicable, mandatory
17BF(1)(b)	N/A	Information on dividends paid or recommended	If applicable, mandatory
17BF(1)(c)	N/A	Details of any community service obligations the government business enterprise has including: (a) an outline of actions taken to fulfil those obligations (b) an assessment of the cost of fulfilling those obligations.	If applicable, mandatory
17BF(2)	N/A	A statement regarding the exclusion of information on the grounds that the information is commercially sensitive and would be likely to result in unreasonable commercial prejudice to the government business enterprise	If applicable, mandatory
17BG Additional requirement for prescribed corporate Commonwealth entities			
17BG(2)	Procurement performance page 80	An assessment of the entity's performance during the period against the Commonwealth Procurement Rules.	

Acronyms and abbreviations

Acronym	Term
AICD	Australian Institute of Company Directors
AM	Member of the Order of Australia
AMT	Australian Medicines Terminology
ANAO	Australian National Audit Office
AO	Officer of the Order of Australia
API	application programming interfaces
APS	Australian Public Service
ASL	Active Script List
CAS	Conformance Assessment Schemes
CCD	Commonwealth Climate Disclosure
CCIO	Chief Clinical Information Officer
CDA	Clinical Document Architecture
CHAP	Comprehensive Health Assessment Program
CMDB	Configuration Management Database
FHIR®	Fast Healthcare Interoperability Resources®
HI	healthcare identifiers
HIPS	Health Information Provider Service
ICT/IT	information and communication technology / information technology
IHI	Individual Healthcare Identifiers
IPS	Information Publication Scheme
KMP	key management personnel
MBS	Medicare Benefits Schedule
NASH	National Authentication Service for Health
NHS	National Health Service (UK)
OAIC	Office of the Australian Information Commissioner
OECD	Organisation for Economic Co-operation and Development
PBS	Portfolio Budget Statements

Acronym	Term
PBS/RPBS	Pharmaceutical Benefits Scheme / Repatriation Pharmaceutical Benefits Scheme
PCA	Provider Connect Australia
PGPA	Public Governance, Performance and Accountability
PHN	Primary Health Network
PKI	public key infrastructure
RAP	Reconciliation Action Plan
RFDS	Royal Flying Doctor Service
RTPM	real-time prescription monitoring
SI / SIAM	Systems Integration / Service Integration and Management
WHS	Work health safety