Medicare rebates were provided for 343 million services – an average of 14.8 services for every Australian.

29% reduction in mortality rates in Indigenous children aged five and under since 1998.

486,000 older people received a service through the Commonwealth Home and Community Care program such as domestic assistance, personal care, meals or transport.

197 million prescriptions were subsidised – an average of 8.6 for every Australian.

Over 630,000 Australians received assistance through the Hearing Services Program.

Over 50,000 people with mental disorders of mild to moderate severity received treatment through the Access to Allied Psychological Services program.

169,218 callers were assisted by the after hours GP helpline.
COMMUNITY
PART 2
DELIVERABLES AND
KEY PERFORMANCE INDICATORS

73.1% MET
20.4% SUBSTANTIALLY MET
6.5% NOT MET

PEOPLE
PART 3
TOTAL STAFFING

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<th>Year</th>
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<td>2012-13</td>
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% OF STAFF WILLING TO GO THE EXTRA MILE

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<th>2012-13</th>
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<tr>
<td></td>
<td>97%</td>
<td>96%</td>
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FINANCE
PART 4
TOTAL ADMINISTERED FUNDING ($BILLION)

<table>
<thead>
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<th>Year</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tr>
<td></td>
<td>$44.7</td>
<td>$49.7</td>
<td>$51.2</td>
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</table>
2012-13 OVERVIEW

THE DEPARTMENT OF HEALTH AND AGEING VALUES

DIVERSITY, EQUALITY, INTEGRITY & INCLUSIVENESS

OUR VISION

Better Health and Active Ageing for all Australians.

The Department of Health and Ageing is a Department of State. We operate under the Public Service Act 1999 and the Financial Management and Accountability Act 1997.

OUR ROLE

The Department’s role is to achieve the Australian Government’s priorities (outcomes) for health and ageing. We do this by developing evidence based policies, managing programs and undertaking research and regulatory activities. We also lead and work closely with other agencies to achieve results for the Australian Government and community, and engage in open and constructive consultation with professionals, providers, industry and community groups.

What is important to us:
- An apolitical, impartial and professional environment.
- The importance of achieving results for the Government and the community.
- Delivering services to the public fairly, effectively and impartially.
- Transparency, accountability and responsiveness.
- A workplace that is fair and free of discrimination.
- Diversity and equity in employment.
- The highest ethical standards.
- Innovation
- Respect

OUR HISTORY

The Commonwealth Department of Health was established in 1921, in part as response to the devastating effects of the Spanish influenza pandemic of 1919 and through the vision of Dr J H L Cumpston. As the first head of the Department, Dr Cumpston championed the need to have a national approach to manage communicable diseases. Since then, the Department has evolved to encompass research and health services endeavouring to deliver universal access to public health services for all Australians.

The Department's role is to achieve the Australian Government's priorities (outcomes) for health and ageing. We do this by developing evidence based policies, managing programs and undertaking research and regulatory activities. We also lead and work closely with other agencies to achieve results for the Australian Government and community, and engage in open and constructive consultation with professionals, providers, industry and community groups.

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- Diversity and equity in employment.
- The highest ethical standards.
- Innovation
- Respect

The Department of Health and Ageing is a Department of State. We operate under the Public Service Act 1999 and the Financial Management and Accountability Act 1997.
The primary purpose of this report is to describe the Department’s activities during 2012–13, reporting on the performance and financial information presented in the 2012–13 Health and Ageing Portfolio Budget Statements, and the 2012–13 Health and Ageing Portfolio Additional Estimates Statements. Its aim is to provide readers with a useful and informative picture of the Department’s performance during the last year.

CONTACT INFORMATION
If you would like to comment on this Annual Report, or have any queries, please contact the Editor at:

The Editor, 2012–13 Annual Report
Australian Government
Department of Health

MDP 51
GPO Box 9848
CANBERRA ACT 2601
AUSTRALIA

Phone: +61 2 6289 7181
Fax: +61 2 6289 7177
Email: annrep@health.gov.au

This Annual Report is available online at www.health.gov.au/internet/main/publishing.nsf/Content/Annual+Reports-3

Further information on the Department of Health is also available online at: www.health.gov.au

COVER IMAGE
Streptococcus Colony-II, ©Martin Oeggerli, supported by School of Life Sciences, FHNW.

DESIGN
Giraffe.com.au

PHOTOGRAPHY
Rob Little – Secretary, Chief Medical Officer
The Mark Agency – Executive Group.

PRINTING
Union Offset, Canberra
STREPTOCOCCUS

Streptococcus bacteria are commonly found in the upper respiratory tract of the human body and are usually harmless. However, at other times these bacteria can cause diseases that vary in severity from mild throat infections to life-threatening infections such as meningitis, septicaemia and pneumonia. Transmission of the Streptococcus bacterium occurs via aerosol droplets of saliva or mucus.

According to the World Health Organization, pneumococcal disease is the leading preventable cause of serious illness and death in young children worldwide and otherwise healthy persons over 85 years of age. In Australia, the rate is highest amongst Aboriginal and Torres Strait Islander children.

Pneumococcal vaccination is provided free of charge to infants and at risk groups, including older Australians, under the National Immunisation Program (NIP) to reduce the incidence of disease. Since the introduction of the pneumococcal vaccine to the NIP at the beginning of 2005, there has been a 77% reduction in the annual rate of invasive pneumococcal disease in children under the age of 5 years. While reductions in the rate of infection are most pronounced in children, decreases in infection have been experienced in all age groups due to the ‘herd immunity’ impacts from the childhood immunisation program.
# CONTENTS

## VOLUME ONE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter of Transmittal</td>
<td>ix</td>
</tr>
<tr>
<td>Secretary’s Review</td>
<td>1</td>
</tr>
<tr>
<td>Chief Medical Officer’s Report</td>
<td>3</td>
</tr>
<tr>
<td>Chief Financial Officer’s Report</td>
<td>7</td>
</tr>
</tbody>
</table>

## PART 1: ABOUT THE DEPARTMENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the Department</td>
<td>11</td>
</tr>
<tr>
<td>Departmental Structure Chart as at 30 June 2013</td>
<td>13</td>
</tr>
<tr>
<td>DoHA National Alignment</td>
<td>14</td>
</tr>
<tr>
<td>Connecting with the Community</td>
<td>17</td>
</tr>
<tr>
<td>Ministerial Responsibilities as at 30 June 2013</td>
<td>19</td>
</tr>
<tr>
<td>Portfolio Outcomes</td>
<td>20</td>
</tr>
</tbody>
</table>

## PART 2: PERFORMANCE REPORTING

### 2.1: PERFORMANCE BY OUTCOME

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1: Population Health</td>
<td>27</td>
</tr>
<tr>
<td>Outcome 2: Access to Pharmaceutical Services</td>
<td>28</td>
</tr>
<tr>
<td>Outcome 3: Access to Medical Services</td>
<td>58</td>
</tr>
<tr>
<td>Outcome 4: Aged Care and Population Ageing</td>
<td>72</td>
</tr>
<tr>
<td>Outcome 5: Primary Care</td>
<td>84</td>
</tr>
<tr>
<td>Outcome 6: Rural Health</td>
<td>106</td>
</tr>
<tr>
<td>Outcome 7: Hearing Services</td>
<td>118</td>
</tr>
<tr>
<td>Outcome 8: Indigenous Health</td>
<td>124</td>
</tr>
<tr>
<td>Outcome 9: Private Health</td>
<td>130</td>
</tr>
<tr>
<td>Outcome 10: Health System Capacity and Quality</td>
<td>140</td>
</tr>
<tr>
<td>Outcome 11: Mental Health</td>
<td>146</td>
</tr>
<tr>
<td>Outcome 12: Health Workforce Capacity</td>
<td>162</td>
</tr>
<tr>
<td>Outcome 13: Acute Care</td>
<td>170</td>
</tr>
<tr>
<td>Outcome 14: Biosecurity and Emergency Response</td>
<td>180</td>
</tr>
</tbody>
</table>

### 2.2: AGENCY RESOURCE STATEMENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEBSITES, GLOSSARY, ACRONYMS</td>
<td>200</td>
</tr>
<tr>
<td>INDEX</td>
<td>202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDEX</td>
<td>208</td>
</tr>
</tbody>
</table>
VOLUME TWO

PART 3: MANAGEMENT AND ACCOUNTABILITY

3.1: CORPORATE GOVERNANCE
3.2: EXTERNAL LIAISON AND SCRUTINY
3.3: FINANCIAL MANAGEMENT
3.4: PEOPLE MANAGEMENT
3.5: STAFFING INFORMATION
3.6: WORK HEALTH AND SAFETY
3.7: CARERS RECOGNITION AND ADDRESSING DISABILITY
3.8: STRATEGIC INDICATORS OF SOCIAL INCLUSION
3.9: ECOLOGICALLY SUSTAINABLE DEVELOPMENT
3.10: ADVERTISING AND MARKET RESEARCH

PART 4: FINANCIAL STATEMENTS

4.1: DEPARTMENT OF HEALTH AND AGEING
   Financial Performance (Administered and Departmental)
   Independent Auditors Report
   Financial Statements

4.2: THERAPEUTIC GOODS ADMINISTRATION
   Independent Auditors Report
   Financial Statements

APPENDICES

Appendix 1: Processes Leading to PBAC Consideration – Annual Report for 2012-13
Appendix 2: Pharmaceutical Benefits Pricing Authority – Annual Report for 2012-13

LIST OF REQUIREMENTS
INDEX
SECRETARY

The Hon Peter Dutton MP
Minister for Health
Parliament House
Canberra ACT 2600

Dear Minister

As required under subsection 63(1) of the Public Service Act 1999, I provide you with the 2012-13 Department of Health and Ageing Annual Report, for your presentation to the Parliament.

Following changes to the Administrative Arrangements Order, announced on 18 September 2013, the Department’s name was changed to the Department of Health and some functions were transferred to other Departments. This annual report is for the period 1 July 2012 to 30 June 2013 and reports on the performance and functions of the Department of Health and Ageing for that period.


The Department has prepared fraud risk assessments and fraud control plans and has in place appropriate fraud prevention, detection, investigation, reporting and data collection procedures and processes that meet the specific needs of the Department and comply with the Commonwealth Fraud Control Guidelines.

Yours sincerely

[signature]

Professor Jane Halton PSM
Secretary

[October 2013]
Australia’s health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.

Compared to similar countries, Australia has an efficient health system. The most recent Global Burden of Disease Study found that Australia achieves strong health outcomes with lower than average spending on health per capita.1

Health policy must take into consideration the effects of an ageing population on demand for health care, increasing risks to the overall health of Australians through poor lifestyle choices and the impact of advancing technology and new drugs. We work with government to develop and implement evidence-based health priorities that are effective and efficient. Australia’s health system faces significant challenges from illness, poor health behavior and health outcome disparities. About one-third of Australia’s burden of disease is due to ‘lifestyle’ health risks such as smoking, obesity, dietary risks, physical inactivity, and alcohol misuse. Significant gains have been made with lower smoking rates across the population. Obesity is being tackled through work to develop dietary guidelines and a front of pack labelling system to provide consumers with the information they need to make healthy eating choices.

We are making a difference. Medicare provides all Australians with free treatment as a public patient in public hospitals. Over 80% of GP services are bulk billed at no cost to the patient. Medicare also provides subsidised access to specialists, optometrical services and certain allied health services.

The Pharmaceutical Benefits Scheme [PBS] allows Australians to access medications at affordable prices. The PBS subsidises around 750 medicines available in more than 1,970 forms.

Australia’s comprehensive immunisation program protects people against harmful diseases. Compared to most other countries, Australia provides a greater range of vaccines free to its citizens.

There have been some improvements between 1998 and 2011, with overall Indigenous mortality rates declining by 12% and Indigenous child mortality rates declining by 29%. The health of Australians in rural areas is also generally poorer than that of people who live in major cities; however, this gap between health outcomes is closing.

1 Institute for Health Metrics and Evaluation, 2010 Global Burden of Disease Study.
In order to ensure that we maintain and continue to improve on health outcomes, we are committed to continuous improvement in all that we do. The Department has been implementing change through the DoHA National Alignment (DNA) to ensure we are in the best position to implement and manage the government’s key health priorities and programs. DNA will help the Department ensure it remains responsive to pressures, while at the same time increasing productivity through simplifying administration and process.

Work has already been undertaken by the Department to address the administrative burden on government funded not-for-profit organisations. The Department has introduced more streamlined administration and business practices, including the implementation of single header, multi-year funding agreements and improved contract management tools and processes. These improvements better able the Department to support these organisations in the delivery of funded services and provide the Department with an increase in health outcomes in return for the same level of investment, through a more strategic approach to health service delivery.

This work is having an immediate benefit. The Department’s Queensland State Office is currently trialling a new initiative with the Royal Flying Doctors Service (RFDS) Queensland which streamlines funding from multiple departmental contracts into a single agreement and schedule. It also replaces the multiple departmental contract managers the RFDS had to deal with, with a single relationship manager. By cutting red tape and ending duplication, considerable efficiencies are being achieved by both the Department and the RFDS. As a result, the RFDS is able to spend more time delivering their services to rural and remote communities and less time on paper work.

Initiatives under the DNA will enable the Department to save time and money, and allow us to do our jobs better on behalf of the Australian community.

Throughout 2013-14, the Department will continue to improve the way we go about our business – within the organisation, with government, our partners and stakeholders, at home and abroad, and for the long-term benefit of the Australian community.

I would like to acknowledge the active contribution the Department’s staff have made in supporting various charities and community events throughout the year. I am particularly proud of the Department’s long-standing support of Hartley Lifecare, with the annual Hartley Lifecare Cycle Challenge raising funds to support its work. Hartley Lifecare is a Canberra-based organisation that provides accommodation support and respite care for children, adults and their families with physical and complex disabilities.

Finally, as part of Canberra’s centenary celebrations, public servants have teamed up to build Boundless Canberra, which will be Australia’s premier all-abilities playground. The playground will cater for children and adults who have vision, hearing and mobility impairments, as well as for people with disorders such as autism.

October 2013
CHIEF MEDICAL OFFICER’S REPORT

Several key health indicators demonstrate the current health status of Australia. This report for 2012-13 highlights the success of Australia’s National Immunisation Program and the reduction in vaccine preventable disease. It discusses the threats posed by emerging new viruses and antimicrobial resistance, and Australia’s preparedness in the event of an outbreak. The impact of early diagnoses of non-communicable diseases, such as cancer, through screening and imaging technologies, is also discussed.

IMMUNISATION

Australia’s comprehensive and successful National Immunisation Program (NIP) contributes to our low infant mortality and high life expectancy rates. The NIP aims to increase national immunisation coverage rates and reduce the incidence of morbidity and mortality due to vaccine-preventable diseases in the Australian community.

The ongoing success of the NIP is demonstrated through the reduction of cases of many vaccine-preventable diseases. For example, since the introduction of the haemophilus influenzae type b (Hib) vaccine in 1993, there has been a 97% reduction in notified cases of Hib in Australia, and we now have one of the lowest rates of Hib in the world.

IMMUNISATION

Australia is achieving good childhood immunisation coverage rates nationally – at or above 90% average coverage for children at one, two and five years of age, although some geographical areas do report significantly lower coverage, which is of significant concern.

EMERGING NEW VIRUSES AND DISEASES

Emerging infectious diseases continue to pose threats to the health of Australians.

Avian influenza A (H5N1), first shown to cause human disease in 1997, continues to pose a threat as a potential pandemic influenza strain. In early 2013, an avian influenza strain A (H7N9) which was not previously reported in people, was identified in China.

Historically, the lowest coverage rate has been for five-year-olds, but coverage in this age group has steadily increased over the past few years, from 89% in 2010-11 to more than 91% in 2012-13. This increase is particularly marked among Indigenous children at five years of age where coverage in 2012-13 was 92.1% compared to 91.5% among all five-year-olds.

Emerging infectious diseases continue to pose threats to the health of Australians. Avian influenza A (H5N1), first shown to cause human disease in 1997, continues to pose a threat as a potential pandemic influenza strain. In early 2013, an avian influenza strain A (H7N9) which was not previously reported in people, was identified in China.
Figure 1: Number of deaths from diseases now vaccinated against in Australia, by decade, 1926-2005

A (H7N9) causes severe respiratory infection. The disease is of concern because most patients have been severely ill, with a death rate of about 30%. Avian influenza A (H7N9) activity declined with the beginning of the Northern Hemisphere summer with sporadic cases reported in July 2013. The Department is maintaining a careful watching brief and can escalate nationally coordinated efforts in response if the virus re-emerges.

Ten years after the severe acute respiratory syndrome, or SARS, virus was first identified and caused severe infections in more than 8,000 people around the world, another related novel virus was identified in September 2012. This virus, now named Middle East Respiratory Syndrome (MERS) coronavirus, resulted in more than 130 laboratory-confirmed cases as of 25 September 2013, with around 40% of those cases dying. Patients presented with severe acute respiratory symptoms, but a number have shown mild flu-like illnesses or have been asymptomatic. All cases had a history of residence in or travel to the Middle East, or contact with travellers returning from these areas.

The source of MERS coronavirus infection and the way it transmits is not known, but it is likely to be of animal origin. However, it is known to have spread on a number of occasions between people who have had close contact, including to health care workers from patients.

So far, there have been no cases of either avian influenza A (H7N9) or MERS coronavirus in Australia.

For both outbreaks, the Department has undertaken a range of planning and response measures in conjunction with the Communicable Diseases Network Australia. This includes issuing advice to health professionals, issuing situation updates, planning surveillance and communications materials and liaising with the Department of Foreign Affairs and Trade on travel advice.

These two international outbreaks highlight that Australia’s continued enhancement of national

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2 Myths and Realities: Number of deaths from diseases now vaccinated against in Australia, by decade 1926-2005.
capabilities has us well-placed to respond to new and emerging communicable disease threats should they occur in Australia.

ANTIMICROBIAL RESISTANCE

Antimicrobial resistance (AMR) is a critical issue impacting on Australia’s health. AMR occurs when a micro-organism becomes resistant to an antimicrobial medicine to which it was originally susceptible. The level of AMR has been increasing globally for a number of years, and there are now some bacterial infections for which there are only a very limited number of antibiotic treatments available. The WHO describes AMR as a looming crisis in which common and usually treatable infections could become life threatening.

If the AMR trend is not reversed, it has the potential to take us to a post-antibiotic era, where life-saving procedures such as chemotherapy, organ transplantation, insertion of medical devices such as catheters, heart valves and hip joints, may no longer be viable treatment options as they depend on antibiotic cover. Along with many other countries, Australia is taking action to combat the problem.

In 2011, an AMR steering committee, comprising clinical experts, researchers and those involved in regulation of antimicrobials as well as safety and quality experts, was formed. In February 2013, we established the Australian Antimicrobial Resistance Prevention and Containment Steering Group. The Steering Group is jointly chaired by the secretaries of the Department of Health and the Department of Agriculture; and the Chief Veterinary Officer and the Chief Medical Officer are members. In recognition that AMR extends across both animal and human health, we are working together to develop a comprehensive, whole-of-system National AMR Prevention and Containment Strategy for Australia.

IMPACT OF EARLY DIAGNOSIS AND SCREENING FOR CANCER

Cancer is a major cause of illness and death in Australia and has a significant impact on individuals, families and the health care system. In 2011, 29.8% of deaths were due to cancer. Early detection of cancer greatly increases the chances for successful treatment.

In Australia, BreastScreen Australia, the National Cervical Screening Program and the National Bowel Cancer Screening Program have shown that screening can detect early signs of the disease, increase the chances of successful treatment and reduce mortality from these cancers. It should be noted that screening tests are not yet available for all cancers.

BreastScreen Australia

- Mortality from invasive breast cancer for women aged 50–69 years has decreased over time in Australia, from 68 deaths per 100,000 women in 1991 to 43 deaths per 100,000 women in 2010. This represents a decrease of 36.5% since the BreastScreen Australia program began in 1991, and is attributable to a number of factors including the early detection of breast cancer through BreastScreen Australia, along with advances in managing and treating invasive breast cancer.  

- In Australia, five-year survival rates from breast cancer have increased from 72% between 1982–1987 to 89% between 2006–2010. Current five-year survival rates are among the best in the world.

Cervical screening

- Cervical cancer incidence in 20–69 year olds remains at a historical low of nine new cases per 100,000 women. This has fallen by approximately 48% (from 17.2 per 100,000 women) since the introduction of the National Cervical Screening Program (NCSP) in 1991.\(^5\)

- The prevalence of vaccine preventable HPV type infections in cervical specimens of females aged 18–24 years decreased significantly from 29% to 7%, four years after the female vaccination program began. This will lead to a reduction in the burden of illness and death due to cervical cancer over time.\(^6\)

- Deaths are also low, historically and by international standards, at two deaths per 100,000 women. The mortality rate has fallen 50% since the introduction of the NCSP in 1991 (four per 100,000 women).

Bowel cancer screening

- Under the National Bowel Cancer Screening Program, Australians turning 50, 55, 60 or 65 years of age are invited to a population-based screening program that aims to help detect bowel cancer early and reduce the number of Australians who die each year from the disease.\(^7\)

- In Australia, five-year relative survival rates for bowel cancer have increased from 48% in 1982-1987 to 66.2% in 2006-2010.

- Program reporting\(^8\) and independent research\(^9\) have indicated that the program has resulted in the detection of earlier stage cancers. The program participants diagnosed as a result of a positive screening test have a higher five-year survival rate than patients presenting with symptoms.

Professor Chris Baggoley
Chief Medical Officer
October 2013

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9 Shift to earlier stage at diagnosis as a consequence of the National Bowel Cancer Screening Program. Cole SR, Tucker GR, Osborne JM, Byrne SE, Bampton PA, Fraser RJ and Young GP; Medical Journal of Australia 2013; 198 (6): 327-30.
I am pleased to provide this Chief Financial Officer Report including an overview of the Department’s 2012-13 financial results.

2012-13 FINANCIAL RESULTS

The Department oversees 42 programs on behalf of Government. Major administered items for 2012-13 included:

- Administered expenses of $51.2 billion primarily related to the payment of subsidies of $9.4 billion for residential, aged care and community programs; personal benefits of $33.7 billion for Medicare services, pharmaceutical services and affordability and choice of health care initiatives; and grants of $7.0 billion with the majority of these made to non-profit organisations ($4.7 billion).

- Administered assets of $1.0 billion incorporating receivables of $0.4 billion, inventories of $0.2 billion predominantly being the National Medical Stockpile and $0.1 billion in internally developed software to support the Personally Controlled Electronic Health Record System.

- Administered liabilities of $2.9 billion principally related to personal benefits of $1.1 billion and provisions for subsidies of $0.4 billion.

The Department successfully delivered its activities to support the 42 programs. A departmental operating deficit, prior to depreciation, of $9.0 million was reported primarily as a consequence of supporting a staff voluntary redundancy program.

The Auditor-General has provided the Department with an unmodified audit opinion for the 2012-13 financial statements. In conducting the 2012-13 financial statement audit the Auditor-General advised that the Department has in place appropriate financial controls which operate effectively.

The Department’s business planning and budgeting framework ensured departmental resources were allocated to meet the Government’s priorities.

Over the last 5 years the Department has proven its ability to support and respond effectively to a number of significant policy reforms while continuing to meet its financial obligations. Key trends for the Department’s financial position for the past 5 years are illustrated in Figures 1, 2 and 3.
KEY BUSINESS REFORMS
The Department is progressing key business reforms to be better placed to meet the financial challenges ahead. Key reforms include automation of grants procurement and program funding in a single system, database alignment in the Department’s Enterprise Data Warehouse, improving IT Governance, expanding the number of agencies receiving services from the Department’s portfolio shared services centre and the introduction of a forecasting and budgeting tool to support improved resource management.

Figure 1: Revenue, Expenses and Operating Result

Note: Expenses from 2010-11 have been reported after the elimination of unfunded depreciation expense under the net cash appropriation framework.
Figure 2: Assets, Liabilities and Net Equity Trend

Figure 3: Current Assets and Liabilities
CHALLENGES AHEAD

The Department is facing a challenging environment in 2013-14 and over the forward estimates period and must continue pursuing all avenues for productivity and efficiency improvement.

The Department’s internal governance framework supports sound decision making which will be required to meet future financial challenges. The Department has a proven track record of sound financial performance.

The Department is taking steps to operate within agreed resources for 2013-14 through undertaking a program of key business reforms and process improvements and maintaining robust budgetary expense controls.

The Department’s limited capital budget requires strong governance over the prioritisation of projects to meet the challenge of maintaining the existing asset base and supporting business process improvement projects.

2012-13 FINANCIAL STATEMENTS

Information on the Department’s financial result can be obtained in Part 4 of the Annual Report including an analysis of the Department’s financial performance.

John Barbeler
Chief Financial Officer
October 2013
From left to right

(Back row): Chris Baggoley AO, Chief Medical Officer; David Learmonth, Deputy Secretary; David Martine, Deputy Secretary; Paul Madden, Deputy Secretary and Chief Information and Knowledge Officer; and Andrew Stuart, Deputy Secretary.

(Front row): David Butt, Deputy Secretary; Jane Halton PSM and Centenary Medal, Secretary, and Kerry Flanagan, Deputy Secretary.
OVERVIEW OF THE DEPARTMENT

The Department’s structure in 2012-13 was based around the key sectors of Australia’s health and ageing system and several cross-portfolio functions. The Department’s state and territory offices represent the organisation’s interests at a local 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 Australian Government agencies.

MACHINERY OF GOVERNMENT CHANGES

On 18 September 2013 the Prime Minister announced changes to the ‘Machinery of Government’. The Hon Peter Dutton MP became Minister for Health, with responsibility also for mental health, and Minister for Sport. Senator the Hon Fiona Nash became Assistant Minister for Health.

Key changes to the Department of Health and Ageing were:

- The Department’s name was changed to the Department of Health.
- Responsibility for aged care was transferred to the new Department of Social Services.
- Responsibility for a number of Indigenous health programs and functions were transferred to the Department of the Prime Minister and Cabinet.
- Responsibility for sport and recreation was transferred to the Department from the Department of Regional Australia, Local Government, Arts and Sport.

Further details on changes to the Department’s responsibilities and legislation administered by the Department is included in the Administrative Arrangements Order issued by the Governor-General on 18 September 2013, available at www.dpmc.gov.au/parliamentary/

This annual report is for the 2012–13 financial year, based on the Department of Health and Ageing’s structure as at 30 June 2013, and reports on the Department’s activities during 2012–13.
### DEPARTMENTAL STRUCTURE CHART AS OF 30 JUNE 2013 CONTINUED

**Secretary** Prof Jane Halton PSM, Centenary Medal

![Therapeutic Goods Administration](image)

<table>
<thead>
<tr>
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<th>Regulatory Support Group</th>
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<tbody>
<tr>
<td>Office of Medicines Authorisation</td>
<td>Office of Laboratories &amp; Scientific Services</td>
<td>Office of Corporate Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of Complementary Medicines</td>
<td>Office of Manufacturing Quality</td>
<td>Office of Information Management</td>
<td></td>
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<tr>
<td>Office of Devices Authorisation</td>
<td>Office of Product Review</td>
<td>Office of Legal Services</td>
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</tr>
<tr>
<td>Office of Scientific Evaluation</td>
<td>Regulatory Compliance Unit</td>
<td>Office of Parliamentary &amp; Strategic Support</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Office of Change &amp; Program Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Office for TGA-ANZTPA
DoHA National Alignment (DNA) is an overarching banner which encapsulates the Department's internal change management program. DNA is seeing the Department become a more modern and contemporary, capable and flexible organisation, where staff are better enabled and supported to deliver on the government's agenda.

Under the DNA the Department is putting into place a range of reforms that will ensure we are in the best position to implement and manage the government's key priorities and programs. During 2012-13 the DNA implemented a number of efficiency measures including:

- updating the Department's office and records management technology;
- streamlining the Department's financial services and human resources practices;
- improvements to the way the Department allocates its spending on information technology; and
- the adoption of a set of best practice principles for working with the not-for-profit sector.

DEPARTMENTAL ACTIVITY SURVEY

To get a clear and up-to-date view of the Department's workload and to measure the effectiveness of efficiencies being made through the DNA, the Departmental Activity Survey was introduced. Staff complete the survey on a randomly selected day, with up to 60 staff being surveyed on a particular day. Most staff will complete the survey up to four times a year.

The survey provides a useful and practical whole-of-department picture of the Department's workload which is used to:

- ensure departmental workloads are sustainable into the future;
- monitor administrative changes to ensure they are increasing the Department's efficiency, and
- allow the Department to find new ways to be more efficient.

FLEXIBLE FUNDS

The Department consolidated 159 programs into 18 flexible Funds with effect from 1 July 2011.

The flexible Funds reduce red tape, provide increased flexibility to respond to emerging issues and deliver better value with public money.

The flexible funding pools are being used to progressively streamline grant funding processes for stakeholders, reduce the administrative burden and allow service providers to focus on service delivery.

The Department continues to undertake both open competitive and targeted grant rounds consistent with relevant Fund guidelines. Since July 2011 nine open funding rounds and twenty six targeted funding rounds have commenced or concluded. These approaches are advertised on the Tenders and Grants page of the Department's website.

The 18 Funds are:

- Chronic Disease Prevention and Service Improvement Fund;
- Communicable Disease Prevention and Service Improvement Grants Fund;
- Substance Misuse Prevention and Service Improvement Grants Fund;
- Substance Misuse Service Delivery Grants Fund;
- Health Social Surveys Fund;
- Aged Care Workforce Fund;
- Aged Care Service Improvement and Healthy Ageing Grants Fund;
- Single Point of Contact for Health Information, Advice and Counselling Fund;
- Regionally Tailored Primary Care Initiatives through Medicare Locals Fund;
- Practice Incentives for General Practices Fund;
- Rural Health Outreach Fund;
- Aboriginal and Torres Strait Islander Chronic Disease Fund;
- Health System Capacity Development Fund;
- Health Surveillance Fund;
- Quality Use of Diagnostics, Therapeutics and Pathology Fund;

1 www.health.gov.au/flexfunds

• Health Workforce Fund;
• Indemnity Insurance Fund; and
• Health Protection Fund.

GRANT REFORM
Following on from the implementation of flexible Funds, the Department has commenced the next stage in improving the management of grants.

The Department will improve how it communicates and works with grant recipients, other government agencies, and internally with a view to further reducing red tape.

In 2012-13 the Department commenced the establishment of a new Grants Services Division. Establishment of the new division will continue in 2013-14. The division will lead the improvement of grants management and reduce red tape and the administrative workload on funded organisations by:
• ensuring funded organisations have a consistent experience when dealing with the Department;
• implementing single-header agreements (for non-government organisations which have multiple agreements with the Department);
• developing a proportional and fit-for-purpose approach to management of grant risk, which includes risk assessment tools, processes and treatments;
• ensuring the timing of grant rounds are consistent with the Department’s principles for grants administration;
• providing procedural, technical, legal and probity advice to areas of the Department;
• ensuring that questions on grants related matters are directed to the most appropriate area of the Department; and
• sharing knowledge and experience within the Department and with grants recipients to support better practice and continuous improvement.


SINGLE DESK TRIAL REDUCING RED TAPE FOR NGOs
Royal Flying Doctor Service (RFDS) Queensland staff will be able to spend more time delivering their often lifesaving service to rural and remote communities and less on paper work under a new initiative being trialled by the Department.

Patients are set to be the winners from the initiative that streamlines funding from multiple areas within the Department into a single agreement and schedule, ending duplication, cutting red tape and achieving efficiencies for both the Department and the RFDS.

The Department also provided a single relationship manager with the RFDS, replacing the many contract managers the RFDS was previously required to be in contact with.

The Queensland RFDS is a major provider of aero-medical services and primary health care services to many of Queensland’s rural and remote communities, including Indigenous communities in some of the most distant corners of the state.

The Single Desk Trial consolidates all program funding into a single schedule and the design of the contract now comprehensively reflects the consolidated service delivery provided by the Queensland RFDS. Duplication of reporting no longer occurs and the RFDS is now able to provide a complete view of the program funding outcomes that are being achieved.

The Queensland RFDS has already provided details of emerging benefits including the ability to reallocate resources from administration to service delivery. The RFDS (Qld) Chief Executive Officer, Mr Nino Di Marco, recently wrote;

“Through the flexibility of the funding streams, we were able to achieve savings in administration support staff, equivalent to 3 full time employees. Not only has this assisted in bringing greater efficiencies through consistent reporting, and reduced administration time, the savings could be redirected to increase frontline staff, allowing increased clinic time and patient contacts.”

The new arrangements support efficiencies in service delivery and enable the RFDS to be more responsive to regional health service needs. Bringing all the funding into a single schedule has enabled the RFDS to better utilise health service teams. Staff who manage delivering services on the ground are now able to mix and use the skills of health teams in direct response to the immediate needs of the community.

The Single Desk Trial is due for completion by mid-2014 and will be used to inform strategies to reduce red tape for other non-government organisations which have multiple agreements with the Department.
CONNECTING WITH THE COMMUNITY

SOCIAL MEDIA

Communication is integral to the Department’s engagement with Australians – and social media is a key part of this. Social media is helping the Department connect with the community in ways that are meaningful to people. Through social media, the Department shares information about health and ageing policies and programs.

Key projects delivered during 2012-13 included:

- Using Twitter to share important information, in real time, about immunisation during the SBS Television documentary, Jabbed.
- Creating and sharing information videos on our website and YouTube, including eHealth case studies.
- Sharing images from our website and portfolio agency websites on Pinterest, including health campaign materials for download.
- Using Facebook to connect with university students about the Department’s Graduate Development Program.
- Developing iPhone and Android apps to make it easier for people to access health information on mobile devices.
- Using blogs to engage with the community on specific programs and health campaigns, including the Aged Care Complaints Scheme.

The Department’s verified Twitter account provides links and information about health and ageing from Department and portfolio agency websites. At 30 June 2013, the account had 10,099 followers. The Department’s Twitter account can be found at www.twitter.com/healthgovau

We look forward to building on these achievements in years ahead.

The my child’s eHealth record app is for Australian health care consumers with children under the age of 14 years. It allows parents and authorised representatives to access the child’s eHealth record and add and view information about the child’s development.

The National Health Services Directory app is a national health information resource supported by all Australian governments. It provides information such as location and opening hours for GPs, pharmacies, emergency departments and hospitals straight to your mobile, whenever and wherever you might need it across Australia.

The Quit For You, Quit For Two smartphone app (for iPhone and Android) is designed to help women fight the urge to smoke by distracting them using games, providing words of encouragement and baby facts.

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THE HON TANYA PLIBERSEK
MP, MINISTER FOR HEALTH

The Minister for Health held overarching policy and coordinating responsibility for issues pertaining to health, including high level responsibility for the portfolio’s responsibilities relating to the Council of Australian Governments’ reform agenda, and had specific administrative responsibility for:

- Medicare benefits;
- hospitals;
- medical indemnity;
- private health insurance;
- health workforce issues (including policy oversight of all areas of workforce distribution, education and training);
- the Pharmaceutical Benefits Scheme;
- pharmacy issues;
- population health, including issues concerning BBVs/STIs including HIV/AIDS, and other communicable diseases, immunisation, obesity, specific women’s health issues, environmental health issues and drug abuse reduction;
- eye health;
- national health priorities (with the exception of injury prevention, arthritis and musculoskeletal conditions);
- rural and regional health;
- biosecurity and bioterrorism;
- diagnostics and technology;
- e-health;
- tobacco;
- human cloning and stem cell research;
- health and medical research; and
- asthma.

THE HON MARK BUTLER MP,
THE MINISTER FOR MENTAL
HEALTH AND AGEING

As Minister for Mental Health and Ageing, the Hon Mark Butler MP, had responsibility for:

- mental health and suicide prevention;
- aged care reform;
- the National Strategy for an Ageing Australia;
- the National Continence Management Strategy;
- a range of programs to meet the needs of Australia’s ageing population, including:

- Home and Community Care Program;
- Residential Care;
- The National Respite for Carers Program – including the Carer Information and Support Program, Carer Respite Centres and Carer Resource Centres;
- Aged Care Assessment;
- Community Aged Care Packages;
- Assistance with Care and Housing for the Aged;
- Complaints Resolution Scheme;
- Dementia Support Services;
- Advocacy Services; and
- Aged Care Standards and Accreditation Agency,

- multipurpose services;
- Hearing Services Program and policy;
- injury and falls prevention;
- arthritis and musculoskeletal conditions;
- palliative care;
- illicit drugs; and
- alcohol.
THE HON WARREN SNOWDON MP, MINISTER FOR INDIGENOUS HEALTH

As Minister for Indigenous Health, the Hon Warren Snowdon MP, had responsibility for:

Indigenous health including;
• The National Aboriginal and Torres Strait Islander Health Plan;
• prevention and management of chronic disease by Indigenous health services;
• child and maternal health;
• improved access to effective substance use and health services;
• social and emotional wellbeing services;
• workforce capacity; and
• men’s health.

THE HON SHAYNE NEUMANN MP, PARLIAMENTARY SECRETARY FOR HEALTH AND AGEING

As Parliamentary Secretary, the Hon Shayne Neumann MP, assisted Minister Plibersek by assuming responsibility for matters relating to:

• Therapeutic Goods Administration;
• Office of the Gene Technology Regulator;
• National Industrial Chemicals Notification and Assessment Scheme;
• Office of Chemical Safety;
• Australian Radiation Protection and Nuclear Safety Agency;
• Food Standards Australia New Zealand;
• National Blood Authority;
• food policy;
• nanotechnologies;
• gene technology; and
• blood and organ donation.

THE HON MELISSA PARKE MP, PARLIAMENTARY SECRETARY FOR MENTAL HEALTH

As Parliamentary Secretary, the Hon Melissa Parke MP, assisted Minister Butler by assuming responsibility for matters relating to:

• suicide prevention including the National Suicide Prevention Program, Taking Action to Tackle Suicide and the Australian Suicide Prevention Advisory Council;
• E-mental health including mindhealthconnect, mindspot and teleweb;
• the National Depression and Anxiety Initiative; and
• the National Pennatal Depression Initiative.
PORTFOLIO OUTCOMES

Outcomes are the Government’s intended results, benefits or consequences for the Australian community. The Government requires agencies, such as the Department, to use outcomes as a basis for budgeting, measuring performance and reporting. Annual administered funding is appropriated on an outcomes basis.

As at 30 June 2013, the Health and Ageing portfolio worked within a 32 outcome structure. 14 outcomes were specific to the Department, while the remaining 18 were specific to the portfolio agencies.

In 2012-13, the portfolio outcome structure was amended to include one new portfolio agency: the National Health Funding Body, to provide transparent and efficient administration and funding of the Australian public hospital system.

DEPARTMENT-SPECIFIC OUTCOMES

Listed below are the 14 outcomes relevant to the Department, the programs managed under each outcome, and the Divisions responsible as at 30 June 2013.

<table>
<thead>
<tr>
<th>Outcome 1 Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>A reduction in the incidence of preventable mortality and morbidity in Australia, including through regulation and national initiatives that support healthy lifestyles and disease prevention.</td>
</tr>
<tr>
<td>1.1: Prevention, Early Detection and Service Improvement</td>
</tr>
<tr>
<td>1.2: Communicable Disease Control</td>
</tr>
<tr>
<td>1.3: Drug Strategy</td>
</tr>
<tr>
<td>1.4: Regulatory Policy</td>
</tr>
<tr>
<td>1.5: Immunisation</td>
</tr>
<tr>
<td>1.6: Public Health</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 2 Access to Pharmaceutical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to cost-effective medicines, including through the Pharmaceutical Benefits Scheme and related subsidies, and assistance for medication management through industry partnerships.</td>
</tr>
<tr>
<td>2.1: Community Pharmacy and Pharmaceutical Awareness</td>
</tr>
<tr>
<td>2.2: Pharmaceuticals and Pharmaceutical Services</td>
</tr>
<tr>
<td>2.3: Targeted Assistance – Pharmaceuticals</td>
</tr>
<tr>
<td>2.4: Targeted Assistance – Aids and Appliances</td>
</tr>
</tbody>
</table>
### Outcome 3 Access to Medical Services
Access to cost-effective medical, practice nursing and allied health services, including through Medicare subsidies for clinically relevant services.

<table>
<thead>
<tr>
<th>3.1: Medicare Services</th>
<th>Acute Care Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2: Targeted Assistance – Medical</td>
<td>Medical Benefits Division</td>
</tr>
<tr>
<td>3.3: Diagnostic Imaging Services</td>
<td>Population Health Division</td>
</tr>
<tr>
<td>3.4: Pathology Services</td>
<td></td>
</tr>
<tr>
<td>3.5: Chronic Disease – Radiation Oncology</td>
<td></td>
</tr>
</tbody>
</table>

### Outcome 4 Aged Care and Population Ageing
Access to quality and affordable aged care and carer support services for older people, including through subsidies and grants, industry assistance, training and regulation of the aged care sector.

<table>
<thead>
<tr>
<th>4.1: Access and Information</th>
<th>Ageing and Aged Care Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2: Home Support</td>
<td>Office of Aged Care Quality and Compliance</td>
</tr>
<tr>
<td>4.3: Home Care</td>
<td></td>
</tr>
<tr>
<td>4.4: Residential and Flexible Care</td>
<td></td>
</tr>
<tr>
<td>4.5: Workforce and Quality</td>
<td></td>
</tr>
<tr>
<td>4.6: Ageing and Service Improvement</td>
<td></td>
</tr>
</tbody>
</table>

### Outcome 5 Primary Care
Access to comprehensive, community-based health care, including through first point of call services for prevention, diagnosis and treatment of ill-health, and for ongoing management of chronic disease.

<table>
<thead>
<tr>
<th>5.1: Primary Care Education and Training</th>
<th>Primary and Ambulatory Care Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2: Primary Care Financing, Quality and Access</td>
<td></td>
</tr>
<tr>
<td>5.3: Primary Care Practice Incentives</td>
<td></td>
</tr>
</tbody>
</table>

### Outcome 6 Rural Health
Access to health services for people living in rural, regional and remote Australia, including through health infrastructure and outreach services.

<table>
<thead>
<tr>
<th>6.1: Rural Health Services</th>
<th>Primary and Ambulatory Care Division</th>
</tr>
</thead>
</table>

### Outcome 7 Hearing Services
A reduction in the incidence and consequence of hearing loss, including through research and prevention activities, and access to hearing services and devices for eligible people.

<table>
<thead>
<tr>
<th>7.1: Hearing Services</th>
<th>Regulatory Policy and Governance Division</th>
</tr>
</thead>
</table>
### Outcome 8 Indigenous Health
Closing the gap in life expectancy and child mortality rates for Indigenous Australians, including through primary health care, child and maternal health, and substance use services.

<table>
<thead>
<tr>
<th>8.1: Aboriginal and Torres Strait Islander Health</th>
<th>Office for Aboriginal and Torres Strait Islander Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health and Drug Treatment Division</td>
</tr>
</tbody>
</table>

### Outcome 9 Private Health
Improved choice in health services by supporting affordable quality private health care, including through private health insurance rebates and a regulatory framework.

<table>
<thead>
<tr>
<th>9.1: Private Health Insurance</th>
<th>Acute Care Division</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Benefits Division</td>
</tr>
</tbody>
</table>

### Outcome 10 Health System Capacity and Quality
Improved long-term capacity, quality and safety of Australia’s health care system to meet future health needs, including through investment in health infrastructure, international engagement, consistent performance reporting and research.

<table>
<thead>
<tr>
<th>10.1: Chronic Disease – Treatment</th>
<th>Acute Care Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2: eHealth Implementation</td>
<td>eHealth Division</td>
</tr>
<tr>
<td>10.3: Health Information</td>
<td>Office of Health Protection</td>
</tr>
<tr>
<td>10.4: International Policy Engagement</td>
<td>Pharmaceutical Benefits Division</td>
</tr>
<tr>
<td>10.5: Research Capacity and Quality</td>
<td>Population Health Division</td>
</tr>
<tr>
<td>10.6: Health Infrastructure</td>
<td>Portfolio Strategies Division</td>
</tr>
<tr>
<td></td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td></td>
<td>Regulatory Policy and Governance Division</td>
</tr>
</tbody>
</table>

### Outcome 11 Mental Health
Improved mental health and suicide prevention, including through targeted prevention, identification, early intervention and health care services.

| 11.1: Mental Health | Mental Health and Drug Treatment Division |

### Outcome 12 Health Workforce Capacity
Improved capacity, quality and mix of the health workforce to meet the requirements of health services, including through training, registration, accreditation and distribution strategies.

| 12.1: Workforce and Rural Distribution | Health Workforce Division |
| 12.2: Workforce Development and Innovation | Mental Health and Drug Treatment Division |
|                                        | Primary and Ambulatory Care Division |
**Outcome 13 Acute Care**
Improved access to public hospitals, acute care services and public dental services, including through targeted strategies, and payments to state and territory governments.

13.1: Blood and Organ Donation Services
Acute Care Division

13.2: Medical Indemnity
Medical Benefits Division

13.3: Public Hospitals and Information
Regulatory Policy and Governance Division

**Outcome 14 Biosecurity and Emergency Response**
Preparedness to respond to national health emergencies and risks, including through surveillance, regulation, prevention, detection and leadership in national health coordination.

14.1: Health Emergency Planning and Response
Office of Health Protection
Regulatory Policy and Governance Division

**PORTFOLIO AGENCY-SPECIFIC OUTCOMES**
Listed below is the outcome belonging to each Health and Ageing portfolio agency in 2012-13. Agencies’ performance against these outcomes is reported in their respective annual report.

<table>
<thead>
<tr>
<th>Portfolio Agency</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care Standards and Accreditation Agency Ltd</td>
<td>High quality residential aged care for older people, including through accrediting Australian Government funded aged care homes, identifying best practice, and providing information and education to the aged care sector.</td>
</tr>
<tr>
<td>Australian Commission on Safety and Quality in Health Care</td>
<td>Improved safety and quality in health care across the health system, including through the development, support for implementation, and monitoring of national clinical safety and quality guidelines and standards.</td>
</tr>
<tr>
<td>Australian Institute of Health and Welfare</td>
<td>A robust evidence-base for the health, housing and community sectors, including through developing and disseminating comparable health and welfare information and statistics.</td>
</tr>
<tr>
<td>Australian National Preventive Health Agency</td>
<td>A reduction in the prevalence of preventable disease, including through research and evaluation to build the evidence base for future action, and by managing lifestyle education campaigns and developing partnerships with non-government sectors.</td>
</tr>
<tr>
<td>Australian Organ and Tissue Donation and Transplantation Authority</td>
<td>Improved access to organ and tissue transplants, including through a nationally coordinated and consistent approach and system.</td>
</tr>
<tr>
<td>Australian Radiation Protection and Nuclear Safety Agency</td>
<td>Protection of people and the environment through radiation protection and nuclear safety research, policy, advice, codes, standards, services and regulation.</td>
</tr>
<tr>
<td>Cancer Australia</td>
<td>Minimised impacts of cancer, including through national leadership in cancer control, with targeted research, cancer service development, education and consumer support.</td>
</tr>
<tr>
<td>Portfolio Agency</td>
<td>Outcome</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Food Standards Australia New Zealand</td>
<td>A safe food supply and well-informed consumers in Australia and New Zealand, including through the development of food regulatory measures and the promotion of their consistent implementation, coordination of food recall activities and the monitoring of consumer and industry food practices.</td>
</tr>
<tr>
<td>General Practice Education and Training Ltd</td>
<td>Improved quality and access to primary care across Australia, including through general practitioner vocational education and training for medical graduates.</td>
</tr>
<tr>
<td>Health Workforce Australia</td>
<td>Improved health workforce capacity, including through a national approach to workforce policy and planning across all health disciplines, which effectively integrates research, education and training.</td>
</tr>
<tr>
<td>Independent Hospital Pricing Authority</td>
<td>Promote improved efficiency in, and access to, public hospital services primarily through setting efficient national prices and levels of block funding for hospital activities.</td>
</tr>
<tr>
<td>National Blood Authority</td>
<td>Access to a secure supply of safe and affordable blood products, including through national supply arrangements and coordination of best practice standards within agreed funding policies under the national blood arrangements.</td>
</tr>
<tr>
<td>National Health Funding Body</td>
<td>Provide transparent and efficient administration of Commonwealth, state and territory funding of the Australian public hospital system, and support the obligations and responsibilities of the Administrator of the National Health Funding Pool.</td>
</tr>
<tr>
<td>National Health and Medical Research Council</td>
<td>Improved health and medical knowledge, including through funding research, translating research findings into evidence-based clinical practice, administering legislation governing research, issuing guidelines and advice for ethics in health and the promotion of public health.</td>
</tr>
<tr>
<td>National Health Performance Authority</td>
<td>Contribute to transparent and accountable health care services in Australia, including through the provision of independent performance monitoring and reporting, the formulation of performance indicators, and conducting and evaluating research.</td>
</tr>
<tr>
<td>Private Health Insurance Administration Council</td>
<td>Prudential safety and competitiveness of the private health insurance industry in the interests of consumers, including through efficient industry regulation.</td>
</tr>
<tr>
<td>Private Health Insurance Ombudsman</td>
<td>Public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.</td>
</tr>
<tr>
<td>Professional Services Review</td>
<td>A reduction of the risks to patients and costs to the Australian Government of inappropriate clinical practice, including through investigating health services claimed under the Medicare and pharmaceutical benefits schemes.</td>
</tr>
</tbody>
</table>
2.1 PERFORMANCE BY OUTCOME

Outcome 1 Population Health 28
Outcome 2 Access to Pharmaceutical Services 58
Outcome 3 Access to Medical Services 72
Outcome 4 Aged Care and Population Ageing 84
Outcome 5 Primary Care 106
Outcome 6 Rural Health 118
Outcome 7 Hearing Services 124
Outcome 8 Indigenous Health 130
Outcome 9 Private Health 140
Outcome 10 Health System Capacity and Quality 146
Outcome 11 Mental Health 162
Outcome 12 Health Workforce Capacity 170
Outcome 13 Acute Care 180
Outcome 14 Biosecurity and Emergency Response 190

2.2 AGENCY RESOURCE STATEMENT 200
OUTCOME 1
POPULATION HEALTH

A reduction in the incidence of preventable mortality and morbidity in Australia, including through regulation and national initiatives that support healthy lifestyles and disease prevention

MAJOR ACHIEVEMENTS

• Australia is a world leader in tobacco control. Taking full effect from 1 December 2012, all tobacco products are required to be sold in plain packaging and have new, larger health warnings.

• Every day, the National Bowel Cancer Screening Program is saving lives through early detection. The Department has successfully negotiated with service providers to expand the program to include people turning 60 from 1 July 2013.

• Australia is the first country to introduce a national Human Papillomavirus (HPV) vaccination program. In early February 2013, the program was extended to include males. Eligible females and males aged 12 to 13 years are receiving the vaccine free of charge through the ongoing school-based vaccination program and a two year catch-up program for males aged 14 to 15 years.
  - The nation’s obesity crisis is being tackled head-on. The 2013 Australian Dietary Guidelines and 2013 Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children were released to help health professionals improve nutrition, treat obesity and overweight and improve community health and wellbeing.

• The potential impact of industrial chemicals on human health and the environment is being reduced. Using the Inventory Multi-tiered Assessment and Prioritisation (IMAP) Framework (introduced in July 2012), the National Industrial Chemicals Notification and Assessment Scheme (NICNAS) conducted close to 1,000 assessments for industrial chemicals already in use in Australia, making recommendations on a significant number of chemicals.

CHALLENGES

• While Australia’s anti-smoking message is being increasingly heard around the world, the fight is not yet over. Australia will continue to respond to international legal challenges to the new requirements for plain packaging of tobacco products.

• It is crucial that public confidence in the safety of the National Immunisation Program is maintained. Ongoing monitoring of correct administration of vaccines to children will continue.

• Adult overweight and obesity rates are continuing to rise, with 62.8% of Australians aged 18 years and over being overweight or obese, according to the 2011-12 Australian Health Survey. The development of revised national guidelines will promote prevention of overweight and obesity.

• Supporting a whole of government response to new psychoactive substances, which often mimic the effects of longstanding illicit drugs.

• Continuing to balance both industry and community considerations as the assessment of the impact of new industrial chemicals becomes increasingly complex.
PERFORMANCE

**PERIOD** | **MET** | **SUBSTANTIALLY MET** | **NOT MET**
---|---|---|---
2012-13 | 71.2% | 23.7% | 5.1%
2011-12 | 73.3% | 18.7% | 6.8%

PROGRAMS CONTRIBUTING TO OUTCOME 1

- Program 1.1: Prevention, early detection and service improvement
- Program 1.2: Communicable disease control
- Program 1.3: Drug strategy
- Program 1.4: Regulatory policy
- Program 1.5: Immunisation
- Program 1.6: Public health
TRENDS

More than nine out of every 10 Australian children are now immunised. Immunisation rates continue to be high. Childhood immunisation rates are measured at one, two and five years of age with five year olds having the lowest rate. In 2011, the fully immunised coverage rate for five year olds reached almost 90% with a rate of 89.84%. This has steadily increased and in 2012, for the first time, the five year old coverage rate exceeded 90% with a rate of 90.80%. In 2013, the rate increased to 91.54%.

See graph under Program 1.5.

OUTCOME STRATEGY

Outcome 1 aims to reduce the incidence of preventable mortality and morbidity throughout Australia by tackling lifestyle factors associated with chronic illness, detecting disease earlier when it does occur, and reducing the spread of infectious disease. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

PROGRAM 1.1: PREVENTION, EARLY DETECTION AND SERVICE IMPROVEMENT

Program 1.1 aims to reduce the incidence of chronic disease by encouraging Australians to lead healthy lifestyles, supporting early detection and prevention of cancer, and improving chronic disease management.

Reduce the incidence of chronic disease and promote healthier lifestyles

Chronic disease is responsible for a significant portion of disease burden in Australia. The Department is tackling this in a number of areas, including asthma and diabetes.

Chronic Disease Prevention and Service Improvement Fund

Established in July 2011, the Chronic Disease Prevention and Service Improvement Fund provides a flexible funding pool for initiatives related to chronic disease service improvement and prevention, particularly within the primary and community sectors.

During 2012-13, the Government provided $67 million for a range of chronic disease prevention and service improvement activities in accordance with the fund guidelines. These included community education programs and training of school and preschool teachers, medical, allied health and aged care staff on asthma and linked chronic respiratory conditions. Aboriginal and Torres Strait Islander health workers located primarily in rural and remote areas were also trained to provide accurate diabetes-related pathology testing on site to better manage diabetes.

Deliverable: Conduct a grants round under the Chronic Disease Prevention and Service Improvement Fund

2012-13 Reference Point: Negotiation of new funding agreements to be completed by June 2013, to enable funding to commence from 2013-14

Result: Met

During 2012-13, the Department conducted a targeted grants round for musculoskeletal activities. Funding agreements were executed with Arthritis Australia and Osteoporosis Australia, with funding commencing from June 2013.
**KPI:** Effective implementation of the Chronic Disease Prevention and Service Improvement Fund activities

**2012-13 Reference Point:** Regular progress reports on key milestones from contracted organisations indicate that activities are being implemented effectively in accordance with contractual arrangements

**Result:** Met

The Department monitored implementation of funded activities through regular progress reports from the funded organisations. Progress was demonstrated across a range of activities, from large well-established national projects, such as quality assurance for Aboriginal and Torres Strait Islander medical services and asthma management, to newer projects addressing specific areas of need, such as macular degeneration and epilepsy activities.

### Support early detection and prevention of cancer through screening initiatives

**Bowel Cancer Screening**

In the 2012–13 Budget, the Australian Government committed to expand the National Bowel Cancer Screening Program to include 60 year olds from July 2013 and 70 year olds from July 2015. The phased implementation of biennial screening for all Australians aged between 50 and 74 years of age will begin from 2017-18.

In 2012–13, the Department worked with program partners, including state and territory governments, to implement the expansion. This included providing information and advice about the changes to the program to GPs and Medicare Locals, and consumer information in 19 different languages.

**Deliverable:** Implement new contract for the provision of faecal occult blood tests and pathology services for the National Bowel Cancer Screening Program following completion of Request for Tender process

**2012-13 Reference Point:** Timely implementation of new contract by March 2013

**Result:** Met

The contract was signed in February 2013.

**KPI:** Percentage of people invited to take part in the National Bowel Cancer Screening Program who participated

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>41.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Actual:</strong></td>
<td>Data not available</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Data not available</td>
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</tbody>
</table>

Eligible Australians who turned 50, 55 and 65 years of age in 2012 were invited to undertake screening in the National Bowel Cancer Screening Program between 1 July 2012 and 30 June 2013. As there is a time lag between an invitation and the return of a test, the participation rates for 2012 will be reported in the Australian Institute of Health and Welfare (AIHW) *National Bowel Cancer Screening Program Annual Monitoring* report published in June 2014. In 2011-12, 35% of invitees returned a test, compared with 37% in 2010-11.
Australian lives are being saved as a result of the National Bowel Cancer Screening Program.

The program provides free bowel cancer tests (faecal occult blood tests, or FOBTs) to mature age people. In 2012-13, the program provided screening to people turning 50, 55 and 65.

Screening to detect cancer before it shows symptoms is important because bowel cancer is one of the most common forms of cancer in Australia. Around 80 Australians each week die from bowel cancer, but it can be treated successfully if detected in its early stages.

The following is a letter received by the Department from one Australian man who is very thankful that he took up the offer of a free bowel cancer test.

Testimonial for the National Bowel Cancer Screening Program

I have always been fit and healthy and had not suffered any symptoms of bowel cancer, so I had no reason to think there was any urgent need for carrying out the FOBT. In fact, when I received the kit I read the instructions and thought it was a good idea, but didn’t get round to doing it for many months. When I did, the results were sent to me within a few days informing me of a positive FOBT result. After a consultation with my GP, I was referred for a colonoscopy which detected cancer. I subsequently had bowel re-section surgery to remove the cancer, and have since been informed that there are no indications of the cancer having spread. I therefore consider myself very fortunate that the cancer was detected in its early stages and that it could be treated. Without the screening program, I would have been totally unaware of the cancer until the symptoms had become life threatening and would have required more extensive surgery and on-going treatment.

I have since learned that the first signs of bowel cancer are invisible and only detectable microscopically. In addition, the earlier the cancer is detected the simpler the procedure to treat it. The screening program aims to detect any cancer at an early stage, prior to any symptoms, so that they can be treated and cured more easily.

I highly recommend the screening program to anyone, and to carry out the simple non-invasive test as early as possible. I very much support and endorse the fantastic work that the NBCSP team do, as they are quite simply saving people’s lives.

Michael Wade, aged 51

People eligible to participate in the program receive an invitation by mail. They can complete the simple test in the privacy of their own home and mail it to a pathology laboratory for analysis.

More detailed information can be found on the Department’s cancer screening website.¹

Anyone, including younger people, who have concerns about their risk of developing bowel cancer, should discuss their health with their general practitioner.

Breast Cancer Screening

Screening for breast cancer saves lives. From 2013-14, BreastScreen Australia will be expanded so that women 70-74 years of age will be actively invited to participate in free breast screening.

During 2012-13, the Department continued to work with the states and territories to provide free screening, targeted at women 50-69 years of age.

¹ www.cancerscreening.gov.au/
Deliverable: Review and update BreastScreen Australia’s accreditation system

2012-13 Reference Point: Review completed by June 2013

Result: Substantially met

In 2011-12, the Department undertook to review BreastScreen Australia’s accreditation system, including the 173 National Accreditation Standards, to streamline the system while maintaining quality of services.

In 2012-13, all aspects of the system were reviewed and in-principle approval for a revised system was provided by the Standing Committee on Screening (SCoS) in November 2012. The pilot of this revised system will be evaluated, and the final accreditation system will be subsequently provided to the SCoS for approval in late 2013.

The revised system will be more streamlined, reduce duplication and increase accountability and transparency in how services are rated. It is anticipated that from 1 January 2015, all BreastScreen Australia services will need to submit applications under the new system.

Deliverable: Undertake a BreastScreen Australia project to improve workforce retention and recruitment of radiographers and radiologists through the provision of development and training opportunities

2012-13 Reference Point: Project completed by June 2013

Result: Met

The BreastScreen Australia workforce project was undertaken to increase the supply, recruitment and retention of the BreastScreen Australia workforce, and to support the rollout of digital mammography. Initiatives included support to complete postgraduate studies in Breast Sonography and the Certificate of Clinical Proficiency in Mammography. Other workforce initiatives included the development of a Graduate Diploma in Mammography and online courses and programs for radiographers and radiologists in order to monitor their performance, assist in professional development, and provide quality assurance training.

KPI: Percentage of women in the target age group participating in the BreastScreen Australia Program

2012-13 Target: 55.2%
2012-13 Actual: 54.6% (for two year period from 2010 to 2011)

Result: Substantially met

From 2010 to 2011, 54.6% of women in the target age group participated in the program. This compares to 55.2% during 2008 and 2009, and 56.1% during 2006 and 2007.

Since the introduction of BreastScreen Australia in 1991, there has been a reduction in breast cancer mortality in women 50-69 years of age of 36.5%. This is attributable to early detection through screening and advances in the management and treatment of breast cancer. The BreastScreen Australia Evaluation Report 2009 found a 25% decrease in mortality which is directly attributable to screening.

In Australia, five-year survival rates from breast cancer have increased from 72% between 1982-1987 to 89% between 2006-2010.

Cervical Screening

The Department continued work in the areas of early detection and prevention of cervical cancer through the National Cervical Screening Program. Since the introduction of this program in 1991, there has been a 50% reduction in deaths from cervical cancer.

An evidence-based review of the national cervical screening policy and program is being managed by the Department. A draft review of the evidence was released for public consultation in June 2013 and the review will be completed by June 2014.

2 Australian Institute of Health and Welfare & Cancer Australia 2012, BreastScreen Australia monitoring report 2009-2010, Cancer series no. 72 Cat. no. CAN68 Canberra AIHW
3 Australian Institute of Health and Welfare & Cancer Australia 2012, Breast cancer in Australia : an overview. Cancer series no. 71 Cat. no. CAN67 Canberra AIHW
KPI: Percentage of women in the target age group participating in the National Cervical Screening Program

2012-13 Target: 58.6%  
2012-13 Actual: 57.2% (for two year period from 2010 to 2011)

Result: Substantially met

Cervical screening rates are typically reported over a two year period in Australia, in line with the policy for women to have a pap smear every two years. The two year participation rate for women aged 20-69 years from 2010 to 2011 is 57.2%. The three year participation rate from 2009 to 2011 for women aged 20-69 years was 70%, which is among the best participation rates internationally.

The number of women aged 20-69 years participating in cervical screening increased by 5,269 in 2010-11. While overall participation is very good, it is thought that HPV vaccinated women may be screening less often, reflecting a slight drop in overall participation rates. The Department is continuing to educate younger women that regular pap tests are important for the prevention of cervical cancer.

NATIONAL HPV VACCINATION PROGRAM

Young Australian women and men are now seeing the benefits of the Human Papillomavirus (HPV) vaccination program.

HPV is one of the most common sexually transmissible infections in Australia. It is highly contagious, passed on through sexual contact. Most people who have the virus are unaware of it, but four out of five Australians are likely to have a HPV infection at some stage in their life. There are different types of HPV. Vaccination can prevent the types which cause genital warts and others associated with cancers such as penile, anal, cervical, vulval, and vaginal cancers. Australia was the first country to introduce an ongoing, government-funded National HPV Vaccination Program. It began with girls and women up to the age of 26 with an ongoing program for girls aged 12-13 years. In February 2013, the program was extended to 12 and 13 year old school boys, with a catch-up program for boys up to 15 years. Vaccinating males helps to protect them from a range of HPV-related cancers and genital warts, and will continue to reduce rates of cervical cancer among females through ‘herd immunity’ effects.

More than 70 per cent of Australian girls aged 15 years have received all three doses of HPV vaccine, one of the highest rates in the world.

More than seven million doses of the vaccine have been distributed in Australia so far. The safety profile of the vaccine is closely monitored, with rapid reporting to the Therapeutic Goods Administration of acute adverse events.

Since the program began in 2007, there has been a significant reduction in HPV-related infections in young women and girls. The incidence of genital warts – caused by HPV – has also fallen among both females and males, as boys and men have been protected by ‘herd immunity’, ie less exposure to HPV.

More detailed information can be found on the Department’s HPV website.5

5 www.australia.gov.au/hpv
Chronic disease management and support

Diabetes
The Department continues to tackle the nation’s diabetes epidemic – including managing the largest randomised controlled trial involving diabetes patients ever conducted in Australia. In 2012–13, the Department worked with a consortium led by McKinsey and Company to implement the Diabetes Care Project in identified sites across Queensland, South Australia and Victoria. The pilot project will test new ways of providing more flexible and better coordinated care, with the aim of improving the management of care for people with diabetes.

The project is piloting four key changes in how care is delivered to people with diabetes:

- a new care facilitator role to collaborate with the care team to support patient care;
- an education and training program to support practitioners and people with diabetes;
- a new chronic disease management IT tool to support care planning, enable information sharing and reduce administration; and
- a new funding model.

The Department will continue to implement the pilot in 2013-14. This will include ongoing data collection to inform formal evaluation starting in February 2014. The evaluation of the pilot will help the Department to identify the most effective models of care for diabetes and other chronic diseases.

Deliverable: Oversee implementation of the Diabetes Care Project to test a more comprehensive, patient-centred approach to improve the care of patients with diabetes

2012-13 Reference Point: Implementation of the Diabetes Care Project in identified sites across three states – Queensland, South Australia and Victoria

Result: Met

In 2012-13, general practice enrolment was completed, with more than 150 practices participating in identified sites across Queensland, South Australia and Victoria. Baseline clinical data (HbA1c, blood pressure and cholesterol) has been collected for participating patients. Care plans have been developed and care facilitation is being provided. Implementation, including clinical data collection, will continue until February 2014, when a formal evaluation of the project will begin.

KPI: Number of patients enrolled in the Diabetes Care Project

2012-13 Target: 10,000

2012-13 Actual: 7,909

Result: Substantially met

Up to a maximum of 10,000 patients could be enrolled in the pilot. Based on voluntary enrolment of 150 practices, a target of 7,500 patients was established, and this was achieved with 7,909 enrolments. A minimum of 3,750 patients is required for evaluation purposes. This is the largest randomised controlled trial for patients with diabetes conducted in Australia.

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6 Glycated Haemoglobin (HbA1c) Test: the HbA1c test shows an average blood glucose level over the previous 10-12 weeks.
7 This pilot project is funded until 30 June 2014.
PROGRAM 1.2: COMMUNICABLE DISEASE CONTROL

Program 1.2 aims to reduce the incidence of blood borne viruses and sexually transmissible infections.

Reduce the incidence of blood borne viruses and sexually transmissible infections

Blood borne viruses and sexually transmissible infections are preventable. The Department continued to support education and prevention programs under the National Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategies 2010-2013 which aim to better connect safe sex and prevention messages with the people most at risk. The strategies aim to improve knowledge, attitudes and behaviours among target groups. These include Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse Australians, youth, people in rural and regional areas, and people who inject drugs.

In October 2012, the Department published a mid-term review of the implementation Plan: National Strategies 2010-2013 for BBVs and STIs.8 Recommendations included addressing increased transmission of HIV among people from, and travelling to, high prevalence countries; scaling up treatment capacity for hepatitis C as new treatments become available; scaling up hepatitis B antiviral treatment to meet demand; and eliminating syphilis in Aboriginal and Torres Strait Islander peoples.

Deliverable: The priority actions contained in the National BBV and STI Strategies 2010-2013 are being undertaken.

2012-13 Reference Point: Have completed or commenced 90% of all the priority actions contained in the National BBV and STI Strategies 2010-2013 as measured by the mid-term review.

Result: Substantially met.

- The Department continues work in this area. A highlight is the registration of the first HIV point of care test9 for use in Australia. It is anticipated that this testing will increase the number of people who voluntarily seek HIV testing. In addition, the Department has continued to increase awareness of BBV and STI issues in Aboriginal and Torres Strait Islander health. For example, in the Torres Strait Island region, the Department is funding a culturally appropriate sexual health campaign, and improving clinical service delivery on Saibai Island.

KPI: Funding provided to non-government organisations under the Communicable Disease Prevention and Service Improvement Grants Fund supports programs which are effective in reducing the spread of communicable disease.

2012-13 Reference Point: Regular progress reports on key milestones from contracted organisations indicate that activities are being implemented effectively in accordance with contractual arrangements.

Result: Met.

- During 2012-13, non-government organisations that focus on BBVs and STIs have been supported through the Communicable Disease Prevention and Service Improvement Grants Fund. These organisations deliver a variety of prevention and education activities aimed at raising awareness of BBVs and STIs, encouraging safe sex and injecting practices, improving access to testing and treatment of BBVs and STIs, reducing discrimination and improving wellbeing of those living with BBVs and STIs, as well as ensuring Australians continue to have access to a safe, high quality national blood supply. All organisations that received funding provided progress reports on milestones within the agreed timeframes.

9  Alere Determine HIV 1/2 Ag/Ab Combo test.
KPI: Percentage of laboratory tests which are positive for Chlamydia infection

2012-13 Target: <12%  
2012-13 Actual: 7.7%  
Result: Met

Chlamydia infections are most prevalent in young people. Based on the number of notifications reported to the National Notifiable Diseases Surveillance System and the number of chlamydia testing services reported under the Medicare Benefits Schedule, an estimated 7.7% of laboratory tests were positive for chlamydial infection. This is a slight decrease from previous years where the proportion of positive tests for chlamydia has been around 8%.

As more than 80% of chlamydia infection notifications are among people aged 15-29 years, the Department continues to support promotion of STI testing. This enables early detection and treatment, and reduces the longer term complications that can be associated with untreated chlamydia.

KPI: Number of newly diagnosed cases of HIV infection

2012-13 Target: <1,100  
2012-13 Actual: 1,253 (2012 calendar year)  
Result: Not met

Numbers of HIV cases are increasing. The number of new HIV diagnoses in Australia in 2012 was 1,253 – up from 719 cases in 1999.

Recent trends in the population rate of newly diagnosed HIV infection show that transmission of HIV in Australia continues to occur primarily through sexual contact between men (67%). Exposure to HIV was attributed to heterosexual contact and injecting drug use in 25% and 2% of diagnoses, respectively.

KPI: Number of newly diagnosed cases of hepatitis C infection

2012-13 Target: <12,250  
2012-13 Actual: 10,173  
Result: Met

Number of hepatitis C infection cases are decreasing. The number of newly diagnosed cases of hepatitis C infections notified to the National Notifiable Diseases Surveillance System in 2012-13 was 10,173. A peak in the notification of cases occurred in the late 1990s. Since 2000-01, total rates have declined by around 50%. In 2011, an estimated 304,000 people living in Australia had been exposed to the virus, with around 226,700 having chronic hepatitis C infection.

**PROGRAM 1.3: DRUG STRATEGY**

Program 1.3 aims to reduce the harmful effects of tobacco use, reduce the harm caused to individuals and communities from excessive alcohol consumption and combat illicit drug use.

**Reduce the harmful effects of tobacco use**

The world’s first tobacco plain packaging legislation, the *Tobacco Plain Packaging Act 2011* and the *Tobacco Plain Packaging Regulations 2011*, took full effect from 1 December 2012. The legislation prohibits tobacco industry logos, brand imagery, colours and promotional text other than brand and product names in a standard colour, position, font style and size appearing on retail packaging of tobacco products. Tobacco product retail packaging is required to appear in a drab dark brown colour in a matt finish. Under the *Competition and Consumer (Tobacco) Information Standard 2011*, requirements for new, larger health warnings on all tobacco products took full effect from 1 December 2012, in line with plain packaging requirements.

Compliance and enforcement activities under the *Tobacco Plain Packaging Act 2011* began on 1 October 2012 for manufacturing and packaging offences, and on 1 December 2012 for supply and sales offences. These include inspections of manufacturers, retailers and suppliers based on information received by the Department. Enforcement action undertaken under the legislation is proportionate to the breach and involves a range of actions including, as appropriate, educational visits, verbal or written warnings, infringement notices and prosecutions. The Tobacco Plain Packaging Enforcement Policy explains the approach to enforcement and is available at www.yourhealth.gov.au.

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10 Notification period 1 July 2012 – 13 June 2013. Newly diagnosed cases for the period include notifications classified as either ‘newly acquired’ (infection acquired within 24 months prior to diagnosis) or ‘unspecified’ (infection acquired more than 24 months prior to diagnosis or not able to be specified).

11 Newly diagnosed case for the period include notifications classified as either ‘newly acquired’ (infection acquired within 24 months prior to diagnosis) or ‘unspecified’ (infection acquired more than 24 months prior to diagnosis or not able to be specified).
During 2012-13, the Department, along with the Attorney-General's Department and the Department of Foreign Affairs and Trade, continued working to defend the international challenges to the tobacco plain packaging legislation.

Also in 2012-13, the Department developed a new National Tobacco Strategy to guide efforts to reduce the harm caused by tobacco smoking. The Department continued to run social marketing campaigns to raise awareness of the dangers of smoking and encourage attempts to quit among high risk and hard to reach populations.

**Deliverable:** Implement public awareness activities for the introduction of tobacco plain packaging

**2012-13 Reference Point:** Public awareness activities to be developed by mid-2012 and evaluation activities by late 2012

**Result:** Met

- Extensive communication activities have increased awareness of the requirements under the *Tobacco Plain Packaging Act 2011* and *Tobacco Plain Packaging Regulations 2011* to support the compliance and enforcement framework. This included providing an information kit and tear pad to 35,000 suppliers of tobacco products. There was also a reminder letter, press and online advertising in late 2012. A letter and frequently asked questions document on the packaging of cigars were sent to tobacco suppliers in 2013.

An evaluation of the range of communication activities ran from October to December 2012. This evaluation found that the campaign messaging was clear and successfully delivered to the intended target audience.

**Deliverable:** Develop new National Tobacco Strategy in conjunction with states and territories

**2012-13 Reference Point:** New National Tobacco Strategy to be finalised by 30 June 2013

**Result:** Met

- The National Tobacco Strategy 2012-2018 was developed during 2012 as a sub-strategy under the National Drug Strategy 2010-2015. It was approved by Health Ministers in November 2012 and published on the National Drug Strategy website in January 2013.

**Deliverable:** Implement social marketing campaigns to raise awareness of the dangers of smoking and encourage and support attempts to quit

**2012-13 Reference Point:** Deliver the National Tobacco Campaign – More Targeted Approach within agreed timeframes

**Result:** Met

- As part of the National Tobacco Campaign – More Targeted Approach (MTA), a new pregnancy campaign was launched in November 2012. This targeted women who smoke, who are pregnant or planning to become pregnant within the next two years, and their partners. This target audience included people from socially disadvantaged, Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds. Advertising comprised of two TV, print and digital commercials, a radio advertisement, and an iPhone and Android App. A second round of advertising started on 19 May 2013 and ended in mid-June 2013. As part of the broader MTA campaign, a range of public relations and sponsorship activities were undertaken throughout 2012-13, targeting hard to reach audiences.

**KPI:** Percentage of population aged 18 years of age and over who are daily smokers

**2012-13 Target:** <16.4%  
**2012-13 Actual:** 16.3%  
**Result:** Met

- Fewer Australians are smoking on a daily basis. Rates of daily smoking have continued to drop to 16.3% of people aged 18 years and over (2.8 million people) in 2011-12, from 19.1% in 2007-08, 21.3% in 2004-05 and 22.3% in 2001.  

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12 www.nationaldrugstrategy.gov.au  
13 Australian Health Survey: Updated Results, 2011-12 (Table 13.3). Age standardised to the 2001 Australian population.
Reduce harm to individuals and communities from excessive alcohol consumption

Under the guidance of the National Drug Strategy 2010-15, the Department continues to partner with a range of stakeholders to increase awareness and promotion of responsible alcohol consumption.

This includes raising awareness among health practitioners of the Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Point of sale information has targeted a range of groups – including patrons of liquor retailers, clubs, pubs and hotels, and pregnant women and women who are breastfeeding – through distribution of over one million brochures. This work has been undertaken in the context of broader activity to reduce the impact of Fetal Alcohol Spectrum Disorders.

Substance Misuse Service Delivery Grants Fund

The Substance Misuse Service Delivery Grants Fund aims to improve the health and social outcomes of Australians with substance misuse issues. The fund supports drug and alcohol treatment services across Australia, to build capacity and effectively identify and treat coinciding mental illness and substance misuse. The fund also supports services targeting Aboriginal and Torres Strait Islander peoples and vulnerable groups, including people from rural and remote locations and those experiencing homelessness.

The Non Government Organisations Treatment Grants Program (NGOTGP) provides funding to improve drug and alcohol treatment outcomes, increase the number of available treatment places, strengthen the capacity of non-government organisations to deliver quality treatment services and to fill geographic service delivery gaps, especially for at-risk groups. The NGOTGP activities complement and support those undertaken through the Fund.

Deliverable: Fund and support drug and alcohol treatment services to strengthen the capacity of service providers across Australia

2012-13 Reference Point: Drug and alcohol treatment service providers receive funding and support through the Substance Misuse Service Delivery Grants Fund

Result: Met

In 2012-13, the Department provided funding to more than 150 organisations to provide alcohol and other drug treatment and prevention services. The funded organisations include large not-for-profit organisations, community controlled treatment services and non-government organisations offering a range of treatment options including counselling, brief interventions and residential rehabilitation programs across urban, regional and remote Australia.

Early Intervention Pilot Program

The Early Intervention Pilot Program (EIPP) aims to get youth who have been participating in under-age drinking back on track before more serious alcohol-related problems emerge. Working with all state and territory police and health departments, young people are moved from engagement with police to the health system, where they receive information and are offered counselling to encourage a change in attitudes and behaviours.

KPI: Early Intervention Programs reduce reported re-offending rates of under-age drinking

2012-13 Reference Point: Reports from jurisdictions indicate there are less underage drinkers re-offending

Result: Met

The EIPP ended in June 2013 with a number of intervention activities embedded into both police and health programs. Early evaluation findings demonstrate that more young people are learning to resolve issues without alcohol. Fewer young people are re-offending after being provided with alcohol education information.
Combat illicit drug use

The National Drugs Campaign continues to educate the public on the risks and harms associated with illicit drug use through targeted information and resources for youth and parents.

**Deliverable:** Provide up-to-date information to young people on the risks and harms of illicit drug use

**2012-13 Reference Point:** Dissemination of materials and delivery of the National Drugs Campaign and providing information through the National Cannabis Prevention and Information Centre on the risks and harms associated with cannabis use

**Result:** Met

In 2012-13, under the National Drugs Campaign, comprehensive developmental research was undertaken to provide further understanding of current youth attitudes and behaviours to a range of illicit drugs. This research will guide development of future campaign activity.

The Department continued to fund the National Cannabis Prevention and Information Centre’s (NCPIC) efforts to educate the community about the harms of cannabis use. The NCPIC continued to develop and distribute, on a national scale, a large number of free resources and training materials. NCPIC also provides extensive training through clinical, community and youth training sessions to deal with cannabis affected clients.

In 2012-13, the Department continued support for new research and data about the harms of illicit drug use and alcohol misuse and prevention of illicit drug and alcohol use in young people. This included sponsoring a virtual collaborative network of three major research institutions – the National Centre for Education and Training on Addiction, the National Drug and Alcohol Research Centre and the National Drug Research Institute – to work together in undertaking joint research, developing new research approaches and establishing an evidence base to inform responses to new and emerging drug issues.

The Department has provided funding to Edith Cowan University to establish an Aboriginal and Torres Strait Islander Peoples Alcohol and Other Drugs Knowledge Centre. This knowledge centre will promote and disseminate high quality culturally appropriate information and provide practical support to communities and those working to prevent and reduce the impact of alcohol and other drugs on Aboriginal and Torres Strait Islander peoples and their families.

**KPI:** Percentage of population 14 years of age and older recently (in the last 12 months) using an illicit drug

**2012-13 Target:** <13.4%  
**2012-13 Actual:** Data not available  
**Result:** Data not available

Data for 2012-13 is currently not available, as it is taken from the National Drug Strategy Household Survey (NDSHS), which is published every three years. Results from the next NDSHS will be available in 2014 and will be based on 2013 data.

In 2013-14, the Department will continue to work with law enforcement agencies, state, territory and local governments, treatment service providers, housing and homelessness services, and local communities under the National Drug Strategy 2010-2015. The strategy aims to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

**PROGRAM 1.4: REGULATORY POLICY**

Program 1.4 aims to provide direction and national leadership in food and gene technology regulatory policy issues, maintain and improve the therapeutic goods regulatory framework, and provide for the safe and sustainable use of industrial chemicals.

**Food regulation policy**

*Develop food standards and food regulation policy*

Food standards and regulation ensure the health of Australians is protected and supported by a safe food supply.
The Department continued to undertake activities to support the development of food standards, food regulation policy and advice. This involved working with stakeholders including industry representatives, Food Standards Australia New Zealand (FSANZ), states and territories and the New Zealand Government.

In 2012-13, the Department reviewed and responded to advances in scientific knowledge and evidence, stakeholder feedback and developments in food regulatory practice at a national level. The Department also helped influence the development of food regulation at the international level through membership of the Codex Committee on Food Labelling.

The Department continued to implement the Government response to Labelling Logic: Review of Food Labelling Law and Policy (2011) in consultation with portfolio agencies including FSANZ, other Australian government departments, states and territories and New Zealand.

**Deliverable:** Develop an interpretive front-of-pack labelling system for foods  
**2012-13 Reference Point:** New labelling system developed by December 2012  
**Result:** Substantially met

- In 2012-13, the Department led the development of a front-of-pack labelling system so that Australians will be able to tell at a glance which processed foods represent the healthiest choices. This will help, in the long term, to alleviate the burden of chronic disease, overweight and obesity issues in Australia.

- In 2013-14, the Department will continue to implement the labelling system, including preparing a social marketing campaign. Industry actively participated in the development of the new system and it is expected it will voluntarily adopt the system by June 2015.

**Deliverable:** Develop advice and policy for the Australian Government on food regulatory issues  
**2012-13 Reference Point:** Relevant, evidence based advice produced in timely manner  
**Result:** Met

- The Department provided advice and policy to the Australian Government, via the Legislative and Governance Forum on Food Regulation, in relation to food regulation issues. Key food regulatory issues for 2012-13 included health and nutrition-related claims, expanding country of origin labelling to all unpackaged meat products and front-of-pack labelling.

**KPI:** Promote a nationally consistent approach to food policy and regulation  
**2012-13 Reference Point:** Consistent regulatory approach across Australia through nationally agreed policy and standards  
**Result:** Met

- In 2012-13, the Department continued to work with the Food Regulation Standing Committee (FRSC) and the Implementation Sub-Committee (ISC) to develop and implement consistent food policies and regulations. Both FRSC and ISC met twice during the year and considered a range of policy and regulatory issues, with the Department providing advice.
Australians will soon be able to tell at a glance which processed foods represent the healthiest choices, thanks to a new front-of-pack labelling system.

Eating too much salt, saturated fat and sugar, coupled with inadequate physical activity, has led many of us to develop chronic health conditions which reduce our quality of life and can even be fatal.

Labelling on processed foods can make it easier to make the right choices to maintain a healthy weight and healthy body. But the variety of labelling systems and styles developed by food manufacturers is confusing and, at times, misleading.

The solution is a single, interpretive front-of-pack labelling system for use on packaged foods sold in Australia.

A star rating system was developed by the Department in 2012-13, in collaboration with governments, industry, nutrition experts, public health and consumer groups.

This new five star rating scale will apply to all packaged, manufactured or processed foods presented ready for sale in retail shops (with some exceptions). At a glance, consumers will be able to see the overall nutritional content of the product, as well as the energy (kilojoules) in the product and easy-to-read information about saturated fat, sugar and salt (sodium) content.

The star rating system supports preventative health by providing consumers the information they need to make healthy eating choices. In the long term, it will help Australians to reduce their burden of chronic disease and other issues related to overweight and obesity. In 2013-14, the Department will continue to work on the labelling system, which is expected to be adopted voluntarily by the food industry by June 2015.
Therapeutic goods

Ensure that therapeutic goods are safe, effective and of high quality

The Therapeutic Goods Administration (TGA) ensures the quality, safety and efficacy of therapeutic goods in Australia. In 2012-13, the TGA continued to regulate therapeutic goods under a national framework, using a risk management approach. Assessment and monitoring were carried out to ensure therapeutic goods available in Australia were of an acceptable standard, and manufactured in accordance with the principles of Good Manufacturing Practice. This included assessment of annual reports from sponsors of Class III and implantable devices following entry on the Australian Register of Therapeutic Goods (ARTG). At the same time, the TGA continued to ensure that the community had access, within a reasonable timeframe, to therapeutic advances.

Deliverable: Percentage of alleged breaches received that are assessed within 10 working days and an appropriate response initiated

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
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<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
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</tbody>
</table>

The TGA assessed all alleged breaches of the Therapeutic Goods Act 1989 within 10 working days and initiated an appropriate response in 100% of the instances notified.

KPI: Percentage of evaluations and appeals regarding the entry of therapeutic goods onto the ARTG made within legislated timeframes

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
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<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
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</table>

The TGA completed all 39 section 60 reviews regarding the entry of therapeutic goods onto the ARTG within legislated timeframes. This compares to 96% in 2011-12, and 97% in 2010-11.

KPI: Percentage of licensing and surveillance inspections completed within target timeframes:

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic: 100%</td>
<td>73%</td>
<td>Not met</td>
</tr>
<tr>
<td>Overseas: 90%</td>
<td>71%</td>
<td>Not met</td>
</tr>
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</table>

In 2012-13:
- 181 of 247 inspections of Australian manufacturers were completed within target timeframes (69% in 2011-12 and 87% in 2010-11); and
- 77 of 109 inspections of overseas manufacturers were completed within target timeframes (60% in 2011-12 and 82% in 2010-11).

Results for 2012-13 are due to a flow on effect from inspections not completed in the previous period. Every effort will be made in 2013-14 to complete these and all newly-scheduled inspections within target timeframes.

KPI: Percentage of prescription medicine evaluations completed within target timeframes

<table>
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<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: 100%</td>
<td>99.7%</td>
<td>Met</td>
</tr>
<tr>
<td>Category 3: 100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012-13:
- 388 of 389 of Category 1 evaluations for prescription medicines were completed within the legislated timeframe of 255 days (99.5% in 2011-12 and 99.4% in 2010-11); and
- all 1,391 Category 3 evaluations for prescription medicines were completed within the legislated timeframe of 45 days (99.4% in 2011-12 and 99.8% in 2010-11).

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15. Legislated timeframes relate to: 255 day timeframe for Design Examination Conformity Assessments for medical devices and for Category 1 prescription medicines applications; 45 days for Category 3 prescription medicines; and 60 days for a section 60 (of the Therapeutic Goods Act 1989) internal review.

16. Category 1 refers to an application to register a new prescription medicine or change to a medicine not meeting the requirements for Category 2 or Category 3 applications. Category 3 refers to an application involving changes to the quality data of medicines already registered and not involving clinical, non-clinical or bioequivalence data. Category 2 refers to an application to register a prescription medicine where two independent evaluation reports from acceptable countries are available. TGA no longer reports on Category 2 evaluations as they are extremely rare.
Implement the TGA Reform Blueprint

Delivering reforms – Implementation plan for TGA Reforms: A blueprint for TGA’s future was published on the TGA website\(^7\) in July 2012 and significant progress has been made in delivering the Blueprint recommendations in accordance with the detailed plan.

**Deliverable:** Implement reforms that enhance TGA’s current regulatory processes

**2012-13 Reference Point:** Reforms implemented in accordance with the published plan

**Result:** Substantially met

At 30 June 2013, 28 of the Blueprint recommendations have been implemented. These include:

- Establishment of the Australian Therapeutic Goods Advisory Council;
- Publication of:
  - Advertising Regulatory Framework – Options for Reform;
  - Consultation principles for therapeutic goods regulatory reforms;
  - TGA External Communication and Education Framework: priorities and projects 2013–15;
  - a clear explanation of the TGA’s risk based framework on the TGA website;
  - further information on the role of statutory advisory committees and clarification of their reporting arrangement;
  - target dates and reports on the completion of key complementary medicines guidance documents;
  - a new Compliance Review Framework for Complementary Medicines and a list of cancelled listed complementary medicines;
  - a paper for comment on the TGA’s approach to the disclosure of commercially confidential material; and
  - a consultation paper incorporating proposals for future regulation of advertising.
- Providing access to online information on Australian and New Zealand adverse event data for medicines and medical devices; an early warning system of potential risks with medicines and medical devices; and publication of product recalls information; and
- Implementation of regulatory changes to re-classify hip, knee and shoulder joint replacement implants.

In addition, significant work has been completed on recommendations which were due for implementation in 2012-13 but are now expected to be completed in 2013-14 due to legislative timeframes, policy approval or further public consultation required. These recommendations are:

- Recommendations relating to complementary medicines; and
- A recommendation relating to investigations of advertising breaches.

Establish the Australia New Zealand Therapeutic Products Agency

The Australian and New Zealand Governments are creating a joint regulatory scheme for therapeutic products in Australia and New Zealand. The scheme will safeguard public health and safety, further economic integration, and benefit industry in both countries.

In 2012-13, the Department continued working with the New Zealand Ministry of Health and other Australian and New Zealand Government policy agencies to establish the arrangements for the Australia New Zealand Therapeutic Products Agency (ANZTPA), which will administer the joint regulatory scheme.

TGA and New Zealand's Medicines and Medical Devices Safety Authority (Medsafe) implemented joint regulatory projects. These resulted in:

- a publicly searchable, joint database of adverse event notifications for medicines and for medical devices;
- increased capability to conduct inspections of manufacturing practices;
- a common early warning system for advising the public about investigations into potential safety concerns associated with medicines and medical devices;
- a common recalls portal; and
- common administrative processes for evaluation of over-the-counter medicine registrations in both countries.

---

The first stage to implement a single entry point for businesses and consumers was launched in November 2012. In January 2013, the TGA and Medsafe released a public consultation paper on a possible joint regulatory scheme for therapeutic products under ANZTPA.

**Deliverable:** Implement a program of work sharing and joint operations

**2012-13 Reference Point:** Agree with Medsafe (New Zealand) to share scheduled Good Manufacturing Practice inspection reports and coordinate inspection schedules by January 2013

**Result:** Met

In 2012-13, five projects between the TGA and Medsafe were completed. These are:

- **Joint Medicine and Medical Device Adverse Events Notifications Databases** – In November 2012, a publicly searchable database for medicine adverse events reported in Australia and New Zealand became available on www.ANZTPA.org. In June 2013, a joint database of medical device adverse event notifications was launched. These databases improve access for consumers, health care professionals and industry to information about the performance of medicines and devices.

- **The Recalls Portal** – In April 2013, a publicly searchable database about recall actions undertaken in Australia and New Zealand for therapeutic products began operation. This provides stakeholders with greater transparency and access to information about product recalls.

- **Integrated Good Manufacturing Practice (GMP) Inspections** – In January 2013, a shared capability to facilitate manufacturing practice inspection planning was completed. It allows the TGA and Medsafe automatic access to all inspection reports through a secure information sharing portal. This improves alignment of inspection priorities and makes best use of scarce inspection resources.

- **Early Warning System** – In June 2013, an agreed system to communicate potential safety concerns with therapeutic products was delivered. This scheme will operate in parallel in Australia and New Zealand.

- **Over-the-Counter (OTC) medicine reforms** – Business processes for the evaluation of OTC medicine registration applications were reformed and an integrated common approach in the TGA and Medsafe was established.

### Industrial chemicals

**Ensure that uses of industrial chemicals are safe for human health and the environment**

In 2012-13, the Department, through the National Industrial Chemicals Notification and Assessment Scheme (NICNAS), continued to protect human health and the environment by promoting safe and sustainable use of industrial chemicals.

This was achieved through 281 pre-market assessments of new industrial chemicals. In addition, NICNAS assessed 727 industrial chemicals already in use, through its Existing Chemicals Program (through the Inventory Multi-tiered Assessment and Prioritisation [IMAP] framework, or as Priority Existing Chemicals [PEC], or when an introducer of a chemical that had been previously assessed advised NICNAS of new information about the chemical [‘secondary notification assessment’]).

To promote the safe use of chemicals, NICNAS continued to engage with its key stakeholders – the chemical industry, the community (including employees who work with chemicals), the Australian Government and state and territory governments – through national networks, advisory committees and information sharing activities.

Under a Better Regulation Ministerial Partnership (BRMP) between the Minister for Health and the Minister for Finance and Deregulation, the Department progressed the review of NICNAS.

The Department held consultations in July and August 2012, which discussed possible reform options. Following key stakeholder workshops in October 2012, a draft Regulatory Impact Statement was released in June 2013 on the possible impacts of reform options. The complex nature of the industrial chemical regulatory environment and the diverse views of industry and community stakeholders present challenges to the development of a preferred package of reform.

The Department will continue to work with NICNAS and other stakeholders to develop a regulatory reform package that would rebalance the industrial chemical regulatory framework to enhance both the competitiveness of the Australian chemical industry and public health and environmental outcomes.
Deliverable: Implement the Inventory Multi-tiered Assessment and Prioritisation (IMAP) framework

2012-13 Reference Point: IMAP framework governance arrangements in place, ongoing stakeholder engagement and communication strategies are effectively implemented

Result: Met

The IMAP framework was introduced in July 2012. NICNAS held a forum during that month to increase stakeholder understanding of the IMAP framework and explore opportunities for greater international and national collaboration. Stage One of the implementation of the IMAP framework, running over four years, involves the evaluation of 3,000 existing chemicals that were prioritised for assessment. Australian scientific experts independently reviewed the IMAP framework and both the chemical industry and interested members of the public have been given the opportunity to comment on IMAP assessments. Publication of assessment reports was communicated through NICNAS consultative committees, the NICNAS website, the Chemical Gazette and targeted e-mails. Fact sheets, the IMAP framework and pilot evaluation papers for the framework were also published on the NICNAS website, providing public information on the methodologies used in risk assessments.

Deliverable: Implement approach for introducing substitutes for perfluorinated chemicals

2012-13 Reference Point: Framework for the assessment of new perfluorinated chemicals implemented

Result: Met

A framework for the assessment of new perfluorinated chemicals was implemented. Several assessments were undertaken for new shorter chain perfluorinated chemicals proposed as substitutes for long chain perfluorinated chemicals that are known to accumulate in the environment.

Deliverable: Contribute to the international harmonisation of assessments, regulatory approaches and methodologies by adjusting, as appropriate, Australian industrial chemicals assessment and management systems

2012-13 Reference Point: Review international assessments, regulatory approaches and methodologies for their application to NICNAS risk assessments from three key subcommittees of the OECD Chemicals Committee

Result: Met

NICNAS participates in chemical safety initiatives sponsored by the World Health Organization (WHO) and represents Australia on key chemical sub-committees of the Organisation for Economic Co-operation and Development (OECD) Chemicals Committee, which reviews international regulatory approaches. This international engagement ensures that NICNAS assessments are scientifically robust and international experience is applied to improve our regulatory systems. In 2012-13, NICNAS participated in the:

- WHO International Programme on Chemical Safety – through the establishment of an international network of risk assessors;
- OECD Task Force on Hazard Assessment – revising guidance on forming chemical categories to increase the efficiency of chemical assessments. This guidance assists in selecting appropriate analogue chemicals, which can provide useful information to assess the likely hazards of a new chemical. NICNAS also contributed to the ‘avoiding duplication’ project by sharing with other regulators its current schedules for existing chemical assessments (PEC and IMAP). In addition, NICNAS participated in the Cooperative Chemical Assessment Program by reviewing the dimethylanilines category of six chemicals of interest to NICNAS and other regulators;
- OECD Working Party on Manufactured Nanomaterials (WPMN) – ensuring that the view of Australian regulatory agencies was reflected in the draft OECD Council recommendation (2013) that “approaches for the testing and assessment of traditional chemicals are in general appropriate for assessing the safety of nanomaterials, but may have to be adapted to the specificities of nanomaterials”. Participation in the WPMN ensures that NICNAS’s approach to hazard and risk assessment and regulation of industrial nanomaterials is science-based and internationally harmonised; and
- OECD Clearing House on New Chemicals – by reviewing the list of low concern polyesters.

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18 Perfluorinated chemicals are a large group of compounds that are widely used to make everyday products more resistant to stains and grease, or as a wetting agent. Certain perfluorinated chemicals are of concern around the world because they are not broken down in the environment and can persist for a long time, accumulating to levels that can be harmful to living systems.
Deliverable: Introducers of industrial chemicals aware of their obligations through NICNAS Registration

2012-13 Reference Point: Registration of all identified introducers

Result: Met

In 2012-13, 99.7% of all identified introducers (5,303) were registered. NICNAS conducted 27 site visits to ensure introducers were complying with their obligations. More than 1,200 desktop audits were undertaken to identify unregistered introducers, contributing to more than 800 chemical introducers registering with NICNAS for the first time.

KPI: Effective use of international information

Reference Point: A. For new chemicals: finalise lessons learnt from US bilateral agreement and explore options for further developing arrangements.
B. For existing chemicals: through implementing the IMAP framework, developing guidance and training on the use of international information

Result: Met

A. More than 30 United States Environmental Protection Agency reports have been provided for NICNAS New Chemicals assessments since the start of the bilateral arrangement. The sharing of this information has helped NICNAS in its assessments and resulted in efficiencies for NICNAS and reduced costs to industry.

B. NICNAS liaised with international regulatory agencies to access information and expertise to assist with the IMAP assessments. Sharing assessment data with other agencies and acquiring expertise in the use of information technology tools have contributed significantly to the successful implementation of the IMAP framework in its first year.

KPI: Percentage of Stage One chemicals19 assessed through effective application of IMAP framework20

2012-13 Target: 20% 2012-13 Actual: 24% Result: Met

In 2012-13, NICNAS undertook 984 assessments for a total of 72321 chemicals (261 were assessed for both human health and environmental impacts) using the IMAP framework. Recommendations to Australian Government and state and territory agencies for additional regulatory controls and/or further assessments have been made for a significant number of chemicals, demonstrating that the IMAP framework is operating effectively.

KPI: Percentage uptake by industry of options to introduce new chemicals that are a lower risk to human health or the environment

2012-13 Target: 80% 2012-13 Actual: 80% Result: Met

The regulatory requirements for chemicals being introduced into Australia were revised in 2008-09 to facilitate the introduction of less hazardous and lower risk chemicals. The percentage of new chemicals assessed that are safer and less hazardous increased by 3% from 77% in 2011-12 to 80% in 2012-13.

KPI: Percentage of those introducing over $500,000 of industrial chemicals assessed for compliance with new chemicals obligations

2012-13 Target: 30% 2012-13 Actual: 30.3% Result: Met

In 2012-13:

- 16 on-site audits were conducted to determine compliance with new chemicals obligations;
- 17 audits were closed where the company was able to demonstrate compliance with obligations; and
- 5 audits are continuing where the company has agreed to provide evidence of compliance within an agreed timeframe.

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19 As detailed under the first deliverable, in July 2012, NICNAS started the process of assessing, over four years, around 3,000 existing chemicals using the IMAP framework. These first 3,000 chemicals are described as ‘Stage One Chemicals’.


21 This includes 20 chemicals that were not included in the initial IMAP Stage One list of 3,000 chemicals. These are members of groups of chemicals already being assessed in Stage One and have been added to gain further efficiencies in the implementation of the IMAP framework.
Gene technology regulation

Protect the health and safety of people and the environment by regulating dealings with genetically modified organisms

The Gene Technology Regulator, supported by the Office of the Gene Technology Regulator (OGTR), administers a national scheme for the regulation of gene technology to protect the health and safety of people and the environment by regulating certain dealings with genetically modified organisms (GMOs).

In 2012-13, OGTR monitored scientific knowledge and developments in regulatory practice to ensure the assessments of applications required under the gene technology legislation were robust, based on current science and represent international best practice. OGTR engaged in international cooperation activities that included the harmonisation of risk assessment of GMOs. OGTR also consulted with experts and key stakeholders on the assessment of licence applications for the release of GMOs into the environment.

In consultation with stakeholders, OGTR conducted reviews to ensure that regulations, guidelines and processes remain current with advances in gene technology and understanding of risks. In 2012-13, OGTR also consulted with the community to resolve issues of concern, for example, risk management of GMOs.

OGTR continued bilateral arrangements with other Australian Government regulators, such as FSANZ; the TGA; the Australian Pesticides and Veterinary Medicines Authority; Department of Agriculture, Fisheries and Forestry; and NICNAS to improve coordinated decision making and avoid duplication in regulation of GMOs and genetically modified products. These activities deliver a risk-based, responsive, efficient and effective regulatory system that protects Australian people and the environment.

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**Deliverable:** Review Risk Analysis Framework to support the assessment of licence applications for the release of GMOs into the environment

**2012-13 Reference Point:** Review completed by 30 June 2013

**Result:** Met

- The revised Risk Analysis Framework was launched at the 5th National Institutional Biosafety Committee Forum in June 2013.

**Deliverable:** Risks posed by GMOs or gene technology assessed and managed appropriately

**2012-13 Reference Point:** Risk assessment and risk management plans prepared for all applications for licensed dealings

**Result:** Met

- In 2012-13, the Gene Technology Regulator prepared comprehensive risk assessments and risk management plans for proposed dealings with GMOs involving intentional release into the environment and in contained facilities. The Regulator imposed stringent conditions to ensure containment of GMOs and management of identified risks for four licences for release into the environment and eight licences for dealings in contained facilities. OGTR monitoring activities demonstrated a high level of compliance with the gene technology legislation and risks to human health or the environment were managed appropriately.
Deliverable: Percentage of field trial sites and higher level containment facilities inspected

| 2012-13 Target: 20% | 2012-13 Actual: 42% | Result: Met |

In 2012-13, OGTR inspected 42% of field trial sites, to monitor compliance with licence conditions ensuring risks to human health and the environment are minimised. The sites inspected were in the Australian Capital Territory, New South Wales, Victoria, Queensland and Western Australia. Genetically modified crop field trials inspected included canola, Indian mustard, wheat, barley, cotton, sugarcane, Perennial Ryegrass/Tall Fescue and white clover.

The OGTR also inspected 25% of higher level containment facilities to ensure compliance with certification conditions. These inspections focus on the integrity of the physical structure of the facility and on the general laboratory practices followed in that facility.

KPI: Protect people and the environment through identification and management of risks from GMOs

| 2012-13 Reference Point: High level of compliance with the gene technology legislation and no adverse effect on human health or environment from GMOs | Result: Met |

Routine monitoring of the regulated community demonstrated a high level of compliance with the gene technology legislation. The OGTR identified a small number of minor non-compliances or alleged breaches during routine monitoring of containment facilities and licensed dealings involving GMOs. In all instances, the Regulator determined that findings of non-compliances presented negligible risk to human health and safety or the environment, were minor in nature, involved negligible or zero culpability, and were resolved by reminders, education and/or cooperative compliance. No adverse effects on human health or the environment were reported.

KPI: Facilitate cooperation and prevent duplication in the implementation of GMO regulation

| 2012-13 Reference Point: High degree of cooperation with relevant regulatory agencies | Result: Met |

The Regulator consulted with other regulatory agencies before making decisions for all intentional release licence applications for GMOs to ensure that any risks to human health or the environment were managed effectively through coordinated action plans. The Regulator also maintained Memoranda of Understanding with these agencies to facilitate exchange of regulatory science information and cooperation.

The Regulator and OGTR facilitated cooperation and harmonisation through the Regulatory Science Network, Regulators Forum, the Regulators Community of Practice Forum and through bilateral cooperation with individual regulators.

OGTR engaged in international forums focusing on the harmonisation of the risk assessment and regulation of GMOs including with the OECD, WHO and Cartagena Protocol on Biosafety.

OGTR contributed to capacity building workshops and conferences on risk assessment and regulation of GMOs including in the region covered by the Association of South/South East Asian Nations, Ghana, United Kingdom, Japan, USA and Europe. OGTR also hosted a study tour for delegates from Bhutan.

KPI: Percentage of licence decisions made within statutory timeframes

| 2012-13 Target: 100% | 2012-13 Actual: 100% | Result: Met |

The Regulator made decisions on all licence applications within the applicable statutory timeframes, maintaining the 100% record of previous reporting periods. There were no appeals of decisions made under the gene technology legislation.
Program 1.5: Immunisation

Program 1.5 aims to strengthen immunisation coverage and ensure a cost-effective process for the supply of vaccines.

Strengthen immunisation coverage

Australia has high rates of immunisation, with more than nine out of 10 children being fully immunised. In 2012-13, the Department continued to provide free vaccines to the Australian community through the National Immunisation Program (NIP).

High immunisation rates were maintained in 2012-13 with more than 91.3% of children at one, two and five years of age fully immunised – a steady improvement on the previous year. This was further strengthened in 2012-13 by linking eligibility with the Family Tax Benefit Part A supplement to encourage parents to fully immunise their children. The Australian Government, through the Department, rewarded all states and territories with incentive payments as they had met performance targets listed in the National Partnership Agreement on Essential Vaccines.

However, while overall immunisation rates remain high, the proportion of Aboriginal and Torres Strait Islander children fully immunised at one year of age remains lower than all other children of the same age. Over the past decade, there have been significant increases in the immunisation coverage rates for Indigenous children across all age groups, with coverage for children over five years improving from just under 60% in 2004 to just over 92% in 2013.

The National Partnership Agreement on Essential Vaccines between the Commonwealth and the states and territories has a specific performance benchmark aimed at increasing immunisation coverage rates for Indigenous children. In July 2012, parents’ eligibility for the Family Tax Benefit Part A supplement was linked to the immunisation status of their children at three age check points – one, two and five years of age. These arrangements create a strong financial incentive for parents to ensure their children are fully immunised.

Figure 1.1: Immunisation coverage – proportion of children fully immunised\(^{22}\) by age, and Indigenous status, 2004–2013

In 2013, the Department saw an increase in demand from those eligible to receive free influenza vaccination under the NIP. More than 4.27 million doses of influenza vaccine were ordered by states and territories compared to an average of 3.7 million doses in previous years. There was also increased demand for influenza vaccine for the private market. The Australian Government has worked closely with vaccine providers to ensure enough influenza vaccine is available for those most at risk of severe influenza.

\(^{22}\) Fully immunised means vaccinated with the following antigens: hepatitis B, diphtheria, tetanus, pertussis, poliomyelitis, Haemophilus influenzae type b, measles, mumps and rubella (MMR)
Following a series of adverse events in 2010, namely febrile convulsions in children, bioCSL Fluvax® was not approved by the TGA for use in children under five from late 2010. The 2013 seasonal influenza campaign communicated the correct use of influenza vaccines in children to GPs and immunisation providers. However, a small number of GPs and immunisation providers administered the bioCSL Fluvax® influenza vaccine to children under five years of age. These providers were followed up by state and territory health authorities. The Department has implemented several measures during 2013 to address this issue and will build on these in 2014. Actions include packaging alerts on bioCSL Fluvax® syringes, targeted messaging to all immunisation providers and monitoring of incorrect vaccine usage through the Australian Childhood Immunisation Register to promptly identify and follow-up with providers where bioCSL Fluvax® was given to children under five years of age.

All states and territories started implementing the extended National Human Papillomavirus (HPV) Vaccination Program in schools in early 2013. The Department led a national communication campaign, developed in consultation with states and territories. To better monitor adverse events following immunisation for HPV, the Department enhanced the existing surveillance system. This included implementation of a rapid school-based reporting of four acute types of adverse events. As expected, there was an increase in reported adverse events due to the increased number of vaccinations being given. However, no unexpected adverse events occurred and no safety concerns have been identified in males or females.

The HPV vaccine coverage rate for Australian girls aged 15 years who have received all three doses is 71.2% and remains among the best in the world, with vaccination coverage already resulting in significant disease prevention. The prevalence of vaccine-preventable HPV type infections in cervical specimens of females aged 18-24 years decreased significantly from 29% to 7%, four years after the female vaccination program began. This will lead to a reduction in the burden of illness and death due to cervical cancer over time. There is already a substantial decline in genital warts amongst females under 21 years (92.6%) and aged 21-30 years (72.6%), and heterosexual males under 21 years (81.8%) and aged 21-30 years (51.1%).

The National Immunisation Strategy 2013-18 builds on the past successes of the NIP and identifies the following eight key strategic priority areas aimed at strengthening the NIP:

- improve immunisation coverage;
- ensure effective governance of the NIP;
- ensure secure vaccine supply and efficient use of vaccines for the NIP;
- continue to enhance vaccine safety monitoring systems;
- maintain and ensure community confidence in the NIP through effective communication strategies;
- strengthen monitoring and evaluation of the NIP through assessment and analysis of immunisation register data and vaccine-preventable diseases surveillance;
- ensure an adequate skilled immunisation workforce through promoting effective training for immunisation providers; and
- maintain Australia’s strong contribution to the region.

The Department, in conjunction with states and territories, will start implementing the strategy in 2013-14.

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**Deliverable:** Release the National Immunisation Strategy  
**2012-13 Reference Point:** Strategy released by 30 June 2013  
**Result:** Substantially Met

The strategy covering the period 2013-18 was endorsed by the Australian Health Ministers’ Advisory Committee in June 2013 but is yet to be considered by the Standing Council on Health and has not been released. Development of the strategy was overseen by the National Immunisation Committee which reports to the Australian Health Protection Principal Committee through the Communicable Diseases Network Australia.

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**Deliverable:** Develop and disseminate information for health professionals, providers and consumers on immunisation programs

**2012-13 Reference Point:** New edition of the Australian Immunisation Handbook released
Inform parents about changes to eligibility for Family Tax Benefit Part A supplement related to immunisation Nationally agreed protocols for identifying and responding to adverse events following immunisation developed

**Result:** Met

- In 2012-13, the Department developed materials to inform health professionals, immunisation providers and consumers.

The 10th edition of the *Australian Immunisation Handbook*, was released in 2013 and distributed to all Australian immunisation providers including GPs, relevant specialist doctors, nurses, midwives and Aboriginal health workers. The handbook provides clinical guidelines for health professionals and is based on the best available scientific evidence. The latest edition provides the most up-to-date clinical information on the safest and most effective use of vaccines in Australia.

The Department reminded parents and immunisation providers of the need for parents to fully immunise children during the financial years that each child turns one, two and five years of age, to obtain the Family Tax Benefit Part A supplement for that period.

The Department distributed a number of communication materials to immunisation providers and parents in preparation for the rollout of the new combined measles-mumps-rubella-varicella (MMRV) vaccine on 1 July 2013.

The 5th edition of *Myths and Realities – Responding to arguments against vaccination* was distributed to relevant health care professionals in June 2013. This booklet responds to some common myths and concerns encountered by health professionals when discussing vaccinations with parents or patients.

To support the launch of the extended National HPV Vaccination Program, the Department ran a national communication campaign which included fact sheets for parents, adolescents and health professionals; information kits, including brochures and posters, for schools; and a HPV website. In addition, an ongoing communication campaign was implemented for Aboriginal and Torres Strait Islander students and parents, as well as targeting culturally and linguistically diverse communities.

**Deliverable:** Number of completed tenders under the National Partnership Agreement on Essential Vaccines (Essential Vaccines Procurement Strategy)

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<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
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<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>Met</td>
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</table>

- During 2012-13, the Department finalised three tender processes as it continued to centralise procurement and contract management processes for vaccines provided under the NIP. The tenders were for the extension of the HPV vaccine program to males and continuation of the vaccine for females; meningococcal *C/Haemophilus influenzae* type b vaccine; and MMRV vaccines.

**KPI:** States and territories meet requirements of the National Partnership Agreement on Essential Vaccines

**2012-13 Reference Point:** The performance benchmarks are used to assess state and territory performance and consist of:
1. maintaining or increasing vaccine coverage for Indigenous Australians
2. maintaining or increasing coverage in agreed areas of low immunisation coverage
3. maintaining or decreasing wastage and leakage
4. maintaining or increasing vaccination coverage for four year olds

**Result:** Met

- All states and territories met benchmarks and were eligible to receive reward payments.

**KPI:** Maintain the immunisation coverage rates among children 12-15 months of age

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<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
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<tbody>
<tr>
<td>91.8%</td>
<td>91.3%</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

- Immunisation rates in 2012-13 continued to be high with the national immunisation rate for children aged 12-15 months at 91.3%. This compares to 91.8% in 2011-12 and 91.5% in 2010-11.

Immunisation rates in 2012-13 continued to be high with the national immunisation rate for children aged 24-27 months at 92.4%. This compares to 92.6% in 2011-12 and 91.9% in 2010-11.

Immunisation rates in 2012-13 continued to be high with the national immunisation rate for children aged 60-63 months at 91.5%. This compares to 90.0% in 2011-12 and 89.2% in 2010-11.

Improve the efficiency of the National Immunisation Program

The Review of the management of adverse events associated with Panvax® and Fluvax® (Horvath review) was undertaken following the 2011 flu season, during which a number of children who were immunised with these vaccines experienced adverse reactions. All seven recommendations of the review have been substantially implemented. Specifically, the Advisory Committee on the Safety of Vaccines was established to advise the Department on vaccine safety and regulatory matters. An improved national system for timely reporting of adverse events was put in place, along with a National Protocol for Program Action which will operate in the event a safety signal arises from an unwanted or unexpected event following administration of a vaccine under the NIP.

In 2012-13, tender processes were completed for the supply of meningococcal C and varicella (‘chicken pox’) vaccines. These vaccines are now included in the list of vaccines that are needed for a child to be considered ‘fully immunised’ to receive Family Tax Benefit Part A. Both the meningococcal C and varicella vaccines are now provided as part of combination vaccines for young children, reducing the overall number of immunisation injections which need to be provided.

Further tender processes will be undertaken in 2013-14 for vaccines under the NIP and in accordance with the Essential Vaccine Procurement Strategy.

PROGRAM 1.6: PUBLIC HEALTH

Program 1.6 aims to increase the health of the public through a range of targeted health programs.

Increase the evidence base for the development of targeted health programs

The Department continues to gather information through several national health surveys to ensure that health programs and policies are based on strong evidence of the health issues affecting the community.

Australian Health Survey

A series of reports with results from the 2011-13 Australian Health Survey on the general population have been released during 2012-13: first results in October 2012, health service usage and related actions in February 2013, and updated results in June 2013. Results on the physical activity component of the survey were released in July 2013 and results from the biomedical component of the survey were released in August 2013.

Key findings from the survey include:

- 90% of Australians aged two years and over did not meet the recommendations for fruit and vegetable intake in 2011-12;
- 72% of two to four year olds, 19% of 5-17 year olds and 43% of adults met the physical activity recommendations for their age group in 2011-12;
- Adults living in areas of greatest disadvantage were less likely to meet the physical activity recommendations (34%) compared with those living in areas of least disadvantage (52%).
In 2011–12, 5.1% of Australians aged 18 years and over had diabetes. This comprised 4.2% with known diabetes and 0.9% with diabetes newly diagnosed from the results of their blood tests;

In 2011–12, one in three Australians aged 18 years and over (32.8% or 5.6 million people) had abnormal or high total cholesterol levels according to their blood test results; and

People who were obese were nearly five times as likely as those who were of normal weight or underweight to have high triglycerides (25.3% compared with 5.3%) and more than twice as likely to have lower than normal levels of HDL ‘good’ cholesterol (36.2% compared with 14.1%).


**Deliverable:** Undertake the Australian Health Survey

**2012-13 Reference Point:** High level results for the survey in the general population will be available in October 2012, with more detailed results available from May 2013

The survey in the Aboriginal and Torres Strait Islander population will be conducted throughout 2012-13: commencing in May 2012 and continuing to July 2013

**Result:** Met

The Department has funded the Australian Bureau of Statistics to undertake the Australian Health Survey. The Department has worked with the ABS to guide the development of the survey and dissemination of outputs. Survey results for the general population were released during 2012-13. First results were released in October 2012. Health service usage and related actions were released in February 2013 and updated results were released in June 2013. Physical activity results were released in July 2013 and biomedical results for chronic disease were released in August 2013. Nutrition results for the general population will be released in 2013-14. The Aboriginal and Torres Strait Islander component of the survey was conducted in 2012-13. First results from this collection will be released in late 2013.

**Australian Longitudinal Study on Women’s Health**

The sixth Australian Longitudinal Study on Women’s Health (ALSWH) major report Adherence to Health Guidelines: Findings from the Australian Longitudinal Study on Women’s Health, was released in September 2012. The report covered preventative health behaviours around issues such as smoking, overweight and obesity, physical activity and diet, as well as selected health screenings such as mammography, pap smear and bowel cancer.

Among women participants in the ALSWH, adherence to guidelines on smoking, alcohol consumption and most health screens has steadily increased or has remained high since the commencement of the study. However, there are substantial differences between recommended health guidelines and actual behaviours relating to energy balance (diet, physical activity, and obesity).

Further results for the ALSWH are available from the ALSWH website at www.alswh.org.au.

**Australian Longitudinal Study on Male Health**

As field work is still underway for the Australian Longitudinal Study on Male Health (ALSMH), results from this study are not yet available.
Deliverable: Undertake the Australian Longitudinal Study on Male Health (ALSMH) and the Australian Longitudinal Study on Women’s Health (ALSWH)

2012-13 Reference Point: ALSWH: Recruitment of the new young women’s cohort (born 1989-94) will commence in October 2012

ALSMH: A dress rehearsal of the ALSMH survey instruments will occur in late 2012. Wave 1 data collection will commence in early 2013 and be completed by June 2013

Result: Substantially met

Recruitment of the ALSWH new young group began in October 2012. ALSMH Dress Rehearsal (pilot testing) occurred in October 2012 and Wave 1 data collection began in mid-2013. This was later than anticipated as pilot testing did not produce the desired survey response rates and further work was required to identify a survey recruitment approach that would provide higher response rates. Wave 1 data collection will be completed by mid-2014.

KPI: Strengthened evidence base to inform targeted health policy and program activities

2012-13 Reference Point: Results from the Australian Health Survey, Australian Longitudinal Study on Women’s Health and Australian Longitudinal Study on Male Health increase the amount of information available to researchers and policy makers

Result: Substantially met

Information continues to be gathered through the surveys detailed above in order to inform targeted health policy and program activities.

Improve child and youth health

The Department continues to work with states and territories to develop meaningful guidelines and frameworks to strengthen and improve child and youth health.

Deliverable: Completion of the Clinical Practice Guidelines for Antenatal Care

2012-13 Reference Point: Module Two of the Guidelines (covering the second and third trimesters of pregnancy) will be completed by June 2013

Result: Substantially met

Module One of the Guidelines (which covers the first trimester) was released in March 2013 and is available on the Department’s website. A complete draft of Module Two was released for public comment on 1 June 2013. Following consideration of feedback and completion of any amendments, Module 2 will need to be approved by the Australian Health Ministers’ Advisory Council, its relevant subcommittees and the National Health and Medical Research Council before its anticipated public release in mid-2014.

KPI: Delivery of health services for children in out-of-home care is consistent, evidence based and appropriate

2012-13 Reference Point: State and territory governments report on the successful implementation of the National Clinical Assessment Framework for Children in Out-of-Home care

Result: Substantially met

State and territory governments are at different stages of implementing the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care. The Department continues to monitor this work through the Standing Committee on Child and Youth Health. This committee works collaboratively with the Department of Families, Housing, Community Services and Indigenous Affairs to monitor the ongoing implementation of the framework and to strengthen it further.

26  Wave 1 data collection- the first collection of data in the ALSMH
Improve men’s and women’s health

An increasing range of innovative programs – many of them lifestyle related – are contributing to the health and wellbeing of Australian men and women.

In 2012-13, the Department continued to fund activities to support men’s health. These included the National Shed Development Program and other support for Men’s Sheds, promoting Men’s Health Week and funding Andrology Australia to address men’s sexual and reproductive health needs.

The Department also continued to facilitate meetings of the Minister’s Male Health Reference Group, and to liaise with other Australian Government agencies on cross-agency issues affecting men’s health, such as employment and workplace safety.

The Department also maintained its support for women’s health activities, including the Jean Hailes Foundation and a number of new initiatives. Key among these was the Department’s support for targeted action on female genital mutilation (FGM). This included facilitating a summit, which brought together representatives across government, peak bodies and community groups. A National Compact on FGM was issued following the summit, to reinforce Australia’s position on FGM and encourage collaborative action to best support the women and girls in Australia affected by FGM and help prevent it from occurring to a new generation. The Department funded FGM grants to support further action. Grants were focused on community awareness and education, workforce training and evidence building activities to help increase understanding of FGM, improve health services and support, and help communities move towards abandoning the practice.

Promote healthy lifestyle choices

The Department continues to deliver policies which encourage healthy lifestyle choices, including healthy eating and physical activity.

<table>
<thead>
<tr>
<th>Deliverable: Number of grants to local governments administered through the Healthy Communities Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 Target: 92</td>
</tr>
</tbody>
</table>

The Healthy Communities Initiative provided funding to 92 local government areas to implement a range of community-based healthy lifestyle programs that facilitate increased access to physical activity, healthy eating and healthy weight programs and activities for adults predominately not in the paid workforce. All 92 local government councils implemented a range of healthy lifestyle programs for the target group in their communities.

During 2012-13, the Department began the revised Stephanie Alexander Kitchen Garden National Program which aims to improve nutrition and develop lifelong healthy eating habits in primary school children. The program now allows teachers to deliver the program as well as specialist staff, provides online support and has also relaxed infrastructure requirements. The changes will result in a greater number of primary school children being taught about growing, harvesting, preparing and sharing healthy food.

### OUTCOME 1 — FINANCIAL RESOURCE SUMMARY

<table>
<thead>
<tr>
<th>Program 1.1: Prevention, Early Detection and Service Improvement</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td>2012-13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>92,377</td>
<td>93,179</td>
<td>802</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>15,109</td>
<td>15,125</td>
<td>16</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>461</td>
<td>767</td>
<td>306</td>
</tr>
<tr>
<td>Total for Program 1.1</td>
<td>107,947</td>
<td>109,071</td>
<td>1,124</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program 1.2: Communicable Disease Control</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td>2012-13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>10,653</td>
<td>9,628</td>
<td>(1,025)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>4,962</td>
<td>4,810</td>
<td>(152)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>148</td>
<td>239</td>
<td>91</td>
</tr>
<tr>
<td>Total for Program 1.2</td>
<td>15,763</td>
<td>14,677</td>
<td>(1,086)</td>
</tr>
</tbody>
</table>
## Program 1.3: Drug Strategy

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>208,704</td>
<td>195,588</td>
<td>(13,116)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>27,461</td>
<td>27,251</td>
<td>(210)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>833</td>
<td>1,385</td>
<td>552</td>
</tr>
<tr>
<td><strong>Total for Program 1.3</strong></td>
<td><strong>236,998</strong></td>
<td><strong>224,224</strong></td>
<td><strong>(12,774)</strong></td>
</tr>
</tbody>
</table>

## Program 1.4: Regulatory Policy

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>5,177</td>
<td>4,899</td>
<td>(278)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>17,439</td>
<td>17,594</td>
<td>155</td>
</tr>
<tr>
<td>to Special Accounts</td>
<td>(11,854)</td>
<td>(11,854)</td>
<td>-</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>153</td>
<td>326</td>
<td>173</td>
</tr>
<tr>
<td>Special Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OGTR Special Account</td>
<td>8,001</td>
<td>7,848</td>
<td>(153)</td>
</tr>
<tr>
<td>NICNAS Special Account</td>
<td>14,532</td>
<td>13,186</td>
<td>(1,346)</td>
</tr>
<tr>
<td>TGA Special Account</td>
<td>131,310</td>
<td>119,543</td>
<td>(11,767)</td>
</tr>
<tr>
<td>Expense adjustment</td>
<td>7,448</td>
<td>3,330</td>
<td>10,778</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>153</td>
<td>326</td>
<td>173</td>
</tr>
<tr>
<td><strong>Total for Program 1.4</strong></td>
<td><strong>157,310</strong></td>
<td><strong>154,910</strong></td>
<td><strong>(2,400)</strong></td>
</tr>
</tbody>
</table>

## Program 1.5: Immunisation

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>25,259</td>
<td>27,101</td>
<td>1,842</td>
</tr>
<tr>
<td>Other Services [Annual Appropriation Bill 2]</td>
<td>15,226</td>
<td>14,980</td>
<td>(246)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>4,927</td>
<td>4,540</td>
<td>(387)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>160</td>
<td>224</td>
<td>64</td>
</tr>
<tr>
<td><strong>Subtotal for Program 1.5</strong></td>
<td><strong>114,234</strong></td>
<td><strong>119,149</strong></td>
<td><strong>4,915</strong></td>
</tr>
</tbody>
</table>

## Program 1.6: Public Health

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>16,009</td>
<td>15,902</td>
<td>(107)</td>
</tr>
<tr>
<td>Other Services [Annual Appropriation Bill 2]</td>
<td>15,226</td>
<td>14,980</td>
<td>(246)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>7,616</td>
<td>7,631</td>
<td>15</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>231</td>
<td>386</td>
<td>155</td>
</tr>
<tr>
<td><strong>Total for Program 1.6</strong></td>
<td><strong>39,082</strong></td>
<td><strong>38,899</strong></td>
<td><strong>(183)</strong></td>
</tr>
</tbody>
</table>

## Outcome 1 Totals by appropriation type

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>358,179</td>
<td>346,297</td>
<td>(11,882)</td>
</tr>
<tr>
<td>Other Services [Annual Appropriation Bill 2]</td>
<td>8,001</td>
<td>7,848</td>
<td>(153)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>77,514</td>
<td>76,961</td>
<td>(563)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>1,986</td>
<td>3,327</td>
<td>1,341</td>
</tr>
<tr>
<td>Special Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OGTR Special Account</td>
<td>14,395</td>
<td>14,945</td>
<td>(550)</td>
</tr>
<tr>
<td><strong>Total expenses for Outcome 1</strong></td>
<td><strong>671,334</strong></td>
<td><strong>660,930</strong></td>
<td><strong>(10,404)</strong></td>
</tr>
<tr>
<td><strong>Average Staffing Level (Number)</strong></td>
<td><strong>1,227</strong></td>
<td><strong>1,223</strong></td>
<td><strong>(4)</strong></td>
</tr>
</tbody>
</table>

1 Departmental appropriation combines 'Ordinary annual services [Appropriation Bill 1]' and 'Revenue from independent sources [s31]'.
2 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
3 The budget estimate for the departmental appropriation to support the Australia and New Zealand Therapeutic Products Agency has been correctly reclassified from program group 1.5 to program group 1.4.
4 Special Accounts are reported on a cash basis. The adjustment reflects the difference between cash and expenses.
OUTCOME 2 ACCESS TO PHARMACEUTICAL SERVICES

Access to cost-effective medicines, including through the Pharmaceutical Benefits Scheme and related subsidies, and assistance for medication management through industry partnerships

MAJOR ACHIEVEMENTS

- Continued to give Australians affordable access to medicines by approving or listing 87 new Pharmaceutical Benefits Scheme (PBS) medicines, or extensions to existing listings, at a net cost of around $1.8 billion.
- Achieved value for Australian taxpayers by delivering further savings through the Expanded and Accelerated Price Disclosure program. Price changes in 2012-13 and beyond will reduce the forward estimates by a further $2 billion, with a total of around $4 billion in savings since these reforms began in 2010.
- Completed post market reviews of medicines used to treat Alzheimer’s disease and Atrial Fibrillation. This has led to improvements in the quality use of medicines, and easier access, where appropriate, for consumers and savings to the Australian community.
- Enabled people in residential aged care facilities to better manage medications through the Supply and Claiming from a Medication Chart in Residential Aged Care Facilities initiative, which by March 2013, was used in around 20 sites in the initial phase.
- Helped more than 30,000 Australians to better manage their medication through the MedsChecks and Diabetes MedsChecks programs. This, in turn, supported and improved peoples’ adherence to the quality use of medicines.

CHALLENGES

- Contesting a legal challenge to the Expanded and Accelerated Price Disclosure program.
- Ensuring a sustainable, efficient and transparent funding model for chemotherapy medicine infusions under PBS arrangements.
PERFORMANCE

81.8% MET
18.2% SUBSTANTIALLY MET
0% NOT MET

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>81.8%</td>
<td>18.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>86.2%</td>
<td>8.8%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

PROGRAMS CONTRIBUTING TO OUTCOME 2

- Program 2.1: Community pharmacy and pharmaceutical awareness
- Program 2.2: Pharmaceuticals and pharmaceutical services
- Program 2.3: Targeted assistance – pharmaceuticals
- Program 2.4: Targeted assistance – aids and appliances
**TRENDS**

Figure 2.1: Government PBS expenditure and cost per capita, 2009-10 to 2012-13

![Graph showing Government PBS expenditure and cost per capita from 2009-10 to 2012-13.](image)

**Figure 2.2: Urban and Rural Pharmacies, 30 June 2009 to 30 June 2013**

![Graph showing the number of PBS approved pharmacies from 2009 to 2013 by urban and rural categories.](image)

Note – As a result of the update of the Pharmacy Access/Remoteness Index of Australia (PhARIA) classifications, 118 pharmacies were reclassified from rural to urban.

**OUTCOME STRATEGY**

Outcome 2 aims to provide reliable, timely and affordable access to cost-effective, sustainable and high quality pharmaceutical services and medicines. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

**PROGRAM 2.1: COMMUNITY PHARMACY AND PHARMACEUTICAL AWARENESS**

Program 2.1 aims to support timely access to medicines and pharmacy services. Support timely access to medicines and pharmacy services through the Fifth Community Pharmacy Agreement (the Fifth Agreement).

The Department continues to ensure that all eligible Australians continue to have timely access to PBS medicines and other professional services through the Fifth Agreement. The Fifth Agreement provides funding to remunerate pharmacists for dispensing PBS medicines and provides pharmacists with a range of professional programs and services which enable them to better service the community.

The medication management continuum is a key focus under the Fifth Agreement. It includes Clinical Interventions, MedsChecks and Diabetes MedsChecks, and Home Medicines Reviews. This approach allows for a graduated focus on helping people with their medication management needs.
Currently more than 80% of pharmacies participate in clinical interventions. The Fifth Agreement introduced this continuum arrangement to assist with medication management. Uptake has been higher than anticipated and the Department, in consultation with key stakeholders, is considering various approaches to ensure medication management programs are sustainable.

<table>
<thead>
<tr>
<th>Deliverable:</th>
<th>Phased rollout of measure: Electronic Recording and Reporting of Controlled Drugs Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong></td>
<td>Measure phased in during the first half of 2012-13, including working with jurisdictions to facilitate the delivery of this measure</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Met</td>
</tr>
<tr>
<td>- First phase of implementation included the Department developing additional functionality for the existing Tasmanian Department of Health and Human Services real-time reporting and monitoring system so it could be used as the National Electronic Recording and Reporting of Controlled Drugs platform. The new system was offered to the states and territories at no charge via a Software Licence Agreement. States and territories that signed a Software Licence Agreement with the Commonwealth began evaluating the extent to which the system met their current and future needs. The Department will continue to work with states and territories in 2013-14 to implement this measure nationally.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable:</th>
<th>Phased rollout of measure: Supply and PBS Claiming from a Medication Chart in Residential Aged Care Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong></td>
<td>Measure phased in during the first quarter of 2012-13, including testing the National Residential Medication Chart used in the aged care sector</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Met</td>
</tr>
<tr>
<td>- The Department, in conjunction with the Australian Commission on Safety and Quality in Health Care, began phased implementation of the National Residential Medication Chart (NRMC) in nominated residential aged care facilities and pharmacies in New South Wales (NSW). The initiative will directly support improved medication safety for residents and streamline access through enabling pharmacists to supply and claim PBS medicines from orders written on standardised medication charts in aged care facilities, instead of requiring an additional prescription. The Commonwealth completed the PBS legislative changes required to allow phased implementation of the NRMC to begin from July 2012. However, state and territory enabling legislation is required to permit a medication chart to act as a prescription. In March 2013, NSW Health granted a legislative exemption to permit piloting of the NRMC. Consequently, the Department began phased implementation of the NRMC in approximately 20 selected aged care facilities in NSW from March 2013. The NSW pilot will be completed in 2013-14, and will include an evaluation to maximise medication safety and administrative efficiency.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable:</th>
<th>Phased rollout of measure: Continued Dispensing of PBS medicines in Defined Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong></td>
<td>Measure phased in during the first quarter of 2012-13, including working with jurisdictions to facilitate the delivery of this measure</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Substantially met</td>
</tr>
<tr>
<td>- The initiative aims to ensure that a patient’s treatment is not interrupted because they are unable to get their prescription renewed on time. Continued dispensing will complement existing state emergency supply provisions and allow pharmacists to process a PBS and Repatriation Pharmaceutical Benefits Scheme claim without the need for a follow-up prescription. The Commonwealth completed the PBS legislative changes required to allow continued dispensing to start from July 2012. Work progressed over 2012-13 with state and territories to support implementation, with national roll out commencing from 1 September 2013.</td>
<td></td>
</tr>
</tbody>
</table>
PROGRAM 2.2: PHARMACEUTICALS AND PHARMACEUTICAL SERVICES

Program 2.2 aims to provide access to cost-effective, innovative, clinically effective medicines to all Australians, and ensure the sustainability of the PBS.

List cost-effective, innovative, clinically effective medicines on the PBS

The PBS aims to provide Australians with timely access to a wide range of affordable and cost-effective medicines. In 2012-13, the PBS subsidised around 750 medicines available in more than 1,970 forms and marketed as more than 4,500 differently branded items.

KPI: Number of prescriptions subsidised through the PBS

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>199m</td>
<td>197m</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

In 2012-13, 197 million PBS prescriptions were subsidised against an estimate of 199 million, representing approximately 8.6 prescriptions per capita. This compares with 194.9 million prescriptions in 2011-12 and 188.1 million in 2010-11.

The listing of medicines on the PBS is based on the advice of the Pharmaceutical Benefits Advisory Committee (PBAC), an independent, expert advisory body comprising doctors, other health professionals and a consumer representative.

The PBAC assesses the safety, therapeutic benefits and cost-effectiveness of a medicine and its intended use, in comparison with other available treatments.
Deliverable: The PBAC meets at least three times a year and provides recommendations to the Minister on new listings for the PBS

2012-13 Reference Point: The PBAC recommendations for listing on the PBS are based on the clinical effectiveness and cost-effectiveness of new medicines, and provided in a timely manner

Result: Met

The PBAC met on six occasions during 2012-13. The PBAC recommendations were provided to product sponsors and the Minister for Health and the Minister for Medical Research, and made publicly available in timeframes consistent with long standing arrangements agreed with industry. All PBAC assessments are based on the clinical and cost-effectiveness of the medicine.

Deliverable: Percentage of the community’s (public) comments included for consideration at each PBAC meeting

2012-13 Target: 100% 2012-13 Actual: 100% Result: Met

In 2012-13, there were 792 consumer submissions on matters before the PBAC, compared with 924 received in 2011-12. Consumer comments on medicines under consideration by the PBAC are summarised, provided to the medicine’s sponsor, and taken into account by the committee in its decision making process.

In 2012-13, the Government approved or listed 87 new PBS medicines, or extensions to existing listings, at a net cost of around $1.8 billion over the forward estimates. In 2012-13, the following high-cost medicines, including the two new breakthrough and innovative medicines to treat hepatitis C, were listed.

Table 2.1: High-cost medicines listed in 2012-13

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>INDICATION</th>
<th>LISTING DATE</th>
<th>ESTIMATED NUMBER OF PATIENTS PER ANNUM</th>
<th>ESTIMATED EXPENDITURE – FIVE YEARS (FISCAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ticagrelor</td>
<td>Acute Coronary Syndrome</td>
<td>1 August 2012</td>
<td>60,000</td>
<td>$116.7m</td>
</tr>
<tr>
<td>Boceprevir and Telaprevir</td>
<td>Hepatitis C</td>
<td>1 April 2013</td>
<td>3,900</td>
<td>$219.3m</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Chronic nerve pain</td>
<td>1 March 2013</td>
<td>270,000</td>
<td>$452.7m</td>
</tr>
</tbody>
</table>
Australia's infected with hepatitis C now have affordable access to two new ground breaking medicines.

On 1 April 2013, the Australian Government listed on the PBS boceprevir (Victrelis®) and telaprevir (Incivo®) – two new and innovative medicines used to treat hepatitis C.

Patients would have to pay up to $78,000 a year for these medicines without subsidised access through the PBS. The PBS listings, which will cost the Australian Government around $220 million over five years, will mean more people with the most common strain of hepatitis C can be treated.

Hepatitis C represents a significant public health problem. It was estimated in 2011 that more than 300,000 Australians had been exposed to the hepatitis C virus and at least 220,000 were living with chronic hepatitis C. An estimated 10,000 Australians are newly infected with hepatitis C each year. Hepatitis C is the leading cause of liver transplants in Australia. The symptoms of chronic hepatitis C can take years to emerge. However, if left untreated, it can lead to cirrhosis (scarring of the liver), liver cancer and liver failure.

The Department plays a pivotal role in the PBS listing process of a medicine.

The Australian Government subsidises medicines through the PBS. The Pharmaceutical Benefits Advisory Committee (PBAC) is an independent, expert advisory body which evaluates medicines for subsidy and makes recommendations to the Australian Government. The Australian Government cannot list a medicine on the PBS unless the PBAC makes a recommendation in favour of its listing.

Following a positive recommendation from the PBAC, the Department negotiated with the relevant pharmaceutical companies to ensure that the PBS listing of the hepatitis C medicines was implemented in a timely manner.

Unlike other common types of hepatitis, there is currently no vaccine to prevent hepatitis C and medication is the only way to manage the disease.

Due to the PBS listing of boceprevir (Victrelis®) and telaprevir (Incivo®), it is estimated that there will be an approximate 75% cure rate for people with the most common and difficult to treat strain of the hepatitis C virus, genotype 1.

Further details about the PBS listing of boceprevir (Victrelis®) and telaprevir (Incivo®), and other useful information about the PBS, can be found on the Department’s PBS website.

On 30 June 2013, the Minister for Health and the Minister for Medical Research announced that the Australian Government had approved the PBS listing of many new medicines, including three groundbreaking medicines to treat cancer:

- Abiraterone (Zytiga®) for the treatment of prostate cancer;
- Ipilimumab (Yervoy®) for the treatment of advanced melanoma; and
- an oral form of vinorelbine (Navelbine®) for the treatment of advanced breast cancer.

The new subsidies for these three cancer medicines will cost the Australian Government more than $430 million over four years.

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31 www.pbs.gov.au
### Outcome 2  Access to Pharmaceutical Services

#### 2.1 Access to Pharmaceutical Services

**Deliverable:** Price negotiations with sponsors and conditions for listing finalised, and quality and availability checks undertaken for new PBS listings

**2012-13 Reference Point:** All negotiations and listing activity completed in a timely manner

**Result:** Met

- The listing requirements for the 87 new medicines or extensions to existing PBS listed medicines announced or listed on the PBS (after consideration by the PBAC and approval by the Government, against appropriate criteria such as quality, availability and price), were completed in a timely manner, taking into account that the Department must negotiate outcomes with sponsors.

**KPI:** Revenue received from the cost recovery of the PBS listing process

<table>
<thead>
<tr>
<th>2012-13 Target: $14.1m</th>
<th>2012-13 Actual: $9.2m</th>
<th>Result: Substantially met</th>
</tr>
</thead>
</table>

PBS cost recovery arrangements for the listing of new medicines or vaccines, or to vary the listing of existing products, were introduced from 1 January 2010. As reported in previous years, revenue from the measure continues to be well below forecast. PBS cost recovery is demand-driven. Revenue depends on factors outside the control of the Department, such as the type and number of submissions, and the number of waivers and exemptions applicable. The revenue of $9.2 million in 2012-13 compares with $6.8 million in 2011-12 and $7.8 million in 2010-11.

As required under Section 99YBC of the *National Health Act 1953*, an independent review into the impact of PBS Cost Recovery was undertaken with the report tabled in both Houses of Parliament on 19 September 2012.

The report contained four recommendations, ‘that the Government’:
- re-evaluate the activities subject to PBS Cost Recovery to ensure that costs for all current activities associated with the evaluation and listing process, such as the cost of maintaining risk share agreements, are updated to reflect current practice;
- consider whether total Government expenditure on a medicine also be considered in deciding whether to grant a fee exemption or waiver, even for those applications, which like the medicines on the Life-Saving Drug Program, involve small patient numbers but millions of dollars in expenditure, as blanket exclusions based solely on the number of patients likely to be treated do not always reflect the profitability of the medicine;
- develop ways in which structured consultation with consumers can be implemented to better inform PBS processes; and
- restructure the terms of reference for future reviews of the Cost Recovery program be structured to better align the terms of reference with the data sources available.

### Increase the sustainability of the PBS

Reforms to the PBS, including price disclosure, are helping to ensure its ongoing sustainability into the future.

Price disclosure helps to ensure that Australian taxpayers benefit from discounts and incentives provided by manufacturers for medicines where there is more than one brand on the PBS. This reduces the price paid by Government for many medicines, which helps to ensure the sustainability of the PBS. In some cases, consumers will also pay less for each PBS prescription.

The price disclosure reforms of 2010 have resulted in further price reductions for many PBS medicines. In the first year of the 2010 reforms, $1.9 billion in savings were achieved over the forward estimates period. Price changes in 2012-13 and beyond will reduce the forward estimates by a further $2 billion, with a total of around $4 billion in savings since these reforms began in 2010.
On 6 December 2012, the Federal Court ruled in favour of a Sanofi-Aventis challenge to 1 December 2012 price disclosure reductions for risedronic acid and docetaxel, resulting in a full reversal of the 23.09% reductions for risedronic acid and a change in the docetaxel reduction from 76.83% to 76.20%. The corrected prices were included in the January 2013 Schedule of Pharmaceutical Benefits. The ruling also affected the way calculations were performed in the 2013 Main Cycle\textsuperscript{32} (for 1 April 2013). In response, the Department amended the National Health (Pharmaceutical Benefits) Regulations 1960 to reflect the decisions made by the Federal Court and has proceeded to calculate all subsequent Experienced and Accelerated Price Disclosure (EAPD) cycles using the new regulations.

**KPI:** Estimated savings to Government from the price disclosure program per annum

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>$121.0m</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

This KPI has previously been reported for the 2007 price disclosure measure. From the 2012-13 financial year onwards, all price disclosure reductions occur under the EAPD measure, which was part of 2010 Further PBS Reform. The savings achieved from Further PBS Reform is reported under the “Estimated savings to Government from Further PBS Reform” KPI set out below. Price disclosure-related price reductions are an adjustment of the prices the Commonwealth pays for heavily discounted drugs, to more closely reflect the prices at which the drugs are supplied to the pharmacist. This KPI will be removed for the next reporting period.

**KPI:** Estimated saving to Government from Further PBS Reform\textsuperscript{33}

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>$528.4m</td>
<td>$661.3m</td>
<td>Met</td>
</tr>
</tbody>
</table>

Further PBS Reform saved the Government $661.3 million in 2012-13. This includes EAPD from 1 April 2012, savings from the 2% and 5% reductions on 1 February 2011 in the prices of all medicines listed on the F2A and F2(T) formularies respectively on 11 October 2010; and savings from the 1 February 2011 increase from 12.5% to 16% in the statutory price reduction applied to all medicines when their first generic competitor lists on the PBS.

**National Medicines Policy**

Australia’s National Medicines Policy (NMP) is the overarching framework that guides the Department in maintaining the community’s access to, and quality use of, medicines. The NMP has four central objectives: timely access to the medicines that Australians need, at a cost individuals and the community can afford; medicines meeting appropriate standards of quality, safety and efficacy; quality use of medicines; and maintaining a responsible and viable medicines industry.

The Department continues to collaborate with consumers, clinicians and all sectors of industry as part of its ongoing discussions on NMP issues. This engagement is important approaching the expiry of the Memorandum of Understanding (MOU) with Medicines Australia in June 2014.

The Department, on behalf of the Australian Health Ministers Advisory Council, oversaw the publishing of the *Australian Medicines Handbook Children’s Dosing Companion* in July 2013. The principal goal of the companion is to ensure health professionals have access to information on the safe delivery of commonly used medicines in Australia for children up to 18 years of age. The first edition contains information on 230 medicines. Updates to the companion will be published every six months.

The Department revised and published the *Guiding Principles for Medication Management in Residential Aged Care Facilities* in October 2012. This includes current evidence, policies and practices with the aim of promoting the safe and quality use of medicines in residential aged care facilities. The guidelines were distributed to pharmaceutical and aged care stakeholders.

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\textsuperscript{32} Each cycle is identified by the year of the first reduction day after the end of its data collection period. This provides consistent naming for main and supplementary cycles and links each cycle to a time period. The 2013 Main Cycle was the second main EAPD cycle, where the end of the data collection period was 1 April 2013.

\textsuperscript{33} Includes savings to both the PBS and the Repatriation Pharmaceutical Benefits Scheme.
Post Market Reviews

Post-market monitoring has been designed to improve patient safety, and quality use of medicines through a coordinated governance framework that draws on existing programs and data sets to monitor the actual use of medicines in clinical practice. This will allow the earlier identification of quality use of medicines issues including adverse events, improving prescribing and dispensing (through an enhanced ability to target education and support) and improve the sustainability of the PBS in the longer term through the integration of routine assessment of medicines use in the real world, including cost-effectiveness reviews for subsidised medicines.

In 2012-13, the Department completed a number of reviews including of Anticoagulation Therapies in Atrial Fibrillation and PBS listed anti-dementia medicines for Alzheimer’s disease, and began two further reviews into products used in the management of diabetes and PBS medicines used to treat asthma in children.

The reviews have contributed to improved quality use of medicines for the Australian community. For example, the review of anti-dementia medicines used to treat Alzheimer’s disease has led to price reductions for these medicines, improving the sustainability of the PBS and resulted in changes in the assessment process required to establish patient eligibility for continued subsidisation. This ensures access to these medicines is made easier for patients benefiting from treatment. It also reduces red tape for clinicians.

PBS Sustainability

The Trends in and Drivers of Pharmaceutical Benefits Scheme Expenditure Report jointly developed by the Department and Medicines Australia was released in May 2013. The report aims to inform future policy discussions between the Department and pharmaceutical industry stakeholders and provides an agreed and authoritative background to discussions on PBS expenditure and sustainability. This report demonstrates PBS growth is being driven by new medicine listings and increases in demand for existing medicines as well as an ageing population. It also confirms price disclosure and other policies are improving PBS sustainability, through growth in generic medicines.

The Department, on behalf of the Government, is seeking to recover compensation from pharmaceutical companies for losses incurred as a result of delays in the listing of generic medicines on the PBS arising out of unsuccessful legal challenges by pharmaceutical patent owners. The Department has commenced proceedings in the Federal Court in separate cases against Sanofi and Wyeth for losses arising out of delayed listing of generic versions of clopidogrel and venlafaxine, respectively.

Pharmaceutical Benefits Consolidated Information System (PharmCIS)

PharmCIS, implemented on 1 December 2012, is a submission processing information technology system that supports the processes of evaluating, pricing and listing medicines on the PBS. The new information system has modernised the PBS data infrastructure providing a consolidated view of all PBS Schedule information and delivering consistent and reliable information for improved decision making. The introduction of the new system has provided the opportunity to better structure information and data (for example PBS restrictions text) that allows downstream recipients of PBS data the capacity to more easily and automatically use the data and provides greater clarity for prescribers and dispensers.

PROGRAM 2.3: TARGETED ASSISTANCE – PHARMACEUTICALS

Program 2.3 aims to improve access to new and existing medicines for patients with life threatening conditions.

Improve access to new and existing medicines for patients with life threatening conditions

The Life Saving Drugs Program provides patients with financial assistance to access expensive and ‘life saving’ drugs not available on the PBS. In 2012-13, the Life Saving Drugs Program provided 228 eligible patients with fully subsidised access to expensive, life saving medicines for very rare life threatening conditions. During the year, 10 medicines were funded through the program for the treatment of seven separate disorders including: imiglucerase (Cerezyme®), velaglucerase (VPRIV®) and miglustat (Zavesca®) to treat Gaucher disease; agalsidase alfa...
2.1

(Replagal®) and agalsidase beta (Fabrazyme®) for Fabry disease; laronidase (Aldurazyme®) for Mucopolysaccharidosis (MPS) Type I; idursulfase (Elaprase®) for MPS Type II; galsulfase (Naglazyme®) for MPS Type VI; alglucosidase alfa (Myozyme®) for infantile-onset Pompe disease; and eculizumab (Soliris®) for Paroxysmal Nocturnal Haemoglobinuria.

Each condition has separate eligibility guidelines, developed and administered with the advice of an expert disease advisory committee.

Global shortages of Fabrazyme® and Cerezyme® in 2012-13 continued to have an impact on the availability of these medicines through the Life Saving Drugs Program for treating Fabry and Gaucher diseases. The Department worked with industry and clinical advisory committees to ensure the best outcome for patients receiving treatment through the program. The supply shortages of Fabrazyme® and Cerezyme® were resolved in 2012-13, and eligible patients will continue to receive treatment through the program.

In 2013-14, the Department will continue to work with industry to finalise Deeds of Agreement for terms of supply for all medicines supplied through the Life Saving Drugs Program.

### Deliverable: Review program guidelines to ensure they remain current and relevant

#### 2012-13 Reference Point: Program guidelines reviewed within agreed timeframes

#### Result: Met

- The guidelines are used by the disease advisory committees to assess patients’ initial and ongoing eligibility. This assessment process can lead to the identification of the need for appropriate changes to guidelines.

### Deliverable: Number of patients assisted through the Life Saving Drugs Program

#### 2012-13 Target: 225

#### 2012-13 Actual: 228

#### Result: Met

- In 2012-13, 228 patients were assisted through the Life Saving Drugs Program. All patients are reviewed every six months against the relevant eligibility criteria for the respective disease.

### KPI: Eligible patients have timely access to the Life Saving Drugs Program

#### 2012-13 Reference Point: Patient applications are processed within 30 calendar days of receipt

#### Result: Met

- All applications were processed within 30 calendar days of receipt of the complete data package to support the application.

### PROGRAM 2.4: TARGETED ASSISTANCE — AIDS AND APPLIANCES

Program 2.4 aims to provide support for people that require specific medical aids and appliances, for those people with diabetes, people who require a stoma and dressings for individuals with Epidermolysis Bullosa. 34

#### Provide support for people with diabetes

The Department ensures that people with diabetes have timely, reliable and affordable access to products and services that help them effectively self-manage their condition. In 2012-13, the Department worked with Diabetes Australia to continue the effective delivery of the National Diabetes Services Scheme (NDSS). This also included work to progress three independent reviews which assess current arrangements under the scheme, to identify potential efficiencies for product supply and delivery, product listing, and registrant support services. These reviews, the final of which were completed in early 2013, will be supplemented by a consultation process that began in June 2013 and will draw together findings of the three reviews to inform future arrangements.

---

34 A genetic disease characterised by extremely fragile and blister prone skin.
### Deliverable: Number of people with diabetes receiving benefit from the National Diabetes Services Scheme

| 2012-13 Target: 1,180,000 | 2012-13 Actual: 1,087,000 | Result: Substantially met |

As at 30 June 2013, an estimated 1,087,000 people with diabetes were registered on the NDSS. The forecast of 1,180,000 was an estimate and it should be noted that the number of people receiving benefits under the scheme reflects the demand-driven nature of the scheme.

### Deliverable: Number of people under 18 years of age with type 1 diabetes receiving a subsidised insulin pump

| 2012-13 Target: 62 | 2012-13 Actual: 76 | Result: Met |

The number of insulin pumps subsidised under the program in 2012-13 exceeded its target due to the variable cost of pumps that are available and subsidised under the program.

### KPI: Percentage of eligible people with diabetes who are able to access clinically appropriate products

| 2012-13 Target: 100% | 2012-13 Actual: 100% | Result: Met |

All eligible people with diabetes have been able to access needles, test strips, syringes and insulin pump consumables through the scheme as required.

### Assist people with a stoma by providing stoma related products

The Department continued to support the revised program pricing and listing framework for the Stoma Appliance Scheme, including listing 22 new products on the scheme. These new products, while being cost neutral to the scheme, have offered a wider choice of subsidised products. In addition, a review of price premiums applied to products has begun as a result of a 2012-13 Budget measure. In April 2013, price premiums were added to 22 products and removed from 23 products, following a review by the Stoma Product Assessment Panel. Further reviews will take place in 2013-14.

### Deliverable: Number of people receiving stoma related products

| 2012-13 Target: 41,000 | 2012-13 Actual: 39,063 | Result: Met |

This figure represents people receiving assistance to the end of March 2013. Directly comparable data for the full financial year is not available due to a system change which has resulted in a change to the way in which individual participants are reported.

However, it is anticipated that if June 2013 figures had been available, they would have shown that the target has been met, as expenditure on the Stoma Appliance Scheme increased in line with predicted growth. In 2012-13 expenditure was 5% more than 2011-12; a 5% increase in the number of people benefiting would give a total of 42,149 at 30 June 2013.

### KPI: Percentage of eligible people with stomas who are able to access clinically appropriate products

| 2012-13 Target: 100% | 2012-13 Actual: 100% | Result: Met |

All participants who met the eligibility criteria received products under the Stoma Appliance Scheme.

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35 An opening in the abdomen for evacuation of products from the bowel or bladder.
36 Figures as at 31 March 2013.
Improve the quality of life for people with Epidermolysis Bullosa

The Department has continued to provide access to clinically appropriate dressings for people with Epidermolysis Bullosa through the National Epidermolysis Bullosa Dressing Scheme. The scheme continues to assist people with Epidermolysis Bullosa by reducing the financial burden associated with purchasing necessary dressings.

KPI: The National Epidermolysis Bullosa Dressing Scheme is reviewed

2012-13 Reference Point: Review completed by 30 June 2013

Result: Met

Following an internal review, ongoing consultation with peak groups including Dystrophic Epidermolysis Bullosa Research Association of Australia, and previous discussions with the Clinical Advisory Committee, the eligibility for the scheme was modified in October 2012 to remove all age restrictions under the scheme.

In addition, regular reports from the program administrators indicate overall satisfaction with the scheme and timely supply of clinically necessary products to ensure positive health outcomes and quality of life for these people.

Deliverable: Number of people with Epidermolysis Bullosa receiving subsidised dressings

2012-13 Target: 79  
2012-13 Actual: 99  
Result: Met

The number of people with Epidermolysis Bullosa who are receiving subsidised dressing has significantly increased in 2012-13, as a result of the expansion of eligibility for the scheme to all age groups.

37 A genetic disease characterised by extremely fragile and blister prone skin.
### Outcome 2 - Financial Resource Summary

#### Program 2.1: Community Pharmacy and Pharmaceutical Awareness

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services</td>
<td>$338,854</td>
<td>$319,430</td>
<td>$(19,424)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>6,784</td>
<td>6,896</td>
<td>112</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>157</td>
<td>264</td>
<td>107</td>
</tr>
<tr>
<td>Total for Program 2.1</td>
<td>$340,795</td>
<td>$326,590</td>
<td>$(14,205)</td>
</tr>
</tbody>
</table>

#### Program 2.2: Pharmaceuticals and Pharmaceutical Services

#### Program 2.3: Targeted Assistance - Pharmaceuticals

#### Program 2.4: Targeted Assistance - Aids and Appliances

#### Outcome 2 Totals by appropriation type

1. Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.
2. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
OUTCOME 3 ACCESS TO MEDICAL SERVICES

Access to cost-effective medical, practice nursing and allied health services, including through Medicare subsidies for clinically relevant services

MAJOR ACHIEVEMENTS

• Enabled more patients to access magnetic resonance imaging (MRI) scans under Medicare.
• Supported telehealth services to give patients better access to specialist medical services where distance is a barrier.
• Promoted patient safety by implementing the removal of out-of-hospital benefits for complex and unsafe procedures.
• Ensured patients can continue to access affordable medical services by improving the management and governance of the Medical Benefits Schedule through implementing the Comprehensive Management Framework for the Medicare Benefits Schedule.

CHALLENGES

• Continue to engage key stakeholders of the Medical Services Advisory Committee and reviews processes. This is fundamental to ensure credibility of the processes and support for an evidence-based approach.
• Support long term sustainability of Medicare expenditure.
• Continue to work co-operatively with the non-Government signatories to the Pathology Funding Agreement in order to achieve the objectives of the terms of the Agreement and the key outcomes of access to high quality and affordable Pathology Services.
PART 2 PERFORMANCE REPORTING

OUTCOME 3 ACCESS TO MEDICAL SERVICES

PERFORMANCE

2012-13

MET 66.7%
SUBSTANTIALLY MET 25.0%
NOT MET 8.3%

2011-12

MET 67.3%
SUBSTANTIALLY MET 23.6%
NOT MET 9.1%

PROGRAMS CONTRIBUTING TO OUTCOME 3

Program 3.1: Medicare services
Program 3.2: Targeted assistance – medical
Program 3.3: Diagnostic imaging services
Program 3.4: Pathology services
Program 3.5: Chronic disease – radiation oncology
**TRENDS**

Figure 3.1: Steady increase of specialists providing telehealth services funded under Medicare

**OUTCOME STRATEGY**

Outcome 3 aims to provide access for eligible people to high quality and clinically relevant medical, dental and associated services. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

**PROGRAM 3.1: MEDICARE SERVICES**

Program 3.1 aims to improve access to evidence-based, best practice and specialist medical services.

**Improve access to evidence-based, best practice medical services**

The Department aims to ensure all Australians have access to free or low-cost medical, optometry and hospital care and, in special circumstances, allied health services.

<table>
<thead>
<tr>
<th>KPI: Number of services delivered through Medicare by providing rebates for items listed on the MBS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Target:</strong> 336m</td>
</tr>
</tbody>
</table>

Medicare rebates were provided for 343.6 million services. This is an average of 14.8 services per capita. It compares with 332.2 million services in 2011-12 and 318.8 services in 2010-11.

To ensure the Medicare Benefits Schedule (MBS) supports cost-effective, evidence-based best practice care, the Department is progressing a number of reviews with the advice of the independent expert Medical Services Advisory Committee (MSAC). MSAC’s role is to advise the Minister on evidence relating to the safety, effectiveness and cost-effectiveness of new and existing medical technologies and procedures. This advice informs Government decisions about public funding for medical services.
Deliverable: Number of reviews of existing MBS items commenced:

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>rapid reviews 0</td>
<td>3</td>
<td>Met</td>
</tr>
<tr>
<td>speciality reviews 2</td>
<td>2</td>
<td>Met</td>
</tr>
</tbody>
</table>

The Department began two specialty reviews for surgical paediatric services and ear, nose and throat services as well as an additional three reviews for vitamin D, vitamin B12 and folate testing. The draft scope and protocol reports have been released for public consultation and are being considered by expert working groups. The review reports will then be considered by the MSAC which will provide advice to the Minister.

Deliverable: Number of appraisals of new items, or amendments to items, commenced

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>32</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012-13, 32 appraisals of new items, or amendments to existing items, began.

Improve access to specialist medical services through the use of telehealth

The Department has introduced six new telehealth MBS items for short specialist consultations and made a range of adjustments to telehealth services funded under the MBS.

Deliverable: MBS rebates paid for specialist telehealth consultations

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>$58.2m</td>
<td>$10m</td>
<td>Not met</td>
</tr>
</tbody>
</table>

MBS rebates continued to be available for private specialist telehealth consultations in 2012-13, with six new MBS items introduced for specialist video consultation which are 10 minutes or less. These MBS rebates have helped more than 40,000 patients in telehealth-eligible areas to access specialist medical services by video consultation.

Medicare is a demand-driven program and deliverables are impacted by patient and provider behaviour.

In 2012-13, the Department of Human Services processed claims for 71,000 telehealth services – an increase from 26,000 telehealth services in the previous financial year.

Using the Internet to Bring Health Services to Rural Patients

For patients who live outside the major cities, seeing a medical specialist can often involve a lot of travel, time and expense.

Many patients in rural and remote Australia are now able to access health care by ‘seeing’ a specialist in their home, GPs’ surgery, Aboriginal Medical Service or Residential Aged Care Facility.

Patients in areas such as Central and North West Queensland, the Eyre Peninsula of South Australia, and the Pilbara and Kimberley regions of Western Australia have obtained the specialist medical advice they needed by video consultation.

Specialists providing these video consultations have included ophthalmologists, cancer specialists and psychiatrists.

In 2012-13, the Medicare Benefits Schedule for telehealth consultations was adjusted to target the use of video consultations in rural, remote and very remote areas.
Improve access to clinically relevant dental services

The Department is focused on improving the dental health of Australian teenagers by promoting preventative dental checks. In 2012-13, the Department worked with the Department of Human Services to provide vouchers to ensure access to preventative dental services for teenagers aged 12-17 years under the Medicare Teen Dental Plan.

The Government closed the Medicare Chronic Disease Dental Scheme to all patients from 1 December 2012. The Department, along with the Department of Human Services, managed patient and provider access during the transition to the scheme closing.

**Deliverable:** Number of vouchers provided to eligible teenagers

<table>
<thead>
<tr>
<th>2013 Target:</th>
<th>1.2m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Actual:</td>
<td>1.2m</td>
</tr>
<tr>
<td>Result:</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012-13, 1.2 million vouchers were posted to all teenagers eligible for the Medicare Teen Dental Plan.

**KPI:** Percentage uptake of preventative dental checks by eligible teenagers

<table>
<thead>
<tr>
<th>2013 Target:</th>
<th>39%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Actual:</td>
<td>31%</td>
</tr>
<tr>
<td>Result:</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

The Medicare Teen Dental Plan is a demand-driven, calendar year program. As eligibility for benefits spans the full calendar year, vouchers issued in 2012 and 2013 can be used for services outside the 2012-13 reporting period. Claims for benefits may also be made for several years after the date of service.

Program 3.2: Targeted assistance – medical

Program 3.2 aims to provide medical assistance to Australians overseas and support access to necessary medical services not available through mainstream mechanisms.

Provide medical assistance to Australians overseas

The Australian Government continued to facilitate the provision of essential medical treatment for Australian residents travelling in certain countries through Reciprocal Health Care Agreements. In 2012-13, the Department took a lead role in managing agreements with 11 countries, in collaboration with the Department of Foreign Affairs and Trade. In 2012-13, visitors to Australia from reciprocal countries accessed 144,223 MBS services with a total of $8.95 million paid in benefits.

Through the Disaster Health Care Assistance Schemes, the Department provides ex-gratia payments to eligible victims and their families to cover out-of-pocket expenses for health care delivered in Australia for ill health or injury which has arisen as a result of specific international disasters. The six schemes cover incidents arising from acts of terrorism, civil disturbances or natural disasters. In recent years, these have included events such as the Bali bombings and the Asian tsunami.

In 2012-13, the Department of Human Services paid more than $414,000 for 3,041 claims on the Department’s behalf.

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38 The Medicare Teen Dental Plan operates on a calendar year basis. As such, estimates are for vouchers provided in the relevant calendar year.
39 The Medicare Teen Dental Plan operates on a calendar year basis. As such, estimates are for vouchers provided in the relevant calendar year.
40 Reciprocal Health Care Agreements provide access to public health services for Australian residents visiting certain countries, and for residents of those countries visiting Australia.
41 The Australian Government has Reciprocal Health Care Agreements with New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway.
42 Out-of-pocket costs are those expenses which are not covered by Medicare, other government programs or private travel or health insurance.
### Deliverable: Provide health care assistance to eligible Australians overseas in the event of overseas disasters

#### 2012-13 Reference Point: Assistance is provided in a timely manner

#### Result: Met

- The Disaster Health Care Assistance Schemes are demand-driven programs. Eligible people receive reimbursement for ‘out-of-pocket’ health care expenses related to any injury or illness which has resulted from one of the incidents covered by the schemes. In 2012-13, all reimbursements were provided in a timely manner.

### National External Breast Prostheses Reimbursement Program

The National External Breast Prostheses Reimbursement Program provides reimbursement of up to $400 for new and replacement external breast prostheses for women who have had a mastectomy as a result of breast cancer.

#### KPI: Percentage of claims by eligible women under the National External Breast Prostheses Reimbursement Program processed within ten days of lodgement

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>98%</td>
<td>Met</td>
</tr>
</tbody>
</table>

- During 2012-13, 14,591 reimbursements were processed under this program. Of the 14,591 eligible claims made, 98% were processed within 10 days of lodgement.

### Support access to necessary medical services not available through mainstream mechanisms

During 2012-13, the Department continued to support access to necessary medical services which are either not available through mainstream mechanisms, such as Medicare, or which are not available in Australia.

The Department funded three organisations through health program grants for a range of targeted services which support groups with special needs, such as the homeless, the disadvantaged and the visually impaired, to overcome barriers to accessing services through mainstream mechanisms such as Medicare.

Services provided under the health program grants include primary health care; intervention counselling; optometry and orthoptic consultations; and scientific aids, assisted technology and adaptive living aids for low vision.

#### Deliverable: Regular review of gaps in service provision to improve individuals’ access to medical services

#### 2012-13 Reference Point: Timely and responsive review process

#### Result: Met

- The Department reviews reports from funded organisations to monitor the volume of services offered and to gauge whether people’s actual needs are being met through the program. Organisations have sought feedback from their clients about the services provided. This feedback has informed the delivery of better tailored services. These include the expansion of services to assist visually impaired young people to become more independent and the extension of local service networks to better meet the primary health care needs of the homeless and those living with a mental illness or suffering drug addiction.
**Outcome 3: Access to Medical Services**

### 2.1 Access to Health Services

**KPI:** Number of health services provided to eligible Australian residents, such as the homeless, the disadvantaged and the visually impaired that could not be provided through Medicare, due to patient access barriers.

<table>
<thead>
<tr>
<th>2012-13 Target: 36,800</th>
<th>2012-13 Actual: 34,864</th>
<th>Result: Substantially met</th>
</tr>
</thead>
</table>

In 2012-13, 34,864 services were provided to eligible Australians. This compares with 38,738 in 2011-12 and 33,332 in 2010-11. These programs are demand driven. Demand for services in 2012-13 was less than anticipated.

### Medical Treatment Overseas Program

The Medical Treatment Overseas Program provides eligible Australians with funding to access approved medical treatments overseas for life threatening illnesses, where treatment is not currently available in Australia. In 2012-13, the Department received 23 applications for financial assistance, of which only 12 applications were eligible for further assessment. On the basis of the assessments, the Department provided financial assistance to six eligible Australian residents to access approved medical treatment overseas.

### Improve access to specialist medical services through the use of telehealth

Incentive payments to practitioners encourage and support provision of telehealth services. In 2012-13, the Department implemented changes to the non-MBS financial incentives to encourage telehealth into normal practice. The telehealth on-board incentives were restructured to be paid in two instalments – one third following the first telehealth service and two thirds following the tenth service. There has been an increase in the proportion of practitioners who have provided five or more telehealth services since splitting the on-board incentive into two instalments.

A total of 12% of medical specialists have provided a telehealth service funded under Medicare. This is an increase from 7% of specialists as at the end of June 2012.

### Program 3.3: Diagnostic Imaging Services

Program 3.3 aims to strengthen the provision of quality diagnostic imaging services and ensure ongoing affordable and effective use of diagnostic imaging services.

#### Magnetic resonance imaging

The Department continued to implement reforms for MRI arising out of the 2011 Review of Funding for Diagnostic Imaging. These reforms ensure more Australians have access to affordable diagnostic imaging and benefit from faster diagnosis and early detection performed by an appropriately qualified practitioner at facilities that meet all necessary accreditation standards.

From 1 November 2012, the MRI expansion included the extension of Medicare requesting rights to GPs for children under the age of 16 years presenting with specified clinical indications. This will enable young Australians to have more direct access to Medicare-eligible MRI services and will also limit the exposure to radiation from alternative imaging modalities such as computed tomography (CT).

During 2012, the number of Medicare-eligible MRI units in Australia increased to 338. This includes the extension of full Medicare eligibility for MRI units operating in regional areas and partial Medicare eligibility for MRI units operating in metropolitan areas before May 2011. Full Medicare eligibility was granted to 12 MRI units in areas of need, which will become operational between 2012 and 2015. Medicare eligibility has been extended for MRI items listed on the MBS for the initial staging of rectal and cervical cancer, and the screening of breast cancer in women under 50 years of age for all partial Medicare-ineligible MRI units operating in major cities.

**Deliverable:** Number of additional MRI units in areas of need given Medicare eligibility

<table>
<thead>
<tr>
<th>2012-13 Target: 2</th>
<th>2012-13 Actual: 4</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

Of the 12 MRI Medicare-eligible units granted as a result of the MRI Areas of Need Invitation to Apply process, Medicare eligibility was granted to four diagnostic imaging providers in 2012-13. These are all currently operational.
Giving younger patients better access to MRI

Thousands of Australian children with suspected broken bones, arthritis, and other conditions requiring urgent attention have received quicker diagnosis and treatment following a change in Medicare regulations on MRI scans.

Between November 2012 and the end of June 2013, 10,354 MRI scans were provided to patients under 16 years using the new regulations.

The new regulations allow young patients with certain conditions to receive Medicare rebates on MRI scans referred by their GPs.

The change means that eligible children and teenagers no longer have to suffer the delays and extra costs involved in getting a referral from a specialist or consultant physician.

A major additional benefit is that these children are able to be diagnosed with MRI rather than being exposed to the radiation associated with computed tomography (CT) scans.

MRIs referred by GPs are now Medicare-eligible if the child needs a:

- scan of head for unexplained seizure or headache, or paranasal sinus pathology;
- scan of spine for significant trauma or unexplained neck or back pain with associated neurological signs;
- scan of knee following radiographic examination for internal joint derangement;
- scan of hip for suspected septic arthritis or suspected slipped capital femoral epiphysis or suspected Perthes disease;
- scan of elbow for significant fracture or avulsion injury; or
- scan of wrist where scaphoid fracture is suspected.

The new regulations follow a detailed review of funding arrangements for diagnostic imaging, to support access to quality diagnostic imaging services.

Encourage more effective use of diagnostic imaging

The Diagnostic Imaging Quality Program (DIQP) brings together the diverse diagnostic imaging specialties to encourage and facilitate industry collaboration and cooperation. This program promotes the funding of high-quality projects, which meet the expectations of both the industry and the Department, ultimately resulting in safer and better quality Medicare-funded services.

All DIQP projects are focused on ensuring that diagnostic imaging services funded through the Health Insurance (Diagnostic Imaging Services Table) Regulation 2012 are safe, effective and of the highest quality.

**Deliverable:** Fund activities to improve the quality of diagnostic imaging services

**2012-13 Reference Point:** Funding agreements with successful applicants to the Diagnostic Imaging Quality Program will be in place with monitoring activities conducted in 2012-13

**Result:** Met

A total of 12 DIQP funding agreements are in place. These projects cover topic areas such as CT dose reduction, informed consumer consent, radiology education enhancement and ultrasound qualifications. Monitoring activities are being conducted to ensure each project outcome is achieved. All projects are running on schedule with most projects due to end by 30 June 2014.
Strengthening the provision of quality diagnostic radiology services

The Strengthen the Provision of Quality Diagnostic Radiology Services initiative, introduced on 1 November 2012, requires that those performing the actual diagnostic imaging procedure hold minimum qualifications for all Medicare funded x-ray, angiography and fluoroscopy services. This will address quality and safety concerns about minimum qualification levels of practitioners and technicians performing diagnostic imaging procedures. These concerns arose from the Review of Funding for Diagnostic Imaging Services. In 2012-13, the Department monitored and evaluated the impact of the new requirements.

Diagnostic Imaging Accreditation Scheme

To ensure uniform safety and quality standards across the entire diagnostic imaging sector, all diagnostic imaging sites wanting to provide MBS eligible services must be accredited through the Diagnostic Imaging Accreditation Scheme (DIAS). The Department continued to manage and work with external accreditors to assist diagnostic imaging providers gain full accreditation by 1 July 2013, under Stage 2 of the DIAS.

KPI: Number of practices participating in the Diagnostic Imaging Accreditation Scheme

| 2012-13 Target: 4,300 | 2012-13 Actual: 3,909 | Result: Substantially met |

The current number of practices participating in the DIAS is slightly lower than anticipated, however it continues to increase. A number of small practices providing low service volumes have reported that they have withdrawn from the accreditation process as they do not believe it is worth the investment. Similarly, a number of chiropractic practices are no longer providing diagnostic imaging services as a result of the implementation of the Strengthen the Provision of Quality Diagnostic Radiology Services initiative, introduced on 1 November 2012. Phase two of the evaluation began in July 2012. The report was completed and submitted to the Department in January 2013. The third and final phase of the evaluation will be completed in February 2014.

Program 3.4: Pathology services

Program 3.4 aims to provide access to high quality and affordable pathology services and ensure pathology services align with best clinical practice.

Assurance of quality and accessibility of services

The Department has continued to ensure access to high quality, clinically relevant and cost-effective pathology services through the management of the Pathology Funding Agreement, National Pathology Accreditation Framework and the Quality Use in Pathology Program.

During 2012-13, the Department undertook a funding round for the program to continuously improve already high quality pathology services. The streamlined accreditation framework refines the best practice standards for laboratories to ensure the delivery of high quality pathology services for consumers.

Deliverable: Number of new and/or revised national accreditation standards produced for pathology laboratories

| 2012-13 Target: 4 | 2012-13 Actual: 0 | Result: Not met |

The Department has continued to work with the National Pathology Accreditation Advisory Council to streamline the pathology accreditation materials to improve the comprehensiveness of the documents and to reduce duplication in individual documents. Six other standards are also under review. The streamlining initiative was a complex process and was not able to be completed in this reporting period. However, it is expected that this will be completed in 2013-14 along with two other revised standards.
KPI: Percentage of Medicare-eligible laboratories meeting pathology accreditation standards laboratories

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>100%</th>
<th>2012-13 Actual:</th>
<th>100%</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

In accordance with the administrative arrangements established by the Department to support the effective operation of the relevant aspects of the Health Insurance Act 1973, the Department of Human Services has liaised with the approved accreditation assessment agency to ensure that Medicare eligibility is only available to laboratories that meet the requirements set out in the national pathology accreditation materials.

KPI: Percentage of pathology services that are bulk-billed laboratories

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>86%</th>
<th>2012-13 Actual:</th>
<th>87%</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

A high bulk-billing rate of 87% was maintained during 2012-13. This compares to 87% in 2011-12 and 86% in 2010-11.

Pathology Funding Agreement

Under the Pathology Funding Agreement, the Department ensures patients have access to quality and affordable pathology services while giving taxpayers value for money. On 1 January 2013, MBS fee reductions were implemented to recover the overspend on MBS pathology services that occurred in 2011-12. In 2012-13, pathology expenditure continued to pose a challenge as it exceeded the expenditure cap (5% growth per year), therefore further MBS fee reductions will be required. Parties signatory to the Pathology Funding Agreement will need to cooperate to address overspends and prevent them in the future.

KPI: Annual growth rate in MBS pathology expenditure

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>4.875%</th>
<th>2012-13 Actual:</th>
<th>6.399%</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

In 2012-13, the annual growth rate was 6.399%. This compares to 6.729% in 2011-12 and 4.285% in 2010-11. The Pathology Funding Agreement outlines the process to manage MBS pathology services outlays.

Deliverable: Work with the National E-Health Transition Authority (NEHTA) to develop national standards for electronic reporting of pathology results

<table>
<thead>
<tr>
<th>2012-13 Reference Point:</th>
<th>Introduce national standards by 30 June 2013</th>
</tr>
</thead>
</table>

Result: Substantially met

The Department continues to work with NEHTA and pathology stakeholders to support the introduction of national standards. The Department funded the Royal College of Pathologists of Australia to standardise units and terminology. National standards will help make pathology requesting and reporting more consistent and help to ensure high quality pathology services for patients.

Deliverable: Develop an approach to genetic testing

<table>
<thead>
<tr>
<th>2012-13 Reference Point:</th>
<th>Review of current genetic testing arrangements and options for reform to be finalised by 30 December 2012</th>
</tr>
</thead>
</table>

Result: Substantially met

The Genetics Working Party has made significant progress by conducting stakeholder consultations with states and territories. The report is expected to be finalised in late 2013.

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43 These figures are as per the Pathology Funding Agreement between the Australian Government and the pathology sector.

44 AS 4700.2-2012: Implementation of Health Level Seven (HL7) Version 2.4 – Pathology and diagnostic imaging (diagnostics).
PROGRAM 3.5: CHRONIC DISEASE — RADIATION ONCOLOGY

Program 3.5 aims to improve access to high quality radiation oncology services.

Improve access to quality radiation oncology services

The Department continues to improve access to high quality radiation oncology services by funding approved equipment, quality programs and initiatives to increase the number of trained radiotherapy professionals.

KPI: Projects are undertaken to increase radiation oncology workforce capacity, both through increased training capacity and enhanced capability of the existing workforce.

2012-13 Reference Point: Strategies and initiatives to increase workforce capacity are adopted by key stakeholders

Result: Met

The Department works closely with states and territories and the radiation oncology professions to ensure sufficient numbers of qualified staff to meet the growing demand for radiation therapy services.

In 2011, a funding round for innovative workforce activities was conducted under the Better Access to Radiation Oncology Grant Program. Fourteen projects relating to radiation oncology workforce capacity and capability were funded. These grants run for three years until 2014. The types of activities being funded include workforce planning, reducing barriers to training and attracting staff to regional areas.

Funding was provided to 65 facilities to contribute to the cost of approved radiotherapy equipment through the Radiation Oncology Health Program Grants Scheme. These grants gradually reimburse service providers for the cost of approved equipment used to provide treatment services, helping to ensure that equipment is replaced regularly and that patients are treated using current techniques and technologies.

KPI: The number of sites delivering radiation oncology

2012-13 Target: 66

2012-13 Actual: 6645

Result: Met

By the end of 2012-13, 65 radiation oncology facilities were providing services to patients. A further site, which was initially predicted to start operations in 2012-13, began treating patients in July 2013.

In addition, the Department continued to fund the Australian Clinical Dosimetry Service. A three year trial by the Australian Radiation Protection and Nuclear Safety Agency continues to undertake equipment audits of radiation oncology facilities to check that the doses of radiation delivered to patients are accurate. In November 2012, the Department engaged an independent consultant to work closely with the sector to evaluate this trial, to best consider future options for quality dosimetry.

KPI: Radiation oncology services are safe and of high quality

2012-13 Reference Point: Radiation oncology practice standards are promoted by the professions as a guide to good practice

Result: Met

The peak bodies representing the three main groups of health professionals involved in delivering radiation treatment are promoting the standards on their member websites. The Department has continued to fund and evaluate the Australian Clinical Dosimetry Service to ensure radiation doses to patients are accurate.

45 This figure includes a facility that started treating patients in July 2013.
Deliverable: Develop a framework to improve patient safety and clinical outcomes from radiation treatment

2012-13 Reference Point: Options for assessment against new radiation oncology practice standards are developed and costed with the professions

Result: Substantially met

The Department has undertaken preliminary work on the development of this project, including reviewing submissions from stakeholders and working with an advisory group to refine implementation options. In 2013-14, more detailed proposals, underpinned by an independent costing analysis, will be developed for stakeholder consultation.

OUTCOME 3 — FINANCIAL RESOURCE SUMMARY

<table>
<thead>
<tr>
<th>Program 3.1: Medicare Services</th>
<th>(A) Budget Estimate 2012-13 $’000</th>
<th>(B) Actual 2012-13 $’000</th>
<th>Variation (Column B minus Column A) $’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>6,078</td>
<td>6,131</td>
<td>53</td>
</tr>
<tr>
<td>Special appropriations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Benefits Act 2008</td>
<td>83,087</td>
<td>59,526</td>
<td>23,561</td>
</tr>
<tr>
<td>Health Insurance Act 1973</td>
<td>18,459,874</td>
<td>18,560,090</td>
<td>100,216</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>28,880</td>
<td>28,138</td>
<td>742</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>846</td>
<td>1,339</td>
<td>493</td>
</tr>
<tr>
<td>Total for Program 3.1</td>
<td>18,578,765</td>
<td>18,655,224</td>
<td>76,459</td>
</tr>
</tbody>
</table>

Program 3.2: Targeted Assistance – Medical

Program 3.3: Diagnostic Imaging Services

Program 3.4: Pathology Services

Program 3.5: Chronic Disease - Radiation Oncology

Outcome 3 Totals by appropriation type

Average Staffing Level (Number) 206 205 (1)

1 Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’

2 ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
OUTCOME 4 AGED CARE AND POPULATION AGEING

Access to quality and affordable aged care and carer support services for older people, including through subsidies and grants, industry assistance, training and regulation of the aged care sector

MAJOR ACHIEVEMENTS

- The Department progressed key elements of the aged care reforms through developing major legislative changes, which were passed by Parliament and became law on 28 June 2013.
- Developed the My Aged Care website and national contact centre, starting from 1 July 2013, making it easier for consumers, their families and carers to access quality information on ageing and aged care.
- The 2012-13 Aged Care Approvals Round marked a key step forward in the delivery of a significantly expanded and more consumer directed Home Care Packages Program.
  - Supported 486,000 people through the Commonwealth Home and Community Care program in its first year of operation following the transfer of full funding and operational responsibility from states and territories except in Western Australia and Victoria.
  - Supported appropriate and inclusive aged care through the release of the National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse backgrounds and the National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy.

CHALLENGES

- Ensuring benefits for both consumers and providers by enabling stakeholders, including consumer groups, provider peak bodies and groups representing aged care workers, to contribute to implementing changes in the aged care system and supporting them through program guidelines and communication.
- Building an appropriately skilled and well-qualified workforce to deliver quality care to older Australians.
- Ensuring the administration of the aged care regulatory framework appropriately accommodates changes in the aged care system, including introducing home care packages and consumer directed care.
- Continuing to focus on building stronger connections between the health and aged care systems, promoting better practice and partnerships and providing for better palliative care and support in the aged care system.
PERFORMANCE

58.7% MET
32.6% SUBSTANTIALLY MET
8.7% NOT MET

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>58.7%</td>
<td>32.6%</td>
<td>8.7%</td>
</tr>
<tr>
<td>2011-12</td>
<td>81.3%</td>
<td>12.1%</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

PROGRAMS CONTRIBUTING TO OUTCOME 4

Program 4.1: Access and Information
Program 4.2: Home Support
Program 4.3: Home Care
Program 4.4: Residential and Flexible Care
Program 4.5: Workforce and Quality
Program 4.6: Ageing and Service Improvement
**TRENDS**

Figure 4.1 shows the increase in aged care funding since 2009-10.

**Figure 4.1: Aged Care Funding Growth 2009-10 to 2012-13**

Figure 4.2 shows the increase in the value of accommodation bonds, with the average bond balance more than $200,000 in 2011-12.

On 30 June 2012, approved providers held in excess of $13.1 billion in accommodation bonds on behalf of approximately 65,700 residents.

**Figure 4.2: Trend in Aged Care Accommodation Bonds 2007-08 to 2011-12**
2.1 Aged Care and Population Ageing

Reforming Aged Care

In 2012-13, the Department undertook essential steps towards reshaping the aged care system to make it better, fairer and more nationally consistent to benefit aged care consumers.

The Department progressed key elements of the aged care reforms through developing major legislative changes, which were passed by Parliament and became law on 28 June 2013. The Department consulted with more than 2,000 industry and consumer representatives during November and December 2012; and March and April 2013 on the proposed legislative changes. The Department released overview documents, information videos and other supporting material to explain the proposed legislative changes.

The Department also made three submissions to, and appeared before, the Senate Community Legislation Committee Inquiry into the Aged Care (Living Longer Living Better) Bill 2013 (Provisions) and related Bills. The Department led the drafting of the Government’s Response to the Inquiry which was instrumental in supporting the proposed legislative changes.

Outcome Strategy

Outcome 4 aims to ensure that older people receive a choice of high quality, accessible and affordable care, and that carers get the support they need to look after frail older people living at home. Through Outcome 4, the Government also aims to encourage older people to live active and independent lives. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

Program 4.1: Access and Information

Program 4.1 aims to provide equitable and timely access to aged care assessments and make it easier to find services through My Aged Care.

Provide equitable and timely access to aged care assessments

Through the Aged Care Assessment Program (ACAP), Aged Care Assessment Teams (ACATs) comprehensively assess the care needs of frail older people and determine their eligibility for Australian Government subsidised aged care services. These assessments assist frail older people to gain access to the most appropriate types of care and improve their health and wellbeing.

The Australian Government and all state and territory governments have agreed to continue to deliver ACAT services through to June 2014. The agreement provides for state and territory governments, as the managers of ACATs, to meet benchmarks that measure improvements to ACAT assessment services against key performance indicators.

Deliverable: Development and trial of assessment framework and tools for the aged care sector

2012-13 Reference Point: National Assessment Framework and tools developed by January 2013 and trialled in six sites by May 2013

Result: Substantially met

A new National Assessment Framework and tool was developed to be used in the aged care sector. The trial of this new National Assessment Framework and tool began in May 2013 in four sites and was finalised in June 2013. The outcomes of the trial are being considered. The aim is to develop a new approach to assessing people’s needs as they enter aged care and this will be implemented nationally through My Aged Care from 2014-15.
**Deliverable:** ACAP training resources reflect current program operation and enable consistent decision making

**2012-13 Reference Point:** Review of ACAP training resources completed by 31 December 2012

**Result:** Substantially met

Training is being improved for ACAT non-clinical staff, assessors and managers. A review of training resources for ACAT delegates was completed in March 2013. The changes to the training resources resulting from these reviews have been completed.

**KPI:** Percentage of completed assessments undertaken on clients in the target population

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>88%</td>
<td>Data not available</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

Final data for 2012-13 was not available in time for publication. States and territories are on track to meet assessment targets. Projected figures indicate that 92% of all complete assessments undertaken by ACATs were for the target population. All states and territories are projected to meet the 2012-13 target of 88%.

**KPI:** Aged Care Assessment Program data is maintained to a high level of accuracy and is provided within the specified timeframe by the state and territory governments to the Commonwealth

**2012-13 Reference Point:** The state and territory governments’ successful upload of Quarter 4 (2011-12) and Quarters 1-3 (2012-13) data files into the Ageing and Aged Care Data Warehouse in the required format with error rate not exceeding 0.1%

**Result:** Substantially met

All state and territory governments successfully uploaded their data files into the Aged Care Data Warehouse in the required format with an error rate not exceeding 0.1%. However, one state was late in providing data following an amalgamation of ACATs.

**KPI:** Percentage of high priority assessments completed within 48 hours of referral

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>Data not available</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

Final data for 2012-13 was not available in time for publication. Projected figures indicate a national average of 95.8% of the highest priority assessments were seen within 48 hours of referral. It is expected the target of 85% will be met by all state and territory governments with the exception of one state which is projected to reach 83.3%. This compares to 93.2% nationally in 2011-12 and 91.5% in 2010-11.

**KPI:** Aged Care Assessment Teams meet National Minimum Training Standards and complete national training resources relevant to their roles and responsibilities

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

The Department requires all ACAT members to have successfully completed, or be working towards completing, their respective assessment component within set time frames. It requires all ACAT delegates to have successfully completed the assessment component of the ACAT National Delegation Training resource.

This process is monitored by ACAT Education Officers, jurisdictional annual reports and a central database integrated with the ACAT online training environment.
Make it easier to find services – My Aged Care

The Department established a single entry point for aged care services. My Aged Care began operating on 1 July 2013 with the introduction of the My Aged Care website and a national contact centre. These services enable the general public, older people, their families and carers, service providers and health professionals to access quality information on ageing and aged care. My Aged Care helps people to navigate the aged care system and provides referrals for assessment and service provision via multiple channels. Over time, My Aged Care will implement a central client record, an assessment capability to identify needs based upon a national assessment framework, and a linking service to help vulnerable people with multiple needs.

In 2012-13, the Department worked with both the Aged Care Gateway Advisory Group (established under the auspice of the National Aged Care Alliance) and the Gateway Consultation Forum (comprising Commonwealth, state and territory governments and National Aged Care Alliance representatives) to design the services that were introduced on 1 July 2013. The Department will continue to work closely with these two external consultation groups in developing and introducing additional My Aged Care services.

### Deliverable: Establish a new Aged Care Gateway call centre and My Aged Care website to improve access to information and services

**2012-13 Reference Point:** Call centre and website established by the end of 2012-13

**Result:** Met

- My Aged Care is an identifiable entry point to the aged care system that enables timely and reliable information to be accessed by older people, their families and carers; and provides support to find aged care services. These services provide information that is easily understood, and is appropriate and sensitive to the language, culture, gender, race, economic circumstances or geographic needs of the individual.

### Deliverable: Number of calls made to the aged care information line

**2012-13 Target:** 280,000  
**2012-13 Actual:** 223,502  
**Result:** Substantially met

- Calls made to the aged care information line were lower than originally estimated.

### Deliverable: Average number of searches per month of the website (My Aged Care from 1 July 2013)

**2012-13 Target:** 24,600  
**2012-13 Actual:** 31,840  
**Result:** Met

- There was an average of 31,840 Aged Care Home Finder searches per month on the Aged Care Australia website for 2012-13. The Aged Care Home Finder provided consumers with detailed information on Government funded aged care facilities nationwide. As of 1 July 2013, the Aged Care Home Finder has been transferred to the new My Aged Care website. The Aged Care Australia website has now been decommissioned.

2.1 Program 4.2: Home Support

Program 4.2 aims to provide integrated aged care services to people in their homes and offer support to carers.

Provide integrated aged care services to people in their homes

From 1 July 2012, the Australian Government assumed full funding and operational responsibility for aged care. This included the transfer of aged care services provided under the Home and Community Care (HACC) program to the Commonwealth, except in Western Australia and Victoria where existing arrangements continued during 2012-13.

In 2012-13, the Department built working relationships with more than 1,200 aged care providers to deliver basic maintenance, support and care services, such as domestic assistance, personal care, meals and transport to older Australians. The Department put in place arrangements to ensure continuity of services in the transition period while the Commonwealth Home Support Program is being established.

Deliverable: Manage funding agreements with HACC service providers

2012-13 Reference Point: Transfer of HACC services for older people to the Commonwealth is achieved with minimal disruption to service delivery

Result: Met

- Service delivery was maintained throughout the transfer of HACC to the Commonwealth from 1 July 2012. Funding agreements with HACC service providers have been established and are being managed by the Commonwealth.

Deliverable: Number of older people who receive a HACC service

2012-13 Target: 516,000
2012-13 Actual: 486,000
Result: Substantially met

- 486,000 older people received a service through the Commonwealth HACC program in 2012-13. An open and competitive funding round was opened in August 2013 to increase Commonwealth HACC Services.

KPI: Older Australians continue to access basic home support services through the Commonwealth HACC program

2012-13 Reference Point: Basic home support services and a mix of service providers are maintained following the implementation of the program

Result: Met

- Under the Commonwealth HACC program, older people are continuing to receive basic home support services and the mix of service providers is similar to that previously available under the joint HACC program.

The HACC program in Victoria and Western Australia continued to be jointly funded by the Commonwealth and state governments to provide basic home support services to frail aged and younger people with disabilities and their carers. The HACC program in these states continued to be administered under the HACC Review Agreement 2007.

In May 2013, the Victorian government agreed to transition responsibility for HACC services for older clients to the Commonwealth, as part of negotiations on the National Disability Insurance Scheme. This transfer is expected to take effect from 1 July 2015.

In August 2013, also as part of the negotiations regarding the National Disability Insurance Scheme, the Western Australian government agreed to commence negotiations on implementing a transition of HACC services for older people to Commonwealth responsibility and control from 2016-17.

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47 Commonwealth HACC program target population is: older people (people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over) and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. Victoria and Western Australian HACC population are not included in these figures.
### 2.1 Aged Care and Population Ageing

#### Outcome 4 Aged Care and Population Ageing

#### Part 2 Performance Reporting

**KPI: Number of HACC older clients receiving services as a percentage of the HACC target population**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥87%</td>
<td>83%</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

83% of the HACC target population received services in 2012-13. An open and competitive funding round was opened in August 2013 to increase Commonwealth HACC Services.

**Offer Support to Carers**

The Department continues to support carers in their role through a number of initiatives including the National Respite for Carers Program, Commonwealth Respite and Carelink Centres, the National Carer Counselling Program and residential respite care.

In 2012-13, the National Respite for Carers Program provided funding to more than 570 respite services Australia-wide, as well as a network of 54 Commonwealth Respite and Carelink Centres. Respite was delivered in a number of settings including in peoples’ homes, day centres and overnight cottage respite. In 2012-13, respite services were provided to 104,124 carers.

**KPI: Number of carers receiving respite**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>69,536</td>
<td>104,124</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012-13, 104,124 carers received assistance through the National Respite for Carers Program. This included more than 30,00048 carers assisted with respite, and 74,124 carers assisted to receive information, support and emergency respite through Commonwealth Respite and Carelink Centres. This compares to a total of 109,210 carers receiving assistance in 2011-12 and 130,477 in 2010-11.

In 2012-13, the Department held an open funding round to expand the number of respite services funded in areas where limited respite was previously delivered. Funding was provided for 55 additional new or expanded respite services which will assist a further 2,500 carers in the 15 months from April 2013. These additional respite services will provide services to carers of frail older people to encourage them to remain living in their community.

Commonwealth Respite and Carelink Centres provide information about support services available for older people, people with a disability and their carers. They also link carers with community services in their area and assist carers with short-term and emergency respite. In 2012-13, the Commonwealth Respite and Carelink Centres provided respite and carer support for 74,124 carers.

In addition, residential respite provides short-term care in aged care homes to people who have been assessed as eligible and approved by an Aged Care Assessment Team to receive residential respite care. It can be used on a planned or emergency basis. In 2012-13, there were 63,796 admissions to residential respite care and more than 1.5 million residential respite days used.

The National Carer Counselling Program reduces carer stress, improves carer coping skills and helps to continue, wherever possible, the caring role through short-term emotional and psychological support services to carers. From 1 July 2012, an additional $1 million per annum was provided to Carers Australia to increase the availability of counselling for carers through this program, bringing the total funding in 2012-13 to more than $4.5 million.

**KPI: Number of carers receiving counselling**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,774</td>
<td>5,913</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

In 2012-13, more than 5,913 carers received counselling services through the National Carer Counselling Program. This compares to 5,134 in 2011-12. Expansion funding in 2012-13 of $1 million has seen an increase from previous years in the number of carers accessing counselling services.

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48 Commonwealth HACC program target population is: older people (people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over) and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. Victoria and Western Australian HACC population are not included in these figures.

49 Estimated and incomplete data. The annual service delivery reports from service providers for 2012-13 were still being received at the time of publication.
Program 4.3: Home Care

Program 4.3 aims to provide more care at home, match funding to care needs and provide greater choice and control in access to care services and delivery.

More care at home

The Department recognises that older people have a strong preference to remain in their own homes for as long as possible. It continues to increase the availability of Home Care Packages which provide nursing care, personal care assistance, meals, transport, domestic assistance, home maintenance and social activities to older people in their own homes.

The Department invited aged care providers to apply for new Home Care Packages through the 2012-13 Aged Care Approvals Round (ACAR).

**Deliverable: Number of new Home Care Packages allocated**

| 2012-13 Target: 3,614 | 2012-13 Actual: 5,835 | Result: Met |

In 2012-13, the Department allocated all 5,835 new Home Care Packages that were advertised through the 2012-13 ACAR. Applications closed in December 2012. More than 1,300 applications were received, requesting approximately 106,000 packages. The applications were assessed by the Department through a competitive assessment process in accordance with the criteria set out in the Aged Care Act 1997. The results of the 2012-13 ACAR were announced in July 2013.

In 2011-12, 1,724 Home Care Packages were allocated, and in 2010-11 this figure was 6,629.

**KPI: Number of operational Home Care Packages at end of financial year**

| 2012-13 Target: 64,776 | 2012-13 Actual: 60,308 | Result: Substantially met |

As at 30 June 2013, 60,308 Home Care Packages were operational. This figure does not include the 5,835 Home Care Packages allocated through the 2012-13 ACAR that will be reported in the 2013-14 Annual Report for the Department of Social Services. The operational places as at 30 June 2013 are in the form of Community Aged Care Package places, Extended Aged Care at Home (EACH) places and EACH Dementia places. This compares to 59,201 packages as at 30 June 2012, and 57,241 packages at 30 June 2011.

**Deliverable: Aged Care planning regions reviewed**

| 2012-13 Reference Point: Final report delivered on review | Result: Not met |

A review of the current aged care planning regions and HACC planning regions is under way. This will consolidate and make recommendations for planning regions in the future. The review is examining the current and projected demographics of each region, and will ascertain current and future priorities for additional aged care places. It is expected to be completed in 2013-14.

Matching funding to care needs

During 2012-13, the Department consulted closely with the National Aged Care Alliance (NACA), including the Home Care Packages Working Group, to develop the implementation arrangements for a new Home Care Packages Program.

This program began on 1 August 2013 replacing the Community Aged Care Packages, Extended Aged Care at Home and Extended Aged Care at Home Dementia packages. The objectives of the program are to assist people to remain living at home for as long as possible; and to enable consumers to have choice and flexibility in the way that care and support is provided at home.

A Home Care Package is a coordinated package of services tailored to meet a person’s specific care needs. The package is co-ordinated by a home care provider, with funding provided by the Australian Government. Under the program, there are four levels of packages.
Work continued on developing new supplements for veterans with a mental health condition associated with their service, and on improving the quality of care in Home Care Packages for consumers who have cognitive impairment such as dementia. These supplements took effect from 1 August 2013.

Work also began to implement the new income testing arrangements which will take effect in Home Care from 1 July 2014.

KPI: Home Care providers continue to deliver services and apply for additional packages through the Aged Care Approvals Round

**2012-13 Reference Point:** All Home Care Packages offered in the 2012-13 Aged Care Approvals Round are allocated

**Result:** Met

- In 2012-13, the Department allocated all 5,835 new Home Care Packages that were advertised through the 2012-13 ACAR.

### Greater choice and control

Consumer Directed Care (CDC) is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care and services they access and the delivery of those services, including who will deliver the services and when.

In the Home Care Packages Program, CDC is used to provide home care services which offers greater flexibility and choice to consumers. All new Home Care Packages allocated to providers through the 2012-13 ACAR will be delivered on a CDC basis.

**Deliverable:** New program guidelines developed to embed Consumer Directed Care (CDC) into Home Care

**2012-13 Reference Point:** Guidelines provided to approved providers applying for packages in the 2012-13 Aged Care Approvals Round

**Result:** Met

- Program Guidelines for the Home Care Packages Program, including the CDC arrangements, were developed in consultation with NACA and the associated Home Care Packages Working Group. A program overview was available to providers applying for packages in the 2012-13 ACAR in November 2012. A consultation draft of the guidelines was released for comment in April 2013 and final guidelines were published in July 2013.

The Home Care Packages Program Guidelines provide policy guidance to support the delivery and management of the Home Care Packages Program, including the policy context. The information in the guidelines is relevant to all types of packages, whether delivered on a CDC basis or not.

**KPI:** CDC continues to deliver benefits to older Australians

**2012-13 Reference Point:** CDC evaluation report confirms that older Australians are satisfied that they have improved choice and control over the services they receive in CDC Home Care Packages

**Result:** Substantially met

- An evaluation of the CDC pilot was completed in 2012. The evaluation found CDC had a more positive impact on consumers’ level of satisfaction with various aspects of their life compared with traditional home care and respite care programs. An evaluation of the new home care arrangements, including CDC, will be conducted over the first two years of the Home Care Packages Program, starting in 2013-14. Scoping and design work for the evaluation was undertaken in 2012-13.
PROGRAM 4.4: RESIDENTIAL AND FLEXIBLE CARE

Program 4.4 aims to improve fairness and sustainability in residential care, provide culturally appropriate care and provide funding to other service models.

Improving fairness and sustainability

During 2012-13, the Department began implementation work on stronger means testing for residential aged care to take effect from 1 July 2014 to promote fairness in the aged care system by supporting people with limited means to have access to the care they require.

In addition, changes were made to the Aged Care Funding Instrument that is used to determine care subsidies in residential care to better match funding levels to the care needs of residents. Work continued on developing new payment supplements for veterans with a mental health condition associated with their service, and to improve the quality of care in aged care homes for residents who have severe behavioural and psychological symptoms of dementia and other conditions. These supplements take effect from 1 August 2013.

The ACAR is an annual application process that enables prospective and existing approved providers to apply for new Australian Government funded aged care places and financial assistance in the form of a capital grant or a zero real interest loan. In 2012-13, an ACAR was conducted where applicants could apply for new residential aged care places, new Home Care Packages, $51 million in capital grants, and more than $150 million in zero real interest loans.

| Deliverable: Number of residential aged care places allocated |
|-------------------|-------------------|-------------------|
| 2012-13 Target: | 7,800 | 2012-13 Actual: | 7,775 | Result: | Substantially Met |
| Through the 2012-13 ACAR, the Department allocated 7,775 new residential aged care places nationally. |

The Department allocated 15 capital grants totalling $51 million to residential aged care services to improve building quality and standards, and to build accommodation for people with special requirements. These include people in rural, regional and remote Australia, Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, people living in areas of need, older people who are homeless or at risk of becoming homeless and concessional, assisted or supported residents. The Department offered 33 zero real interest loans totalling $156.4 million.

| Deliverable: Total value of zero real interest loans offered to aged care providers to build in areas of high need |
|-------------------|-------------------|-------------------|
| 2012-13 Target: | $150m | 2012-13 Actual: | $156.4m | Result: | Met |
| A total of $156.4 million in zero real interest loans were offered to 33 approved providers in conjunction with the 2012-13 ACAR. The loans will assist providers to build 986 new residential aged care places and bring into operation 257 provisionally allocated residential aged care places. |

| Deliverable: Undertake a review of Specified Care and Services Schedule |
|-------------------|-------------------|-------------------|
| 2012-13 Reference Point: | The review of Specified Care and Services is finalised |
| Result: | Not met |

From 1 July 2014, the Government will remove the distinction between low care and high care in permanent residential aged care. To support this, a review of the Schedule of Specified Care and Services for Residential Care Services (Schedule 1, Quality of Care Principles) began in August 2012 to identify the care and services that providers are to deliver to residents from 1 July 2014.

In June 2013, the Specified Care and Services Advisory Group delivered a National Aged Care Alliance endorsed preliminary report and recommendations.
### Outcome 4: Aged Care and Population Ageing

#### Part 2: Performance Reporting

<table>
<thead>
<tr>
<th>Deliverable: Establish the Aged Care Financing Authority</th>
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</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong> Aged Care Financing Authority established by 30 June 2013</td>
</tr>
<tr>
<td><strong>Result:</strong> Met</td>
</tr>
</tbody>
</table>

- The Aged Care Financing Authority was established in August 2012 to provide the Government with independent and transparent advice and information on pricing and financing issues in aged care. The authority met 14 times during 2012-13 and provided the Minister with advice on significant refurbishment, accommodation payments, and its operating framework. The authority provided the Government with its first annual report on funding and financing in the aged care sector.

<table>
<thead>
<tr>
<th>KPI: Improved transparency in pricing arrangements for providers and consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong> Initial guidelines on transparent pricing arrangements developed in 2012-13</td>
</tr>
<tr>
<td><strong>Result:</strong> Substantially met</td>
</tr>
</tbody>
</table>

- In 2012-13, the Department moved to improved transparency in pricing arrangements by actively consulting with consumer groups and the aged care and finance industries. A specific achievement in this area was the draft Accommodation Pricing Guidelines released in April 2013. These are designed to give consumers greater choice and protection by requiring providers to set prices that reflect the value of the accommodation offered and publish their accommodation prices in advance. Further consultation on the Accommodation Pricing Guidelines is expected in 2013-14.

<table>
<thead>
<tr>
<th>KPI: Better links between the health and aged care sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Reference Point:</strong> Competitive funding round completed and available funding offered to successful applicants</td>
</tr>
<tr>
<td><strong>Result:</strong> Met</td>
</tr>
</tbody>
</table>

- In 2012-13, $9.3 million over four years was allocated under Better Health Care Connections: Multidisciplinary Care Coordination and Advisory Services to nine trial sites across Australia. This will establish care coordination services and pilot GP video consultations for aged care clients of participating residential aged care facilities. In addition, $6 million over 18 months has been provided to 13 organisations and for an evaluation under Better Health Care Connections: Short-Term Intensive Healthcare Innovative Models to deliver short term, more intensive health care services to aged care recipients. Funding for this initiative is appropriated through Program 4.5 and 4.6.

### Provide Culturally Appropriate Care

The Australian Government is committed to delivering aged care that is appropriate for all older people regardless of race, culture, language, gender, economic circumstances or geographic location.

The Department supports the delivery of culturally appropriate aged care services to older Indigenous Australians, particularly those in rural and remote areas, through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. A total of 29 services are currently funded under the program. In addition, development continues for two new flexible services in the Northern Territory at Mutitjulu (Central Australia) and in East Arnhem Land.

<table>
<thead>
<tr>
<th>Deliverable: Number of flexible places available for Aboriginal and Torres Strait Islander peoples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Target:</strong> 715</td>
</tr>
</tbody>
</table>

- The National Aboriginal and Torres Strait Islander Flexible Aged Care Program supports flexible high and low care residential places, as well as flexible home care places. In recent years, the allocation of new places has been weighted towards more expensive high care places, providing more care for older Aboriginal and Torres Strait Islander peoples with complex care needs. In 2012-13, 679 places were made available. This compares to 675 in 2011-12 and 645 in 2010-11.
KPI: Percentage of Aboriginal and Torres Strait Islander Flexible Care places allocated

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>80%</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

Approximately 40 additional aged care places were available for allocation in 2012-13, of which 32 new places have been allocated. More places will be allocated in 2013-14.

Other service models

In 2012-13, the Department continued to provide funding for 4,000 flexible care places through the Transition Care Program. The Transition Care Program is a joint initiative between the Australian Government and all state and territory governments. It helps older people leaving hospital to improve their health and wellbeing, while assisting them and their family or carers to make long-term care arrangements, if necessary. In many cases, this resulted in older people returning to their own homes rather than entering residential care prematurely.

Deliverable: Number of operational transition care places

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,000</td>
<td>4,000</td>
<td>Met</td>
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</table>

The Department continued to provide funding for 4,000 transition care places in 2012-13.

In 2012-13, the Australian Government provided $92.4 million to state and territory governments under the National Partnership Agreement on Financial Assistance for Long Stay Older Patients. This funding recognises that there are some older people in public hospitals who have finished acute and post-acute care and have remained in hospital longer than would otherwise be necessary, while they secure an appropriate aged care place.

PROGRAM 4.5: WORKFORCE AND QUALITY

Program 4.5 aims to ensure the availability of a skilled workforce, empower consumers and promote quality in aged care.

Ensuring availability of a skilled workforce

In 2012-13, the Department implemented the first stage of an aged care workforce strategy. Two initiatives were commenced – the Aged Care Workforce Supplement and the Aged Care Workforce Development Plan.

Deliverable: A Workforce Compact will be developed with employers, unions, and training body representatives

2012-13 Reference Point: Workforce Compact commences from 1 January 2013

Result: Substantially met

The Department convened a Strategic Workforce Advisory Group (SWAG) which operated from July to October 2012 to consider a Workforce Compact between Government, providers and unions. Commissioner Anne Gooley from the Fair Work Commission chaired the SWAG, which comprised representatives from aged care unions, providers and the Government. The SWAG considered a range of workforce issues, including remuneration, training and skills development, career progression, flexible working arrangements, workplace health and safety, and productivity.

The report by Commissioner Gooley concluded that members of the SWAG had reached in-principle agreement on a number of important elements of the proposed Workforce Compact, but were unable to endorse the Workforce Compact due to outstanding issues.

The Aged Care Workforce Development Plan will support the sector to build an appropriately skilled and qualified workforce by addressing longer term workforce pressures, including career structures and pathways; training and education; career development; work practices and workplace safety; and workforce planning.
In addition, the Department continues to help delivery of workforce programs through the Aged Care Workforce Fund. This provides funding for training, education and support for the aged care workforce, brings together the aged care, training and research sectors and provides training for Aboriginal and Torres Strait Islander aged care workers to deliver culturally appropriate care.

In 2012-13, funding was provided to support:

- approximately 11,000 aged care workers to study nationally accredited short courses, including dementia short courses, and palliative care and medication assistance skill sets;
- the delivery of more than 4,500 Certificate III and IV aged care qualifications;
- 31 Aged Care Nurse Practitioner projects to develop, test and evaluate a range of models in the aged care sector;
- 16 Teaching and Research Aged Care Service models and the Aged Care Nursing Clinical Placements and Graduate Nurse Placements, which promote partnerships among aged care and education providers;
- approximately 15,000 aged care employees to undertake further studies through education and training incentives and aged care nursing scholarships; and
- more than 800 people enrolled in accredited training courses. These promote culturally appropriate training in rural and very remote communities to improve recruitment and retention of local Aboriginal and Torres Strait Islander aged care workers.

**KPI:** Workforce training addresses skills gaps and the diverse needs of the aged care sector

**2012-13 Reference Point:** The Aged Care Workforce Strategic Advisory Group develops training priorities for the Aged Care Workforce Fund

**Result:** Not met

It was decided that the training priorities for the Aged Care Workforce Fund will be considered when developing the Aged Care Workforce Development Plan in 2013-14, to allow training priorities for the Fund to support the goals articulated in the plan.

**Empowering Consumers**

The Department continues to strengthen the handling of aged care complaints through the Aged Care Complaints Scheme. A recent audit of the scheme by the Australian National Audit Office (ANAO) found that consumers were generally positive about the scheme’s enhanced focus on people receiving care and more timely resolutions of complaints. The Department agreed with the ANAO’s two recommendations to improve access to the scheme for isolated care recipients and to get more value from customer satisfaction surveys.

The Department has implemented measures to address these recommendations, such as providing information about the scheme to public guardians, advocacy groups and people involved with the Community Visitors Scheme (CVS). These groups are important touch points to reach care recipients who may be socially isolated. To improve the value of customer feedback about aged care complaints processes, in 2012-13, the feedback questionnaire, and how it is disseminated, was reviewed to increase response rates.

The Department continues to fund the national CVS which provides companionship to socially or culturally isolated people living in Australian Government-subsidised aged care homes.

In 2013, the CVS was expanded to include group visits within residential aged care, as well as visits to people receiving Home Care Packages. An open competitive funding round was held in early 2013 to allocate these places to successful applicants.
Deliverable: New models of Community Visitors Scheme developed and implemented

2012-13 Reference Point: New models implemented by 30 June 2013

Result: Substantially met

In 2012-13, a new CVS model was developed. This model will expand the CVS from 7,500 one-on-one residential care visitor places in 2012-13 to include additional visitor places in 2013-14 for group visits in residential aged care and one-on-one visits to people receiving Home Care Packages. An open competitive funding round for these new places was advertised in February 2013 and closed in April 2013.

Promoting Quality

The Department has helped aged care providers understand their responsibilities under the Aged Care Act 1997. This includes continuing to monitor the increased protections for accommodation bonds, monitoring approved provider Aged Care Funding Instrument (ACFI) claims, and developing national aged care quality indicators for residential aged care. This will inform consumers and their families about the quality of residential aged care services and help providers to deliver them.

While strengthening evidence requirements and regulatory powers for the ACFI, a focus on educating approved providers has been maintained, including talking with industry through education sessions. The review program also supported approved providers to understand their obligations through the review process and has started exercising broader regulatory powers in response to repeated failure to correctly apply the ACFI.

Deliverable: Number of annual reviews of Aged Care Funding Instrument funding claims to ensure residents are correctly funded

2012-13 Target: 20,000  
2012-13 Actual: 21,426  
Result: Met

In 2012-13, the Department continued its improved approach to the review of aged care funding claims to better target resources to those services identified as being at highest risk of inaccurate claiming. This has continued to be balanced by review activity in other services.

Deliverable: Percentage of accommodation bond refunds paid through the Accommodation Bond Guarantee Scheme refunded within the statutory timeframe

2012-13 Target: ≥95%  
2012-13 Actual: Not applicable  
Result: Not applicable

The Accommodation Bond Guarantee Scheme provides security to residents of aged care facilities by refunding any outstanding bonds in the event that a provider becomes insolvent or bankrupt and cannot repay the bond. No refunds were required in 2012-13.

Deliverable: Percentage of General Purpose Financial Reports submitted by approved providers reviewed to assess financial risk

2012-13 Target: 100%  
2012-13 Actual: 100%  
Result: Met

All General Purpose Financial Reports received from approved providers were analysed to assess financial risk. Where concerns around financial performance were identified, detailed risk assessments encompassing a number of financial and non-financial items were undertaken in relation to those approved providers in the highest risk level.

KPI: Percentage of occasions where the Department has taken appropriate action against approved providers to address serious non-compliance that threatens the health, welfare or interests of care recipients

2012-13 Target: 100%  
2012-13 Actual: 100%  
Result: Met

The Department responded appropriately and effectively to rectify all instances of identified non-compliance. Sanctions were imposed on all approved providers where an immediate and severe risk to the safety, health or wellbeing of care recipients was identified.
KPI: Adequate progress is made in the development of quality indicators

2012-13 Reference Point: Aged Care Reform Implementation Council reports on progress

Result: Met

- A Quality Indicators Reference Group, consisting of consumer, provider and workforce representatives and technical experts, was established under the National Aged Care Alliance and started work in March 2013. The Reference Group met several times throughout 2012-13. Consistent with its Terms of Reference, the Quality Indicators Reference Group produced a preliminary draft report on the development of quality indicators.

Under the Aged Care Complaints Scheme, the Department focused on influencing industry to encourage better practice in complaints management. This was achieved through engaging and consulting with industry, service providers and their staff regarding effective complaints management. The scheme has also produced resources for industry and communicated with aged care providers in the community following the introduction of Commonwealth HACC complaints from 1 July 2012. Strengthened powers were also developed for the Aged Care Commissioner starting from 1 August 2013, giving the Commissioner the capacity to direct the scheme to undertake a new complaints resolution process and take the views of the Commissioner into account.

Deliverable: Increasing consumer awareness and supporting the industry in effective complaints handling through education

2012-13 Reference Point: Update aged care complaints publications, brochures and poster targeting industry and consumers. Publish online complaints resolution toolkit incorporating industry education alerts and resources

Result: Met

- In 2012-13, a number of resources targeting industry and consumers were developed under the scheme. These include a training DVD for staff, additional fact sheets, industry feedback alerts, and a Complaint Handling Toolkit for industry to support better practice in complaint handling. All the scheme resources are available on the scheme website.50

Deliverable: Percentage of complaints referred by the Aged Care Complaints Scheme for investigation completed within 90 days

2012-13 Target: 77%  
2012-13 Actual: 85%  
Result: Met

- The calculation of this deliverable reflects the number of cases finalised during the early resolution and phases. With a focus on early resolution and non-investigative techniques, timeliness of resolution has improved compared with previous years.51 In 2012-13, 85% of complaints were finalised during the resolution phase, compared with 83% in 2011-12.

Deliverable: Percentage of complaints resolved by the Aged Care Complaints Scheme at intake

2012-13 Target: 31%  
2012-13 Actual: 72%  
Result: Met

- The calculation reflects the number of cases resolved during early resolution under the improved complaint framework. In 2012-13, 72% of complaints were resolved at intake. This compares to 61% in 2011-12.

---

50 www.agedcarecomplaints.govspace.gov.au

51 The complaints management process comprises four phases: intake, assessment, resolution and outcome. Early resolution refers to complaints resolved during the intake or assessment phase. Cases not resolved at early resolution progress to the resolution phase which utilises a range of techniques to resolve a complaint including service provider resolution, conciliation, investigation and mediation.
**KPI:** Satisfaction with the operation of the Complaints Scheme

**2012-13 Reference Point:** Results of satisfaction surveys indicate that the majority of complainants and approved providers responding to the survey are satisfied with the operation of the Complaints Scheme

**Result:** Met

The satisfaction survey allows complainants and service providers to provide feedback on their experiences of dealing with the scheme. Results of the survey indicate high levels of satisfaction with the operation of the scheme among complainants and industry.

**PROGRAM 4.6: AGEING AND SERVICE IMPROVEMENT**

Program 4.6 aims to provide support for people living with dementia and to meet the needs of a diverse community, creating better links to the health system.

**Support for people living with dementia**

The Aged Care Service Improvement and Healthy Ageing Grants Fund provides a large, flexible funding pool for initiatives that strengthen the capacity of the health and aged care sectors to deliver high quality aged care and promote healthy ageing, including initiatives to support people with dementia.

During 2012-13, the Department implemented initiatives to improve care for people with dementia. Support and care for people with dementia, their families and carers has increased through expanding the Dementia Behaviour Management Advisory Service into the acute and primary care settings.

Support was provided for people with Younger Onset Dementia who now have access to specialist key workers, who provide individualised support and advice, through Alzheimer's Australia. Alzheimer's Australia has continued to deliver the National Dementia Support program with exceptional services being provided in all areas. For example, more than 7,500 people received support through counselling, support groups and early intervention.

The Australian Commission for Safety and Quality in Health Care started work on improving the standards of care for people with dementia in hospitals. Hospital environments will be examined under this initiative with specialised consultants being made available nationally to provide advice.

**Deliverable:** Consultation with stakeholders on implementation of Living Longer Living Better, Tackling Dementia package

**2012-13 Reference Point:** Timely initial contact and follow up consultation where this is required

**Result:** Met

The Department consulted with internal and external stakeholders on implementing the Tackling Dementia Package. The Minister's Dementia Advisory Group has played a pivotal role in advising the Department on implementing the package.

**KPI:** Activities undertaken to better support people with dementia in the health and aged care systems

**2012-13 Reference Point:** Regular progress reports on key milestones from contractual organisations indicate that activities are being implemented in accordance with contractual arrangements

**Result:** Met

All agreements have requirements for regular reporting which contain detailed information on the progress against activities and key milestones. In 2012-13, progress reports have indicated that activities are being implemented in accordance with contractual arrangements.
KPI: Number of dementia key workers supporting younger people with dementia

| 2012-13 Target: 40 | 2012-13 Actual: 40 | Result: Met |

Alzheimer’s Australia has been engaged to establish a national network of key workers who will act as a single point of contact for people with younger onset dementia and their families. The purpose of the key worker is to help younger people with dementia to access the care and support services most appropriate for their needs. In 2012-13, 40 younger onset dementia key workers have been recruited across Australia.

Support for a diverse community

In 2012-13, through the Aged Care Service Improvement and Healthy Ageing Grants Fund, the Department supported a number of projects that were aimed at meeting the needs of older people from diverse communities. Activities such as staff training and information dissemination projects are supporting people from a range of special needs groups including people from culturally and linguistically diverse (CALD) backgrounds and people from the lesbian, gay, bisexual, transgender and intersex (LGBTI) community.

In 2012-13, the Department began funding a multi-year project to deliver LGBTI sensitivity training for all aged care workers nationally.

In December 2012, the Australian Government released two National Ageing and Aged Care Strategies: The National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse backgrounds and the National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy. These strategies have been developed to inform how the Government supports the aged care sector to deliver care that is appropriate and inclusive.

Deliverable: Amend the aged care legislation to include people in the lesbian, gay, bisexual, transgender and intersex community as a special needs group

2012-13 Reference Point: Changes made by January 2013

Result: Met

The Aged Care Allocation Principles were amended effective 1 July 2012 to include people from LGBTI communities as a special needs group. On 28 June 2013, the Aged Care Act 1997 was amended to bring all existing special needs groups directly into the Act, including people from LGBTI communities.

Deliverable: Review of Aged Care Service Improvement and Healthy Ageing Fund guidelines to reflect support for diverse populations

2012-13 Reference Point: Guidelines are reviewed by September 2012

Result: Met

Aged Care Service Improvement and Healthy Ageing Grants Fund guidelines were reviewed and updated to reflect the initiatives introduced as part of the aged care reforms.

KPI: Activities undertaken to better support older people from diverse backgrounds

2012-13 Reference Point: Regular progress reports on key milestones from contractual organisations indicate that activities are being implemented in accordance with contractual arrangements

Result: Met

Progress reports were received consistent with contractual obligations for all activities funded through the Aged Care Service Improvement and Healthy Ageing Grants Fund. These reports identified the project outcomes were being met and highlighted key achievements made within the specific reporting period.
The National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse Backgrounds

Within the next 10 years, around a third of Australia’s older population will have been born outside Australia. The proportion of older people from culturally and linguistically diverse (CALD) backgrounds is increasing at a faster rate than other older people.

Older Australians with diverse needs can find it difficult to access aged care information and services that are sensitive to their backgrounds and circumstances. This is particularly important for older Australians whose first language is not English.

Robust consultation with CALD consumers and stakeholders in 2012-13 has been central to successfully developing a framework to support these diverse groups.

The Department worked with the Federation of Ethnic Communities’ Councils of Australia to hold a series of consultation sessions around the country, in each capital city and a number of regional centres, during October 2012.

These sessions brought together aged care providers, medical professionals, community groups and CALD aged care consumers, and allowed the Department to hear first-hand the key issues, needs and concerns of a diverse range of people. These conversations were crucial to developing the National Ageing and Aged Care Strategy for people from CALD backgrounds, which was launched by the Australian Government in December 2012.

The strategy includes five principles that are based on making the needs of people from CALD backgrounds understood, respected and visible in all Australia’s aged care policies and programs.

The strategy also includes six wide-ranging goals to be achieved by 2017. Some of the goals focus on how CALD consumers will be empowered, through ongoing consultation, to participate in developing aged care policies that will affect the future services delivered to them. Others focus on supporting the aged care sector to become more inclusive of the diversity of CALD consumers in their practices.

One major goal is to ensure that the My Aged Care website and contact centre is used by older Australians, their families and loved ones to access information about aged care and the services available. The consultation focus adopted in developing the strategy was continued in developing the CALD-focused elements of My Aged Care for its launch on 1 July 2013.

The strategy will guide the way forward for both the industry and CALD consumers, as it will help the aged care sector develop and deliver services that are as inclusive and relevant as possible.

The Department is committed to successfully implementing the strategy and will report annually on progress towards achieving the strategy’s goals. CALD consumers of aged care services and organisations that support older people from CALD backgrounds will play a crucial role in helping the Department to achieve these goals and the Department will continue to work closely with CALD stakeholders to set future annual priorities for the strategy.

More information on the strategy is available at www.health.gov.au/caldstrategy
Better links to the health system

The Department continues to focus on building stronger connections between the health and aged care systems. In 2012-13, activities to strengthen the interface between the health and aged care systems were begun. These included promoting better practice and partnerships and providing for better palliative care and support in the aged care system.

<table>
<thead>
<tr>
<th>KPI:</th>
<th>Funded organisations provide improved access to complex health care in aged care facilities. Activities are undertaken that support multidisciplinary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 Reference Point:</td>
<td>Evaluation shows improved outcomes</td>
</tr>
<tr>
<td>Result:</td>
<td>Not met</td>
</tr>
</tbody>
</table>

Models for short term, more intensive health care for aged care recipients and aged care multidisciplinary care coordination and advisory services have been funded. Evaluations were delayed to align with the establishment of the program which commenced in June 2013.
### Outcome 4 – Financial Resource Summary

<table>
<thead>
<tr>
<th>Program</th>
<th>Access and Information¹</th>
<th>Home Support¹</th>
<th>Home Care¹</th>
<th>Residential and Flexible Care¹</th>
<th>Workforce and Quality</th>
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</thead>
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<tr>
<td>Administered Expenses</td>
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</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
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<td>121,681</td>
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<td>Special appropriations</td>
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<tr>
<td>Aged Care Act 1997 - Community Care Subsidies</td>
<td>595,586</td>
<td>598,855</td>
<td>3,269</td>
<td></td>
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<tr>
<td>Aged Care Act 1997 - Flexible Care Subsidies</td>
<td>548,573</td>
<td>557,710</td>
<td>9,137</td>
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<tr>
<td>Departmental Appropriation²</td>
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<td>12,313</td>
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<td>597</td>
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<td>Total for Program 4.1</td>
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<td>134,591</td>
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<td>557,710</td>
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<td>Administered Expenses</td>
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<tr>
<td>Special appropriations</td>
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<tr>
<td>Aged Care Act 1997 - Community Care Subsidies</td>
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<td>Aged Care Act 1997 - Flexible Care Subsidies</td>
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<td>Departmental Appropriation²</td>
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<td>Expenses not requiring appropriation in the current year³</td>
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<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
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<tr>
<td>Aged Care Act 1997 - Residential Care Subsidies</td>
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<tr>
<td>Aged Care (Bond Security) Act 2006</td>
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<td>Departmental Appropriation²</td>
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<tr>
<td>Expenses not requiring appropriation in the current year³</td>
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<td>Total for Program 4.4</td>
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<td>8,364,629</td>
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<td>Departmental Appropriation²</td>
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<tr>
<td>Expenses not requiring appropriation in the current year³</td>
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<tr>
<td>Total for Program 4.5</td>
<td>253,974</td>
<td>248,666</td>
<td>(5,308)</td>
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*(A) Budget Estimate 2012-13 $’000 (B) Actual 2012-13 $’000 Variation (Column B minus Column A) $’000*
### Program 4.6: Ageing and Service Improvement

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ordinary Annual Services [Annual Appropriation Bill 1]</strong></td>
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<td></td>
</tr>
<tr>
<td>Special appropriations</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>National Health Act 1953 - Continence Aids Program</td>
<td>63,326</td>
<td>62,047</td>
<td>(1,279)</td>
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<td><strong>Departmental Expenses</strong></td>
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<tr>
<td>Departmental Appropriation²</td>
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<td>22,290</td>
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<tr>
<td>Expenses not requiring appropriation in the current year³</td>
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<td>3,315</td>
<td>1,293</td>
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<td><strong>Total for Program 4.6</strong></td>
<td>184,317</td>
<td>174,257</td>
<td>(10,060)</td>
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</table>

**Outcome 4 Totals by appropriation type**

<table>
<thead>
<tr>
<th>Administered Expenses</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ordinary Annual Services [Annual Appropriation Bill 1]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- expense adjustment²</td>
<td>(93,666)</td>
<td>51,547</td>
<td>42,119</td>
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<tr>
<td>Special appropriations</td>
<td>9,378,028</td>
<td>9,455,903</td>
<td>77,875</td>
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<tr>
<td><strong>Total expenses for Outcome 4</strong></td>
<td>11,500,645</td>
<td>11,501,689</td>
<td>1,044</td>
</tr>
<tr>
<td><strong>Average Staffing Level (Number)</strong></td>
<td>1,407</td>
<td>1,410</td>
<td>3</td>
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</tbody>
</table>

1. This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2. Departmental appropriation combines ‘Ordinary annual services [Appropriation Bill 1]’ and ‘Revenue from independent sources [s31]’.
3. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
4. Ordinary annual services (Bill 1) against program 4.4 excludes amounts appropriated in Bill 1 for Zero Real Interest Loans as this funding is not accounted for as an expense.
5. Payments under the Zero Real Interest Loans program are a loan to aged care providers and not accounted for as an expense. The concessional loan discount is the expense and represents the difference between an estimate of the market rate of interest, and that recovered under the loan agreement, over the life of the loan. This adjustment recognises the difference between the appropriation and the concessional loan discount expense.
OUTCOME 5
PRIMARY CARE

Access to comprehensive, community-based health care, including through first point of call services for prevention, diagnosis and treatment of ill-health, and for ongoing management of chronic disease

MAJOR ACHIEVEMENTS

- Strengthened primary health care through the completion of 284 Primary Care Infrastructure Grant projects which are delivering expanded health care services and additional training for health professionals.
- Improved access to integrated, multidisciplinary, team-based primary health care services through GP Super Clinics. Thirty-one fully operational Clinics are better meeting local community health needs.
- Delivered improved primary health care to patients by helping the network of 61 Medicare Locals better respond to identified priorities and by working closely with the representative peak body – the Australian Medicare Local Alliance.
- Developed the first National Primary Health Care Strategic Framework which identifies initiatives that can lead to better integrated care across the health system.
- Provided access for consumers and health practitioners to accurate and current health provider service information through the new National Health Services Directory.

CHALLENGES

- Implementing the National Primary Health Care Strategic Framework requires developing state and territory-specific bilateral agreements. A key challenge of these agreements is to work in partnership to integrate care across settings and implement programs that will lead to improved health outcomes.
### PERFORMANCE

**Outcome 5: Primary Care**

<table>
<thead>
<tr>
<th>Period</th>
<th>Met</th>
<th>Substantially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012–13</td>
<td>72.7%</td>
<td>18.2%</td>
<td>9.1%</td>
</tr>
<tr>
<td>2011–12</td>
<td>83.9%</td>
<td>6.4%</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

**Programs Contributing to Outcome 5**

- Program 5.1: Primary care education and training
- Program 5.2: Primary care financing, quality and access
- Program 5.3: Primary care practice incentives
OUTCOME STRATEGY

Outcome 5 aims to provide cost-effective, community-based primary health care. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

PROGRAM 5.1: PRIMARY CARE EDUCATION AND TRAINING

As a result of a review of departmental administered arrangements, the activities funded through Program 5.1 are discussed in Outcome 11 – Mental Health.

PROGRAM 5.2: PRIMARY CARE FINANCING, QUALITY AND ACCESS

Program 5.2 aims to improve the infrastructure, coordination and integration of primary health care services across the health system.

Establish Medicare Locals

Medicare Locals are a national network of primary health care organisations established to coordinate primary health care delivery, identify local health care needs and seek to address service gaps. They are driving improvements in primary health care and ensuring that services are better tailored to meet the needs of local communities.

On 1 July 2012, the Department completed the establishment of 61 Medicare Locals. Each Medicare Local is an independent, locally run organisation responsible for responding to the primary health care needs of their local communities. The national map overleaf provides the location of each Medicare Local.

Medicare Locals are working to make it easier for patients to navigate the health system by coordinating and integrating primary health care services at the local level with other sectors including acute care, aged care and Aboriginal and Torres Strait Islander health providers. Building upon a comprehensive analysis of local health needs, Medicare Locals are planning and coordinating services to improve health outcomes.

Medicare Locals are expanding existing primary health care services, establishing new services where none have previously been available and engaging frontline staff to work with their local communities. Medicare Locals are funded to respond to existing and emerging health priorities and provide tailored health services that make a difference to the lives of Australians.

The Department is responsible for supporting the network of 61 Medicare Locals in achieving their objectives and building their capacity as regional primary health care coordinators.

In 2012-13, the Department established the Australian Medicare Local (AML) Alliance to act as a peak representative body for the 61 Medicare Locals. The AML Alliance promotes and supports Medicare Locals as high performing regional health system planners with responsibility for assessing service needs and improving patient care.
Figure 5.1: Location of the 61 Medicare Locals
### 2.1 NEW SOUTH WALES

1. Eastern Sydney  
2. Inner West Sydney  
3. South Eastern Sydney  
4. South Western Sydney  
5. Western Sydney  
6. Nepean – Blue Mountains  
7. Northern Sydney  
8. Sydney North Shore and Beaches  
9. Central Coast NSW  
10. Illawarra – Shoalhaven  
11. Hunter  
12. North Coast NSW  
13. New England  
14. Western NSW  
15. Murrumbidgee  
16. Southern NSW  
17. Far West, NSW

### VICTORIA

18. Inner North West Melbourne  
19. Bayside  
20. South Western Melbourne  
21. Macedon Ranges and North Western Melbourne  
22. Northern Melbourne  
23. Inner East Melbourne  
24. Eastern Melbourne  
25. South Eastern Melbourne  
26. Frankston – Mornington Peninsula  
27. Barwon  
28. Grampians  
29. Great South Coast  
30. Lower Murray  
31. Loddon – Mallee – Murray  
32. Hume  
33. Goulburn Valley  
34. Gippsland

### QUEENSLAND

35. Metro North Brisbane  
36. Greater Metro South Brisbane  
37. Gold Coast  
38. Sunshine Coast  
39. West Moreton – Oxley  
40. Darling Downs – South West Queensland  
41. Wide Bay  
42. Central Queensland  
43. Central and North West Queensland  
44. Townsville – Mackay  
45. Far North Queensland

### SOUTH AUSTRALIA

46. Northern Adelaide  
47. Central Adelaide and Hills  
48. Southern Adelaide – Fleurieu – Kangaroo Island  
49. Country South SA  
50. Country North SA

### WESTERN AUSTRALIA

51. Perth Central and East Metro  
52. Perth North Metro  
53. Fremantle  
54. Bentley – Armadale  
55. Perth South Coastal  
56. South West WA  
57. Goldfields – Midwest  
58. Kimberley – Pilbara

### TASMANIA

59. Tasmania

### NORTHERN TERRITORY

60. Northern Territory

### AUSTRALIAN CAPITAL TERRITORY

61. ACT
**Deliverable:** Establish a Medicare Local national body

**2012-13 Reference Point:** The AML Alliance will be established in July 2012

**Result:** Met

- On 1 July 2012, the Department established the AML Alliance to act as a lead change agent for the Medicare Local network. During 2012-13, the AML Alliance provided support to Medicare Locals to achieve their strategic objectives and work cohesively as a network capable of responding to evolving Government priorities. In 2013-14, the Department will continue to work with the AML Alliance to promote best practice and outcome focused activities across the network.

**KPI:** Percentage of Medicare Locals meeting performance reporting requirements

<table>
<thead>
<tr>
<th>2012-13 Target: 100%</th>
<th>2012-13 Actual: 100%</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

- In 2012-13, the network of 61 Medicare Locals met all the Department’s reporting requirements including needs assessments, strategic plans, annual plans, budget and bi-annual progress reports. These deliverables outline ongoing and planned activities and progress against key reporting areas consistent with the strategic objectives of the program. In 2013-14, the Department will continue to monitor performance reporting with an increasing focus on outcomes.

**Medicare Locals Accreditation Standards**

In 2012-13, the Medicare Locals Accreditation (MLA) Standards and Guidelines were completed to support Medicare Locals and put in place the best possible processes to ensure high quality service delivery and organisational management. In developing the Standards, the Department consulted with key stakeholders including selected Medicare Locals, the Australian Medicare Local Alliance, the Australian Commission on Safety and Quality in Health Care (the Commission) and accrediting agencies.

By 31 May 2013, all 61 Medicare Locals had registered for accreditation with one of the six accreditation agencies awarded full approval by the Commission and the Department to administer the accreditation process. Medicare Locals have from 3 June 2013 to 30 June 2014 to achieve accreditation.

**Tasmanian Health Assistance Package**

In June 2012, the Australian Government announced an assistance package for Tasmania’s health system, outlining a number of significant investments to ease pressures and equip Tasmania’s health system to meet future challenges. The Department engaged the Tasmanian Medicare Local to implement initiatives to improve primary health care services to improve health outcomes for Tasmanians.

Progress has been made in planning services to address social determinants of health and health risk factors. Care coordination for people with chronic diseases and assistance for aged care clients is improving. Initiatives to better meet the post hospital care needs of patients are also being developed. In addition, the Tasmanian Medicare Local is evaluating implementation progress and effectiveness of the initiatives.
MEDIcare LocoALs IMPROVing HeAlth ONS THE CEnTRAl COASp

An innovative mobile x-ray service is enabling elderly people living in aged care facilities on the NSW Central Coast to obtain x-rays when needed, without leaving their home.

For a frail older person, a visit to the hospital for an x-ray can be a mentally and physically stressful experience. It can also be expensive, as an ambulance or taxi is usually needed to get the patients to and from the hospital.

Recognising this problem, the Central Coast NSW Medicare Local (ML) worked with a local mobile x-ray provider to devise a solution.

The resulting mobile x-ray service visits aged care facilities whenever residents need x-rays, to allow their doctors to obtain the images they need for a correct diagnosis with minimal disruption to the patient.

The mobile service, which began in April 2013, is funded by the Central Coast NSW ML from its 2012-13 flexible funding pool. In its first three months of operation, the service attended to up to 5 residents of aged care facilities each day.

An additional benefit is a reduced burden on both the Central Coast ambulance service and local hospital emergency departments, allowing these services to concentrate on other patients requiring urgent attention.

The ML hopes to be able to expand the mobile x-ray service in the future to include older patients living in the community.

The flexible funding to MLs is intended to be used to fill gaps in local health services. Central Coast ML has also used its funding to establish a Community Health Grants Program.

The program has provided up to $5,000 each to 15 local groups to promote healthy lifestyles and nutrition. Their diverse initiatives funded through the grants include a healthy breakfast program for disadvantaged young people and a menopause lifestyle and exercise program for women.

Improve the coordination and integration of primary health care services across the health system

In 2012-13, the Department worked with the states and territories to develop the National Primary Health Care Strategic Framework. The framework was submitted to the National Standing Council on Health in December 2012, and was agreed in April 2013. The framework sets out agreed future policy directions and priority areas for primary health care including the following strategic outcomes:

• build a consumer-focused integrated primary health care system;
• improve access and reduce inequity;
• increase the focus on health promotion, prevention, screening and early intervention; and
• improve quality, safety, performance and accountability.

These strategic outcomes are the focus of the ongoing work of the Department with each of the states and territories in developing bilateral plans that will support implementation of the framework.
Deliverable: Develop a national strategic framework to set out agreed future policy directions and priority areas for primary health care

2012-13 Reference Point: Framework developed by December 2012

Result: Met

The National Primary Health Care Strategic Framework was developed by December 2013 and agreed in April 2013.

Improve access to health and information services

In 2012-13, the National Health Services Directory (NHSD) was established to provide consumers and health practitioners with access to accurate current service information including, but not limited to, general practices, pharmacies and hospital emergency departments. The NHSD is available online and as free smartphone applications on Apple and Android. In 2013-14, the NHSD will expand to include additional primary care and allied health information, greater service detail, an endpoint location service to help with secure clinical messaging and the personally controlled electronic health record adoption strategy, and the inclusion of telehealth information.

Improve primary health care infrastructure

Improved infrastructure is pivotal to increasing the capacity of primary health care to adapt to and meet current and future challenges, such as the growing burden of chronic disease.

GP Super Clinics

The GP Super Clinic Program is establishing more than 60 clinics across Australia. GP Super Clinics bring together GPs, nurses, allied health professionals, visiting medical specialists and other health providers to deliver primary health care that is tailored to the needs and priorities of the local community.

In 2012-13, the Department worked in collaboration with state, territory and local governments and funding recipients to establish the remaining GP Super Clinics. A total of 50 GP Super Clinics have either started operations, provided early services or were under construction by 30 June 2013, including 31 which are fully operational.

During 2012-13, the Department awarded three grants to expand or establish new primary health care services in Bridgewater, Sorell and Brighton in Tasmania. These three grants were awarded in lieu of funding for the Sorell GP Super Clinic not proceeding.

Deliverable: Number of grants awarded to establish GP Super Clinics

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>6</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

The Emerald GP Super Clinic grant was one of the eight grants expected to be awarded in 2012-13, however this occurred earlier than expected, in June 2012. In 2012-13, grants were awarded to establish GP Super Clinics in Liverpool, Lower Hunter (NSW), Caboolture, Wynnum (QLD), and Mount Barker (SA). The awarding of grants for Darwin and Deeragun/Northern Beaches of Townsville (Deeragun) GP Super Clinics were delayed. Grants to the preferred applicants for both sites were awarded in July 2013.

KPI: Number of GP Super Clinics that commence delivery of services, including early services

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>5</td>
<td>Not met</td>
</tr>
</tbody>
</table>

As published in the 2013-14 Portfolio Budget Statements, the target was revised to six during the year to factor in additional time for extended council development application processes, land acquisition, state government approvals and associated processes outside the Commonwealth’s control. This revised target is considered to have been substantially met. In 2012-13, the ACT, Coffs Harbour, Sunshine Coast, Tweed Heads and South Morang GP Super Clinics all began delivering services, including early services. As at 30 June 2013, a total of 40 GP Super Clinics were delivering services.

52 www.nhsd.com.au
53 Includes the Emerald GP Super Clinic which was delivered earlier than expected in June 2012.
Grafton GP Super Clinic brings more doctors and new services to local patients

The Grafton GP Super Clinic in Clarence Valley, New South Wales has made a big difference to the health of local patients since it opened in October 2011.

With four additional GPs, the Clinic has made it easier for local people to see a doctor quickly. Attracted by the clinic’s commitment to becoming a centre of primary health care research, and supporting clinical education and training, the extra doctors have also made it possible to offer increased after hours services in Grafton.

Patients with Type 2 Diabetes have particularly benefited. They have received integrated care to manage their condition, with health professionals at the Super Clinic working as a team to meet their needs.

Other patients with chronic diseases are also showing improved health outcomes as a result of the clinic’s team-based approach.

Grafton GP Super Clinic has broadened the services on offer in the area. As well as GP services it has a GP specialising in paediatrics, nursing services including mental health nursing, and allied health services including dietetics, podiatry, speech pathology, occupational therapy, and exercise physiology.

GP Super Clinics are a key element of the National Health Reforms aimed at building a stronger national primary health care system, including a greater focus on management of chronic disease and illness prevention.

GP Super Clinic services are tailored to meet the needs of the local community. They are coordinated between privately provided GP services, allied health providers, community health and other state or territory government services.
Primary Care Infrastructure Grants

Primary Care Infrastructure Grants aim to improve the quality and accessibility of primary health care services in Australia and increase capacity to train the future health workforce. Projects are providing expanded and improved facilities for GPs and other health professionals, leading to better integrated primary health care services, more clinical training and expanded opening hours. Local communities are benefiting from improved access to a broader range of integrated health services coordinated through general practice, that meet local community health needs with a focus on preventive health activities and better chronic disease management.

Deliverable: Number of grants to upgrade or extend existing general practices, primary and community care services or Aboriginal Medical Services

| 2012-13 Target: 70 | 2012-13 Actual: 85 | Result: Met |

In 2012-13, the Department awarded 85 grants from the first and second round of the Primary Care Infrastructure Grants Program. As of 30 June 2013, 417 grants have been awarded. Of these, 284 have been completed and are delivering expanded primary health care services and additional training for health professionals.

Improve access to after hours primary health care

Medicare Locals After Hours Program

Through Medicare Locals, the Department aims to improve the coordination and integration of face-to-face after hours primary health care services. This seeks to ensure all Australians, regardless of where they live, have access to effective after hours primary health care services. In 2012-13, Medicare Locals developed locally tailored solutions to address priority gaps in after hours primary health care services in their areas. Initiatives include funding for new and extended opening hours predominantly via general practice, increased after hours support for residential aged care facilities and awareness campaigns about after hours services availability.

In 2013-14, the Department and the AML Alliance will continue to work with Medicare Locals to promote improved after hours access and integration with national services such as the after hours GP helpline.

After hours GP helpline

In 2012-13, the Department continued to support improved community access to primary care through the 24 hour nurse-based triage telephone service, healthdirect Australia, and the after hours GP helpline. From July to December 2012, a pilot video consultation service was introduced in selected residential aged care facilities to improve the ability of the after hours service to effectively assess a caller’s medical condition. In 2013-14, the after hours GP helpline and the Pregnancy, Birth and Baby service will both become video-enabled which will provide these benefits to a broader audience, and provide data for further evaluation of the technology.

KPI: Number of calls to the after hours GP helpline


The after hours GP helpline is a demand driven service with forecasts, rather than targets. healthdirect Australia, 13HEALTH and NURSE-ON-CALL transferred 169,218 calls to the after hours GP helpline in 2012-13. Residents in Queensland were referred to the after hours GP helpline at a significantly lower rate than forecast. Residents in Tasmania continued to access after hours GP services through the GP Assist service.

Phone numbers:

healthdirect Australia and the after hours GP helpline are available nationally on 1800 022 222
Residents of Queensland can contact 13HEALTH on 13 43 25 84
Residents of Victoria can contact NURSE-ON-CALL on 1300 60 60 24
**Program 5.3: Primary Care Practice Incentives**

Program 5.3 aims to provide incentive payments to general practices and GPs to support activities that encourage continuing improvements, increase quality of care, enhance capacity, and improve access and health outcomes for patients.

**Provide general practice incentive payments**

In 2012-13, the Department worked with the Department of Human Services to make around 20,000 Practice Incentives Program (PIP) payments to general practices and 55,000 payments to GPs for services such as:

- cervical cancer screening;
- diabetes management;
- asthma management;
- procedures in rural and remote areas;
- appropriate and timely access for older people to primary health care services in residential aged care facilities; and
- comprehensive and consistent care for Aboriginal and Torres Strait Islander patients with chronic disease.

**KPI: Percentage of GP patient care provided by PIP practices**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>83.4%</td>
<td>84.4%</td>
<td>Met</td>
</tr>
</tbody>
</table>

As at May 2013, 84.4% of GP patient care was provided by PIP practices. This compares to 84.0% in 2011-12 and 82.8% in 2010-11.

**KPI: Number of general practices receiving Indigenous health incentives**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,800</td>
<td>3,333</td>
<td>Met</td>
</tr>
</tbody>
</table>

Participation in the Practice Incentives Program Indigenous Health Incentive continued to increase in 2012-13 with 3,333 practices registered for the incentive by May 2013. This compares to 2,900 in 2011-12 and 2,100 in 2010-11.

**Practice Incentives Program eHealth Incentive**

In 2012-13, the Department implemented new eligibility requirements for the Practice Incentives Program (PIP) eHealth Incentive to encourage general practices to keep up to date with the latest developments in eHealth and to promote uptake of the personally controlled electronic health record. The Department will continue to consult closely with the National eHealth Transition Authority, the PIP Advisory Group, medical software developers and the Department of Human Services in implementing the new requirements.

**Deliverable: Implementation of new eligibility requirements for the PIP eHealth Incentive**

**2012-13 Reference Point:** New eligibility requirements are introduced from 1 February 2013

**Result: Met**

The new eligibility requirements came into effect from 1 February 2013, with further requirements effective from 1 May and 1 August 2013.

**KPI: Percentage of PIP practices receiving the eHealth incentive under new eligibility requirements**

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>80%</td>
<td>Met</td>
</tr>
</tbody>
</table>

3,712 practices were eligible from 1 February 2013, and 4,176 eligible from 1 May 2013. Participation in the PIP eHealth Incentive under the new eligibility requirements was 80% of PIP practices at 1 May 2013.
### Outcome 5 — Financial Resource Summary

<table>
<thead>
<tr>
<th>Program 5.1: Primary Care Education and Training</th>
<th>(A) Budget Estimate 2012-13 $’000</th>
<th>(B) Actual 2012-13 $’000</th>
<th>Variation (Column B minus Column A) $’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services (Annual Appropriation Bill 1)</td>
<td>6,852</td>
<td>6,654</td>
<td>198</td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>1,054</td>
<td>1,085</td>
<td>31</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>33</td>
<td>56</td>
<td>23</td>
</tr>
<tr>
<td>Total for Program 5.1</td>
<td>7,939</td>
<td>7,795</td>
<td>144</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program 5.2: Primary Care Financing, Quality and Access</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services (Annual Appropriation Bill 1)</td>
<td>546,167</td>
<td>545,053</td>
<td>1,114</td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>29,057</td>
<td>28,003</td>
<td>1,054</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>914</td>
<td>1,428</td>
<td>514</td>
</tr>
<tr>
<td>Total for Program 5.2</td>
<td>576,138</td>
<td>574,484</td>
<td>1,654</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program 5.3: Primary Care Practices Incentives</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services (Annual Appropriation Bill 1)</td>
<td>280,507</td>
<td>299,842</td>
<td>19,335</td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>1,455</td>
<td>1,394</td>
<td>61</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>46</td>
<td>71</td>
<td>25</td>
</tr>
<tr>
<td>Total for Program 5.3</td>
<td>282,008</td>
<td>301,307</td>
<td>19,299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 5 Totals by appropriation type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services (Annual Appropriation Bill 1)</td>
<td>833,526</td>
<td>851,549</td>
<td>18,023</td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>31,566</td>
<td>30,482</td>
<td>1,084</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>993</td>
<td>1,555</td>
<td>562</td>
</tr>
<tr>
<td>Total expenses for Outcome 5</td>
<td>866,085</td>
<td>883,586</td>
<td>17,501</td>
</tr>
<tr>
<td>Average Staffing Level (Number)</td>
<td>215</td>
<td>213</td>
<td>2</td>
</tr>
</tbody>
</table>

1 Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources [s31]’.
2 ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
OUTCOME 6
RURAL HEALTH

Access to health services for people living in rural, regional and remote Australia, including through health infrastructure and outreach services

MAJOR ACHIEVEMENTS

• Provided people in rural Australia with better access to medical specialists, GPs and allied and other health providers under the Rural Health Outreach Fund.

• Provided essential health services to rural, remote and very remote communities, including health clinics and emergency aero-medical evacuations, through further support for the Royal Flying Doctor Service.

• Provided information to people in regional and remote Australia to let them know what local health programs and services are available to them.

• Delivered better information to the community by expanding the Rural and Regional Health Australia website. The website now includes an improved map locator, GP statistics, locations of Medicare Locals and details about the Visiting Optometrists Scheme.

CHALLENGES

• Continue to support recruitment of health professionals to deliver vital outreach services in rural, regional and remote locations under the Rural Health Outreach Fund.

PERFORMANCE

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>87.5%</td>
<td>12.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>84.6%</td>
<td>15.4%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

PROGRAM CONTRIBUTING TO OUTCOME 6

Program 6.1: Rural health services
TRENDS

During 2012-13, the Royal Flying Doctor Service provided more than 43,142 patient contacts throughout Australia, up from 41,657 in 2011-12. With Government support, the Royal Flying Doctor Service continues to provide essential health services to Australia’s rural, remote and very remote communities.

Figure 6.1: Patient Consultations – Royal Flying Doctor Service

OUTCOME STRATEGY

Outcome 6 aims to improve access to health services for people living in rural, regional and remote Australia by supporting a range of targeted rural health programs and activities. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the program outlined below.

PROGRAM 6.1: RURAL HEALTH SERVICES

Program 6.1 aims to improve access to medical specialists, GPs and allied and other health providers in rural and remote areas of Australia.

Provide rural health outreach services

*Rural Health Outreach Fund*

Established on 1 July 2011, the Rural Health Outreach Fund provides a flexible funding pool to help improve access to medical specialists, GPs and allied and other health providers in rural and remote areas. Since then, the Department has been working with fund holders, health professionals and representative organisations to maximise the delivery of outreach health services.

The fund specifically addresses financial disincentives incurred by health professionals providing outreach services relating to maternity and paediatric health, eye health, mental health and chronic disease management. In addition, the Australian College of Rural and Remote Medicine was approved to receive funding to expand telehealth services.

---

Deliverable: Hold first funding round of the Rural Health Outreach Fund

2012-13 Reference Point: Funding round held before 30 June 2013

Result: Met

In May 2013, the Department selected organisations in each state and the Northern Territory to administer the funds. The delivery of these services began in July 2013.

Deliverable: Number of communities receiving outreach services through the Rural Health Outreach Fund

2012-13 Target: 135
2012-13 Actual: 421
Result: Met

421 communities received outreach services. This compares to 384 communities in 2011-12 and 388 in 2010-11.

KPI: Ongoing medical specialist, GP, and allied and other health services provided through the Rural Health Outreach Fund meet the needs of regional, rural and remote communities

2012-13 Reference Point: Organisations funded to support rural outreach will consult with stakeholder groups, and will be guided by Advisory Forums and Indigenous Health Partnership Forums, to identify community needs

Result: Met

In 2012-13, organisations consulted with stakeholder groups to identify community needs. These consultations were guided by Advisory Forums, which included a Departmental representative.

KPI: Number of patient contacts supported through the Rural Health Outreach Fund

2012-13 Target: 80,000
2012-13 Actual: 192,985
Result: Met

In 2012-13, there were 192,985 patient contacts. This compares to 191,786 contacts in 2011-12 and 174,750 in 2010-11.

Improve access to health and information services in regional, rural and remote areas

Australians in rural and regional areas face unique difficulties accessing health services. The Department has continued to support programs that improve access to health services in these communities, such as the National Rural and Remote Health Infrastructure Program, Royal Flying Doctor Service, and Rural Women’s GP Services. The Rural and Regional Health Australia information service, established in 2011 as part of Rural and Regional Health Australia, provides Australians with a central point where they can access information on local health and aged care services.

Rural and Remote Health Infrastructure

The National Rural and Remote Health Infrastructure Program (NRRHIP) continues to fund projects in rural and remote communities across Australia to establish and refurbish health facilities that provide a range of primary care services. These include health services such as podiatry, physiotherapy, speech pathology and dental health services. The NRRHIP also improves resources and establishes facilities to support private GPs to train medical students and registrars in rural and remote communities.

In 2012-13, the NRRHIP was revised to prioritise future grant rounds for projects, providing greater access for people living in remote and Indigenous communities. In 2013-14, a seventh funding round is due to be conducted to support projects providing better health outcomes for people living in remote and Indigenous communities with populations under 20,000 people.
### Deliverable: Number of new projects funded annually through the National Rural and Remote Health Infrastructure Program

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>50</td>
<td>Met</td>
</tr>
</tbody>
</table>

In May 2012, 50 projects were approved under round six of the NRRHIP and were scheduled to be funded in 2012-13. However, these projects were funded ahead of schedule in June 2012. Therefore no projects were funded in 2012-13, with a total of 92 projects funded in 2011-12 (including 42 under round five).

### Royal Flying Doctor Service

In 2012-13, the Department continued to provide funding for the Royal Flying Doctor Service to provide health care clinics, primary aero-medical evacuations, medical chests (medical and pharmaceutical supplies) and remote consultations. The delivery of the Rural Women’s GP Service was extended for two years to 2014-15 and will continue to give women in rural and remote Australia access to female GPs.

#### Deliverable: Number of rural locations visited by female GPs

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>170</td>
<td>163</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

In 2012-13, female GPs visited 163 rural locations. This compares to 149 locations in 2011-12 and 159 in 2010-11.

#### KPI: Number of patients attending Royal Flying Doctor Service clinics

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>39,000</td>
<td>43,142</td>
<td>Met</td>
</tr>
</tbody>
</table>

The Royal Flying Doctor Service continued to provide essential community health and general practice clinics in locations that are not otherwise serviced. In 2012-13, 43,142 patients attended a Royal Flying Doctor Service clinic. This compares to 41,657 in 2011-12 and 40,981 in 2010-11.

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#### RESCUED BY THE ROYAL FLYING DOCTOR SERVICE

When a health emergency happens far from a hospital, help often arrives via the Royal Flying Doctor Service (RFDS).

This was the case when a woman was crushed by two bulls fighting at her family property in far western New South Wales in September 2012.

The young woman was helping her father and husband muster cattle on the family property outside Tilpa. She climbed onto the side of the cattle yard to do a head count when two bulls charged her from behind, her leg was jammed between the bulls and a steel fence. Her husband rescued her from the fence and immediately rang the on-call RFDS medical officer from his car.

The medical officer assessed the injuries over the phone and told the husband to head for Tilpa, the closest landing strip. He also advised him to stop at the Tilpa pub, a repository for a RFDS medical chest containing pain relief medicine.

The RFDS plane landed at the Tilpa airstrip to help the young woman. They advised her that her thick work boots may have saved her ankle from breaking.

The woman and her family are incredibly grateful for the help the RFDS was able to provide in this emergency and the ongoing health services they provide to people in rural and remote Australia.

The RFDS is funded by the Department to provide essential health services for people living in rural and remote Australia, including aero-medical evacuations and medical chest facilities.

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55 Includes the projects that were delivered earlier than expected in June 2012.


**Rural and Regional Health Australia**

In 2012-13, Rural and Regional Health Australia (RRHA) continued to give rural and remote communities access to information about health and aged care programs and services available outside metropolitan areas. Its Information Service comprises a free call 1800 information line, email facility and website.\(^5^6\)

The RRHA website includes information on the Rural Health Workforce Strategy, GP statistics, Medicare Locals locations, the Visiting Optometrists Scheme, and an improved map locator tool. These features inform consumers, medical and health care professionals and students about access to services in rural, regional and remote areas. The site also links to the National Health Services Directory, which provides information on the location of health services, including GPs, pharmacies and hospitals.

In 2012-13, the Information Service received 1,256 enquiries (1,090 calls to the information line and 166 emails) from the public and health professionals, and the RRHA website has been accessed 71,763 times.

**KPI:** Rural and Regional Health Australia Information Service provides accurate, quality place-based information

**2012-13 Reference Point:** Regular reporting and revision of the Information Service to maintain information accuracy and quality

**Result:** Met

In 2012-13, the Department updated information available for the Rural and Regional Health Australia Information Service on a quarterly basis. This review process ensures that the content of the Information Service is up-to-date, accurate and easy to access.

**Rural and Regional Health Australia Information Service**

Finding local health and aged care information is now a whole lot easier.

The Rural and Regional Health Australia Information Service can be accessed:

- through the Rural and Regional Health Australia website at www.ruralhealthaustralia.gov.au
- by calling 1800 899 538 (free from land lines)
- by emailing infoRRHA@health.gov.au

**National Strategic Framework for Rural and Remote Health**

Geographic spread, low population density, limited infrastructure and the significantly higher cost of health service delivery present unique challenges for providing health care in rural and remote Australia.

The National Strategic Framework for Rural and Remote Health (the Framework), developed by the Rural Health Standing Committee (RHSC), provides the foundation for a nationally coordinated approach to addressing these challenges. The Department has continued to work with jurisdictions through the RHSC to improve access to quality and safe health care services for people living in rural and remote Australia. During 2012-13, the Department has also supported the RHSC to start developing a set of indicators to monitor progress against the Framework.

\(^5^6\) Phone 1800 899 538 or go to www.ruralhealthaustralia.gov.au

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122 DEPARTMENT OF HEALTH AND AGEING ANNUAL REPORT 2012–2013 VOLUME 1
### Outcome 6 – Financial Resource Summary

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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<td></td>
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<tr>
<td><strong>Program 6.1: Rural Health Services</strong></td>
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<tr>
<td>Administered Expenses</td>
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<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>87,480</td>
<td>86,946</td>
<td>(534)</td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>12,295</td>
<td>11,785</td>
<td>(510)</td>
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<td>Expenses not requiring appropriation in the current year²</td>
<td>385</td>
<td>601</td>
<td>216</td>
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<tr>
<td><strong>Total for Program 6.1</strong></td>
<td>100,160</td>
<td>99,332</td>
<td>(828)</td>
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<td>Outcome 6 Totals by appropriation type</td>
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<tr>
<td>Administered Expenses</td>
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<tr>
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<td>385</td>
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<td>216</td>
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<tr>
<td><strong>Total expenses for Outcome 6</strong></td>
<td>100,160</td>
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<td>Average Staffing Level (Number)</td>
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1 Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.

2 ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
OUTCOME 7
HEARING SERVICES

A reduction in the incidence and consequence of hearing loss, including through research and prevention activities, and access to hearing services and devices for eligible people

MAJOR ACHIEVEMENTS

- Secured agreement to deliver the Australian Government Hearing Services Program to DisabilityCare Australia participants.
- Implemented a more targeted, risk-based audit program of hearing service providers to assess their compliance with contractual and legal obligations.
- Completed first round of user acceptance testing of the new online portal to improve access to services for consumers.

CHALLENGES

- Meeting the needs of a diverse user group including clients and service providers in developing an online application processing system.

PERFORMANCE

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
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<td>71.4%</td>
<td>14.3%</td>
<td>14.3%</td>
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<tr>
<td>2011-12</td>
<td>55.0%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

PROGRAM CONTRIBUTING TO OUTCOME 7

Program 7.1: Hearing Services
TRENDS

The level of fitting services was maintained from 2011-12 to 2012-13 as shown in the following figure.

Figure 7.1: Initial and return fitting rates for the Voucher Program, 2008-09 to 2012-13

For new clients who received a hearing assessment in 2012-13, 77.7% received a fitting service compared with 79.2% in 2011-12. The proportion of return clients receiving an assessment and then a fitting service was also similar for 2012-13 and 2011-12 (36.4% versus 39.5% respectively).

The number of new clients applying for the Voucher Program has remained steady with a slight increase from 2011-12 to 2012-13.

Figure 7.2: Number of voucher applications for new and return clients, 2008-09 to 2012-13

From 1 January 2012, the voucher period for the Voucher Program changed from two to three years. The transition to a three year voucher was expected to result in less return clients (i.e. clients who have received at least one hearing service voucher previously) receiving services under the Voucher Program from 2012-13 until 2014-15. Consistent with this, there were fewer return clients in 2012-13 compared to the previous year.
Outcome 7 aims to reduce the incidence and consequences of avoidable hearing loss in the Australian community and provide access to high quality hearing services and devices. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the program outlined below.

**PROGRAM 7.1: HEARING SERVICES**

Program 7.1 aims to support access to quality hearing services for eligible clients, provide better targeted hearing services and support research into hearing loss prevention and management.

The Hearing Services Program supports pensioners, veterans, children and young people, Aboriginal and Torres Strait Islander clients and those with complex hearing problems to access hearing assessments and rehabilitation aids, via a network of private and public service providers.

**Support access for eligible clients to quality hearing services**

Supporting eligible clients to manage their hearing loss and better engage in the wider community is a cornerstone of the Hearing Services Program. In 2012-13, 287,778 eligible clients received hearing services vouchers for free hearing assessments, and hearing rehabilitation and, where clinically appropriate, free hearing devices.

In 2012-13, through the Community Service Obligation (CSO) Program, the Department continued funding Australian Hearing – a nationwide government agency – where eligible clients with hearing impairment can receive government-funded hearing services. Eligible clients include children and young adults up to the age of 26 years, adult clients with complex needs, clients living in rural and remote areas and eligible Aboriginal and Torres Strait Islander people. The timeliness and quality of service delivery under the CSO Program was consistent with the agreed standards in the Memorandum of Agreement between the Department and Australian Hearing.

The Department has worked closely with DisabilityCare Australia (DCA) to allow DCA clients with hearing needs to access the range of services available under the Hearing Services Program from 1 July 2013. Arrangements also ensure that DCA will benefit from the program’s quality assurance and device (hearing aid) procurement arrangements.

Work has also been undertaken to review how devices are acquired for the Hearing Services Program. Views on the current arrangements were sought from stakeholders through a Technical Reference Group (TRG) established to provide advice on minimum device specifications. Work will continue in 2013-14, including consultation with consumers on the TRG recommendations.

In 2012-13, a better targeted, risk-based audit program to assess service providers’ compliance with their obligations was introduced. This new audit framework helps service providers to implement continuous quality improvement processes through education and engagement, supports consistent delivery of quality services to clients and ensures legislative and contractual obligations where necessary.

<table>
<thead>
<tr>
<th>Deliverable: Number of people who receive voucher services nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 Target: 662,000 2012-13 Actual: 636,389 Result: Substantially met</td>
</tr>
</tbody>
</table>

The Voucher Program is demand-driven and the number of services provided was less than expected. 636,389 people received voucher services in 2012-13. This compares to 616,639 services in 2011-12 and 599,581 services in 2010-11.

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57 In 2012-13, to be eligible to receive services under the Voucher Program, a person had to be an Australian Citizen or permanent resident 21 years or older and must have been either: a Pensioner Concession Card Holder; receiving Sickness Allowance from Centrelink; the holder of a Gold Repatriation Health Card issued for all conditions; the holder of a White Repatriation Health Card issued for conditions that include hearing loss; a dependant of a person in one of the above categories; a member of the Australian Defence Force; or undergoing an Australian Government funded disability management service and are referred by a disability employment services case manager.
KPI: Proportion of voucher applications processed within 14 days of receipt

2012-13 Target: 82%  
2012-13 Actual: 99%  
Result: Met

99% of vouchers were processed within 14 days of receipt which meets the set target for voucher application processing times. This compares with 98% of vouchers processed within 14 days in 2011-12.

KPI: Proportion of claims for a hearing aid fitting that relate to voucher clients who have a hearing loss of greater than 23 decibels

2012-13 Target: 95%  
2012-13 Actual: 95%  
Result: Met

In 2012-13, 95% of clients met the Minimum Hearing Loss Threshold (MHLT) when fitted with a hearing aid. This meets the set target. The proportion of fittings meeting the MHLT has been consistent for the past three years, which was 96% for both 2010-11 and 2011-12. The threshold aims to ensure that services are targeted to those who need them most.

During 2012-13, the Department improved access to quality hearing services. Initiatives included working collaboratively with stakeholders on developing a new online portal, and with DCA and the Department of Families, Housing, Community Services and Indigenous Affairs on how the program links with the National Disability Insurance Scheme (NDIS).

The development of an online portal has raised a number of challenges, including the importance of responding to issues and concerns identified by a diverse range of consumers and industry representatives during user acceptance testing. This has resulted in some delays in the portal going live. However, extending the development time will ensure the portal meets the needs of a diverse audience and achieves the aim of building improved communication channels with hearing service providers and consumers. This will have positive flow on effects across the program in the future.

Deliverable: Voucher Program clients can lodge voucher applications through an online portal

2012-13 Reference Point: An online portal is available from early in 2013  
Result: Not met

User acceptance testing of the new portal identified improvements that could be made to enhance accessibility and usability for consumers. As these groups will be regularly using the portal, it was important to respond to the issues raised before the online portal was made available to the public. Following additional system development, a second round of user acceptance testing will be completed in the first quarter of 2013-14.

Deliverable: Implementation of a risk based audit program for service providers

2012-13 Reference Point: Audits commence from 1 July 2012, with monitoring and evaluation of program efficacy and risk indicators to occur throughout 2012-13  
Result: Met

A trial of the new Audit and Compliance Framework started in July 2012 with a series of trial onsite audits from October 2012 to March 2013. This allowed practical industry testing of, and input into, the new process before the national rollout. Auditing, monitoring and evaluation are ongoing.
**KPI:** Policies and program reforms are developed and implemented in consultation with consumers and service providers

**2012-13 Reference Point:** Opportunity for stakeholders to participate through a range of avenues including through consultative committees, meetings, focus groups and online

**Result:** Met

- The Department consulted with consumers on a range of issues. It has attended a number of forums and meetings with consumers, exchanging information and enhancing understanding of program changes. Formal consultation processes have occurred on a number of administrative, clinical and technical issues, including regulatory reform of device arrangements and a review of Rehabilitation Plus. The outcomes of these consultations have informed advice to Government. Consumer participation in user acceptance testing has resulted in improvements to the website and Hearing Services online portal.

### Support research into hearing loss prevention and management

The Department continued to support ongoing research into hearing loss prevention through the Hearing Loss Prevention Program (HLPP) and through providing funding to the National Acoustic Laboratories (NAL). The HLPP supports research into measures to reduce the incidence of preventable hearing loss, targeting Aboriginal and Torres Strait Islander people, young people and those in the workplace. The National Health and Medical Research Council (NHMRC) administers the HLPP on behalf of the Department.

Since 2008-09, 15 research projects have been funded under the HLPP, with one project being funded in 2012-13. Projects cover a range of issues, including identifying and reducing the sources of noise exposure in children and young adults, education for young children, and measures to prevent and treat otitis media (middle ear infection) in Aboriginal and Torres Strait Islander children.

The 2012-13 project will employ innovative technology to diagnose otitis media in infants and determine the risk factors for otitis media in infants. The Department renegotiated its Memorandum of Understanding with the NHMRC during 2012-13 and all remaining HLPP funds have been transferred to this organisation. The Department will work closely with the NHMRC to allocate remaining HLPP funds to eligible projects.

Funding to the NAL has contributed to research into auditory processing, outcomes for children with hearing loss, and overcoming barriers to hearing device use.

**Deliverable:** Funding round for the allocation of research grants under the Hearing Loss Prevention Program completed

**2012-13 Reference Point:** At least one funding round held in 2012-13

**Result:** Met

- One funding round was held in 2012-13 and the NHMRC is scheduled to complete its assessment of eligible projects in September 2013. Successful projects will be announced in November 2013. Remaining funds held by the NHMRC after this round will be offered in 2013-14 funding rounds.
Outcome 7 – Financial Resource Summary

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $’000</th>
<th>(B) Actual 2012-13 $’000</th>
<th>Variation (Column B minus Column A) $’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program 7.1: Hearing Services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ordinary Annual Services ( Annual Appropriation Bill 1)</td>
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<td>372,652</td>
<td>(31,605)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
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</tr>
<tr>
<td>Departmental Appropriation</td>
<td>12,269</td>
<td>12,224</td>
<td>(45)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>345</td>
<td>580</td>
<td>235</td>
</tr>
<tr>
<td>Total for Program 7.1</td>
<td>416,871</td>
<td>385,456</td>
<td>(31,415)</td>
</tr>
<tr>
<td>Outcome 7 Totals by appropriation type</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Administered Expenses</td>
<td></td>
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<td>Expenses not requiring appropriation in the current year</td>
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<tr>
<td>Total expenses for Outcome 7</td>
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<td>385,456</td>
<td>(31,415)</td>
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<tr>
<td>Average Staffing Level (Number)</td>
<td>81</td>
<td>82</td>
<td>1</td>
</tr>
</tbody>
</table>

1 Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.
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OUTCOME 8
INDIGENOUS HEALTH

Closing the gap in life expectancy and child mortality rates for Indigenous Australians, including through primary health care, child and maternal health, and substance use services

MAJOR ACHIEVEMENTS

• The Indigenous Chronic Disease Package is now fully implemented. All initiatives to boost the health workforce have been rolled out to improve Aboriginal and Torres Strait Islander peoples’ access to health services, including primary health care, follow-up, and coordinated, multidisciplinary care.

• A total of 87,741 health assessments have been provided to Aboriginal and Torres Strait Islander people 15 years and over from July 2012 to June 2013 – an increase of 26% over 2011-12. Since the first year of the Indigenous Chronic Disease Package, the uptake of Aboriginal and Torres Strait Islander health assessments has increased by more than 277%.

• A total of 44,663 Indigenous specific follow-up services have been provided by Aboriginal health workers and practice nurses to Aboriginal and Torres Strait Islander people 15 years and over from July 2012 to June 2013 – more than double the number of services in 2011-12.

• Service providers are better able to focus on tailoring services for communities, with the launch of a new web-based reporting tool.

• We are on track to halve the gap in child mortality by 2018. There has been significant improvement in Indigenous child mortality from 1998 to 2011, with the Indigenous child mortality rate declining by 29%.

CHALLENGES

• Chronic disease remains a major cause of the life expectancy gap. Programs to improve the prevention, detection and management of chronic disease will continue to be a significant focus.

• Continue the momentum to halve the child mortality rate by 2018.

• Encourage uptake of governance reform within the community controlled Aboriginal and Torres Strait Islander health services sector.

• Ensure quality data is provided by streamlining reporting arrangements which also enables services to focus on delivering care to patients.
PERFORMANCE

<table>
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<th>PERIOD</th>
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</thead>
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</tr>
<tr>
<td>2011-12</td>
<td>86.7%</td>
<td>11.1%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

PROGRAM CONTRIBUTING TO OUTCOME 8

Program 8.1: Aboriginal and Torres Strait Islander health
2.1 TRENDS

Figure 8.1 shows that from 1998 to 2010 there has been a statistically significant decrease in chronic disease mortality rates in both Indigenous and non-Indigenous populations. There has been no statistically significant change in the gap between the two populations over this period. However, the trend from the 2006 baseline to 2010 has shown a small but statistically significant decrease in the gap.

Figure 8.1: Chronic disease mortality rates from 1998 to 2031 required to close the gap

![Graph showing chronic disease mortality rates from 1998 to 2031 required to close the gap.](image)

Figure 8.2 and related statistical analysis shows that from 1998 to 2010 there has been a statistically significant decrease in child mortality rates under five years of age in both, Indigenous and non-Indigenous populations. The gap between the two populations has shown a statistically significant decrease and is within the range required to meet the 2018 target.

Figure 8.2: Child mortality rates from 1998 to 2018 required to halve the gap

![Graph showing child mortality rates from 1998 to 2018 required to halve the gap.](image)

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58 ABS and AIHW analysis of ABS mortality data 1998 to 2010 (unpublished) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).

59 ABS and AIHW analysis of ABS mortality data 1998 to 2010 (unpublished) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).
OUTCOME STRATEGY

Outcome 8 aims to improve access for Aboriginal and Torres Strait Islander people to effective health care services essential to improving health and life expectancy, and reducing child mortality. In 2012-13, the Department worked to achieve this Outcome by managing initiatives outlined below.

PROGRAM 8.1: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Program 8.1 aims to improve access for Aboriginal and Torres Strait Islander people to effective primary health care services, maternal and child health services, and social and emotional wellbeing services, as well as promoting the prevention and management of chronic disease.

Improve social and emotional wellbeing

The Social and Emotional Wellbeing Program supports Aboriginal and Torres Strait Islander people affected by past government removal policies. It provides family tracing, reunion, counselling services and workforce support through the network of eight Link Up services, nine Workforce Support Units, nine Indigenous Registered Training Organisations and counsellors in more than 90 Aboriginal and Community Controlled Health Organisations (ACCHOs) across Australia.

Deliverable: Provide high quality social and emotional wellbeing services

2012-13 Reference Point: Revised program manuals distributed and in use across funded services

Result: Met

Revised program manuals for Link Up, counselling and workforce support and training organisations funded through the Social and Emotional Wellbeing Program were distributed, are in use and are helping organisations to provide improved culturally appropriate and nationally consistent services.

Reduce chronic disease

Aboriginal and Torres Strait Islander people experience more than twice the burden of disease than other Australians. The Indigenous Chronic Disease Package aims to address this burden, and was the Commonwealth’s contribution to the $1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. The package is a comprehensive set of inter-related initiatives designed to improve the prevention, early detection and ongoing management of chronic diseases that are the main causes of mortality for Aboriginal and Torres Strait Islander people.

The Commonwealth has committed $777 million over three years (to 30 June 2016) to continue programs to improve Indigenous health under a further National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. When MBS and PBS estimates are taken into account, the Commonwealth contribution will be around $992 million over three years.

Regional Tackling Indigenous Tobacco and Healthy Lifestyle Teams

Tobacco smoking is a major cause of chronic disease among Aboriginal and Torres Strait Islander people. The Regional Tackling Indigenous Tobacco and Healthy Lifestyle Teams continue to work with local communities to address high smoking rates and develop health promotion activities that promote smoke free lifestyles, improved nutrition and increased physical activity. The program has significantly increased the focus on preventive health and is now funded to provide national coverage in 57 regions. In 2012-13, the Department funded the third tranche of Regional Tackling Smoking and Healthy Lifestyle Teams, including 18 Regional Tobacco Coordinators, 49 Tobacco Action Workers and 37 Healthy Lifestyle Workers. This brings the total number of workers funded under this element of the package to 58 Full-time Equivalent (FTE) Regional Tobacco Coordinators, 168 FTE Tobacco Action Workers, and 118 FTE Healthy Lifestyle Workers.
2.1

YAMBA THE HONEY ANT’S HEALTHY LIVING ROADSHOW

Pre-school Aboriginal and Torres Strait Islander children are learning about the importance of healthy lifestyles with the aid of a television character, Yamba the honey ant.

A popular character on the Indigenous television network, Imparja, Yamba and her “handler” and best friend Jacinta Price tour communities across Queensland and the Northern Territory to spread positive health messages in a fun and entertaining way.

Musical performances featuring song, dance and actions have been presented to thousands of children since February 2011. They promote proper nutrition and hygiene, regular physical activity, trachoma prevention, ear and nose health and use of primary health care services.

A set of 15 animated advertisements featuring Yamba and encouraging healthy lifestyle behaviours have also been produced. They are used as Community Service Announcements on Imparja Television and in “Yamba’s Playtime” broadcast on Nine Network’s digital channel, GO!

The shows have received a rapturous response at communities including Mornington Island, Doomadgee, Mt Isa, Cloncurry, Normanton, Karumba, Burketown, Gregory Downs, Charleville, Roma, Mitchell, St George, Cunnamulla, Quilpie, Bollon, Blackall, Barcaldine, Longreach and Winton.

Yamba and Jacinta are ANTastically excited about their roadshow and will hit the road again in Queensland throughout 2013 and 2014, to help children stay healthy and strong.

Their roadshow is funded by the Department through the Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Program. This is one of 14 measures in the Commonwealth’s Indigenous Chronic Disease Package, to help close the gap in Indigenous health outcomes.

Local Community Campaigns projects are grass roots, culturally appropriate projects to raise awareness within Aboriginal and Torres Strait Islander communities that conditions such as heart disease, diabetes, kidney disease and stroke are preventable, and to encourage them to use health services.

Coordinated primary health care

The Indigenous Chronic Disease Package has improved access to well-coordinated, multi-disciplinary primary health care services. Initiatives in this area include funding for Aboriginal and Torres Strait Islander Outreach Workers, additional primary health care staff and a Care Coordination and Supplementary Services program. More than 100 Full-time Equivalent (FTE) Care Coordinators have been employed and assist Aboriginal and Torres Strait Islander patients with chronic disease to access specialist and allied health services.

More than 85,000 care coordination and supplementary services were delivered from June 2010 to 31 December 2012. In addition a boost to funding for outreach services through the Medical Outreach – Indigenous Chronic Disease program has meant 1,141 services, involving 39,086 patient contacts, in 320 locations were delivered nationally between 1 July 2012 and 31 December 2012.
The Department also continued to fund 101.75 FTE Indigenous Health Project Officers to improve access to mainstream primary care.

Funding for 88 FTE Aboriginal and Torres Strait Islander Outreach Workers and 90 FTE Indigenous Health Project Officers in Medicare Locals has helped reduce many of the barriers Aboriginal and Torres Strait Islander people experience in accessing primary health care, delivering better health outcomes.

**Practice Incentives Program**

In addition, the Practice Incentives Program (PIP) Indigenous Health Incentive was introduced to encourage primary health care services to register eligible Aboriginal and Torres Strait Islander patients for chronic disease management. Further incentives are paid for providing a targeted level of care (Tier 1) to a registered patient, and for providing the majority of care (five or more eligible MBS services) in a calendar year to a registered patient (Tier 2).

To receive Tier 1 payments, a service provider must develop either a GP Management Plan (GPMP) or Team Care Arrangement (TLA) for a registered patient, and monitor the plan regularly. These plans aim to improve the management of chronic disease by documenting and arranging for the health services required by the patient, such as specialist and allied health services.

The number of Aboriginal and Torres Strait Islander patients registered under the program increased from 31,646 in 2010 to 52,321 in 2012 – a 65% increase. Over this period, the proportion of registered patients who triggered a Tier 2 payment has been consistently high, at around 70%. The proportion of the patients triggering a Tier 1 payment was initially very low, at 5% in 2010. However, the number has steadily increased to about 16% in 2012 (Figure 8.3).

**Figure 8.3: Patients triggering an outcome payment under the Practice Incentives Payment Indigenous Health Incentive program**

![Graph showing the increase in patients triggering outcome payments](image)

*includes the number of patients triggering a Tier 1 as well as a Tier 2 payment.

Source: PIP Indigenous Health Incentive data, Department of Health and Ageing.

All jurisdictions demonstrated an increase in patients triggering Tier 1 payments between 2010 and 2012. The NT had the highest proportion of patients triggering a Tier 1 payment. This is consistent with the growth in the proportion of Aboriginal and Torres Strait Islander patients in the NT with GP Management Plans and/or Team Care Arrangements in place, representing better management of chronic disease.

Figure 8.4 shows the significant increase in the percentage of Aboriginal and Torres Strait Islander patients with Type II diabetes and/or coronary heart disease getting the target level of care between 2010 and 2012. This achievement reflects the success of programs including the PIP Indigenous Health Incentive and concerted efforts by the Department, the NT Department of Health, and the ACCHOs to improve chronic illness care. This partnership has implemented the NT Aboriginal Health Key Performance Indicator system along with a continuous quality improvement strategy to help health services improve chronic illness care.
Figure 8.4: Growth in the proportion of Indigenous patients with Type II diabetes and/or coronary heart disease with GPMP or TCA in NT, between 2010 and 2012 who are receiving the target level of care.

<table>
<thead>
<tr>
<th>Year</th>
<th>GPMP</th>
<th>TCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>43%</td>
<td>61%</td>
</tr>
<tr>
<td>2012</td>
<td>44%</td>
<td>62%</td>
</tr>
</tbody>
</table>

Deliverable: Additional staff working on the prevention and management of chronic disease including Aboriginal and Torres Strait Islander outreach workers, practice managers and other health professionals.

2012-13 Target: 242  
2012-13 Actual: 246.65  
Result: Met

In 2012-13, the Department funded 246.65 FTE additional workforce positions for the prevention and management of chronic disease (173.25 FTE Aboriginal and Torres Strait Islander Outreach Workers, 41.4 FTE Practice Managers and 32 FTE additional health professionals).

KPI: Chronic disease related mortality rate per 100,000.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 Target</td>
<td>Indigenous: 897</td>
<td>Non-Indigenous: 469</td>
<td>Rate Difference: 428</td>
</tr>
<tr>
<td>Result</td>
<td>Met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 2010 Indigenous chronic disease mortality rate (897 per 100,000) was within the target range for 2010 (819-920 per 100,000). The difference between the Indigenous and non-Indigenous chronic disease mortality rates for 2010 (428 per 100,000) was also within the target range for 2010 (346-448 per 100,000). Over 1998-2010, there has been no statistically significant change in the gap between the two populations.

Improve child and maternal health

The Department aims to improve the health of Aboriginal and Torres Strait Islander mothers and children. There is a particular focus on improving access to, and uptake of, maternal and child health services, starting pre-pregnancy, protecting the health and wellbeing of Aboriginal and Torres Strait Islander families and enhancing early childhood development.

In 2012-13, the Department worked closely with the Department of Education, Employment and Workplace Relations in implementing and evaluating the Indigenous Early Childhood Development National Partnership Agreement (IECD-NPA), due to be completed in 2014. The Department also worked with the Australian Institute of Health and Welfare to prepare the first report on the IECD-NPA health key performance indicators. Following endorsement by Health Ministers, this report will be released in 2013-14.

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60 Source: NT Aboriginal Health Key Performance Indicators (AHKPIs) – KPI 1.7.  
61 Totals are cumulative over the life of the measure.  
62 ABS and AIHW analysis of ABS mortality data 1998 to 2010 (unpublished) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).
The Department worked closely with the ACCHOs and primary health care providers to continue implementing New Directions: Mothers and Babies Services in 85 sites. This program provides families with access to antenatal care, information about baby care, practical advice and assistance with breastfeeding, nutrition and parenting, monitors developmental milestones, immunisation status and infections; and undertakes health checks for Indigenous children before starting school.

### Deliverable: Number of organisations funded to provide New Directions: Mothers and Babies Services

<table>
<thead>
<tr>
<th>2012-13 Target: 82</th>
<th>2012-13 Actual: 85</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

Due to the cost per service being less than originally anticipated, the Department exceeded the target and funded a total of 85 New Directions services in 2012-13. Organisations undertake activities in a variety of service delivery models, including home visiting, outreach models, provision of antenatal classes, and education and awareness about early childhood development. The New Directions: Mothers and Babies Services program is part of the Australian Government’s contribution to the IECD-NPA.

The Department continued to implement the Australian Nurse Family Partnership program in three sites in the NT, NSW and Qld. This is an evidence-based program that aims to improve pregnancy outcomes by helping women engage in good preventive health practices, support parents to improve their child’s health and development, and help parents develop a vision for their own future, including continuing education and finding work.

### KPI: Child 0-4 mortality rate per 100,000

| Non-Indigenous: 91-104 | Non-Indigenous: 95 |
| Rate Difference: 54-130 | Rate Difference: 108 |

The 2010 Indigenous child mortality rate (203 per 100,000) was within the target range for 2010 (152-226 per 100,000). The difference between the Indigenous and non-Indigenous child mortality rates for 2010 (108 per 100,000) was also within the target range for 2010 (54-130 per 100,000).

### Improve remote service delivery and access to effective health services

The Department aims to deliver prevention, treatment and integrated long-term management of the health needs of Aboriginal and Torres Strait Islander people, particularly focusing on delivering services in remote areas.

In 2012-13, the Department provided grant funding to 278 organisations to provide primary and allied health care services to meet the needs of Indigenous communities in urban and regional areas, with a specific focus on remote areas. These grants delivered clinical services for the treatment of illnesses and management of chronic conditions, as well as a range of population health programs.

### Deliverable: Number of organisations funded to provide Indigenous specific primary health care and social and emotional wellbeing services

|--------------------|------------------|------------|

The Department exceeded the target and funded a total of 278 organisations in 2012-13. Of these, 172 (62%) were ACCHOs.

Through these services, the Department funds a broad range of comprehensive primary health care services enabling Aboriginal and Torres Strait Islander people to access timely and effective health care.

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63 ABS and AIHW analysis of ABS mortality data 1998 to 2010 (unpublished) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined).
2.1

**KPI:** Percentage of organisations funded to provide Aboriginal and Torres Strait Islander-specific services which have action plans in place

<table>
<thead>
<tr>
<th>2010 Target: 100%</th>
<th>2012-13 Actual: 100%</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

In 2012-13, all organisations which received funding to provide Aboriginal and Torres Strait Islander-specific services had action plans in place.

In 2012-13, the Department, through the *Stronger Futures in the Northern Territory* initiative, continued to improve the health and wellbeing of Aboriginal and Torres Strait Islander people in the NT, working in partnership with the NT Government and the ACCHOs. This was achieved through a range of programs including: integrated hearing and oral health programs for Aboriginal children under 16; child abuse trauma counselling and support services for Aboriginal children under 18 and their families in remote communities; a Territory-wide integrated and comprehensive primary health care system; and continuing reform of the Aboriginal primary health care system.

Through this initiative, the Department continued to fund the Continuous Quality Improvement (CQI) Investment Strategy for Aboriginal and Torres Strait Islander primary health care services in the NT. This involved employing CQI specialists who work with service providers in each region to identify opportunities and strategies to improve access to and delivery of primary health care. The CQI strategy has led to increased interpretation and use of clinical data at the health service level. Services are beginning to share, compare and benchmark data at a regional level. This has led to changes and improvements in processes resulting in the delivery of better targeted health care.

Good corporate governance plays a crucial role in the efficiency, effectiveness and sustainability of the ACCHOs. As such, identifying, promoting and supporting best governance practice is a key element for success. The Governance Enhancement Working Group reported to the Government on recommended changes and enhancements to improve corporate governance. The Working Group’s report and recommendations will be the basis for discussions with the ACCHOs to continue the improvement in governance in 2013-14.

The Department continued to fund the Remote Area Health Corps to recruit urban-based health professionals for short-term deployments to help meet workforce shortages in remote locations in the NT. Over the year, 548 health professionals were deployed to remote communities for a combined total of 1,923 weeks of service delivery.

Investment in Indigenous health infrastructure is critical to support the quality health care needed to prevent and treat the chronic and complex health conditions. During 2012-13, 21 capital infrastructure projects totalling $33.8 million (GST exclusive) were completed. This has included six clinics and 15 dwellings for health professionals with most of these works conducted in remote areas where there is limited infrastructure. Major achievements included the completion of the health clinic in remote Western Australia at Wiluna and the substance use day care centre at Coober Pedy in central remote South Australia.

**HEALTH PLAN**

The Australian Government released a National Aboriginal and Torres Strait Islander Health Plan (the Health Plan). The Health Plan was developed as a collaborative effort, and was informed by advice from the National Aboriginal and Torres Strait Islander Health Equality Council and the Stakeholder Advisory Group established to guide the development of the Health Plan. Throughout 2012-13, the Department engaged with the community through 17 nation-wide community consultations, including a specific youth forum, an online submissions process, and expert roundtables to provide an opportunity for all points of view in the community to be heard and considered throughout the development of the Health Plan. The Health Plan is intended to guide policy and program development to improve Aboriginal and Torres Strait Islander health over the next ten years.
Online community health reporting environment

In 2012-13, further enhancements were made to the web-based reporting tool – known as OCHREStreams. This will streamline the reporting process for health services, reducing administration and increasing the time available for service delivery.

OCHREStreams enables services to generate regular and ad hoc reports on demand to support continuous quality improvement and management planning. Services are able to identify health and demographic trends and use that information to shape and improve service delivery.

OCHREStreams has made reporting obligations easier for funded health services while providing high quality health outcome and service provision data to the Australian Government.

**OUTCOME 8 – FINANCIAL RESOURCE SUMMARY**

<table>
<thead>
<tr>
<th>Program 8.1: Aboriginal and Torres Strait Islander Health¹</th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services (Annual Appropriation Bill 1)</td>
<td>701,959</td>
<td>693,057</td>
<td>(8,902)</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation²</td>
<td>46,809</td>
<td>45,246</td>
<td>(1,563)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year³</td>
<td>1,484</td>
<td>2,300</td>
<td>816</td>
</tr>
<tr>
<td>Total for Program 8.1</td>
<td>750,252</td>
<td>740,603</td>
<td>(9,649)</td>
</tr>
</tbody>
</table>

Outcome 8 Totals by appropriation type

| Administered Expenses                                    |                                  |                         |                                      |
| Ordinary Annual Services (Annual Appropriation Bill 1)   | 701,959                          | 693,057                 | (8,902)                              |
| Departmental Expenses                                    |                                  |                         |                                      |
| Departmental Appropriation²                              | 46,809                           | 45,246                  | (1,563)                              |
| Expenses not requiring appropriation in the current year³ | 1,484                            | 2,300                   | 816                                  |
| Total expenses for Outcome 8                             | 750,252                          | 740,603                 | (9,649)                              |

| Average Staffing Level (Number)                          | 327                              | 325                     | 2                                     |

¹ This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

² Departmental appropriation combines ‘Ordinary annual services [Appropriation Bill 1]’ and ‘Revenue from independent sources [s31]’.

³ ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
OUTCOME 9
PRIVATE HEALTH

Improved choice in health services by supporting affordable quality private health care, including through private health insurance rebates and a regulatory framework

MAJOR ACHIEVEMENTS
- Introduced means testing of the private health insurance rebate.
- Introduced legislative changes that mean the Lifetime Health Cover loading portion of health insurance premiums will no longer attract the Government rebate on private health insurance.
- Streamlined how applications for health insurance premium increases are assessed.

CHALLENGES
- Ensure that implementation of changes in private health insurance rebate arrangements are informed by consultation with industry and the community.
- Continue to streamline the premium round process in consultation with industry.
### Outcome 9 Private Health

**Performance**

- **MET**: 75.0%
- **Substantially Met**: 25.0%
- **Not Met**: 0%

<table>
<thead>
<tr>
<th>Period</th>
<th>Met</th>
<th>Substantially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>75.0%</td>
<td>25.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>93.3%</td>
<td>0.0%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

**Program Contributing to Outcome 9**

- Program 9.1: Private health insurance
**TRENDS**

A record number of Australians continue to join health funds. Almost 12.7 million Australians have some form of private health insurance, and 47% (10.85 million people) are now covered by private hospital insurance.

**Figure 9.1: Number of People with Private Hospital Cover, 1971–2013**

Introduction of Life Time Health Cover from 1 July 2000

Introduction of Medicare Levy Surcharge July 1997

Medibank began on 1 July 1975. A program of universal, non contributory, health insurance it replaced a system of government subsidised voluntary health insurance.

Commonwealth medical benefits at 30% flat rate restricted to those with at least basic medical cover from September 1981

Medicare began on 1 January 1984.

**OUTCOME STRATEGY**

Outcome 9 aims to promote the sustainability of private health insurance and support consumer choice in health care. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the program outlined below.

**PROGRAM 9.1: PRIVATE HEALTH INSURANCE**

Program 9.1 aims to support the sustainability of private health insurance and improve information for consumers of private health services.

**Ensure the sustainability of the private health insurance rebate**

The Department continued to help make expenditure on the private health insurance rebate sustainable by helping to introduce incoming testing of the rebate and developing legislation to remove the rebate on Lifetime Health Cover loadings and indexing the rebate.

---

64 Sourced from PHIAC June Quarterly Statistics available at: www.phiac.gov.au
**Deliverable:** Insurers affected by changes to the private health insurance rebate are adequately informed of these changes

**2012-13 Reference Point:** Stakeholder discussions will be undertaken to convey the relevant information

**Result:** Met

The Department met with insurers regularly during the year to consult on the proposed implementation of changes to rebates, indexation and the premium round process. Private health insurance circulars were also used to communicate changes to insurers and other stakeholders.

---

**Improve access to prostheses through private health insurance**

People needing prostheses should have choice, while knowing they are getting products that provide value for money and are safe.

The Department aims to achieve a fair, equitable and sustainable prostheses reimbursement framework. This will ensure private health insurance expenditure is directed to clinically appropriate and cost effective prostheses. During 2012-13, the Department continued to work with stakeholders to find the best way to improve how new products are assessed and existing ones are maintained. Similar products – and their benefits – have now been grouped together.

The Department continued to administer cost recovery of the prostheses arrangements and the National Joint Replacement Registry.

**Deliverable:** Recommendations of HTA Review are implemented to ensure consumers have access to no gap prostheses arrangements under the prostheses schedule

**2012-13 Reference Point:** Grouping and benefit assignment process is finalised during 2012-13. Prostheses Listing arrangements are streamlined for all stakeholders and consumers have access to clinically effective prostheses with a group benefit and no gap payments

**Result:** Substantially met

All groupings of products on the Prostheses List have been reviewed and more than 95% of changes were implemented in 2012-13. The remainder will be finalised in 2013-14.

---

**Improve information for consumers**

With the Department of Human Services, the Department continued to inform people about Lifetime Health Cover. Information about Lifetime Health Cover loadings on private health insurance premiums is mailed to people turning 31 and new migrants. The mailout seeks to ensure people know about Lifetime Health Cover, as set out in the Private Health Insurance Act 2007. Individual health insurers pay for the mailout based on their share of the market.

**Deliverable:** New migrants and 31 year olds are informed appropriately about Lifetime Health Cover and how it affects them

**2012-13 Reference Point:** Information is provided to new migrants within 12 months of when they register with Medicare and to individuals who are approaching their 31st birthday

**Result:** Met

The 2013 Lifetime Health Cover mailout was sent in May 2013 to 190,780 people approaching the 1 July deadline following their 31st birthday and 78,805 new migrants. The Department will continue to support the mailout by providing additional Lifetime Health Cover information to consumers through a dedicated telephone hotline on 1800 307 446, as well as via internet and mail.

---

65 Review of Health Technology Assessment in Australia.
### Deliverable: Publish information on private hospital performance against national hospital performance indicators

**2012-13 Reference Point:** Information published on the My Hospitals website in a timely manner

**Result:** Met

The National Health Performance Authority reports on the performance of hospitals and primary health care organisations across Australia – informing consumers and empowering clinicians and service providers to drive improvements, and increase transparency and accountability. In 2012-13, the Authority assumed responsibility for the My Hospitals website, which compares the performance of more than 1,000 public and private hospitals.

### Ensure private health insurance covers clinically proven treatments

An evidence based review of natural therapies, which began in 2012-13, is aimed at ensuring that people using these services should be able to get the private health insurance rebate only where they are safe, clinically effective and cost effective.

**Deliverable:** Remove private health insurance rebate from ‘natural therapies’ that do not have an established evidence base

**2012-13 Reference Point:** A review of the clinical efficacy of natural therapies will be conducted in 2012-13 and stakeholder discussions will be undertaken to identify and convey the findings

**Result:** Substantially met

The Department, through a Memorandum of Understanding with the National Health and Medical Research Council, is undertaking an ‘evidence review’ of natural therapies. This will include assessing existing evidence and submissions made to the Department. The Natural Therapy Review Advisory Committee has been formed to review the findings and provide advice to the Australian Government. Stakeholder discussions will occur once the findings are finalised. The review began in July 2012 and is expected to be completed in 2013-14.

### Promote an affordable and sustainable private health insurance sector

**KPI:** Maintain the number of people covered by private health insurance hospital treatment cover

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.3m</td>
<td>10.85m</td>
<td>Met</td>
</tr>
</tbody>
</table>

The number of people with hospital cover has reached 10.85 million (47% of the Australian population). This is the highest participation rate in more than 24 years (47% in June 1988).

In 2012-13, the Department worked with the Private Health Insurance Administration Council (PHIAC) to streamline how premiums are increased. The new process went smoothly and will continue to be discussed between stakeholders, PHIAC and the Department.

**Deliverable:** Percentage of insurers’ average premium increases publicly released

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

When the 2013 approved premium increase was announced, average premium increases for individual private insurers and reasons for the increase at the industry level, along with a media release, were published on the Department’s website.
**KPI:** Applications for private health insurance premium increases are assessed in an efficient, effective and transparent way

**2012-13 Reference Point:** Consumer and industry feedback will be used to assess the effectiveness of the premium increase process and the Department’s communication of its outcomes

**Result:** Met

In October 2012, the Minister endorsed a new approach for the 2013 private health insurance premium round, with an expanded, clearer role for the PHIAC and a shorter timeframe. Industry feedback on the revised process has been positive. In addition, the Department is talking with industry and consumer groups to further improve the process.

---

**Outcome 9 — Financial Resource Summary**

<table>
<thead>
<tr>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program 9.1: Private Health Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>2,591</td>
<td>2,581</td>
</tr>
<tr>
<td>Special appropriations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Health Insurance Act 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Private Health Insurance Rebate</td>
<td>5,135,350</td>
<td>5,184,345</td>
</tr>
<tr>
<td>- Risk Equalisation Trust Fund</td>
<td>420,195</td>
<td>403,202</td>
</tr>
<tr>
<td>- Council Administration levy</td>
<td>6,226</td>
<td>6,226</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation¹</td>
<td>11,410</td>
<td>11,422</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>321</td>
<td>500</td>
</tr>
<tr>
<td>Total for Program 9.1</td>
<td>5,576,093</td>
<td>5,608,276</td>
</tr>
</tbody>
</table>

Outcome 9 Totals by appropriation type

<table>
<thead>
<tr>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>2,591</td>
<td>2,581</td>
</tr>
<tr>
<td>Special appropriations</td>
<td>5,561,771</td>
<td>5,593,773</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
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<tr>
<td>Departmental Appropriation¹</td>
<td>11,410</td>
<td>11,422</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year²</td>
<td>321</td>
<td>500</td>
</tr>
<tr>
<td>Total expenses for Outcome 9</td>
<td>5,576,093</td>
<td>5,608,276</td>
</tr>
</tbody>
</table>

Average Staffing Level (Number) 63 67 4

¹ Departmental appropriation combines ‘Ordinary annual services [Appropriation Bill 1]’ and ‘Revenue from independent sources [s31]’.
² ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
OUTCOME 10 HEALTH SYSTEM CAPACITY AND QUALITY

Improved long-term capacity, quality and safety of Australia’s health care system to meet future health needs, including through investment in health infrastructure, international engagement, consistent performance reporting and research.

MAJOR ACHIEVEMENTS

- Implemented the Personally Controlled Electronic Health Record (PCEHR), allowing for more effective and efficient health information for consumers and their health care providers.

- Progressed implementation of the 221 projects funded under the four rounds of the Health and Hospitals Fund, which is providing nation-building health infrastructure. As of 30 June 2013, work had begun on 164 projects, of which 53 had been completed.

- More than 3,400 women and their families received support from the McGrath Foundation Breast Care Nurses Program.

- The CanTeen Youth Cancer Networks model was fully established in 2012-13, providing specialised cancer care to adolescents and young adults in every state and territory.

CHALLENGES

- Managing the large and diverse portfolio of capital works projects funded by the Health and Hospitals Fund and ensuring that community benefits are fully realised.

- Improving consumer safety by managing the increasing volume of unwanted medicines being returned under the National Return and Disposal of Unwanted Medicines program.

- Coordinating and managing partners and stakeholders to build and deliver the National Prescribing and Dispense Repository and the Child eHealth Record in a timely and successful manner.

- Continuing to embed safety and quality into the Australian health system to improve patient care outcomes, maximise patient safety and enhance accountability.
### Performance

**Outcome 10: Health System Capacity and Quality**

#### Performance

- **Met**: 72.7%
- **Substantially Met**: 18.2%
- **Not Met**: 9.1%

<table>
<thead>
<tr>
<th>Period</th>
<th>Met</th>
<th>Substantially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>72.7%</td>
<td>18.2%</td>
<td>9.1%</td>
</tr>
<tr>
<td>2011-12</td>
<td>78.3%</td>
<td>13.3%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

#### Programs Contributing to Outcome 10

- Program 10.1: Chronic disease – treatment
- Program 10.2: eHealth implementation
- Program 10.3: Health information
- Program 10.4: International policy engagement
- Program 10.5: Research capacity and quality
- Program 10.6: Health infrastructure
OUTCOME STRATEGY

Outcome 10 aims to improve the long-term capacity of Australia’s health care system with a particular emphasis on quality and safety. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

PROGRAM 10.1: CHRONIC DISEASE – TREATMENT

Program 10.1 aims to improve detection, treatment and survival outcomes for people with cancer:

Improve detection, treatment and survival outcomes for people with cancer

Cancer Centres

The Department continued to monitor the construction of 24 regional cancer centres funded under the Health and Hospitals Fund (HHF) at a total cost of $653 million. This national network will dramatically improve access and support for cancer patients, their carers and families in rural and regional Australia. Of these 24 projects, nine projects are finalised, 14 are under construction and one project is in the design phase. The final project is expected to be contracted in 2013-14.

In addition, $19 million was allocated from the Better Access to Radiation Oncology Budget measure for the Alan Walker Cancer Care Centre in Darwin, which was officially opened in January 2010. This will result in a national network of 25 regional cancer centres.

BALLARAT REGIONAL INTEGRATED CANCER CENTRE

A quarter of a million people living in the Ballarat and Grampians regions now have access to a world class cancer care facility, providing diagnostic, chemotherapy and radiotherapy services closer to home.

The Ballarat Regional Integrated Cancer Centre (BRICC) provides expanded and enhanced cancer treatment services at the Ballarat Health Services’ Base Hospital.

It has four new radiotherapy bunkers, two linear accelerators, a CT scanner, and four new chemotherapy chairs – bringing the total to 16 chairs. There are also oncology consulting and outpatient rooms for specialists, a satellite pharmacy, and clinical trials and research facilities.

The dedicated facility will allow an additional 800 patients per year to receive treatment without needing to travel to Melbourne.

Included is a Wellness Centre, that provides support to patients, families and carers to help them cope with the emotional and physical side effects of cancer diagnosis, treatment and recovery.

The BRICC received just over $42 million from the Health and Hospitals Fund, with additional funding from the Victorian Government.

It is one of a network of 25 regional cancer centre projects built with Health and Hospitals Fund assistance to help to close the gap in cancer outcomes between rural and city residents. The BRICC and other regional cancer centres represent an important element of the world-class cancer care system being developed in Australia.

Cancer affects many Australians, with over 100,000 new cancer cases diagnosed every year.
Additionally, three nationally significant cancer centre projects funded under the HHF aim to improve cancer outcomes for all Australians:

- The Kinghorn Cancer Centre in Sydney, completed in August 2012, has a focus on rapidly translating research findings into clinical application for the prevention, diagnosis and treatment of individual cancer patients.

- The Chris O’Brien Lifehouse at Royal Prince Alfred Hospital in Sydney, expected to start providing services in late 2013, will be an Australian centre of excellence as an integrated cancer research and treatment facility.

- The Victorian Comprehensive Cancer Centre in Melbourne, is expected to open in late 2015 and bring together a critical mass of cancer experts to drive world-class innovation in cancer treatment through translating research discoveries.

**KPI:** Percentage of progress reports for cancer infrastructure projects (including regional cancer centres) that meet agreed requirements

<table>
<thead>
<tr>
<th>2012-13 Target: 100%</th>
<th>2012-13 Actual: 100%</th>
<th>Result: Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>All progress reports submitted for cancer infrastructure projects met the agreed requirements.</td>
<td></td>
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</tr>
</tbody>
</table>

**Youth Cancer Network**

The Department has worked with CanTeen to establish the Youth Cancer Networks Program which is delivering better models of care for adolescents and young adults diagnosed with cancer.

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**CANTEEN YOUTH CANCER NETWORKS**

Young Australians who are diagnosed with cancer can now obtain care and support from centres specially designed for their needs.

Five national Youth Cancer Services have been established. They are providing age-appropriate multidisciplinary outpatient and inpatient care to adolescents and young adults diagnosed with cancer from across Australia.

Funding to create the Youth Cancer Network over four years was provided to CanTeen in the 2008-09 Budget. The Department has worked with CanTeen to fully implement the program, which was completed in 2012-13.

Over the next 4 years, a further $18.2 million will be provided to enable the Youth Cancer Service to reach, assess and support as many young Australians diagnosed with cancer as possible, to ensure that they receive the very best care.

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**Ashleigh’s Story – Testimonial for the Youth Cancer Network Program**

I first experienced pain when exercising in the summer of 2010. My pain escalated rapidly in April 2012, so I decided to make an appointment with a new GP who organised a bone scan that showed a large pelvic mass and following this, a number of investigations in the hospital.

I was told by doctors that I had Ewing’s Sarcoma of my pelvis. This is a cancer that occurs in the bone. The cancer started in my pelvis but had spread through to my spine and brain. I was in an adult hospital, however the initial consultant had heard about the Youth Cancer Service providing care to all young people diagnosed with cancer.
The team had a clinical trial open and although I was older than most patients, my consultant had organised for me to have my treatment there so I had an opportunity of the best chance of survival.

Everything was explained to me carefully and in detail, which helped me understand the required steps to treat the cancer. The treatment involved 12 months of chemotherapy as well as surgery, radiotherapy and then a transplant, with a 25% chance of survival.

Chemotherapy treatment was received in Sydney Children’s Hospital under the care of the Sydney Youth Cancer Team. Unfortunately, I was having treatment before a dedicated space had been built and some of the treatment was delivered next to much younger children. I found myself feeling uncomfortable on a couple of occasions.

After three months of intense chemotherapy I was told that the tumour had responded really well to treatment and no active cells could be seen on the PET scan. It was then time to have the operation to remove the tumour. I had the tumour resected and also needed a hip replacement. After the operation I was told that some areas of my pelvic mass had active cells so I needed to have further radiotherapy to the pelvis. This made me feel very anxious about my future fertility and I was seen by the adolescent gynecology team to discuss options for fertility preservation.

Chemotherapy was hard but I was lucky to have lots of support around me. My family came to every appointment; they allowed me to make decisions and supported me when making decisions was very difficult. The Sydney Youth Cancer Team gave me appropriate information and support so I could understand my treatment and the effects on my body. I felt supported and trusted the decisions I made.

I celebrated my 18th birthday in an isolation room having my transplant but I have been able to get through the year thanks to the medical and psychosocial support I received by the Sydney Youth Cancer Team. I am a much stronger person and have lots of hopes and dreams which are still positive.

I have recently found out that the cancer has returned in my spine. I know I will get the support I need from the Youth Cancer Service.

BreastScreen Cancer Infrastructure

In 2012-13, the Department provided funding of $120 million to BreastScreen Australia to install new digital technology to replace existing analogue mammography technology used to detect breast cancer. The majority of these upgrades are now in place with the final units to be installed and operational in 2014. This will ensure that women in Australia are screened using the best available technologies, including electronic transfer of mammography images from remote locations to major cities for analysis.

| Deliverable: Improve the early detection of breast cancer through the installation of new digital technology |
| 2012-13 Reference Point: Continue upgrade from analogue to digital mammography |
| Result: Met |

A total of 124 mammography machines were upgraded to digital across fixed sites and mobile units, with 42 being completed in 2012-13. This project will see all remaining digital mammography upgrades completed by 30 June 2014.

The Department funds McGrath breast care nurses to provide information, care, practical and emotional support to women diagnosed with breast cancer, their families and carers.

| Deliverable: Number of breast care nurses employed through the McGrath Foundation |
| 2012-13 Target: 30 |
| 2012-13 Actual: 44 |
| Result: Met |

Through the McGrath Foundation 44 breast care nurses were employed in 2012-13. These nurses are located in predominantly rural and remote communities around Australia.
PART 2 PERFORMANCE REPORTING

OUTCOME 10 HEALTH SYSTEM CAPACITY AND QUALITY

PROGRAM 10.2: EHEALTH IMPLEMENTATION

Program 10.2 aims to provide national eHealth leadership and develop systems to provide eHealth services.

Provide national eHealth leadership

The eHealth Memorandum of Understanding (MOU) recognises that the Commonwealth and all states and territories have a mutual interest in developing a national eHealth capability that will lead to significant improvements in the quality and delivery of health care. The MOU, which is underpinned by national specifications, standards, services and infrastructure, commits parties to interim priorities and current investment, including to the National E-Health Transition Authority (NEHTA). The Department managed the development of the MOU, overseen by the eHealth Working Group (EHWG).

NEHTA is funded to manage the COAG eHealth work program by all jurisdictions under the Australian Health Ministers’ Advisory Council (AHMAC) cost shared formula. The Commonwealth and each jurisdiction have individual funding arrangements with NEHTA to undertake this work. The Commonwealth also has a separate funding agreement in place with NEHTA for the PCEHR work stream.

NEHTA is an effective way for the Commonwealth, states and territories to work together to develop strong foundations for a national eHealth system. The focus is on operation of priority solutions that are already being implemented by parts of the health sector, and development of key standards for medication management and diagnostics.

Deliverable: Fund the National E-Health Transition Authority (NEHTA) to develop better ways of electronically collecting and securely exchanging health information

2012-13 Reference Point: Procurement and funding agreements between NEHTA and the Commonwealth in place by mid 2012-13

Result: Met

Agreements between the Commonwealth and NEHTA were in place by mid 2012-13. These two agreements support the Commonwealth’s work undertaken by NEHTA in relation to the COAG and PCEHR workstreams.

Develop systems to support a national eHealth system

The PCEHR system has been up and running since 1 July 2012. By 30 June 2013, almost 400,000 consumers had registered for an eHealth record. This number climbed to more than 500,000 consumers registered by mid July. Government support, provided by the Practice Incentive Program eHealth incentive (ePIP), has helped more than 96% of Australian practices get the information technology they need for eHealth, with more than 4,300 health care organisations participating, by 30 June 2013.

In the 2012-13 Budget, more than $233.7 million over two years was allocated for eHealth. This included $161.6 million to operate the eHealth record system, $4.6 million to maintain privacy safeguards and $67.4 million as the Commonwealth’s share of joint funding with the states and territories for the NEHTA work program. This investment builds on $467 million over two years allocated in 2010 to build the complex national infrastructure for the national eHealth records system.
Deliverable: Set up processes and infrastructure for support of the PCEHR system

2012-13 Reference Point: Processes and infrastructure to support the PCEHR system developed during 2012-13

Result: Met

The 2012-13 Budget provided funding up to 30 June 2014 to operate and maintain the PCEHR system including a portal for consumers to register for a PCEHR, see their PCEHR, set access controls and upload their own information. A portal also allows health care providers to access their patients’ PCEHRs online and repositories securely store information. Disaster recovery systems and an audit service are also maintained.

Funding was also provided over two years for NEHTA to establish and manage the Healthcare Identifiers Service, the National Authentication Service for Health, clinical terminologies service for consistent clinical descriptions, specifications to ensure conformance and compliance with technical, security and clinical standards and the National Product Catalogue.

KPI: Number of consumers who register for a PCEHR

2012-13 Target: 500,000
2012-13 Actual: 397,745

Result: Substantially met

As at 30 June 2013, 397,745 consumers were registered. By 16 July 2013, more than 500,000 consumers were registered. The Department has implemented the PCEHR system using a staged approach, with consumer registrations starting on 1 July 2012. The program has targeted consumers and health care providers that exhibit a high level of readiness, or will realise the most significant benefits from participating in the eHealth records system. This includes mothers and their newborns, Aboriginal and Torres Strait Islander peoples, older Australians, people with chronic and complex conditions, people with mental health needs, and people in rural and remote areas.

From July 2012, the Department promoted the PCEHR through local channels and targeted mailouts, enabling consumers and providers to join as functionality was released. In June 2013, the Department launched a national campaign to raise awareness of the system.

The Department has also launched an Assisted Registration initiative, which offers consumer a face-to-face channel through which to engage with the PCEHR.

In light of ongoing adoption activities, registration numbers are expected to increase in 2013-14.

Provide eHealth services

In 2012-13, the Department continued delivery of the NBN Enabled Telehealth Pilots Program, funding nine pilot projects. These projects deliver high quality health care services to people in their homes and community hubs via the National Broadband Network (NBN). The focus of the program is on aged care, cancer care and palliative care.

In delivering the program, the Department manages individual funding agreements for each of the nine projects. This includes assessment of deliverables, risk management, governance and comprehensive stakeholder communications, which includes close liaison with the Department of Broadband, Communications and the Digital Economy.
2.1 10

PROGRAM 10.3: HEALTH INFORMATION

Program 10.3 aims to provide support to the Australian Health Ministers’ Advisory Council and support maternity services reform.

Provide support to the Australian Health Ministers’ Advisory Council

The Australian Health Ministers’ Advisory Council (AHMAC) provides support to the Standing Council on Health (SCoH) by advising it on strategic issues relating to the coordination of health services across the nation and, as applicable, with New Zealand.

Throughout 2012-13, the Department worked to progress key areas of focus for AHMAC and SCoH, including national health reform, health workforce, eHealth, safety and quality, and continued implementation of the Australian National Breastfeeding Strategy, the Aged Care Reform package, and the Fourth Mental Health Plan. Also during 2012-13 SCoH finalised the Primary Health Care Strategic Framework and the National Tobacco Strategy. The Commonwealth’s priorities were also progressed through the work programs of AHMAC’s six Principal Committees.

Support maternity services reform

During 2012-13, the Department undertook a number of significant activities under the National Maternity Services Plan to address the four key priorities of the Plan – access, service delivery, workforce and infrastructure. These activities included:

- re-launch of the Pregnancy, Birth and Baby online service (pregnancybirthbaby.org.au);
- providing scholarships to midwives to undertake the Nursing and Midwifery Board of Australia’s approved prescribing courses under the Nursing and Allied Health Scholarship and Support Scheme;
- extensive consultation with relevant medical and midwifery groups and consumers relating to legislation on collaborative arrangements;
- evaluation of the Improving Maternity Services Budget Package; and
- continued work with the Australian Institute of Health and Welfare to develop a comprehensive, nationally consistent approach to maternal and perinatal mortality data collection.
The Department also worked with states and territories, though the Maternity Services Inter-Jurisdictional Committee, to implement actions under the National Maternity Services Plan. There has been considerable progress in developing a Birthing on Country service delivery model which aims for Indigenous women to give birth in their communities giving the baby a spiritual, physical and social connection to the land. This has the potential to improve health outcomes for Aboriginal and Torres Strait Islander mothers and babies.

**Deliverable:** Develop nationally consistent maternal and perinatal mortality and morbidity data collections

**2012-13 Reference Point:** Data collected meets the needs of researchers and policy makers

**Result:** Met

- Data development work is progressing well, with data priorities agreed and in different stages of development. The first batch of items is expected to be submitted for approval as national standards at the end of 2013.

**Breastfeeding**

Breastfeeding helps protect infants against a number of conditions, including diarrhoea, respiratory and ear infections, and obesity and chronic diseases later in life. Breastfeeding also benefits a mother's own health by reducing the risks of breast cancer, ovarian cancer, type 2 diabetes and osteoporosis.

To increase breastfeeding rates, the Department continues to fund the Australian Breastfeeding Association to run the National Breastfeeding Helpline. The helpline, 1800 MUM 2 MUM, is staffed by Australian Breastfeeding Association volunteers right across Australia and provides free, confidential breastfeeding advice and support, 24 hours a day.

**KPI:** Number of people to contact the National Breastfeeding Helpline

<table>
<thead>
<tr>
<th>2012-13 Target: 75,000</th>
<th>2012-13 Actual: 84,256</th>
<th>Result: Met</th>
</tr>
</thead>
</table>

- In 2012-13, 84,256 people contacted the National Breastfeeding Helpline. This compares to 84,769 in 2011-12 and 84,057 in 2010-11. In 2013-14, the Department will continue working with the Australian Breastfeeding Association to optimise the support provided through the helpline.

**Program 10.4: International Policy Engagement**

Program 10.4 aims to facilitate international engagement on global health issues.

**Facilitate international engagement on global health issues**

The Department engages in multilateral, regional and bilateral international health fora to help protect and advance the health of the Australian population, and to help fulfill Australia’s responsibility as an advanced country to contribute to improving global and regional public health.

**Deliverable:** Promote good governance in Pacific health systems

**2012-13 Reference Point:** Departmental representatives will have facilitated and participated in the Pacific Senior Health Officials Network Annual Meeting planned for late 2012

**Result:** Met

- In 2012-13, the Department hosted, and provided secretariat support for, the 2012 annual Pacific Senior Health Officials Network meeting in Brisbane, and preparatory meetings. The meeting provided an opportunity for members to discuss shared health challenges and possible policy approaches to improve the health of Pacific Island populations.
The Department’s primary international engagement is through the World Health Organization (WHO), of which Australia has been a Member State since its establishment in 1948. The WHO is the United Nations’ authority for health and provides leadership on global health matters. Australian delegations led by the Department participated in all WHO governing body meetings for 2012-13, including the World Health Assembly, two Executive Board meetings, three Programme, Budget and Administration Committee meetings, the 2013 Governing Council meeting of the International Agency for Research on Cancer (IARC), and the 2012 Western Pacific Regional Committee meeting.

Following Australia’s election to the WHO Executive Board in 2012, the Department’s Secretary, Professor Jane Halton, was elected Chair of the Executive Board in May 2013. The Executive Board advises the World Health Assembly, gives effect to its decisions and policies and facilitates its work.

In 2012-13, the Department worked closely with the WHO Secretariat and other Member States to finalise three new global plans of action to address non-communicable diseases, mental health and avoidable blindness. The Department actively participated in debates on WHO reform, including reforms to financing, organisational structures and governance.

The Department continued its collaborative international work on communicable disease control and outbreak response, providing support for WHO’s efforts in pandemic preparedness and its responses to outbreaks of the H7N9 avian influenza and Middle East Respiratory Syndrome (MERS). The Department worked closely with AusAID to support the 2012 Asia Pacific Malaria Summit and follow-up activity, and on global plans to eradicate polio. The Department led debate in the Executive Board and the World Health Assembly on the elimination of asbestos.

In our region, the Department is an active participant in the Western Pacific Regional Committee of WHO. In 2012-13, the Department continued to facilitate, and participate in, the Pacific Senior Health Officials Network, with support from AusAID, helping to build capacity amongst senior health officials in the western Pacific. The Department played an active role in the Asia Pacific Economic Cooperation (APEC) Health Working Group, leading work on a new strategic plan for that grouping.

The Secretary continued to chair the Organisation for Economic Cooperation and Development (OECD) Health Working Group, which oversees the OECD’s work on health. The Department’s work in the OECD forum has helped build a growing body of evidence on best practice in health systems and health financing against which Australia can benchmark its own approaches.

Incoming visits from overseas delegations are an important means of engaging with other countries to build networks and professional linkages between individuals and organisations, and to share technical information and experiences in different aspects of health systems development.

In 2012-13, the Department facilitated visits from 25 overseas delegations interested in learning more about Australia’s health system. The Department also worked with the Department of Foreign Affairs and Trade and AusAID to facilitate meetings for delegations hosted by those agencies.
### Deliverable: Number of cooperative agreements with overseas health ministries

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7</td>
<td>4</td>
<td>Substantially met</td>
</tr>
</tbody>
</table>

As at June 2013, four health-specific cooperative agreements are in place with China, Indonesia, Iraq and Japan. Health is also identified as an area for technical cooperation in whole-of-government agreements, for example with Mexico and the European Union.

Under the framework of the co-operative agreement with the Iraq Ministry of Health, the Department facilitated a visit by a technical delegation in March 2013. Priority issues for the Iraq delegation included emergency management, regulation of medicines and therapeutic goods, regulation of imported food products, food safety, implementation of the International Health Regulations, patient safety and aged care and respite services.

### Program 10.5: Research capacity and quality

Program 10.5 aims to improve research capacity and improve safety and quality in health care.

#### Improve research capacity

**Improve Safety and Quality in Health Care**

The Department continues to assist the Australian Commission on Safety and Quality in Health Care (the Commission) in leading and coordinating improvements in safety and quality in Australian health care by identifying issues and policy directions, and recommending priorities for action. The priority areas for 2012-13 included the national safety and clinical standards, formulation and implementation of national accreditation schemes and national data set development.

The Commission continued its work to embed safety and quality into the Australian health system to improve patient care outcomes, maximise patient safety and enhance accountability.

The Department, in conjunction with state and territory governments, also supported the Australian Health Service Safety and Quality Accreditation Scheme, which began on 1 January 2013. The Scheme aims to enhance safety and quality through a nationally consistent approach to health care accreditation.

The Department engaged the Commission to coordinate Australia’s participation in an OECD study investigating unwarranted variations in clinical care across a specific set of procedures including caesarean section, cardiac catheterisation, knee arthroscopy and hysterectomy. The results will be used to develop future initiatives to improve best practice. The Department will examine this evidence to explore referral behaviours of GPs and community-based specialists and expand the work through implementing the 2013-14 Budget measure that provides revised and more targeted arrangements for Commonwealth safety and quality initiatives.

**Health and Hospitals Fund**

Of the 12 medical research infrastructure projects that began in 2009-10 under the HHF, six are complete with the remainder to be finalised before the end of 2015. The centres cover areas such as mental health, neurological disorders, child health and Indigenous health. The projects aim to improve community health through discovering new treatments and translating new research findings into improved treatment.

**KPI:** Effective monitoring of HHF health and medical research projects for compliance with agreed outputs.

**2012-13 Reference Point:** Progress reports are received for all projects in the required timeframe and remedial action taken as required.

**Result:** Met

The Department received progress reports from contracted parties during 2012-13, the majority of which met agreed requirements. For those that did not meet requirements, all outstanding reports were finalised following consultations with the parties concerned.

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68 Number of agreements excludes licenses, funding agreements for specific activities under other programs and reciprocal health care agreements.
**Health and Medical Research**

In May 2011, the Minister for Mental Health and Ageing announced a major independent review of health and medical research in Australia. The Review focused on optimising Australia’s capacity to produce world class health and medical research to 2020.

**Deliverable:** Undertake a review to identify improvement areas for Australia’s health and medical research system

**2012-13 Reference Point:** Strategic Review of Health and Medical Research in Australia completed by December 2012

**Result:** Substantially met

The Panel’s report was due in December 2012, however to fully take account of the extensive feedback, an extension to February 2013 was granted.

The Final Report for the Review was provided to Government on 28 February 2013.

**Maintain effective health surveillance**

To develop effective health policy and programs, researchers and policy makers must have access to current information. The Department funds a range of activities to collect and publish data and statistics on topics such as injuries, drug use and communicable and chronic disease.

For example, in 2012-13, the Department implemented the first stages of a Human Papilloma Virus (HPV) surveillance system. This included a serosurvey\(^69\) to establish baseline levels of HPV infection in males, genotyping\(^70\) of HPV in the Indigenous population, and extension of a genital warts surveillance program in rural and remote communities.

The Department also continued to fund the Vaccine Preventable Diseases Surveillance Program. Reporting of nationally consistent, high quality data on vaccine preventable diseases allows national monitoring, analysis and timely reporting of data to inform immunisation policy. Information from this program provides national data on the vaccination status of cases and tracks the serogroups\(^71\) causing disease, particularly among children.

This information is used by expert groups such as the Australian Technical Advisory Group on Immunisation to evaluate the effectiveness of the National Immunisation Program. The provision of genotype data associated with outbreaks of measles in Australia contributes to the evidence of Australia having eliminated endemic transmission of this disease. High quality measles data also contributes to the wider goal of measles elimination in the WHO Pacific Region.

**Deliverable:** Produce relevant and timely evidence-based surveillance data, information and research

**2012-13 Reference Point:** Surveillance information available to inform national strategies supported by the Health Surveillance Fund

**Result:** Met

Through the Health Surveillance Fund, the Department continued to support the timely collection, analysis and reporting of data, information and research.

**High Risk Implantable Medical Devices**

The Department aims to improve patient safety through enhanced post-market surveillance of high risk implantable medical devices, including facilitating contact with patients affected by safety concerns of such devices.

In 2012-13, the Department engaged the Commission to consult stakeholders including consumers, clinicians and industry on how best to respond to the challenges posed to patient safety by high risk implantable medical devices. The report informed the development of the 2013-14 Budget measure. This measure announced that two national registers are to be established which aim to help monitor and report to the TGA on the performance of specific high risk implantable devices. Additionally, the measure will establish a national protocol to

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69 Serosurvey measures immunity in a population.

70 Genotyping is a molecular technique that determines the genetic identity of viruses.

71 Bacteria can be distinguished into serogroups determined by the type of polysaccharides present on the outer shell. Vaccines are available that protect against these bacteria by targeting their specific serogroup.
facilitate contact with patients with a high risk implantable device, in the event of a serious
risk associated with their device.

Monitor the use of diagnostics, therapeutics and pathology

Through the Quality Use of Diagnostics, Therapeutics and Pathology Fund, the Department
continued to assist the National Prescribing Service (NPS) and the National Return and Disposal
of Unwanted Medicines (NatRUM) program to improve the quality use of medicines and medical
services by health professionals and consumers.

In 2012-13, the NPS continued to run the four year Generic Medicines are an Equal Choice
campaign to increase consumers’ understanding that generic medicines are of equivalent
quality, safety and efficacy to popular brand medicines. In 2012-13, the NPS also continued its
work to address antibiotic resistance in Australia. This involved a campaign targeted at health
professionals to provide the latest evidence and equip them with tools to encourage more
informed clinical decisions when they are deciding whether to prescribe antibiotics. It also
involved a campaign to increase consumer awareness of issues surrounding antibiotic resistance.

The NPS continued important work through Rational Assessment of Drugs and Research and
Australian Prescriber publications to provide independent, evidence based information to
health professionals and consumers regarding new therapeutics, including expert advice and
intervention design. The Department, with the assistance of the NPS, continued to implement
the Post-Market Monitoring program, which began in June 2011. This program monitors
medicines use in clinical practice through research and evidence based assessment and aims to
improve patient safety and the quality use and cost effectiveness of medicines.

The Department continued to promote evidenced based pathology and diagnostic imaging
services through ongoing funding of the NPS. The Department funded a range of projects
to improve pathology and diagnostic imaging referral quality and consistency, including
the introduction of education and quality assurance programs for health professionals
and consumers and introduction of peer feedback programs amongst practitioners. This
additional support and information will help doctors request services that are the most
beneficial for patients.

Deliverable: Information regarding quality use of medicines newly listed on the PBS is provided to health
professionals where appropriate

2012-13 Reference Point: The Department will produce information in a variety of formats throughout the
year, including the Rational Assessment of Drugs and Research, the Australian Prescriber and an annual
evaluation report

Result: Met

○ The Department has funded production of all scheduled publications, including the Rational
Assessment of Drugs and Research, the Australian Prescriber and an annual evaluation report.

Deliverable: Number of general practitioners participating in education initiatives

2012-13 Target: 13,500  2012-13 Actual: 14,112  Result: Met

○ In 2012-13, NPS reported that 14,112 general practitioners participated in education activities
provided by NPS. This represents a steady increase in the number of general practitioners
participating in these Quality use of Medicines initiatives.

The NatRUM program was established to reduce accidental childhood poisoning, medication
misuse and toxic releases into the environment. Consumers can return unwanted or out-of-
date medicines to any pharmacy. Medicines are destroyed in an environmentally friendly manner
using high-temperature incineration.

The volume of unwanted medicines collected under the NatRUM program has increased steadily
since the program began in 1998. In 2000-01, the collection totalled 235,267 kilograms, rising
to more than 600,000 kilograms in 2012-13. The Department continues to work with NatRUM
on long-term strategies to improve the sustainability of the program. This will ensure that
increasing demand for collection services into the future is met.
Program 10.6: Health Infrastructure

Program 10.6 aims to invest in major health infrastructure.

Invest in major health infrastructure

Health and Hospitals Fund

The HHF was established in January 2009 and forms part of the broader nation-building infrastructure program. HHF investments underpin major improvements in efficiency, access and outcomes of health care through renewal and refurbishment of acute and primary care facilities, medical technology equipment and major medical research facilities and projects.

The Department worked with the funding recipients to continue to progress projects. While infrastructure projects often take several years to complete, some projects are now finalised and community benefits are being realised.

The 85 projects funded under HHF Rounds One and Two span four critical areas – the fight against cancer; translational research; research workforce infrastructure; and the modernisation of the hospital system. Forty-two of these 85 projects have now been completed, with 17 finalised in 2012-13.

Under the two regional priority rounds of the HHF, funding was awarded for 139 projects to establish new or improved health facilities in regional communities that aim to close the gap in health outcomes between major metropolitan areas and regional areas of Australia. Eleven of these 139 projects have now been completed, with 10 finalised in 2012-13.

In 2013-14, the Department will continue to work with the states and territories, non-government organisations, universities and medical research institutes to progress these projects. The Department will pursue negotiations for the remaining projects with a view to finalising agreements with successful applicants.

Deliverable: Funding arrangements in place for successful projects under the 2010 Regional Priority Round of HHF grants

2012-13 Reference Point: Remaining funding agreements signed by 30 June 2013

Result: Substantially met

- Funding arrangements are in place for 87% of successful projects under this round. Three projects have been terminated due to the relevant state and territory governments indicating that they are no longer able to fund the operational costs. The Department will continue to work with the relevant state government and non-government organisations to ensure the remaining seven funding arrangements will be finalised early in 2013-14.

Deliverable: Development of funding agreements for successful projects under the 2011 Regional Priority Round of HHF grants

2012-13 Reference Point: Negotiation of funding agreements concluded where practicable by 30 June 2013

Result: Not met

- Funding arrangements are in place for 37% of successful projects under this round. The target for this HHF round is being progressively met. For a number of the funding agreements, negotiations have taken longer than expected because of the need to address issues specific to the particular funding recipient. The Department will continue to work with state and territory governments and non-government organisations to ensure the remaining funding arrangements are finalised in 2013-14.

KPI: Effective monitoring of HHF projects for compliance with agreed outputs

2012-13 Reference Point: Progress reports are received for all projects in the required timeframe and remedial action taken as required

Result: Met

- The majority of funding receipts were compliant and achieved the agreed project outputs. Where projects were found to be noncompliant, the Department undertook remedial action in a timely manner.
### Outcome 10 — Financial Resource Summary

#### Program 10.1: Chronic Disease – Treatment

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<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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<tbody>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
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<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>3,026</td>
<td>3,031</td>
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<td>Health and Hospital Fund Health Portfolio Special Account</td>
<td>211,642</td>
<td>222,628</td>
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<tr>
<td><strong>Departmental Outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>4,138</td>
<td>4,085</td>
<td>(53)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>125</td>
<td>205</td>
<td>80</td>
</tr>
<tr>
<td><strong>Total for Program 10.1</strong></td>
<td>218,931</td>
<td>229,949</td>
<td>11,018</td>
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</table>

#### Program 10.2: e-Health Implementation

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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<tbody>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
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<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>68,636</td>
<td>68,160</td>
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<tr>
<td>Non cash expenses</td>
<td>18,309</td>
<td>18,309</td>
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<tr>
<td><strong>Departmental Outputs</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Departmental Appropriation</td>
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<td>18,288</td>
<td>25</td>
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<td>Expenses not requiring appropriation in the current year</td>
<td>503</td>
<td>840</td>
<td>337</td>
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<td><strong>Total for Program 10.2</strong></td>
<td>105,711</td>
<td>105,597</td>
<td>(114)</td>
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</table>

#### Program 10.3: Health Information

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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<tbody>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>32,561</td>
<td>33,097</td>
<td>536</td>
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<td><strong>Departmental Outputs</strong></td>
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<td></td>
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</tr>
<tr>
<td>Departmental Appropriation</td>
<td>1,590</td>
<td>1,593</td>
<td>3</td>
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<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>49</td>
<td>93</td>
<td>44</td>
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<tr>
<td><strong>Total for Program 10.3</strong></td>
<td>34,200</td>
<td>34,773</td>
<td>573</td>
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</table>

#### Program 10.4: International Policy Engagement

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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<tbody>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>14,912</td>
<td>14,728</td>
<td>(184)</td>
</tr>
<tr>
<td><strong>Departmental Outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>18</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total for Program 10.4</strong></td>
<td>14,931</td>
<td>14,747</td>
<td>(184)</td>
</tr>
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</table>

#### Program 10.5: Research Capacity and Quality

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13 $'000</th>
<th>(B) Actual 2012-13 $'000</th>
<th>Variation (Column B minus Column A) $'000</th>
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</thead>
<tbody>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>28,764</td>
<td>28,543</td>
<td>(221)</td>
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<td><strong>Departmental Outputs</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>9,204</td>
<td>10,694</td>
<td>1,490</td>
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<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>178</td>
<td>524</td>
<td>346</td>
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<tr>
<td><strong>Total for Program 10.5</strong></td>
<td>74,351</td>
<td>75,952</td>
<td>1,601</td>
</tr>
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</table>
### Program 10.6: Health Infrastructure

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>-</td>
<td>12,000</td>
<td>12,000</td>
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<tr>
<td>Special Accounts</td>
<td></td>
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<tr>
<td>Health and Hospital Fund Health Portfolio Special Account</td>
<td>466,244</td>
<td>470,455</td>
<td>4,211</td>
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<td></td>
<td></td>
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<tr>
<td>Departmental Appropriation</td>
<td>3,224</td>
<td>3,170</td>
<td>54</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>97</td>
<td>158</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total for Program 10.6</strong></td>
<td>469,565</td>
<td>485,783</td>
<td>16,218</td>
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</table>

#### Outcome 10 Totals by appropriation type

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>147,899</td>
<td>159,559</td>
<td>11,660</td>
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<tr>
<td>Non cash expenses</td>
<td>18,309</td>
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<td></td>
</tr>
<tr>
<td>Special Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>36,437</td>
<td>37,848</td>
<td>1,411</td>
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<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>953</td>
<td>1,811</td>
<td>858</td>
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<tr>
<td><strong>Total expenses for Outcome 10</strong></td>
<td>917,689</td>
<td>946,801</td>
<td>29,112</td>
</tr>
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</table>

| Average Staffing Level (Number) | 194 | 204 | 10 |

1. This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2. ‘Non cash expenses’ relates to the depreciation of computer software.
3. Departmental appropriation combines ‘Ordinary annual services [Appropriation Bill 1]’ and ‘Revenue from independent sources [s31]’.
4. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
OUTCOME 11
MENTAL HEALTH

Improved mental health and suicide prevention, including through targeted prevention, identification, early intervention and health care services

MAJOR ACHIEVEMENTS

- Adopted a long-term vision and reform plan for mental health through the Council of Australian Governments’ Ten Year Roadmap for National Mental Health Reform 2012-2022.
- Continued roll out of *headspace* centres with 55 centres operational of the 70 *headspace* centres announced around Australia.
  - Finalised contractual arrangements with *headspace* to deliver early psychosis services, based on the Early Psychosis Prevention and Intervention Centre model, at nine *headspace* locations, with at least one located in each state and territory. The first of these sites, south-east Melbourne, was launched in June 2013.
- Launched the online MindSpot virtual clinic. People with a mild to moderate mental illness can access therapy programs online and over the phone through the new virtual clinic.
- Engaged organisations in 48 Medicare Local regions under the Partners in Recovery initiative, which will start delivering services in 2013-14.
- Finalised Australia’s first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

CHALLENGES

- Improving mental health requires supports beyond those provided by mental health services and there are challenges in raising awareness, strengthening coordination and improving access to services particularly for people with severe mental illness. The Department will continue to address this in its implementation of programs and liaison with stakeholders.
- Optimal mental health service delivery requires information about mental health, evidence about the services that are available and measurement and reporting of the outcomes for those affected by mental ill health. The Department will continue to work with key mental health stakeholder groups and provider organisations to improve the reporting of relevant mental health data to provide this information.
Performance

90.0% MET
0% SUBSTANTIALLY MET
10.0% NOT MET

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>90.0%</td>
<td>0.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>85.7%</td>
<td>7.1%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Program Contributing to Outcome 11

Program 11.1: Mental health
OUTCOME STRATEGY

Outcome 11 aims to improve services and support for people with mental illness, their families and carers. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the program outlined below.

PROGRAM 11.1: MENTAL HEALTH

Program 11.1 aims to strengthen leadership in mental health, invest in more and better coordinated services for people with mental illness and expand suicide prevention activities.

Strengthen leadership in mental health

In any given year, mental illness affects one in every five Australians.

In 2012-13, the Department continued working with state and territory governments and key stakeholders to deliver a mental health system that gives Australians with a mental illness timely access to support and the best chance of recovery. The Department has continued to strengthen mental health services with a strong focus on prevention and early intervention. Key priorities have been the need to take action across a person’s life, to recognise the spectrum of mental illness people may face and to address the early age onset of some mental illness and current barriers to accessing help.

The five year National Partnership Agreement Supporting National Mental Health Reform supports state and territories to provide stable accommodation and support for those with a severe mental illness and improve presentation, admission and discharge planning in emergency departments and major hospitals.

The Council of Australian Government’s (COAG) Ten Year Roadmap for National Mental Health Reform 2012-2022 provides a long-term vision and reform plan for mental health. The Roadmap provides a commitment by the Commonwealth and the states and territories to promote the importance of good mental health and wellbeing, to maximise opportunities to prevent and reduce the impact of mental health issues and to support people with mental health issues, their families and carers to live contributing lives.

COAG has established a Working Group on Mental Health Reform to progress priority areas of work arising from the Roadmap, including developing a successor to the Fourth National Mental Health Plan, and establishing achievable national whole of life outcomes-based indicators and targets for mental health that will be understood by the community. The Department is coordinating the Commonwealth’s involvement in the working group. An expert reference group on mental health chaired by the National Mental Health Commission advises this group.

Invest in more and better coordinated services for people with mental illness

The Department remains focused on delivering better coordinated mental health services. It is implementing initiatives that recognise mental illness as being more than just about the provision of clinical services and delivering programs which improve economic and social participation for people with a mental illness.

The Partners in Recovery initiative aims to better support people with severe and persistent mental illness with complex needs, and their carers and families. The initiative will ensure that the broad range of services and supports this vulnerable group needs work in a more collaborative and integrated way. In 2012-13, the Department engaged organisations under the Partners in Recovery initiative in 48 of 61 Medicare Local regions. These organisations will be working at a systems level and will drive collaboration between relevant sectors, services and supports within the region. The Department is working with the remaining 13 Medicare Local regions to increase their readiness to deliver services from 2013-14.

Support for Day to Day Living in the Community

The Department also continued to increase the quality of life for individuals with severe and persistent mental illness through structured social activities delivered by non-government organisations under the Support for Day to Day Living in the Community program.
Deliverable: Increase mental health support to the community for people living with a severe and persistent mental illness through the Support for Day to Day Living program

2012-13 Reference Point: Community mental health supports are increasingly being accessed by people with a severe and persistent mental illness

Result: Met

Day to Day Living services are available at 60 sites around Australia, with overall service targets being exceeded under Phase 3 funding agreements.

**headspace**

The Department continued to build on youth mental health programs through the successful rollout of additional funding for headspace sites, with a total of 70 headspace sites announced and 55 centres operational around Australia in 2012-13. Furthermore, contractual arrangements have been finalised to deliver early psychosis services across nine headspace centres, based on the Early Psychosis Prevention and Intervention Centre (EPPIC) model. Initially, four sites will be established, building to nine over three years. The first of these sites was launched in June 2013 in south-east Melbourne.

Deliverable: Total number of headspace youth-friendly service sites funded

| 2012-13 Target: 70 | 2012-13 Actual: 70 | Result: Met |

All locations for the first 55 headspace sites are operational. In August 2012, locations for a further 15 headspace sites were announced and these are expected to be operational in late 2013.

**HEADSPACE — THE NATIONAL YOUTH MENTAL HEALTH FOUNDATION**

Young people all over Australia are getting help with mental health and related issues, through the rapidly expanding network of headspace youth mental health centres. Mental health is one of the biggest issues for young people aged 12 to 25 years, with around one in four experiencing a mental health issue in any one year.

In the past, up to three quarters of these young people did not receive any professional help because they did not know who to turn to or did not want to use mainstream mental health services.

headspace makes it easier for young people to find early intervention help by providing a youth-friendly, holistic and stigma-free environment. Its centres in rural, regional and metropolitan areas are committed to making all young people feel welcome and comfortable about seeking help. The headspace model provides for holistic care in four areas – mental health, related physical health, alcohol and other drug use, and social and vocational support.

Each centre provides direct treatment aligned with current best practice and training, and fosters relationships with other local services which headspace clients might need. For example, headspace Bathurst, in Central West NSW, commenced services in 2008. This centre offers information and support services in a confidential and non-judgemental environment about a wide range of concerns including bullying, sexual health, housing, nutrition and diet or caring for someone with a mental health condition. As well as psychologists and social workers, the team is supplemented by a women’s health nurse, an exercise physiologist, work and education advisors. The centre also offers information for parents and carers and a range of short-term programs, along with providing a satellite service for young people in Cowra, NSW.

Early intervention gives young people a better opportunity to enjoy a better future and participate in the social and economic life of our community.
2.1

MindSpot clinic

In 2012-13, the MindSpot virtual clinic was launched. The online clinic provides step-by-step cognitive behavioural therapy for people with mild to moderate mental illness. In its first six months of operation, 42% of people seeking help from the MindSpot clinic reported never having previously sought help for a mental health problem. This suggests that the online format has been successful in reaching people who may not otherwise access treatment.

MindSpot – online and phone help with anxiety and depression

A new online service which began in December 2012 is providing free mental health services to thousands of Australians, many of whom would otherwise not have sought help.

MindSpot is a virtual clinic offering real time online and telephone therapy for people experiencing mild to moderate anxiety and depression. It can be accessed with or without a referral by a health professional at www.mindspot.org.au or by phone on 1800 614 434 for people without internet access.

It is the first service in Australia to offer free mental health therapy to people regardless of where they are located. It is particularly useful for people in rural and remote areas who may not have easy access to face-to-face mental health support.

Clients are carefully assessed using a simple, easy to understand questionnaire. They are then provided with the level of therapy that is appropriate to them. This can range from self-directed learning to online clinical intervention such as cognitive behavioural therapy from a trained health professional.

If MindSpot cannot offer appropriate help, clients are referred to other services.

MindSpot was specifically targeted at people who could not, or would not usually, access traditional face-to-face services.

In its first six months, the service assessed 4,551 clients, 42% of whom had reported never having previously sought help for a mental health problem.

MindSpot estimates that about 38,000 people will benefit from its therapies in the first three years, and about 15,000 clients per year after that. MindSpot is delivered by Access Macquarie, a subsidiary of Macquarie University, under contract to the Department.

Access to Allied Psychological Services (ATAPS)

During 2012-13, people with mental disorders of mild to moderate severity who have difficulty in accessing Medicare-subsidised mental health services continued to access such services under ATAPS. Funding to Medicare Locals for these services was significantly expanded during 2012-13 as a result of additional ATAPS funding provided in the 2011-12 Budget, with particular focus on children, Aboriginal and Torres Strait Islander peoples, those at risk of suicide and self-harm and those in low socioeconomic areas.
## Deliverable: Number of additional people assisted under the expansion of the Access to Allied Psychological Services program (ATAPS)

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>27,850</td>
<td>13,226</td>
<td>Not met</td>
</tr>
</tbody>
</table>

Data available at the time of printing indicates that in 2012-13, 52,300 people were assisted under ATAPS and 307,700 services were provided. This compared with 47,200 people assisted in 2011-12 with 241,800 services provided and 39,074 people in 2010-11 with 207,300 services provided. Revised 2012-13 figures will be reflected in the 2013-14 Annual Report.

## KPI: Percentage of Divisions of General Practice/Medicare Locals with the capacity to provide services through the ATAPS initiative to people in hard to reach groups such as children, Indigenous communities and socioeconomically disadvantaged communities

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

All Medicare Locals are delivering services through ATAPS and have enhanced and/or expanded services to children, Aboriginal and Torres Strait Islander peoples, people at risk of suicide or self-harm and those on low incomes.

## KPI: Percentage of Medicare Locals providing specialised services for children by trained allied health professionals

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

All Medicare Locals are providing specialised services for children by trained allied health professionals under ATAPS. Online training was developed to up-skill allied health providers delivering services to children and their families. The training was undertaken by 600 providers.

## KPI: Improve uptake of primary mental health care by groups with lower usage such as young people, men and people living in rural and remote areas

### 2012-13 Reference Point: Primary mental health care services are increasingly used by groups with lower uptake, such as young people, men and people living in rural and remote areas

Result: Met

Psychological support continues to be provided through the Better Access to Psychiatrists, Psychologists and General Practitioners program through the Medicare Benefits Schedule. Additional support is provided to those who have difficulty accessing this service through both the ATAPS program, which is delivered through all Medicare Locals, and by online primary mental health care, through the MindSpot virtual clinic.

## Deliverable: Deliver additional new services for children and young people with mental health and behavioural issues

### 2012-13 Reference Point: Increase in services provided for children and young people with mental health and behavioural issues and their families

Result: Met

Data available at the time of printing indicates that in 2012-13, 19,200 services were delivered through ATAPS to children and their families. This compared with 10,130 services in 2011-12 and 3,622 in 2010-11. Additional support is provided through headspace.

---

**KidsMatter**

KidsMatter is a mental health and wellbeing framework for primary schools and early childhood education and care services which supports mental health promotion, prevention and early intervention for all children.
KPI: Number of schools participating in the KidsMatter Primary Initiative

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,200</td>
<td>1,352</td>
<td>Met</td>
</tr>
</tbody>
</table>

The KidsMatter Primary initiative grew from 793 participating schools in 2011-12 to 1,352 participating schools in 2012-13, which includes the 101 schools that participated in the pilot during 2007 and 2008. The continued national rollout of the KidsMatter Primary initiative seeks to ensure that Australian primary school-aged children are attending schools where improved children’s mental health and wellbeing outcomes are supported.

Expand suicide prevention activities

The Department continued to implement suicide prevention projects to reduce the impact of suicide on individuals, families and communities. This included a focus on those groups identified as being at highest risk of suicide under the National Suicide Prevention Action Framework, such as Aboriginal and Torres Strait Islander peoples, men, people bereaved by suicide, and gay, lesbian, bisexual, transgender and inter-sex people.

In 2012-13, the Department continued to expand projects under the Taking Action to Tackle Suicide (TATS) package, including consulting with state and territory governments on the location of new sites to expand the StandBy Suicide Bereavement Response Service and Wesley LifeForce Community Networks. StandBy provides a 24 hour face-to-face response service for those bereaved by suicide, training for frontline emergency response services in the community, and coordination of suicide response services. The Wesley LifeForce program is a service which builds community capacity to engage in suicide prevention activity, improve access to appropriate services and support those at risk of suicide and bereaved by suicide. The TATS package comprises a mixture of suicide prevention specific activities and broader initiatives, which build on the National Suicide Prevention Program.

In addition, Australia’s first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released. The Strategy identifies six broad action areas:

- Building strengths and capacity in Aboriginal and Torres Strait Islander communities;
- Building strengths and resilience in individuals and families;
- Targeted suicide prevention services;
- Coordination approaches to prevention;
- Building the evidence base and disseminating information; and
- Standards and quality in suicide prevention.

The Strategy focuses on early intervention and building stronger communities with the aim of reducing the prevalence of suicide and the impact on individuals, their families and communities. New funding was provided in the 2013-14 Budget to implement key recommendations of the Strategy.

Deliverable: Implement projects under the National Suicide Prevention Program

<table>
<thead>
<tr>
<th>2012-13 Reference Point</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects implemented in a timely manner</td>
<td>Met</td>
</tr>
</tbody>
</table>

All projects have been implemented and continue to provide suicide prevention support to those areas in need. Significant achievements in 2012-13 include the expansion of the Wesley LifeForce community networks to 25 networks, approval and groundwork done on an additional five networks, with an additional 14 networks planned for 2013-14. In 2012, awareness of R U OK? Day rose by 65% nationally and participation increased significantly. The National Suicide Call Back Service maintained strong service delivery, answering a total of 11,623 calls over the 12 months from June 2012 to May 2013.
2.1

Deliverable: Number of funded initiatives focusing on suicide prevention in identified high risk groups

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>79</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012-13, the Department delivered 52 projects under the National Suicide Prevention Program. As part of the TATS initiative, the Department delivered 27 projects including continuing to roll out significant suicide projects targeted at Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, men, people bereaved by suicide, and gay, lesbian, bisexual, transgender and inter-sex people. As part of the TATS initiative, the Mates in Construction (MIC) project, which targets the male dominated building and construction industries, became operational in all target states during 2012-13, and is now available in Queensland, Western Australia, South Australia and New South Wales. More than 7,000 workers have received General Awareness Training in mental health and suicide prevention under the MIC initiative.

OUTCOME 11 – FINANCIAL RESOURCE SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Program 11.1: Mental Health¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>380,938</td>
<td>377,380</td>
<td>3,558</td>
</tr>
<tr>
<td>Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation²</td>
<td>18,588</td>
<td>18,691</td>
<td>103</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year³</td>
<td>566</td>
<td>957</td>
<td>391</td>
</tr>
<tr>
<td>Total for Program 11.1</td>
<td>400,092</td>
<td>397,028</td>
<td>3,064</td>
</tr>
<tr>
<td>Outcome 11 Totals by appropriation type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>380,938</td>
<td>377,380</td>
<td>3,558</td>
</tr>
<tr>
<td>Departmental Expenses</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation²</td>
<td>18,588</td>
<td>18,691</td>
<td>103</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year³</td>
<td>566</td>
<td>957</td>
<td>391</td>
</tr>
<tr>
<td>Total expenses for Outcome 11</td>
<td>400,092</td>
<td>397,028</td>
<td>3,064</td>
</tr>
<tr>
<td>Average Staffing Level (Number)</td>
<td>130</td>
<td>130</td>
<td>–</td>
</tr>
</tbody>
</table>

1 This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2 Departmental appropriation combines “Ordinary annual services (Appropriation Bill 1)” and “Revenue from independent sources (s31).”
3 “Expenses not requiring appropriation in the budget year” is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.
OUTCOME 12 HEALTH WORKFORCE CAPACITY

Improved capacity, quality and mix of the health workforce to meet the requirements of health services, including through training, registration, accreditation and distribution strategies

MAJOR ACHIEVEMENTS

• An extra 60 doctors are working in Australia’s hospitals after extra intern places were created to ensure all Australian trained medical graduates were offered an internship starting in 2013.

• More of our future doctors, dentists and nurses have experienced rural practice, following the successful delivery of rural training. This training supported 815 graduating medical students to complete long term rural placements; 4,851 medical, nursing and allied health students completed shorter term clinical placements organised by University Departments of Rural Health; and 242 dentistry students completed rural clinical placements.

• Patients will be better able to see doctors. More doctors are training to be GPs – 1,108 in 2013 compared to 1,000 in 2012 – and specialist training places have increased – from 600 in 2012 to 750 in 2013.

• To help more overseas trained doctors to live and work in rural and remote areas, new guidelines were introduced that provide greater clarity on the factors considered in granting exemptions to allow them to access Medicare and reduce red tape and paperwork.

• The nation’s dental workforce is being boosted – 50 dental graduates started the Voluntary Dental Graduate Year Program in January 2013.

• Nearly 4,000 accredited general practices across Australia are funded to assist the employment of nurses and other allied health workers to provide immunisations, wound care and other services, working as a team to provide coordinated health care.

CHALLENGES

• Managing the ongoing demand for places in the Government’s medical vocational training programs, and for most health professional scholarships, which exceeds funded places available.

• Supporting the GP Rural Incentives Program, which continues to exceed forecast expenditure due to high demand.

• Increasing Australia’s dental workforce, particularly in rural and remote Australia and areas of need.
PERFORMANCE

80.0% MET
10.0% SUBSTANTIALLY MET
10.0% NOT MET

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>80.0%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>77.1%</td>
<td>8.8%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

PROGRAMS CONTRIBUTING TO OUTCOME 12

- Program 12.1: Workforce and rural distribution
- Program 12.2: Workforce development and innovation
TRENDS

Number of Specialist Training Program places for each academic (calendar) year from 2010 to 2013.

Figure 12.1 Specialist Training Program places per year

Number of emergency medicine training places for each academic (calendar) year from 2011 to 2015.

Figure 12.2 Emergency medicine training places per year
OUTCOME STRATEGY

Outcome 12 aims to ensure that Australia has the workforce necessary to address its current and future health needs. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

PROGRAM 12.1: WORKFORCE AND RURAL DISTRIBUTION

Program 12.1 aims to increase the number of health professionals in regional, rural and remote Australia; increase investment in health workforce training; and increase access to health services through overseas recruitment.

Increase the supply of, and support for, health professionals in regional, rural and remote Australia

The Department recognises the challenges faced by regional, rural and remote communities in accessing health care. It continues to tackle this through delivering programs aimed at increasing the number of health professionals working and living in these areas.

Australian General Practice Training Program

The Australian General Practice Training Program (AGPT) offers post-graduate vocational training placements for medical graduates wanting to pursue a career in general practice in Australia. At least 50% of all AGPT training is undertaken in regional, rural and remote locations to encourage health professionals to work in these areas. In 2013, the number of training places increased to 1,108. All these places were filled by General Practice Education and Training Limited, which manages the program through a network of Regional Training Providers.

Prevocational General Practice Placements Program

The Prevocational General Practice Placements Program (PGPPP) is a prevocational training program that enhances junior doctors’ understanding of primary health care and encourages them to take up general practice as a career. The program gives junior doctors experience outside of hospitals with 12 week training placements in GP practices. At least 50% of all PGPPP training is undertaken in regional, rural and remote locations. In 2012, the target was 975 with 918 places filled. It is expected that the 2013 target of 961 will be met with General Practice Education and Training Limited working with Regional Training Providers around Australia to increase interest in this program.

Specialist Training Program

In 2012-13, the Department continued to support specialist training by funding medical specialist training posts situated beyond the traditional public teaching hospitals, including private, community and regional and rural settings. The Department funds these posts through specialist medical colleges. The Department has seen continued growth in training places in the public and private health sectors. This has strategically positioned the medical workforce to respond to the dual demands of a growing and ageing population.

Meeting demand for places in the program is an ongoing challenge. The Department will continue to work with program stakeholders to ensure that allocation of new places meets the needs of communities, including in rural and regional areas.

As part of the Tasmanian Health Assistance Package, the Department began planning for additional specialist training places and clinical supervisors in Tasmania’s public hospitals.

<table>
<thead>
<tr>
<th>Deliverable: Number of training positions funded through the Specialist Training Program72</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Academic Year Target: 600</td>
</tr>
<tr>
<td>In the 2012 academic year, 600 places were funded through the program. This compares to 518 places in 2011 and 360 in 2010. 750 places are being funded in the 2013 academic year.</td>
</tr>
</tbody>
</table>

72 Specialist Training Program places are allocated on a calendar/academic year basis.
Remote Vocational and Procedural Training

In 2013, the Department increased access to maternity services for women living in rural and remote communities by awarding 50 training grants under the General Practice Procedural Training Support Program. This included 35 obstetric training grants and 15 anaesthetic training grants, enabling GPs in rural areas to attain procedural skills.

In addition, the Remote Vocational Training Scheme, which allows GP registrars to remain working in rural and remote areas while training through distance education, filled all the 22 new places available in the 2013 training year.

Practice Nurse Incentive Program

The Practice Nurse Incentive Program (PNIP) provided incentive payments to accredited general practices and Aboriginal Community Controlled Health Services that employed practice nurses and Aboriginal and Torres Strait Islander Health Workers and other allied health workers to provide services such as immunisations, wound care and cervical screening. This support has enabled more effective use of practice nurses within their health care team and provides Australians with access to more coordinated and comprehensive primary care and better chronic disease management.

Deliverable: Support general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services across Australia to employ practice nurses and Aboriginal and Torres Strait Islander Health Workers

2012-13 Reference Point: Incentive payments paid quarterly to all participating practices

Result: Met

Incentive payments were paid to all participating practices.

KPI: Number of practices supported through the Practice Nurse Incentive Program

2012-13 Target: 4,000 2012-13 Actual: 3,978 Result: Substantially met

The PNIP is progressing in line with expectations. PNIP began in January 2012, with 3,978 practices approved by the end of 2012-13, including 83 Aboriginal Medical Services and 49 Aboriginal Community Controlled Health Services.

General Practice Rural Incentives

The Department continued delivery of the General Practice Rural Incentives Program to provide financial incentives for doctors to move to and/or remain in regional, rural and remote areas. Payments are scaled to provide the greatest incentive to those living and working in the most isolated regions. The more remote, the larger the incentive. Doctors receive a retention payment based on their length of service in a rural community, clinical workload and location of the practice.

KPI: Number of doctors relocating to rural or remote locations under the General Practice Rural Incentives Program payments

2012-13 Target: 70 2012-13 Actual: 31 Result: Not met

Participation in the Rural Relocation Incentive Grant has increased slightly from previous years. In 2011-12, 22 medical practitioners relocated under the program.

Increased investment in medical training and education

The Department delivered a range of innovative training and education programs to improve workforce capacity.

Rural Clinical Training Support

In 2012-13, the Department continued to support 17 Rural Clinical Schools, 11 University Departments of Rural Health and six dental schools under the Rural Health Multidisciplinary Training (RHMT) initiative. People who train and work in rural and remote areas are more likely to
relocate there. Recognising this, programs under the RHMT ensure that medical, dental, nursing and allied health students can complete a proportion of their clinical training in a rural or remote area.

**DRAWING MORE MEDICAL GRADUATES, NURSES AND DOCTORS TO RURAL AREAS**

More than 5,000 patients in regional Victoria were able to get high quality health care in 2012-13, as a result of an innovative clinic using the talents of medical and nursing students.

The University of Melbourne Shepparton Medical Centre is the first dedicated student-assisted clinic in Australia.

The clinic allows medical and nursing students and student Aboriginal Outreach Workers to gain clinical experience under supervision, while also filling a gap in health services in the region.

An active partner in the clinic is the University’s Rural Clinical School, which operates in Ballarat, Shepparton, and Wangaratta. It is one of 17 rural clinical schools for medical students operated by 16 universities across Australia, funded by the Department’s Rural Clinical Training and Support program.

The premise of the program is strong evidence that medical students and graduates who spend time training in country areas are much more likely to choose a “country practice” when they qualify.

The University of Melbourne’s student-assisted clinic has expanded the ability of the program to correct the chronic shortage of doctors in rural and remote areas.

Students who attended the University of Melbourne’s Rural Clinical School also showed benefits from their hands-on experience, achieving better educational outcomes than their city cohorts in terms of both aggregate marks and the percentage of first class honours.

The Rural Clinical School has also established another innovative program to attract more doctors to rural Victoria.

The Extended Placement Year provides community-based training posts to prepare graduates for any medical specialty and also showcase the rewards of rural generalist practice.

This encourages interns to undertake postgraduate training in the region and ultimately to practice in a rural area, providing an integrated learning environment using infrastructure funded by the Department.

The Victorian Government’s Murray to Mountain intern program provides pathways for medical graduates wishing to undertake their postgraduate training in rural Victoria. In 2012, four out of five interns who completed their first postgraduate year elected to continue training in the region.

In 2013, the Mason Review of Health Workforce Programs recommended the development of an integrated rural training pathway for medical students – building on the model supported by University of Melbourne’s Rural Clinical School.
### Outcome 12: Health Workforce Capacity

#### KPI: Percentage of medical students participating in the Rural Clinical Schools program

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥25%</td>
<td>32%</td>
<td>Met</td>
</tr>
</tbody>
</table>

32% of Commonwealth Supported Places medical students who graduated in 2012 completed at least one full year of clinical training in a rural or remote location. This exceeds the minimum 25% target agreed by the Department and universities under the Rural Clinical Training and Support program.

#### Deliverable: Number of rural placements by University Departments of Rural Health

<table>
<thead>
<tr>
<th>2012 Academic Year Target</th>
<th>2012 Academic Year Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,500</td>
<td>4,851</td>
<td>Met</td>
</tr>
</tbody>
</table>

In 2012, the University Departments of Rural Health facilitated 4,851 rural clinical training placements of two or more weeks duration for nursing and allied health students. This exceeded the target of 3,500 rural clinical placements for the year.

### Building Emergency Department Workforce Capacity

Under the More Doctors and Nurses for Emergency Departments Program, the Department funds the Australasian College of Emergency Medicine (ACEM) to deliver an additional 22 emergency medicine specialist trainees each year over four years from 2011, reaching a total of 110 in 2015.

In 2012-13, the Department worked with ACEM to deliver 66 emergency medicine specialist trainees. These specialist trainees provided an immediate boost to the delivery of emergency medicine services and will be a critical component of the future specialist workforce. The Department has also engaged with private sector emergency departments to support new senior clinical training supervisors. These private sector positions are critical in building the capacity to train more doctors in new settings, complementing investments in public sector clinical training.

#### KPI: Number of additional emergency medicine specialist trainee positions delivered in private settings

<table>
<thead>
<tr>
<th>2012 Academic Year Target</th>
<th>2012 Academic Year Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>44</td>
<td>Met</td>
</tr>
</tbody>
</table>

In the 2012 academic year 44 places were funded through the program. 66 places are being funded in the 2013 academic year.

### Training for telehealth

In 2012-13, the Department continued to fund activities to support the introduction and uptake of Medicare-eligible telehealth. Through the Telehealth Support Program, which began in 2011, 28 organisations were funded to develop education, continuing professional development activities, and other support services.

Projects across all states and territories supported rural health professionals and specialists to establish telehealth-ready practices. These activities were funded as part of the broader commitment to increase access to services in rural and remote areas, specifically access to specialist services. Many of the projects funded have delivered educational material that will be used for many years.

The program has met its objectives and ceased on 30 June 2013.

### Additional Medical Internship 2013 Initiative

In 2013, the Additional Medical Internships 2013 (AMI 2013) initiative resulted in an additional 60 junior doctors starting work as medical interns in Australia. This ensured that all Australian-trained medical graduates who applied for a medical internship were offered a position. The Department worked closely with state and territory governments, private hospital operators, accreditation bodies, the Medical Deans of Australia and New Zealand, and the Australian Medical Students’ Association to establish and implement the AMI 2013.
Of the 60 additional intern places created, 22 were directly funded by the Commonwealth and are located mainly in private hospitals in Western Australia, Queensland, the Australian Capital Territory, Northern Territory and New South Wales. The AMI 2013 has also delivered additional clinical training capacity through encouraging and supporting private hospitals to take a greater role in training junior doctors, and created opportunities for greater collaboration between private and public hospitals to improve medical education and training opportunities for all Australian doctors.

**Increase access to medical services through overseas recruitment**

The Department continued to support the recruitment of overseas-trained doctors (OTDs) to work in outer-metropolitan, regional and remote areas through the International Recruitment Strategy (IRS). Funding to Rural Health Workforce Australia (RHWA) and its seven-member Rural Workforce Agency network provides a case managed recruitment service for appropriately trained OTDs as well as orientation for the doctor and family members into the local community.

In 2012-13, the number of OTDs recruited through the support of the IRS increased by 51% compared to the previous year. During this period, RHWA undertook an international market expansion project and for the first time subcontracted an overseas recruitment agency to help identify suitably qualified OTDs from the United Kingdom. As a result, 124 OTDs were recruited, which has exceeded the target by 8.8%.

<table>
<thead>
<tr>
<th>KPI: Number of suitably qualified overseas-trained doctors recruited under the International Recruitment Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Target:</strong> 114</td>
</tr>
</tbody>
</table>

In 2012-13, the Department worked with RHWA to increase the number of OTDs supported under this program. The result is an improvement on previous years, with 98 OTDs recruited in 2010-11 and 82 in 2011-12 under this program.

**19AB Exemptions for overseas trained doctors and foreign graduates of an accredited medical school**

In 2012-13, the Department introduced new legislative guidelines to provide greater clarity for OTDs and foreign graduates of an accredited medical school (FGAMS) on the factors considered in granting exemptions under Section 19AB of the *Health Insurance Act 1973*.

OTDs and FGAMS are required to seek an exemption so they can obtain a Medicare provider number. Medicare provider number restrictions are one of the mechanisms used to achieve a more equitable distribution of the Australian medical workforce. OTDs and FGAMS are restricted from accessing Medicare arrangements unless they practice within a district of workforce shortage for their medical specialty. A district of workforce shortage is defined as an area that has less access to medical services when compared to the national average. At 31 March 2013, more than 9,708 OTDs and FGAMS (both GPs and specialists) were accessing the Medicare arrangements across Australia.

**PROGRAM 12.2: WORKFORCE DEVELOPMENT AND INNOVATION**

Program 12.2 aims to develop innovative workforce models in specific health disciplines, such as mental health and dentistry.

**Mental health nurses**

In 2012-13, the Mental Health Nurse Incentive Program continued to enable eligible general practices, private psychiatrist services, Medicare Locals and Aborginal and Torres Strait Islander Medical Services to engage credentialed mental health nurses to provide coordinated clinical care for people with severe and persistent mental illness. Incentive payments for up to 160,000 credentialed mental health nurse sessions were available to eligible organisations. Support provided under this initiative targets patients with severe and persistent mental illness living in the community during periods of significant disability.
Deliverable: Evaluation of the Mental Health Nurse Incentive Program

2012-13 Reference Point: Evaluation completed before the end of 2012-13

Result: Met

The evaluation of the MHNIP was completed in December 2012 and is available on the Department’s website. The evaluation notes support for the program from GPs, psychiatrists and mental health nurses with evidence that patients experience improved health outcomes. However, the report highlighted a number of areas for improvement including the need to address the uneven geographic spread of MHNIP services, better control program expenditure, strengthened operational guidelines and improved data collection.

The Department will work with stakeholders in 2013-14 to redesign the program in response to the evaluation findings.

Increased investment in the dental workforce

In 2012-13, the Dental Training – Expanding Rural Placements (DTERP) Program continued to address the shortage and maldistribution of dentists, especially in rural and remote areas. It encourages dental students to take up a career in rural practice by providing positive, high quality clinical education and training experiences for dental students in rural areas.

In the 2012 academic year, 242 placements were funded through the DTERP Program.

Voluntary Dental Graduate Year Program

In 2013, the Voluntary Dental Graduate Year Program (VDGYP) provided 50 dental graduates with a structured program for enhanced practice experience and professional development opportunities, increasing dental workforce and service delivery capacity. Where possible, graduate placements have been directed towards the public sector and areas of need.

KPI: Number of dental graduates participating in the Voluntary Dental Graduate Year Program

2012-13 Target: 50  
2012-13 Actual: 50  
Result: Met

In 2013, 50 graduates are participating in the VDGYP. Of these, 27 placements are being undertaken in metropolitan areas, 18 graduates are placed in regional areas and five graduates are placed in remote areas.
### Outcome 12: Financial Resource Summary

<table>
<thead>
<tr>
<th>Program 12.1: Workforce and Rural Distribution</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>1,020,248</td>
<td>1,026,159</td>
<td>5,911</td>
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<tr>
<td>Departmental Appropriation</td>
<td>13,766</td>
<td>13,482</td>
<td>(284)</td>
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<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>433</td>
<td>685</td>
<td>252</td>
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<tr>
<td><strong>Total for Program 12.1</strong></td>
<td>1,034,447</td>
<td>1,040,326</td>
<td>5,879</td>
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</table>

<table>
<thead>
<tr>
<th>Program 12.2: Workforce Development and Innovation</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
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</thead>
<tbody>
<tr>
<td>Administered Expenses</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>300,920</td>
<td>295,963</td>
<td>(4,957)</td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>10,111</td>
<td>9,921</td>
<td>(190)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year</td>
<td>342</td>
<td>523</td>
<td>181</td>
</tr>
<tr>
<td><strong>Total for Program 12.2</strong></td>
<td>311,373</td>
<td>306,407</td>
<td>(4,966)</td>
</tr>
</tbody>
</table>

### Outcome 12 Totals by appropriation type

| Administered Expenses                             |                             |                    |                                    |
|---------------------------------------------------|-----------------------------|--------------------|                                    |
| Ordinary Annual Services [Annual Appropriation Bill 1] | 1,321,168                   | 1,322,122          | 954                                |
| Departmental Expenses                             |                             |                    |                                    |
| Departmental Appropriation                        | 23,877                      | 23,403             | (474)                              |
| Expenses not requiring appropriation in the current year | 775                         | 1,208              | 433                                |
| **Total expenses for Outcome 12**                 | 1,345,820                   | 1,346,733          | 913                                |

| Average Staffing Level (Number)                   | 164                         | 163                | (1)                                |

1 Departmental appropriation combines ‘Ordinary annual services [Appropriation Bill 1]’ and ‘Revenue from independent sources [s31]’.

2 ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
OUTCOME 13
ACUTE CARE

Improved access to public hospitals, acute care services and public
dental services, including through targeted strategies, and payments
to state and territory governments

MAJOR ACHIEVEMENTS

• Around 400,000 patients will have better access to public dental services
  following the establishment of the National Partnership Agreement on Treating
  More Public Dental Patients, which will provide $344 million to states and
  territories over three years.

• Public hospitals will be funded for the services they actually deliver under a new national
  system of Activity Based Funding for public hospital services, which started on 1 July 2012.
  The Department provided national leadership for implementation of national health reform.
  Commonwealth payments for public hospital services of over $13 billion were made through
  the National Health Funding Pool to Local Hospital Networks and states and territories.

• Tasmanians will get improved health care under new palliative care and elective surgery
  measures.

CHALLENGES

• Enable more people to get life-saving and life-transforming organ and tissue transplants by
  working with states and territories to develop a nationally consistent policy for the special
  release of cord blood units for purposes other than bone marrow reconstitution.
### PERFORMANCE

**Outcome 13: Acute Care**

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>MET</th>
<th>SUBSTANTIALLY MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>89.5%</td>
<td>0.0%</td>
<td>10.5%</td>
</tr>
<tr>
<td>2011-12</td>
<td>72.2%</td>
<td>13.9%</td>
<td>13.9%</td>
</tr>
</tbody>
</table>

**Programs Contributing to Outcome 13**

- Program 13.1: Blood and organ donation services
- Program 13.2: Medical indemnity
- Program 13.3: Public hospitals and information
OUTCOME STRATEGY
Outcome 13 aims to improve access to and the efficiency of public hospitals and acute and subacute care services. In 2012-13, the Department worked to achieve this Outcome by managing initiatives under the programs outlined below.

PROGRAM 13.1: BLOOD AND ORGAN DONATION SERVICES
Program 13.1 aims to improve Australians' access to organ and tissue transplants, and support access to blood and blood products.

Improve Australians’ access to organ and tissue transplants
In 2012-13, the Department continued to help implement organ and tissue transplant reforms by providing advice and governance support to the Australian Organ and Tissue Donation and Transplantation Authority. The reforms aim to achieve a significant increase in the number of life-saving and life-transforming transplants for Australians by introducing nationally consistent donation processes and systems in hospitals. This will be supported by dedicated donation specialists, together with a nationally coordinated approach to community and professional awareness and education. The Department also implemented the Supporting Leave for Living Organ Donors initiative to help alleviate the financial stress of living organ donation.

The Department continued to fund the Australian Bone Marrow Donor Registry (ABMDR) to maximise the chance of a suitable donor match, either in Australia or overseas, for a patient needing a bone marrow, cord blood or peripheral blood stem cell transplant. In 2012-13, the ABMDR undertook 638 donor searches on behalf of Australian patients, with 288 Australian patients with leukaemia or other life-threatening haematological or immune system diseases receiving a bone marrow, peripheral blood or cord blood transplant. Of these, 116 Australians accessed treatment through the ABMDR and 172 Australians accessed treatment through international registries. Australia provided 77 bone marrow, cord blood or peripheral blood stem cell donations to overseas recipients. Through the Bone Marrow Transplant Program, the Department approved financial assistance for 285 patients in Australia, for the costs of obtaining and transporting bone marrow or stem cells from international donors.

The Department also funded the National Cord Blood Collection Network to collect, process, bank and release high quality umbilical cord blood stem cell units to Australian and international transplant centres for patients needing a transplant. In 2012-13, 44 Australian patients received single or double cord blood unit transplants. The network used 27 cord blood units from the Australian inventory and imported 31 cord blood units from international registries for patients for whom a suitably matched unit was not available from within the Australian inventory. In addition, 49 units were exported to international patients.

Scientific developments in the cord blood sector required collaboration between the Department and state and territory governments to consider the medical, ethical, financial and legal implications for the release of cord blood units for purposes other than bone marrow reconstitution. Work will continue in 2013-14 to develop a robust national policy to guide future operations of the network.

**Deliverable:** Support the Australian Bone Marrow Donor Register and the National Cord Blood Collection Network to identify matched donors and stem cells for transplant

**2012-13 Reference Point:** Increase diversity of tissue types of donors and cord blood units available for transplant

**Result:** Met

- The ABMDR started developing recruitment and collection strategies targeting donors from ethnically diverse populations to improve the prospects of finding a match for an Australian patient within the Australian donor pool or cord blood inventory, and reducing the reliance on overseas donors of cord blood.

  Genetic diversity of the cord blood inventory increased from 48% to 52% of cord blood units donated from parents who identify as not from North-West European ancestry in 2012-13 (baseline target is 45%).
KPI: Targeted collection strategies to increase the diversity of tissue type and cord blood units

2012-13 Reference Point: Reporting demonstrates ongoing implementation of agreed targeted collection strategies

Result: Met

During 2012-13, targeted collection strategies were implemented as planned. The ABMDR updated their online donor information and provided promotional material. Brochures and posters were given to bone marrow donor centres to encourage ethnically diverse and younger people to join the registry. In 2013-14, additional efforts will focus on engaging dedicated education officers to communicate with ethnically diverse communities and align cord blood unit testing and banking procedures with expected regulatory changes.

Deliverable: Number of banked cord blood units

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 2,379</td>
<td>523</td>
<td>Not met</td>
</tr>
<tr>
<td>Indigenous 129</td>
<td>64</td>
<td>Not met</td>
</tr>
</tbody>
</table>

In 2012-13, a total of 1,398 cord units were collected, of which 875 remain subject to regulatory clearance before they can be banked. The number of cord units collected overall, including from Indigenous donors, was below target. This was in part due to delays in processing times which occurred due to delays in recruitment of cord blood bank staff and delayed implementation of anticipated regulatory changes. Additionally, transplant outcome data has informed changes in clinical practice for a preference for selecting high value cord blood units with higher total nucleated cell counts. This is in line with global trends. Cord blood transplant outcomes correlate with a high degree of matching and the total nucleated cell count of a cord blood unit.

The Clinical Services Plan was developed in 2010-11 and the recommended collection and banking strategies continued to be implemented in 2012-13. This included targeting donations from ethnically diverse populations and units with a high total nucleated cell count, which improves the likelihood of the unit being selected for transplant. Given this, collection targets will be reviewed to align with clinical practice and to improve the value of the inventory, in light of emerging evidence in relation to ethnically diverse units, quality and size of the total nucleated cell count.

Historically, reaching the target for Indigenous donors has been challenging. In 2012-13, collection strategies targeted donations from Indigenous mothers at all network centres and provided culturally appropriate education activities to raise awareness and participation of Northern Territory Indigenous donors.

KPI: Percentage of eligible Australians in need of a bone marrow, cord blood or peripheral stem cell transplant who are able to access appropriate treatment

<table>
<thead>
<tr>
<th>2012-13 Target</th>
<th>2012-13 Actual</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

To be eligible for appropriate treatment, Australians in need of a bone marrow, cord blood or peripheral stem cell transplant will require a suitably matched donor. Where a suitably matched donor was found, all eligible Australians were able to receive treatment.

Support access to blood and blood products

The Department ensured access to affordable and quality blood supply by providing governance support to the National Blood Authority (NBA) and delivering the Commonwealth’s contribution of funding to the blood sector. In addition, the Department chaired the Jurisdictional Blood Committee (JBC) and continued to support the development of strategies that support appropriate blood use, a reduction in inventory wastage, and better forecasting and demand management across jurisdictions.

The Department also contributed to the Hepatitis C Litigation Settlement Scheme, which provides a contribution to the out-of-court settlement costs for eligible individuals who contracted hepatitis C as a result of a blood transfusion in Australia between 1985 and 1991.
Deliverable: Effective planning of the annual blood supply through the National Supply Plan and Budget

2012-13 Reference Point: The 2013-14 National Supply Plan and Budget agreed by all Health Ministers in 2012-13

Result: Met

- Health Ministers agreed to the 2013-14 National Supply Plan and Budget on 14 June 2013. The Commonwealth’s contribution in 2013-14, based on the national cost-sharing arrangements, is expected to be up to $715 million. This funding will ensure Australians have access to blood and blood products that they require for treatment of numerous medical conditions. These include cancer, heart, stomach, bowel, liver and kidney diseases, during and after surgery, treatment of traumatic injury or burns and for treatment of chronic conditions including bleeding disorders (eg haemophilia) and immunodeficiency conditions.

Deliverable: Percentage of the total contribution, made by the Australian Government, to the approved National Supply Plan and Budget

2012-13 Target: 63% 2012-13 Actual: 63% Result: Met

- The Australian Government contributed 63% of the approved National Supply Plan and Budget, with state and territory governments providing the remaining 37%.

KPI: Improved evidence based policy on funded blood products and services

2012-13 Reference Point: Number of applications for assessment of new blood products submitted to Medical Services Advisory Committee (MSAC)

Result: Met

- In 2012-13, the Department continued to work with the states and territories through the JBC, the NBA, and the MSAC to implement the health technology assessment framework for blood and blood products. This ensures that patients get access to blood products that have been proven to be safe, effective and cost-effective. One application, subcutaneous immunoglobulin (SCIg) was referred to the MSAC by the JBC for consideration.

KPI: Percentage of applications for funding of new blood products that have undergone a cycle one assessment, with those requiring a detailed assessment submitted to MSAC

2012-13 Target: 90% 2012-13 Actual: 100% Result: Met

- In July 2012, MSAC began consideration of an application of subcutaneous immunoglobulin (SCIg) that had been referred by JBC. In November 2012, MSAC provided advice to the JBC in relation to the safety, efficacy and cost-effectiveness of the SCIg application. Based on advice from JBC, SCIg was approved by the JBC for inclusion on the 2013-14 National Product and Services List for funded supply by Health Ministers.

PROGRAM 13.2: MEDICAL INDEMNITY

Program 13.2 aims to ensure the stability of the medical indemnity insurance industry so that insurance products for medical professionals are available and affordable.

Ensure the stability of the medical indemnity insurance industry

Medical indemnity insurance is a specialised form of professional indemnity cover that provides surety to medical practitioners and their patients in the event of an adverse outcome arising from medical negligence. Affordable and stable medical indemnity insurance allows the medical workforce to focus on the delivery of high quality medical services.

By subsidising high cost claims and providing a guarantee to cover exceptional claims, the Government ensures that the medical indemnity insurance industry continues to remain stable and secure.

74 Immunoglobulin products are derived from blood plasma and are used to provide protection against infection and modulate the immune system. These products can be administered to patients via subcutaneous route.
Deliverable: Continued participation in the Medical Indemnity National Collection through the Medical Indemnity National Collection Coordinating Committee and the Medical Indemnity Data Working Group

2012-13 Reference Point: Reports published by the Australian Institute of Health and Welfare

Result: Met

The Department worked closely with the Australian Institute of Health and Welfare and other Medical Indemnity Data Working Group and Medical Indemnity National Collection Coordinating Committee stakeholders to assist in the publication of two reports on medical indemnity claims. The reports present data on both public and private sector medical indemnity claims and an analysis of claim trends over time.

Ensure that insurance products are affordable for doctors

The Department administers a number of schemes – such as the Premium Support Scheme and the Run-off Cover Scheme – designed to maintain and improve premium affordability for medical practitioners.

Deliverable: Percentage of eligible applicants receiving a premium subsidy through the Premium Support Scheme

2012-13 Target: 100%  
2012-13 Actual: 100%  
Result: Met

All eligible doctors who applied received a premium subsidy.

KPI: Number of doctors who receive a premium subsidy support through the Premium Support Scheme

2012-13 Target: 2,300  
2012-13 Actual: 1,847  
Result: Met

In 2012-13, 1,847 doctors received a premium subsidy. This is a reduction from the 1,944 doctors in 2011-12. This is a positive result – it indicates that medical indemnity premiums are affordable.

KPI: Percentage of medical indemnity insurers that have a Premium Support Scheme contract with the Commonwealth that meet the Australian Prudential Regulation Authority’s Minimum Capital Requirement

2012-13 Target: 100%  
2012-13 Actual: 100%  
Result: Met

All medical indemnity insurers that have a Premium Support Scheme contract with the Commonwealth meet or exceed the Australian Prudential Regulation Authority’s Minimum Capital Requirement.

Ensure availability of professional indemnity insurance for eligible midwives

Privately practising midwives need insurance to meet the requirements of the Government’s National Registration and Accreditation Scheme. Indemnity insurers are reluctant to offer professional indemnity insurance to midwives, as the small potential premium pool and potentially high risk exposure means it is not commercially viable. The Australian Government contracted an insurer, Medical Insurance Group Australia (MIGA), to provide professional indemnity insurance to eligible midwives, to ensure that women and their families can access midwifery care.

Deliverable: Percentage of eligible midwife applicants covered by the Midwife Professional Indemnity Scheme

2012-13 Target: 100%  
2012-13 Actual: 100%  
Result: Met

All eligible privately practising midwives who applied for Commonwealth-supported professional indemnity insurance through Medical Insurance Group Australia were offered cover.

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75 Premium support is demand driven, with subsidies paid in response to applications from eligible doctors.
76 Applications for a premium subsidy for 2012-13 can still be made until 30 June 2014.
KPI: The continued availability of professional indemnity insurance for eligible midwives

2012-13 Reference Point: Maintain contract with Medical Insurance Group Australia to provide professional indemnity insurance to eligible midwives

Result: Met

Eligible privately practising midwives were able to purchase Commonwealth supported professional indemnity insurance from MIGA. The Commonwealth has recently extended the contract with MIGA for a further two years, expiring 30 June 2015.

PROGRAM 13.3: PUBLIC HOSPITALS AND INFORMATION

Program 13.3 aims to increase efficiency and capacity in public hospitals through National Health Reform, improved access to public dental services, and increase support for health services for the Torres Strait.

Increase efficiency and capacity in public hospitals

The Council of Australian Governments’ National Health Reform Agreement introduced nationally consistent Activity Based Funding (ABF) for public hospital services aimed at improving the efficiency of Australia’s public hospital system. Under ABF, Local Hospital Networks receive Commonwealth payments based on the actual number and type of services they provide.

In 2012-13, the Department made submissions to the Independent Hospital Pricing Authority (IHPA) to help develop the 2013-14 Pricing Framework, National Efficient Price (NEP) and National Efficient Cost Determinations. These determinations have applied to Commonwealth public hospital payments since 1 July 2013.

Deliverable: Provide financial contribution to states and territories to support the delivery of initiatives

2012-13 Reference Point: Payments to states and territories are made in a timely manner

Result: Met

In accordance with the National Health Reform Agreement, Commonwealth funding for public hospital services has been provided on an activity basis calculated using the NEP, wherever practicable, since 1 July 2012. The Administrator of the National Health Funding Pool has been making payments to Local Hospital Networks since July 2012.

The National Partnership Agreement on Improving Public Hospital Services commits up to $3.4 billion to states and territories over eight years between 2010 and 2018. These funds will help to improve emergency department treatment times, reduce the length of elective surgery waiting lists and increase subacute care services.

All jurisdictions will get improved access to emergency departments, elective surgery and sub-acute care through investment under the National Partnership Agreement on Improving Public Hospital Services. This includes projects such as $61 million for the state wide Surgery Connect Program in Queensland, $3.9 million for new emergency department treatment spaces at The Canberra Hospital in the ACT and $17.59 million of subacute care funding to develop a 20 bed rehabilitation unit at the Moruya Hospital, in New South Wales.

Funding of $572 million was allocated during 2012-13 to support the delivery of initiatives with all allocations paid to states and territories on satisfactory reporting of progress.
Subacute Care

**KPI:** Enhanced provision and improved mix of subacute care services in hospital and community settings

**2012-13 Reference Point:** States and territories reporting consistently demonstrates enhanced provision and improved mix of services

**Result:** Met

States and territories have continued to report every six months on progress against subacute bed targets and the mix of services delivered. In 2012-13, states and territories remained on track to exceed the national target of 1,316 new subacute beds over four years from 2010-11 to 2013-14. Each jurisdiction has planned the delivery of subacute beds based on identified needs including rehabilitation, palliative care, psychogeriatric care, subacute mental health care and geriatric evaluation and management.

Elective Surgery

Elective surgery is surgery that, in the opinion of the treating clinician, is not an emergency and can be delayed for at least 24 hours. The National Partnership Agreement on Improving Public Hospital Services rewards those states and territories that achieve their National Elective Surgery Target (NEST). This increases the percentage of patients who receive their elective surgery within clinically recommended times (NEST Part 1) and at the same time reduces the number of patients who have already waited longer than the clinically recommended time (NEST Part 2). Measurement of the NEST began on 1 January 2012 with the Department monitoring state and territory calendar year progress towards achieving the targets.

**KPI:** Percentage of elective surgery patients seen within the clinically recommended times

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 Actual:</td>
<td>Cannot be reported</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Cannot be reported</td>
</tr>
</tbody>
</table>

The percentage of elective surgery patients seen within the clinically recommended times is no longer reported for financial years. During 2012-13, there was an increase in the volume of surgery for all jurisdictions except Victoria and Tasmania. For NEST Part 1, the ACT and the NT achieved their 2012 interim targets in all three categories. NSW, Queensland and SA exceeded their baseline performance. Victoria, WA and Tasmania performed below the 2010 baseline in at least one urgency category. For NEST Part 2, only the ACT achieved its target in all three urgency categories.

Emergency Departments

The National Partnership Agreement on Improving Public Hospital Services rewards states and territories that achieve their National Emergency Access Target (NEAT), requiring by 2015 that 90% of patients leave the emergency department within four hours of presentation, either by admission, transfer to another hospital or discharge. Measurement of the NEAT began on 1 January 2012 with the Department monitoring state and territory calendar year progress towards achieving the targets.

**KPI:** Percentage of emergency department patients admitted, referred or discharged within 4 hours

<table>
<thead>
<tr>
<th>2012-13 Target:</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 Actual:</td>
<td>Cannot be reported</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Cannot be reported</td>
</tr>
</tbody>
</table>

Performance against the NEAT saw every jurisdiction record an increase in the number of emergency department presentations. Most jurisdictions demonstrated improvements on the previous year’s performance. WA was the only jurisdiction to meet or exceed its NEAT target in 2012. Queensland, SA, Tasmania and the ACT performed above their baselines, while NSW, Victoria and the NT performed at a level below their baseline.

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77 In 2012 the NEST reporting framework was introduced which provides performance reporting on a calendar year basis. Therefore an accurate overall figure cannot be provided for the 2012-13 financial year.

78 In 2012 the NEAT reporting framework was introduced which provides performance reporting on a calendar year basis. Therefore an accurate overall figure cannot be provided for the 2012-13 financial year.
### Improve access to public dental services

The 2012-13 Budget included $344 million over three years for states and territories to provide public dental services to around 400,000 patients waiting for public dental services. States and territories will use this funding to provide a range of dental services including preventive and restorative services and dentures by expanding the workforce; extending opening hours; purchasing specialist services; engaging the private sector; and building infrastructure.

The Department also continued to provide funding for mobile Indigenous dental pilot projects that use transportable equipment and mobile staff in rural and regional areas.

<table>
<thead>
<tr>
<th>KPI: Number of additional public dental patients treated by the states and territories above agreed baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-13 Target:</strong> 80,000&lt;sup&gt;79&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

The National Partnership Agreement on Treating More Public Dental Patients has now been signed by all states and territories. Only three jurisdictions that have reported so far have achieved at least the minimum target threshold of 65 per cent and will be paid accordingly for the associated performance period. The funds and targets under this NPA are cumulative. Therefore, any target unmet, and funds unattained, will roll over into the next period, allowing individual jurisdictions to make up their unachieved target.

Not all reports have been received from the states and territories, therefore, the final figures are not yet known.

#### Deliverable: Implement the Mobile Indigenous Dental Pilot projects

<table>
<thead>
<tr>
<th><strong>2012-13 Reference Point:</strong> Mobile Indigenous Dental Pilot projects commence and program evaluation completed in a timely manner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Result:</strong> Met</td>
</tr>
</tbody>
</table>

Seven pilot project sites for 2012-13 have been implemented and program evaluation completed.

#### KPI: Improve access to dental services for Aboriginal and Torres Strait Islander communities in rural and regional Australia

<table>
<thead>
<tr>
<th><strong>2012-13 Reference Point:</strong> Overall evaluation of the pilot program will identify the most effective models for future service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Result:</strong> Met</td>
</tr>
</tbody>
</table>

The final evaluation report was received before 30 June 2013.

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<sup>79</sup> This figure was indicative at the time of publication of the Portfolio Budget Statements as negotiations with states and territories had not commenced.
### OUTCOME 13 — FINANCIAL RESOURCE SUMMARY

| Program                  | Administered Expenses                                                                 | Departmental Expenses       | Total for Program |
|--------------------------|----------------------------------------------------------------------------------------|-----------------------------|-------------------|-------------------|
| **Outcome 13 Totals by appropriation type** |                                                                                       |                             |                   |                   |
| to Special Accounts      | (107,000) (107,000)                                                                  |                             |                   |                   |
| Special appropriations   | 771,271 674,348 (96,923)                                                             |                             |                   |                   |
| Special Account          | 107,000 105,739 (1,261)                                                              |                             |                   |                   |
| **Outcome 13 — Financial Resource Summary** |                                                                                       |                             |                   |                   |

1. This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2. Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.
3. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.

#### Program 13.1: Blood and Organ Donation Services

<table>
<thead>
<tr>
<th></th>
<th>Administered Expenses</th>
<th>Departmental Expenses</th>
<th>Total for Program 13.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>(A) Budget Estimate 2012-13: 14,600 14,114 (486)</td>
<td>Departmental Appropriation: 3,492 3,222 (270)</td>
<td>692,530 691,843 (687)</td>
</tr>
<tr>
<td>Special appropriations</td>
<td>National Health Act 1953 - Blood Fractionation, Products and Blood Related Products - to National Blood Authority</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Program 13.2: Medical Indemnity

<table>
<thead>
<tr>
<th></th>
<th>Administered Expenses</th>
<th>Departmental Expenses</th>
<th>Total for Program 13.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>(A) Budget Estimate 2012-13: 175 174 (1)</td>
<td>Departmental Appropriation: 489 450 (39)</td>
<td>97,600 645 (96,955)</td>
</tr>
<tr>
<td>Special appropriations</td>
<td>Medical Indemnity Act 2002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Program 13.3: Public Hospitals and Information

<table>
<thead>
<tr>
<th></th>
<th>Administered Expenses</th>
<th>Departmental Expenses</th>
<th>Total for Program 13.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordinary Annual Services [Annual Appropriation Bill 1]</td>
<td>(A) Budget Estimate 2012-13: 207,203 197,533 (9,670)</td>
<td>Departmental Appropriation: 49,894 48,856 (1,038)</td>
<td>258,110 261,461 (3,351)</td>
</tr>
<tr>
<td>to Local Hospital Network Special Account</td>
<td>(107,000) (107,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Account</td>
<td>Local Hospital Network Special Account</td>
<td>107,000 105,739 (1,261)</td>
<td></td>
</tr>
</tbody>
</table>

1. This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2. Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.
3. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses – please refer to the departmental financial statements for further information.

---

<table>
<thead>
<tr>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td>Ordinary Annual Services</td>
<td>14,600</td>
<td>14,114</td>
</tr>
<tr>
<td>Special appropriations</td>
<td>674,348</td>
<td>674,348</td>
</tr>
<tr>
<td>Departmental Appropriation</td>
<td>3,492</td>
<td>3,222</td>
</tr>
<tr>
<td>Expenses not requiring</td>
<td>90</td>
<td>159</td>
</tr>
<tr>
<td>appropriation in the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>current year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program 13.1</td>
<td>692,530</td>
<td>691,843</td>
</tr>
</tbody>
</table>

**Outcome 13 Acute Care**
OUTCOME 14 BIOSECURITY AND EMERGENCY RESPONSE

Preparedness to respond to national health emergencies and risks, including through surveillance, regulation, prevention, detection and leadership in national health coordination

MAJOR ACHIEVEMENTS

• The increasing resistance to antibiotics poses serious risks to our health. To respond to what is described by the World Health Organization as “a looming crisis”, the Department, along with the Department of Agriculture, Fisheries and Forestry, established the Australian Antimicrobial Resistance Prevention and Containment Steering Group.

• Australia continues to be well placed to deal with new and emerging threats, following our response to the 2013 avian influenza outbreak. The Department worked closely with the World Health Organization, other Australian Government agencies and stakeholders to implement systems to detect, collect information and report on cases should they occur in Australia.

CHALLENGES

• Maintain the Department’s regulatory capacity to process the increase in applications for licences and permits to import, export and manufacture controlled drugs and substances.

• Provide an effective regulatory response to the emergence of synthetic drugs.
### Performance

**Outcome 14: Biosecurity and Emergency Response**

#### Program Contributing to Outcome 14

Program 14.1: Health emergency planning and response

<table>
<thead>
<tr>
<th>Period</th>
<th>Met</th>
<th>Substantially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>57.1%</td>
<td>42.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2011-12</td>
<td>75%</td>
<td>7.1%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>
OUTCOME STRATEGY

Outcome 14 aims to strengthen the nation’s capacity to identify, monitor and implement effective and sustained responses to national health emergencies and risks. In 2012-13 the Department worked to achieve this Outcome by managing initiatives under the program outlined below.

PROGRAM 14.1: HEALTH EMERGENCY PLANNING AND RESPONSE

Program 14.1 aims to provide national health emergency planning and response, improve biosecurity, drug and chemical safety, and minimise the risks posed by communicable diseases.

National health emergency planning and response

The Australian Government’s capacity to support a response to a health emergency was maintained through replenishment of pharmaceuticals and personal protective equipment for the National Medical Stockpile. In 2012-13, the Department worked collaboratively with BioCSL to ensure the national capacity for antivenom production was maintained. In addition, the Department provided increased funding to BioCSL to guarantee the continued production and distribution of antivenom products to state and territory health departments.

The Department works collaboratively with states and territories to ensure Australia has the capacity to detect, assess and respond to the spread of disease, and to provide an appropriate public health emergency response. The Department also supports developing countries and countries with economies in transition to build, strengthen and maintain their core public health capacities.

In 2012-13, the Department continued to fund and collaborate with the National Critical Care and Trauma Response Centre based at Royal Darwin Hospital to maintain and improve a state of preparedness for response to major onshore and offshore incidents both in Australia and South East Asia. The Centre enhances preparedness nationally through a variety of activities such as trauma and disaster training for local and interstate clinicians. In addition, the Department continues to fund the Australian Red Cross Society for a broad range of health-related humanitarian work and community development activities. These include disaster preparedness and response, first aid and refugee support services nationally.

Deliverable: Develop, exercise and refine national health emergency policy under the National Health Emergency Response Arrangements

2012-13 Reference Point: National Health Emergency Response Arrangements will be exercised and revised and an annex detailing health response to a terrorist incident will be developed

Result: Substantially met

In 2012-13, the Department developed and revised plans and guidelines underpinning the National Health Emergency Response Arrangements, including the development of a Criminal and Terrorism Incident Annex to support the Domestic Response Plan for Mass Casualty Incidents of National Consequence.

The Department is also close to finalising the new Health Chemical, Biological, Radiological and Nuclear Incidents of National Consequence (CBRNINC) Plan. The Health CBRNINC Plan is the domestic response plan which provides an agreed framework and mechanism for the effective national coordination, response and recovery arrangements for chemical, biological, radiological and nuclear incidents of national consequence. The final CBRNINC Plan and the Chemical Guidelines are scheduled to be finalised by November 2013. The Anthrax and Radiological Guidelines have been finalised and are available on the Department’s website. The Smallpox Guidelines is scheduled to be available in April 2014.

80 Available at: www.health.gov.au
REVISION OF THE AUSTRALIAN HEALTH MANAGEMENT PLAN FOR PANDEMIC INFLUENZA (AHMPPI)\textsuperscript{81}

The AHMPPI presents a framework that allows for tailored measures appropriate to the severity of any pandemic and the availability of resources. The AHMPPI is being revised and is incorporating recommendations made in the Review of Australia’s Health Sector Response to Pandemic (H1N1) 2009: Lessons identified. The revised AHMPPI will focus on the government health sector, building on existing seasonal influenza systems and governance mechanisms. It is based on a targeted emergency response approach, which will assist decision makers to communicate more easily with others outside the health sector. It also allows for a more flexible public health response, which can be varied to suit the level of impact of the pandemic and the needs of the community.

Extensive stakeholder consultation has been undertaken with health sector advisory bodies, industry peak bodies, Australian and jurisdictional government agencies and clinical stakeholder groups.

A Surveillance Plan for Pandemic Influenza is also being developed in collaboration with the states and territories as a component of the revised AHMPPI. This will ensure that a national plan is available for the timely and efficient collection of the data necessary to implement a pandemic response.

A full draft is expected to be available by the end of 2013.
KPI: Containment of national health emergencies through the timely engagement of national health coordination mechanisms and response plans

2012-13 Reference Point: National responses to health emergencies are successfully managed

Result: Met

The Australian Health Protection Principal Committee, chaired by the Chief Medical Officer of the Department, coordinates and supports national health emergency management. In 2012-13, the committee considered and agreed to policies on Australian Medical Assistance Team arrangements, pandemic influenza preparedness and asbestos guidelines for householders and the general public. The committee held five short notice extraordinary meetings to discuss heatwave and burns preparedness, preparedness for a potential avian influenza outbreak, the Asbestos – a guide for householders and the general public and a shortage of the Hospira® – DBL Morphine Sulfate Injection. On 31 March 2013, Chinese authorities notified the World Health Organization (WHO) of the identification of avian influenza A (H7N9) in three people. As this was the first time H7N9 had been identified in humans, immediate monitoring and surveillance of this influenza strain was activated by the WHO. In the last official update provided by the WHO on 7 June 2013, 132 people had laboratory-confirmed infections of H7N9 and 37 people had died. The majority of people infected with H7N9 displayed influenza-like symptoms such as fever, cough, headache, muscle ache and fatigue. The virus has shown no evidence of sustained or efficient human-to-human transmission. The Department responded to this outbreak in collaboration with other Australian Government agencies, the states and territories, and health experts through key committees and working groups.

The Department’s immediate response to the H7N9 outbreak was to coordinate the development of a working case definition, the review of relevant border measures, review of stocks of personal protective equipment, the preparation of public health laboratory capacity and procedures, and the development of public health communication materials.

The Department also provided regularly updated information on its website, including general information for the public, specific advice for Australians travelling in or returning from China, and advice to clinicians, laboratories and GPs. The Department’s daily surveillance activities and epidemiological analyses informed a regular situation report that was distributed to key internal and external stakeholders including the WHO.

Leaflets providing information for travellers with specific advice about H7N9 and what to do if feeling unwell were prepared for distribution at international airports across Australia.

In coordinating the response to this outbreak, the Department engaged with WHO, the Australian Health Protection Principal Committee, the Communicable Diseases Network of Australia, the Public Health Laboratory Network, the Pandemic Review Implementation Advisory Committee, the Department of Foreign Affairs and Trade, the Australian Customs and Border Protection Service, and the Department of Agriculture, Fisheries and Forestry.

The actions demonstrate that the Department has built on the success of the national response to the 2009 influenza pandemic and is well situated to deal with new and emerging threats, with systems in place to detect, collect information and report on cases should they occur in Australia.

Improve biosecurity, drug and chemical safety

The Department undertakes human health risk assessment policy and practice for veterinary medicines and pesticides on behalf of the Australian Pesticides and Veterinary Medicines Authority (APVMA).

The Department is responsible for updating and maintaining the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP). The SUSMP publishes the schedules which form a national classification system that controls how medicines and poisons are made available to the public.

The Department is responsible for ensuring that Australia fulfils its obligations under international agreements relating to the regulation of chemicals and for collecting statistics about chemicals.
Chemical safety

The Department continued to provide advice to the APVMA about the public health effects of human exposure to chemicals and pesticides. The Department also considered the toxicology profile and intended uses of chemicals (and the products that contain them) and provided recommendations to APVMA on whether they were safe for use.

**KPI:** Perform human health risk assessments and regulate access to chemicals and drugs

**2012-13 Reference Point:** Chemical assessments completed in a timely manner and authorisation to access drugs and chemicals issued in accordance with legislative requirements

**Result:** Substantially met

In 2012-13, the Department, through the Office of Chemical Safety, continued to undertake human health risk assessments for the APVMA. The Department conducted 81 assessments, and recommended against granting some applications on human health grounds. The Department continued to develop and maintain the database of health standards arising from these assessments (for example, acceptable daily intake and acute reference dose values, which provide reference points against which agricultural and veterinary chemicals are regulated).

The assessments of agricultural and veterinary chemicals provided to the APVMA were comprehensive, accurate and of good quality. Ongoing difficulty in recruiting appropriate staff meant that the Department did not meet its timeframe target — 2012-13 (52%) compared to 2011-12 (61%). Timeframe compliance is expected to continue to improve in 2013-14.

**Deliverable:** Update and maintain the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)

**2012-13 Reference Point:** SUSMP to be amended as soon as practicable after the Secretary’s, or the Secretary’s delegate’s, final decision under the Therapeutic Goods Regulations 1990

**Result:** Met

In 2012-13, a total of 82 scheduling decisions were made under the Therapeutic Goods Regulations 1990, with 45 being delegate-only decisions and 37 being made following advice from an advisory committee. All decisions requiring amendments to the Standard for the Uniform Scheduling of Medicines and Poisons were published within acceptable timeframes.

Management of controlled substances

Australia is a signatory to three international drug conventions – the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. These conventions enable international cooperation in ensuring access to essential medications, while minimising the potential for diversion into illicit use.

Under these conventions, the Department is the Competent National Authority for Australia, and administers a framework for controlling the manufacture, import, export and supply of internationally controlled drugs in Australia. It does this with cooperation from the Australian Customs and Border Protection Service, law enforcement agencies and states and territories.

As required by the international drug conventions, in 2012-13 the Department monitored the stock and manufacture of internationally controlled drugs and monitored approximately 3.6 million wholesale transactions of these drugs within Australia. The data collected contributed to Australia’s reporting obligations, under the international drug conventions, and assisted states and territories with monitoring potential drug diversions.

Australia is a major global producer of narcotic materials from poppy cultivation, providing almost half the world’s legal supply. Careful control and supervision of all stages of poppy growing and production of narcotic raw materials is required under the international drug conventions. To facilitate this, the Department issued manufacturing licenses and permits under the Narcotic Drugs Act 1967 to regulate supply of narcotics, and provided regular reports on the cultivation areas, harvest and narcotic production to the International Narcotic Control Board to enable better regulation of global narcotic drug supply.
2.1

14

Outcome 14: Biosecurity and Emergency Response

The Department cooperated with other countries to control the export of chemicals (precursors) that have the potential to be used to manufacture illicit drugs. Pre-export notifications provide an early warning system to countries and customs authorities of chemical shipments which may be diverted from licit channels. In 2012-13, there were 1,691 pre-export notifications processed by the Department for all precursor substances controlled under the international drug conventions.

An escalation of emerging drugs, including new psychoactive substances (NPS), and a continued rise in import and export activities has continued to present a challenge to the Department’s capacity to process applications to import and export drugs in a timely manner while ensuring regulatory compliance and meeting international reporting obligations. For 2012-13, the focus was on ensuring access to essential medications was maintained. This resulted in a 15% increase from 2011-12 in applications completed on time.

In 2012-13, the Department started regulating new drugs, which included six classes of synthetic cannabinoids and eight NPS. In addition, the Department moved to harmonise the import regulations with controlled drugs and prohibited drugs which are scheduled in the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP). The SUSMP provides the states and territories with guidance to enable consistent drug controls. By aligning the import regulations with the SUSMP, the Department and Customs add a further level of control at the Australian border, which assists drug control activities.

**Deliverable:** Percentage of applications for the import, export, and manufacture of controlled substances that are assessed and processed within agreed timeframes

<table>
<thead>
<tr>
<th>2012-13 Target: 95%</th>
<th>2012-13 Actual: 90%</th>
<th>Result: Substantially met</th>
</tr>
</thead>
</table>

In 2012-13, the Department issued a total of 7,955 licences and permits authorising the import, export and manufacture of controlled drugs, an increase of 4.7% from 2011-12. This increase and related activities contributed to processing being outside the target of 95%.

The Department also issued 1,692 pre-export notifications (a decrease of 2.6% from 2011-12) and recorded an 18% increase in formal statements provided to law enforcement agencies.

With the increasing challenge of NPS, international obligations and the need to ensure regulatory compliance to avoid regulatory failure, applications completed within timeframes will be placed under further stress for 2013-14.

**Minimise the risks posed by communicable diseases**

The communicable disease issues facing Australia are diverse and associated with foodborne diseases, zoonoses, antimicrobial resistant (AMR) bacteria, sexually transmissible infections, vector-borne diseases, and vaccine preventable diseases. New and emerging diseases, such as Middle Eastern Respiratory Syndrome Coronavirus also pose a potential threat to public health.

The Department conducted national surveillance on 65 communicable diseases through the National Notifiable Diseases Surveillance System (NNDSS) which enabled health authorities to respond to outbreaks in a timely manner. Additional surveillance data were also collected through the National Influenza Surveillance Scheme and OzFoodNet.
Deliverable: Collect and disseminate data in the National Notifiable Disease Surveillance System (NNDSS) and monitor data quality in accordance with the National Health Security Act 2007

2012-13 Reference Point: Data is collected and available for regular reporting by the Commonwealth and adhoc requests by stakeholders, including for publication in the Department’s journal Communicable Diseases Intelligence

Result: Met

The Department continued to support the ongoing and systematic collection, analysis and reporting of surveillance data related to domestic and international incidents of communicable and foodborne diseases. The Department used relevant data sources, including the NNDSS and links with WHO to identify outbreaks and predict communicable disease trends.

In 2012-13, the Department provided relevant and timely surveillance data and reports to the Communicable Diseases Network Australia and other relevant committees for enhanced monitoring. Communicable disease surveillance reports were completed and disseminated on schedule. These included the National Arbovirus and Malaria Advisory Committee annual report, fortnightly reports through the Communicable Diseases Network Australia, seasonal influenza reports during the 2012 influenza season and monthly measles and annual tuberculosis and polio reports to the WHO. Four quarterly issues of the journal, Communicable Disease Intelligence, were also published in 2012-13.

Surveillance

In collaboration with states and territories, the Department’s National Surveillance Committee and other subcommittees worked to improve the quality, timeliness and completeness of national surveillance data. States and territories also collaborated with the Department on the Case Definition Working Group to ensure that nationally agreed case definitions were used by all jurisdictions for consistent case notifications.

Throughout the influenza season, influenza data were collected from all components of the national influenza surveillance system, and was analysed and reported fortnightly to decision makers, health professionals and the public.

The Department continued to work with the Influenza Surveillance Strategy Working Group to develop the national influenza surveillance systems to ensure that the epidemiology and virology of influenza across Australia can be measured.

In addition, the Department continued to fund Queensland Health to monitor and control the spread of Aedes albopictus mosquitoes in the Torres Strait. Reports submitted by Queensland Health showed progress towards project objectives. In 2012-13, ongoing surveillance indicated that there was no established exotic mosquito (Aedes albopictus) population on mainland Australia, thus restricting the spread of dengue fever and other mosquito-borne diseases.

OzFoodNet

The Department funded OzFoodNet to enhance surveillance and investigation of foodborne disease in Australia in conjunction with jurisdictions. In 2012-13, OzFoodNet conducted an outbreak investigation of listeriosis with 34 cases, from six jurisdictions identified linked to products from a Victorian manufacturer of soft cheese. The Department liaised with state and territory authorities, the Communicable Diseases Network of Australia, and Food Standards Australia and New Zealand to identify the link between the consumption of soft cheese and these cases. Data from OzFoodNet’s National Enhanced Listeriosis Surveillance System was used to identify and monitor this outbreak.

OzFoodNet also continues to gather evidence on outbreaks of gastroenteritis associated with the consumption of raw or minimally cooked eggs. Foods commonly served with an uncooked raw egg ingredient such as chocolate mousse, tiramisu and sauces (aioli and mayonnaise) have been linked to outbreaks of salmonellosis. Data from the OzFoodNet Outbreak Register show that in 2011, around 20% of the outbreaks investigated by OzFoodNet were linked to the use of raw or minimally cooked egg.
Antimicrobial resistance

Antimicrobial resistance (AMR) occurs when a microorganism (including bacteria, fungi, viruses and some parasites) becomes resistant to an antimicrobial medicine to which it was originally susceptible. The WHO describes AMR as a “looming crisis” in which common and treatable infections are becoming life threatening with potential for substantial increases to health care system costs and financial burden to the community. In 2012-13, the Department began to develop a national antimicrobial resistance strategy. This will benefit all Australians by preserving the usefulness of antibiotics important to human and animal health and reducing costs to the health care system.

Biosecurity risks

In 2012-13, the Biosecurity Bill 2012 was introduced into Parliament to replace the century old Quarantine Act 1908. This Bill sought to provide a modern regulatory framework to better manage biosecurity risks, including human health risks entering, establishing and spreading in Australia. The Bill was to be jointly administered by the Department and the Department of Agriculture, Fisheries and Forestry.

| KPI: Percentage of designated points of entry into Australia capable of responding to public health events, as defined in the International Health Regulations |
|---|---|---|
| **2012-13 Target:** 100% | **2012-13 Actual:** 100% | **Result:** Met |

- All airports and seaports designated under the International Health Regulations must have an emergency plan in place to address human health emergencies.
## Outcome 14 – Financial Resource Summary

<table>
<thead>
<tr>
<th>Program 14.1: Health Emergency Planning and Response ¹</th>
<th>(A) Budget Estimate 2012-13</th>
<th>(B) Actual 2012-13</th>
<th>Variation (Column B minus Column A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$'000</td>
<td>$'000</td>
<td>$'000</td>
</tr>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordin ary Annual Services [Annual Appropriation Bill 1]</td>
<td>26,883</td>
<td>22,998</td>
<td>(3,885)</td>
</tr>
<tr>
<td>Non cash expenses - write down of assets ²</td>
<td>38,147</td>
<td>36,297</td>
<td>(1,850)</td>
</tr>
<tr>
<td>Special accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Pituitary Hormone Special Account</td>
<td>150</td>
<td>150</td>
<td>-</td>
</tr>
<tr>
<td><strong>Departmental Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Appropriation ³</td>
<td>24,208</td>
<td>23,151</td>
<td>(1,057)</td>
</tr>
<tr>
<td>Expenses not requiring appropriation in the current year ⁴</td>
<td>1,515</td>
<td>1,769</td>
<td>254</td>
</tr>
<tr>
<td><strong>Total for Program 14.1</strong></td>
<td>90,903</td>
<td>84,365</td>
<td>(6,538)</td>
</tr>
<tr>
<td><strong>Outcome 14 Totals by appropriation type</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>1,769</td>
<td>254</td>
</tr>
<tr>
<td><strong>Total expenses for Outcome 14</strong></td>
<td>90,903</td>
<td>84,365</td>
<td>(6,538)</td>
</tr>
<tr>
<td><strong>Average Staffing Level (Number)</strong></td>
<td>163</td>
<td>160</td>
<td>(3)</td>
</tr>
</tbody>
</table>

1. This program includes National Partnerships paid to state and territory governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
2. Non cash expenses relate to the write down of the drug stopckpile inventory due to expiration, consumption and distribution.
3. Departmental appropriation combines ‘Ordinary annual services (Appropriation Bill 1)’ and ‘Revenue from independent sources (s31)’.
4. ‘Expenses not requiring appropriation in the budget year’ is made up of depreciation expense, amortisation, make good expense and audit fees. This estimate also includes approved operating losses - please refer to the departmental financial statements for further information.
## AGENCY RESOURCE STATEMENT 2012-13

<table>
<thead>
<tr>
<th></th>
<th>ACTUAL AVAILABLE APPROPRIATION FOR 2012-13 $'000</th>
<th>PAYMENTS MADE 2012-13 $'000</th>
<th>BALANCE REMAINING 2012-13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ordinary Annual Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental appropriation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior year departmental appropriation</td>
<td>115,567</td>
<td>108,155</td>
<td>7,412</td>
</tr>
<tr>
<td>Departmental appropriation</td>
<td>623,162</td>
<td>516,918</td>
<td>106,244</td>
</tr>
<tr>
<td>Departmental capital budget²</td>
<td>7,984</td>
<td>6,258</td>
<td>1,726</td>
</tr>
<tr>
<td>S.31 Relevant agency receipts</td>
<td>80,738</td>
<td>80,738</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>827,451</td>
<td>712,069</td>
<td>115,382</td>
</tr>
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</table>

### Administered expenses

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PAYMENTS MADE 2012-13 $'000</th>
<th>BALANCE REMAINING 2012-13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1</td>
<td>366,036</td>
<td>317,421</td>
</tr>
<tr>
<td>Outcome 2</td>
<td>675,571</td>
<td>592,167</td>
</tr>
<tr>
<td>Outcome 3</td>
<td>115,171</td>
<td>91,279</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>2,027,190</td>
<td>1,808,042</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>866,574</td>
<td>773,631</td>
</tr>
<tr>
<td>Outcome 6</td>
<td>87,480</td>
<td>79,020</td>
</tr>
<tr>
<td>Outcome 7</td>
<td>404,257</td>
<td>368,580</td>
</tr>
<tr>
<td>Outcome 8</td>
<td>705,659</td>
<td>669,982</td>
</tr>
<tr>
<td>Outcome 9</td>
<td>5,091</td>
<td>2,505</td>
</tr>
<tr>
<td>Outcome 10</td>
<td>160,399</td>
<td>157,149</td>
</tr>
<tr>
<td>Outcome 11</td>
<td>386,596</td>
<td>367,284</td>
</tr>
<tr>
<td>Outcome 12</td>
<td>1,321,168</td>
<td>1,164,167</td>
</tr>
<tr>
<td>Outcome 13</td>
<td>221,962</td>
<td>201,026</td>
</tr>
<tr>
<td>Outcome 14</td>
<td>24,083</td>
<td>23,923</td>
</tr>
<tr>
<td>Payments to CAC Act Bodies</td>
<td>34,748</td>
<td>34,632</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,401,985</td>
<td>6,650,808</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Total ordinary annual services</strong></th>
<th>PAYMENTS MADE 2012-13 $'000</th>
<th>BALANCE REMAINING 2012-13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>8,229,436</td>
<td>7,362,877</td>
</tr>
</tbody>
</table>

### Other services³

#### Administered expenses

**Specific payments to States, ACT, NT and local government**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PAYMENTS MADE 2012-13 $'000</th>
<th>BALANCE REMAINING 2012-13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1</td>
<td>15,226</td>
<td>14,580</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15,226</td>
<td>14,580</td>
</tr>
</tbody>
</table>

#### Departmental non-operating

<table>
<thead>
<tr>
<th>Prior year departmental appropriation</th>
<th>PAYMENTS MADE 2012-13 $'000</th>
<th>BALANCE REMAINING 2012-13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>101,926</td>
<td>49,943</td>
</tr>
</tbody>
</table>

---

² Departmental capital budget
³ Other services include specific payments to States, ACT, NT and local government.
### Administered non–operating

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual Available Appropriation for 2012–13 $'000</th>
<th>Payments Made 2012–13 $'000</th>
<th>Balance Remaining 2012–13 $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior year administered appropriation</td>
<td>16,967</td>
<td>14,004</td>
<td></td>
</tr>
<tr>
<td>Administered Assets and Liabilities</td>
<td>19,793</td>
<td>2,170</td>
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</tr>
<tr>
<td>Total</td>
<td>36,760</td>
<td>16,174</td>
<td></td>
</tr>
<tr>
<td>Total other services</td>
<td></td>
<td>B 153,912</td>
<td>80,697</td>
</tr>
</tbody>
</table>

### Total Available Annual

<table>
<thead>
<tr>
<th>Appropriations and payments</th>
<th>8,383,348</th>
<th>7,443,574</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special appropriations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special appropriations limited by criteria/entitlement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged Care Act 1997</td>
<td>9,407,646</td>
<td></td>
</tr>
<tr>
<td>Aged Care Bond Security Act 2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurance Act 1973</td>
<td>18,565,706</td>
<td></td>
</tr>
<tr>
<td>National Health Act 1953</td>
<td>9,825,652</td>
<td></td>
</tr>
<tr>
<td>Medical Indemnity Act 2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Benefits Act 2008</td>
<td></td>
<td>59,634</td>
</tr>
<tr>
<td>Private Health Insurance Act 2007</td>
<td></td>
<td>409,428</td>
</tr>
<tr>
<td>Financial Management and Accountability Act 1997 s 28(2)</td>
<td></td>
<td>310</td>
</tr>
<tr>
<td>Total special appropriations</td>
<td>C 43,831,233</td>
<td></td>
</tr>
</tbody>
</table>

### Special Accounts

<table>
<thead>
<tr>
<th>Description</th>
<th>Opening balance</th>
<th>Appropriation receipts¹</th>
<th>Payments made</th>
<th>Total Special Account D</th>
<th>Total resourcing and payments⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78,445</td>
<td>121,901</td>
<td>984,914</td>
<td>1,067,167</td>
<td>9,450,515</td>
</tr>
</tbody>
</table>

Less appropriations drawn from annual or special appropriations above and credited to special accounts and CAC Act bodies through annual appropriations.

Total net resourcing and payments for the Department of Health and Ageing 9,293,866 52,259,721.

1 Appropriation Bill (No.1) 2012–13 and Appropriation Bill (No.3) 2012–13.
2 For accounting purposes this amount has been designated as 'contributions by owners'.
3 Appropriation Bill (No.2) 2012–13 and Appropriation Bill (No.4) 2012–13.
4 Does not include 'Special Public Money' held in Services for Other Entities and Trust Moneys special account (SOETM).
5 Appropriation receipts from the Department of Health and Ageing annual and special appropriations for 2012–13 included above.
6 Total resourcing excludes the actual available appropriation for all Special Appropriations.
<p>| WEBSITES |
|-----------------|----------------------------------------------------------|
| Aged Care Complaints Scheme | <a href="http://www.agedcarecomplaints.govspace.gov.au">www.agedcarecomplaints.govspace.gov.au</a> |
| Australia New Zealand Therapeutic Products Agency | <a href="http://www.anztpa.org">www.anztpa.org</a> |
| Australian Childhood Immunisation Register | <a href="http://www.humanservices.gov.au">www.humanservices.gov.au</a> |
| Australian Health Survey | <a href="http://www.abs.gov.au">www.abs.gov.au</a> |
| Australian Register of Therapeutic Goods | <a href="http://www.tga.gov.au/industry/artg.htm">www.tga.gov.au/industry/artg.htm</a> |
| Bowel Cancer Screening Program | <a href="http://www.cancerscreening.gov.au">www.cancerscreening.gov.au</a> |
| BreastScreen Australia | <a href="http://www.cancerscreening.gov.au">www.cancerscreening.gov.au</a> |
| Diabetes Care Project | <a href="http://www.dcp.org.au">www.dcp.org.au</a> |
| headspace | <a href="http://www.headspace.org.au">www.headspace.org.au</a> |
| Healthy Communities Initiative | <a href="http://www.healthyactive.gov.au">www.healthyactive.gov.au</a> |
| mindspot | <a href="http://www.mindspot.org.au">www.mindspot.org.au</a> |
| My Aged Care | <a href="http://www.myagedcare.gov.au">www.myagedcare.gov.au</a> |
| My Hospitals | <a href="http://www.myhospitals.gov.au">www.myhospitals.gov.au</a> |
| National Cervical Screening Program | <a href="http://www.cancerscreening.gov.au">www.cancerscreening.gov.au</a> |
| National E-Health Transition Authority (NEHTA) | <a href="http://www.nehta.gov.au">www.nehta.gov.au</a> |
| National Health Services Directory | <a href="http://www.nhsd.com.au">www.nhsd.com.au</a> |
| National Industrial Chemicals Notification and Assessment Scheme (NICNAS) | <a href="http://www.nicnas.gov.au">www.nicnas.gov.au</a> |
| National Mental Health Commission | <a href="http://www.mentalhealthcommission.gov.au">www.mentalhealthcommission.gov.au</a> |
| National Tobacco Campaign – More Targeted Approach | <a href="http://www.quitnow.gov.au">www.quitnow.gov.au</a> |
| Pharmaceutical Benefits Scheme | <a href="http://www.pbs.gov.au">www.pbs.gov.au</a> |
| Pharmacy Practice Incentive Program | <a href="http://www.medicareaustralia.gov.au">www.medicareaustralia.gov.au</a> |
| Private Health Insurance Administration Council (PHIAC) | <a href="http://www.phiac.gov.au">www.phiac.gov.au</a> |
| Rural and Regional Health Australia | <a href="http://www.ruralhealthaustralia.gov.au">www.ruralhealthaustralia.gov.au</a> |
| Therapeutic Goods Administration (TGA) | <a href="http://www.tga.gov.au">www.tga.gov.au</a> |
| Acute Care | Short-term medical treatment, usually in a hospital, for patients with an acute illness or injury, or recovering from surgery. Acute illness/injury is one that is severe in its effect or approaching crisis point, for example acute appendicitis. |
| Antenatal | The period prior to birth. |
| Blood Borne Viruses | Viruses that are transmitted through contact between infected blood and uninfected blood. |
| Cervical cancer | A cancer of the cervix, often caused by human papillomavirus, which is a sexually transmissible infection. |
| Chemotherapy | The treatment of disease by chemical agents, for example the use of drugs to destroy cancer cells. |
| Chronic Disease | The term applied to a diverse group of diseases, such as heart disease, cancer and arthritis, that tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the general term chronic diseases is usually confined to non-communicable diseases. |
| Closing the Gap | COAG Closing the Gap initiatives designed to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. |
| Computed Tomography (CT) Scanning | An imaging method that uses computer processing to generate an image of tissue density in a ‘slice’ through the body. The images are spaced at 5 to 10 mm intervals allowing an anatomical cross-section of the body to be constructed. |
| Communicable Disease | Illnesses caused by microorganisms and transmitted from an infected person or animal to another person or animal. |
| Deliverables | Tangible program products developed to meet program objectives. |
| Dementia | A general and worsening loss of brain power such as memory, understanding and reasoning. |
| Diabetes | Refers to a group of syndromes caused by a malfunction in the production and release of insulin by the pancreas leading to a disturbance in blood glucose levels. Type 1 diabetes is characterised by the abrupt onset of symptoms, usually during childhood, and inadequate production of insulin requiring regular injections to regulate insulin levels. Type 2 diabetes is characterised by gradual onset, commonly between 50 and 60 years old, and is usually able to be regulated through dietary control. |
| Digital mammography | Specialised form of mammography that uses digital receptors and computers instead of x-ray film to help examine breast tissue for breast cancer. |
| eHealth | Application of internet and other related technologies in the health care industry to improve the access, efficiency, effectiveness and quality of clinical and business processes utilised by health care organisations, practitioners, patients and consumers to improve the health status of patients. |
| Epidermolysis Bullosa | A rare inherited skin disorder which causes blistering. The Department provides access to clinically appropriate dressings through the National Epidermolysis Bullosa Dressing Scheme. |
| Faecal occult blood test | A test that detects tiny amounts of blood, often released from bowel cancers or their precursors (polyps or adenomas) into the bowel motion. |
| Generic | When referring to a drug, ‘generic’ means not covered by a trademark; where a drug is marketed under its chemical name without advertising. |</p>
<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gene technology</td>
<td>Gene technology involves techniques for understanding the expression of genes and taking advantage of natural genetic variation for the modification of genetic material. It does not include sexual reproduction or DNA crossover.</td>
</tr>
<tr>
<td>Hepatitis A [infectious hepatitis]</td>
<td>An acute but benign form of viral hepatitis transmitted by ingesting food or drink that is contaminated with fecal matter.</td>
</tr>
<tr>
<td>Hepatitis B [serum hepatitis]</td>
<td>An acute (sometimes fatal) form of viral hepatitis transmitted by sexual contact, by transfusion or by ingestion of contaminated blood or other bodily fluids.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>A blood borne viral disease that can result in serious liver disease such as cirrhosis, liver failure and liver cancer. Hepatitis C is usually transmitted by parenteral means (as injection of an illicit drug or blood transfusion or exposure to blood or blood products).</td>
</tr>
<tr>
<td>Key Performance Indicators</td>
<td>Indicators which measure agency effectiveness through program deliverables in achieving the program objectives.</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>A non-invasive nuclear medicine technology that uses strong magnetic fields and radio frequency pulses to generate sectional images of the body. The image gives information about the chemical makeup of the tissues, allowing, for example, normal and cancerous tissues to be distinguished.</td>
</tr>
<tr>
<td>Measles</td>
<td>An acute, contagious viral disease, usually occurring in childhood and characterized by eruption of red spots on the skin, fever, and catarrhal symptoms. Also called rubeola.</td>
</tr>
<tr>
<td>Melanoma</td>
<td>A tumour arising from the skin, consisting of dark masses of cells with a tendency to metastasis. It is the most aggressive form of skin cancer.</td>
</tr>
<tr>
<td>Memorandum of Understanding</td>
<td>A written but noncontractual agreement between two or more agencies or other parties to take a certain course of action.</td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>The inflammation of meninges of the brain and the spinal cord caused by meningococcal bacteria which invade the body through respiratory tract. The infection develops quickly and is often characterised by fever, vomiting, an intense headache, stiff neck and septicemia (an infection in the bloodstream).</td>
</tr>
<tr>
<td>Mumps</td>
<td>An acute, inflammatory, contagious disease caused by a paramyxovirus and characterised by swelling of the salivary glands, especially the parotids, and sometimes of the pancreas, ovaries, or testes. This disease mainly affects children and can be prevented by vaccination.</td>
</tr>
<tr>
<td>Oncology</td>
<td>The study, knowledge and treatment of cancer and tumours.</td>
</tr>
<tr>
<td>Otitis media</td>
<td>Middle Ear Infection. It is a significant health issue, especially for Aboriginal and Torres Strait Islander children.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>As used in the Australian Government’s Outcomes Framework, are the results, consequences or impacts of Government actions on the Australian community.</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Care provided to achieve the best possible quality of life for patients with a progressive and far-advanced disease, with little or no prospect of cure.</td>
</tr>
<tr>
<td>Pandemic</td>
<td>An epidemic affecting a wide geographic area.</td>
</tr>
<tr>
<td>Pathology</td>
<td>The study and diagnosis of disease through the examination of organs, tissues, cells and bodily fluids.</td>
</tr>
<tr>
<td>Perinatal</td>
<td>The period shortly before and after birth. The term generally describes the period between the 20th week of gestation and one to four weeks after birth.</td>
</tr>
<tr>
<td>Plain Packaging</td>
<td>The Tobacco Plain Packaging Act 2011 requires all tobacco products manufactured or packaged in Australia for domestic consumption from 1 October 2012 to be in plain packaging, and all tobacco products to be sold in plain packaging by 1 December 2012.</td>
</tr>
<tr>
<td>Portfolio Additional Estimates Statements</td>
<td>Statements prepared by portfolios to explain the Additional Estimates Budget appropriations in terms of outcomes and programs.</td>
</tr>
<tr>
<td>Portfolio Budget Statements</td>
<td>Statements prepared by portfolios to explain the Budget appropriations in terms of outcomes and programs.</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>Provides the patient with a broad spectrum of care, both preventive and curative, over a period of time and coordinates all of the care the person receives.</td>
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</tr>
<tr>
<td><strong>Prosthesis</strong></td>
<td>An artificial device that replaces a missing body part lost through trauma, disease, or congenital conditions.</td>
</tr>
<tr>
<td><strong>Radiation Oncology</strong> (Radiotherapy)</td>
<td>The study and discipline of treating malignant disease with radiation. The treatment is referred to as radiotherapy or radiation therapy.</td>
</tr>
<tr>
<td><strong>Remote</strong></td>
<td>Used for centres with a population up to 4,999 as identified by the Australian Institute of Health and Welfare.</td>
</tr>
<tr>
<td><strong>Rubella (German Measles)</strong></td>
<td>A highly contagious viral disease which spreads through contact with discharges from the nose and throat of an infected person. Although rubella causes only mild symptoms of low fever, swollen glands, joint pain and a fine red rash in most children and adults, it can have severe complications for women in their first trimester of pregnancy. Complications include severe birth defects or death of the fetus.</td>
</tr>
<tr>
<td><strong>Rural</strong></td>
<td>Used for centres with populations between 5,000 and 99,999 as identified by the Australian Institute of Health and Welfare.</td>
</tr>
<tr>
<td><strong>Stoma</strong></td>
<td>Artificial body opening in the abdominal region, for the purpose of waste removal.</td>
</tr>
<tr>
<td><strong>Telehealth</strong></td>
<td>The delivery of health services using different forms of communications technology such as video conferencing giving access to healthcare services to people in rural and remote areas.</td>
</tr>
<tr>
<td><strong>Tumour</strong></td>
<td>An abnormal growth of tissue in which cell multiplication is uncontrolled and occurs faster than normal tissue growth.</td>
</tr>
<tr>
<td><strong>Varicella (Chicken pox)</strong></td>
<td>A very contagious disease, an affected child or adult may develop hundreds of itchy, fluid-filled blisters that burst and form crusts. Varicella is caused by a virus, varicella-zoster.</td>
</tr>
<tr>
<td><strong>Viral Hepatitis</strong></td>
<td>Inflammation of the liver caused by a virus.</td>
</tr>
</tbody>
</table>
# ACRONYMS

<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP</td>
<td>Aged Care Assessment Program</td>
</tr>
<tr>
<td>ACAR</td>
<td>Aged Care Approvals Round</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
</tr>
<tr>
<td>ACCHO</td>
<td>Aboriginal and Community Controlled Health Organisations</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>ALSMH</td>
<td>Australian Longitudinal Study on Male Health</td>
</tr>
<tr>
<td>ALSWH</td>
<td>Australian Longitudinal Study on Women’s Health</td>
</tr>
<tr>
<td>ANZTPA</td>
<td>Australia New Zealand Therapeutic Products Agency</td>
</tr>
<tr>
<td>APEC</td>
<td>Asia-Pacific Economic Cooperation</td>
</tr>
<tr>
<td>ASGC-RA</td>
<td>Australian Standard Geographical Classification – Remoteness Areas</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Viruses (1.2 Deliverable)</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CDC</td>
<td>Consumer Directed Care</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CT</td>
<td>Computed Tomography</td>
</tr>
<tr>
<td>FFR</td>
<td>Federal Financial Relations</td>
</tr>
<tr>
<td>FOBT</td>
<td>Faecal occult blood test</td>
</tr>
<tr>
<td>FTE</td>
<td>Full-time Equivalent</td>
</tr>
<tr>
<td>FSANZ</td>
<td>Food Standards Australia New Zealand</td>
</tr>
<tr>
<td>GMO</td>
<td>Genetically Modified Organism</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>HHF</td>
<td>Health and Hospitals Fund</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
</tr>
<tr>
<td>IMAP</td>
<td>Inventory Multi-tiered Assessment and Prioritisation</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender and intersex</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>MSAC</td>
<td>Medical Services Advisory Committee</td>
</tr>
<tr>
<td>NBN</td>
<td>National Broadband Network</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
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<tr>
<td>NDSS</td>
<td>National Diabetes Services Scheme</td>
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<tr>
<td>NEHTA</td>
<td>National E-Health Transition Authority</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NHFB</td>
<td>National Health Funding Body</td>
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<tr>
<td>NIP</td>
<td>National Immunisation Program</td>
</tr>
<tr>
<td>NNDSS</td>
<td>National Notifiable Disease Surveillance System</td>
</tr>
<tr>
<td>NPS</td>
<td>National Prescribing Service</td>
</tr>
<tr>
<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OGTR</td>
<td>Office of Gene Technology Regulator</td>
</tr>
<tr>
<td>PBAC</td>
<td>Pharmaceutical Benefits Advisory Committee</td>
</tr>
<tr>
<td>PBPA</td>
<td>Pharmaceutical Benefits Pricing Authority</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PCEHR</td>
<td>Personally Controlled Electronic Health Record</td>
</tr>
<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
</tr>
<tr>
<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
</tr>
<tr>
<td>SCoH</td>
<td>Standing Council on Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infections</td>
</tr>
<tr>
<td>SUSMP</td>
<td>Standard for the Uniform Scheduling of Medicines and Poisons</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>Topic</td>
<td>Page(s)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Aboriginal Australians  see Indigenous Australians</td>
<td>133,135, 137, 138</td>
</tr>
<tr>
<td>Aboriginal and Community Controlled Health Organisations (ACCHO)</td>
<td>133,135</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Chronic Disease Fund</td>
<td>17</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Cultural Awareness Training</td>
<td>233, 271–274</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Outcome</td>
<td>133–139</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Medical Services</td>
<td>174, 177</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Outreach Workers</td>
<td>134–136, 175</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Peoples Alcohol and Other Drugs Knowledge Centre</td>
<td>40</td>
</tr>
<tr>
<td>Aboriginal Community Controlled Health Services</td>
<td>174</td>
</tr>
<tr>
<td>Aboriginal Health Key Performance Indicators</td>
<td>135</td>
</tr>
<tr>
<td>Access and Information Aged Care Program</td>
<td>87–89</td>
</tr>
<tr>
<td>Access to Allied Psychological Services program</td>
<td>166–167</td>
</tr>
<tr>
<td>Access to Medical Services Outcome</td>
<td>23, 72–83</td>
</tr>
<tr>
<td>Access to MRI services</td>
<td>78–79</td>
</tr>
<tr>
<td>Access to Pharmaceutical Services Outcome</td>
<td>22, 58–71</td>
</tr>
<tr>
<td>Accommodation Bonds for aged care</td>
<td>86, 98</td>
</tr>
<tr>
<td>Accommodation Pricing Guidelines</td>
<td>95</td>
</tr>
<tr>
<td>acronyms</td>
<td>206–207</td>
</tr>
<tr>
<td>Activity Based Funding</td>
<td>180, 186</td>
</tr>
<tr>
<td>Acute Care Outcome</td>
<td>25, 180–189</td>
</tr>
<tr>
<td>Additional Medical Internships initiative</td>
<td>176–177</td>
</tr>
<tr>
<td>Adherence to Health Guidelines report</td>
<td>54</td>
</tr>
<tr>
<td>administered items</td>
<td>7</td>
</tr>
<tr>
<td>Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health audit</td>
<td>236–237</td>
</tr>
<tr>
<td>Administration of Government Advertising Arrangements: August 2011 to March 2013</td>
<td>237</td>
</tr>
<tr>
<td>Administration of the GP Super Clinics Program</td>
<td>237</td>
</tr>
<tr>
<td>Administrative Appeals Tribunals</td>
<td>239</td>
</tr>
<tr>
<td>Administrative Arrangements Order</td>
<td>13</td>
</tr>
<tr>
<td>Advisory Committee on the Safety of Vaccines</td>
<td>52</td>
</tr>
<tr>
<td>Aedes albopictus mosquitos</td>
<td>197</td>
</tr>
<tr>
<td>after hours GP Helpline</td>
<td>115</td>
</tr>
<tr>
<td>after hours primary health care, access to</td>
<td>115</td>
</tr>
<tr>
<td>aged care</td>
<td></td>
</tr>
<tr>
<td>Access and Information Aged Care Program</td>
<td>87–89</td>
</tr>
<tr>
<td>Accommodation Bonds for aged care</td>
<td>86, 98</td>
</tr>
<tr>
<td>Aged Care Allocation Principles</td>
<td>101</td>
</tr>
<tr>
<td>Aged Care and Population Ageing Outcome</td>
<td>23, 84–105</td>
</tr>
<tr>
<td>Aged Care Approvals Round</td>
<td>84, 92–93</td>
</tr>
<tr>
<td>Aged Care Assessment Program</td>
<td>87–88</td>
</tr>
<tr>
<td>Aged Care Commissioner</td>
<td>99</td>
</tr>
<tr>
<td>Aged Care Complaints Scheme</td>
<td>19, 97, 99–100, 236</td>
</tr>
<tr>
<td>Aged Care Financing Authority</td>
<td>95</td>
</tr>
<tr>
<td>Aged Care Funding Instrument</td>
<td>94, 98</td>
</tr>
<tr>
<td>Aged Care Gateway Advisory Group</td>
<td>89</td>
</tr>
<tr>
<td>Aged Care Home Finder searches</td>
<td>89</td>
</tr>
<tr>
<td>Aged Care Nurse Practitioner projects</td>
<td>97</td>
</tr>
<tr>
<td>Aged Care Nursing Clinical Placements</td>
<td>97</td>
</tr>
<tr>
<td>Aged Care Reform Implementation Council</td>
<td>99</td>
</tr>
</tbody>
</table>
Aged Care Reform package 153
Aged Care Service Improvement and Healthy Ageing Grants Fund 17, 101
Aged Care Standards and Accreditation Agency Ltd 25
Aged Care Workforce Development Plan 96–97
Aged Care Workforce Fund 17, 97
Aged Care Workforce Strategic Advisory Group 97
Aged Care Workforce Supplement 96
Ageing and Aged Care Data Warehouse 88
Ageing and Service Improvement Program 100–103
Community Aged Care Packages 92
culturally appropriate 95
Extended Aged Care at Home places 92
fairness and flexibility in 94
growth in funding for 86
Guiding Principles for Medication Management in Residential Aged Care Facilities 66
Indigenous Australians 95–96
Living Longer Living Better aged care reforms 262
Managing Aged Care Complaints audit 236
My Aged Care website 84, 87, 89, 102, 262
National Aged Care Alliance 89, 92, 99
National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse backgrounds 84, 101–102, 262
National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy 101, 262
performance measurement 85
responsibility for transferred to Social Services 13
Senate Community Legislation Committee Inquiry into the Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related Bills 87
Supply and Claiming from a Medication Chart in Residential Aged Care Facilities 58, 61
Teaching and Research Aged Care Service models 97
training in 97
Agency Multicultural Plan 263
Agency Resource Statement 200–201
Alan Walker Cancer Care Centre 148
alcohol use control 39
Alzheimers disease, drug treatments for 58, 67
Anatomical Therapeutic Chemical Groups 445–447
Andrology Australia 56
Anthrax and Radiological Guidelines 192
anticoagulation therapies in atrial fibrillation 58, 67
antimicrobial resistance 5, 198
app development 19
APS Bargaining Framework 246
APS Code of Conduct 249
APS Values 249
asbestos elimination 155
Asia Pacific Economic Cooperation Health Working Group 155
Asia Pacific Malana Summit 155
atrial fibrillation, drug treatments 58, 67
Attracting More People to Work in Indigenous Health campaign 271
Audit and Compliance Framework 127–128
Audit and Fraud Control Branch 234–236
INDEX

Audit Committee 232, 281
Audit Work Plan 234
Auditor-General’s opinion 7
Australasian College of Emergency Medicine 176
Australia
  death rates due to cancer 5
  health fund membership 142
  lifestyle health risks 1
  National Immunisation Program 1, 3–4
Australia New Zealand Therapeutic Products Agency 44–45
Australian Antimicrobial Resistance Prevention and Containment Steering Group 5, 190
Australian Bone Marrow Donor Registry 182
Australian Breastfeeding Association 154
Australian Bureau of Statistics 54, 263
Australian Childhood Immunisation Register 51
Australian Clinical Dosimetry Service 82–83
Australian College of Rural and Remote Medicine 119
Australian Commission on Safety and Quality in Health Care 25, 100, 111, 156
Australian Dietary Guidelines 28
Australian General Practice Training Program Australian 173
Australian Government Cost Recovery Guidelines 438–439
Australian Government Hearing Services Program 124
Australian Guidelines to Reduce Health Risks from Drinking Alcohol 39
Australian Health Management Plan for Pandemic Influenza 193
Australian Health Ministers’ Advisory Council 151, 153
Australian Health Protection Principal Committee 194
Australian Health Service Safety and Quality Accreditation Scheme 156
Australian Health Survey 28–29, 53–54, 236
Australian Hearing 126
Australian Immunisation Handbook, new edition of 52
Australian Information Commissioner 240
Australian Institute of Health and Welfare 25, 136, 153
Australian Longitudinal Study on Male Health 54–55
Australian Longitudinal Study on Women’s Health 54
Australian Medical Assistance Team arrangements 194
Australian Medicare Local Alliance 106, 108, 111
Australian Medicines Handbook Children’s Dosing Companion 66
Australian National Audit Office 97, 232, 236, 242–243, 281
Australian National Breastfeeding Strategy 153
Australian National Preventive Health Agency 25, 236
Australian Nurse Family Partnership program 137
Australian Organ and Tissue Donation and Transplantation Authority 25, 182
Australian Pesticides and Veterinary Medicines Authority 194
Australian Prescriber publication 158
Australian Prudential Regulation Authority’s Minimum Capital Requirement 185
Australian Public Service... see APS...
Australian Radiation Protection and Nuclear Safety Agency 25
Australian Red Cross Society 192
Australian Register of Therapeutic Goods 43
Australian Therapeutic Goods Advisory Council 44
Australian Workplace Agreements 246
Australians overseas, medical aid for 76–77
avian influenza 3–4, 155, 194

Baggoley, Chris 3–6, 3, 12
Ballarat Regional Integrated Cancer Centre 148
Barbeler, John 7–9, 7, 281
Better Access to Psychiatrists, Psychologists and General Practitioners program 167
Better Access to Radiation Oncology Grant Program 82, 148
Better Health Care Connections 95
Better Regulation Ministerial Partnership 45
BioCSL 51, 192
Biosecurity and Emergency Response Outcome 25, 190–199
Blood and Organ Donation Services Program 182–184
blood borne viruses 36–37
Bone Marrow Transplant Program 182
Boundless Canberra 2
bowel cancer 5–6, 28, 31–32
Brand Premium Policy 447
breast cancer 5–6, 32–33, 150
breastfeeding, support for 153–154, 261
BreastScreen Australia 5, 32–33, 150
Budget and Forecasting Improvement project 233
bulk-billing for pathology services 81
Business Continuity Plan 233

Canberra Hospital 186
cancer prevention, screening and treatment
  bowel cancer 5–6, 28, 31–32
  breast cancer 5–6, 32–33, 150
Cancer Australia 25
Cancer Centres 148–149
CanTeen Youth Cancer Networks 146
cervical cancer 5–6, 33–34, 51–52
  early screening initiatives 31–34
  impact of early diagnosis and screening 5–6
  new medicines to treat 64
Capability Development Strategy 245
Capability Needs Analysis 247
Care Aware Workplaces 261
Care Coordination and Supplementary Services Program 134
carer recognition 261–263
Carers Australia 91
Carers Week 261
Case Definition Working Group 197
Certificate of Compliance 241
cervical cancer 5–6, 33–34, 51–52
chemical safety 195
Chief Financial Officer’s Report 7–9
Chief Medical Officer’s Report 3–6
INDEX

children
Australian Childhood Immunisation Register  51
Australian Medicines Handbook Children’s Dosing Companion  66
Child eHealth Records  19, 146
improving health of  55
Indigenous child vaccination rates  3
Indigenous Early Childhood Development National Partnership Agreement  136–137
Kidsmatter Primary Initiative  167–168
mental health care delivery  167–168
mortality rates  264–265
mortality rates of Indigenous children  130, 132, 136–137
National Clinical Assessment Framework for Children and Young People in Out–of–home Care  55
Standing Committee on Child and Youth Health  55
chlamydia infections, notifications and treatment  37
cholesterol levels  54
Chris O’Brien Lifehouse  149
chronic disease management and support
  Chronic Disease Prevention and Service Improvement Fund  17, 30–31
  Chronic Disease – Radiation Oncology Program  82–83
  Chronic Disease – Treatment Program  148–150
diabetes  35
Clinical Practice Guidelines for Antenatal Care  55
Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children  28
Clinical Services Plan  183
Codex Committee on Food Labelling  41
Comcover – Better Practice Guide: Risk Management  235
common law employment contracts  246
Commonwealth Disability Strategy  263
Commonwealth Grant Guidelines  237
Commonwealth Home and Community Care Program  84
Commonwealth Home Support Program  90–91
Commonwealth Ombudsman  236, 240
Commonwealth Procurement Guidelines  242
Commonwealth Respite and Carelink Centres  91
Commonwealth Supported Places  176
communicable disease prevention and control  36–37
  Communicable Disease Prevention and Service Improvement Grants Fund  17, 36
  Communicable Diseases Intelligence publication  197–198
  Communicable Diseases Network Australia  4, 197
  minimising risks of  196–198
Community Aged Care Packages  92
Community Health Grants Program  112
community health, highlights iii
Community Pharmacy and Pharmaceutical Awareness  60–62
community relations  19
Community Service Obligation Program  126
Community Visitors Scheme  97–98
Competition and Consumer (Tobacco) Information Standard  2011:  37
Complaint Handling Toolkit  99
Comprehensive Management Framework for the Medicare Benefits Schedule  72
Confidentiality in Government Contracts: Senate Order for Departmental and Agency Contracts 237
consultants 242
consumers
  Consumer Directed Care  93
  empowerment of  97
  Private Health Insurance information for  143–144
  submissions to PBAC  63
contact information  v, 230
Continued Dispensing of PBS Medicines in Defined Circumstances  61
Continuous Quality Improvement Investment Strategy  138
Control of Credit Card Agencies’ Implementation of Performance Audit Recommendations  237
Control of Credit Card Use audit  237
controlled substances management  195–196
Convention on Psychotropic Substances  195
Cooperative Chemical Assessment Program  46
copyright statements  v, 230
coronary heart disease, Indigenous Australians with  135–136
corporate governance  232–235
Corporate Leadership Council  248
Criminal and Terrorism Incident Annex  192
Critical Role Skills Development Framework  245
cross agency audits  237
culturally appropriate aged care  95

Data Governance Council  234
dementia support services  92, 100
dental care services
  Dental Training – Expanding Rural Placements Program  178
  for Indigenous Australians  188
  improving access to  188
  Medicare Chronic Disease Dental Scheme  76
  Medicare Teen Dental Plan  76
  National Partnership Agreements  180, 188
  preventative dental checks  76
  Voluntary Dental Graduate Year Program  170, 178
Department of Regional Australia, Local Government, Arts and Sport  13
Department of Social Services  13
Departmental Activity Survey  17, 233
departmental structure  14–16, 251–252
development  247–248
Di Marco, Nino  18
diabetes
  aids and appliances to assist with  68–70
  among Indigenous Australians  135–136
  Diabetes Care project  35
  Diabetes MedsChecks Program  58, 62
  National Diabetes Services Scheme  68–69
  prevalence of  54
Diagnostic Imaging Accreditation Scheme  80
Diagnostic Imaging Quality Program  79
Diagnostic Imaging Services Program  78–80
INDEX

diphtheria, results of immunisation program  4
disability, addressing  233, 261–263
DisabilityCare Australia  124, 126
Disaster Health Care Assistance Schemes  76–77
Disaster Recovery Plan  233
Disclosure Log  240
DNA  2, 17–18, 246
DoHA National Alignment [DNA]  2, 17–18, 246
Domestic Response Plan for Mass Casualty Incidents of National Consequence  192
Drug Strategy programs  37–40
Drug Utilisation Sub-Committee  439
Dutton, Peter, becomes Minister for Health  ix, 13
Dystrophic Epidermolysis Bullosa Research Association  69

Early Intervention Pilot Program for under-age drinkers  39
Early Psychosis Prevention and Intervention Centre  162, 165
Early Warning System for therapeutic products  45
Earth Hour 2013:  269
Ecologically Sustainable Development  268–270
Economics Sub-Committee  439, 444
Edith Cowan University  40
eHealth Implementation Program  151–153
eHealth Memorandum of Understanding  151
eHealth Working Group  151
elective surgery  187
Employee Assistance Program  262
Employment Principles  249
energy consumption  269
Enterprise Agreements  246, 253, 259, 261
Enterprise Data Warehouse  8
Enterprise Risk Management Plan  235
Environmental Management System  268
Epidermolysis Bullosa Dressing Scheme  68–70
Essential Vaccine Procurement Strategy  52
ethical standards  249
Executive Committee  232
Executive Group  12
exempt contracts  243
Existing Chemicals Program  45
Expanded and Accelerated Price Disclosure Program  58, 66
expenses  8, 277, 279
Extended Aged Care at Home places  92
Extended Placement Year program  175
external liaison and scrutiny  236–240

Facebook use  19
fairness in aged care  94
Family Tax Benefit, immunisation linked to  50, 52
Federation of Ethnic Communities’ Councils of Australia  102
female genital mutilation, action on  56
Fetal Alcohol Spectrum Disorders  39
Fifth Community Pharmacy Agreement  60–62
Finance, Risk and Security Committee  233, 235, 241
financial management  iii, 7–9, 241–244
financial performance  277–280
Financial Resource Summary
  Acute Care Outcome  189
  Access to Pharmaceutical Services Outcome  71
  Access to Medical Services Outcome  83
  Aged Care and Population Ageing Outcome  104–105
  Biosecurity and Emergency Response Outcome  199
  Health System Capacity and Quality Outcome  160–161
  Health Workforce Capacity Outcome  179
  Hearing Services Outcome  129
  Indigenous Health Outcome  139
  Mental Health Outcome  169
  Population Health Outcome  56–57
  Primary Care Outcome  117
  Private Health Outcome  145
  Rural Health Outcome  123
Financial Statements  281–435
Financial Statements Sub-Committee  281
flexibility in aged care  94
flexible funds  17
Food Regulation policy  40–42
Food Standards Australia New Zealand  26, 41
Fourth National Mental Health Plan  153, 164
Freedom of Information  240
front-of-pack labelling system  41–42

Gateway Consultation Forum  89
gender; staff numbers by  251
Gene Technology Regulator  48–49, 268
General Awareness Training  169
General Practice Education and Training Ltd  26, 173
General Practice Procedural Training Support Program  174
General Practice Rural Incentives Program  174
General Purpose Financial Reports  98
Generic Medicines Are An Equal Choice campaign  158
Genetics Working Party  81
Global Burden Of Disease study  1
glossary  203–205
Good Manufacturing Practice regulations  43, 45
Gooley, Anne  96
Governance Enhancement Working Group  138
GP Management Plans  135
GP Rural Incentives Program  170
GP Super Clinics Program  106, 113–114, 237
Graduate Development Program  19, 248
Graduate Diploma in Mammography  33
Graduate Nurse Placements  97
Grafton GP Super Clinic  114
grant reform 18
grants awarded by Department 242
Grants Services Division 18

Guiding Principles for Medication Management in Residential Aged Care Facilities 66

H7N9 avian influenza 3–4, 155, 194

Haemophilus influenzae type b infections 3

Halton, Jane 1, 12, 281

Certification of Departmental Fraud Control Arrangements 235

Chairs WHO Executive Board 155

letter of transmittal ix

Secretary's Review 1–2

Hartley Lifecare 2

headspace youth friendly service sites 165

Health, Chemical Biological Radiological and Nuclear Incidents of National Consequence Plan 192

Health and Hospitals Fund 146, 148, 156, 159

Health and Life Strategy 259

Health Emergency Planning and Response Program 192–198

Health Information Program 153–154

Health Infrastructure Program 159

Health Project Officers 135

Health Protection Fund 18

Health Social Surveys Fund 17

Health Surveillance Fund 18, 157

Health System Capacity and Quality Outcome 24, 146–161

Health System Capacity Development Fund 17

Health Workforce Australia 26

Health Workforce Capacity Outcome 24, 170–179

Health Workforce Fund 18

Healthy Ageing Grants Fund 100

Healthy Communities Initiative 56

healthy lifestyle choices, promoting 56

Healthy Lifestyle Workers 133

Hearing Loss Prevention Program 128

Hearing Services Outcome 23, 124–129

Hepatitis C infections 37, 64, 183

high risk implantable medical devices 157–158

high-cost medicines 63

HIV infections, increasing rates of 37

Home and Community Care Program 90

Home Care Packages Program 84, 92–94, 97–98, 262

Home Medicines Review Program 62

How Australia Is Faring report 263

Human Papillomavirus surveillance system 157

Human Papillomavirus vaccination program 28, 34

human resource policies 261–262

ICT Sustainability Plan 269

immunisation see National Immunisation Program

Implementation Sub-committee 41–42

Improving Wellness and Motivation in the Workplace program 259, 261
Indemnity Insurance Fund 18
Independent Hospital Pricing Authority 26, 186

Indigenous Australians
  Aboriginal and Community Controlled Health Organisations (ACCHO) 133, 135, 137, 138
  Aboriginal and Torres Strait Islander Chronic Disease Fund 17
  Aboriginal and Torres Strait Islander Cultural Awareness Training 233, 271–274
  Aboriginal and Torres Strait Islander Health Outcome 133–139
  Aboriginal and Torres Strait Islander Medical Services 174, 177
  Aboriginal and Torres Strait Islander Outreach Workers 134–136, 175
  Aboriginal and Torres Strait Islander Peoples Alcohol and Other Drugs Knowledge Centre 40
  access to dental care 188
  aged care services 95–96
  Attracting More People to Work in Indigenous Health campaign 271
  child vaccination rates 3
  closing gap with 264–266
  communicable disease control among 36
  cord blood donations from 183
  drug knowledge campaigns 40
  hearing loss prevention and treatment 128
  in rural and remote areas 137–138
  Indigenous Chronic Disease Package 130, 133, 134
  Indigenous Early Childhood Development National Partnership Agreement 136–137
  Indigenous Health Incentive 116, 135
  Indigenous Health Outcome 24, 130–139
  Indigenous Health Partnership Forums 120
  Indigenous Health Project Officers 135
  Indigenous Pathways Programs 248
  Indigenous Registered Training Organisations 133
  Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Program 134
  Medical Outreach – Indigenous Chronic Disease program 134
  Mobile Indigenous Dental Pilot projects 188
  mortality rates 1, 130, 132, 136–137
  National Aboriginal and Torres Strait Islander Flexible Aged Care Program 95–96
  National Aboriginal and Torres Strait Islander Health Equality Council 138
  National Aboriginal and Torres Strait Islander Health Plan 138
  National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 162, 168
  National Partnership Agreements 133
  Regional Tackling Indigenous Tobacco and Healthy Lifestyle Teams 133
  suicide prevention activities 168
  tobacco control campaigns 38, 133
  training in aged care 97
  vaccination rates 50
  with coronary heart disease 135–136
  with diabetes 135–136
  Individual Flexibility Arrangements 247, 252–253
  industrial chemicals regulation 28, 45–47
  Influenza Surveillance Strategy Working Group 197
  influenza vaccine supplies 50–51
  Information, Knowledge and Technology Committee 234
  Information and Communications Technology Program 248
INDEX

Information and Communications Technology Workforce Plan  245
Information Publication Scheme  240
Integrated Good Manufacturing Practice Inspections  43, 45
internal audit arrangements  234–235
Internal Audit Work Plan  232
International Health Regulations  156, 198
International Narcotic Control Board  195
International Policy Engagement Program  154–156
International Recruitment Strategy  177
Inventory Multi-tiered Assessment and Prioritisation Framework  28, 45–46
IT Strategy  234

Jean Hailes Foundation  56
Joint Committee of Public Accounts and Audit  239
Joint Medicine and Medical Device Adverse Notifications Databases  45
judicial decisions  239
Jurisdictional Blood Committee  183

Key Business Process Reform  280
key business reforms, CFO's Report  8
Kidsmatter Primary Initiative  167–168
Kinghorn Cancer Centre  149

Labelling Logic: Review of Food Labelling Law and Policy  41
Leadership Insight Groups  248
learning and development  247–248
Legislative and Governance Forum on Food Regulation  41
letter of transmittal ix
liabilities, trends in  9
Life Saving Drugs Program  65, 67–68
Lifetime Health Cover  140, 142–144
List of Requirements  450–453
Living Longer Living Better aged care reforms  262
Living Longer Living Better; Tackling Dementia package  100
Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Program  134
Local Hospital Networks  180, 186

machinery of government changes  13
magnetic resonance imaging scans, access to  72, 78–80
Male Health Reference Group  56
Managing Aged Care Complaints audit  236
market research  271–274
Mason Review of Health Workforce Programs  175
maternity services reform  153–154
McGrath Foundation Breast Care Nurses Program  146, 150
McPhee, Ian  281
Medical Indemnity Data Working Group  185
Medical Indemnity National Collection  185
Medical Indemnity Program  184–186
Medical Insurance Group Australia  185–186
Medical Outreach – Indigenous Chronic Disease program 134
Medical Services Advisory Committee 72, 74, 184
Medical Treatment Overseas Program 78
Medicare Benefits Schedule 74
Medicare Chronic Disease Dental Scheme 76
Medicare for All campaign 271
Medicare Locals network 106–112
  Accreditation Standards and Guidelines 111
  After Hours Program 115
  extent of 1
    mental health care delivery by 162, 164, 167
Medicare Services Program 74–76
Medicare Teen Dental Plan 76
Medicines and Medical Devices Safety Authority (NZ) 44
Medicines Australia, Memorandum of Understanding with 66
MedsChecks program 58, 62
Men's Health Week 56
Mental Health Nurse Incentive Program 177–178
Mental Health Outcome 24, 162–169
Mental Health Services, use of 266–267
Middle East Respiratory Syndrome coronavirus 4, 155, 196
Middle Managers’ Development Program 233, 248
Midwife Professional Indemnity Scheme 185–186
MindSpot virtual clinic 166
Minimum Hearing Loss Threshold 127
ministerial responsibilities 20–21
Mobile Indigenous Dental Pilot projects 188
mobile x-ray service 112
More Doctors and Nurses for Emergency Departments Program 176
mortality rates
  among Indigenous Australians 1, 130, 132, 136–137
  as indicator 264–265
  due to cancer 5, 6
  reducing 30
Moruya Hospital 186
mosquitoes 197
Multidisciplinary Care Coordination and Advisory Services 95
Murray to Mountain intern program 175
My Aged Care website 84, 87, 89, 102, 262
my child's eHealth record app 19
My Hospitals website 144

Nash, Fiona, as Assistant Minister for Health 13
National Aboriginal and Torres Strait Islander Flexible Aged Care Program 95–96
National Aboriginal and Torres Strait Islander Health Equality Council 138
National Aboriginal and Torres Strait Islander Health Plan 138
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 162, 168
National Accreditation Standards, BreastScreen Australia 33
National Acoustic Laboratories 128
National Aged Care Alliance 89, 92, 99
National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse backgrounds  84, 101–102, 262
National AMR Prevention and Containment Strategy  5
National Arbovirus and Malaria Advisory Committee  197
National Assessment Framework and tool  87
National Australian Built Environmental Rating System  269
National Authentication Service for Health  152
National Blood Authority  26, 183
National Blood Borne Viruses and Sexually Transmissible Infections Strategies  36–37
National Bowel Cancer Screening Program  5–6, 28, 31–32
National Breastfeeding Helpline  154
National Broadband Network  152–153
National Cannabis Prevention and Information Centre  40
National Carer Awareness Initiative  261
National Carer Counselling Program  91
National Carer Strategy  262
National Centre for Education and Training on Addiction  40
National Cervical Screening Program  5–6, 33–34
National Clinical Assessment Framework for Children and Young People in Out-of-home Care  55
National Compact on female genital mutilation  56
National Cord Blood Collection Network  182–183
National Critical Care and Trauma Response Centre  192
National Dementia Support Program  100
National Diabetes Services Scheme  68–69
National Disability Insurance Scheme  90, 127, 233
National Disability Strategy  263
National Drug and Alcohol Research Centre  40
National Drug Research Institute  40
National Drug Strategy  38–40
National Efficient Cost and Price determinations  186
National E-Health Transition Authority  81, 151
National Elective Surgery Targets  187
National Electronic Recording and Reporting of Controlled Drugs Supply  61
National Emergency Access Targets  187
National Enhanced Listeriosis Surveillance System  197
National External Breast Prostheses Reimbursement Program  77
National Health Act 1953:  438–440
National Health and Medical Research Council  26, 128, 144
National Health Emergency Response Arrangements  192
National Health Funding Body  22, 26
National Health Funding Pool  180
National Health Performance Authority  26, 144
National Health Reform Agreement  186
National Health Services Directory  19, 106, 113, 122
National Human Papillomavirus Vaccination Program  51–52
National Immunisation Committee  51
National Immunisation Program
  cost recovery from  439
  monitoring  157, 443
  public confidence in  28
  success of  1, 3
support for 50–53
trends in 30
National Immunisation Strategy 51
National Industrial Chemicals Notification and Assessment Scheme 28, 45–47
National Influenza Surveillance Scheme 196
National Institutional Biosafety Committee Forum 48
National Joint Replacement Registry 143
National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy 84, 101, 262
National Maternity Services Plan 153–154
National Medical Stockpile 7, 192
National Medicines Policy 66
National Mental Health Commission 164
National Minimum Training Standards 88
National Notifiable Disease Surveillance System 37, 196–197
National Partnership Agreements
  on Closing the Gap in Indigenous Health Outcomes 133
  on Essential Vaccines 50, 52
  on Financial Assistance for Long Stay Older Patients 96
  on Improving Public Hospital Services 186–187
  on Preventive Health 236
  on Supporting National Mental Health Reform 164
  on Treating More Public Dental Patients 180, 188
National Pathology Accreditation Council 80
National Prescribing and Dispense Repository 146
National Prescribing Service (NPS) 158
National Primary Health Care Strategic Framework 106, 112–113
National Product and Services List 184
National Product Catalogue 152
National Protocol for Program Action 52
National Registration and Accreditation Scheme 185
National Residential Medication Chart 61
National Respite for Carers Program 91
National Return and Disposal of Unwanted Medicines program 146, 158
National Rural and Remote Health Infrastructure Program 120–121
National Shed Development Program 56
National Standing Council on Health 112
National Strategic Framework for Rural and Remote Health 122
National Suicide Call Back Service 168
National Suicide Prevention Program 168–169
National Supply Plan and Budget 184
National Surveillance Committee 197
National Tobacco Campaign 271
National Tobacco Strategy 38, 153
Natural Therapy Review Advisory Committee 144
NBN Enabled Telehealth Pilots Program 152–153
Neumann, Shayne, ministerial responsibilities 21
New Chemicals assessments 47
New Directions: Mothers and Babies Services 137
Non Government Organisations Treatment Grants Program 39
non-salary benefits 257
notifiable incidents 260
NPS (National Prescribing Service)  158
NSW Central Coast Medicare Local  112
Nursing and Allied Health Scholarship and Support Scheme  153
Nursing and Midwifery Board of Australia  153

obesity, control and treatment of  1, 28, 54, 265
OCHREStreams  139
OECD
- Chemicals Committee  46
- Clearing House on New Chemicals  46
- Health Committee  155
- Task Force on Hazard Assessment  46
- Working Party on Manufactured Nanomaterials  46
Office of Chemical Safety  195
Office of the Gene Technology Regulator  48, 268
Optimising Performance initiative  246
otitis media infections, treatment of  128
outcomes, highlights  i–ii
out-of-home care, delivery of health services in  55
overseas recruitment of doctors  177
Over-the-Counter Medicine Reforms  45
overview of the Department  iv, 13
OzFoodNet  196–197

Pacific Senior Health Officials Network meeting  154
Parke, Melissa, ministerial responsibilities  21
parliamentary scrutiny  237–240
Partners in Recovery initiative  164
Pathology Funding Agreement  72, 80–81
Pathology Services Program  80–81
People Capability Framework  245–246
People Committee  233
people deferring recommended treatment  266
people management  iii, 245–249  see also staffing
People Strategy Action Plan  233, 248
Performance Development Scheme  245, 247
performance measurement
- Access to Medical Services Outcome  73
- Access to Pharmaceutical Services Outcome  59
- Acute Care Outcome  181
- Aged Care and Population Ageing Outcome  85
- Biosecurity and Emergency Response Outcome  191
- Health System Capacity and Quality Outcome  147
- Health Workforce Capacity Outcome  171
- Hearing Services Outcome  124
- Indigenous Health Outcome  130
- Mental Health Outcome  163
- Population Health Outcome  29
- Primary Care Outcome  107
- Private Health Outcome  141
- Rural Health Outcome  118
performance pay arrangements  247, 258
Personally Controlled Electronic Health Record  7, 146, 151–152
pertussis, results of immunisation program  4
Pharmaceutical Benefits Scheme
  cost of  447
  extensions to  58–59
  extent of  1, 62–67
  Pharmaceutical Benefits Advisory Committee  438–443
  Pharmaceutical Benefits Pricing Authority  439, 443–449
  Pharmaceutical Evaluation Branch  444
  processes leading to consideration for  438–442
Pharmaceuticals and Pharmaceutical Services  62–67
Pharmacy Practice Incentives Program  62
Plibersek, Tanya
  ministerial responsibilities  20
Policy Advisory Group  233
poliomyelitus, results of immunisation program  4
Population Health Outcome  22, 28–57
portfolio agency-specific outcomes  25–26
portfolio outcomes  22–26
Post-Market Monitoring program  158
potentially preventable hospitalisations  266
Practice Incentives Programs
  eHealth Incentive  116, 151
  General Practices Fund  17
  Indigenous Health Incentive  116, 135
  Primary Care  116
Practice Managers  136
Practice Nurse Incentives Program  174
Premium Support Scheme  185
Prevention, Early Detection and Service Improvement Program  30–35
Prevocational General Practice Placements Program  173
Price Disclosure Program  65–66
Pricing Framework  186
primary health care
  coordination and integration of  112–113
  Primary Care Education and Training Program  108
  Primary Care Financing, Quality and Access Program  108–115
  Primary Care Infrastructure Grants  106, 115
  Primary Care Outcome  23, 106–117
  Primary Care Practice Incentives  116
  Primary Health Care Strategic Framework  153
Priority Existing Chemicals  45
Private Health Insurance Administration Council  26, 144
Private Health Insurance Ombudsman  26
Private Health Insurance Program  142–145
Private Health Outcome  24, 140–145
productivity gains  248–249
Professional Services Review  26
Prostheis List  141, 143
Public Health programs  53
INDEX

Public Hospitals and Information Program 186–188
purchasing 242

Quality Indicators Reference Group 99
Quality Use in Pathology Program 80
Quality Use of Diagnostics, Therapeutics and Pathology Fund 17,158
Quit for You, Quit for Two app 19

R U Ok? Day 168
Radiation Oncology Health Program Grants Scheme 82
Rational Assessment of Drugs and Research publication 158
Recalls Portal 45
Reciprocal Health Care Agreements 76–77
recommended treatment, people deferring 266
regional and remote Australia see rural and remote areas
Regional Priority Round 159
Regional Tackling Indigenous Tobacco and Healthy Lifestyle Teams 133
Regional Tackling Smoking and Healthy Lifestyle Teams 133
Regional Tobacco Coordinators 133
Regional Training Providers 173
Regionally Tailored Primary Care Initiatives through Medicare Locals Fund 17
Regulators Community of Practice Forum 49
Regulatory Impact Statement, industrial chemicals regulation 45
Regulatory Policy programs 40–49
Regulatory Science Network 49
Rehabilitation Management System 260
Rehabilitation Plus, review of 128
remote and regional service delivery see rural and remote areas
Remote Area Health Corps 138
Remote Vocational Training Scheme 174
remuneration
non-salary benefits 257
performance pay arrangements 247,258
salary structures 254–256
Senior Executive Staff 246–247,252,257
Repatriation Pharmaceutical Benefits Scheme 446
Research Capacity and Quality Program 156–158
Residential and Flexible Care Program 94–96
Residential Medication Management Review Program 62
resource efficiency 269–270
revenue, trends in 8
Review of Australia’s Health Sector Response to Pandemic (H1N1) 2009: 193
Review of Funding for Diagnostic Imaging 78,80
Review of Health Technology Assessment in Australia 141
Review of the management of adverse events associated with Panvax® and Fluvax® 52
Risk Analysis Framework, revision of 48
Risk Management Framework 233–235
Risk Management Improvement Roadmap 233
Royal College of Pathologists of Australia 81
Royal Flying Doctor Service 2,18,118–121
Run-off Cover Scheme 185
rural and remote areas
  approved pharmacies in  60, 62
  Indigenous Australians located in  137–138
  Regional Priority Round  159
  Regional Tackling Indigenous Tobacco and Healthy Lifestyle Teams  133
  Regional Tackling Smoking and Healthy Lifestyle Teams  133
  Regional Tobacco Coordinators  133
  Regional Training Providers  173
  Regionally Tailored Primary Care Initiatives through Medicare Locals Fund  17
  Remote Area Health Corps  138
  Remote Vocational Training Scheme  174
  Rural and Regional Health Australia Information Service  118, 120, 122
  Rural Clinical Schools Program  174–176
  Rural Clinical Training and Support program  176
  Rural Health Outcome  23, 118–123
  Rural Health Outreach Fund  17, 118–120
  Rural Health Services Program  119
  Rural Health Standing Committee  122
  Rural Health Workforce Australia  177
  Rural Relocation Incentive Grant program  174
  Rural Women’s GP Service  120–121
  Rural Workforce Agency network  177
  telehealth services  75

*Safety, Rehabilitation and Compensation Act 1988:  259*
Saibai Island  36
salary structures  254–256
Sanofi-Aventis challenge to price disclosure reductions  66
SARS virus  4
Secretary  see Halton, Jane
Secretary’s Review  1
Senate Committees  87, 238
Senior Executive Staff
  non-salary benefits  257
    working conditions and remuneration  246–247, 252
severe acute respiratory syndrome  4
sexually transmissible infections  36–37
Short-Term Intensive Healthcare Innovative Models  95
Single Convention on Narcotic Drugs  195
Single Desk Trial  18
Single Point of Contact for Health Information, Advice and Counselling Fund  17
Smallpox Guidelines  192
smoking, treatment of  see tobacco control
Snowdon, Warren, ministerial responsibilities  21
Social and Emotional Wellbeing Program  133
social inclusion, indicators of  263–264
social media use  19
Socio-Economic Indexes for Areas  264
Sorell GP Super Clinic  113
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>spatial reporting</td>
<td>244</td>
</tr>
<tr>
<td>Special Patient Contributions</td>
<td>447–448</td>
</tr>
<tr>
<td>Specialist Training Program</td>
<td>172–173</td>
</tr>
<tr>
<td>Specified Care and Services Schedule, review of</td>
<td>94</td>
</tr>
<tr>
<td>sport and recreation, responsibility for transferred to Department</td>
<td>13</td>
</tr>
<tr>
<td>staff retention</td>
<td>245</td>
</tr>
<tr>
<td>Staff Survey</td>
<td>245, 248–249</td>
</tr>
<tr>
<td>staffing information</td>
<td>250–258</td>
</tr>
<tr>
<td>Stage One chemicals</td>
<td>47</td>
</tr>
<tr>
<td>Stakeholder Advisory Group</td>
<td>138</td>
</tr>
<tr>
<td>Standard for the Uniform Scheduling of Medicines and Poisons</td>
<td>194–196</td>
</tr>
<tr>
<td>StandBy Suicide Bereavement Response Service</td>
<td>168</td>
</tr>
<tr>
<td>Standing Committees</td>
<td></td>
</tr>
<tr>
<td>on Child and Youth Health</td>
<td>55</td>
</tr>
<tr>
<td>on Health</td>
<td>153</td>
</tr>
<tr>
<td>on Health and Ageing</td>
<td>239</td>
</tr>
<tr>
<td>on Petitions</td>
<td>239</td>
</tr>
<tr>
<td>on Screening</td>
<td>33</td>
</tr>
<tr>
<td>on Social Policy and Legal Affairs</td>
<td>239</td>
</tr>
<tr>
<td>State and Territory, staff numbers by</td>
<td>252</td>
</tr>
<tr>
<td>Statement for Australia's Carers</td>
<td>261</td>
</tr>
<tr>
<td>Stephanie Alexander Kitchen Garden National Program</td>
<td>56</td>
</tr>
<tr>
<td>Stoma Appliance Scheme</td>
<td>69</td>
</tr>
<tr>
<td>Stoma Product Assessment Panel</td>
<td>69</td>
</tr>
<tr>
<td>strategic change indicators of social inclusion</td>
<td>264–267</td>
</tr>
<tr>
<td>Strategic Review of Health and Medical Research in Australia</td>
<td>157</td>
</tr>
<tr>
<td>strategic risk assessment</td>
<td>235</td>
</tr>
<tr>
<td>Strategic Workforce Advisory Group</td>
<td>96</td>
</tr>
<tr>
<td>Strengthen the Provision of Quality Diagnostic Radiology Services initiative</td>
<td>80</td>
</tr>
<tr>
<td>Streptococcus bacteria</td>
<td>vi</td>
</tr>
<tr>
<td>Stronger Futures in the Northern Territory initiative</td>
<td>138</td>
</tr>
<tr>
<td>subacute care services</td>
<td>187</td>
</tr>
<tr>
<td>Substance Misuse Prevention and Service Improvement Grants Fund</td>
<td>17</td>
</tr>
<tr>
<td>Substance Misuse Service Delivery Grants Fund</td>
<td>17, 39</td>
</tr>
<tr>
<td>suicide prevention activities</td>
<td>162, 168–169</td>
</tr>
<tr>
<td>Supply and Claiming from a Medication Chart in Residential Aged Care Facilities</td>
<td>58, 61</td>
</tr>
<tr>
<td>Support for Day to Day Living in the Community program</td>
<td>164–165</td>
</tr>
<tr>
<td>Supporting Leave for Living Organ Donors initiative</td>
<td>182</td>
</tr>
<tr>
<td>Surgery Connect Program</td>
<td>186</td>
</tr>
<tr>
<td>Surveillance Plan for Pandemic Influenza</td>
<td>193</td>
</tr>
<tr>
<td>sustainability</td>
<td>280</td>
</tr>
<tr>
<td>Tackling Dementia Package</td>
<td>100</td>
</tr>
<tr>
<td>Taking Action to Tackle Suicide program</td>
<td>168</td>
</tr>
<tr>
<td>Talent Management Strategy</td>
<td>245</td>
</tr>
<tr>
<td>targeted assistance programs</td>
<td>67–70, 76–78</td>
</tr>
<tr>
<td>Tasmanian Health Assistance Package</td>
<td>111, 173</td>
</tr>
</tbody>
</table>
### Tasmanian Medicare Local  111
### Teaching and Research Aged Care Service models  97
### Team Care Arrangements  135
### Technical Reference Group  126

**telehealth**
- initiatives  152–153
- specialists in  74–75
  - Telehealth Support Program  176
- training in  177

**Ten Year Roadmap for National Mental Health Reform**  162, 164

**tetanus, results of immunisation program**  4

**TGA Reform Blueprint**  44

**Therapeutic Goods Administration**  43

**Therapeutic Goods Regulations 1990:**  195

**Therapeutic Group Premium Policy**  447

**therapeutic relativities**  445

**Tilpa, woman injured and treated by RFDS**  121

**tobacco use control**
- among Indigenous peoples  133
- effect of programs  37–39
- indicators of smoking  265
  - National Tobacco Campaign  271
  - National Tobacco Strategy  38, 153
- plain packaging regulations  28, 37–38
- smoking control and treatment  1
  - Tobacco Action Workers  133
  - *Tobacco Plain Packaging Act 2011*:  239–240

**Torres Strait Islanders**  see Indigenous Australians

**Transition Care Program**  96

*Trends in and Drivers of Pharmaceutical Benefits Scheme Expenditure Report*  67

**turnover**  245

**Twitter use**  19

**United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances**  195

**United States Environmental Protection Agency reports**  47

**university departments of rural health**  170, 174–176

**University of Melbourne Shepparton Medical Centre**  175

**Vaccine Preventable Diseases Surveillance Program**  157

**vaccine preventable HPV type infections**  6

**vehicle fleet**  270

**Victorian Comprehensive Cancer Centre**  149

**Victorian Health Funding advertising campaign**  271

**Visiting Optometrists Scheme**  118, 122

**Voluntary Dental Graduate Year Program**  170, 178

**Voucher Program**  125–127
Walton Review  236
waste management  269–270
water conservation  270
websites  202
Wesley LifeForce Community Networks  168
work health and safety  259–260
workers’ compensation claim rate  260
Workforce and Quality Program  96–100
Workforce and Rural Distribution Program  173–177
Workforce Compact  96
Workforce Development and Innovation Program  177
Workforce Diversity Plan  233
workforce planning  245
Workforce Support Units  133
Working Group on Mental Health Reform  164
workplace agreements  246
World Health Organization
  industrial chemicals regulation  46
  on biosecurity and emergency response  190
  participation in meetings of  155
x-rays, mobile service for  112
Yamba the Honey Ant  134
Younger Onset Dementia  100
Youth Cancer Service  149–150
youth health see also children
  assistance for visually impaired youth  77
  CanTeen Youth Cancer Networks  146
  headspace youth friendly service sites  165
  Medicare Teen Dental Plan  76
  preventative dental checks  76
  Standing Committee on Child and Youth Health  55
Youth Cancer Service  149–150