

SUBMISSION

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AMA submission— Review of the My Health Records Legislative Instruments

Consultation closes 6 September 2025 — Received extension to 12 September

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Introduction

The Australian Medical Association (AMA) welcomes the opportunity to contribute to the Department of Health, Disability and Ageing's [review of the legislative instruments underpinning the My Health Record \(MHR\)](#). The AMA has long supported the development of a secure, interoperable, and clinically useful digital health infrastructure that enhances patient care and supports the work of healthcare professionals across all settings.

It is vital to ensure the legislative framework governing the MHR is fit for purpose. In particular, the AMA's feedback highlights the need to strengthen privacy protections, improve usability and integration with clinical workflows, support culturally safe and equitable care, enhance cyber security and data governance, and ensure the system is adaptable to emerging technologies and models of care.

Should rule 19 of the My Health Records Rule 2016, which relates to restrictions on uploading certain health information, be reviewed? If so, what amendments would you propose and why? What considerations should guide the review of this rule?

The AMA supports a review of rule 19. The current restriction prevents Australian Defence Force (ADF) practitioners, Aboriginal and Torres Strait Islander health practitioners, and other qualified professionals without an HPI-I from uploading to the MHR. This is inconsistent with the principles of equity, cultural safety, and best practice multidisciplinary care. We recommend amending rule 19 to permit all appropriately qualified and regulated health practitioners to upload health information, provided authorship is clearly identified and subject to professional accountability.

In the case of the ADF, medical history, information, and documents produced by medics cannot be uploaded to the MHR, preventing access to reliable and up-to-date vaccination records. The AMA has also maintained Aboriginal and Torres Strait Islander patient data sovereignty principles should be upheld when handling the health data of the Aboriginal and Torres Strait Islander population.

This amendment is also necessary to ensure culturally safe, comprehensive care and to address inequities in access and participation. The exclusion of these practitioners limits the completeness and clinical utility of the record, particularly for patients who rely on them for primary care. A connected, interoperable healthcare system must be founded on data safety, quality, privacy, and portability.¹

Should the definition of a ‘nominated healthcare provider’ be expanded to include other health professionals involved in patient care (e.g. pharmacists, or enrolled nurses, or midwives who are not registered nurses)? Explain why or why not.

The AMA supports a review of the definition of ‘nominated healthcare provider’ to better reflect contemporary, team-based models of care. Expanding the definition to include other registered health professionals may improve continuity of care, particularly in rural and aged care settings.

However, any change must preserve the central coordinating role of the general practitioner (GP). The AMA recommends any expansion be accompanied by clear governance arrangements to maintain clinical accountability and avoid fragmentation of care. A medical doctor must be included in any expanded definition of ‘nominated healthcare provider’, preferably a general practitioner. There is considerable evidence the inclusion of GPs, in particular, results in better health outcomes, less duplication, and more efficient use of resources.

Should other health professionals also be able to author a shared health summary? If so, what types of health professionals and why?

The AMA acknowledges the potential benefits of allowing a broader range of health professionals to author shared health summaries, particularly within multidisciplinary teams. However, this should not be an unrestricted expansion. The AMA recommends only appropriately qualified and regulated professionals be permitted to author or co-author shared health summaries, with clear identification of authorship and robust clinical governance. This approach will support team-based care while maintaining the integrity and clinical utility of the record, and will ensure the GP or nominated primary care provider retains oversight of the patient’s overall clinical record.²

Where direct-to-specialist referrals may be issued by allied health providers, these practitioners should be granted access and responsibility to author shared health summaries to the same standards. This will help ensure an accurate and accessible record is maintained in instances where the GP or another doctor is no longer part of the referral process.

Do you think that shared health summaries are still relevant as we modernise the MHR system? Explain why or why not and if possible, detail your experience with shared health summaries.

¹ System Interoperability in Healthcare Position Statement

² AMA Submission National Healthcare Interoperability Plan

The AMA considers shared health summaries to be a valuable component of the MHR system, providing a concise and accessible summary of a patient's health status. However, to remain clinically useful, shared health summaries require modernisation, including integration with real-time data and broader care team inputs. While summaries by nature reflect only a single point in time, true integration requires interoperability at both ends; the MHR should allow summaries to be exported to other clinical software systems to ensure consistency across medical records.

Clinicians frequently express frustration with manual uploads and the time spent searching across systems. These inefficiencies detract from patient care and increase the administrative burden. The AMA recommends enhancements to improve usability for both clinicians and patients, ensuring summaries are current and support effective clinical decision-making. Improved interoperability and streamlined workflows are essential, as is the need for shared summaries to be easily accessible and integrated into the clinical software used across various care settings. Any changes should aim to increase broad clinical relevance and usability, and adopt a patient-centred design to reduce administrative burden.³

Are the participation requirements as set out in the My Health Records Rule 2016 fit for purpose?

While the foundational participation requirements have served the system well, they require updates to reflect evolving cyber threats, interoperability standards, and the diversity of healthcare providers. Exemptions for small operators may no longer be appropriate, as any weak link can compromise system security and trust. The AMA recommends a review to ensure requirements are robust, enforceable, and adaptable to new risks and technologies, with regular audits and clear accountability.⁴

Do the provisions in the My Health Records Rule 2016 need to be more specific in their application to cyber security?

The AMA strongly supports the introduction of clearer, enforceable minimum standards for cyber security within the MHR Rule. Recent high-profile cyber incidents in Australia and internationally have demonstrated sensitive health data is a prime target for malicious actors, and the consequences of breaches are severe for both patients and providers. Given the majority of patients will gain their understanding of the MHR through interactions with their GP, any breach of patient data is likely to be perceived as the fault of both the government, and the doctor who uploaded the information to the MHR.

The AMA has consistently argued robust, mandatory cyber security measures — including regular audits, mandatory breach reporting, and the adoption of best-practice protocols such as two-factor authentication — are essential to maintain public trust in digital health systems.⁵

³ Data Governance AMA Position Statement

⁴ Ibid.

⁵ AMA Ethical Guidelines for Doctors on Disclosing Medical Records to Third Parties (2015)

The current provisions are insufficiently prescriptive and leave too much room for interpretation, particularly for small and medium-sized providers. The AMA recommends the rules specify minimum technical and organisational standards, including requirements for encryption, access controls, incident response planning, and regular staff training. There should also be clear guidance and support for providers to achieve compliance, recognising the diversity of the healthcare sector.

While healthcare providers are subject to mandatory reporting obligations for cyber incidents under the Privacy Act, there is room for stronger enforcement and oversight. We recommend clear articulation of these obligations within the MHR legislative instruments, with reference to requirements and how they apply to the MHR users. As central health data systems become more sophisticated, it becomes more difficult for providers to navigate those systems and remain compliant with cybersecurity standards. There should be more support for providers, especially smaller practices, to meet these obligations consistently.

Provisions should require all participants in the MHR are held to a high and consistent standard of cyber security, as the system is only as strong as its weakest link. Only by embedding these requirements in regulation can the system remain resilient in the face of evolving threats and continue to maintain the confidence of both clinicians and the public.

Are rules 7 and 8 under the My Health Record Rule 2016, which pertains to emergency access, still fit for purpose in their current form?

We recognise the importance of emergency access provisions. However, the AMA has noted evidence of misuse, including use in non-emergency situations. We recommend a review of rules 7 and 8 to clarify the circumstances under which emergency access is appropriate, strengthen audit and enforcement mechanisms, and ensure all uses are logged and subject to oversight.

We refer to the principles of patient privacy, clinical necessity, and accountability in evaluating the current measures, as outlined in the AMA's ethical guidelines regarding the disclosure of medical records to third parties.⁶

Should authorised and nominated representatives continue to have access to a deceased recordholder's MHR? Explain why or why not.

Should nominated healthcare providers and/or other healthcare providers continue to have access to a deceased recordholder's MHR? Explain why or why not.

The AMA supports continued access to a deceased recordholder's MHR for authorised and nominated representatives, but only under strict safeguards. Access should not apply equally to both groups: authorised representatives — such as executors or those with enduring power of attorney — should have a higher level of access than nominated representatives, whose relationship may be less formal or enduring. This distinction is important to ensure access is granted only to those with a legitimate legal or care relationship to the deceased.

⁶ Ibid.

Access for both groups should be limited to viewing information only and not allow alteration or addition of records. The scope of access should be restricted to information necessary for specific, justified purposes — such as managing the estate, supporting bereavement, or investigating genetic or family medical history.

Doctors' ethical, professional and legal duty to protect the confidentiality of medical records continues even after a patient has died, and access requirements should proportionately support this.⁷ The AMA believes access to a deceased recordholder's MHR by healthcare providers should be strictly limited to circumstances where it is legally required or justified for specific purposes, such as coronial investigations or public health research. The default should be to maintain confidentiality after death, in line with ethical and legal obligations.

In all circumstances, access should be time-bound, retained solely to fulfil the above purposes, and subject to robust audit trails and oversight. Adjustments should be guided by respect for the deceased's privacy, ensuring access is justified, limited, and appropriately monitored.

Is there an ongoing need for assisted registration?

The AMA supports retention of assisted registration, recognising vulnerable populations — including those from culturally and linguistically diverse backgrounds, aged care residents, people in remote communities, and children with reduced capacity — may still require support. Assisted registration is an important equity measure to ensure all Australians can access and benefit from the MHR system.

If assisted registration is to be retained, should any revisions to the process be considered?

As set out above, the AMA supports the retention of assisted registration. The AMA recommends strengthening identity proofing and parental responsibility processes within assisted registration to prevent misuse or unauthorised access. This includes clear guidelines for verifying identity, documenting authority, and ensuring staff are appropriately trained.

The AMA recommends that, if assisted registration is retained, the process be revised to strengthen identity proofing and clarify parental responsibility, particularly in relation to adolescent privacy. There have been cases where parents have become aware their teenage children have accessed healthcare for sensitive matters, such as sexually transmitted infections, reproductive health, or mental health counselling. This can occur if parents retain access to their child's MHR after the child has reached an age at which they are legally entitled to confidential care.

The law recognises some minors deemed to have sufficient decision-making capacity and understanding are capable of consenting to medical treatment. The confidentiality of these minors should be respected; therefore, parents may not have automatic access to their medical records without the minors' consent.⁸ Any changes to the legislative instruments must continue to uphold the privacy rights of mature minors, in accordance with both legal requirements and best clinical practice.

⁷ AMA Ethical Guidelines for Doctors on Disclosing Medical Records to Third Parties (2015)

⁸ System Interoperability in Healthcare AMA Position Statement

The AMA recommends the assisted registration process include robust verification of both the identity of the applicant and their legal authority to act on behalf of the minor, and that clear mechanisms be established to transition control of the record to the young person as they reach the age of medical consent. Instruments should ensure young people can access confidential healthcare — particularly for sensitive issues — without fear of unwanted disclosure to parents or guardians, except where required by law or where there is a serious risk to the young person’s safety.

Are there any instruments that you believe are no longer fit for purpose, necessary or require revision? If yes, please explain reasoning.

The My Health Records (Opt-Out Trials) Rule 2016 is now obsolete and should be repealed, as the opt-out model has been fully implemented. The AMA recommends the regular review of all legislative instruments to ensure they remain necessary, effective, and aligned with current policy and technology.⁹

Are there any specific provisions in the instruments that you believe are no longer fit for purpose, necessary or require revision to better support the operation of the MHR system? If yes, please explain reasoning.

The AMA recommends revising provisions to better align with the National Digital Health Strategy and Interoperability Plan, improve usability, and future-proof the system for emerging technologies. Alignment is needed to ensure seamless data exchange and reduce administrative burden. Usability must be improved so the MHR is intuitive and integrated into clinical workflows, supporting rather than hindering care.

Finally, data sharing, consent, and secondary use provisions should reflect modern expectations for privacy and transparency, giving patients confidence their information is used ethically and only for the purposes to which they have consented. These changes are necessary to ensure the MHR system is interoperable, user-friendly, innovative, and trusted by both clinicians and patients.

The issues identified are not always the result of problematic existing clauses, but rather the absence or inadequacy of provisions within the current legislative instruments to address operational realities. The AMA’s recommendations therefore focus on the inclusion or strengthening of provisions in these areas to ensure the legislative framework is fit for purpose and responsive to the needs of clinicians and patients.

Are there any issues that you would like to address that have not been covered by any other questions? If yes, please explain reasoning.

Digital inclusion: Ongoing reforms to the MHR should be guided by principles of inclusivity, stakeholder engagement, and continuous improvement. Investment in our broader digital health infrastructure should be co-designed with consumers and providers, support digital literacy, and enhance readiness for future technologies such as increasing AI capabilities. Digital inclusion must be prioritised to ensure all Australians can access and benefit from the MHR.

⁹ AMA Data Governance Position Statement

Patient interaction with the MHR is limited, leading to a lack of understanding of the system coupled with a healthy degree of caution regarding the use of personal health data. To address this, the government should deliver accessible information through targeted awareness campaigns aimed at both patients and their supporting GPs. These campaigns should clearly communicate the practical benefits of the MHR and the high standards of data security the public can expect.

Vendor compliance with interoperability standards: Current legislative instruments (such as the My Health Records Rule 2016 and Regulation 2012) do not contain explicit, enforceable requirements or timelines for software vendors to implement interoperability features. Instead, they set out general requirements for system operation and participation. The AMA is concerned the lack of specific, enforceable provisions has allowed vendors to delay the implementation of critical features, which undermines the intent of the legislation.

Usability and workflow integration: There is no explicit provision in the legislative instruments requiring the MHR be integrated into clinical workflows or usability for clinicians be prioritised. The instruments focus on technical and security requirements but do not address user experience or administrative burden, both of which present barriers to effective use. Provisions should support a focus on MHR interoperability with core clinical systems, assistive technologies, mobile health applications, and web-based innovations. This is essential to ensure the system is practical and beneficial in clinical settings. Provisions should also be flexible enough to accommodate innovations such as artificial intelligence (AI), wearables, and big data analytics, while maintaining high standards of privacy and security.

Flexibility for emerging technologies: The legislative instruments do not contain explicit provisions for the integration of emerging technologies such as AI, wearables, or big data analytics. While they are drafted to be technology-neutral, the absence of specific guidance or flexibility can hinder the safe and timely adoption of new tools and innovations.

My Medicare registration: Following the July 2025 changes, patients must be registered with My Medicare to access chronic condition management plans (GPCCMPs), longer MBS-funded telehealth consultations (Level C and D), and to be eligible for the in-Aged Care Incentive (GPACI). While transitional arrangements are in place (to 1 July 2027), access to Medicare rebates for allied health services under a care plan will soon require a valid GPCCMP.

The current means of checking whether a patient is enrolled in My Medicare is limited to the MHR and Health Professional Online Services (HPOS), and in most circumstances, doctors do not have sufficient time to check outside of consultations. This leads to patients accessing clinically appropriate care plans for which they are nevertheless ineligible. The practitioner cannot bill them and therefore the patient cannot access the allied health services they need.

As the AMA has consistently advocated, with our digital health system moving toward tighter linkage between registration and access, these tools must be updated with a modern user interface and integrated with other key clinical software so these processes can be incorporated efficiently into clinical workflows. System functionality must keep pace with access requirements to ensure patients receive the care they need.

Do you have any concerns or comments about the My Health Records (National Application) Rules 2017 being repealed and remade into a new instrument with alignment of the other instruments?

The AMA has no major concerns about the repeal and remaking of the My Health Record (National Application) Rules 2017, provided this ensures alignment and coherence with other legislative instruments. Fragmentation can undermine usability and trust, so harmonisation is essential.

Do you have any overall feedback or comments about the operation of the MHR system?

The AMA remains committed to working with government and stakeholders to realise the full potential of the MHR, which must be considered the functional backbone of an interoperable health system. Considerable investment is needed to enhance both the functional capabilities and consumer understanding of the MHR, enabling patients and doctors to benefit from clearer communication of medical history that is both current and accurate. Success will depend on meaningful co-design with clinicians, sustained investment in usability and interoperability, and a clear commitment to safety, privacy, and clinical relevance.

Modernising the MHR is not just a technical upgrade — it's a necessary tool to support safe, effective, and patient-centred care across Australia. The points below reiterate some key capabilities we have previously mentioned that must be developed for the MHR to perform effectively:

- The MHR must integrate directly with the clinical software used in general practice and other care settings, making it more useful in day-to-day clinical practice. Clinicians should not be required to log into separate portals or manually upload documents. Integration should be automatic, secure, and intuitive.
- Improvements must focus on the interface to reduce clinician workload, including features such as auto-populated fields and streamlined authentication (e.g. avoiding repeated PRODA logins). Real-time access to results is essential.
- Clarify “share by default” arrangements to ensure diagnostic imaging and pathology results are sent to the requesting GP as soon as possible. This is essential to manage clinical risk associated with patient expectations and to ensure abnormal results are reviewed promptly. Clear standards are needed to ensure GPs receive results directly and are supported with guidance on follow-up responsibilities.
- The system must uphold privacy rights, especially for adolescents and vulnerable populations. Access controls must be robust, and patients must retain meaningful control over who sees their information. The AMA supports alignment with privacy legislation and ethical standards.
- The MHR must be interoperable across all care settings and adaptable to emerging technologies such as AI scribes, wearables, and predictive analytics. The AMA supports investment in digital infrastructure and standards that foster safe, scalable innovation across the health system.
- Doctors should not be penalised for not using the MHR through measures such as withholding Medicare rebates. Reform must focus on improving functionality and clinician engagement through incentivisation — not coercion.

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