Australian Government
Australian Digital Health Agency

Brief 1

Supplementary Budget Estimates — October 2018

Consumer participation in the MHR

Subject

Transitioning MHR from opt in to opt our model or participation.

Key points

- The MHR system was implemented on 1 July 2012 — known then as the personally controlled electronic health record or PCEHR system.
- The system was designed for national participation.

> In the 2013 PCEHR Review the Consumer Health Forum's submission stated *'the PCEHR system will be more successful if it is to be opt-out, rather than opt-in. Our extensive consultation with consumers, consideration of the positions of other key stakeholder groups and review of international experience support and consolidate this position'*.

- The MHR system was designed around privacy, security and consumer choice and control — not a model of registration.
- The original legislative debate in 2012 focused on consumer choice and privacy.
- An independent review in 2013, found there was overwhelming support for the MHR system, with the recommendation that the system move to a model of opt out participation.
- In 2015, the Australian Parliament legislated to make the MHR an opt out model of registration.
- In late 2016 participation trials were held across Australia with two opt out trial sites in Nepean Blue Mountains and Northern Queensland.
- The opt out trials occurred in Nepean Blue Mountains and North Queensland, and resulted in 971,000 people being registered. The opt out rate was 1.9 per cent.
- The independent evaluation of these participation trials found a high level of support by individuals and healthcare providers for the automatic creation of MHRs, and recommended that Government proceed to a national opt out approach.
- Opt out participation for individuals was agreed by all state and territory governments in March 2017 at the Council of Australian Governments Health Council. This was reaffirmed unanimously in August 2018.

- As part of the 2017–18 Budget, the Government confirmed that the MHR system would transition to an opt out system and that all Australians would have a MHR by the end of 2018, unless they opted out.
- On 30 November 2017 the Minister for Health, the Hon Greg Hunt MP, made the *My Health Records (National Application) Rules 2017* to apply the opt out model of registration to everyone in Australia, and to specify the period in which individuals could opt out.
- The opt out period commenced on 16 July 2018 and will now end on 15 November 2018 following a decision to lengthen the opt out period to four months.
- Since it commenced participation in the MHR has grown as shown in the table below. As at 14 October 2018 there have been 6,214,229 records created for Australians since 1 July 2012.

As at	Number of records created for Australians since 1 July 2012
30 June 2013	397,720
30 June 2014	1,729,736
30 June 2015	2,276,981
30 June 2016	3,847,130
30 June 2017	4,969,112
30 June 2018	5,904,315

- Participation for healthcare providers continues to be on an opt in basis.

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Brief 2

Supplementary Budget Estimates — October 2018

Opt out numbers

Subject

Opt out rates and expectations for total opt out.

Key points

- The Agency has not been monitoring the opt out rates of Australians during the opt out period – this is because Australians are able to opt out online, over the phone and via post.
- A final reconciliation will be undertaken after the opt out period ends on 15 November 2018, at which point final numbers will be known.
- The Agency has undertaken extensive international and local research to understand the factors people will consider when deciding to have a record created for them or to opt out.
- s.47C [redacted]
- It should be noted that no target has been set by Government, s.47G [redacted]

If pressed — what is the current opt out rate

- Over the past eight weeks since the commencement of opt out, the weekly online and over the phone opt out rates are:

	Week 1 16–22 July	Week 2 23–29 July	Week 3 30 July –5 Aug	Week 4 6–12 Aug	Week 5 13–19 Aug	Week 6 20–26 Aug	Week 7 27 Aug –2 Sept	Week 8 3–9 Sept	Week 9 10–16 Sept
Total Number									TBA

Tipping point

- The Agency has not been set a target for the number of Australians who will have a MHR by the end of 2018.

- There is a tipping point in terms of participation before clinicians will meaningfully use an electronic records system.
- s.47G [redacted]
- s.47G [redacted]

International examples of opt out (see brief 5 — International comparison)

- The rates of citizen access to record ranges from 18–50% of total population depending upon digital maturity within each country.

2016 participation trials (refer to Department of Health)

- In the 2016 My Heath Record participation trials people were given the option of opting out over a fixed two-month period (between 4 April and 27 May).
- Out rates of individuals in opt out trial sites was low (1.9%) representing 971, 245 created as part of the opt out trials.
- The independent trial evaluation report found that over 40% of respondents in the opt out trial had heard about the MHR system.
- This is compared to 11% awareness for the rest of Australia in 2016.
- Public awareness of MHR currently — following the commencement of public communications — is 87%.
- Almost 60% of the community is currently aware of the opt out period, compared to a rate of 16% at the beginning of opt out.

Agency Independent Australian Consumer Survey (CATI Survey)

- In November–December 2017, the Agency commissioned a national telephone survey with 1,000 consumers.
- s.47C [redacted]

Self registering

- Most people have registered themselves or their children for a MHR in one of the following ways:
  - online via a myGov account;
  - when completing a Medicare enrolment form (for a newborn);
  - at a Medicare Service Centre; or
  - by calling the Help line on 1800 723 471.

Assisted registration

- You may have been assisted to register at a general practice or hospital. This may have occurred by completing a form or electronically.

MHR opt out trials 2016

- Just under 1 million Australians were registered for a MHR in 2016, during the Department of Health's opt out participation trials.
- These trials were held from March to November 2016 in the Nepean Blue Mountain region of New South Wales and Northern Queensland area. If your address registered with Medicare was in a trial area at the time, you would have received a letter informing you that you were going to get a MHR. After the 2016 trial opt out period ended, records were created for individuals who did not elect to opt out.

Personally Controlled Electronic Health Record is now a MHR

- The MHR system was once called the Personally Controlled Electronic Health Record (PCEHR) and the eHealth record. It's possible that you may have registered under PCEHR or eHealth, and didn't know the name had changed to MHR.

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Brief 3

Supplementary Budget Estimates — October 2018

Pre-MHR expansion program communications impact

Subject

The MHR expansion program communications was resourced soon after the May 2017 budget announcement and provided a steady stream of content and events to raise awareness leading up to the opt out period.

Key points

Between the dates of the May 2017 budget announcement and 16 July 2018 (commencement of the opt out period):

- Medicare Service Centres and MyGov shopfronts ran digital posters and screensavers for three months commencing in August 2017.
- On 5 October 2017 the Agency supported the 7th International Carer's conference in Adelaide, also launching the video case study of Donna and Marnie, with over 2,000 views.
- A carer's toolkit was distributed to among six provider groups, all 31 Primary Health Networks, 20 jurisdictions and eight consumer peak organisations.
- Posters and Screensavers were distributed nationally to all hospitals (digital files).
- More than 5,000 Cyber booklets were printed and distributed in support of Stay Smart online (October 2017) along with a comprehensive online campaign.
- A key awareness campaign was launched for Men's Health Week and for the month of 'Movember'.
  - Radio Release of 'Tiger' Corrigan for the 'Men Take Control with MHR' reached more than 1.5 million listeners, playing on 153 stations.
  - Tiger's video case study played more than 5,000 times.
  - Toolkits prepared for a range of partnership distribution channels consisting of flyers, posters, social media tiles, newsletter tiles, digital banners, and articles for print and digital use.
  - Partnered with s.47G [redacted] reaching 1,000 s.47G [redacted] across Australia, each with up to 250 members as well as 3,000 newsletter mailing list.

  - A video case study for 'Morto' played over 1,000 times.

- A series of newspaper journalist briefings, broadsheet coverage increased in national and state papers.
- Newsletters distributed through various partner organisations with articles placed in hard copy trade magazines such as:
  - the Pharmacy Guild Magazine;
  - Postscript;
  - Australian Pharmacist;
  - Retail Pharmacy;
  - Australian Doctor;
  - Australian Journal of Pharmacy;
  - Skytrans inflight magazine;
  - The Last Post, Anzac Day edition and Winter edition (2018);
  - Australian Healthcare and Hospitals Association, The Health Advocate; and
  - The Practice Manager.
- More than 5,000 people were involved in primary research and testing of creative concepts and messaging s.47C [redacted]
- On 1 February 2018 Mr Ken Wyatt MP and the Western Australia Primary Health Alliance ran an event for older Australians and 'grey nomads' to bring forward the benefit of MHR.
  - Five (then) Members of Parliament supported with media releases:
    - Deputy Prime Minister Barnaby Joyce;
    - Minster for Aged Care and Indigenous Health, Ken Wyatt;
    - Assistant Minister for Vocational Education and Skills Hon Karen Andrews MP;
    - Luke Hartsuyker MP; and
    - Liew O'Brien MP.
  - More than 2 million people were reached through regional television coverage.

- At 9:00pm AEST Thursday, 8 February 2018, Australian pharmacists held a 'TweetChat' with MHR as the primary topic.
  - The Agency participated via colleagues who are pharmacists on Twitter.
  - This had more than 60,000 opportunities to see (impressions).
- A presentation was given to s.47G CEO Parliamentary Forum at Parliament House.
- Federal Member for Farrar Sussan Ley, collaborated on an event to celebrate Berrigan as the first MHR 'connected town'.
- The new MyHealthRecord.gov.au website was launched in April 2018.
  - Prior to this new website, nearly a million people had visited the old site (983,633).
  - Between the site launched and the commencement of the opt out period, 560,000 unique visitors spent more than two minutes and read up to three pages per session.
- The Agency provided parliamentary briefing letters and packs to all 76 Senators and 150 sitting federal members, for the benefit of electorate offices and constituents.
- Televised National Press Club Address by Mr Tim Kelsey on 24 May 2018.
- A letter was sent to 680,000 Australian Health Practitioner Regulation Agency registered health practitioners and 40,000 members of the National Alliance of Self Regulating Health Professions.
- The Agency hosted the MP and senators briefing at Parliament House on Tuesday, 19 June 2018.

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Australian Government
Australian Digital Health Agency

Brief 4

Supplementary Budget Estimates — October 2018

MHR Expansion Provider Readiness

Subject

The MHR Expansion Program Provider Readiness stream is tasked with delivering MHR awareness and education to all Australian health care providers in readiness for the national opt out; and to enable providers to increase clinical use after the opt out period.

The Provider Readiness stream leverages a range of delivery partners across Australia to reach all health care professionals including: primary health networks (PHNs); state and territory jurisdictions; private hospital organisations; clinical and regulatory peak bodies and Aboriginal Medical Services (National Aboriginal Community Controlled Health Organisation and Affiliates).

Key points

Nation Wide

- Provider Readiness Awareness activities are now complete.
- Provider Readiness has moved into the Enablement phase of delivery, focused on education and support for clinicians in primary care, jurisdictions, ACCHOs and private hospitals to drive MHR registration and use.
- 31 PHN's have been engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent awareness target reached prior the commencement of opt out:
    - 5515 Community Pharmacies provided MHR awareness via face-to-face awareness activities; and
    - 7779 GP Practices provided MHR awareness via face-to-face awareness activities.
- All Jurisdictions are engaged and providing awareness across all hospitals:
  - jurisdictional awareness and education activities targeting frontline staff are complete and continuing;
  - All jurisdictional health organisation provided awareness to staff prior to the commencement of opt out;

- Private Hospitals:
  - all connected private hospitals in Australia engaged to provide clinical and front line staff awareness prior to the commencement of opt out;
  - awareness activities of all engaged health facilities prior the commencement of opt out are complete.
- Clinical and Regulatory Peaks:
  - RACGP and PSA contracted to provide education and awareness to members Australia wide, including messaging for the expansion; and
  - AHPRA and NASRHP direct email to all 720,000 combined members with notification complete.
- s.47G [redacted]

New South Wales

- 10 PHN's engaged to provide awareness to General Practices and Community Pharmacies
  - 100 per cent (1,301) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities
  - 100 per cent (1,059) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities
- eHealth NSW engaged to provide awareness across 18 LHDs and Health Networks
  - LHD Roadshows complete
  - NSW Health provided awareness to clinical frontline staff prior to the commencement of opt out
- s.47G [redacted]

Australian Capital Territory

- Capital PHN engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (99) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (16) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- ACT Health engaged to provide awareness across all hospitals and health faculties:
  - awareness activities complete and ongoing at all ACT Health Hospitals;
  - strong collaboration between ACT Health and ACT PHN to reach all clinicians; and
  - ACT Health provided awareness to clinical frontline staff prior to the commencement of opt out.
- s.47G [redacted]

South Australia

- 2 PHN's engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (459) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (432) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- SA Health provided awareness across all hospitals:
  - health awareness activities targeting frontline staff complete and ongoing; and
  - SA Health provided awareness to clinical frontline staff prior to the commencement of opt out.

- s.47G [redacted]

Northern Territory

- NT PHN engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (54) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (24) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- NT Health engaged to provide awareness across all hospitals:
  - Hospital education sessions ongoing; and
  - NT Health provided awareness to clinical frontline staff prior to the commencement of opt out.
- s.47G [redacted]

Western Australia

- 3 PHN's (WAPHA) engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (333) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (66) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- WA Health engaged to provide awareness across all hospitals:
  - hospital awareness targeting frontline and clinical staff complete and ongoing; and
  - WA Health provided awareness to clinical frontline staff prior to the commencement of opt out.

- s.47G [redacted]

Tasmania

- Tasmania PHN engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (58) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (45) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- Tasmania Health and DHS engaged to provide awareness across all hospitals:
  - awareness activities complete and ongoing; and
  - Tasmania Health provided awareness to clinical frontline staff prior to the commencement of opt out.
- s.47G [redacted]

Victoria

- 6 PHN's engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (655) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (949) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- Victoria DHHS engaged to provide awareness across all hospitals and Health Networks:
  - Hospital Roadshows complete; and
  - Victoria DHHS provided awareness to clinical frontline staff prior to the commencement of opt out.

- s.47G [redacted]

Queensland

- 7 PHN's engaged to provide awareness to General Practices and Community Pharmacies:
  - 100 per cent (701) of GP Practices provided MHR Expansion Awareness via face-to-face awareness activities; and
  - 100 per cent (366) of Community Pharmacies provided MHR Expansion Awareness via face-to-face awareness activities.
- Queensland Health engaged to provide awareness across all Hospitals and Health Networks:
  - Roadshows complete – frontline staff and awareness activities ongoing; and
  - Queensland Health provided awareness to clinical frontline staff prior to the commencement of opt out.
- s.47G [redacted]

Background

- 31 contracts with PHN's; totalling approximately $30 million (combined with communications funding).
- Contract management meetings with each PHN are held quarterly.
- Project Management roles backfilled at each jurisdiction to support Provider Readiness.

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Supplementary Budget Estimates — October 2018

Communication activities

Subject

The objective of the planned activities is to inform all eligible person that they will have a MHR created for them in 2018, unless they choose not to.

Key points

Communication progress

From Monday, 15 July 2018 until Friday, 12 October 2018:

- more than two million people (2,176,363) visited the MHR website following interest and publicity from the media;
- there have been over one billion opportunities to see social media content (1,020,652,567 impressions) with more than:
  - 88 million confirmed social media accounts with in Australia having the opportunity to see social media content;
  - 141 thousand pieces of content have been posted;
  - nearly 23 thousand authors;
- more than 139 million unique individuals across the world had an opportunity to see the social media content through social media reach;
- traditional media cumulative audience opportunity to see content 194 million times:
  - television – 51.3 million;
  - AM radio – 68.7 million;
  - FM radio – 14.5 million; and
  - newspaper – 53.9 million.
- 2,184 events completed through Primary Health Networks.
- 4,528 consumer surveys completed at events on iPads showing 87.1 per cent awareness that they would have a MHR created for them in 2018 and more than 67.2 per cent positive about this.
- 200 provider surveys completed showing 95.5 per cent awareness that people will have a MHR created for them in 2018 and more than 60.5 per cent positive about this. 53.5 per cent likely to view a patient's MHR, 49 per cent likely to upload, 56 per cent likely to recommend.

- Among 1,000 computer assisted telephone interviews for Wave 11 the total awareness (have heard of MHR) remains steady at around 87 per cent.

Communication strategy

A comprehensive channel matrix is being delivered with channels leveraged across Health, Community, Advocacy, Television, Digital, Paid Media and News.

Health

- Information is available via posters and brochures in over 15,000 healthcare locations include general practices, pharmacy, public and private hospitals and indigenous health services.
- s.47G [redacted]
- A national television campaign commenced on 14 October 2018 and will run for two weeks, break for a week, then recommence for another week ahead of the opt out Period end date.
- There is a 60 second animation and a 30 second human narrative that will play with strong programming across primetime channels Seven and Nine, Sky News after 6pm on Sunday. In Sydney, Melbourne and Brisbane the commercial will be seen on 7Flix, 7Two and 9 Life — in programs such as Modern Family, Come Dine with me and The Block.
- Paid advertising placement via the Tonic Media network includes 30 second animation on TV screens in 1,539 sites, 987 poster panels in GP's and 440 poster panels in pharmacy.
- Advertising in 20 million printed copies of magazines through s.47G [redacted]
- All information packs to all locations provided with a link to additional materials for download or printing.

Community

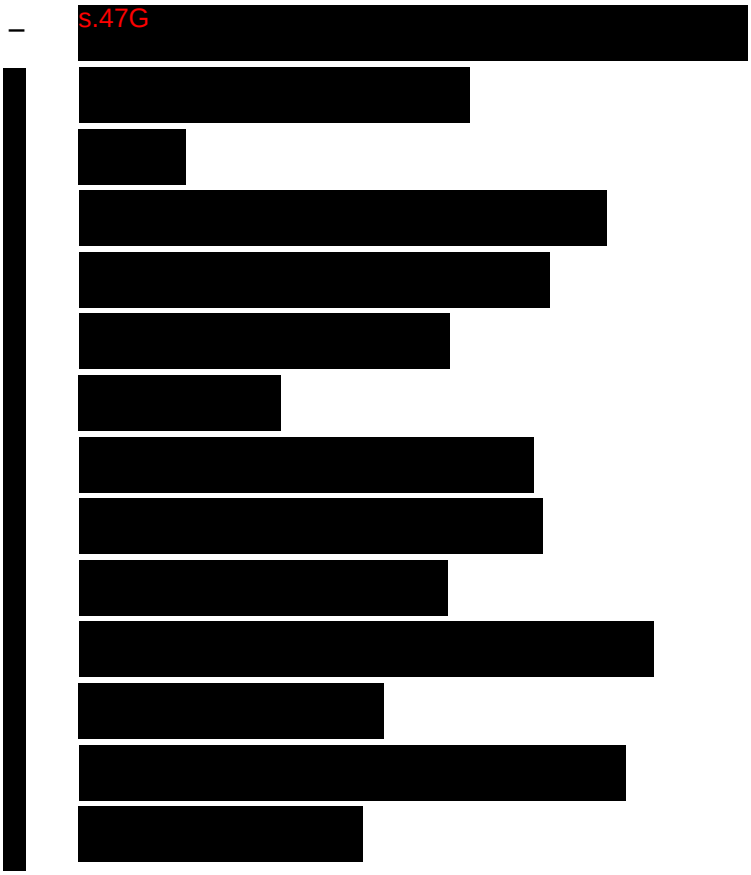
- 31 primary health network partners will have community engagement officer attendance at over 2,500 events nationally to answer consumer questions. Over 2,184 events have already been attended. This includes coverage in identified remote areas.
- 4,353 Australia Post outlets have brochures and posters. Video is being played in outlets across 243.

- s.47G [redacted]
- s.47G [redacted]
- DHS Community Engagement Officers, Multicultural Service Officers and Indigenous Service Officers have been trained to provide MHR information in their engagement with vulnerable individuals.
- Information available for all Federal MP's and State MP's via Jurisdictions with packs distributed as requested.
- Brochures available at 1,400 libraries.
- s.47G [redacted]

Advocacy

- There are 18 contracts with peak consumer organisations, and informal agreements with another 15 organisations — to undertake collaborative communications activity around MHR opt out communications to members and stakeholders. Scheduled activity varies by partner but may include:
  - distribution of MHR digital kits;
  - distribution of content and social media messaging;
  - presence at organisations' events;
  - conduct of webinars with member organisations;
  - briefing of organisation Boards and members meetings/forums;
  - hosting and presentations at organisations' conferences;
  - drafting and distribution of standalone organisation media releases; and
  - presentation of briefings to State and regionally based organisations.
- The list of 18 contracted organisations to complete the above activities during the opt out period are:
  - s.47G [redacted]

– s.47G



- 30 video case studies (across opt out) featuring consumers and clinicians available on the MHR website, via social channels and available for download. All will be available in 3x time lengths. 18 have been released, two are being delivered for release the week of 12 October 2018 and the remaining 10 are currently in various stages of post-production.
- The Agency has 47 clinical digital experts who are available for media and event appearance to discuss clinical concerns with consumers.
- The Agency is also starting to work with DHS outreach teams (Community Engagement Officers, Multicultural Service Officers, and Indigenous Service Officers) to educate their 240 staff members nationally so they can include information about MHR in their outreach with the community.

Digital

- Daily updates across the MHR social media channels, including Facebook, Instagram, Twitter, LinkedIn and YouTube.
- Activity via partner social channels including Primary Health Networks and stakeholders with social media kits and tiles provided.
- Responses to valid queries received on social channels to connect people with information or refer to the Help line or other referral points for assistance.

- MHR website and information available on other websites including DHS, OIAC, HealthDirect.
- s.47G [redacted]
- Paid digital advertising across Facebook, Instagram, digital display and audio, with creative messaging targeting key audiences including: working adults, parents, older Australians, young adults, carers, Australians Living a chronic diseases, Aboriginal or Torres Strait Islanders, veterans.
- The MHR website includes in-depth information for both providers and consumers and was relaunched prior to the commencement of opt out to improve user experience.
- Supporting consumer peak organisations to hold information webinars for their members, including a series of webinars with s.47G [redacted] disability peaks.

Advertising

- A total of over 7,000+ placements across digital, outdoor, radio and print.
- As above — paid advertising in Health locations via Tonic Media Network. A total of over 3,000 placements.
- As above — paid advertising on social and digital channels.
- As above — paid advertising on national television.
- Outdoor placements nationally utilising available formats within the region including large format billboards, transport advertising, and bus/tram shelter panels. Over 3,000 placements.
- Over 170 stations spanning FM and AM Radio, ethnic and indigenous radio. Over 12,000 spots booked.
- Print placements across 394 mastheads spanning metropolitan, local, ethnic and indigenous press. A total of over 1,000 placements.
- Imparja TV — to reach 1 million people in the most remote areas of Australia. Over 600 spots booked.
- A focussed outdoor media and social media campaign targeting young people aged 14–17 years commencing towards the end of October and during the last two weeks of opt out.

Publicity

- All 31 PHN's contracted to identify stories of MHR consumer use and or clinical benefit for the purpose of communication and publicity.

Brief 5

- Media management of all journalist enquiries with responses aimed to increase coverage of MHR in all media outlets nationally and locally.
- Spokespeople availability including Agency management, clinical representatives, consumer champions and stakeholder partners.
- Proactive identification of media opportunities with minimum 1 x media call per week during the opt out period.

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Supplementary Budget Estimates — October 2018

Aboriginal and Torres Straight Island remote engagement

Subject

The Agency has developed a relationship with the National Aboriginal Community Controlled Health Organisation (NACCHO) and have established contracts with each state and territory NACCHO Affiliate member to progress the delivery of digital health initiatives including MHR.

Key points

Indigenous health services awareness and education

- The Provider Readiness team were responsible for ensuring all Aboriginal Community Controlled Health Services (ACCHS) were aware of the MHR Expansion Program.
- This was done in conjunction with the National Aboriginal Community Controlled Health Organisation (NACCHO), the NACCHO State Affiliates and PHNs with extensive support from the Agency Education and Support Team and Aboriginal Community Liaison Officers.
  - Contact was established with NACCHO and each State Affiliate to gain support for planned approach for services. NACCHO and the Affiliates provided increased communication and support to assist with initial contacts with their member services.
  - Where the PHNs had existing relationships with the ACCHS, this was utilised and the PHN provided the education regarding awareness of the MHR Expansion Program.
  - Educational resources/toolkits with scenarios and case studies were developed.
  - The Education Support Team with support from the Aboriginal Community Liaison Officers visited all ACCHS that are members of the State Affiliates (and that the PHNs were not working with), to provide education regarding awareness of the MHR Expansion Program.
  - MHR Expansion Program workshops for Indigenous Health Services were run in every capital city in May 2018.

- 100 percent of NACCHO member ACCHS which provide clinical services were visited and provided with education by the Agency Education Support Team, or by the PHN staff by 27 July 2018.

Other peak body engagement

- The Agency has engaged with and invited collaboration from four s.47G [redacted]
- The Agency has contacted Commonwealth and State Indigenous government branches to provide information about the MHR expansion.
- Mr Tim Kelsey has sent letters with information about the MHR expansion to:
  - Aboriginal Legal Services;
  - Aboriginal Land Councils; and
  - The Congress of Australia's First Peoples.

Remote access plans

- Five PHNs have been contracted to develop and implement Remote Access Plans for communicating and directly engaging (face to face) Indigenous consumers living in Very Remote regions of the PHN. These have been delivered by the PHNs with assistance from the Agency's Aboriginal Community Liaison Officers.
- The Remote Access Plans have been complemented by other reach mechanisms including:
  - s.47G [redacted]

- s.47G [redacted]
  - Distribution of communication collateral through all health centres, and
- Paid advertising via social and digital channels targeting Indigenous audiences.

Aboriginal and Torres Strait Islander communication strategy

- Since September 2017, the Agency has conducted:
  - 81 Focus Groups including 11 with Aboriginal and Torres Strait Islander stakeholders at Sydney, Western Sydney, Bathurst, Melbourne, Brisbane, Broome, Palm Island and Millingimbi;
  - 65 In Depth Interviews including ten with Aboriginal and Torres Strait Islander stakeholders at Sydney, Western Sydney, Melbourne, Brisbane, Broome, Palm Island and Millingimbi;
  - 1000 Phone interviews including 1 percent who self-identified as Aboriginal and/or Torres Strait Islander;
  - 1007 online surveys;
  - 14 in depth phone surveys with a diverse range of PHNs to gather input into approach; and
  - 7 Indigenous Health Service Training and Engagement Workshops in each State and Territory.
- The Agency contracted a consultant who is a fluent Yolngu matha speaker with many years experience in Indigenous cross-cultural community engagement.
- All of this input has informed the collateral and other materials the Agency developed to meet the diverse needs of Aboriginal and Torres Strait Islander stakeholders and communities, while remaining within time and budgetary constraints.

Collateral for Aboriginal and Torres Strait Islander consumers

- A broad range of input and feedback informs the approach to meet the diversity of language and literacy needs while maintaining a consistent and culturally appropriate approach.
- Print Collateral Toolkits were sent to all ACCHS identified by NACCHO and all Indigenous Health Services identified by State and Territory Jurisdictions.

- Tailorable materials have been provided to PHNs to populate with locally relevant imagery. The availability of tailorable materials has also been communicated to all NACCHO members via email, and they will be able to access these through their PHN.
- Translated print materials have been made available in Yumplatok and Kriol including the poster, brochure, general factsheet and security and privacy factsheet.
- Translated audio and video materials in thirteen additional Aboriginal and Torres Strait Islander languages based on analysis of 2016 Census data. These will be made available on the Agency microsite and via the Aboriginal Community Controlled Health Services (ACCHS). Please note: These language resources were delayed due to interpreter availability.
- Paid advertisements on Imparja TV which reaches remote areas of Australia (excluding WA).
- Videos of Aboriginal and Torres Strait health providers and consumers have been recorded and are available online. These include:
  - Digital Health hits the road with the Awabakal Medical Service - when paper-based records became unfeasible to manage, the Awabakal Medical Service went digital, and discovered that quicker, more secure access to health information leads to better outcomes.
  - Rob & Sandra's MHR Story - Rob and his wife Sandra use MHR when they travel, to give their healthcare providers a convenient snapshot of their health, so they don't need to worry about remembering and repeating their health history.
  - MHR supports Esther after health scare – Esther Montgomery, an Aboriginal LGBTI woman, is living with a number of chronic health conditions including high blood pressure, high cholesterol, diabetes and stage 2 renal disease. Her initial concerns about confidentially were overcome when she learnt more about MHR's privacy and access controls. Esther is encouraging everyone to find out the facts about MHR to decide whether it's right for them.

Enhanced consumer support services

- Enhanced Consumer Support Services have been developed for identified populations, including Aboriginal and Torres Strait Islander populations, that do not have access to, choose not to, or are unable to, use the phone or online channels to elect not to be registered for a MHR.

- The Agency has introduced an Election not to be registered (opt out) form for MHR and has engaged with ACCHS, s.47G [redacted] and Australia Post outlets to make these forms available. ACCHS will provide assistance to their consumers to complete the form.

Other channels

- The Agency will also be communicating to Aboriginal and Torres Strait Islander consumers about the MHR Expansion Program via local Indigenous radio, local events and networks, Facebook groups and engagement with local champions and advocates.

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Brief 7

Supplementary Budget Estimates — October 2018

Hard to reach and vulnerable groups

Subject

The Agency identified several consumer cohorts that are considered hard to reach with consideration of the standard consumer communications strategy which would require additional and tailored approaches to ensure the opportunity to see MHR expansion messaging.

Key points

- Determination of the groups considered hard to reach for the purposes of the MHR Expansion Program was through size of the group based on Census data (or other credible data found online), the likely challenge for the group to come into contact with national communications being planned, s.47E(d) [redacted]
- Groups considered hard to reach are people (in size order):
  - that are illiterate or with low literacy;
  - that are living or travelling in rural and remote areas, including those living on Australian islands or Australian External Territory;
  - from culturally and linguistically diverse backgrounds (CALD) and/or that are permanent or temporary migrants;
  - that have a disability, are blind or with low vision, are deaf or have an intellectual disability;
  - Australians living or travelling overseas;
  - from an Aboriginal and Torres Strait Islander community (particularly those living remotely);
  - living with dementia;
  - that are homeless or have no fixed abode;
  - living in family and domestic violence refuges;
  - staying in a residential mental health care service, or that are temporarily incapacitated (during the opt out window); and
  - that are Fly in Fly Out (FIFO) workers (e.g. remote mine workers, oil rig workers).
- The Agency is committed to using all channels available to ensure that all Australians have the opportunity to hear about the expansion of the MHR system this year, and how to opt out if they don't want one.

- An end to end review was undertaken early in the program to ensure that communications channels and formats were used to reach all Australians, and also that all Australians have the opportunity to opt out if they choose.
- The Agency has engaged with over 40 national and state-based peak advocacy and other organisations which represent or support a wide range of 'hard to reach' and vulnerable groups including the Australian Council of Social Services (ACOSS), Mental Health Australia, LGBTI Health Alliance, National Rural Health Alliance, and others.
- The Agency has engaged the 31 Primary Health Networks (PHNs) throughout Australia to provide locally based engagement within the community, which includes hard to reach and vulnerable groups.
- There are over 150 local events scheduled across the country during the opt out period specifically targeting vulnerable groups.

Background

People with low literacy

- A plain text factsheet is available on the website and via delivery partners.
  - This was developed in conjunction with the Council of Intellectual Disability.
- Video formats are also available.

People living in rural and remote areas

- The Agency has agreements in place with Australia Post offices nationally to display MHR information and to provide opt out forms in remote areas where there may be limited/no internet connection and phone access.
- s.47G [redacted]
- s.47G [redacted]
- Several PHNs have also developed Remote Access Plans to ensure awareness in remote locations.
- Paid media through Imparja TV with reach of 1 million people living in remote areas.

Culturally and Linguistically Diverse Communities

- s.47G [redacted]
- We have consumer materials translated into 17 different languages and have an agreement with the Translation and Interpretation Service (TIS)
- We are working with DHS Multicultural Service Officers nationally to support MHR awareness raising in their outreach activities.

People with a disability

- Extensive engagement with key disability peak advocacy organisations has been undertaken to receive advice on the appropriateness and accessibility of Agency communications material and distribution approach.
- s.47G [redacted]
- s.47G [redacted]
- We have recently undertaken an independent accessibility review of the opt out portal s.47G [redacted] to enhance user experience of the portal, and MHR website for people with disabilities.

People living or travelling overseas during opt out

- We are working with s.47G [redacted] to communicate using their channels to reach this cohort.
- We are also targeting Australians overseas using digital and social media channels.

Aboriginal and Torres Strait Islanders (particularly those living remotely)

- We are working with the National Aboriginal Community Controlled Health Organisation to communicate with and educate the state based affiliates and indigenous health services to support Aboriginal and Torres Strait Islander communities nationally.
- Several PHNs have also developed Remote Access Plans to ensure awareness in remote locations, including
- We are working with DHS Indigenous Service Officers nationally to support awareness raising in their outreach activities.
- Paid media through Imparja TV with reach of 1 million people living in remote areas.

Living with Dementia

- We are working with state and territory health jurisdictions to provide awareness across state-run aged care facilities
- s.47G [redacted]
- s.47G [redacted]

Homeless/no fixed abode

- A number of key shelter, community housing and homelessness groups (national and state based) have been engaged to assist in the dissemination of information amongst those experiencing homelessness. A number of these groups have agreed to work closely with the Agency during the opt out period and will distribute communications and collateral to their service provider networks via existing channels (e-newsletters, social media, frontline service centres).
- The Agency attended the National Homelessness Conference in Melbourne, reaching over 800 delegates from the homelessness, community housing and social services sector.
- We are working with DHS Community Engagement Officers nationally to support MHR awareness raising in their outreach activities.
- Paid outdoor advertising will also reach people living on the streets or in temporary housing.

Living in family and domestic violence refuges

- The Agency is engaging with peak associations and support organisations to seek input into communications materials and for channels for communicating to people living in refuges during the opt out period.
- A Family Safety brochure is available on the website, and through delivery partners

Living in residential mental health care service or that are temporarily incapacitated

- The Agency has engaged with state and territory health jurisdictions to provide information materials to their hospitals and health services and to raise awareness across all their facilities, including mental health facilities and acute care.

Fly in Fly Out workers

- The Agency has communicated with FIFO workers through s.47G [redacted]
- Paid advertising at Darwin and Perth airport aims to help reach large FIFO work-force travelling through these airports.

Other vulnerable groups

- The Agency is engaging with national and state organisations that provide advocacy and support to other vulnerable groups, including those with specific health conditions (such as HIV positive or AIDS), people experiencing domestic and family violence, and for young people (specifically aged 14-17 when they can take control of their MHR).
- These organisations, including Positive Life NSW, s.47G [redacted], headspace, who are helping to shape messaging for these groups and to communicate relevant and factual information to these audiences.

Brief prepared by:	s.22 [redacted] Director, Channel Relationships CSSOD	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 8

Supplementary Budget Estimates — October 2018

International Comparison of approaches to digital health systems

Subject

How MHR compares to alternative systems of digitising health records internationally.

Key points

- Definition of an electronic medical record (EMR) and a personal health record (PHR).
  - EMR: contains information that is created and resides within a single healthcare organisation (e.g. a clinic, medical centre, or a hospital).(1)
  - PHR: is an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorised, in a private, secure and confidential environment.(2)
- Seven countries have a national PHR or similar (i.e. a citizen can view their records through a national digital platform) these include Austria, Denmark, Estonia, Finland, France, Norway and Sweden.
- An online PHR or national platform is under development in: Hong Kong SAR (due 2018),(3) UK (due 2018),(4) and Germany (due 2019).(5)
- France as an opt in model at a rate of 1.9 per cent.(6)

Citizen control

All countries (listed above) allow their citizens to hide or delete certain documents from the record. Advanced editing by citizens is uncommon.

Australia and France are the only two countries identified that have an editing or authoring functionality of their national PHR platforms.(7)

MHR therefore offers additional controls to individuals in comparison to many other national PHR systems reviewed as individuals have a number of privacy, editing and authoring rights.

Opt out rates

Information on opt out rates is unavailable for many countries. Of the countries listed below six have an opt out model. The rates of citizen access to record ranges from 18–50 per cent of total population depending upon digital maturity within each country.

Brief 8

International participation models, opt out rates and citizen control

Country (Population)	Participation model for record creation	Opt in/opt out rate of total pop.	Citizen control	Rate of citizen access
Australia (25 mil)	Opt out	N/A *1.9% opt out rate **in opt out trial sites**	Can author or edit parts. Can block certain documents or full record. Give access to nominated representative.	
Austria (8.7 mil)	Opt out[8]	3%[8]	Can hide or delete documents from their record.[7]	50% of population have had contact with system since go-live in 2015.[8]
Denmark (5.7 mil)	N/A. Created automatically.[9]	N/A.	Can block a record from specific clinicians or specific hospitals.[9] Can also block for a period of time that clinicians won't be at to access.[9]	In 2017, an estimated 30% of eligible users had logged on to the portal.[9]
Estonia (1.3 mil)	Record created automatically at birth[10] Can opt out.	s.33 [redacted]	Can close of data to all doctors or specific doctors. Can block either all of their medical data or only a part of it. Can grant access to their health data to other citizens (e.g. carer). Cannot edit or author, nor can they delete any health records. Can hide certain information.[7]	s.33 [redacted]

Country (Population)	Participation model for record creation	Opt in/opt out rate of total pop.	Citizen control	Rate of citizen access
Finland (5.5 mil)	Opt out[7]	N/A	Can block local municipal to use record.[11] Can block records associated with particular unit, register, in-patient period or individual visit. [11]	9.6% of population in July 2018 (528,753 unique users).[12] s.33 [redacted]
France (66 mil)	Opt in[7]	1.9% opt in[6] 1.25 million records created (e.g. rates of opt in as of July 2018) from target population of 66 million.[6]	Rolled out in 2010. Can author or edit parts of their record, can restrict access to documents.[7]	National redeployment planned for October 2018.[6]
Norway (5.2 mil)	Opt out[7]	N/A	Can decide which healthcare providers can access.[7]	N/A
Sweden (9.9 mil)	Opt out[13] (two distinct processes for opting out of portal vs opting out of shared record with providers).[13]	Estimated approx. 150 people (2018 to date).[13] Estimated 20-30 people per month.[13]	Can block access to certain parts of the record or the entire record.[13] Patients can add comments to their record in one region in Sweden only.[13]	1.8 million users = 18% of the population have accessed their medical records.[13] Over 1 million log-ins each month (not unique).[13]

Additional international EHR systems

Below are additional international EHR systems. This is in contrast to the PHRs and portals described above.

- **Hong Kong SAR:** Electronic Health Record Sharing System launched March 2016. It is the two-way EHR sharing among public and private healthcare providers. s.33 [redacted]
- **Israel:** Health plans have EHR systems that link community-based providers. Hospitals are computerised but not fully integrated with health

plan EHRs. The ministry of health is leading a major national health information exchange project to create a system for sharing relevant information across all hospitals and health plans. Patients can access some components online but full records not generally available.(14)

- **Singapore:** National Electronic Health Record launched in 2011 and has been progressively deployed in both public and private healthcare institutions. The system collects summary health records across different providers.
- s.33 [redacted]

Brief prepared by:	Name: s.22 [redacted] Position: Research Specialist Division: Office of the CMA	Work ohone: s.22 [redacted]

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Supplementary Budget Estimates — October 2018

Benefits realisation to date, including test beds

Subject

Expected benefits of the MHR benefits measurement approach, and evidence of benefits realisation to date.

Key points

- MHR will deliver real health benefits to all Australians. The key expected benefits are:
  - better access to clinical information, resulting in improved decision making;
  - reduction in unnecessary duplication of pathology and diagnostic imaging tests;
  - improved quality use of medicines, including a reduction in adverse events; and
  - time saved gathering clinical information and communicating with other health professionals.
- There is qualitative and quantitative evidence that key benefits are being realised. For example, in a survey of over 500 providers during April and May 2018, 61 per cent of general practitioners and 79 per cent of pharmacists who had used MHR, reported that they had experienced one or more benefit, which is comparable to 62 per cent of general practitioners and 69 per cent of pharmacists surveyed during July and August 2018 in the second wave of the survey.
- s.47C [redacted]
- To evaluate the impact of the MHR system the Agency has partnered with a range of institutions including: the University of Melbourne; Flinders University; University of Wollongong; Western Sydney University; the Australian Institute of Health and Welfare; NPS MedicineWise; and the NSW Ministry of Health.
- The Agency has invested $8.5m in 15 new Digital Health Test Beds to evaluate the impact of enhanced models of care. The test beds will utilise the MHR system and national infrastructure services as a platform to

foster sustainable, scalable innovation by entrepreneurs, industry, and health services.

- There is strong agreement that MHR has the potential to deliver a range of benefits (>80 per cent agreement amongst surveyed healthcare providers). In addition, a qualitative study which interviewed 35 GPs and practice staff in a s.47G found that providers no longer question the introduction of MHR and or the use of it in their practice; rather they focus on how they can better use and promote functionality of the system.
- s.47C
- This information is being used to calibrate awareness and educational activities, and tracking will continue through to mid-2019 to enable the Agency to monitor the effectiveness of the Expansion Program and identify areas where new approaches or additional effort is required.

Background

Evidence of reduction in unnecessary duplication of pathology and diagnostic imaging tests

- In the first wave, 14 per cent of GPs surveyed during April and May reported not needing to order a pathology or diagnostic imaging test through being able to see previous test results. In the second wave of the survey undertaken over July and August this proportion rose to 19 per cent.
- s.47G
- s.47G

Evidence of improved quality use of medicines, including reduction in adverse events

- In the first wave, 13 per cent of GPs and 29 per cent of pharmacists surveyed reported observing an avoided potential adverse medicines event by having access to a patient's medicines information. In the second wave of the survey undertaken over July and August these proportions were 15 per cent of GPs and 19 per cent of pharmacists.
- s.47G [redacted]
- s.47G [redacted]
- s.47G [redacted]

Evidence of better access to clinical information and time saving

- During July 2018, over 11,000 documents were viewed which had been uploaded by *other* organisations. This is more than double July 2017 (115 per cent increase), and more than quadruple July 2016 (419 per cent increase).
- In the first survey wave, 36 per cent of GPs and 57 per cent of pharmacists surveyed reported being able to view information via MHR which was previously unknown and otherwise would not have been accessible. In the second wave of the survey undertaken over July and August these proportions were 32 per cent of GPs and 50 per cent of pharmacists.
- Approximately 1 out of 3 GPs and pharmacists surveyed reported saving time requesting and gathering patient medical information, and also communicating information to other providers.
- s.47G [redacted]

Brief prepared by:	s.22 [redacted] Director GICSD	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 10

Supplementary Budget Estimates — October 2018

Children and young people (14 and 17 year olds)

Subject

Parent's access to the MHR for their children changes as the child grows older.

Key points

- A parent or guardian (with documented proof) can be an Authorised Representative and access a child's MHR.
- At age of 18 years of age the System Operator automatically revokes an Authorised Representative access.
- The role of Authorised Representative is legislated under the MHR Act and the MHR Rule.
- A person 14 years old or over, can at any time take control of their own record and remove an Authorised Representative.
- Children under 14 are able to take control of their own record by establishing that they are a mature minor.
- s.47G [redacted]
- Of the 6 million MHRs, more than one third (2.05 million) are for a person under 18. Of those, the vast majority, 1.8 million, have a parent as an Authorised Representative (AR).
- s.47G [redacted]
- The Agency has developed specific materials to communicate on the MHR to young people and their parents which have been reviewed by young people through s.47G [redacted].

Background

- The role of an Authorised Representative until a child turns 18 is specified in the *My Health Record 2012 Act* and the *My Health Records Rule 2016*.
- This means that they can take control of and manage the child's MHR on the child's behalf. If a parent does not take control of the child's record, the record will still be available to health professionals who are providing care to the child.

- A child can take control of their record either online or via the call centre (1800 723 471).
- When this occurs, the parents (Authorised Representatives) and any Nominated Representatives are automatically removed at this point. The child can provide access to their parents (or others) if they choose by appointing them as Nominated Representatives.
- s.47G [redacted]

Mature Minor

- Agency policy specifies that for children under 14, the child is able to take control of their own record by establishing that they are a mature minor.
- This is done by contacting the call centre and providing a letter from a health professional or a court. The child can still choose to provide access to a parent (or others) by appointing them as a Nominated Representative.

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Australian Government
Australian Digital Health Agency

Brief 11

Supplementary Budget Estimates — October 2018

Children in care

Subject

The Agency is supporting all eight state and territory Care Agencies to manage MHRs for children in their care.

Key points

- States and territories have responsibility for managing the welfare of children in out of home care.
- The Agency is supporting the eight state and territory Care Agencies to manage MHRs for children in their care given Care Agencies have responsibilities for children in out of home care.
- A specific portal has been provided to jurisdictions to enable care agency employees to easily (direct from their desktop computer) become Authorised Representatives and to access and manage MHRs on behalf of children in their care.
- The portal also enables the care agency employee to advise the System Operator of appropriate access by the child's parents, foster parents and carers in line with local Care Agency policies and processes.
- s.47B(a), s.47B(b) [redacted]
- Engagement with Care Agencies has been at the highest level and the Agency's Chief Executive Officer has written to all the Chief Executives of the Care Agencies on multiple occasions.
- Children in out of home care can have complex health issues and having access to up to date health information in the MHR will be invaluable for those children and their carers, and presents a real opportunity to improve health outcomes for these children.

Brief prepared by:	s.22 [redacted] Director, Policy and Strategy GICSD	Work phone: s.22 [redacted]

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Brief 12

Supplementary Budget Estimates — October 2018

Family safety issues

Subject

Concerns that MHR may be misused in domestic violence situations.

Key points

- There is no default access by a partner or family member to an individual's MHR. An individual can only access another person's MHR if they are appointed as a Nominated Representative or an Authorised Representative by the individual that owns the record.
- In relation to children's records:
  - For opt in, if a parent opted their child in s.47G [redacted] that parent is automatically set as the Authorised Representative of that child when the child is added to the parent's Medicare card.
  - For opt out, people with parental responsibility must apply to be an Authorised Representative on their child's MHR. This means that there is no default access by a partner or family member to a record.
- There are concerns regarding the potential for inappropriate access to information in a child's MHR by an estranged parent. The Agency has already acted to proactively address these issues:
  - s.47B(a), s.47B(b) [redacted]
  - s.47E(d) [redacted]
  - Engaging with a number of organisations including s.47G [redacted] to determine how best the Agency should work with consumers and raise awareness of the privacy and access controls available in the MHR system.

- In addition, a number of jurisdictions have also undertaken some mitigation activity by either:
  - not sending documents to the MHR for consumers under the age of 18 s.47B(a), s.47B(b) or
  - sending documents with the address masked s.47B(a), s.47B(b).
- A parent who has a concern regarding a non-custodial parent's access to their child's MHR can call the 24/7 helpline where the MHR can be immediately suspended (which removes access to any representatives).
  - When the record is suspended no representatives can access the child's health information in their MHR.
  - In line with the policies of other government agencies, the System Operator then investigates eligibility. Following investigation, an Authorised Representative's access can be reinstated where appropriate.
  - This can even be done before the child has a MHR and will ensure a record cannot be created if one does not already exist.
- In addition, Authorised Representatives have a number of options to manage sensitive information in their child's record.
  - An individual can opt their child out of having a record.
  - An individual can ask a health care provider to not upload information and the health care provider must comply.
  - An individual can see a full history of all access to their MHR, and are able to contact the Agency to get more information about these accesses.
  - An individual can cancel their record at any time which ensures no one can access the information in the record.

s.47E(a), s.47E(d)

##

s.47E(a), s.47E(d)

[redacted]

Brief prepared by:	Name: s.22 [redacted]	Work phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 13

Supplementary Budget Estimates — October 2018

Genetics and genomics and the MHR

Subject

Genetics and genomics and the MHR system.

Key points

- The MHR system cannot store a person's genome (complete set of DNA).
- Genetic tests are part of the standard suite of diagnostic investigations that have been commonplace in medicine for many years to help make accurate diagnoses to ensure people receive the best possible treatments.
- Conditions like cystic fibrosis, anaemia and iron disorders have been diagnosed in general practice with genetic tests for many years.
- Genetic testing is also depended on to routinely screen for neural tube and other issues in early pregnancy as a standard practice for all Australian women as part of routine antenatal care.
- Genetic screening plays an important role in the early diagnosis and screening for cancers like breast cancer and ovarian cancer, and plays a vital role in tailoring specific treatments for people with many different types of cancers.
- Like any other pathology tests, a person in consultation with their clinician can discuss whether to have a test result uploaded into their MHR.
- In addition a person can exercise a range of privacy controls so that they can choose which clinicians have access to these results.

Genome.One

- In 2017, the Agency released an open tender to pathology providers, to support them to connect and upload pathology reports into MHR.
- Genome.One applied and was successful in the open tender.
- Genome.One and the Agency signed an agreement in late September 2017.
- Genome.One is an accredited pathology laboratory under the RCPA/NATA accreditation scheme, and the Agency agreement is for the supply of a pathology report (not for the supply of genomic information).

Brief 13

Joint committee on Genomics

- The Joint Committee, established in 2017, is a collaboration between the Australian Genomics Health Alliance (Australian Genomics) and the Agency.
- The purpose of the Joint Committee is to advise, exchange knowledge and contribute to building the evidence to inform how digital health can support the advancement of precision medicine and other public good activities that are enabled by the integration of genomic information with health and related data.

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Brief 14

Supplementary Budget Estimates — October 2018

Access to the MHR by employers and insurers

Subject

Access to MHR by insurers and employer organisations.

Key points

- Concerns have been raised in the community that insurance companies may be able to access an individual's MHR to set premiums, or that employers could get access to their employees' record through employer appointed healthcare professionals.
- These actions are specifically prohibited under the governing legislation.
- Under the *Healthcare Identifiers Act 2010* (the Act), specifically subsection 14(2), healthcare providers cannot use a healthcare identifier for employment and insurance purposes, and as a consequence cannot access an individual's MHR for such purposes.
- Under the Act it is expressly prohibited and using or disclosing a healthcare identifier without authority is an offence and subject to severe penalties, including two years in jail and a fine of $126,000.

Access by doctors/nurses employed by insurance companies

- The healthcare service of an insurance company are prohibited from sharing an individual's health information with any other part of the insurance company that is not directly involved in providing health care to the individual.
- MHR data cannot be accessed by insurance companies who offer direct health care services for any other reason.

Professional Indemnity (decisions made by doctors)

- Professional indemnity insurers are only authorised to access the MHR system where it relates to the investigation of a clinical incident, where the clinician relied on information supplied by the MHR system.

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Australian Government
Australian Digital Health Agency

Brief 15

Supplementary Budget Estimates — October 2018

Clinician access to the MHR System

Subject

Who can access the MHR system?

Key points

- It is not possible for the MHR system to be browsed.
- There are two mechanisms by which a healthcare provider can view an individual patient's MHR, both of which have robust authentication processes in place, through the National Provider Portal or through a Clinical Information System, both of which are explained below.
- To access the MHR system through the National Provider Portal, the health care provider needs to:
  - have an individually assigned Healthcare Provider Identifier - Individual (HPI-I);
  - work within an organisation that has registered for and received a Healthcare Provider Identifier - Organisation (HPI-O); and
  - provide the name, Medicare card number, gender and date of birth of the individual whose record they are trying to access.
- To access the MHR system through the Clinical Information System, the healthcare provider needs to:
  - be using conformant software which has a secure and encrypted connection to the MHR system;
  - be authorised to access the system by the healthcare provider organisation; and
  - be providing care to a patient of the practice who has had a record created on the local Clinical Information System (with patient name, Medicare number, date of birth and gender as part of the local record).
- These safeguards are in place to ensure that only members of a patient's healthcare team who are authorised and are treating a person are able to access a record.

900,000 registered health practitioner's access to system

- Some media reporting on privacy elements of the MHR system have required clarification since the opt out period began.
- In particular the assertion that the system is open access and available to 900,000 registered health practitioners who can see people's sensitive medical results.
- This is incorrect.
- Only registered health practitioners directly involved in the care of a person may access their MHR.
- Deliberate unauthorised access of a person's MHR may result in criminal penalties, including up to two years in prison and $126,000 in fines.

Types of Individuals who can received an HPI-O (see list below)

- While a number of health professionals are eligible to apply for an HPI-I, they still must be part of a Registered Health Care Provider Organisation.
- These provider organisations must have conformant clinical software and appropriate security and privacy protocols in place.

Administrative staff access to MHR

- Administrative staff — or any other staff — who are not involved in providing healthcare are not permitted to access MHR.
- Healthcare provider organisation access is logged in the patient's MHR.
- If an individual or corporation were to misuse information in the MHR system they would be subject to criminal and civil penalties.

Brief prepared by:	s.22 [redacted] Director, Policy and Strategy GICSD	Work phone: s.22 [redacted]

Provider Organisation type breakdown

Provider Organisation Type	Comprises
General practice	General practice and super clinics
Hospital	Hospitals (except Psychiatric Hospitals)
	Mental Health Hospitals
Pharmacy	Retail Pharmacy
Specialists	Specialist Medical Services
Aged care providers	Aged care providers
Other	Central Government Healthcare Administration
	Chiropractic and Osteopathic Services
	Contract Service Providers (CSP)
	Dental Services
	General Health Administration
	Local Government Healthcare Administration
	Optometry and Optical Dispensing
	Other Allied Health Services
	Other Healthcare Services
	Other Professional, Scientific and Technical Services
	Other Residential Care Services
	Other Social Assistance Services
	Pathology and Diagnostic Imaging Services
	Physiotherapy Services
	Provision and administration of public health program
	State Government Healthcare Administration

AHPRA Registered Practitioners	**Self-regulated professions**
Aboriginal and Torres Strait Islander Health Practitioner	Audiologiologists
Chinese Medicine Practitioner	Arts Therapists
Chiropractor	Holistic and Transpersonal Counsellors
Dentist	Social Workers
Medical Health Professional	Counsellors
Medical Radiation Practitioner	Diabetes Educators
Nurse and Midwife	Natural Therapists
Occupational Therapist	Traditional Medicine Practitioners
Optometrist	Dietitians
Osteopath	Exercise and Sports Science Providers
Paramedic	Herbalists
Pharmacist	Psychotherapists
Physiotherapist	Paramedics
Podiatrist	Pedorthic
Psychologist	

Australian Government
Australian Digital Health Agency

Brief 16

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Contact centre services

Subject

MHR contact centre services and performance.

Key points

- The contact centre provides one of three channels (online, paper form and phone) for consumers to opt out of the MHR system.
- The contact centre is operational 24/7, with the exception of national public holidays and responds to opt out, general, registration and record content enquiries.
- Call duration depends on the topic of the call and complexity of individual enquiries.
- From 16 July to 7 October 2018 the contact centre had:
    - responded to approximately 207,000 calls with approximately 132,000 of these calls relating to opt out. (Note: this does not directly correlate to an opt out decision.)
    - an average wait time of 15 seconds (opt out calls answered) plus 15 seconds (complex enquiries), or 34 seconds (dedicated cancellations line established on 19 July).
    - 35.3 per cent of callers have responded to the Customer Satisfaction Survey and of those 95.3 per cent were satisfied or very satisfied.
- Following consumer feedback a Help line wait times webpage was developed to help inform consumer's expectations of wait times throughout the day.
- Consumers were also reminded of the information needed (Medicare card details) to complete opt out via phone.
- s.47E(a), s.47E(d) [redacted]

Background

- s.47E(a), s.47E(d) [redacted]
- [redacted]
- [redacted]
- Call centre staff cannot see the content of any clinical or Medicare documents. They are able to see that a clinical or Medicare document has been uploaded e.g. discharge summary but not the information contained in it.

Brief prepared by:	Name: s.22 [redacted] Position: General Manager Division: CSSO	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 17

Supplementary Budget Estimates — October 2018

Mobile apps

Subject

The Agency Mobile Developer Program allows consumers to choose to view their MHR through third party apps.

Key points

- Organisations wishing to connect to the MHR via an app, must undergo an assessment and then become a Registered Portal Operator.
- The purpose of the Agreement is to satisfy the System Operator (the Agency) that the party applying to be a Registered Portal Operator:
  - complies with the MHRs Act and Rules, and
  - agrees to be bound by the conditions of registration outlined in the Portal Operator Registration Agreement.
- The Agreement is covered under section 47 of the *My Health Records Act 2012*.
- There are currently five authorised third party apps which allow consumers secure 'view only' access to their MHR.
- These apps do not permit any storage of MHR information on their systems.
- They are also prohibited from using MHR information for secondary purpose — like passing the information onto a third party.
- Consumers must download and explicitly consent to an authorised app connecting to their MHR and at any time are able to withdraw this consent.
- If a person or organisation were to deliberately access an individual's MHR without authorisation, criminal penalties may apply.
- These may include up to two years in jail and fines.

Review of mobile apps

- Late last year with the announcement that the MHR system would move to an opt out model of registration, the Agency undertook a review of the Mobile Developer Program to ensure it met community expectations around security and privacy.

- Following a review, the Agency has made changes to the Agreement which sets out terms and conditions that developers must agree to before connecting to the MHR Gateway in the Production Environment.
  - Management has strengthened a number of terms, including:
    - the right for the Agency to terminate for convenience; and
    - a more detailed and expansive change of control provisions that would permit the Agency to terminate the agreement.
- The updated Agreement has been approved and is published on the Agency's website under the Freedom of Information page.

Background

- The Agency has taken a risk-based view only approach to continue the Mobile Developer Program;
  - All MHR data accessed by Mobile Apps is view only — MHR data may not be modified or updated by Mobile Apps.
- The Agency continues to regularly review the terms and conditions contained in contracts it has with various suppliers and partners. This reflects contract management and procurement best practice.
  - Specifications for integrating into the MHR System through the MHR FHIR (mobile) Gateway are published on the Agency's website.
- Mobile apps may only access MHRs of consumers that have provided informed consent; consumers may reverse their consent at any time by logging into myhealthrecord.gov.au.
- The current apps in Production that users can download are: Telstra's HealthNow; Chamonix's Healthi; Tyde's Tyde Health; Health Engine; and the Agency's My Child eHealth.
- s.47C, s.47E(d), s.47G [redacted]

Budget allocation

- s.47C, s.47E(d) [redacted]

[redacted]

Current work packages

s.47E(d) [redacted]

Roadmap

s.47C [redacted]

Brief prepared by:	s.22 [redacted] General Manager, Service Delivery Innovation and Development	Mobile phone: s.22 [redacted]

Notifiable data breaches under the *My Health Records Act 2012*

Subject

- Notifiable data breaches and mandatory breach reporting.

Key points

- The Office of the Australian Information Commissioner (OAIC) has a regulatory oversight role in the *My Health Record Act 2012* (the Act), which is administered in part under a Memorandum of Understanding (MoU) with the Agency.
- Under section 75 of the Act, the System Operator has an obligation to notify the OAIC of certain data breaches. Data breaches are described in section 75 of the Act, which requires those entities to notify the OAIC as soon as practicable where there has or may have been:
  - unauthorised collection, use or disclosure of health information included in a MHR; or
  - events or circumstances that compromise, may compromise, have compromised or may have compromised, the security or integrity of the MHR system. This covers circumstances where there was the potential for unauthorised access to data but the access did not actually occur.
- Under the Act, the obligation to notify the OAIC is triggered when there may have been a data breach.
- The OAIC then considers whether the circumstances warrant opening an investigation.
- Each breach is examined by the OAIC and to date all data breaches have been satisfactorily closed with no negative findings against the System Operator.

Security breaches

- Security breaches are a type of data breach where the system or data is accessed by bypassing the security controls in place, for example if a person were to break the authentication controls and gain access to a record.
- In six years of operation there has never been a Security Breach of the system.

Privacy breaches

- The term 'privacy breach' is not defined in legislation but is a term commonly used in the community.
- A reasonable person would say their privacy had been breached if another person without authorisation had viewed their personal health information (e.g. test results, reports or medical notes).
- There is no evidence of deliberate unauthorised access to health information in the MHR system.
- The term 'privacy breach' is not a term we use in our management of the System — instead, we refer to data breaches as per the legislation.

Office of the Australian Information Commissioner Memorandum of Understanding

- The OAIC publishes reports on its activities conducted under the MoU (including information on data breach notifications) in relation to the MHR system. These reports are released on the OAIC website.
- The last OAIC report (2016–17) was released in October 2017 with six data breaches reported by the System Operator which impacted 11 people.
- Separately, the Department of Human Services monitors and addresses fraudulent Medicare claims and processing errors and reported 29 data breaches to the OAIC.
- These data breaches involved information created through fraudulent claims or processing errors which ware sent to the MHR.
- In 2017–18, three data breaches were reported by the System Operator which impacted four people.
- In addition, The Department of Human Services reported 39 data breaches resulting from fraudulent Medicare claims and processing errors.
- All of the data breaches reported to the OAIC have been addressed and affected parties have been notified.

Background

- The 2016–17 OAIC report contains details of six data breaches reported by the Agency as the MHR System Operator.

- Of the six data breaches detailed in the 2016–17 OAIC report, four were the result of unauthorised access s.47E(a) [redacted]
- s.47E(a) [redacted]
- There is no evidence that an unauthorised person actually viewed any health information in the MHR; only demographic information such as name and date of birth was viewed.
  - s.47E(a) [redacted]
- Separately, the 2016–17 OAIC report notifies of 29 reports made by the Department of Human Services. Twenty arose from Medicare fraud s.47E(a) [redacted] and another nine where Medicare records were incorrectly attributed to people who shared the same demographic details (e.g. same first name, second name, surname or date of birth).

- Of the three breaches reported by the System Operator in 2017–18, two resulted from unauthorised access which stemmed from alleged fraud against Medicare.
  - s.47E(a) [redacted]
- The third breach occurred due to incorrect processing of the form FA081 s.47E(a) [redacted]
  - s.47E(a) [redacted]
- Of the 39 data breaches reported by the Department of Human Services, 22 arose from Medicare fraud s.47E(a) [redacted] and another 17 where Medicare records were incorrectly attributed to people who shared the same demographic details (e.g. same first name, second name, surname or date of birth).

Brief prepared by:	s.22 [redacted] Director, Policy and Strategy GICSD	Mobile phone: s.22 [redacted]

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Australian Digital Health Agency

Brief 19

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Effective removal of a MHR

Subject

Can a MHR be deleted?

Key points

- As part of the Government's announced legislative changes, the legislation will be amended to ensure if someone wishes to cancel their MHR they will be able to do so permanently, with their record deleted from the system.
- This will ensure if someone wishes to cancel their record they will be able to do so permanently, with their record deleted from the system.
- Under the current law, the Agency cancels a record and archives the record for 30 years after the death of the record holder (if that date is not known, 130 years after the birth of that person).
- Only the System Operator can access this archive and it is not visible to any healthcare providers or the individual.
- These changes acknowledge the evolving expectations of the community since the legislation was first debated and approved in Parliament in 2012, and the willingness of Government to listen and to deliver a MHR system that supports all Australians to have better and safer health care.
- Once the legislative process concludes, the necessary technical changes will need to be made to the MHR system to allow for records to be permanently deleted.
- This will include the deletion of records of any individual who has cancelled their MHR since the system began operating on 1 July 2012.

Brief prepared by:	s.22 General Manager Office of the Chief Executive	Mobile phone: s.22

Supplementary Budget Estimates — October 2018

Payments to peak bodies from AusTender

Subject

The Agency has, in line with the MHR Expansion Program provider readiness stream, worked with a range of organisations including peak bodies to create awareness, enable use and drive participation.

Key points

- s.47G [redacted] from 1 January 2018 the Agency would become a prescribed Corporate Commonwealth Entity (CCE) and would be subject to the Commonwealth Procurement Rules (CPRs) as outlined at section 3.7 of the CPRs.
- As a prescribed CCE, the Agency was provided access to AusTender (the Australian Government's central procurement system) for the publication of a range of procurement related information including, for example, planned procurements, relevant contracts and open tenders.
  - Reporting of all contracts on AusTender valued above $80,000 (GST inclusive) became mandatory at that time.
- Up until 31 December 2017, the Agency was classified as a CCE, and was not allowed to use AusTender.
  - Therefore, contracts were not reported on AusTender as was required of non-corporate Commonwealth Entities (such as the Department of Health).
- The Provider Readiness delivery stream is built on a three tier approach across the two year program: awareness, enablement and participation.
- Procurement within the 2017–18 year focussed on awareness in the primary health care space covering general practice, pharmacy, allied health and practice management.
- Deliverables for awareness focused on reach across the health sector, alignment with other program deliverables and the need for a range of channels to reach clinicians.
- To achieve awareness, a multi-channelled approach was specified by profession with alignment across health care environment including jurisdictions, Primary Health Networks (PHNs), private hospitals and regulating bodies for health professions.

Deliverable design

- Following identification of key professions (general practice, allied health, pharmacy and practice management), the specific requirements of each cohort were derived.
- The key learnings of large scale health change management campaigns informed the required deliverables with inclusion of self-paced education, peer to peer messaging, communications and face to face education.
- Procurement across the initial wave of awareness built on the provider readiness strategy using delivery partners that held the credibility, trust and reach of the focus professions.
- s.47E(d) [redacted]
- The decision to engage clinical peak bodies across the provider readiness strategy drew on the need to reach clinicians in a multi-channelled strategy, driven by the need of clinicians across the health care environment to draw appropriately designed information from trusted sources.
- Clinical peak bodies are frequently a trusted contact for clinicians, supporting Continuous Professional Development (CPD) education, information on current topics of interest, changes in national policy and updates in clinical work flows.
- The breadth of engagement through clinical peak organisations facilitated the adaptation of key deliverables to meet the needs of specific health care provider groups as identified in the primary focus group (general practice, pharmacy, allied health, practice managers).
- The work of the clinical peak bodies in providing information to members sits in parallel to other trusted channels for health care providers including jurisdictions, PHNs, private hospitals, and health regulating bodies.

Background

The procurement of deliverables by clinical peak bodies is outlined below with deliverable, budget and reach specified in table 1.

Peak body	Deliverable	Total contract value (incl. GST)
RACGP (38,000 members)	Peer to peer education hosted nationally, with face to face and webinar events Presence at conferences nationally Communication strategy	$1,463,000
RACGP (38,000 members)	CPD compliant self-paced modules and allocation of points Provider brochure on the MHR Communication strategy	$391,501
s.47G, s.47E(d) [redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Brief prepared by:	s.22 [redacted] General Manager, Community and Clinical Partnerships CCECGD	Mobile phone s.22 [redacted]

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Australian Digital Health Agency

Brief 21

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MHR reported event — management process

Subject

The Agency has a reported Event Management Framework. This framework ensure all reported events are managed consistently, effectively and efficiently.

Key points

- The Agency has a robust 24/7 reported Event Management Framework to support the active investigation, mitigation and resolution of events reported in the MHR System.
- The framework is supported by an experienced and dedicated team of clinical, security, privacy and systems experts.
- The framework has clinical safety at its heart, with all events assessed for clinical safety impact.
- The majority of the events are administrative and do not have clinical aspects.

Types of incidents

- s.47E(a) [redacted]

- s.47E(a) [redacted]
- [redacted]
- [redacted]
- [redacted]

Brief prepared by:	s.22 [redacted] General Manager Operations	Mobile phone: s.22 [redacted]

Consumer complaints

Subject

The Agency takes all complaints seriously and actively manages complaints through our complaint management process.

Key points

- Consumers can make a direct complaint to the Agency through a variety of channels including our dedicated consumer call centre and our website portal.
- The Agency also manages consumer complaints that may come through indirect channels such as the Minister's office or the Ombudsman's office.
  - The Agency has only received one complaint via the Ombudsman's office s.47C [redacted]
- The Agency has a number of escalation points for complaint management including:
  - complaints that are received via the website portal are escalated to our Tier 3 call centre;
  - complex complaints can be escalated to the Tier 3 call centre; and
  - complaints may also be transferred to our internal event management team if there is early evidence that an investigation may be warranted.

Data

s.47E(d) [redacted]

s.47E(d) [redacted]

Background

- Consistent with the 2016–17 Budget, consumer contact centre functions were transferred to the Agency from the Department of Human Services (DHS) on 19 March 2018.
- DHS continue to provide all MHR Provider services due to their high inter-relationship to HI and National Authentication Service for Health support functions.
- s.47G, s.47E(d) [redacted]
- Call centre staff cannot see the content of any clinical or Medicare documents. They are able to see that a clinical or Medicare document has been uploaded e.g. discharge summary but not the information contained in it.
- s.47E(a) [redacted]

Brief prepared by:	s.22 [redacted] General Manager Operations	Mobile phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

System performance

Subject

The MHR system has been performing as expected since the commencement of the opt out period on 16 July 2018.

Key points

- The core MHR system has been stable throughout the opt out period to date.
  - System performance and availability have exceeded service level agreements.
- s.47G [redacted]
- s.47E(a), s.47G [redacted]
- There was a significant spike in additional activity across the key usage channels when comparing the three week period before and after opt out started on 16 July 2018.
  - s.47C [redacted]

- s.47C [redacted]

- Following this initial spike, system usage has levelled out s.47C [redacted]
- As expected the system has been able to meet the additional usage without any difficulties; availability and responsiveness service level agreements continue to be exceeded, and technical errors rates are well within normal operating limits.

s.47G [redacted]

- s.47E(a) [redacted]

Brief prepared by:	s.22 [redacted] General Manager Operations	Mobile phone: s.22 [redacted]

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Brief 24

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MHR program governance and assurance

Subject

The MHR Expansion Program has been planned and implemented with the highest standard of governance and robust internal and external assurance.

Key points

- The Expansion Program is on track to deliver by December 2018, to cost, quality standards and benefits realisation.
- s.47G, s.47E(d), s.47E(a) [redacted]

Background

- The Agency has adopted an industry recognised Program Management Framework based on Managing Successful Programs and PRINCE2 which

provides for a consistent approach and governance model for delivery of large scale programs like the MHR Expansion Program.

- In alignment with the PRINCE2 Methodology, the Agency Program Delivery Framework consists of four stage gates (Initiation, Plan, Delivery and Closure) and also defines the:
  - specification of required programs and project artefacts;
  - required entry and exit criteria for each program stage; and
  - stage gate and stage review compliances for each program stage.
- MHR is delivered to a Program Delivery Framework which clearly defines the:
  - Program Governance framework;
  - the Quality Plans and framework;
  - the Risk Management Plans and framework;
  - Change Control Framework;
  - Benefit Realisation framework;
  - a communication strategy;
  - a Procurement strategy; and
  - a Program Implementation Plan.
- The Program has a robust 3–Tier governance structure (Strategic, Programme, Operational) in place, consisting of:
  - Tier 1 — Agency Board and Program Board to oversee MHR expansion and is responsible for setting the overall strategic design, direction and alignment to strategy, overseeing all strategic investment decisions and responsible for the realisation of benefits;
  - Tier 2 — Program Management Office and Program Delivery Committee to oversee execution and provide decision and execution guidance at program level; and
  - Tier 3 — Program Management Working Groups to manage, delivery of projects within the program and manage day to day operational delivery of MHR Expansion.
- A Reporting framework exists with an established cadence schedule of reporting consisting of:
  - monthly Agency and Program Board papers outlining significant or material changes, summary of budget position, agency levels of risks and issues;

- fortnightly program status reports presented to Program Board including program level summary, financial updates, any proposed changes and program level risks and issues; and
- weekly project status reports presented to the Project Management Office and Project Delivery Committee reporting on progress to date, key project risks and issues, financials and escalations.

- s.47G [redacted]

Brief prepared by:	s.22 [redacted] EPMO Manager CSSOD	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 25

Supplementary Budget Estimates — October 2018

Cyber security

Subject

The MHR system has robust multi-tiered security controls to protect the integrity and confidentiality of citizen health records. The system is accredited in accordance with Australian Government security requirements.

Key points

- The security of individuals' health information is a top priority for the Agency.
- The MHR system has robust multi-tiered security controls to protect the system from malicious attack. The system has been built and tested to Australian Government standards to protect the confidentiality, integrity, and availability of the health records.
- The system has been certified and accredited to the Protected level under the Australian Government Information Security Manual.
- Cyber security capabilities include comprehensive security monitoring; strong process and technology security controls; security assurance for all new releases; and dedicated security operations management.
- Continuous improvements in the cyber security environment will help ensure that the security of the MHR is maintained and improved, especially in preparation for the MHR Expansion.
- The Agency has developed guidance on MHR security and privacy for healthcare consumers and providers, which is available in hard copy print and on the MHR website.
- Personnel involved with management of the MHR system are required to have a Baseline security clearance, as a minimum. This is granted by the Australian Government Security Vetting Agency.
- s.47E(a) [redacted]

[redacted]

Background

- s.47E(a), s.47E(d) [redacted]
- [redacted]
- Threat and risk assessments are routinely undertaken to independently audit the effectiveness of security controls.
- Regular penetration testing is undertaken to understand and monitor security threats, risks and vulnerabilities. s.47E(a), s.47E(d) [redacted]
- Pre-release testing and technical reviews occur, to identify and rectify any security vulnerabilities, prior to release of new system functionality.
- Personnel involved with management of the MHR system have, as a minimum, a baseline security clearance, granted by the Australian Government Security Vetting Agency.
- Strategic partnerships are established with Australian and international cyber security organisations, to leverage shared knowledge and experience.
- Continuous improvement of security occurs using an internationally recognised framework to mitigate risks in a timely manner.
- Engagement with health sector organisations in relation to security issues, is undertaken to assist with improved security awareness and maturity.

Additional activities to improve the security posture and cyber resilience of the MHR system and the health sector more broadly include:

- support for the Agency's project teams and operational staff to ensure security considerations are embedded from design to implementation;
- development of security awareness and education materials for providers, consumers, vendors and healthcare managers;

- undertaking security awareness campaigns for the Agency's workforce; and
- conducting crisis management simulation exercises to improve the Agency's preparedness to respond to a security incident.

Additional background

Security enhancements are implemented during the 2016–17 and 2017–18 financial years have included:

- enhancements to technical security controls s.47E(a), s.47E(d) to improve cyber resilience;
- strengthening host-based firewalls, host-based intrusion detection and prevention systems;
- enhancements to application whitelisting, and file integrity monitoring tools;
- improvements to inbound and outbound filtering processes;
- enhanced audit logging capabilities; and
- improved operational security vulnerability and compliance management processes and activities.

Brief prepared by:	s.22 Chief Information Security Officer CSSOD	Mobile phone: s.22

Auditing access to MHR

Subject

Comprehensive auditing capabilities are in place for the MHR system to meet legislative, privacy and security requirements. This enables the Agency to identify and respond to malicious or inappropriate use of the system.

Key points

Individual citizen/consumer auditing

- All consumers who have a record in the MHR system can view a complete audit trail of all access to their record.
- This audit trail provides details of the time and date of any access or changes to their record including consumer access, healthcare provider organisation access, authorised representative access, and any other access that occurs.
- In addition, consumers can set an automated email or SMS notification for every time a new healthcare provider accesses their record, and every time the Emergency Access function is used on their account.
- If a consumer identifies access to their account that they believe should not have occurred, they can contact the Agency, as the System Operator, who will conduct an investigation into the access.

How is the individual clinicians details recorded?

- A consumer's audit history displays the Health Care Provider Organisation (based on the Healthcare Provider Identifier — Organisation), this is in part to protect the privacy of individual clinicians.
- Where a healthcare consumer suspects unauthorised access, they should contact the Helpline on 1800 723 471 for the issue to be investigated.
- The MHR System Operator is able to and frequently assist consumer to investigate individual access either through the organisations unique local identifier or the Healthcare Provider Identifier — Individual (HPI–I).
- In all circumstances when information is uploaded into the MHR the author must either have an HPI–I or a Unique Local Identifier.

- In the instance where a Unique Local Identifier is used, the System Operator will request the Health Care Provider Organisation provide the name of this individual should an investigation require.
- Under Section 32 of the *My Health Records Rule 2016*, a healthcare provider organisation must, by law, promptly provide all necessary assistance in relation to any inquiry, audit, review, assessment, investigation or complaint.

My Health Record system security auditing

The Agency monitors and audits all activity that occurs on the MHR system.

s.47E(a), s.47E(d)

- s.47E(a), s.47E(d) [redacted]

Brief prepared by:	s.22 [redacted] Chief Information Security Officer CSSOD	Mobile phone: s.22 [redacted]

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Privacy controls in the MHR

Subject

Privacy related aspects of the MHR system is an issue that attracts community concern and media interest.

Key points

- The MHR system is a world-first in enabling consumers to access their own national health record, control what information is in their record and control which healthcare provider organisations it is shared with.
- The *My Health Records Act 2012* and *My Health Record Rules 2016* provide the framework for the system's privacy controls.
- Individuals have a number of options to manage their privacy.
  - An individual can opt out of having a record.
  - An individual can ask a health care provider to not upload information to their record and the health care provider must comply.
  - An individual can place a Record Access Code on their record that needs to be given to healthcare provider organisations, who they wish to grant access.
  - An individual can place a Limited Document Access Code to restrict access to specific documents relating to visits to healthcare providers, or medicines that are taking, such that they have to provide the code for the health care provider organisation to gain access to the restricted set of documents.
  - An individual can choose to be notified via an SMS alert or email when certain activities occur in their record e.g. a new healthcare organisation accesses their record.
  - An individual can remove previously uploaded documents from their record. When this is done these documents will not be available to the consumer or healthcare provider organisations, including in an emergency.
  - An individual can see a full history of all access to their MHR, and are able to contact the Agency to get more information about these accesses.

- An individual can cancel their record at any time.

- The Office of the Australian Information Commissioner (OAIC) is assigned a regulatory oversight role in the MHR legislation, which is administered in part under a Memorandum of Understanding with the Agency. The OAIC undertakes a number of regular audits of the System Operator and publishes an Annual Report.

Brief prepared by:	s.22 Director, Policy GICSD	Mobile phone: s.22

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Privacy policy, protections and safeguards in the MHR

Subject

Privacy policy, protections and safeguards in the MHR system.

Key points

- The Agency must comply with the *Privacy Act 1988 (Cth)*, and the Australian Privacy Principles in its handling of personal and health information.
- As System Operator, the Agency is also subject to a range of specific privacy requirements in relation to the handling of personal information and healthcare identifiers in the MHR system, as set out in the *My Health Records Act 2012 (Cth)*, the *Healthcare Identifiers Act 2010 (Cth),* and associated rules and regulations.
- The Agency takes the protection and security of an individual's personal information very seriously. We are committed to keeping the personal information we hold secure.
- We take robust precautions, and have a range of practices and policies in place, to protect personal information from misuse and loss, and from unauthorised access, modification or disclosure.
- Where the MHR is concerned, in addition to the security and privacy of the system design, consumers can also use additional privacy and security features — *see* brief 27 Privacy controls in the MHR.
- The Agency works closely with the Office of the Australian Information Commissioner to ensure that the MHR meets legislative requirements and consumer expectations.
- The Agency is advised by the Agency Board's Privacy and Security Advisory Committee, established under the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* (the Rule).

Background

Privacy and Security Advisory Committee

The functions of the Privacy and Security Advisory Committee are set out under section 51 of the Rule and include:

- to examine legal issues in relation to Agency systems, including the following issues:
  - copyright issues;
  - data privacy issues;
  - confidentiality issues;
  - data security issues;
  - legal liability issues;
- to provide advice to the Board in relation to issues examined under paragraph (a), including interim solutions to problems arising from such issues;
- to make recommendations to the Board about the long-term legal framework of Agency systems;
- to monitor privacy and security issues in relation to Agency systems and to provide advice to the Board on the resolution of any problems arising from such issues;
- to provide advice and recommendations to the Board in relation to standards (including compliance with standards) relating to privacy and security in relation to Agency systems; and
- to provide advice to the Board about privacy and security issues encountered by users of Agency systems.

Brief prepared by:	s.22 Director, Policy and Strategy GICSD	Mobile phone: s.22

MHR connections

Subject

In order for the MHR to deliver value to Australians and their health professionals, it needs to contain high value clinical content.

Key points

The opt out state-wide readiness dashboard is attached to this brief.

Community pharmacy connections

- **2018–19 Portfolio Budget Statements (PBS) target**: 80 per cent of community pharmacies connected and uploading dispense records to the MHR system by June 2019.
- s.47C, s.47E(d) [redacted]

Pathology connections

- **2018–19 PBS target**: six states and territories (public), and more than 60 per cent of private pathology labs are connected and sharing reports with the MHR system by June 2019.
- s.47C, s.47E(d) [redacted]

Diagnostic imaging connections

- **2018–19 PBS target:** six states and territories (public), and 10 per cent of private diagnostic imaging practices connected and sharing reports with the MHR.
- s.47C, s.47E(d) [redacted]

Public hospital connections

- **2018–19 PBS target**: connect an additional 30 public hospitals to the MHR.
- s.47C, s.47E(d) [redacted]

Private hospital connections

- **2018–19 PBS target**: connect an additional 15 private hospitals to the MHR.
- s.47C, s.47E(d) [redacted]

Sensitivities

- s.47B(a), s.47B(b) [redacted]
- s.47C [redacted]

Budget allocation

- s.47C, s.47E(d) [redacted]

Background

- The availability of high value clinical content is essential for consumers and providers to realise the benefits associated with MHR.
- The Agency, in consultation with clinicians and peak bodies, identified the participation of the following healthcare providers uploading core content as essential. They are:
  - general practitioners — shared health summaries;
  - hospitals — discharge summaries, pathology and diagnostic imaging reports;
  - community pharmacies — dispensed medication records;
  - private pathology — pathology reports; and
  - private diagnostic imaging — diagnostic imaging reports.

Subject Matter Lead:	s.22 [redacted] General Manager, My Health Record Expansion Program, Core Services Systems Operations	Work Phone s.22 [redacted]

Supplementary Budget Estimates — October 2018

Re-platforming

Subject

In accordance with the Commonwealth Procurement Rules, the Agency will re-platform the current infrastructure to a new digital ecosystem that is efficient, flexible and fiscally responsible.

Key points

- The MHR 2017 Budget Measure announced that the Government would re-tender the National Infrastructure Operator (NIO) contract for the MHR for the delivery of a new, more flexible platform.
- s.47E(d) [redacted]
- From 1 January 2018, s.47G [redacted] the Agency that it would be prescribed under the *Public Governance, Performance and Accountability Act 2013* and therefore must meet all obligations of the Commonwealth Procurement Guidelines.
- s.47C, s.47E(d) [redacted]
- s.47C, s.47E(d) [redacted]
- [redacted]
- A program office and associated governance structure has been established and work continues to deliver on this significant piece of work.

Background

- s.47E(d), s.47G [redacted]
- s.47C, s.47E(d) [redacted]
- [redacted] The 2017–18 Budget papers flagged this process would begin in the 2017–18 year:

  'This measure allows the Australian Digital Health Agency to implement plans that will increase efficiency and sustainability and reduce the ongoing operational costs of the system in the longer term through the transition of Department of Human Services' support functions to the Agency, the re-tender of the national infrastructure operator and delivery of a new, more flexible platform'.

Brief prepared by:	s.22 [redacted] General Manager CSSOD	Mobile phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

Australian Medical Association guidance on MHR

Subject

Australian Medical Association (AMA) guidance on medico legal consequences of MHR.

Key points

- The AMA released its guide for doctors on how to use the personally controlled electronic health record (PCEHR) (now called the MHR) in 2012.
- s.47G [redacted]
- It provides information and guidance to help medical practitioners decide whether or not to participate in the MHR system, and explains how they might use the MHR in their day-to-day practice.
- Section 6.7 of the guide provides medico legal considerations for AMA members.

The following recommendations are made in Section 6.7:

- 6.7.1 It may be that you are exposed to medico-legal risk relating to the PCEHR system or the record itself whether or not you or your patients use the PCEHR system.
- 6.7.2 Defending any medico-legal action requires clear documentation about your interaction with your patients.

This consists of:

  - 6.7.2.1 Deciding how you will use the PCEHR system yourself and in your practice;
  - 6.7.2.2 Recording this in a practice protocol;
  - 6.7.2.3 Implementing the practice protocol consistently; and
  - 6.7.2.4 Documenting the details of any action that is not consistent with the protocol in patient notes.
- 6.7.3 Where you have made a decision to use the PCEHR in a particular way for a patient, you should record this in the patient's notes in your own record keeping system.
- 6.7.4 Recommendations throughout this guide describe how interactions that involve the PCEHR should be recorded.

- 6.7.5 If you have any doubts or uncertainties, or if you believe that you have been exposed to medico-legal risk either as a result of using the PCEHR or not using the PCEHR, contact your medical indemnity provider immediately. You may always obtain your own independent legal advice.

Brief prepared by:	s.22 Director, Policy and Strategy GICSD	Work phone: s.22

Supplementary Budget Estimates — October 2018

Organisational structure

Subject

The Agency was established under the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016*. The organisational structure outlined in this briefing paper reflects the Agency operation as a Corporate Commonwealth Entity.

Key points

The Agency has a dual model of employment, comprising Australian Public Service (APS) and non-APS (common law) employees.

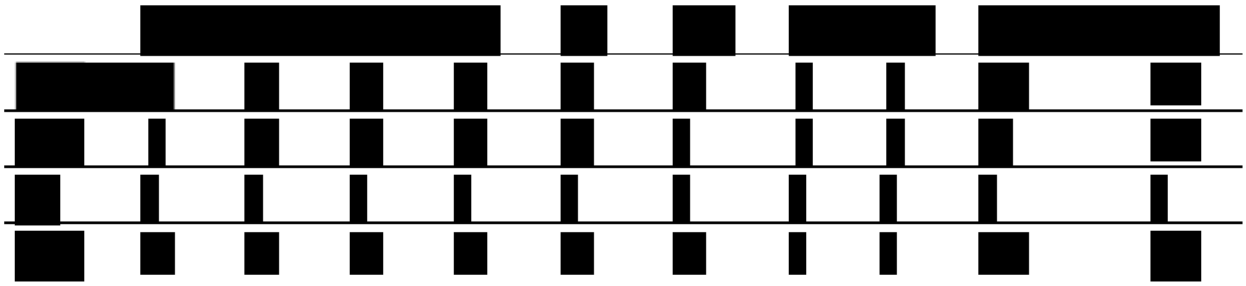
The following data is accurate as at 30 September 2018.

The Agency is accommodated across three cities: Brisbane, Canberra and Sydney and is divided into seven Divisions, each responsible for specific functions and deliverables.

- Clinical and Consumer Engagement and Clinical Governance.
- Core Services Systems Operations.
- Government and Industry Collaboration, Strategy and Delivery.
- Innovation and Development.
- Organisational Capability and Change Management.
- Office of the Chief Executive Officer.
- Office of the Chief Medical Advisor.

s.47E(d), s.47E(c) [redacted]

s.47E(d), s.47E(c) [redacted]



Budget allocation

- The fiscal year Budget for Agency Employee Benefits totals $42.12 million, as referenced on page 207 of the PBS 2018–19. s.47E(d) [redacted]

Background

- The Agency's Board sets the strategic direction, organisational priorities and immediate focus of the organisation. The Board delegates responsibility for operational management to the Chief Executive Officer, who, with a team of executives leads and coordinates the delivery of the digital health priorities determined by the Board.

Brief prepared by:	s.22 [redacted] Director People and Capability OOCMD	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 33

Supplementary Budget Estimates — October 2018

Agency information and communications technology

Subject

The Agency's information and communications technology is focussed on a program of work to deliver and maintain ongoing business continuity, compliance and operational efficiency and improvements.

Key points

Compliance

- s.47E(a), s.47E(d) [redacted]

Efficiency

- s.47E(a), s.47E(d) [redacted]

Business Continuity

- All operational systems, serving internal and externally, are backed up and tested to required standards.

Brief prepared by:	s.22 [redacted] General Manager Communications Services OCCMD	Mobile phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 34

Supplementary Budget Estimates — October 2018

Finance — COAG Funding

Subject

The Agency receives funding, referred to as Council of Australian Governments (COAG) funding, from States and Territories via an Intergovernmental Agreement.

Key points

- COAG funding:

	2016–17 Actual $ million	2017–18 Actual $ million	2018–19 Budget $ million	Three year Total $ million
COAG funding	107.73	64.50	s.47C, s.47E(	[redacted]
COAG expenditure	(78.30)	(79.30)	s.47C, s.47E(d)	[redacted]
Net COAG expenditure	**29.43**	**(14.80)**	s.47C, s.47E(d)	[redacted]

- COAG funding includes $64.50 million per year from Intergovernmental Agreement and $43.20 million from transfer of National e-Health Transition Authority funds.
- COAG funded activities include:
  - operating national infrastructure (e.g. HI Service, NASH, national directory service for secure messaging);
  - operating national services and maintaining products e.g. terminology service, online eHealth forms and service desk); and
  - connecting systems to the MHR.
- 2017–18 and 2018–19 COAG expenditure was determined through cost attribution in accordance with principles agreed with the Jurisdictional Advisory Committee
- Detailed cost attribution was not available for 2016–17.

Brief prepared by: Steven Momcilovic	Name: s.22 [redacted] Position: Chief Financial Officer Division: Office of the CEO	Work phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

Finance — Agency funding

Subject

The Agency receives funding through Commonwealth appropriations and contributions from States and Territories via an Intergovernmental Agreement.

Key points

- Agency funding:

Activity	2016–17 Actual $ million	2017–18 Actual $ million	s.47C, s.47E(d) [redacted]	[redacted]
Commonwealth Funding				
COAG — Commonwealth	32.25	32.25	s.47C, s.47E(	[redacted]
Operating funding	78.05	164.81	s.47C, s.47E(d)	[redacted]
Capital funding	10.59	53.46	s.47C, s.47E(	[redacted]
Total Commonwealth Funding	**120.89**	**250.52**	s.47C, s.47E(d)	[redacted]
COAG — States and Territories	30.50	31.67	s.47C, s.47E(	[redacted]
NEHTA funding — transferred	53.20	–	s.	[redacted]
Other (including Interest)	5.05	6.25	s.47 C,	[redacted]
Total Agency Funding	**209.64**	**288.44**	s.47C, s.47E(d)	[redacted]

- Commonwealth funding increased in 2017–18 and 2018–19 to fund the MHR Expansion Program
- Average staffing level budget:

	2016-17	2017-18	2018-19	
Average staffing level	51	250	250	

Budget allocation

- The Agency's 2016–17 Commonwealth appropriation was provided through baseline funding to establish the Agency.

- 2017–18 Budget measure continued and expanded the MHR allocating funding of $386.83 million (page 191, 2017–18 PBS).
- 2018–19 Budget measure to develop a national digital baby book allocating funding of $5 million (page 197, 2018–19 PBS).

Background

- As a corporate Commonwealth entity, the Agency receives the appropriation from Commonwealth through Department of Health.

Brief prepared by: Steven Momcilovic	Name: s.22 Position: Chief Financial Officer Division: Office of the CEO	Work phone: s.22

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Australian Digital Health Agency

Brief 36

Supplementary Budget Estimates — October 2018

Finance — Expenditure summary

Subject

The Agency receives funding through Commonwealth appropriations and contributions from States and Territories via an Intergovernmental Agreement.

Key points

- Expenditure summary:

	2016–17 Actual $ million	2017–18 Actual $ million	s.47C, s.47E(d) [redacted]	[redacted]
Operating expenditure	149.72	239.54	s.47C, s.47E(d)	[redacted]
Capital expenditure	17.35	57.03	s.47C, s.47E(	[redacted]
Total	**167.07**	**296.57**	s.47C, s.47E(d)	[redacted]

- Expenditure increased in 2017–18 and 2018–19 to deliver the MHR Expansion Program.

Budget allocation

- The Agency operational funding is made up Commonwealth Bill 1 appropriation and States and Territory COAG contribution.
- The Agency capital funding is Commonwealth Bill 2 appropriation.

Brief prepared by: Steven Momcilovic	Name s.22 [redacted] Position: Chief Financial Officer Division: Office of the CEO	Work phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

Finance — MHR Expansion Program

Subject

MHR Expansion Program Actual expenditure for 2017–18, and Budget figures for 2018–19.

Key points

- The impact of the recent announcements regarding opt out date extension and the hard to delete capability (s.47E(d) [redacted], are not included in the figures below. s.47C, s.47E(d) [redacted]
- The increase to Communications costs above the baseline budget of $27.75 million is due to additional costs for Remote Access and Australia Post distribution. The increase will be managed within the overall program funding.

s.47E(d) [redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

- s.47E(d) [redacted]

Brief prepared by: s.22 [redacted]	Name: s.22 [redacted] Position: Management Accountant Division: OCEOD	Work phone s.22 [redacted]

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Australian Digital Health Agency

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Supplementary Budget Estimates — October 2018

Finance — MHR Operating Expenditure

Subject

MHR Operating Costs are funded through Commonwealth Government appropriations.

Key points

Activity	2016–17 Actual $ million	2017–18 Actual $ million	s.47C, s.47E(d) [redacted]	[redacted]
MHR Operating Expenditure	48.37	47.02	s.47C, s.47E(	[redacted]
MHR Capital Expenditure	16.13	26.53	s.47C, s.47E(	[redacted]
Total	**64.50**	**73.55**	s.47C, s.47E(	[redacted]

- MHR Operating Expenditure included above consists of the direct cost of operating and maintaining the MHR system.
- Exclusions:
  - MHR Expansion Program
  - Corporate and Overhead costs
  - Costs of other Commonwealth funded activities
  - COAG funded activities
- MHR Capital Expenditure represents the MHR system improvements cost.

Brief prepared by: Steven Momcilovic	Name: s.22 [redacted] Position: Chief Financial Officer Division: Office of the CEO	Work phone: s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 39

Supplementary Budget Estimates — October 2018

MHR opt out extension and hard delete

Subject

The Australian Government has announced it will extend the opt out period for MHR by one-month to give Australians more time to consider their options and amend the MHR legislation to allow records to be permanently deleted from the system.

Key points

s.47C, s.47E(d)

[redacted]

- s.47C, s.47E(d) [redacted]

[redacted]

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s.47C, s.47E(d) [redacted]

s.47C, s.47E(d) [redacted]

[redacted]

[redacted]

Brief prepared by: Steven Momcilovic	Name: s.22 [redacted] Position: Chief Financial Officer Division: Office of the CEO	Work phone: s.22 [redacted]

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Australian Digital Health Agency

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Supplementary Budget Estimates — October 2018

Key facts and figures

Subject

Key financial information is summarised in the table below.

Key points

Item	2016–17 Actual	2017–18 Actual	2018–19 Budget	Three year total	Basis	Notes
Total Agency Funding ($ million)	209.64	288.44	s.47C, s 47E(	[redacted]	Commonwealth funding, COAG funding (including Commonwealth contribution) and National e-Health Transition Authority (NEHTA) funding transferred.	Further detail Brief 35
Total Agency Expenditure ($ million) (combined Opex & Capex)	167.07	296.57	s.47C, s 47E(	[redacted]	Total expenditure (excluding depreciation, amortisation and write-downs)	Further detail Brief 36
MHR Operations ($ million)	64.50	73.55	s.47C	[redacted]	Opex & Capex for Core MHR operating sections, including Accenture contract Excludes MHR Expansion Program	Further detail Brief 38
MHR Expansion Program ($ million)	n/a	110.23	s.47C, s 47E(	[redacted]	Includes Call Centre costs	Further detail Brief 37

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Item	2016–17 Actual	2017–18 Actual	2018–19 Budget	Three year total	Basis	Notes
Opt out extension costs ($ million)	n/a	n/a	s.47C		Per briefs prepared by MHR Expansion Program	Further detail Brief 39
Council of Australian Governments (COAG) funding ($ million)	107.70	64.50	64.50	236.70	Includes $64.50 million per year from Intergovernmental Agreement and $43.20 million from transfer of NEHTA funds	Further detail Brief 34
COAG expenditure ($ million)	78.30	79.30	s.47C	[redacted]	2017–18 and 2018–19 COAG expenditure was determined through cost attribution in accordance with principles agreed with the Jurisdictional Advisory Committee	Further detail Brief 34
Contractors expenditure ($ million)	9.14	24.22	s.47C	[redacted]	Per 2017–18 Annual Financial Statements and 2018–19 Budget	
Average Staffing Levels (ASL)	217	230	250		Per Portfolio Budget Statements	2018–19 year to date: 233
s.47C, s.47E(d) [redacted]	[redacted]	[redacted]	[redacted]		[redacted]	

Item	2016–17 Actual	2017–18 Actual	2018–19 Budget	Three year total	Basis	Notes
MHR Expansion Program Communication a Readiness costs ($ million) • Total Includes: • s.47G	n/a	45.53 28.72	s.47C, s.47E(d)		Per MHR Expansion Program Budget and transaction analysis for PHNs	
Significant 2017–18 contracts ($ million): • Oracle Corporation Australia (Oracle licences) • Datacom Connect Pty Ltd (Consumer Call Centre operation) • Department of Human Services (Call Centre)		3.32 32.72 14.54			Extracted from Senate Order 192 (Murray Motion) 2017–18 report	
Travel Costs ($ million)	1.88	2.57	s.47C		Per transaction analysis and 2018–19 Budget	
s.47E(d)					s.47E(d)	

Brief 40

Item	2016–17 Actual	2017–18 Actual	2018–19 Budget	Three year total	Basis	Notes
Number of Freedom of Information (FOI) requests	1	9	30*	40	From FOI register	*2018–19 year to date to 13/09/2018
IT Security spend (Opex and Capex) ($ million)	7.50	11.52	s.47C [redacted]	[redacted]	Cyber Security Centre costs Per Cost Centre reports and 2018–19 Budget	

Brief prepared by: Steven Momcilovic	Name: s.22 [redacted] Position: Chief Financ al Officer Division: Office of the CEO	Work phone: s.22 [redacted]

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Australian Digital Health Agency

Brief 41

Supplementary Budget Estimates — October 2018

Secondary uses of data — implementation

Subject

The Agency's role in implementing the Secondary Use of data framework.

Key points

- The Department of Health has developed a *Framework to guide the secondary use of My Health Record data*, in its policy making capacity.
- The Agency will implement this Framework, in our capacity as System Operator.
- We are currently working closely with the Department of Health and Australian Institute for Health and Welfare — the data custodian for research and public health purposes — to implement the Framework over the next 12–24 months.
- Our first step to implement the Framework has been to build an option into the My Health Record system that allows an individual to choose not to have their data used for secondary use purposes. This option is now available.
- Refer any questions on the Framework to the Department, including questions about legislating the secondary use framework.

Brief prepared by:	s.22 [redacted] Director, Benefits Evaluation Government and Industry Collaboration, Strategy and Delivery	Work phone: s.22 [redacted]

MHR opt out period process

Subject

Operationalising the MHR 'opt out process'.

Key points

- By the end of 2018, every Australian citizen will have a MHR created for them, unless they choose not to have one.
- The Agency will conduct a comprehensive layered communications campaign to ensure every Australian is aware of the opt out process and the mechanisms available to opt out.
- Between July and September 2018, eligible individuals or dependents under their care, will have the opportunity to request not to have a MHR created for them.
- No records will be created prior to the end of the three month opt out period.
- Following the opt out period, a 30-day reconciliation period will commence to ensure all opt out requests have been processed.
- s.47G, s.47E(d) [redacted]
- Once records have been created, consumers and providers will be able to access the records.
- There are three key channels where consumers are able to complete the opt out process:
  - logging onto the MHR website and accessing the opt out portal;
  - calling the consumer contact centre; and
  - via specialised processes specifically targeted to groups considered Hard to Reach and Hard to Service.
- The Agency has created a specialised process to assist consumers such as those who may be homeless, who live in remote areas and indigenous

communities, adult prisoners, juveniles in detention, Defence Force personnel deployed overseas and children in out of home care.

- These specialised processes include:
  - development and distribution of collateral and forms for hard to service and hard to reach populations:
    - s.47G [redacted]
    - correctional facilities will distribute a specialised form to all detainees. Couriers have been contracted to deliver and securely collect forms;
    - care agency employees will manage the records of children in care through a secure portal built specifically for this cohort; and
    - the Agency has identified a range of initiatives to support consumers in the hard to reach categories (e.g. forms being made available in select Australia Post outlets).
- The opt out portal has been designed and delivered and will be activated when the opt out period commences.
- s.47G [redacted] The call centre is operating 24 hours a day, seven days per week in readiness for the opt out period.

Evidence of identity

- Online opt out portal —an individual who connects to the Document Verification Service (DVS) needs to provide 100 points of identity — this can be licence or passport which is validated with DVS, then continues through to finalise opt out.
- Telephony with contact centre — if an individual who fails DVS lodgement, or prefers to call, they will need to pass Evidence of Identity (EOI). s.47G [redacted]
- Form — for individuals who fail the EOI telephony check or request a form, the call centre operator will send a form and the individual can complete and return the opt out form.

If Evidence of Identity fails

- Online opt out portal — if an individual fails DVS checks, they'll be directed to call the contact centre.
- Telephony with contact centre — if an individual fails EOI, the contact centre will warm transfer to Tier 3 who will perform a more detailed search. If they then pass EOI, the Tier 3 operator will opt them out. If they still fail EOI, Tier 3 would then ask the customer to scan and send in certified copies of their EOI e.g. drivers license or a bill showing their address.
- Form — if details on the form cannot be matched with information stored in our systems, the contact centre will follow the relevant call back process (they will attempt to call the customer on two attempts on different days at different times of the day), if no contact is made the form is disposed securely.

Aboriginal and Torres Strait Islander people

- There is additional support in place through the enhanced customer support model for this cohort
- s.47G [redacted]
- s.47G [redacted]

Brief prepared by:	s.22 [redacted] General Manager, Core Operations Core Services Systems Operations	Work phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

Pharmacy registration

Subject

Community Pharmacy MHR registration process causing delays in pharmacy participation in MHR.

Key points

- Pharmacy registration and participation in MHR is a three step process.
  - **Apply** to participate (pharmacist) → **Register** with MHR [redacted] → **Install and activate** National Authentication Service for Health Public Key Infrastructure certificate and dispensing software (software vendor).
- On average, the current length of time from application to activation of software is taking approximately 11 weeks.
- A key factor determining this length of time is:
  - correctly completing application form;
  - timely processing of application forms s.47G [redacted]; and
  - timely installation of certificates and activation of software by vendors.
- Correctly completing application forms.
  - The Agency is pre-filling forms for pharmacy Tier 1 and Tier 2 'banner' groups to ensure forms are completed accurately and the time burden is removed from busy pharmacists. Agency pre-filling has reduced the time pharmacists need to spend applying for MHR participation from approximately four hours to approximately 15 minutes. The Agency is also in discussions with s.47G [redacted] to ascertain the viability of pre-filling forms for smaller, independent pharmacies.
- Timely processing of application forms s.47G [redacted].
  - s.47G, s.47E(d) [redacted]

- Timely installation of certificates and activation of software by vendors.
  - The Agency and pharmacy software vendors have put in place strategies to deal with the demand from pharmacists to activate software. This includes better coordinated demand and resource planning and support for vendor help desk staff.
- As of October 2018 there were 3,814 (69 per cent) community pharmacies registered for MHR with a target of s.47C, s.47E(d) [redacted] 80 per cent registered by June 2019. This target is expected to be achieved because of the improvements made to the end-to-end process s.47G, s.47E(d) [redacted].

Sensitivities

- Nil.

Attachments

- Nil.

Brief prepared by:	s.22 [redacted] General Manager, My Health Record Expansion Program, Core Services Systems Operations	Work Phone s.22 [redacted]

Australian Government
Australian Digital Health Agency

Brief 44

Supplementary Budget Estimates — October 2018

MHR Expansion Program — individual healthcare identifier reconciliation

Subject

The Agency is undertaking a number of pre-requisite background activities in preparation of the National opt out for MHR Expansion Program. Below is a brief explanation of various processes involved.

Key points

- Over 19,385,162 eligible individual healthcare identifiers (IHI) have been received s.47G, s.47E(d) [redacted] as eligible for a MHR.
- This excludes:
  - pseudonymous IHI;
  - consumers who have opted out in 2016 trials; and
  - active or cancelled MHRs.
- Newly eligible IHI are s.47G, s.47E(d) [redacted] and processed on a fortnightly basis. They include:
  - new Medicare/IHI registrations (newborns, migrants); and
  - consumers who opt in (up to the commencement of the opt out window).
- Consumers can still choose to register for a MHR (opt in) via the current process.
- s.47E(a), s.47E(d), s.47G [redacted]

Background

s.47E(d), s.47G [redacted]

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s.47E(d), s.47G

- s.47E(a), s.47E(d), s.47G [redacted]

Opt out

- Portals: consumers can express their opt out preference using the MHR portal or by contacting the call centre help line.
- Bulk opt out: paper forms are received for Hard to Service groups to express their opt out preference. These are either be processed by call centre staff or by using the IHI matching and bulk opt out.

Ongoing registration

- s.47G [redacted]

s.47E(d), s.47E(a), s.47G [redacted]

Opt in

- At any point a consumer can choose to get a MHR even during the opt out period.
- Consumers can contact the MHR help contact centre if they wish to get a MHR post opt out.
- Post opt out, every eligible consumer who has not opted out will get a MHR.

s.47E(a), s.47E(d) [redacted]

Sensitivities

- No.

Background

- Nil.

Attachments

- Nil.

Brief prepared by:	s.22 General Manager, Service Delivery	Work Phone s.22

2018–19 Budget implications

Summary of the recent Budget funding:

- The Federal Government will provide the Agency $5 million over two years to support national deployment of the child digital health record and a national pre-natal digital screening standard and digital tools.
- There is $3.7 million available in 2018–19 and $1.3 million available in 2019–20.
- The funding is part of the broader $77.9 million infant and maternal health package to ensure our children get the best possible start in life.

National Children's Digital Health Collaborative

The Agency and eHealth New South Wales (NSW) media release on the Children's Digital Health Collaborative pilots is attached at Attachment A.

eHealth NSW media response re Children's Digital Health Collaborative

The Agency cleared media response that eHealth NSW sent to Pulse IT on 1 March 2018 regarding the Children's Collaborative is provided below.

What does the Children's Health Collaborative's current work program consist of?

- The Collaborative is a result of engagement and consultations with around 400 consumers, clinicians, community representatives, information and communications technology experts, policy makers and researchers across Australia. The initial work was undertaken last year and was led by eHealth NSW and Sydney Children's Hospitals Network on behalf of the Australian Digital Health Agency.
- The primary objectives are:
  - to explore how digital health technology can help make Australia the best place in the world to raise healthy children, and to be raised; and
  - to ensure all Australian children, irrespective of location, socioeconomic status or cultural background, have the same opportunity to be healthy, safe and thriving.
- The Collaborative is exploring how every child in Australia can have the option of a comprehensive digital health record from the time they are conceived, through those critical first years and adolescence; readily

accessible by parents and healthcare providers and ultimately for that individual throughout their life.

- The initiatives will test how information can be captured not only through a child's interaction with the health system and other services such as school immunisation programs, but also through their mother's relevant interactions during her pregnancy.
- The consultations generated a large number of ideas that were consolidated and refined into five initiatives, which were then presented to the Agency Board for approval to progress into a proof of concept phase. The initiatives provide a momentous opportunity to make a lasting difference to the long-term health of all young Australians, given that many predictors of adult disease have their origins in childhood, and all five initiatives were approved.
- Initiative timeframes and lead and partner jurisdictions are as follows, with descriptions of each project below:

Initiative	**Lead**	**Partner**	**Kick-off**
Child Digital Health Record	NSW	VIC	FY 2017–18
School Immunisations to Australian Immunisation Register	ACT	TAS	FY 2017–18
Digital Pregnancy Health Record	QLD	SA	FY 2018–19
Child Digital Health Checks	NT	WA	FY 2019–20

A National Child Digital Health Record

- Currently a child's health and development information is captured in hard copy baby books, such as the Red Book in Queensland, Blue Book in NSW and Green Book in Victoria.
- These books must be carried between healthcare appointments by a child's parents and carers, and are often forgotten or misplaced. This initiative will capture this information digitally so it is easily accessible by a child's parents and families and available to healthcare providers where and when it is needed.

Upload of school immunisation records to the Australian Immunisation Register

- Australian Immunisation Register (AIR) does not currently capture and record all of the vaccinations adolescents receive through the school immunisation programs.
- Adolescents may be given a paper record of a vaccine they received in school, which is often lost or misplaced, meaning they have an incomplete knowledge of their vaccination history. This results in potentially missed vaccinations or duplicate vaccinations being given.
- This initiative will support the upload of school vaccination records to the AIR so a full history of a young person's vaccinations from birth through to early adulthood is stored securely in one place and accessible to them, their parents, and their healthcare providers.

A National Digital Pregnancy Health Record

- Currently a woman's antenatal or pregnancy records are mostly captured on paper, with women needing to carry them between their healthcare providers and appointments.
- These handwritten records are often difficult to read and providers need to double-enter the handwritten information into separate paper and digital systems, and this important information is often not brought to hospital when the woman goes into labour.
- This initiative will develop a digital shared care pregnancy plan accessible by pregnant women and their healthcare providers.

National Digital Child Health Checks

- Child health checks such as the Medicare Health Assessment for Aboriginal and/or Torres Strait Islander People (MBS Item 715) are conducted by general practitioners (GPs) and Aboriginal Medical Services (AMS).
- However, the information often stays within the GPs or AMS software, it is not shared electronically, and it is not readily accessible to other care providers.
- This may limit the opportunities for early detection, diagnosis, and intervention for common and treatable conditions by a child's wider care team, and reduces the ability to offer integrated care and to better identify any services a child may require.

- This initiative will digitise child health checks to help support the early identification of a child's health and wellbeing needs.

Research into the Longitudinal Digital Child Health Record

- The implementation of the above four initiatives will help to build a longitudinal child digital health record. This will create a national repository of high quality, commonly understood, and structured child development information contributed by young people, their families and carers, primary care and jurisdictions.
- This will be a valuable national asset that, following all required legalisation, policy and privacy protocols, could help researchers and policy-makers better understand children's health and wellbeing needs, and ensure that policies and programs aimed at improving health outcomes for children and young people are evidence-based and informed by robust health research and data systems.
- Some of the identified research themes this information could support include:
  - quality Use of Medicines in pregnant women and children
  - prenatal and early childhood influences into obesity's developmental origins; and
  - research into early childhood development across developmental domains.

**3301.0 — Births, Australia, 2016*, Australian Bureau of Statistics.

Attachment

- Attachment A — A new national digital collaborative to improve child health media release

Brief prepared by:	s.22 [redacted] Chief of Staff	Work Phone s.22 [redacted]

Australian Government
Australian Digital Health Agency

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NSW GOVERNMENT Health

Media release **6 March 2018**

A new national digital collaborative to improve child health

Australia's states and territories have joined forces in a unique and transformative partnership that harnesses technology to improve the health and wellbeing of Australian children.

In one of the first initiatives of *Australia's National Digital Health Strategy – Safe, Seamless, and Secure*, the Australian Digital Health Agency is partnering with eHealth NSW and the Sydney Children's Hospitals Network (SCHN) to establish the National Children's Digital Health Collaborative.

SCHN Chief Executive Dr Michael Brydon said that records on a child's health and development are currently captured in multiple paper and digital systems, meaning they are not always available when they are needed.

"The Collaborative is exploring how every child in Australia can have the option of a comprehensive digital health record from the time they are conceived, through those critical first years and adolescence; readily accessible by parents and healthcare providers and ultimately for that individual throughout their life.

"This will be of enormous value – not only to healthcare professionals providing care to those children – but to the children themselves as they become young adults and start making decisions about their own health and care," Dr Brydon said.

The Collaborative comprises around 400 clinicians, consumers, IT experts, and researchers from across Australia and is aimed at making a positive impact on children's health and wellbeing.

Agency CEO Tim Kelsey said the Collaborative is a momentous opportunity to make a lasting difference to the long-term health of all young Australians, given that many predictors of adult disease have their origins in childhood.

"This work will enable the establishment of lifetime digital health records for all Australian children, wherever they live or present for treatment," Mr Kelsey said.

The Collaborative comprises a wide variety of experts, including clinicians, consumers, governments, researchers, providers and industry representatives, who will co-design and test a way for parents and healthcare providers to easily access standardised information on a child's health and development.

This initiative will test how information can be captured not only through a child's interaction with the health system and other services such as school immunisation programs, but also through their mother's relevant interactions during her pregnancy.

eHealth NSW Chief Executive Dr Zoran Bolevich said the aim is to create a holistic digital view of a child's health for families who choose to have one. The Collaborative will also test the ways in which parents, carers and healthcare providers want to access this information, including through systems such as My Health Record. This work will then provide a base of evidence and experience with a view to rolling out solutions nationally.

"We want to engage and empower children and their families by providing them with consumer-friendly digital access to their health information and evidence-based health resources," Dr Bolevich said.

The initiatives identified in the Collaborative align with the National Digital Health Strategy's models of care to improve accessibility, quality, safety, and efficiency in improving child health.

"In 2016 more than 311,000 babies were born in Australia.* When these initiatives are implemented, Australian children will have a lifelong digital health record their healthcare providers can refer and contribute to. How powerful a treatment aid will that be?" Mr Kelsey said.

Mr Kelsey said this is a platform for innovation for industry to develop new tools and digital health services.

The National Digital Health Strategy outlines a test bed for children's health that will examine how every child in Australia can have access to a comprehensive digital health record. This record will be readily accessible by parents and healthcare providers, to track key childhood healthcare interventions such as immunisations and to ensure that healthcare providers are able to offer safe, high-quality care.

In October 2017, the Agency's Board approved funding to design, build, and evaluate proofs of concept for five nationally focused initiatives that include:

1. A National Child Digital Health Record – Currently a child's health and development information is captured in hard copy baby books, such as the Red Book in Queensland, Blue Book in NSW and Green Book in Victoria. These books must be carried between healthcare appointments by a child's parents and carers, and are often forgotten or misplaced. This initiative will capture this information digitally so it is easily accessible by a child's parents and families and available to healthcare providers where and when it is needed. *New South Wales and Victoria are leading this work.*

2. Upload of school immunisation records to the Australian Immunisation Register (AIR) – The AIR does not currently capture and record all of the vaccinations adolescents receive through the school immunisation programs. Adolescents may be given a paper record of a vaccine they received in school, which is often lost or misplaced, meaning they have an incomplete knowledge of their vaccination history. This results in potentially missed vaccinations or duplicate vaccinations being given. This initiative will support the upload of school vaccination records to the AIR so a full history of a young person's vaccinations from birth through to early adulthood is stored securely in one place and accessible to them, their parents, and their healthcare providers. *Australian Capital Territory and Tasmania are leading this work.*

3. A National Digital Pregnancy Health Record – Currently, women's antenatal or pregnancy records are mostly captured on paper, with women needing to carry them between their healthcare providers and appointments. These handwritten records are often difficult to read and providers need to double-enter the handwritten information into separate paper and digital systems, and this important information is often not brought to hospital when the woman goes into labour. This initiative will develop a digital shared care pregnancy plan accessible by pregnant women and their healthcare providers. *Queensland and South Australia are leading this work.*

4. National Digital Child Health Checks – Child health checks such as the Medicare Health Assessment for Aboriginal and/or Torres Strait Islander People (MBS Item 715) are conducted by GPs and Aboriginal Medical Services (AMS). However, the information often stays within the GP or AMS software, it is not shared electronically, and it is not readily accessible to other care providers. This may limit the opportunities for early detection, diagnosis, and intervention for common and treatable conditions by a child's wider care team, and reduces the ability to offer integrated care and to better identify any services a child may require. This initiative will digitise child health checks to help support the early identification of a child's health and wellbeing needs. *Northern Territory and Western Australia are leading this work.*

5. Research into the Longitudinal Digital Child Health Record – The implementation of the above four initiatives will help to build a longitudinal child digital health record. This will create a national repository of high quality, commonly understood, and structured child development information contributed by young people, their families and carers, primary care and jurisdictions. This will be a valuable national asset that, following all required legalisation, policy and privacy protocols, could help researchers and policy-makers better understand children's health and wellbeing needs, and ensure that policies and programs aimed at

improving health outcomes for children and young people are evidence-based and informed by robust health research and data systems.

Some of the identified research themes this information could support include:

(i) Quality Use of Medicines in pregnant women and children
(ii) Prenatal and early childhood influences into obesity's developmental origins and
(iii) Research into early childhood development across developmental domains.

*3301.0 - Births, Australia, 2016, Australian Bureau of Statistics at:
http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3301.0

Further information
Australia's National Digital Health Strategy – *Safe, Seamless, and Secure* is available on the Agency website.

ENDS

Notes for Editors

- The Australian Digital Health Agency commenced operations on 1 July 2016.
- The Agency is tasked with improving health outcomes for all Australians through the delivery of digital healthcare systems and the National Digital Health Strategy.
- The Agency's focus is on putting data and technology safely to work for patients, consumers and the healthcare professionals who look after them.
- More than 3,000 people participated in the consultation on the *National Digital Health Strategy* between October 2016 and January 2017. Public meetings were held in more than 103 locations across Australia. More than 1,000 formal submissions and survey responses were received. These submissions are published at https://conversation.digitalhealth.gov.au.
- Australian consumers, carers, healthcare providers, and other health stakeholders informed the consultation.
- Health consumers and carers expressed a strong desire to be increasingly empowered – to take control of decisions regarding their own health, and to be provided with access to their own personal health information.
- The National Children's Digital Health Collaborative is a good example of the Agency addressing health consumer's needs with practical solutions.

Media contact
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About the Australian Digital Health Agency
The Agency is tasked with improving health outcomes for all Australians through the delivery of digital healthcare systems, and implementing *Australia's National Digital Health Strategy* – *Safe, Seamless, and Secure* in collaboration with partners across the community. The Agency is the System Operator of the My Health Record, and provides 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. These improvements will give individuals more control of their health and their health information, and support healthcare professionals to provide informed healthcare through access to current clinical and treatment information. Further information: www.digitalhealth.gov.au.

About eHealth NSW
A dedicated agency of NSW Health, eHealth NSW partners with NSW Health organisations in the planning, adoption, and ongoing development of digital technologies and capabilities that deliver value. It plans and

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manages ICT investments, maintains standards, designs and procures systems, manages implementations and commissions or provides ICT support services.
www.ehealth.nsw.gov.au

About the Sydney Children's Hospitals Network
Sydney Children's Hospitals Network cares for thousands of children each year in our hospitals and in their homes — with one purpose in mind — to help young people live their healthiest lives.
www.schn.health.nsw.gov.au

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Australian Digital Health Agency

Brief 46

Supplementary Budget Estimates — October 2018

Agency Achievements from January to June 2018

Subject

- The Agency's key achievements in the first six months of 2018.

Key points

- MHR Expansion:
  - the **Consumer Contact Centre operations launched** in March 2018 to support the opt out process; and
  - the **Agency has delivered two releases of the MHR (January and April 2018)** in readiness for the opt out period. A final release is scheduled for June 2018. The technology releases have delivered enhancements to the security surveillance capability of the system.
- **National consultation for the Framework for Action (FFA) has been completed** which included stakeholders such as jurisdictions, clinical, consumer and industry peak bodies. Launch of the finalised FFA is planned for June.
- **Accelerated uploading of clinical content into the MHR** (at June 2018).

Pharmacy achievements

- In addition to Fred Dispense and Aquarius who are already connected, three more software vendors ([redacted], RxOne and Pos Dispense) were connected to the MHR. The remaining vendors (Corum, Z Dispense, [redacted], MyScript and ScriptPro Dispense) are on track to connect by the end of October 2018.
- By the end of 2018 all major pharmacy dispensing vendors will have connections to the MHR system.
- Public pharmacy dispense records are now being uploaded from two jurisdictions. [redacted]
- **As at 30 June 2018**, 51 per cent of community pharmacies nationally were registered for the MHR system and 8 per cent were connected and uploading reports.

- **As at 16 October 2018**, 69 per cent of community pharmacies were registered for the MHR system and 32 per cent were connected and uploading reports.
- The program is on track to meet its forecast of s.47C [redacted] 80 per cent by June 2019, providing clinicians with important medicines information essential to the provision of healthcare and avoiding adverse drug events.

Pathology achievements

- The two largest private pathology services (Sonic and Primary) connected and commenced uploading Pathology reports to the MHR system in 2017/18.
- All Jurisdictions executed contracts with the Agency to connect and upload Pathology reports to the MHR system by June 2019.
- **As at 30 June 2018**, 30 per cent of pathology labs nationally (totalling 134: 39 public, 95 private) were connected to the MHR system and uploading reports.
- **As at 16 October 2018**, 161 (36 per cent) pathology labs connected to MHR of which 66 are public (NT 6, NSW 34, ACT 2, QLD 23, TAS 1) and 95 private (Primary s.47G, s.47G [redacted], Sonic s., Mater Brisbane s., InfinityPath 1, VCS s., Genome.One s.).
- The program is on track to meet its forecast of 80 per cent of all Pathology labs across Australia (comprising all States and Territories) to be connected to the MHR by June 2019, providing clinicians with important diagnostic pathology information essential to the provision of healthcare and avoiding unnecessary duplicate tests.

Diagnostic imaging achievements

- All Jurisdictions executed contracts with the Agency to connect and upload Diagnostic Imaging reports to the MHR system by June 2019.
- **As at 30 June 2018**, 60 (4 per cent) diagnostic imaging sites across Australia were connected and uploading to the MHR system across public and private sectors.
- **As at 16 October 2018**, 351 (23 per cent) diagnostic imaging practices are uploading to MHR, of which 191 are public (NT 6, NSW 137, QLD 48, ACT 2, TAS 2) and 160 private (Primary s.47G, PRC s.47G, GIG Radiology s., Paradise Ultrasound s., Mater Brisbane s., Newcastle Ultrasound s., Marina Radiology s.47G, Heartscope Victoria s.47G, Southwest Ultrasound s.).

- The program is on track to meet its forecast of 30 per cent of all Diagnostic Imaging sites to be connected to the MHR by June 2019, providing clinicians with important diagnostic imaging information essential to the provision of healthcare and avoiding unnecessary duplicate tests.
- **Two projects are well underway to implement seamless flow of secure electronic messages and ensure national scalability.** s.47G, s.47E(d) [redacted]
- **The scope and outcomes for an End of Life care project has been agreed** with s.47B(a), s.47B(b), [redacted] on the use of MHR to support a person's wishes prior to entering a clinical care pathway.
- **High level technical and strategic planning is well underway for the digital children's health record being led by NSW Health**; the first initiative of the top five priorities for improving children's health through digital initiatives.
- **The Agency has commenced broad consultation with key peak bodies and other key stakeholders** to deliver a package of standards, roadmap and approach to implementation for an interoperability framework later in 2018.
- **The Agency convened the Global Digital Health Partnership in** March 2018, hosting representatives from thirteen governments and the World Health Organization, to share learnings with international policy makers on how best to put data and technology to work for healthcare providers, health systems and citizens.
- **All Agency staff have been transitioned to a single IT network** for improved productivity, collaboration and efficiency.
- **The Agency has engaged an expanded cohort of Clinical Reference Leads** to provide greater breadth and depth of clinical coverage and input to Agency products and services.
- **The Agency is the inaugural host organisation and work placement** for the Australasian College of Health Informatics Fellowship by Training program.

- **The Agency is operating national infrastructure to high levels of reliability** — the Healthcare Identifiers Service, NASH, Clinical Terminology Service, HIPS 'middleware' tool, online training and test environments.

Budget allocation

- N/A.

Sensitivities

- N/A.

Background

- N/A.

Attachments

- Nil.

Brief prepared by:	s.22 General Manager, My Health Record Expansion Program, Core Services Systems Operations	Work Phone s.22

National Authentication Service for Health and Provider Digital Access

Subject

In alignment with the MHR Expansion Program, the Agency has implemented a number of system and process improvements for healthcare provider registration and authentication with the Healthcare Identifiers (HI) Services and MHR system.

Notably, these improvements provide a mechanism for National Authentication Service for Health (NASH) individual Public Key Infrastructure (PKI) users to transition to Provider Digital Access (PRODA), used and managed by the Department of Human Services (DHS) for authentication.

Key points

- Healthcare Provider Organisations and Individuals currently use NASH PKI to interact with the MHR system and other Digital Health systems and services such as Secure Messaging.
- NASH Individual PKI certificates are USB tokens used by individual healthcare providers to assess the National Provider Portal (NPP), a read-only portal for the MHR system.
- NASH Organisation PKI certificates are used by Clinical Information Systems interacting with other Digital Health systems including the MHR system.
- PKI certificates are managed under the Gatekeeper Identity Framework managed by the Digital Transformation Agency and are audited yearly for compliance.
- s.47G, s.47E(d) [redacted]
- As part of the MHR Expansion Program, the Agency is working to transition the authentication of healthcare providers to the NPP from the use of NASH Individual certificates to the use of PRODA.
- Transition to PRODA for individuals will simplify the registration process and reduce requirements and delays associated with the delivery of physical certificates.

- s.47E(d) [redacted]
- The Agency is also working to streamline the healthcare provider organisation registration process. This will move a multi stage form based process to fully online registration to streamline and reduce the time to completion from weeks to hours.
- The Agency is also working to transition the use of PKI Individual certificates to PRODA. s.47G [redacted]
- s.47G, s.47E(d) [redacted]

Budget allocation

- s.47G, s.47E(d) [redacted]

Background

Summary of issues and implemented solutions

Registration

Previously, to register for a Healthcare Provider Identifier for Organisations (HPI-O), a healthcare organisation is required to fill in an online form and attach evidence to confirm key information such as business name/Australian Business Number (ABN).

s.47G, s.47E(d) [redacted]

Solution implemented for registration

The solution integrates the Document Verification Service and the online ABN checker into an online process so that where the applicant is the business owner manual verification is no longer required.

This has resulted in a reduction in typical processing time from weeks to hours.

Authentication

Currently, in order for healthcare providers to interact with the MHR system they authenticate using either a NASH Organisation certificate loaded into their clinical information system or by using a NASH Individual token and logging directly into the NPP website.

Following registration of the organisation with the HI Service and the MHR, applications for NASH Organisation certificates were processed manually. s.47G, s.47E(d) This process took up to 20 business days.

s.47G, s.47E(d)

Additional issues identified included:

- The need for multiple forms to be completed for multiple PKI certificates that then need to be installed and managed. This has been found to be time consuming and confusing.
- s.47G, s.47E(d)

Solution implemented for Individuals

The solution for individual healthcare provider access to the NPP integrated the NPP as a PRODA relying party. PRODA now allows access to the NPP via a verified username and password with two-factor authentication. As a result, NASH Individual PKI tokens are no longer required.

Upon successful registration of a healthcare provider individual registered in the HI services that is authorised by a healthcare organisation registered with the MHR, the applicant has immediate access to the NPP. This has eliminated processing and delivery delays of up to 20 business days for receipt of a NASH Individual PKI.

Solution implemented for Organisations

For healthcare organisations, the solution provides an electronic online process that supports the request, issuance and secure download of a NASH Organisation certificate. This solution also supports the renewal of certificates.

The ability to request and receive certificates electronically:

- removes paper-based forms and the need to submit verification details multiple times;
- improves the manual processes in receiving a certificate, streamlining processes of the renewal of an expiring certificate;
- eliminates processing and shipping delays and misplacement of physical certificate media; and
  - results in the ability for an organisation to obtain a certificate in minutes or hours rather than up to 20 business days.

Subject Matter Lead:	s.22 [redacted] General Manager, Service Delivery	Work Phone s.22 [redacted]

National Digital Health Strategy

Subject

The development of the National Digital Health Strategy and Framework for Action.

Key points

- In August 2017, the COAG Health Council approved the National Digital Health Strategy: safe, seamless, and secure (the Strategy).
- This was a major milestone for digital health in Australia.
- The Agency co-produced the Strategy with extensive engagement and an evidence base of benefits that prioritise national-level digital health activity and investment over the next four years.
- The Strategy identifies seven key priorities for digital health in Australia:
    1. My Health Record — health information that is available whenever and wherever it is needed.
    2. Secure messaging — health information that can be exchanged securely.
    3. Interoperability and data quality — high-quality data with a commonly understood meaning that can be used with confidence.
    4. Medication safety — better availability and access to prescriptions and medicines information.
    5. Enhanced models of care — digitally-enabled models of care that improve accessibility, quality, safety and efficiency.
    6. Workforce and education — a workforce confidently using digital health technologies to deliver health and care.
    7. Driving innovation — a thriving digital health industry delivering world-class innovation.
- The Agency consulted extensively with healthcare consumers, clinicians, governments and industry through the *'Your Health. Your Say'* national conversation between October 2016 and February 2017.
- More than 3,000 people attended the 103 forums, workshops, webcasts and town hall meetings held across Australia, and over 1,000 individuals and organisations provided the Agency with submissions and survey responses.

Framework for action

- Importantly, this is not the Agency's strategy — this is Australia's National Digital Health Strategy. That is why a Framework for Action has been developed with the Agency's partners in the community to highlight the projects, innovations, public and private investments and new ways of working that will progress the Strategy's seven strategic priorities.
- The Agency has developed the Framework with all governments of Australia, and over 85 consumer, clinical and industry organisations shared with the Agency how their priorities align to the 44 priority activities outlined in the Framework's consultation draft. They also shared details of the initiatives they are delivering which contributes to achieving the outcomes and benefits of the Strategy.
- The Agency launched the Framework on 3 July to coincide with the commencement of the National Digital Health Strategy.
- As steward of the Strategy, the Agency will continue to play a lead role in coordinating national activities to achieve the digital health vision, and realise the benefits for the healthcare system and the Australian community.

Background

- The *'Your Health. Your Say.'* national consultation process which was run over five months and included:
  - Intensive outreach to consumers and clinicians in metropolitan, rural and remote communities across capital cities in all states **and** territories and regional centres including Broken Hill, Dubbo, Emerald, Gippsland, Port Headland, Toowoomba, Tweed Heads, Alice Springs and rural north western Victoria.
- Workshops in all major cities organised by stakeholder groups — clinical, consumer and industry — to share themes emerging from the initial stages of consultation and to refine those themes into national priorities.
  - Three national webcasts, and a webinar in the Northern Territory and Western Australia that focused on rural and remote clinicians.
  - Overall, more than 3,000 people engaged with us through these interactions.
- The cost to undertake this national consultation, including producing and designing the website and analyse the surveys and submissions, which elicited more than 1,000 responses, was $815,000.

Brief prepared by:	s.22 [redacted] Director, Policy and Strategy GICSD	Mobile phone: s.22 [redacted]

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Australian Digital Health Agency

Brief 49

Supplementary Budget Estimates — October 2018

Australian National Audit Office 2017–18 closing report

Subject

The Australian National Audit Office (ANAO) audited the Agency's 2017–18 financial statements and provided an audit closing report and an unmodified audit opinion on 24 September 2018.

Key points

s.47E(d), s.47E(a), s.47G

Budget allocation

- 2017–18 annual appropriations for the Agency's operating expenditure and capital budget is $197.062 million and $53.464 million respectively, as referenced on page 196 of the Portfolio Budget Statement 2017–18.

Background

- As a corporate Commonwealth entity, the Australian Digital Health Agency is required to prepare annual financial statements by the *Public Governance, Performance and Accountability Act 2013*.
- s.47E(d), s.47E(a), s.47G [redacted]

Brief prepared by:	s.22 [redacted] Director financial services OCEOD	Work phone: s.22 [redacted]

Supplementary Budget Estimates — October 2018

2017–18 Financial Statements

Subject

The Agency's 2017–18 financial statements were approved and signed on 20 September 2018.

Key points

- The Agency reported an operating loss of $20.49 million for 2017–18 (2017: operating surplus $19.44 million), in line with the Operating Loss Application approved by the Minister for Finance.
- The deficit in 2017–18 relates to the carry forward of 2016–17 Council of Australian Governments funding under the Inter-Governmental Agreement for the delivery of the agreed work plan and also an allowance for depreciation/amortisation.
- The Agency reported net assets of $112.58 million as at 30 June 2018 (2017: $79.61 million), with the increase predominantly arising from further development of the MHR system intangible asset and other Agency assets.
- Key movements between 2016–17 and 2017–18:
    - Revenue from Government: higher appropriation received to deliver the first year of the MHR Expansion Program.
    - Supplier Expenses: higher contractor and contract for service arrangements to support the delivery of the MHR Expansion Program.
    - Financial Assets: higher cash held at 30 June 2018 to meet outstanding creditors and accruals.
    - Supplier Payables: increased creditors and accruals relating to year end activity in the lead up to the opt out period commencing
    - Reserves: creation of $15 million Cash Reserve to meet potential operation winding up costs.

Budget allocation

- 2017–18 annual appropriations for the Agency's operating expenditure and capital budget is $197.062 million and $53.464 million respectively, as referenced on page 196 of the Portfolio Budget Statement 2017–18.

Background

- As a corporate Commonwealth entity, the Australian Digital Health Agency is required to prepare annual financial statements by the *Public Governance, Performance and Accountability Act 2013*.

Brief prepared by:	s.22 Director financial services OCEOD	Work phone s.22

Supplementary Budget Estimates — October 2018

Global Digital Health Partnership Summit

Subject

- The Global Digital Health Partnership (GDHP) is a collaboration of governments, territories, government agencies and the World Health Organization. It has been created to provide an international forum to facilitate global collaboration and cooperation, and to share policy insights and evidence of best practice in the implementation of digital health services.

Key points

- The GDHP was established in February 2018 at the inaugural summit in Canberra, Australia on 19 and 20 February 2018.
- On 24 and 25 April 2018, the second GDHP meeting was hosted by the United States (US) Department of Health and Human Services in Washington DC.
  - Deputy Secretary of the US Department of Health and Human Services, Eric Hargan, described the GDHP as one of the key international initiatives of the US administration.
- The third summit, in London was on 3 and 4 September. Twenty-three countries and territories and the World Health Organization participated in the discussions.
  - The London summit was hosted by the UK Department of Health and Social Care, NHS England and NHS Digital.
  - Among the attendees included s.33 [redacted] and Dr Soumya Swaminathan, Deputy Director General of Programmes, World Health Organization (WHO).
  - Dr Soumya Swaminathan commended the formation of the GDHP to facilitate collaboration and learning s.33 [redacted]

  - s.33 [redacted]
  - s.33 [redacted]
  - The London Summit officially recognised four new participant countries to the GDHP, namely Argentina, Brazil, Ukraine and Uruguay, bringing the number of formally participating countries and territories to 18 plus the WHO. Other formal participants currently include Australia, Austria, Canada, Hong Kong SAR, India, Indonesia, Italy, New Zealand, Saudi Arabia, Singapore, South Korea, Sweden, UK and USA.
  - s.33 [redacted]

- The GDHP currently has participants from 18 countries and territories (*see* Appendix 1) and the WHO.
- The Agency is looking to expand the partnership and is currently in conversation with a number of other countries about their participation.
- Participating countries are expected to fund their own costs in participating in the GDHP including attending face to face meetings.
- The Agency has agreed to host the secretariat of the GDHP in the first 18 months of operation.
- The next planned GDHP meeting is in New Delhi, India in the week commencing 25 February 2019.
- s.33, s.47C [redacted]

Global Digital Health Partnership work plan

- Eighteen participating governments are now taking forward a work plan looking into five key topics including:
  - interoperability,
  - cyber security,

  - policy environments,
  - clinical and consumer engagement, and
  - evidence and evaluation.

- Each of these programs aims to share the experiences from partner countries and support in defining success factors for each partner to take back to their own country ideas in which to improve the quality and safety of their own health systems.
- Additionally, shared intelligence particularly around issues like cyber security and interoperability have the potential to reduce costs in the event of global attacks while multiplying effort.
- s.47C, s.33 [redacted]

Budget for Global Digital Health Partnership Secretariat

- s.47E(d) [redacted]
- All participants fund their own costs in attending GDHP meetings.
- s.47E(d) [redacted]
- The Agency, in its remit to liaise and cooperate with overseas and international bodies on matters relating to digital health, was appointed as the inaugural Chair and secretariat for the GDHP in February 2018.

- s.47E(d) [redacted]

International Digital Health Symposium

- s.33, s.47E(d) [redacted]
- The Agency has no financial commitment to the Symposium, with no funding being provided to the conference organisers to host the event.

Interdepartmental cooperation

- s.47G, s.47E(d) [redacted]

Background

The Agency Rule specifies that an Agency function is to consult internationally on digital health:

> *9(1)(g) to liaise and cooperate with overseas and international bodies on matters relating to digital health;*
>
> *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016*

To deliver on this key function in an efficient and effective manner, the Agency has been working with governments internationally to establish the GDHP.

Brief prepared by:	Name: s.22 [redacted] Position: Chief of Staff Division: Office of the CEO	Mobile Phone s.22 [redacted]

Appendix 1

Participant Countries and Territories as at October 2018	s.47C, s.47E(d), s.33 [redacted]
Argentina	s.33 [redacted]
Australia	Chile
Austria	s.33 [redacted]
Brazil	[redacted]
Canada	[redacted]
Hong Kong SAR	Estonia
India	s.33 [redacted]
Republic of Indonesia	[redacted]
Italy	Japan
New Zealand	The Netherlands
Kingdom of Saudi Arabia	s.33 [redacted]
Singapore	Portugal
The Republic of Korea	s.33 [redacted]
Sweden	Poland
Ukraine	
United Kingdom	
United States of America	
s.33 [redacted]	

Communications activity budgets

Subject

This paper overviews the budget allocation to the MHR expansion communications plan with reference to post opt out communication funding and aims. It details the funding allocated to communications for the extended opt out period.

Key points

In the 2017 Budget, the Australian Government announced a commitment of $374.2 million over two years to the MHR to continue and expand the system.

- Of this, $181.53 million is allocated to the expansion program, which includes $27.75 million for comprehensive communication and engagement activities with both consumers and healthcare providers.
- The majority of the $27.75 million has been allocated to ensure all Australians are aware of the MHR and their right to opt out during the three-month opt out period.

Post opt out communication and engagement activities

- An amount of $4.85 million has been allocated to undertake ongoing activities to engage consumers and health care providers in utilisation of the system. This activity will commence from when records are created (December 2018) and continue to the end of the expansion program 30 June 2019.
- The objectives for post opt out for both consumers and health care providers is to support enablement of individuals integrating MHR into their healthcare journey. Activities will include:
  - Communication aimed to maintain awareness and activate interest for users of the health system who have chosen to get a MHR.
  - Consumer education to enable effective discussion with their doctor, usage of the system and to set privacy controls.
  - Stakeholder engagement with bodies who represent vulnerable groups in the areas of family safety, 14–17 year olds, culturally and linguistically diverse, Aboriginal and Torres Strait Islander people, sensitive clinical conditions, mental health.

- Communication to health care providers to encourage increased uploading and viewing of the MHR system.

Extension of opt out period and uplift in communication activities

- Due to the extension of the opt out period and Ministerial commitment to uplift communication activities in response to stakeholder feedback, s.47G, s.47E(d) [redacted]
- Modelling for the extension of the opt out communication was based upon the current communication campaign (provided in Brief 5), ensuring that Australians are able to make an informed choice during the opt out extension period.
  - This required:
    - Maintenance of awareness of the opt out period and end date.
    - Opportunities to learn more through relevant avenues to assist in making an informed choice.
    - Continuance of engagement with more vulnerable and hard to reach groups to ensure they benefit from the extension of the opt out period in making an informed choice.
- All communication activities have been extended in channels including Health, Advocacy, Community, Digital and Advertising as detailed in Brief 5.
- Materials with the 15 November date have been distributed to over 17,000 locations. To reduce cost, stickers with the new date were provided to health care locations and Australia Post to place on brochure holders, rather than re-print and distribute millions of brochures. This has saved substantial printing and distribution spend.
- Of the $5 million allocated to the extension period, $2.3 million has been allocated to an uplift in communication activities.
- The Agency undertook stakeholder interviews with clinical and consumer peak bodies to determine the expectation for an uplift in communication activities. An increase in paid media, specifically TV and radio was advised.
- A $2 million national TV campaign commencing 14 October and continuing until the 15 November has been booked utilising a 60 second and 30 second creative.
- $300,000 has been allocated to AM radio stations nationally with activity commencing from the beginning of August.

- Research has been undertaken to test the creative with consumers, to ensure that the creative will be effective in achieving objectives to help Australians make an informed choice, and to assure the effective utilisation of public funds on the expense of a TV campaign.

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Clinical reference leads program

Subject

Budget, remuneration and contract details for the Agency's clinical reference leads (CRLs) program since July 2016.

Key points

There are 2 classes of clinicians engaged in the work of the Agency:

1. The Agency engages representatives of Clinical Peaks/Colleges/ Associations to participate in Steering Groups, as representatives of those organisations.
   - These Colleges/Peak representatives are paid according to the Remuneration Tribunal Determination 2018/10 — Remuneration and Allowances for Holders of Part-Time Public Office.
   - The daily fee for Medical or Clinical professional representatives under the Remuneration Tribunal Determination are:
     - Chair — $1,143; and
     - Member — $858.

Clinical reference leads remuneration

2. The payment rates for CRLs engaged via the public expression of interest round in October 2017 CRL falls within the *not specified Offices* category where representatives are paid as individuals, where the member is not representing their member organisation.
   - CRL daily rates are considered in the context of the highly-specified requirements outlined in the expression of interest.
   - CRL requirements include:
     - being experienced and knowledgeable healthcare providers,
     - being digital health subject matter experts,
     - having extensive digital health advocacy experience,
     - having recognition and standing in their community,
     - are well connected within their professional associations, and
     - have established networks.

- The CRL fees also aims to adequately compensate CRLs required to take time out of their professional day to undertake Agency activities and for

their attendance at evening and weekend events supporting provider education and community/provider awareness raising.

- CRLs are allocated an hourly rate considered commensurate with their level of suitability against these requirements — ***see* below**.

Clinical reference leads rates

The CRL tiered levels of hourly and daily rates (GST exclusive) are as follows:

Hourly rate	**Capped (8 hours) daily rate**	**CRL category**
$250	$2,000	(3) Senior CRLs with relevant clinical experience, are considered leaders in their field, advocates of digital health and have many years of experience in the role, including with NEHTA prior to the Agency being established.
$200	$1,600	CRLs, some senior, with relevant clinical experience and are considered leaders in their field and advocates of digital health.
$150	$1,200	Junior CRLs with relevant clinical experience, may be leaders in their field and advocates of digital health. The variation in rates for CRLs in this group reflects their clinical experience and background (i.e. younger clinicians and/or those with less clinical experience but are demonstrated high achievers in their field, including Residential Medical Officers).

- All CRL contracts also have a capped number of days which is within the limits of the CRL program funding allocation.
- CRLs are selected to support the Agency in a range of activities based on their professional background and location.
- Where possible 'local' CRLs are sourced to participate in activities to reduce travel and related expenses.

Current contract arrangements with clinical reference leads

- Over 50 CRLs were successful in their application for the CRL program.
- 41 CRLs are currently contracted with the Agency (2018–19) under a contract for service.
- Other CRLs have chosen not to sign a contract this financial year/as yet due to changing circumstances i.e. changes in their work life (accepting acting positions reducing their availability to the Agency) or personal lives (pregnancy), working or studying overseas or we are awaiting further details from the CRL to finalise the contract for services.

Budget allocation (clinical reference leads program)

	16/17	17/18	18/19	Year to date July–Sept 18
Actuals — BAU	681,333	673,737	–	68,159
s.47C [redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Actual — Expansion	–	–	–	165,498
s.47C [redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Background

- The Agency has an established a broad CRL program that comprises healthcare professionals with contemporary clinical practice experience and digital health subject matter experts from varying fields across the healthcare sector.
- s.47E(d) [redacted]
- Recognising the expansive nature of the work plan, the Agency undertook an **expressions of interest process in October 2017** to engage interested and suitably qualified clinicians to expand the CRL program.

- The Agency's intention was to maintain a CRL program that is representative of the Australian health sector and offers a diverse range of backgrounds, skills, experiences and perspectives to benefit the work of the Agency. The program also aims to maintain dedicated representation from across Australia.
- The Agency has engaged CRLs who:
  - are active users of digital health and have an understanding of contemporary clinical practice and of national digital health infrastructure, its possibilities and limitations
  - are advocates of the establishment and adoption of a national digital health infrastructure and will represent the Agency in this regard.

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