Introduction

Australians are very fortunate in terms of health compared to most of the world and we continue to live longer lives. In 2006–07, Australia was ranked in the international top ten on numerous aspects of health and was in the top five for life expectancy.

Death rates from cardiovascular disease including heart attack and stroke continue to fall and our overall cancer death rates declined by approximately 14 per cent between 1986 and 2004. This was largely due to the excellent public health and medical systems in place in Australia.

However, Australia’s health cannot be isolated from the health of our region and of the broader world. The need for protection against overseas health threats was the main reason why Australia’s states agreed to create the national Department of Health, 88 years ago, and this need has become much more extreme in an age of rapid travel and trade. International and regional partnerships are becoming increasingly critical to achieving our national health objectives.

In 2006–07, the Department has risen to new challenges in providing leadership and administration for the nation’s health services and programs, by developing, guiding and implementing a series of significant reforms in health and aged care.

The Department’s activities have made significant progress with approaches aimed at preventing and treating chronic disease, as well as implementing major initiatives in significant areas of mental health and the health workforce. A number of these initiatives have the backing of the Council of Australian Governments (COAG), which reflects the importance of good health outcomes and a strong health sector to our nation as we continue a demographic transition to an older population.

In addition to delivering these reform packages, the Department also dealt with its ongoing work, and efficiently administered a budget of $41.1 billion. Successes that stand out this year include:

- **Exercise Cumpston 06** – The Department tested and improved the nation’s preparedness for responding to an influenza pandemic by conducting the largest health simulation exercise in Australia and one of the largest in the world. The operation simulated the arrival of two people infected with avian flu at Brisbane airport and included a series of exercises and live drills with over 1,000 people involved at national and state levels (see Outcome 15 for more information);

- **Roll-out of Opal fuel** – By the end of June 2007, the Department had expanded the availability of non-sniffable Opal fuel within the Central Desert Region from 59 sites to 104, including 72 remote Aboriginal communities, 29 roadhouses and service stations and three pastoral properties.
Early evidence shows that the removal of sniffable fuel has had an immediate positive impact, with an 80 per cent reduction in the prevalence of petrol sniffing in the Anangu Pitjantjatjara Yankunytjatjara Lands since the introduction of Opal (Outcome 8);

• COAG Mental Health Reform Package - The Department implemented new team work arrangements for psychiatrists, general practitioners, psychologists and mental health nurses; and new non-clinical, community-based services for people with mental illness, their families and their carers (Outcome 11);

• Pharmaceutical Benefits Scheme Reform - The Department progressed a major reform package for the Pharmaceutical Benefits Scheme to ensure continued access to new and expensive medicines for Australians, and to keep the scheme affordable in the future (Outcome 2);

• Private Health Insurance Reform - The Department established a new legislative framework enabling health insurers to pay benefits for a broader range of health care services such as hospital-substitute treatment, programs to manage and prevent chronic diseases and self-management programs for healthier lifestyles (Outcome 9); and

• National Human Papillomavirus Vaccination Program - The Department worked closely with the states and territories to implement the National Human Papillomavirus Vaccination Program within a very tight timeframe. This new program protects girls and young women against four strains of the virus, two of which cause 70 per cent of cervical cancers. A school-based vaccination program for girls aged 12 to 18 years commenced in April 2007 and a community-based program for women aged 18 to 26 and those not at school, commenced from 1 July 2007 (Outcome 1).

Highlights of 2006-07

Promoting Good Health and Preventing Disease

Australian Better Health Initiative

Australia has one of the best health systems in the world and one of the highest life expectancies. Many people, however, suffer from chronic illness, which is an emerging global phenomenon. The development of chronic disease depends on a number of factors, including lifestyle choices and individual behaviours. While some things such as age, gender, background and family history cannot be changed, other factors influencing health such as weight, blood pressure, stress levels and physical fitness can be influenced by the lifestyle of individuals.

This year, the Department worked with the states and territories to coordinate and finalise implementation plans for the COAG Australian Better Health Initiative which seeks to reduce the incidence of avoidable chronic disease by promoting healthier lifestyles. We commenced a number of associated programs which focused on reducing obesity and encouraged physical activity. For example, the Healthy Active Ambassador program engaged well-known Australians who live healthy and active lives to promote the benefits of healthy life choices to the community and especially to young people. The ambassadors included sports people such as Harry Kewell, chef Luke Mangan and children's entertainment group Hi-5.

The Department also included the 45 year old health check on the Medicare Benefits Schedule, enabling general practitioners to conduct a thorough assessment of patients between the ages of 45 and 49 years to help them avoid chronic disease through planned intervention strategies (Outcomes 1, 3, 5 and 10).

Early Detection and Prevention of Cancer

While cancer remains the leading cause of death in Australia, survival rates for many common cancers have increased greatly in recent years. During the year, the Department continued to implement the Strengthening Cancer Care initiative to reduce the burden of cancer in Australia, including continued support for the National Breast Cancer Centre for the ongoing delivery of breast and ovarian cancer programs. The Department also coordinated the Government’s response to the Senate Community Affairs Committee report Breaking the Silence: a National Voice for Gynaecological Cancers and commenced a major evaluation of the BreastScreening Australia program.

Another major achievement for the Department was the introduction of the National Bowel Cancer Screening Program. Bowel cancer is currently the second most common internal cancer affecting Australians, but the risk of death can be greatly reduced if the disease is detected early. The new national screening program allows
eligible Australians to take a simple and non-evasive test in the privacy of their own home at no cost. The Department distributed over 400,000 screening invitations to 55 and 65 year olds in all states and territories in 2006–07 (Outcomes 1 and 10).

Reducing the Risk of Type 2 Diabetes

Many Australians, particularly those over 40, are at risk of developing type 2 diabetes through lifestyle factors relating to nutrition and physical activity. Without effective interventions, it has been estimated that by 2030 around 3.3 million Australians are likely to have this disease.

During the year, the Department played a strong role in the development of COAG initiatives to improve the detection and reduce the risk of type 2 diabetes in Australia (Outcome 10).

Enhancing Access to Mental Health Care

As part of the Government’s contribution to the COAG Mental Health Reform Package, the Department introduced a range of new initiatives. This included funding for more than 55 community-based and national projects to enhance community capacity in suicide prevention and funding to enable greater access to mental health services for people living in rural and remote Australia. In addition, funding of over $23 million was committed over five years to expand Lifeline and Kids Help Line and funding of $19 million for the non-government sector to deliver new day program places for people with severe mental illness.

Significantly, new Medicare Benefit Schedule items were introduced in November 2006 to increase access to mental health care. The items encourage private psychiatrists to see more new patients. They also allow people with mental disorders to access Medicare rebates for treatment by psychologists and other allied mental health professionals, on referral from their general practitioner under a mental health care plan, or from a psychiatrist or paediatrician. Uptake of the new items has been positive, with more than 1.2 million Medicare items claimed in the period to 30 June 2007 (Outcomes 3, 5 and 11).

Commitment to Aboriginal and Torres Strait Islander Health

Addressing the health needs of Aboriginal and Torres Strait Islander people continued to be a priority in 2006–07. Our focus was on improving access to mainstream health services and listing medicines with specific benefits for Indigenous people on the Pharmaceutical Benefits Scheme. The Department provided funding for the five urban brokerage services to link Indigenous people with networks of mainstream health service providers. We also conducted workshops for Indigenous health services about Medicare, and promoted the Aboriginal and Torres Strait Islander Child Health Check using a travelling roadshow led by Nova Peris and other prominent Indigenous advocates.

Towards the end of 2006–07, the Department established a Northern Territory Emergency Coordination Centre to support the Government’s response to the Ampe Akeyernemane Meke Mekarle Little Children are Sacred report on the sexual abuse of Indigenous children in the Northern Territory. The Department set up the centre to manage the conduct of health checks for Indigenous children aged under 16 years in the 73 affected Aboriginal communities in the Northern Territory, to identify significant health issues and to plan follow-up treatment. With bases in Canberra, Alice Springs and Darwin, the centre is responsible for the recruitment, assembly, training and deployment of health care teams to carry out these health checks (Outcome 8).

Caring for Older Australians

Changes to the Aged Care Sector

Reforming the aged care sector based on the recommendations put forward in Professor Warren Hogan’s 2004 Review of Pricing Arrangements in Residential Aged Care was a key activity during 2006–07. The Department provided advice to the Government on options which informed the resulting Securing the Future of Aged Care for Australians package that focuses on increasing community care places and encouraging investment in quality residential aged care. The reforms also aim to ensure that people get the right level of care at a fair price.

The Department implemented new compulsory reporting and complaints investigation arrangements to protect people from physical and sexual assault when receiving government-
ANNUAL REPORT 2006–07

subsidised aged care, and to enforce quality standards. This included establishing a new Aged Care Commissioner to hear complaints about action taken by the Department in relation to investigations, or about the conduct of the Aged Care Standards and Accreditation Agency (Outcome 4).

Improving the Care of Older Patients in Public Hospitals

Another focus during the year was on addressing the needs of older patients who no longer need acute hospital care but experience delays in accessing more appropriate forms of care. In rural areas this may be due to fewer aged care options, while in urban areas people with high complexity and/or high cost care needs may have difficulty accessing residential aged care places.

Following a commitment from COAG, the Department worked with the states and territories to put programs in place to assist older people experiencing these problems in rural and urban areas. As of 30 June 2007, all states and territories had Memoranda of Understanding and implementation plans in place and received their first year funding (Outcome 13).

Improving Access to Medicines and Medical Treatments

The Pharmaceutical Benefits Scheme continued to provide access to a wide range of medicines, including new and expensive drugs, in a way that was affordable for individuals and the community. Newly listed drugs included Herceptin® for early breast cancers, Lantus® and Levemir® for the management of diabetes, and Protos® for the treatment of established osteoporosis.

Pharmaceutical Benefits Scheme Reform

A priority for the Department this year was developing a package of reforms to support the long-term sustainability of the Pharmaceutical Benefits Scheme. These reforms will result in the Australian community paying less for certain medicines and potentially saving more than $580 million over the next four years. Reducing cost pressures will make it easier for the Pharmaceutical Benefits Scheme to include new expensive drug treatments as they become available through medical research and clinical trials, and to meet the needs of the ageing population.

Implemented from 1 July 2007, the reforms comprise changes to the pricing arrangements for listed medicines, a pharmacy and wholesaler adjustment package, and streamlined authority approvals for some medicines to increase the time prescribers can spend with patients (Outcome 4).

Amendments to the Medicare Benefits Schedule Revisions were also made to the Medicare Benefits Schedule to ensure that medical services remain clinically relevant and financially sustainable. Some of these changes include new items to fund antenatal checks for women in rural and remote Australia which are undertaken by nurses, midwives and registered Aboriginal Health Workers on behalf of medical practitioners. Other new items will also assist in the treatment of paediatric patients with fractures and provide for the placement of catheters for administering high dose rate brachytherapy to treat prostate cancer (Outcome 3).

Expanding Private Health Insurance

Following an extensive consultation process with the private health sector, the Department implemented a comprehensive package of reforms aimed at making private health insurance better value for consumers and more relevant to current medical practices. The reforms include a policy and legislative framework to enable and encourage health insurers to pay benefits for a broader range of health care services. They allow health funds to extend hospital cover to include medical treatments that are done without the patient having to go into hospital, for instance, dialysis or chemotherapy undertaken in a patient’s home; and programs to manage and prevent heart disease, diabetes and other chronic diseases.

Standard product information requirements were put in place which make it compulsory for all health funds to describe each of their products, including the price, in a common format. The Department also assisted the Private Health Insurance Ombudsman to develop a new consumer website, www.PrivateHealth.gov.au, which provides information about private health insurance and helps consumers to search for, and compare, private health insurance products (Outcome 9).
Combating Drugs and Alcohol Misuse

Illicit drug use and high risk alcohol consumption create significant health, economic and social costs to individuals, families and the community. During 2006–07, the Department worked towards reducing the problems caused by illicit drugs through prevention, treatment and diversion components of the Government’s Tough on Drugs Initiative. The Department administered funding to numerous community-based organisations to implement a broad range of drug prevention activities.

The Department finalised and disseminated national guidelines for emergency departments and ambulance services on the management of acute behavioural disturbances associated with psychostimulants (such as ‘ecstasy’, ‘Ice’, cocaine or ‘speed’) and supported approximately 120 non-government organisations to operate a range of alcohol and drug treatment services. We also introduced a range of education initiatives promoting the responsible consumption of alcohol (Outcome 1).

Building the Health Workforce to Meet Community Needs

Developing and expanding the health workforce to meet the nation’s needs now, and into the future, is another issue which has been given attention by COAG. Throughout the year, the Department worked closely with the states and territories on a range of initiatives aimed at ensuring the health workforce is able to respond to the evolving health care needs of the Australian community.

The Department worked in consultation with states and territories, medical colleges and private hospitals to expand medical specialist training beyond traditional public teaching schools, into regional, rural and ambulatory settings, private hospitals and community settings. This led to funding for 10 new pathology training positions from July 2007 and identification of 16 other specialist training positions across Australia for agreement with jurisdictions and specialist colleges to commence in January 2008. The Department also contributed to the COAG agreement for national arrangement for the registration of practitioners and accreditation of training courses, starting with the nine health professions currently registered in all jurisdictions. These arrangements will aid workforce mobility, improve safety and quality, and reduce red tape (Outcome 12).

Progressing National Health Systems

Establishment of the National Health Call Centre Network

The Department played a lead role in implementing COAG’s February 2006 commitment to a National Health Call Centre Network. The network will provide callers with round-the-clock phone access to nurses who can consider symptoms and advise callers on how urgently they may need to be seen by a health professional. If treatment is necessary, nurses can also advise the type of treatment that callers should seek – whether in a hospital or from a general practitioner.

The Department worked collaboratively with all jurisdictions to develop the overarching framework for the establishment of the National Health Call Centre Network company. The company has responsibility for ensuring the roll-out of the service with full national coverage to be achieved by July 2011. Currently, the Commonwealth, the Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Western Australia have formally joined the network, with Queensland, Victoria and Tasmania signalling their intent to join in the future. Calls are currently being taken in the Australian Capital Territory, Western Australia, the Northern Territory, and South Australia. It is expected that calls will be taken in New South Wales in mid-2008, with other states following after that (Outcome 5).

e-Health

The Department continued to provide national leadership in the electronic management of health information through a range of e-Health initiatives to improve the accuracy of patient records and other information available to doctors. For example, with our support, a Shared Electronic Health Record is being rolled out across the Northern Territory. Currently, over 12,000 people have a shared record, with their essential health information available, with their permission, to around 320 health care providers in hospitals, general practice and community care. Registered health care providers can create health profiles for their patients which can be viewed online, as well as medical event summaries and pathology results. They will
also be able to access participating patients’ hospital inpatient discharge and emergency event summaries (Outcome 10).

**Knowledge Growing, Knowledge Sharing**

**Support for Medical Research**

Investment in health and medical research into new ways to treat and prevent disease has more than doubled in recent years, with a significant portion of these funds provided by the Department. In 2006-07, this included funding for research into serious childhood diseases and conditions, and support for the establishment of a research and development facility which will develop and test life-saving biopharmaceuticals. The Department provided funding to support the National Adult Stem Cell Centre, which will enable researchers to apply stem cell research to diseases such as Schizophrenia, Parkinson’s disease and Motor Neurone Disease (Outcome 10).

**APEC Health Ministers’ Meeting**

The Asia-Pacific Economic Cooperation (APEC) Health Ministers’ Meeting from 6 to 8 June 2007 provided policy and logistical challenges for the Department which was responsible for the event. The Department worked closely with other agencies such as the Department of the Prime Minister and Cabinet, the Department of Foreign Affairs and Trade, and AusAID to ensure that the event was successful. The meeting provided a unique setting for an open dialogue between economies in the region about emerging health threats, such as avian influenza, and agreed collaborative measures to reduce the risk of these threats and their impact should they occur (Outcome 10).

**World Health Assembly**

This year I had the honour of being elected as President of the World Health Assembly – the supreme decision making body of the World Health Organization. The Assembly met in Geneva in May to discuss issues relating to avian and pandemic influenza, and the application of the International Health Regulations, smallpox eradication, and non-communicable diseases. Attention was also given to the need for better medicines for children and progress in the rational use of medicines. Information on World Health Assembly achievements in 2007 can be found at <www.who.int> (Outcome 10).

**New Portfolio and Organisational Arrangements**

On 21 March 2007, the Department welcomed the Hon Christopher Pyne MP as Minister for Ageing and Senator the Hon Brett Mason as Parliamentary Secretary to the Minister for Health and Ageing.

We implemented a new divisional structure on 1 August 2006 to more effectively manage new and expanded responsibilities and to improve the alignment of related functions under the leadership of the Executive team. This followed the move of the National Health and Medical Research Council from a departmental business unit to an independent statutory authority within the Health portfolio on 1 July 2006. Full details on the new divisional structure can be found in the following ‘Departmental Overview’.

**Our People**

The continuing strong performance of the Department could not have been achieved without our dedicated and professional staff.

**2006 Staff Survey**

A record 90 per cent of staff at work on 22 November 2006 participated in our 2006 Staff Survey. I believe this reflects broad recognition that the survey is an important activity and a way for staff to make their views known.

I was pleased to see from the results that we have made improvements since last year. More staff consider that they have real opportunities to participate in decision making. An increasing number of staff also feel that the Department appreciates the skills and knowledge of mature age workers, and the cultural diversity of our workforce in general. While great progress has been made, there are still some areas where we will strive to do better. I will continue to focus our collective energies on these areas.

**Staff Generosity**

No matter how busy their lives, our staff remain willing to give time, effort and donations to support others. In 2006-07, staff made a wonderful contribution of $53,050 to 15 chosen charities under our voluntary Workplace Giving Program. The Department’s long-standing support for Hartley Lifecare, which supports children and adults living with a physical disability
to maximise their potential, also continued with a passion, with over $119,000 raised by staff in this year’s cycle challenge. I am extremely proud of our participation in this event, which gets better each year. In addition, staff made 382 donations to the 2006 Annual Red Cross Canberra Sunday Times Corporate and Community Blood Donor Challenge, placing us third for the number of donations made by a public sector agency.

Collective Agreement Five

In 2006-07, the Department negotiated with staff and union representatives on the development of a new collective agreement. The aim of the negotiations was to settle an employment package of salary and flexible conditions that is both affordable and as competitive as possible, and to continue to build a supportive work environment. An in-principle agreement was reached providing competitive pay increases and a four year agreement which was subsequently put to a staff vote and accepted by 91% of respondents in August 2007.

The Year Ahead

During the coming year, the Department will continue to help Australians to adopt healthier lifestyles and reduce their risk of preventable disease through new public information and education campaigns on nutrition, physical activity, skin cancer and breastfeeding. We will expand the Medicare Benefits Schedule to include items that encourage new medical graduates to train in non-procedural specialties and enable families to access after-hours general practice services. We will also deliver initiatives aimed at addressing the shortage of general practitioners in rural and remote Australia.

Improving the health of Aboriginal and Torres Strait Islander people will continue to be a priority. Better health outcomes are expected from initiatives such as Health@Home Plus - a nurse-led home visiting program for mothers and babies, and other ongoing activities.

We will focus on the roll-out of child health checks as part of the Northern Territory Emergency Response and necessary follow-up services, including for oral health and ear, nose and throat conditions.

In addition, the Department will work with the sector to deliver the additional services to be funded by the $100 million injection for 2008-09 to 2009-10. This will include further adult health checks, primary care and allied health, and specialist services delivered from regional centres, and the establishment of the Remote Area Health Corps to help recruit, deploy and support the necessary health workforce.

Implementation of the mental health, health workforce, Pharmaceutical Benefits Scheme and aged care reforms will continue to produce not only short-term, but medium and long-term benefits for the nation as a whole.

Finally, we will continue to focus on the delivery of high quality policy advice and program administration in order to ensure our objective of better health, better care and better life for all Australians.

For a comprehensive discussion of the Department’s key objectives and priorities for the next reporting year, please refer to the 2007-08 Health and Ageing Portfolio Budget Statements.

Jane Halton PSM
Secretary
Department of Health and Ageing
Introduction

This year will be remembered for many achievements that will have a major impact on the delivery of health services to the Australian people. We have seen exciting new breakthroughs, such as treatments for blinding eye disease and breast cancer, and new vaccines to prevent cervical infections and cancer. The Organisation for Economic Co-operation and Development (OECD) reported that Australia had the best outcomes of all reporting countries in patients who had suffered a heart attack or had cervical cancer. Australia also had the best immunisation rates for seasonal influenza. 

Health was a major focus of the Council of Australian Governments, which agreed to promising new initiatives that focused on workforce and training as well as major investments to tackle mental illness. Avian influenza continued to require a lot of attention, as the risk of a pandemic has not subsided. The preparedness of our health system to cope with a pandemic was tested in October 2006 with Exercise Cumpston 06. Important work was done in preparing to implement the International Health Regulations that came into effect in June 2007. There were also some significant wins in Indigenous health, with the roll-out of ‘non-sniffable’ Opal fuel and the subsequent reduction of harm caused by petrol sniffing, as well as a very successful roll-out of cataract surgery occurring in central Australia, with many people having their vision restored.

On a less happy note are the problems of lifestyle diseases, especially obesity and the epidemic of diabetes. If we are to maintain the health gains achieved over the past decade, childhood and adult obesity and their consequent adverse health events will need to be managed. New approaches to these lifestyle diseases and increased investment in research are being implemented.

Public Health and Management of Chronic Disease

The many years of successful public health campaigns to reduce smoking in the community, working in cooperation with the National Heart Foundation and similar organisations, have significantly reduced the impact of heart disease, once the greatest killer of men and women in often their most productive years. Mortality from heart attacks is down from 88.7 per 100,000 population in 1995 to 53.0 in 2002. Australia now rates amongst the best of the OECD countries for survival after a heart attack. 

Similar excellent outcomes have been seen for survival of women with cervical cancer, with 76 per cent of women still alive five years after diagnosis. Mortality in the past decade has fallen from 3.2 per 100,000 in 1995 to 1.7 in 2002, due to Australia’s very active cervical screening program. However, there remains a challenge for health professionals to continue to encourage women aged 18 to 69 years to participate in the National Cervical Screening Program and to manage those women with screen-detected abnormalities and those who present with symptoms of cervical cancer.

2 OECD Health Data 2006. Causes of Mortality, Acute myocardial infarction, Deaths per 100,000 population (standardised rates).
3 OECD 2007 Health Care Quality Indicators Project. (Chart 6.13a:Cervical cancer, 5-year relative survival rates, latest available).
4 OECD Health Data 2006 Causes of Mortality, Malignant neoplasms of the cervix, Deaths per 100,000 females (standardised rates).
It was exciting that this year a vaccine became available to immunise women against future infections with four of the human papillomavirus types that cause significant disease. It was particularly exciting that this vaccine was pioneered by an Australian scientist, Professor Ian Frazer. The vaccine has the potential to protect Australian women from developing cervical cancer. A national immunisation program for girls aged 12-13 years, and a catch-up program for girls aged 14-18 years and women aged 18-26 years, have already started. The vaccine is offered free of charge to these women and girls.

Like the successful National Cervical Screening Program, Australia has had a breast cancer screening program for nearly 20 years. As technology is changing and new imaging techniques are available, the BreastScreen program is being reviewed to ensure that our screening program continues to be equal to world best practice. A committee of international and Australian experts is reviewing the entire program and will make recommendations to the Commonwealth, and State and Territory governments on the best way forward.

The National Bowel Cancer Screening Program began this year. After a few months this program was achieving participation rates of 30 per cent and that rate is continuing to rise. Preliminary figures from the program show that, after nine months of screening using faecal occult blood tests, 44 adenomas and 29 cancers have been detected. These numbers indicate the program’s potential to achieve its goal of reducing the mortality and morbidity associated with bowel cancer in Australia.

The new public health challenge for Australia is the burden that obesity and its subsequent effects are likely to place on health and wellbeing. Emerging data shows that an increase in obesity is not only a problem of middle age but is also affecting children from a very early age. The epidemic of obesity not only predisposes individuals to diabetes and all its attendant complications, but for nearly 50 years obesity has been known to be a major risk factor for heart disease. The gains we have made from smoking cessation may well be overtaken by obesity unless we can reverse the obesity trend. The Government has initiated a wide variety of programs that are consistent with the National Chronic Disease Strategy, from primary prevention, exercise and healthy eating in school to early detection programs, with the health check for people aged 45 years and over and improved management strategies available as a result of improved access to lipid-lowering agents on the Pharmaceuticals Benefit Scheme. We are also examining a new screening tool – The Absolute Risk Assessment – that may be more sensitive at detecting people at risk of developing cardiovascular disease.

The Australian Better Health Initiative is picking up on the strategic intent outlined in the National Chronic Disease Strategy by promoting healthy lifestyles, disease prevention pathways, risk-mitigation strategies, improving primary care interventions and care pathways, etc. The development of the National Chronic Disease Strategy highlighted several areas where seamless delivery of care could be enhanced by increasing patients’ access to ambulatory health care services. New items on the Medicare Benefits Schedule have been created to meet these concerns, such as ‘for and on behalf of’ items for practice nurses, items for case conferencing in cancer care, and new item numbers for long, complex consultations with consultant physicians. The initiatives will go a long way to improving effectiveness of primary health care for patients with complex chronic disease.

The number of adult Australians being admitted to hospital for asthma-related conditions (10.05 per 10,000 population) or experiencing mortality from asthma for individuals aged 5-39 years (0.40 per 100,000 population) compares unfavourably with the OECD average (5.82 and 0.18 respectively).6 The Asthma Awareness Campaign was launched in May 2007 to raise awareness of the seriousness of asthma and to encourage individuals to take action by visiting a doctor and taking preventive and management measures through a written asthma action plan. In addition, from 1 November 2006, the Asthma 3+ Visit Plan was replaced by the Asthma Cycle of Care in the Medicare Benefits Schedule, which seeks to improve asthma management. I hope the investment by the Government and the commitment by many expert health professionals will improve the outlook for all patients with asthma.

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6 OECD 2007 Health Care Quality Indicators Project. (Chart 6.15: Asthma mortality rates, ages 5 to 39 years, 2005 and Chart 6.16: Adult asthma admission rates. Per 10,000 population ages 18 and over, 2005).
We have sustained high rates of immunisation, and excellent results in decreases of vaccine-preventable diseases. For example, Australian influenza vaccination rates of people aged 65 plus years are the highest for all OECD countries, at 79.1 per cent, compared with the OECD average (54.6 per cent). 6

But some challenges remain. There has been an increase in the incidence of pertussis in Australia (65.8 per 100,000 population) in comparison with other OECD countries (United Kingdom 1.0; United States, 8.9). 7 This situation is due to differences in surveillance practices as well as clinical and laboratory investigations of chronic cough in adults. New vaccines for children have been added to the current immunisation schedule over time, such as rotavirus, Haemophilus influenzae type b (Hib), chickenpox and pertussis. Additional vaccines for meningococcus, hepatitis B, influenza and pneumococcus are available for adolescents and adults.

The Australian Childhood Immunisation Register was established ten years ago to record the immunisation coverage of children aged 0–7 years against various preventable diseases, including measles, mumps, rubella, tetanus and polio. By March 2007, 91.0 per cent of all Australian children aged 12 months had been immunised. 8 The Government has decided to scope the feasibility of establishing a national whole-of-life immunisation register to monitor child, adolescent and adult vaccination. Additional aims are to improve health and reduce unnecessary vaccinations for people who do not remember when they had their last shot.

Health Protection

To test Australia’s preparedness, the Australian Pandemic Plan was tested in a live exercise in Brisbane in October 2006. Components such as border responses to public health threats, lines of communication between various levels of government and the cohesiveness of emergency services were tested.

A major focus of activity was Exercise Cumpston 06. This was the largest live simulation that has been carried out to test our preparedness for an influenza pandemic. The scenario involved importation of a new pandemic strain from a country where there was human-to-human transmission. The exercise tested several aspects of our preparedness, including public health responses at our borders and within all states and territories. The exercise involved a whole-of-government response with the participation and involvement of Federal Cabinet.

A large number of overseas visitors and observers watched the exercise. Overall, Exercise Cumpston 06 went very well, with excellent coordination between all participants. As expected, a small number of things did not go to plan. There are matters in our pandemic readiness that are currently being examined.

The International Health Regulations came into force in June 2007 and there was a lot of activity throughout the year to ensure we had the necessary public health infrastructure and legislative apparatus in place to make implementation possible. Although we are in a very favourable position to introduce the International Health Regulations, there is still work to be done through the National Health Security legislation to ensure their complete implementation.

A major focus of this year’s Asia-Pacific Economic Cooperation (APEC) Health Ministers’ Meeting, in Sydney in June 2007, was the regional preparedness for avian influenza and regional implementation of the International Health Regulations. The conference also considered the diverse concerns of Australia’s regional partners.

In 2006–07, the World Health Organization Collaborating Centre for Reference and Research on Influenza was transferred from CSL Limited to the Victorian Infectious Diseases Laboratory. While the centre remained at CSL premises, the design for new facilities for the centre at Victorian Infectious Diseases Laboratory premises was finalised. The centre will physically re-locate to the new premises in 2008.

In addition, the National Trauma Centre, based in Darwin, has been further developed with the appointment of the two foundation chairs,

6 OECD 2007 Health Care Quality Indicators Project. (Chart 6.21a: Influenza vaccination rates ages 65 and over, 2005 or latest available).
7 OECD 2007 Health Care Quality Indicators Project. (Chart 6.24: Incidence of vaccine preventable diseases, 2005 or latest available. Per 100,000 population).
8 Australian Childhood Immunisation Register. 31 March 2007.
Professor David Cooper and Professor Frank Plani. The construction and fit-out of the new centre are nearing completion. Despite work still to be done, the centre functioned without a hitch in the real emergency of evacuating injured passengers from the plane crash in Yogyakarta, Indonesia, in March 2007.

**Education and Training**

This year’s Council of Australian Governments meeting resolved that there will be a major reform of how all health professionals will have their training accredited and how individual health professionals will be registered to practise. This is a significant change from the 100-year tradition whereby the functions were largely state-based. The new procedures will ensure that all health professionals practising in Australia will be of a uniform high standard and able to move freely throughout the Commonwealth. Discipline-specific boards will be established to set standards and manage registration, while state committees will implement the procedures and manage professional issues such as discipline and impairment matters. It is anticipated that this will all be in place by June 2008 following the completion and signing of the Intergovernmental Agreement by all governments.

Another project that has moved to the implementation phase is the establishment of training for specialists in a much broader setting than the traditional teaching hospital. It has been recognised for some time that changes in how health care is delivered no longer allow trainees to experience a full range of teaching in these traditional environments. Discussions with a number of health-care organisations, medical colleges, and state and territory departments have ensured that there will be up to 50 training places commencing in 2008. These are complementary to established training places in the public hospital system and will provide those experiences that are necessary to give the training program complete coverage.

**New Drugs**

As I foreshadowed last year, several exciting new drugs that make a dramatic change to people’s wellbeing have become available.

Herceptin®, for the treatment of patients with advanced breast cancer, has been available through the Herceptin® Program since December 2001. Recent evidence has shown that Herceptin® is also of value in preventing the recurrence of breast cancer in an important sub-group of women who are HER-2 positive. Following a recommendation from the Pharmaceutical Benefits Advisory Committee, Herceptin® was made available on the Pharmaceutical Benefits Scheme.

Another important new drug on the PBS is Lucentis®, which is now available to treat macular degeneration, one of the most common causes of blindness. As part of the arrangements for listing Lucentis® on the Pharmaceutical Benefits Scheme, Visudyne®, which is currently available under a Health Program Grant, will be transferred to the Pharmaceutical Benefits Scheme. Lucentis® has the potential to delay or even prevent blindness. About 11,500 people are expected to begin treatment with Lucentis® in the first full financial year of listing.

In all, 34 new drugs were assessed and made available on the Pharmaceutical Benefits Scheme throughout the year.

**Mental Health**

The mental health reform package, which is the Government’s commitment to the Council of Australian Governments National Action Plan on Mental Health (2006-2011), is improving services for people with a mental illness, their families and carers. It includes a range of new Medicare Benefits Schedule items in November 2006 that allow the community to access team-based mental health care from general practitioners, psychiatrists, psychologists and other allied mental health professionals through Medicare. The success of this measure can be judged by the very significant uptake of these items. The Medicare Benefits Schedule data used by the Department of Health and Ageing to monitor uptake and spread of Medicare Benefits Schedule funded services indicates that during the 2006-07 financial year (from 1 November 2006 to 30 June 2007) more than 400,000 patients have accessed services provided under the Better Access Initiative, with more than 1.2 million new mental health services subsidised through Medicare.

The package complements and strengthens a variety of existing programs and initiatives that the Government has been progressing through the National Mental Health Strategy. This includes services provided by the Better Outcomes in Mental Health Care Program, beyondblue, Lifeline Australia, headspace: National Youth Mental...
Health Foundation, and funding provided under the National Suicide Prevention Strategy.

**Indigenous Health**

This year we have seen a continuation of gains in some important health indicators. The first report against the Aboriginal and Torres Strait Islander Health Performance Framework showed some areas of improvement, such as declining mortality rates for Indigenous Australians (i.e. all-cause, infant, perinatal, circulatory disease, hospitalisation for pneumonia). Unfortunately, there are also areas that remain unchanged or are worsening, such as deaths caused by chronic diseases other than cardiovascular disease, hospitalisation for injury and poisoning, rates of end-stage kidney disease, chronic ear disease, oral health and some sexually transmissible infections. The report found that, although the health status of Aboriginal and Torres Strait Islander people is improving, large disparities between Indigenous and non-Indigenous Australians persist. In fact the relative gap between the two populations is widening because the rate of improvement in some areas has been greater for non-Indigenous Australians over recent years.

New initiatives that were introduced this year include Health@Home Plus and Family Centred Primary Health Care as well as the emergency response to protect Aboriginal children in the Northern Territory which was announced on 21 June 2007. These initiatives build on the support for the child health check which has been promoted by a range of high profile Indigenous advocates through the National Child Health Check Roadshow. The Council of Australian Governments’ Accelerated Rollout of Aboriginal and Torres Strait Islander Child Health Check in May 2006 helps to ensure prevention, early diagnosis and management of disease for Indigenous children up to 14 years of age. It is anticipated there will be further improvements in health outcomes for many Indigenous individuals and families.

The progressive roll-out of Opal fuel and the subsequent reduction of petrol sniffing and its disastrous effects has continued and will have an ongoing beneficial effect on communities.

Another area that has been a challenge is the delivery of renal dialysis services to many patient groups, especially in Central Australia. Patient numbers threaten to overwhelm the capacity of the staff and facilities to deliver services, and there is a need to have these services much closer to the communities. In September 2006, I convened a meeting of all interested clinicians in Central Australia and we had a highly productive roundtable in Alice Springs. As a result, there has been a lot of progress and the Department is working with the Northern Territory, South Australian and Western Australian health departments to expand and improve current models of service delivery and care for renal patients.

This year saw the first ‘eye health blitz’ take place when a team of medical staff provided eye surgery to 41 patients with blinding cataract disease and restored their sight. As one grateful man commented, it returned his manhood, as he could now see and thus could hunt and be independent. This initiative involved the Department working in partnership with the Fred Hollows Foundation, the Northern Territory Department of Health and Community Services, the Central Australian Aboriginal Congress, Anyinginyi Health Aboriginal Corporation and the Eye Foundation.

**Research**

Many health policy initiatives are underpinned by high quality health and medical research. This year saw significant new government investment in infrastructure for medical research. The work of research institutes covers the areas of our national health goals, such as the diagnosis and management of cancer, diabetes and heart disease, the healthy development of children, new drugs and a range of Indigenous health problems, among others. These investments, along with support of the National Health and Medical Research Council and other sources of research funding, go a long way to ensuring our achievements in medical and health research continue to be highly competitive internationally.

**Future Challenges**

The rapid pace of change means that most of our diagnostic and treatment systems are either changed or significantly altered every 10-15 years. The change in the technology of organ imaging is a very good example. In 30 years we’ve seen...
the developments where we had plain x-rays with limited contrast medium to the use of radio-nuclear scans, ultrasound, cat scans, MRIs and PET scans. We now have the prospect of new and complex applications for all of these modalities. Similarly, drugs for vascular disease and cancer treatment have rapidly developed into highly specific and sophisticated therapies. This creates a real challenge for all of us to remain active rather than reactive so that we can ensure that the best treatment is available to the Australian public, while simultaneously ensuring that the advances are ‘real’, safe and affordable.

Infectious diseases continue as a potential threat and a major focus of concern to the Australian health system. The recent outbreaks of Nipah Virus in India and Bangladesh; the re-emergence of the drug resistant tuberculosis and the potential for the development of a new hitherto unknown infectious disease require us to remain constantly aware of these issues.

What is Coming?

The science of pharmacogenetics will potentially enable new drugs to be developed that target particular diseases and address the specific gene profiles of individuals or communities. Work is under way to determine why different groups in our community respond differently to a range of infections.

The mapping of the Human Genome Project will provide opportunities for gene profiling for a whole range of diseases, with the potential for new treatments or cures, but also some risks if information is misapplied.

In the near future we will see several new imaging modalities that use a combination of traditional and new techniques, such as a combination of CAT scans and PET scans, new uses for magnetic resonance imaging, and newer and more sensitive ultrasound machines. To ensure patient safety and quality in health care, it will be important to appropriately manage the introduction of an ever-expanding range of increasingly sophisticated medical devices.

Risks

The risk of another Severe Acute Respiratory Syndrome (SARS) outbreak or a similar event, and the impact on the health system and the economy, remains a concern. Much of what we have done in the time since the SARS outbreak, and the subsequent activity around the risk of avian flu, has sought to mitigate these risks.

Another area of ongoing concern is the international health workforce shortage. The World Health Organization has estimated that, worldwide, around 4.3 million additional health workers are needed. The potential for this shortage to worsen is real as emerging economies spend more on health care and our workforce becomes older and works fewer hours. Overall, the health workforce is very mobile and maintaining our comparative attractiveness will be important.

Professor John Horvath AO
Chief Medical Officer

DEPARTMENTAL OVERVIEW

The Departmental Overview provides information on the Department’s role, its management and its 2006-07 outcomes and outputs framework.

ABOUT THE DEPARTMENT

Vision

The Department of Health and Ageing’s vision is of better health and active ageing for all Australians. The Department aims to achieve this objective through the delivery of the key priorities and outcomes outlined in the 2006-09 Department of Health and Ageing Corporate Plan, accessible at <www.health.gov.au>.

Role

In 2006-07, the Department was responsible for achieving the Government’s priorities (outcomes) for: population health; pharmaceutical and medical services; ageing and aged care; primary care; rural health; hearing services; Indigenous health; private health; health system capacity and quality; mental health; health workforce capacity; acute care; and biosecurity and emergency response.

The Department worked to achieve the Government’s priorities through its policy, program, research and regulation activities, and by leading and working with other government agencies, consumers and stakeholders. The Department operated under the Public Service Act 1999 and the Financial Management and Accountability Act 1997. The Department also administered a large number of Acts, which are listed in Part 4.6 – Freedom of Information.

A detailed discussion of the Department’s activities in 2006-07 can be found in Part Two – Performance Reporting.

DEPARTMENTAL STRUCTURE

Executive Team

Back: Mary Murnane, Deputy Secretary; Professor John Horvath AO, Chief Medical Officer; Jane Halton PSM, Secretary; David Kalisch, Deputy Secretary.

Front: David Learmonth, Deputy Secretary; Philip Davies, Deputy Secretary.

Jane Halton PSM – Secretary

Ms Jane Halton has been Secretary to the Department since January 2002. She has responsibility for the efficient administration of the Department and for the corporate and strategic directions of the Department and portfolio. She also provides the most senior policy counsel on major and sensitive policy issues to the ministerial team.

Ms Halton currently chairs the National Aboriginal and Torres Strait Islander Health Council, is a member of the board of the Australian Institute of Health and Welfare, a board member of the National E-Health Transition Authority and a Commissioner of the Australian Commission on Safety and Quality in Health Care.

Ms Halton is the Chair of the Organisation for Economic Co-operation and Development’s Health Committee. She was an Executive Board Member on the World Health Organization (WHO) 2004-07 and President of the World Health Assembly (2007), and was Vice-Chair of the Executive Board 2005-06 and Chair of the WHO Program, Budget and Administration Committee 2005-07. Ms Halton was also Chair of the Australian Obesity Taskforce (2003-06).
Professor John Horvath AO - Chief Medical Officer

Professor John Horvath has been the Chief Medical Officer for the Government since September 2003. Professor Horvath provides support to the Minister and the Department across the full range of professional health issues, including health and medical research, public health, medical workforce, quality of care, evidence-based medicine, and an outcomes-focused health system. He also has responsibility for the continuous development of professional relationships between the Department and the medical profession, medical colleges and universities.

Mary Murnane - Deputy Secretary

Ms Mary Murnane has been a Deputy Secretary with the Department since May 1993. Ms Murnane's responsibilities in 2006-07 encompassed ageing and aged care, health protection and biosecurity, medical and biological research, and regulatory policy.

Ms Murnane oversaw the Department’s Ageing and Aged Care Division, the Office of Health Protection, the Regulatory Policy and Governance Division, the Therapeutic Goods Administration, the Department’s offices in Tasmania and Victoria, as well as portfolio interests in the National Health and Medical Research Council and the Office of the Gene Technology Regulator, and the Asia-Pacific Economic Cooperation Health Ministers’ Meeting in Sydney in June 2007.

Ms Murnane chairs the Australian Health Protection Committee and is a member of the Australian Government Counter Terrorism Policy Committee.

Philip Davies - Deputy Secretary

Mr Philip Davies has been a Deputy Secretary with the Department since 2002. Mr Davies’ responsibilities in 2006-07 included primary care, rural health and Aboriginal and Torres Strait Islander health.

Mr Davies oversaw the Department’s Primary and Ambulatory Care Division, the Office for Aboriginal and Torres Strait Islander Health, Business Group and the Department’s offices in New South Wales and the Northern Territory.

Mr Davies is an Honorary Fellow of the Health Services Research Centre at the Victoria University of Wellington, New Zealand and has provided consultancy advice on health policy to the World Bank and the WHO.

David Kalisch - Deputy Secretary

Mr David Kalisch was appointed Deputy Secretary with the Department in June 2006. Mr Kalisch's responsibilities in 2006-07 included acute care, mental health, health workforce and portfolio strategies.

Mr Kalisch oversaw the Department’s Acute Care Division, the Mental Health and Workforce Division, the Portfolio Strategies Division and the Department’s offices in South Australia and Western Australia.

David Learmonth - Deputy Secretary

Mr David Learmonth was appointed Deputy Secretary with the Department in June 2006. Mr Learmonth’s responsibilities in 2006-07 included population health and medical and pharmaceutical benefits.

Mr Learmonth oversaw the Department’s Population Health Division, the Medical Benefits Division, the Pharmaceutical Benefits Division, and the Department’s offices in the Australian Capital Territory and Queensland.
The Department’s Divisional Structure

The Department's divisional structure in 2006-07, as outlined in the following Department Structure Chart, was based around the key sectors of Australia’s health and ageing system and a number of cross-portfolio functions.

<table>
<thead>
<tr>
<th>Health and Ageing Sector</th>
<th>Cross Portfolio</th>
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</thead>
<tbody>
<tr>
<td>Acute Care Division</td>
<td>Portfolio Strategies Division</td>
</tr>
<tr>
<td>Ageing and Aged Care Division</td>
<td>Business Group</td>
</tr>
<tr>
<td>Medical Benefits Division</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
</tr>
<tr>
<td>Mental Health and Workforce Division</td>
<td>Regulatory Policy and Governance Division</td>
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<tr>
<td>Office of Health Protection</td>
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<tr>
<td>Office of Aged Care Quality and Compliance</td>
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<tr>
<td>Pharmaceutical Benefits Division</td>
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<tr>
<td>Population Health Division</td>
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<tr>
<td>Primary and Ambulatory Care Division</td>
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</tbody>
</table>

The Audit and Fraud Control Branch, the Therapeutic Goods Administration, the National Industrial Chemicals Notification and Assessment Scheme, the Office of the Gene Technology Regulator and the Office of Chemical Safety also formed part of the Department.

Changes to the Divisional Structure

Following the creation of a new executive management structure in June 2006, which saw the appointment of two additional Deputy Secretaries, the Department implemented a new divisional structure on 1 August 2006.

The enhanced structure is designed to respond to the Department's greater scope of responsibility in recent years, and to the increase in resources and responsibilities allocated in the 2006-07 Budget. The changes also ensure that the Department has the capacity to effectively deliver on the Government’s health and ageing agenda. They balance responsibilities across divisions and align related functions under the leadership of the new Executive team.

The number of divisions increased from 10 to 13. The Department established the Office of Aged Care Quality and Compliance to implement a major reform package to improve the quality of care for recipients of government-subsidised aged care.

The Medical Benefits Division and the Pharmaceutical Benefits Division were created from the former Medical and Pharmaceutical Services Division, reflecting the increasing challenges associated with the Department’s ongoing responsibilities in these areas. A new Mental Health and Workforce Division was created to continue to drive major Council of Australian Government-driven reforms, while the work of the former Health Services Improvement Division is being continued by other divisions. The Regulatory Policy and Governance Division was created to coordinate the governance arrangements for health portfolio agencies and provide policy advice and support for consideration of regulatory and ethical issues associated with new and emerging technologies. This division also provides advice to Government on matters associated with the new Australia New Zealand therapeutic products regulation scheme. Finally, the National Health and Medical Research Council became an independent statutory authority within the Health and Ageing portfolio on 1 July 2006. Prior to this, the National Health and Medical Research Council was a business unit within the Department.

The Department’s State and Territory Offices

The State and Territory Offices play a significant role in the function of the Department. They represent the Department’s interests at state and territory level and ensure appropriate integration of services on the ground with State and Territory government agencies. The State and Territory Offices also work in cooperation with other Government agencies and are well positioned to assist in identifying policy links.

In 2006-07, State and Territory Office staff continued to work in partnership with local stakeholders to ensure services provided through departmental programs were responsive to diverse local needs and conditions. Contact details for each office can be found at Part 6 - Department of Health and Ageing Contact Details.
Department Structure Chart as at 30 June 2007

Jane Halton
Secretary

Prof. John Horvath
Chief Medical Officer

Mary Murnane
Deputy Secretary

- Ageing and Aged Care
  - Andrew Stuart: First Assistant Secretary
- Policy and Evaluation
  - Peter Broadhead: Assistant Secretary
- Residential Program Management
  - Allison Rosevear: Assistant Secretary
- Community Care
  - Melinda Bromley: A/Assistant Secretary
- Office for an Ageing Australia
  - Helen Hambling: A/Assistant Secretary
- Office of Aged Care Quality and Compliance
  - Carolyn Smith: First Assistant Secretary
- Compliance
  - Carolyn Schetz: Assistant Secretary
- Quality Policy and Programs
  - Fiona Nicholls: Assistant Secretary
- Prudential Regulation
  - Iain Scott: Assistant Secretary

- Office of Health Protection
  - Cath Habert: First Assistant Secretary
- Research Policy and Biotechnology
  - Simon Cotterill: Assistant Secretary
- Surveillance
  - Ranell Thompson: Assistant Secretary
- Regulatory Policy and Governance
  - Linda Addison: A/Assistant Secretary
- Health Emergency Management and Biosecurity
  - Rob Cameron: Assistant Secretary
- Governance and Agency Relationships
  - Teressa Ward: Assistant Secretary
- Principal Medical Adviser
  - Dr Julie Hall

Philipp Davies
Deputy Secretary

- Business Group
  - Margaret Lyons: Chief Operating Officer
- Finance
  - Stephen Sheehan: Assistant Secretary
- Corporate Support
  - Dean Harpen: Assistant Secretary
- Health Strategies
  - Dr John Walker: A/Assistant Secretary
- Strategic Management
  - Taltana Utihn: Assistant Secretary
- Policy and Analysis
  - David de Carvalho: Assistant Secretary
- People
  - Georgie Harman: Assistant Secretary
- Senior Medical Adviser
  - Dr Tim Williams
- IT Strategy and Service Delivery
  - John Trabing: Assistant Secretary
- Performance Management
  - Haylene Grignon: Assistant Secretary
- IT Solutions Development
  - Ida Thornton: A/Assistant Secretary
- NT Emergency Coordination Centre
  - Joy Savage: Assistant Secretary
- Communications
  - Laurie Van Veen: Assistant Secretary
- Legal Services
  - David Watts: Assistant Secretary

- Office for Aboriginal and Torres Strait Islander Health
  - Lesley Podesta: First Assistant Secretary
- Budget and Planning
  - Mark Thomann: Assistant Secretary
- Health Strategies
  - Dr John Walker: A/Assistant Secretary
- Primary Care
  - Louis Andreatta: Assistant Secretary
- Policy and Analysis
  - David de Carvalho: Assistant Secretary
- Senior Medical Adviser
  - Dr Tim Williams
- IT Strategy and Service Delivery
  - John Trabing: Assistant Secretary
- Performance Management
  - Haylene Grignon: Assistant Secretary
- IT Solutions Development
  - Ida Thornton: A/Assistant Secretary
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  - Dr Tim Williams
- IT Strategy and Service Delivery
  - John Trabing: Assistant Secretary
- Performance Management
  - Haylene Grignon: Assistant Secretary
- IT Solutions Development
  - Ida Thornton: A/Assistant Secretary
- NT Emergency Coordination Centre
  - Joy Savage: Assistant Secretary
- Communications
  - Laurie Van Veen: Assistant Secretary
- Legal Services
  - David Watts: Assistant Secretary

- Acute Care
  - Kerry Flanagan: First Assistant Secretary
- Primary Care
  - Louis Andreatta: Assistant Secretary
- Acute Care Strategies
  - Gail Yopp: Assistant Secretary
- Blood, Organ and Tissue Policy
  - Yael Caz: Assistant Secretary
- Medical Indemnity
  - Charles Mazzoli-Knight: Principal Advisor
- Healthcare Services and Financing
  - Dr Brendan Gibson: Assistant Secretary
- Medical Officer
  - Dr Bernice Towler

Tasmania State Office
- Katharine Campbell: State Manager

Victoria State Office
- Helen Hambling: State Manager

New South Wales State Office
- Vicki Murphy: State Manager

Northern Territory Office
- Fay Gardner: Territory Manager
MINISTERIAL TEAM

The Department is responsible to the Minister for Health and Ageing, the Minister for Ageing and the Parliamentary Secretary to the Minister for Health and Ageing.

As at 30 June 2007, the Hon Tony Abbott MHR, as senior Minister and member of Cabinet, held overarching policy responsibility for all issues pertaining to health and ageing. He was appointed Minister for Health and Ageing on 7 October 2003.

The Hon Christopher Pyne MP, Minister for Ageing, had responsibility for all matters relating to ageing, as well as other areas including hearing services, illicit drugs, alcohol and tobacco issues. He was appointed Minister for Ageing on 21 March 2007.

Senator the Hon Brett Mason, Parliamentary Secretary to the Minister for Health and Ageing, assisted Minister Abbott by assuming responsibility for matters relating to the Therapeutic Goods Administration, the Australian Radiation Protection and Nuclear Safety Agency and food policy. Senator Mason is also responsible for mental health and suicide prevention, blood and organ donation regulation and human cloning and stem cell research. He was appointed Parliamentary Secretary to the Minister for Health and Ageing on 21 March 2007.

A full description of ministerial responsibilities can be found at Part 3.6 – Ministerial Responsibilities.

OUTCOMES AND OUTPUTS STRUCTURE

Department-Specific Outcomes

In 2006-07, the Department's activity, resource and performance reporting fell under 15 department-specific outcomes within the Health and Ageing outcome structure. The outcomes reflect the Government's desired results or impacts on the community.

The Department revised its outcome structure in 2006-07, to account for the separation of the National Health and Medical Research Council from the Department. The National Health and Medical Research Council became its own portfolio agency on 1 July 2006.

PORTFOLIO STRUCTURE

In 2006-07, the Health and Ageing portfolio comprised the Department and 11 portfolio agencies. The portfolio worked within a 23 outcome structure, 15 of which were specific to the Department. These are discussed in the following section. The remaining eight were specific to the portfolio agencies that received direct funding from the Government.

A full description of portfolio agencies' outcomes, functions and key achievements for 2006-07 can be found at Part 3.7 – Corporate Governance in Portfolio Agencies.
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Divisions Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Population Health</strong></td>
<td>Population Health Division</td>
</tr>
<tr>
<td>The incidence of preventable mortality, illness and injury in Australians is minimised</td>
<td>Regulatory Policy and Governance Division</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td></td>
<td>National Industrial Chemicals Notification and Assessment Scheme</td>
</tr>
<tr>
<td></td>
<td>Office of the Gene Technology Regulator</td>
</tr>
<tr>
<td>2. <strong>Access to Pharmaceutical Services</strong></td>
<td>Pharmaceutical Benefits Division</td>
</tr>
<tr>
<td>Australians have access to cost-effective medicines</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Access to Medical Services</strong></td>
<td>Medical Benefits Division</td>
</tr>
<tr>
<td>Australians have access to cost-effective medical services</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Aged Care and Population Ageing</strong></td>
<td>Ageing and Aged Care Division</td>
</tr>
<tr>
<td>Older Australians enjoy independence, good health and wellbeing. High quality, cost-effective care is accessible to frail older people, and their carers are supported</td>
<td>Office of Aged Care Quality and Compliance</td>
</tr>
<tr>
<td>5. <strong>Primary Care</strong></td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td>Australians have access to high quality, well integrated and cost-effective primary care</td>
<td>Mental Health and Workforce Division</td>
</tr>
<tr>
<td>6. <strong>Rural Health</strong></td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td>Improved health outcomes for Australians living in regional, rural and remote locations</td>
<td>(Other areas across the Department also contribute to this outcome.)</td>
</tr>
<tr>
<td>7. <strong>Hearing Services</strong></td>
<td>Medical Benefits Division</td>
</tr>
<tr>
<td>Australians have access through the Hearing Services Program to hearing services and devices</td>
<td>(Includes the Office of Hearing Services.)</td>
</tr>
<tr>
<td>8. <strong>Indigenous Health</strong></td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
</tr>
<tr>
<td>Improved access by Aboriginal and Torres Strait Islander peoples to effective primary health care and substance use services and population health programs</td>
<td>(Although this outcome is primarily the responsibility of the Office, all programs within the Department are managed to ensure effective and accessible health care for Indigenous Australians.)</td>
</tr>
<tr>
<td>9. <strong>Private Health</strong></td>
<td>Acute Care Division</td>
</tr>
<tr>
<td>A viable private health industry to improve the choice of health services for Australians</td>
<td></td>
</tr>
</tbody>
</table>
Departmental Outputs

The Department described its core activities in 2006–07 in terms of the following three output groups:

- Output Group 1 - Policy Advice: this included the provision of policy advice and ministerial services to the Ministers, Parliamentary Secretary and Parliament;
- Output Group 2 - Program Management: this included the development and management of contracts and grants for administered funds and the payment of administered funds. This output group also included the administration of legislation; and the provision of information to stakeholders on departmental programs; and
- Output Group 3 - Agency-specific Service Delivery: this included reporting of direct delivery of services to the community. The Department’s activities under this output group were, in 2006–07, conducted by the Therapeutic Goods Administration, the National Industrial Chemicals Notification and Assessment Scheme and the Office of the Gene Technology Regulator in relation to therapeutic goods, genetically modified organisms and industrial chemicals, pesticides and veterinary medicines.