2.2 BUDGETED EXPENSES AND PERFORMANCE

OUTCOME 2 – HEALTH ACCESS AND SUPPORT SERVICES

Outcome 2:	**Support for sustainable funding for public hospital services and improved access to high quality, comprehensive and coordinated preventive, primary and mental health care for all Australians, with a focus on those with complex health care needs and those living in regional, rural and remote areas, including through access to a skilled health workforce**

Programs Contributing to Outcome 2

Program 2.1:	**Mental Health**
Program 2.2:	**Aboriginal and Torres Strait Islander Health**
Program 2.3:	**Health Workforce**
Program 2.4:	**Preventive Health and Chronic Disease Support**
Program 2.5:	**Primary Health Care Quality and Coordination**
Program 2.6:	**Primary Care Practice Incentives**
Program 2.7:	**Hospital Services**

Outcome 2 is the responsibility of Health Services Division, Health Systems Policy Division, Health Workforce Division, Indigenous Health Division, People Capability and Communication Division, Population Health and Sport Division, and Research, Data and Evaluation Division.

Linked Programs

Commonwealth entity and linked program	Contribution to Outcome 2 made by linked programs
Cancer Australia **Program 1.1:** Improved Cancer Control	Cancer Australia provides national leadership in cancer control and works with the Department of Health to improve the detection, treatment and survival outcomes for people with cancer (2.4).
Food Standards Australia New Zealand **Program 1.1:** Food regulatory activity and services to the Minister and Parliament	Food Standards Australia New Zealand (FSANZ) contributes to the protection of public health and safety by developing food standards for implementation by the States and Territories. FSANZ also coordinates national food surveillance and recall activities, to minimise the risk of adverse health events from food (2.4).

Department of Human Services **Program 1.2:** Services to the Community - Health	The Department of Human Services administers payments and services to eligible recipients under the following programs/ initiatives administered by the Department of Health, to contribute to achievement of the Government's objectives within this Outcome: - Indigenous access to the Pharmaceutical Benefits Scheme (2.2) - General Practice Rural Incentives Program (2.3) - Practice Nurse Incentive Program (2.3) - Rural Procedural Grants Program (2.3) - Rural Locum Education Assistance Program (2.3) - Scaling of Rural Workforce Program (2.3) - Support cervical cancer screening (2.4) - Health Care Homes Program (2.5 and 2.6) - Incentive payments to general practices, GPs and Indigenous health services (2.6). In addition, the Department of Human Services administers the National Bowel Cancer Screening Register (2.4).
Department of Immigration and Border Protection **Program 2.4:** Refugee and Humanitarian Assistance	The Department of Immigration and Border Protection contributes to the achievement of this Outcome by determining annual client numbers for the Program of Assistance for Survivors of Torture and Trauma (2.1).
Department of Industry, Innovation and Science **Program 3:** Program Support	Through the National Measurement Institute, the Department of Industry, Innovation and Science contributes to reducing smoking prevalence in Australia by conducting tobacco plain packaging compliance and enforcement activities (2.4).
Independent Hospital Pricing Authority **Program 1.1:** Public hospital price determinations	The Independent Hospital Pricing Authority determines the National Efficient Price for public hospital services, as the basis for Activity Based Funding and the National Efficient Cost for those public hospital services under block funding arrangements (2.7).
National Health Funding Body **Program 1.1:** National Health Funding Pool Administration	The National Health Funding Body is responsible for the transparent and efficient administration of Commonwealth, State and Territory funding of public hospital services. This includes the administration of payments to and from the National Health Funding Pool to Local Hospital Networks and other parties in accordance with the National Health Reform Agreement. Commonwealth funding is provided by the Treasury (2.7).
National Mental Health Commission **Program 1.1:** National Mental Health Commission	The National Mental Health Commission (NMHC) provides insight, advice and evidence on ways to improve Australia's mental health and suicide prevention systems. The NMHC also acts as a catalyst for change to achieve these improvements (2.1).

Department of the Prime Minister and Cabinet **Program 2.3:** Indigenous Advancement - Safety and Wellbeing	The Department of the Prime Minister and Cabinet works closely with the Department of Health to ensure the effectiveness of Indigenous health funding, and that mainstream policy, programs and services deliver benefits to Indigenous Australians (2.2).
Department of Social Services **Program 3.2:** National Disability Insurance Scheme	The Department of Social Services contributes to improving access to services and supports for people with psychosocial disability through implementation of the National Disability Insurance Scheme (2.1).
Department of Veterans' Affairs **Program 2.1:** General Medical Consultations and Services	The Department of Veterans' Affairs (DVA) contributes to the Government's objectives for the Practice Nurse Incentive Program. Practices eligible for this program that provide GP services to the DVA gold card holders are eligible for an annual payment for each veteran. These practices are identified by Department of Human Services (2.3).
The Treasury **Program 1.9:** National Partnership Payments to the States	The Treasury makes National Partnership Payments to the State and Territory Governments as part of the Federal Financial Relations Framework.[1] Activities funded through the following National Partnership Agreements contribute to the achievement of the Government's objectives within this Outcome: - Improving trachoma control services for Indigenous Australians (2.2) - Rheumatic Fever Strategy (2.2) - Northern Territory remote Aboriginal investment (2.2) - Accommodation and infrastructure related to renal services for Aboriginal and Torres Strait Islander peoples in the Northern Territory (2.2) - Expansion of the BreastScreen Australia Program (2.4) - National Bowel Cancer Screening Program – participant follow-up function (2.4) - Victorian Cytology Service (2.4) - Hummingbird House (2.4) - National Coronial Information System (2.4) - Additional assistance for public hospitals (2.7) - Reducing elective surgery waiting lists in Tasmania (2.7) - Improving patient pathways through clinical and system redesign (2.7) - Subacute and acute projects (2.7).

[1] For Budget estimates relating to the National Partnership component of the program, refer to *Budget Paper No. 3* or Program 1.9 of the Treasury's Portfolio Budget Statements.

Table 2.2.1: Budgeted Expenses for Outcome 2

This table shows how much the entity intends to spend (on an accrual basis) on achieving the outcome, broken down by program, as well as by Administered and Departmental funding sources.

	2015-16 Estimated actual $'000	2016-17 Budget $'000	2017-18 Forward Year 1 $'000	2018-19 Forward Year 2 $'000	2019-20 Forward Year 3 $'000
Program 2.1: Mental Health[1]					
Administered expenses					
Ordinary annual services[2]	663,578	679,453	697,108	709,898	528,823
Departmental expenses					
Departmental appropriation[3]	21,407	19,429	19,342	19,121	19,130
Expenses not requiring appropriation in the budget year[4]	779	748	754	803	679
Total for Program 2.1	**685,764**	**699,630**	**717,204**	**729,822**	**548,632**
Program 2.2: Aboriginal and Torres Strait Islander Health[1]					
Administered expenses					
Ordinary annual services[2]	729,135	780,207	849,147	884,028	921,580
Departmental expenses					
Departmental appropriation[3]	44,581	40,925	40,934	41,228	41,308
Expenses not requiring appropriation in the budget year[4]	1,153	964	971	1,035	876
Total for Program 2.2	**774,869**	**822,096**	**891,052**	**926,291**	**963,764**
Program 2.3: Health Workforce					
Administered expenses					
Ordinary annual services[2]	1,288,282	1,291,530	1,305,728	1,274,986	1,266,940
Departmental expenses					
Departmental appropriation[3]	45,328	41,915	41,076	41,327	41,352
Expenses not requiring appropriation in the budget year[4]	1,191	1,008	1,016	1,082	916
Total for Program 2.3	**1,334,801**	**1,334,453**	**1,347,820**	**1,317,395**	**1,309,208**
Program 2.4: Preventive Health and Chronic Disease Support[1]					
Administered expenses					
Ordinary annual services[2]	278,015	378,306	345,089	357,647	358,541
Departmental expenses					
Departmental appropriation[3]	41,470	38,089	37,568	37,789	37,809
Expenses not requiring appropriation in the budget year[4]	1,076	903	910	970	820
Total for Program 2.4	**320,561**	**417,298**	**383,567**	**396,406**	**397,170**

Table 2.2.1: Budgeted Expenses for Outcome 2 (continued)

	2015-16 Estimated actual $'000	2016-17 Budget $'000	2017-18 Forward Year 1 $'000	2018-19 Forward Year 2 $'000	2019-20 Forward Year 3 $'000
Program 2.5: Primary Health Care Quality and Coordination					
Administered expenses					
Ordinary annual services[2]	432,603	405,876	357,794	374,989	317,649
Departmental expenses					
Departmental appropriation[3]	25,427	23,514	23,420	23,584	23,596
Expenses not requiring appropriation in the budget year[4]	648	548	552	588	498
Total for Program 2.5	**458,678**	**429,938**	**381,766**	**399,161**	**341,743**
Program 2.6: Primary Care Practice Incentives					
Administered expenses					
Ordinary annual services[2]	357,971	372,977	353,802	368,200	368,628
Departmental expenses					
Departmental appropriation[3]	2,250	1,966	1,965	1,976	1,977
Expenses not requiring appropriation in the budget year[4]	58	47	47	50	43
Total for Program 2.6	**360,279**	**374,990**	**355,814**	**370,226**	**370,648**
Program 2.7: Hospital Services[1]					
Administered expenses					
Ordinary annual services[2]	92,639	92,534	77,286	77,722	77,936
Non cash expenses[5]	963	963	963	963	963
Departmental expenses					
Departmental appropriation[3]	29,615	40,928	41,816	40,915	38,951
Expenses not requiring appropriation in the budget year[4]	4,028	4,164	4,196	4,471	3,782
Total for Program 2.7	**127,245**	**138,589**	**124,261**	**124,071**	**121,632**

Table 2.2.1: Budgeted Expenses for Outcome 2 (continued)

	2015-16 Estimated actual $'000	2016-17 Budget $'000	2017-18 Forward Year 1 $'000	2018-19 Forward Year 2 $'000	2019-20 Forward Year 3 $'000
Outcome 2 totals by appropriation type					
Administered expenses					
Ordinary annual services[2]	3,842,223	4,000,883	3,985,954	4,047,470	3,840,097
Non cash expenses[5]	963	963	963	963	963
Departmental expenses					
Departmental appropriation[3]	210,078	206,766	206,121	205,940	204,123
Expenses not requiring appropriation in the budget year[4]	8,933	8,382	8,446	8,999	7,614
Total expenses for Outcome 2	**4,062,197**	**4,216,994**	**4,201,484**	**4,263,372**	**4,052,797**

	2015-16	2016-17
Average staffing level (number)	1,132	1,118

1 Budget estimates for this program exclude National Partnership funding paid to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework. National Partnerships are listed in this chapter under each program. For Budget estimates relating to the National Partnership component of this program, please refer to Budget Paper 3 or Program 1.9 of the Treasury's Portfolio Budget Statements.

2 Appropriation (Bill No. 1) 2016-17.

3 Departmental appropriation combines "Ordinary annual services (Appropriation Bill No. 1)" and "Revenue from independent sources (s74)".

4 Expenses not requiring appropriation in the Budget year are made up of depreciation expense, amortisation expense, makegood expense and audit fees.

5 "Non cash expenses" relates to the depreciation of buildings.

Movement of Funds

There were no movements of Administered funds between years for Outcome 2.

Planned Performance for Outcome 2

Tables 2.2.2 - 2.2.8 below detail the performance criteria for each program associated with Outcome 2.[2] These tables also summarise how each program is delivered and where 2016-17 Budget measures have created new programs or materially changed existing programs.

Table 2.2.2 – Performance Criteria for Program 2.1

Outcome	**2: Support for sustainable funding for public hospital services and improved access to high quality, comprehensive and coordinated preventive, primary and mental health care for all Australians, with a focus on those with complex health care needs and those living in regional, rural and remote areas, including through access to a skilled health workforce**
Program	**2.1: Mental Health** The Australian Government is committed to supporting Australians with, or at risk of, mental illness and improving service integration in order to develop a more effective mental health system. In response to the National Mental Health Commission's review of Australia's mental health system, *Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services*, the Government will transform Commonwealth mental health funding and leadership to achieve a more efficient, integrated and sustainable mental health system.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, which are intended to benefit Australians with, or at risk of, mental illness and their families, will be delivered under the following program objective: A. Investing in more and better coordinated services for people with mental illness
Program objective	
A. Investing in more and better coordinated services for people with mental illness	
Central to the Government's mental health reforms will be a regional approach to service planning and integration, and better matching of services to individual needs. The Government's response takes a whole of system perspective, enabling Commonwealth services to complement the role of State and Territories in mental health care. In 2016-17, the Government will commence implementing its reform agenda, with an immediate focus on establishing and rolling out the expanded Primary Health Network (PHN) role, child and youth integration, the digital mental health gateway and the new community-based approach to suicide prevention. From July 2016, through a newly established flexible primary mental health care funding pool, PHNs will plan and commission regionally delivered primary mental health services in partnership with relevant services. PHNs will play a key role in leading the development	

[2] Progress against the performance criteria published in the *2015-16 Portfolio Budget Statements* will be reported in the 2015-16 Annual Report.

of regional mental health and suicide prevention plans. A new digital mental health gateway will be established which will streamline access to existing evidence-based information, advice and digital mental health treatment, and will connect people to the services they need through a centralised telephone and web portal. In 2016-17, the Government will fund the development of a new online perinatal depression support tool and smart phone application, to help women who are affected by, or at risk of, perinatal depression.	
Qualitative performance criteria	**2016-17 Reference point or target**
Support PHNs to effectively implement reform activities and maximise use of the flexible funding pool.	Transition of regionally delivered mental health and suicide prevention programs to the PHNs funding pool, to enable service commissioning to commence from July 2016.
Support better coordination and integration of mental health and suicide prevention services at a national and regional level to improve consumer outcomes.[3]	Development of PHNs regional mental health and suicide prevention plans commenced by 30 June 2017.
Establish a new digital mental health gateway that promotes access to information, advice and digital mental health treatment.	Early consultation with the digital mental health sector in the design, development and delivery of the gateway to be completed by 31 August 2016.
Material changes to Program 2.1 resulting from the following measures:	
• *National Disability Insurance Scheme Savings Fund* (Department of Social Services)	

Table 2.2.3 – Performance Criteria for Program 2.2

Program	**2.2: Aboriginal and Torres Strait Islander Health** The Australian Government will continue delivery of high quality essential health services to Aboriginal and Torres Strait Islander people, and respond to new and emerging health needs. In 2016-17, the Department will continue to focus on activities which support the Aboriginal and Torres Strait Islander Health Plan (2013-2023) and associated Implementation Plan.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, which are intended to benefit Aboriginal and Torres Strait Islander people, will be delivered under the following program objectives: A. Improving access to comprehensive and culturally appropriate health care in areas of need B. Reducing chronic disease C. Improving child and maternal health

[3] This performance criterion has been revised. The target reported in the *2015-16 Portfolio Budget Statements* has been achieved.

Program objective
A. Improving access to comprehensive and culturally appropriate health care in areas of need
Through the Indigenous Australians' Health Programme, Aboriginal and Torres Strait Islander people have access to effective health services in urban, regional, rural and remote areas. Services are provided through Aboriginal and Torres Strait Islander Community Controlled Health Organisations as well as other primary health care services, to deliver comprehensive, culturally appropriate primary health care. Funding is also provided for system-level support to the Indigenous primary health care sector to improve the effectiveness and efficacy of these services. From 2016-17, Aboriginal and Torres Strait Islander people will be provided with better access to coordinated and culturally appropriate mental health care, as part of the Government's refocus of mental health programs. In 2016-17, the Department will continue to develop a new funding approach to ensure that program funds are targeted at areas of health need and population growth.

Qualitative performance criteria	2016-17 Reference point or target
Continue to implement actions in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (the plan) 2013-2023.[4]	Monitor and review progress against the plan in consultation with the Indigenous health sector.

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Number of Indigenous adult and child health checks completed.[5]	164,476	189,394	198,864	208,807	219,247

Program objective
B. Reducing chronic disease
The Government is committed to reducing the high rates of chronic disease experienced by Aboriginal and Torres Strait Islander people. This includes improving access to quality care including through disease management plans, better care coordination and follow up, and assistance with medicines. In 2016-17, the Department will continue to focus on improving the prevention, detection and management of chronic disease, particularly through the continued implementation of the redesigned Tackling Indigenous Smoking program, and better alignment of services through the Integrated Team Care activity (previously the Care Coordination and Supplementary Services and Improving Indigenous Access to Primary Care programs). The Government will continue the rheumatic fever strategy working with relevant State and Territory Governments to protect Aboriginal and Torres Strait Islander children at risk of acute rheumatic fever and rheumatic heart disease.

[4] This performance criterion has been revised. The target reported in the *2015-16 Portfolio Budget Statements* has been achieved.

[5] Targets for 2016-17 and forward years have been revised to reflect an increase in the uptake of health checks.

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Percentage of regular Aboriginal and/or Torres Strait Islander clients with type 2 diabetes that have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.	60-65%	60-65%	60-65%	60-65%	65-70%
Quantitative performance criteria	**2014 Actual**	**2015 Target**	**2016 Forward Year 1**	**2017 Forward Year 2**	**2018 Forward Year 3**
Chronic disease related mortality rate per 100,000:[6]					
• Aboriginal and Torres Strait Islander	757	614-650	593-628	572-606	551-584
• Non-Aboriginal and Torres Strait Islander	447	426-431	417-424	409-414	400-405
• Rate difference	309	185-222	173-209	161-195	148-182
Child 0-4 mortality rate per 100,000:[7]					
• Aboriginal and Torres Strait Islander	159	107-158	101-151	95-143	89-135
• Non-Aboriginal and Torres Strait Islander	73	78-89	76-86	74-84	72-82
• Rate difference	86	23-76	19-70	16-65	12-59
Program objective					
C. Improving child and maternal health					
The Government is committed to improving health, education and employment outcomes to help overcome Indigenous disadvantage. To support this, in 2016-17, the Department will continue to implement the Better Start to Life approach which includes the continued expansions of the Australian Nurse Family Partnership Program and New Directions: Mothers and Babies Services.					

[6] Note that this data is reported on a calendar year basis. The targets are amended each year as new mortality data becomes available. The targets are based on a trajectory required to close the gap between Indigenous and non-Indigenous Australians by 2031. Source: AIHW National Mortality Database, calendar years 1998-2013 (which is the most up-to-date data available) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).

[7] Note that this data is reported on a calendar year basis. The targets are amended each year as new mortality data becomes available. The 2015 target and forward years are based on a trajectory required to halve the gap between Indigenous and non-Indigenous Australians by 2018. Source: AIHW National Mortality Database, calendar years 1998-2014 (which is the most up-to-date data available) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Number of services funded to provide New Directions: Mothers and Babies Services.	110	124	136	136	136
Number of organisations funded to provide Australian Nurse Family Partnership Program Services.	5	9	13	13	13
Material changes to Program 2.2 resulting from the following measures:					
There are no material changes to Program 2.2 resulting from measures.					

Table 2.2.4 – Performance Criteria for Program 2.3

Program	**2.3: Health Workforce** The Australian Government aims to ensure that Australia has the workforce necessary to meet the needs of a sustainable health system. The Government is continuing to address workforce distribution by better targeting and refocussing investment in workforce support and training.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, which are intended to benefit the Australian community, including health professionals, medical students and people living in regional, rural and remote areas, will be delivered under the following program objectives: A. Increasing the capacity and effectiveness of training and education for the future health workforce B. Redesigning the supply of, and support for, health professionals in rural, regional and remote Australia C. Improving access to health services for rural Australians
Program objective	
A. Increasing the capacity and effectiveness of training and education for the future health workforce	
The Australian Government recognises that investment in medical training and education underpins the delivery of sustainable health care services for all Australians. In 2016-17, the Government will continue to ensure high quality training is provided for GP registrars under the Australian General Practice Training (AGPT) Program, and support 1,500 commencing GP registrars each year as well as ongoing participants. At least 50 per cent of all GP training is undertaken in rural and regional areas. The Government will continue to work closely with GP training and accreditation organisations to reduce costs, further streamline administration and ensure appropriate engagement of the profession in the delivery of training. The Government will seek to grow the AGPT Program in partnership with business and the medical profession. To further support appropriate clinical training and broader registrar expenses, the Specialist Training Program (STP) enables medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals, including the	

private sector and in rural areas. Following a comprehensive review undertaken in 2015-16, the program will be continued and will be more closely aligned with workforce planning data to ensure STP places are allocated according to the needs of communities.

In 2016-17, the Australian Government will continue to ensure that an appropriately skilled and well-qualified workforce is available to care for older people who need aged care in their own homes or in residential care. The Department will continue to consult with the sector on future aged care workforce needs, provide targeted training for Aboriginal and Torres Strait Islander people, respond to emerging issues and support innovative practice in the health and aged care workforces.

Qualitative performance criteria	2016-17 Reference point or target
Establish a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors.	Implement a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors commencing in semester one 2017.

Quantitative performance criteria[8]	Academic Year 2015 Target	Academic Year 2016 Target	Academic Year 2017 Target	Academic Year 2018 Target	Academic Year 2019 Target
Number of commencing GP trainees funded through the Australian General Practice Training Program.	1,500	1,500	1,500	1,500	1,500
Number of medical internship positions funded through the Commonwealth Medical Internships Program.	84	≤100	≤100	≤100	≤100
Number of training positions funded through the Specialist Training Program.[9]	900	900	950	1,000	1,000

Program objective

B. Redesigning the supply of, and support for, health professionals in rural, regional and remote Australia

The Department will implement the Integrated Rural Training Pipeline initiative, which was announced as part of the *2015-16 Mid-Year Economic and Fiscal Outlook*. The initiative will help to retain medical graduates in rural areas by better coordinating the different stages of training within regions and funding new places to help meet student demand.

The Department will expand support for the Rural Health Multidisciplinary Training (RHMT) Program, including establishing an additional three University Departments of Rural Health (UDRH) to increase clinical training capacity for nursing, midwifery and allied health students in rural areas. The Department will also establish a competitive funding

8 Placements are allocated on an academic year basis.

9 Targets for 2017, 2018 and 2019 have been revised to reflect the impact of the Integrated Rural Training Pipeline initiative.

round to support clinical training for professional entry students of nursing, midwifery and allied health in the private and non-government sectors. In 2016-17, the Department will continue to deliver a range of programs to support health professionals in rural, regional and remote Australia, including the Practice Nurse Incentive Program.

In 2016-17, the Government will help boost Australia's rural health workforce by better supporting general practice registrars training to be GPs in rural areas. This will give all GP registrars the same access to GP-related Medicare benefits for the services they provide while training. These registrars train through the Australian College of Rural and Remote Medicine (ACRRM).

Qualitative performance criteria	**2016-17 Reference point or target**
Implementation of the *Integrated Rural Training Pipeline for Medicine* measure.	Regional training hubs selected through a competitive process by 1 January 2017.

Quantitative performance criteria	**2015-16 Target**	**2016-17 Target**	**2017-18 Target**	**2018-19 Target**	**2019-20 Target**
Percentage of medical students participating in the Rural Health Multidisciplinary Training Program – 1 year rural clinical placement.[10]	>25%	>25%	>25%	>25%	>25%
Number of weeks of rural multidisciplinary placements supported through the Rural Health Multidisciplinary Training Program.	18,113	20,384[11]	21,294	21,294	21,294
Number of practices supported through the Practice Nurse Incentive Program.	4,100	4,100	4,100	4,100	4,100

Program objective

C. Improving access to health services for rural Australians

People living in regional, rural and remote areas face greater health care challenges than Australians based in metropolitan areas.

The Australian Government provides significant investment through a range of measures to encourage the right health professional to work in the right place, at the right time. This includes training scholarships for health professionals; incentives for doctors, nurses and allied health professionals working in small regional, rural and remote locations; funding the delivery of outreach services; and support for Rural Workforce Agencies to deliver recruitment and retention activities to the rural health workforce.

[10] This performance criterion has been revised to reflect the change in the name of the RHMT.

[11] Targets for 2016-17 and forward years have been revised based on agreed targets in the RHMT university agreements. Targets may be further revised following the implementation of the RHMT expansion announced at *2015-16 Mid-Year Economic and Fiscal Outlook*.

Qualitative performance criteria	2016-17 Reference point or target
Strengthen the quality, capacity and training opportunities of the health workforce.	Implement a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors commencing in semester one 2017.
Establishment of the Health Workforce Program to strengthen the capacity of the health workforce.	Implementation of the new Health Workforce Program by 30 June 2016 with funding agreements to commence in 2016-17.
Improve access to training scholarships for health professionals.	Through the delivery of scholarships by a single agency to the health workforce for the 2017 academic year.
Medical specialist, GP, allied and other health services provided through the Rural Health Outreach Fund meet the needs of regional, rural and remote communities.	Organisations funded to support rural outreach will be guided by existing advisory forums and Indigenous Health Partnership forums, to identify community needs and better meet the needs of regional, rural and remote communities.[12]

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Number of communities receiving outreach services through the Rural Health Outreach Fund. [13]	350	375	375	375	375
Number of patient contacts delivered[14] through the Rural Health Outreach Fund.[15]	165,000	163,000	163,000	163,000	163,000
Number of patient consultations at Royal Flying Doctor Service primary health clinics.[16]	40,000	36,000	36,000	36,000	36,000

Material changes to Program 2.3 resulting from the following measures:

- *Health Flexible Funds – pausing indexation and achieving efficiencies*

[12] Target has been revised to provide a clear focus on regional, rural and remote communities.
[13] Targets for 2017-18 and 2018-19 have been revised to reflect the 2015-16 Budget measure *Rationalising and Streamlining Health Programs.*
[14] This number represents the number of patient contacts, not the number of individual patients.
[15] This performance criterion has been revised to reflect the 2015-16 Budget measure *Rationalising and Streamlining Health Programs.*
[16] This performance criterion and targets for 2016-17 and forward years have been revised to 36,000 to reflect improved reporting of services by the Royal Flying Doctor Service.

Table 2.2.5 – Performance Criteria for Program 2.4

Program	**2.4: Preventive Health and Chronic Disease Support** The Australian Government aims to improve the health and wellbeing of Australians and to reduce preventable mortality and morbidity caused by chronic disease and substance misuse. This will be achieved through evidence-based promotion of healthy lifestyles and good nutrition, early detection of cancer and other lifestyle limiting conditions, a range of tobacco control measures, and through the implementation of strategies to reduce illegal drug use, legal drug misuse and harmful levels of alcohol consumption.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs and best practice regulation.
Delivery	Program activities, which are intended to benefit the Australian community, will be delivered under the following program objectives: A. Reducing the incidence of chronic disease and complications, and promoting healthier lifestyles B. Supporting the development and implementation of evidence-based food regulatory policy C. Improving early detection, treatment and survival outcomes for people with cancer D. Improving access to high quality palliative care services for all Australians E. Reducing harm to individuals and communities from misuse of alcohol, pharmaceuticals and use of illicit drugs F. Reducing the harmful effects of tobacco use
Program objective	
A. Reducing the incidence of chronic disease and complications, and promoting healthier lifestyles	
The Australian Government aims to reduce the Australian population's incidence and complications of chronic disease and promote healthier lifestyles. This includes activities and programs encouraging Australians to make healthy eating choices by promoting and following the *Australian Dietary Guidelines* and the *Australian Guide to Healthy Eating*; being physically active and maintaining a healthy weight. In 2016-17, the Australian Government will work with industry and public health groups to successfully implement actions of the Healthy Food Partnership. This will include supporting industry food reformulation efforts and encouraging, supporting and enabling consumers to consume appropriate levels of energy and core foods.	

Qualitative performance criteria	2016-17 Reference point or target
Implementation Plan for the *Australian National Diabetes Strategy 2016-2020* developed in negotiation with jurisdictions.[17]	*Australian National Diabetes Strategy 2016-2020* Implementation Plan finalised by the end of 2016.
Australian Government nutrition policy is informed by evidence-based advice.	Ongoing promotion and implementation of *Australian Dietary Guidelines* and *Australian Guide to Healthy Eating*.
A National Strategic Framework for Chronic Conditions is developed in partnership with jurisdictions to guide chronic conditions policy and strategies into the future.	The National Strategic Framework for Chronic Conditions is submitted for approval through the AHMAC process by the end of 2016.
Program objective	
B. Supporting the development and implementation of evidence-based food regulatory policy	
The Australian Government administers a strong, evidence-based food regulatory system to ensure that food sold in Australia is safe. The Department will ensure that all food regulatory policy is considered in the context of the Government's deregulation agenda and will promote the reduction of unnecessary regulatory burden and red tape. The Department collaborates with the Department of Agriculture and Water Resources, States and Territories and New Zealand to develop robust policy to assist Food Standards Australia New Zealand[18] to develop, and the States and Territories to implement, the food standards necessary to ensure a safe food supply for Australia. Food labelling plays an integral role in assisting consumers to make informed healthy food purchasing decisions. The Australian Government will continue to undertake promotional activities in partnership with the States and Territories during 2016-17, to raise awareness of the Health Star Rating system and support industry's adoption of the system.	
Qualitative performance criteria	**2016-17 Reference point or target**
Develop advice and policy for the Australian Government on food regulatory issues.	Relevant, evidence-based advice is produced for Government in a timely manner.
Promote a nationally consistent, evidence-based approach to food policy and regulation.	Consistent regulatory approach across Australia is achieved through nationally agreed evidence-based policies and standards.[19]

17 This performance criterion has been revised. Target reported in the *2015-16 Portfolio Budget Statements* has been achieved.

18 For further information on the work of Food Standards Australia New Zealand (FSANZ), refer to the FSANZ chapter in these Portfolio Budget Statements.

19 This performance criterion has been revised. The target reported in the *2015-16 Portfolio Budget Statements* has been achieved.

Program objective	
C. Improving early detection, treatment and survival outcomes for people with cancer	
The Australian Government recognises the importance of cancer screening in the early detection and treatment of cancer. In 2016-17, the Australian Government will continue to expand the National Bowel Cancer Screening Program to a biennial screening interval for Australians 50-74 years of age by 2020. Free bowel cancer screening using an immuno-chemical faecal occult blood test will be offered to people turning 54, 58 and 68 years old in 2017. This will build on the program which currently invites people turning 50, 55, 60, 64, 65, 70, 72 and 74 years of age to participate. The remaining cohorts will be included from 2018 to 2020. Breast cancer is the most common cancer in Australian women. In 2016-17, the Australian Government will continue to work with State and Territory Governments to provide breast and cervical cancer screening for women in the eligible age cohorts. Breast care nurses funded through the McGrath Foundation will provide vital information, care and support to women diagnosed with breast cancer and their families. The Australian Government will continue to work with State and Territory Governments to implement the Medical Services Advisory Committee's recommendation to replace the current two yearly Pap test with a five yearly Human Papillomavirus test. Items will be available on the Medicare Benefits Schedule from 1 May 2017. In 2016-17, the Australian Government will implement a single National Cancer Screening Register that will be a fundamental enabler to support the renewal of the National Cervical Screening Program and the expansion of the National Bowel Cancer Screening Program. The transition to a National Cancer Screening Register will be a key step towards connecting the health system and deliver capability that can be reused for future screening programs.	
Qualitative performance criteria	**2016-17 Reference point or target**
Continue to implement the accelerated expansion of the National Bowel Cancer Screening Program to a biennial screening interval (by 2020).[20]	Commencement of invitations to 54, 58 and 68 year olds in 2017 and the continued delivery of communication and program enhancement activities.
Support the renewal of the National Cervical Screening Program and expansion of the National Bowel Cancer Screening Program.	*Implementation of the National Cancer Screening Register to commence on 1 May 2017.*
Support the expansion of the BreastScreen Australia Program to extend the invitation to Australian women 70-74 years of age through the implementation of a nationally consistent communication strategy.[21]	Continue delivery of communication activities such as print, radio and online promotion.

[20] This performance criterion has been revised to reflect the additional ages being added to the eligible age cohorts.

[21] This performance criterion has been revised to reflect continuing delivery of the program.

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Number of breast care nurses employed through the McGrath Foundation.	57	57	N/A[22]	N/A	N/A
Percentage of people invited to take part in the National Bowel Cancer Screening Program who participated.[23]	41%	41%	41%	41%	41%
Percentage of women 50-69 years of age participating in BreastScreen Australia.[24]	55%	55%	55%	55%	54%
Percentage of women 70-74 years of age participating in BreastScreen Australia.[25]	53%	54%	54%	54%	54%
Percentage of women in the target age group participating in the National Cervical Screening Program.[26]	57%	57%	57%	57%	58%

22 The current funding agreement for this program terminates in June 2017.

23 Australian Institute of Health and Welfare 2015, *National Bowel Cancer Screening Program: monitoring report 2012-2013*, Cancer series no. 94, Cat. no. CAN 92, AIHW, Canberra. Targets for 2016-17 and forward years have been revised based on the most recent data (2013-2014) on participation in the National Bowel Cancer Screening Program.

24 Australian Institute of Health and Welfare 2015, *BreastScreen Australia monitoring report 2012-2013*, Cancer series no. 95, cat. no. CAN 93, AIHW, Canberra. Targets for 2016-17 and forward years have been revised based on the most recent data (2012-2013) on participation in BreastScreen Australia Program. Small changes in these figures are unlikely to be statistically significant. Participation data for the program cannot be projected into the future.

25 From 2013-14, the program started actively inviting women 70-74 years of age to participate in BreastScreen Australia. Estimated participation rates are expected to reach 54 per cent by 2016-17. Targets for 2016-17 and forward years have been revised based on the most recent data (2012-2013) on participation in BreastScreen Australia Program.

26 Australian Institute of Health and Welfare 2015, *Cervical screening in Australia 2012-13*, Cancer series no. 93, cat. no. CAN 79, AIHW, Canberra. Targets for 2016-17 and forward years have been revised based on the most recent data (2012-2013) on participation in the National Cervical Screening Program. Small changes in these figures are unlikely to be statistically significant. Participation data for the program cannot be projected into the future.

Program objective	
D. Improving access to high quality palliative care services for all Australians	
The Australian Government funds a range of national palliative care activities that contribute to building and enhancing the capacity of health services to provide quality palliative care. These activities focus on education, training, quality improvement and advance care planning. In collaboration with State and Territory Governments and key providers of end of life care, the Government will commence a review of the National Palliative Care Strategy. The Government will continue to support State and Territory Governments to implement palliative care services with a specific allocation under the Federal Financial Relations Framework to increase access to hospice services for children and their families in Queensland.	
Qualitative performance criteria	**2016-17 Reference point or target**
Implementation of the National Palliative Care Projects and other activities consistent with the National Palliative Care Strategy 2010.[27]	Continue to implement national projects that support quality improvement in palliative care priority areas including education, training, quality standards and advance care planning. Full implementation of the National Palliative Care Projects by 30 June 2017. Following June 2017, evaluation of these projects will inform future palliative and end of life care funding and activities.

[27] This performance criterion has been revised to reflect continuing delivery of the initiative.

Program objective	
E. Reducing harm to individuals and communities from misuse of alcohol, pharmaceuticals and use of illicit drugs	
The Australian Government will continue to work with States and Territories, experts and communities to minimise the harms associated with alcohol, tobacco and other drug use. This will include continuing to defend tobacco plain packaging against disputes, finalisation of the next iteration of the National Drug Strategy, the National Alcohol Strategy and establishment of the new Ministerial Forum on Alcohol and Drugs which will report directly to the Council of Australian Governments. Another key focus is the implementation of measures announced in late 2015 through the Government's response to the report of the National Ice Taskforce and the National Ice Action Strategy, which will seek to improve nationally coordinated approaches to reducing harms associated with illicit drug use, improve access to treatment services and information across the community. The Government will also continue to support service delivery and education initiatives promoting responsible alcohol consumption including to reduce the prevalence and impact of Fetal Alcohol Spectrum Disorders. The next Australian National Drug Strategy Household Survey will be conducted during 2016-17. The Government will continue to fund the National Coronial Information System (NCIS). The NCIS contains data on deaths reported to an Australian coroner from July 2000, and to a New Zealand coroner from July 2007. It enables coroners, their staff, public sector agencies, researchers and other agencies to access coronial data to inform death and injury prevention activities.	
Qualitative performance criteria	**2016-17 Reference point or target**
Establish a new Centre for Clinical Excellence for Emerging Drugs of Concern, which will provide timely and relevant data and research that informs the development of alcohol and other drug information, early intervention, prevention, and treatment activities.	Clinical Centre of Excellence will be established during 2016-17.
Provide up-to-date information to young people on the risks and harms of illicit drug use.	Continue dissemination of materials and delivery of the National Drugs Campaign including provision of resources for parents, teachers and students.
Provide funding to drug and alcohol organisations to support early intervention, prevention, information, and treatment activities.	Implementation of the new Drug and Alcohol Program commencing in 2016-17.
Availability of prevention and early intervention substance misuse resources for teachers, parents and students.	Increasing access to new material through the National Drugs Campaign website as measured by an increase in site visits.[28]

[28] Available at: www.drugs.health.gov.au

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Percentage of population 14 years of age and older recently (in the last 12 months) using an illicit drug.[29]	<13.4%	<13.4%	<13.4%	<13.4%	<13.4%
Program objective					
F. Reducing the harmful effects of tobacco use					
Smoking continues to be one of the leading causes of preventable disease and premature death in Australia. To reduce the harmful effects of tobacco use, the Australian Government continues to work with States and Territories to implement the National Tobacco Strategy 2012-2018. The strategy aims to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs and the inequalities it causes. In 2016-17, the Government will also support the next phase of the National Tobacco Campaign.					
Qualitative performance criteria	**2016-17 Reference point or target**				
Implement social marketing campaigns to raise awareness of the dangers of smoking and encourage and support attempts to quit.	Deliver a campaign within the agreed timeframes focussing on groups with high smoking prevalence, which will raise awareness of the dangers of smoking.[30]				
Quantitative performance criteria	**2015-16 Target**	**2016-17 Target**	**2017-18 Target**	**2018-19 Target**	**2019-20 Target**
Percentage of population 18 years of age and over who are daily smokers.	12.6%	11.3%	10%	<10%	<10%
Material changes to Program 2.4 resulting from the following measures:					
• *Health Flexible Funds – pausing indexation and achieving efficiencies* • *National Cancer Screening Register*					

[29] Data on this target is currently taken from the 2013 National Drug Strategy Household Survey, which is published every three years. Data from the 2016 survey will be available in late 2017.

[30] Target has been revised to include a focus on groups with high smoking prevalence.

Table 2.2.6 – Performance Criteria for Program 2.5

Program	**2.5: Primary Health Care Quality and Coordination** The Australian Government aims to strengthen primary care by focussing funding to frontline health services and improving the delivery, quality and coordination of primary care services. This will help improve health outcomes for patients, focussing on those who are most in need, including those with chronic conditions or mental illness. It will also assist in reducing unnecessary visits or admissions to hospitals.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, intended to benefit the Australian community, will be delivered under the following program objectives: A. Focussing investment in frontline medical services for patients through Primary Health Networks B. Improving models of primary care C. Establishing the Primary Health Care Development Program
Program objective	
A. Focussing investment in frontline medical services for patients through Primary Health Networks	
Through Primary Health Networks (PHNs), the Australian Government will continue to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure that patients receive the right care, in the right place, at the right time. PHNs will work directly with general practice, other primary health care providers, secondary care providers, hospitals, and private providers to ensure better coordination of care across the local health system and improve outcomes for patients. From July 2016, PHNs will commence their commissioning activities to address the priorities identified through their baseline regional needs assessments, and in their activity work plans, prepared in 2015-16. Later in 2016-17, PHNs will review and update their needs assessments and activity work plans to determine their commissioning activities for 2017-18. As announced by the Government in its response to the National Mental Health Commission's Review of Mental Health Programs and Services, PHNs will take on a much larger role in the commissioning of primary mental health services from 2016-17. As part of the Government's response to the National Ice Taskforce's final report, PHNs will also commission more drug and alcohol treatment services.	

Qualitative performance criteria	2016-17 Reference point or target
Primary Health Networks move to a commissioning role.[31]	All Primary Health Networks commence commissioning activities within the first six months of 2016-17.
Percentage of Primary Health Networks with updated baseline needs assessments and strategies for responding to identified service gaps.[32]	Completed by 100% of Primary Health Networks by 30 June 2017.
Program objective	
B. Improving models of primary care	
The Government recognises the challenge posed by increasing rates of chronic and complex disease in the Australian community and is committed to investigating new, innovative models of primary health care delivery that will deliver high quality and sustainable care to patients. In 2016-17, the Government will begin implementation of Health Care Homes, which will provide patients with continuity of care and coordinated services using a team based approach according to the needs and wishes of the patient.	
Qualitative performance criteria	**2016-17 Reference point or target**
Establishment of a governance structure to facilitate stage 1 of a new Health Care Home model.	*The governance structure will be established by November 2016.*
Number of Primary Health Network regions which have begun patient enrolment into Health Care Homes.	*Patient enrolment has commenced in up to seven Primary Health Network regions by 30 June 2017.*
Program objective	
C. Establishing the Primary Health Care Development Program	
The Program will fund measures that seek to provide better access to innovative and cost effective health, and medical care, accurate advice and information about health, illness and service availability, so that people are better able to care for themselves and their families.	
Qualitative performance criteria	**2016-17 Reference point or target**
Improved delivery of health services through current and emerging interactive communication channels.	Increased use of the National Health Services Directory and first point of call services by the Australian population and health professionals.
Material changes to Program 2.5 resulting from the following measures:	
• *Health Flexible Funds – pausing indexation and achieving efficiencies* • *Healthier Medicare – trial of Health Care Homes*	

[31] This performance criterion has been revised. Target reported in the *2015-16 Portfolio Budget Statements* has been achieved.

[32] Ibid.

Table 2.2.7 – Performance Criteria for Program 2.6

Program	**2.6: Primary Care Practice Incentives** The Australian Government provides incentive payments to general practices and general practitioners (GPs) through the Practice Incentives Program (PIP) to support activities that encourage continuing improvements, increase quality of care, enhance capacity and improve access and health outcomes for patients.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, which are intended to benefit GPs and the Australian community, will be delivered under the following program objectives: A. Providing general practice incentive payments

Program objective

A. Providing general practice incentive payments

In 2016-17, the Government will implement changes to the Digital Health Incentive to encourage practices to use and realise the benefits of the *My Health Record* system.

The Government will continue to provide PIP teaching payments to support general practices to provide teaching sessions to medical students and will continue to support general practices to provide after-hours service provision to ensure that all Australians have access to high quality after hours care, integrated with their usual general practice. The rural loading incentive which recognises the difficulties of providing care in rural and remote regions will also continue.

In 2016-17, the Government will work towards introducing changes to the Practice Incentives Program (PIP) to include a new quality improvement incentive payment that will streamline and simplify current PIP payments to help general practice achieve high quality health care and improved patient outcomes.

Qualitative performance criteria	2016-17 Reference point or target
Revise the Digital Health PIP Incentive.	Provide general practices with access to the revised Digital Health Incentive from 1 August 2016.

Quantitative performance criteria	2015-16 Target	2016-17 Target	2017-18 Target	2018-19 Target	2019-20 Target
Percentage of GP patient care services provided by PIP practices.[33]	84.1%	84.2%	84.2%	84.2%	84.2%
Number of general practices participating in the PIP After Hours Incentive.	4,600	4,650	4,700	4,750	4,800

Material changes to Program 2.6 resulting from the following measures:

- *Health Flexible Funds – pausing indexation and achieving efficiencies*
- *Quality Improvement in General Practice – simplification of the Practice Incentives Program*

[33] This is calculated as the proportion of total Medicare Benefit Schedule (MBS) schedule fees for non-referred attendances provided by PIP practices, standardised for age and sex.

Table 2.2.8 – Performance Criteria for Program 2.7

Program	**2.7: Hospital Services** The Australian Government aims to improve access to, and the efficiency of, public hospitals through the provision of funding to States and Territories.
Purpose	Lead and shape Australia's health and aged care systems and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.
Delivery	Program activities, which are intended to benefit the Australian community, will be delivered under the following program objectives: A. Supporting the States and Territories to deliver efficient public hospital services B. Improving health services in Tasmania C. Supporting the Mersey Community Hospital

Program objective

A. Supporting the States and Territories to deliver efficient public hospital services

States and Territories are responsible for the delivery of efficient public hospital services. To assist States and Territories in fulfilling this responsibility, the Commonwealth will increase its funding contribution to public hospital services from $17.2 billion in 2015-16 to $17.9 billion in 2016-17.

The Council of Australian Governments has agreed a Heads of Agreement for public hospital funding from 1 July 2017 to 30 June 2020 ahead of consideration of longer term arrangements. Commonwealth funding to States and Territories for this period includes an estimated additional $2.9 billion in funding for public hospital services.

The Department will continue to work with States and Territories and relevant Commonwealth entities to support the efficient pricing, funding, delivery, performance, and reform of public hospital services.

Qualitative performance criteria	2016-17 Reference point or target
Provide accurate advice to the Minister on public hospital funding policy.	Relevant advice produced in a timely manner.

Program objective

B. Improving health services in Tasmania

The Australian and Tasmanian Governments will work together to improve the effectiveness, efficiency and sustainability of the State's health services through the National Partnership Agreement (NPA) on Improving Health Services in Tasmania. The NPA will contribute to an increase in Tasmania's ability to provide cost-effective and sustainable elective surgery, alleviate pressure on emergency departments, avoid unnecessary hospitalisation and reduce re-admission.

Qualitative performance criteria	2016-17 Reference point or target
Implementation of elective surgery reform activities across Tasmania.	Reform activities, including the purchase of elective surgery procedures from public and private providers, are undertaken in accordance with the NPA requirements.

Program objective	
C. Supporting the Mersey Community Hospital	
The Australian Government currently funds the Tasmanian Government to operate and manage the Mersey Community Hospital at Latrobe, to provide a range of public hospital services for the community in the north-west region of Tasmania. A new Heads of Agreement between the Commonwealth and the Tasmanian Government commenced on 1 September 2015 and is due to expire on 30 June 2017. The Australian Government will work with the Tasmanian Government to determine future arrangements for the management, administration and operation of the Mersey Community Hospital once the current Heads of Agreement expires on 30 June 2017.	
Qualitative performance criteria	**2016-17 Reference point or target**
Ensure that residents of north-west Tasmania have ongoing access to hospital services.	The Australian Government will work with the Tasmanian Government to determine future arrangements for the management, administration and operation of the Mersey Community Hospital once the current Heads of Agreement expires on 30 June 2017.
Material changes to Program 2.7 resulting from the following measures:	
• *Public Hospitals – new funding arrangements*	