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RACP Submission to Review of the My Health Records Legislative Instruments

Royal Australasian College of Physicians submission to the Digital Health Branch of the Department of Health, Disability and Ageing

September 2025

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 23,200 physicians and 8,700 trainee physicians, across Australia and Aotearoa New Zealand.

The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the Department of Health, Disability and Ageing's (the Department) review of the legislative instruments underpinning the My Health Record (MHR) system.

As a professional medical college representing over 30,000 physicians and paediatricians across Australia and New Zealand, the RACP supports the development of a robust, secure, and clinically useful digital health infrastructure that enhances patient care and safety.

This submission draws on previous RACP statements and submissions, including to the Community Affairs References Committee Inquiry into the My Health Record system[1], the draft report from the Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review Taskforce[2] and the Productivity Commission's efficiency review[3]. It focuses on the current state of specialist engagement with MHR and identifies key legislative reforms needed to improve uptake and utility among specialist physicians.

Current Specialist Engagement with My Health Record

As of June 2025, the My Health Record system holds more than 1.8 billion documents, with greater than 24 million consumers and more than 99% of records containing data, meaning the clinical value for specialist review is real and increasing[4]. However, specialist participation continues to lag behind other healthcare providers.

Physicians play a critical role in managing complex and chronic conditions, often requiring coordination across multiple providers. Despite this, specialist engagement with MHR remains limited due to several systemic and legislative barriers:

- **Low incentive structures**: Unlike general practitioners, specialists have not been offered targeted incentive payments to support MHR adoption.
- **Technical and workflow challenges**: Many specialist practices face integration issues with clinical software, lack of templates for specialist letters, and administrative burdens associated with MHR setup and use.
- **Limited awareness and training**: There is insufficient tailored education and support for specialists, particularly in private and rural settings.
- **Privacy and access concerns**: Ambiguities around access controls and patient consent have led to hesitancy among clinicians.

Despite these challenges, the RACP has supported and will continue to support MHR's significant potential to improve patient outcomes by delivering optimal clinical decision making, reducing misdiagnosis, medication error and unnecessary duplication of tests, and tackling care fragmentation while emphasising the need for robust privacy arrangements and appropriate clinician/consumer education.

Instrument-by-instrument recommendations

The following section details recommended amendments to the rules and regulations that make up the suite of My Health Record regulation. These amendments are designed to foster physician engagement with MHR, in turn creating a better integrated and more comprehensive information sharing system.

My Health Records Regulation 2012 (sunsets 1 April 2026)

Expand prescribed classes for nominated healthcare providers and uploaders.

- Enable additional professions commonly embedded in specialist teams (e.g. nurse practitioners in specialty clinics, genetic counsellors) to contribute under defined conditions, with specialist oversight and recorded provenance.

Reinforce System Operator obligations to publish conformance/usability guidance.

- Anchor expectations that the System Operator (ADHA) will maintain transparent, testable conformance and usability criteria to drive vendor alignment for specialist settings, consistent with the National Healthcare Interoperability Plan and Digital Health Blueprint.

Aid adolescent and vulnerable-group protections.

- Use the regulations to prescribe safeguards and defaults that support privacy for adolescents and people with sensitive diagnoses, while preserving safe information-sharing within the treating team.

My Health Records (Assisted Registration) Rule 2015 (sunsets 1 April 2026)

- Retain and modernise to reflect contemporary identity practices and digital channels, ensuring hospitals and specialist clinics can assist patients with low digital literacy, limited English proficiency, or complex disability to engage with MHR safely.

- Clarify assisted registration workflows in inpatient and outpatient specialist settings (including consent capture, interpreter use, and record control for adolescents and substitute decision-making).

My Health Records Rule 2016 (sunsets 1 April 2026)

Review and amend Rule 19 (upload restrictions).

- Allow specialist-appropriate uploads (e.g. specialist-authored Shared Clinical Summaries or equivalent specialist summary types) beyond the narrowly nominated provider construct, with clear provenance and accountability.
- Permit supervised delegation so members of a treating team (e.g. accredited registrars, nurse practitioners, allied health practitioners working to a specialist's plan) can prepare documents for specialist review/authorisation and upload in defined circumstances.
- Clarify multi-author documents and versioning to reflect team-based care without losing individual accountability. This will improve completeness and timeliness of specialist information in MHR and aligns Rule 19 with contemporary care models.

Access control and treating-team clarity.

- Codify treating-team access definitions and obligations so hospital-based teams, cross-provider shared care and virtual teams can access and upload in ways that reflect real workflows, with auditable access logs and clear patient controls.

Usability and interoperability obligations for participants

- For registered portal and repository operators, insert explicit obligations to support current national interoperability plans/standards and publish conformance claims so specialist systems can seamlessly query, render, and upload clinically useful documents (not just PDFs).
- Require minimum usability baselines (e.g., medication reconciliation views, allergy/intolerance visibility, clear document provenance) in certified portals to reduce clinician time.

Safety timing for sensitive results.

- Retain and clarify the ability to delay consumer visibility for certain sensitive results (e.g., genetics, oncology) so specialists can counsel patients first, accompanied by guidance for clinicians and consumers.

Education and obligations.

- Pair any expanded upload scope with clear guidance from ADHA developed in collaboration with key stakeholders on what content needs to be uploaded, minimum content for specialist summaries, and defined responsibilities for reconciling medications and allergies.

My Health Records (Opt-Out Trials) Rule 2016 (sunsets 1 April 2026)

- Repeal as the trial provisions are no longer relevant following the 2019 national opt-out transition.

My Health Records (National Application) Rules 2017 (sunsets 1 April 2028)

- Note that while not sunsetting until 2028, consequential updates may be required to maintain alignment with any changes to the core legislative instruments—particularly around document types, participation models, and treating-team definitions.

Implementation enablers

Please see below the RACP's recommendations for the Department's next steps regarding MHR legislation and implementation.

1. **Incentives:** Create specialist-appropriate incentives to offset the cost of workflow changes, documentation and software upgrades to support modernisation and reduce administrative burden.
2. **Standards & conformance**: Mandate and publish conformance/usability profiles for specialist-relevant document types (e.g. outpatient letter, operative note, cancer multidisciplinary team summary, genetics report), with structured data where feasible (medications, allergies, problem list) to maximise downstream utility.
3. **Education**: A refreshed education program for specialists and trainees on what to upload, how to manage sensitive information, and how to use MHR efficiently in clinics and multidisciplinary teams. RACP members specifically mentioned their desire to understand whether training will be ongoing as MHR systems evolve, how risk related to MHR data breaches is mitigated and where, domestically or otherwise, MHR data is being kept.
4. **Monitoring & feedback**: Publish de-identified specialty-level adoption and quality metrics (e.g. proportion of encounters with a specialist summary uploaded within a given number of days; completeness of medicine and allergy fields) to drive improvement without punitive framing.

Conclusion

The RACP strongly supports the continued development of the My Health Record system and recognises its potential to transform healthcare delivery. However, to realise these benefits, legislative instruments must evolve to support greater specialist engagement, address technical and privacy concerns, and ensure equitable access and participation across all sectors of the healthcare system.

We welcome further consultation and collaboration with the Department and the ADHA to ensure that the legislative framework supports a modern, inclusive, and clinically valuable digital health system.

Please contact Christian White, Policy & Advocacy Officer, for questions or comments about this submission via email: policy@racp.edu.au

References

[1] Royal Australasian College of Physicians. RACP Submission to Inquiry into the My Health Record system. September 2018. racp-submission-to-inquiry-into-the-my-health-record-system.pdf

[2] Royal Australasian College of Physicians. Submission to Report from the Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review Taskforce. June 2019. racp-submission-to-the-report-from-the-specialist-and-consultant-physician-consultation-clinical-committee-of-the-mbs-review-taskforce.pdf

[3] Royal Australasian College of Physicians. Submission to Productivity Commission. June 2025. submission-to-the-productivity-commission-inquiry-delivering-quality-care-more-efficiently.pdf

[4] Australian Digital Health Agency. My Health Record: Statistics and Insights, April 2025. mhrapril2025_landscapev1.pdf