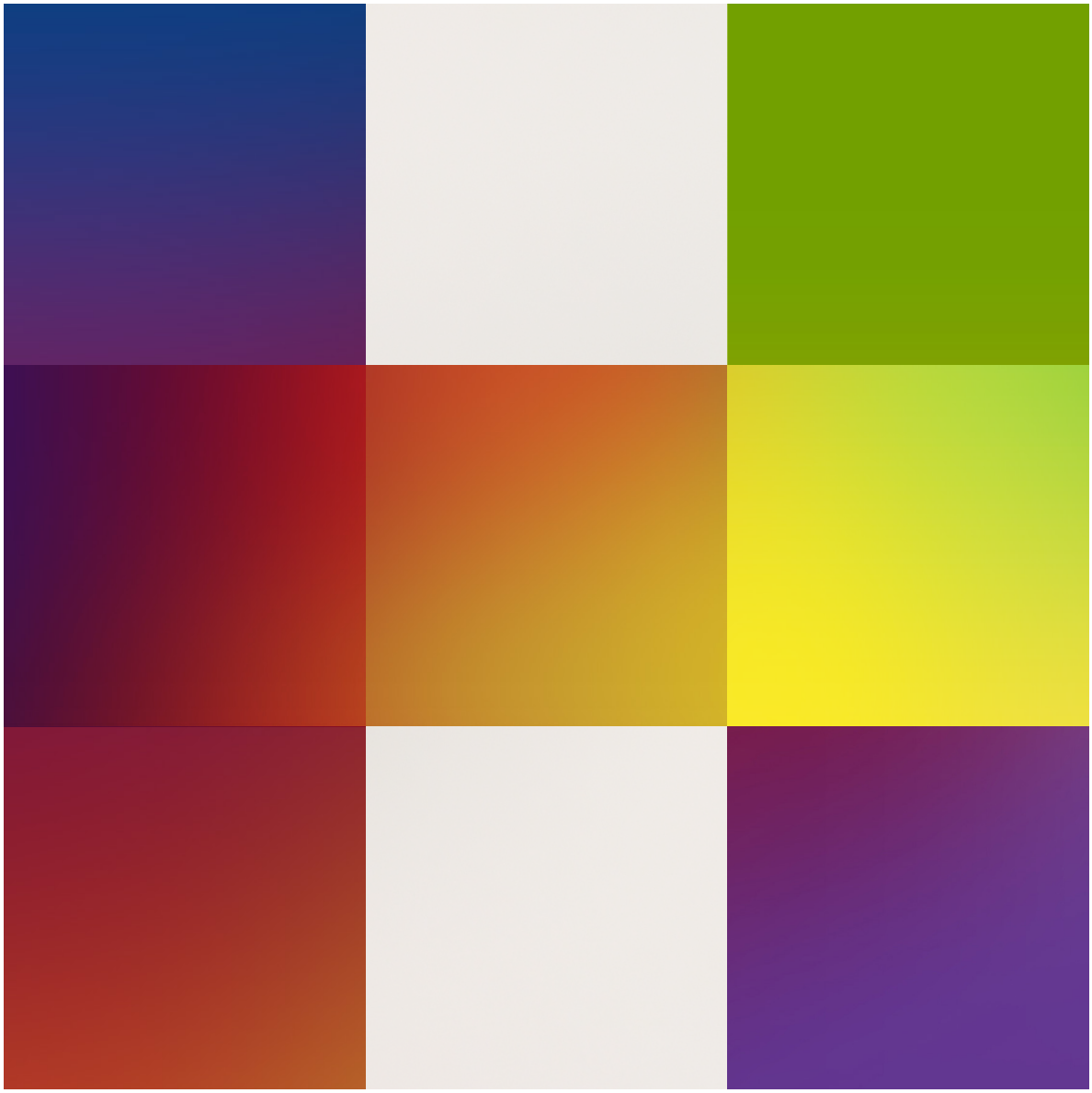


Australian Government

Department of Health

Annual Report

2015-2016

Better health and wellbeing for all Australians, now and for future generations

Part 2 Annual Performance Statements



Over 634,000

calls were made to the My Aged Care Contact Centre Consumer line

$17.2 billion

of hospital funding provided to State and Territory Governments to improve access to and the efficiency of public hospitals

Over 100,000

spectators safely enjoyed the 2015 INF Netball World Cup

11.3 million

Australians have private health insurance hospital treatment cover

33%

decline in Aboriginal and Torres Strait Islander child mortality rates from 1998 to 2014

324,797

hearing services vouchers were issued

Over 90%

of all Australian children aged 1, 2 and 5 years old were fully immunised

1,700

cord blood units were banked ensuring access to lifesaving treatment for cancer and other serious conditions

Over 4,500

practices participating in the Practice Nurse Incentive Program

150

health-related incidents were responded to by the National Incident Room

Over 230,000

Australians living with chronic hepatitis C now have access to a subsidised break-through cure

Part 3 Management and Accountability

108
Indigenous employees

5,037
employees

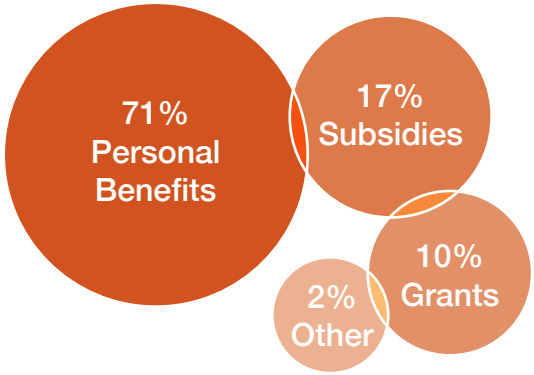
70%
of employees feel supported to achieve work-life balance

21%
of employees work part-time

Part 4 Financial Statements

Total Administered Expenses

$55.8 billion



About this Report

This is the Secretary's report to the Minister for Health for the financial year ended 30 June 2016.

As the primary mechanism of accountability to the Parliament of Australia, this report has been prepared in line with the *Resource Management Guide No.135 Annual reports for non-corporate Commonwealth entities*.

As required under the *Public Governance, Performance and Accountability Act 2013*, this report contains the Department of Health's Annual Performance Statements for 2015-16. The Annual Performance Statements detail results achieved against the planned performance criteria set out in the *2015-16 Health Portfolio Budget Statements*, the Department's *2015-16 Corporate Plan* and the *2015-16 Health Portfolio Additional Estimates Statements*.

This report also contains other mandatory reporting requirements and key corporate information.

The compliance index (on page 440) will direct you to where required information can be found.

Navigation/access aids include:

- Tables of contents (overarching and also at the beginning of each part);
- Comprehensive index;
- Glossary; and
- List of acronyms and abbreviations.

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SECRETARY

27 September 2016

The Hon Sussan Ley MP
Minister for Health and Aged Care
Minister for Sport
Parliament House
Canberra ACT 2600

Dear Minister

As required under subsection 63(1) of the *Public Service Act 1999*, I provide you with the Department of Health Annual Report for the period 1 July 2015 to 30 June 2016, which reports on the performance and functions of the Department for that period.

This report has been prepared for the purposes of section 46 of the *Public Governance, Performance and Accountability Act 2013*, which requires that an annual report be given to the responsible Minister for presentation to the Parliament. It reflects the mandatory requirements for the content of annual reports as prescribed by the *Public Governance, Performance and Accountability Rule 2014* (PGPA Rule 2014).

This report contains information as required under other applicable legislation including the *National Health Act 1953*, the *Environment Protection and Biodiversity Conservation Act 1999*, the *Work Health and Safety Act 2011*, the *Tobacco Plain Packaging Act 2011*, the *Freedom of Information Act 1982* and the *Commonwealth Electoral Act 1918*.

This report also includes the:

- Processes leading to Pharmaceutical Benefits Advisory Committee consideration annual report for 2015-16 (refer Appendix 1);
- Report from the Director of the National Industrial Chemicals Notification and Assessment Scheme (refer Appendix 2);
- Health Provider Compliance Report (refer Appendix 3);
- Australian National Preventive Health Agency financial statements (refer Appendix 4); and
- Australian Digital Health Agency 2015-16 annual report (refer Appendix 5).

The Department's fraud control arrangements comply with section 10 of the PGPA Rule 2014 (for certification refer Part 3.1: Corporate Governance).

Yours sincerely

Martin Bowles PSM

GPO Box 9848 Canberra ACT 2601

Contents

Secretary's **Review**

The main focus of 2015-16 has been change and reform, both in our external environment, the Australian health care system, and our internal working environment.

While Australia's health system performs well, there are many pressures on it that will drive change and adaptation.

Health spending continues to rise faster than GDP growth, raising concerns about the long-term fiscal sustainability of our health system. Underlying causes of this trend include new medical technology and pharmaceuticals, increasing consumer expectations, an ageing population, and increasing chronic disease.

Reforms are essential to ensure that Australia's world-class health system serves us long into the future.

This year saw reforms developed or implemented in primary care, mental health, Medicare, the Pharmaceutical Benefits Scheme (PBS), aged care, hospital funding, and digital health.

These reforms will build over time and support each other, bringing our health care system into the 21st century, and provide better health outcomes for Australians. They have three broad objectives: to make our health system more patient-centred and effective for consumers; to drive more efficient and effective use of public funding; and to provide the system with the capacity to respond to future challenges.

The Department has worked hard to progress these reforms, in consultation with stakeholders across the health and aged care sectors.

At the same time, we have made changes in our structure and culture to improve our ability to achieve our goals. This has included a new focus on more strategic policy development, better data analytics, innovation and meaningful engagement with all stakeholders, including the States and Territories.

Rebuilding the primary health care system

One in two Australians are living with chronic conditions such as diabetes, asthma, heart disease, respiratory illness and mental illness.[1] Innovative ways to fund and deliver primary care will help more people to avoid preventable diseases, and to manage their conditions to avoid health crises.

[1] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

This will bring greater efficiency to health care, reduce pressure on hospitals and improve health outcomes.

On 1 July 2015, 31 Primary Health Networks (PHNs) became operational, replacing the previous Medicare Locals network. The key objective of PHNs is to increase the efficiency and effectiveness of medical services for patients. They improve coordination of care for patients, especially those with chronic and complex conditions, to ensure patients receive the right care in the right place at the right time.

To ensure integration and continuity in local services, PHNs commission, plan and purchase medical and health care services. They have six key priorities set by the Government – mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, and aged care.

The Health Care Homes initiative, a key recommendation of the Primary Health Care Advisory Group also represents a fundamental reform of primary care. It integrates care into a single contact point – the Health Care Home base. It simplifies the interface between the individual and the system. It empowers general practices and Aboriginal Health Services to tailor care to the individual – in a true partnership between the patient and the health care team.

In November 2015, the Government response to the National Mental Health Commission's Review of Mental Health Programmes and Services was released. The response set out a bold reform package that will put the individual needs of patients at the centre of our mental health system.

Other health system improvements

Another important health reform process under way is the Medicare Benefits Schedule (MBS) Review. The Review Taskforce is considering all 5,700 services listed on the MBS to ensure that Medicare funds quality, cost-effective and contemporary services. The Taskforce's first round of recommendations identified a number of obsolete services to be removed from the MBS.

A milestone was also reached in relation to public hospital funding, with agreement in April 2016 by the Council of Australian Governments (COAG) to an additional estimated $2.9 billion committed to public hospitals from 1 July 2017 to 30 June 2020. Activity-based funding will continue so hospitals will be paid based on the number and complexity of patients they treat.

The Commonwealth, States and Territories also agreed to improve the quality of care in hospitals and reduce the number of avoidable admissions by better coordinating care for patients with chronic and complex conditions. The COAG agreement will mean greater efficiency, better quality of care, and less waste and pressure on Commonwealth, State and Territory health budgets in the medium to long-term.

Key elements of the landmark pharmacy and PBS reform package under the 6th Community Pharmacy Agreement came into effect in 2015-16. In April 2016, millions of prescriptions for medicines treating common conditions such as high cholesterol and high blood pressure among others, dropped in price for consumers by as much as 60 per cent. A range of breakthrough medicines was also listed on the PBS for the first time. New treatments for patients with chronic hepatitis C were available through the PBS from 1 March 2016, which could eliminate hepatitis C as a public health threat in Australia within a generation.

Building an appropriately trained and supported health workforce, and attracting workers to areas of need, is central to health reform. Location incentives and better targeted training, particularly for GPs, will further help to bridge the city-country divide in health services delivery.

From 1 July 2015, the General Practice Rural Incentives Program was based on the new remoteness classification system, the Modified Monash Model. This model is widely agreed to be a better system for informing the distribution of workforce incentives to draw GPs to areas where they are in shortage, especially rural, regional and remote areas.

Health inequality between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians continues. Achieving the Closing the Gap targets in health remains a key focus for the Department. Child mortality rates are steadily reducing and are on track to meet the target of being halved by 2018. Greater efforts, however, are needed to achieve equality in life expectancy by the target date of 2031. The National Aboriginal and Torres Strait Islander Health Plan Implementation Plan was launched in October 2015 as a ten-year strategy to achieve better health for Aboriginal and Torres Strait Islander children, youth and adults.

Aged care returns to Health

Responsibility for aged care was transferred back to Health in September 2015. Aged care is an essential part of an integrated health system to care for Australians throughout their lives.

The process of transforming aged care from a traditionally welfare-based system where consumers received set services to a system that is more responsive to consumers' needs, continued during 2015-16. In March 2016, the Aged Care Sector Committee presented Government with the Aged Care Road Map which provides its views on what is needed to achieve a sustainable, consumer driven and market-based system.

From 1 July 2015, the majority of Home Care Packages were delivered on a consumer-directed care basis. After intense consultations between the Department and the aged care sector, the first stage of reforms to home care were passed by Parliament without dissent in March 2016. Preparation is well progressed for changes to occur in February 2017 that will see funding for home care packages follow the consumer, allowing them to choose their service provider.

Better use of health data

The Department is an active contributor to the Australian Government's public sector data agenda, including the Digital Transformation Agenda for more digitised, streamlined and innovative interactions with consumers.

Better use of health data is the basis for more informed policies for the health system. Health care data analytics can help us learn about patient populations, enhance preventive care and drive policy innovation.

Data analytics is also strengthening our health provider compliance activity, ensuring rigorous monitoring of the appropriate use of the MBS and PBS by practitioners, staff and consumers.

Major progress was made towards realising the potential of the national digital health record system. In March 2016, the system was renamed My Health Record. Two large trials were launched of opt-out participation in which My Health Records were automatically created for residents of trial areas unless they chose not to have one. To date, around 17 per cent of all Australians have a My Health Record. The use of My Health Records reduces occurrences of adverse medical events; decreases in the number of tests; and less duplication and better coordination and quality of health care.

This year also saw the commencement of preliminary work to consider options for modernising health and aged care payment services.

Promoting preventive health and improving sport for all

The Department continues to promote the importance for physical and mental health of being active. Lack of physical activity is a risk factor for many preventable lifestyle related diseases. The *Girls Make Your Move* campaign was launched in February 2016 and encourages young women to actively engage with sport and physical activity. The campaign followed research showing that young women were 46 per cent more likely than boys to report no or low levels of physical activity.

In August 2015, the 2015 INF Netball World Cup was staged in Sydney, proudly supported by the Department on behalf of the Australian Government. As part of a 10-day festival, Netball Australia put on the *World's Biggest Netball Clinic* for more than 550 New South Wales primary school students. As well as picking up some netballing tips from the world champion Australian Diamonds, the clinic spread important messages about the importance of a healthy and active lifestyle.

The Department is committed to safeguarding the integrity of sport in Australia and internationally from threats such as doping, match-fixing, illicit drug use and criminal infiltration. In April 2016, the Illicit Drugs in Sport e-learning education program was launched by Minister Ley, following its development by the Department's National Integrity of Sport Unit, in partnership with the Australian Sports Commission.

Engaging in global health issues

Australia worked in consultation with other countries and key international institutions on a broad range of health issues, including supporting the response to international communicable disease outbreaks such as Ebola, Middle East Respiratory Syndrome Coronavirus and Zika virus, and in preparation for potential outbreaks in Australia. Health worked closely with the Department of Agriculture to develop the first implementation plan to support our national strategy to combat antimicrobial resistance due to the overuse of antibiotics. These issues are discussed in more detail in the *Chief Medical Officer's Report*.

In May 2016, I led the Australian delegation to the World Health Assembly, the World Health Organization's (WHO) governing body, in Geneva. I had the privilege of chairing the committee which, among other things, established a new WHO Health Emergencies Programme, and adopted the first ever global strategy on healthy ageing, which Australia played a key leadership role in developing.

Investing in our people

During 2015-16, I continued to pursue the recommendations of our Health Capability Program. The Executive's Strategic Policy and Innovation Group worked to create an environment which fosters high quality strategic policy development, collaboration and innovation. *Our Behaviours in Action* and new Stakeholder Engagement Framework encourage better relations both within the Department and with our stakeholders.

The Department adopted a new operating model for our Health State Network. This model reinforces the important contribution people in our State and Territory offices make, through harnessing their local knowledge and on-the-ground engagement with stakeholders to better inform the development and delivery of policies and programs. The new Health State Network is discussed further in the *Chief Operating Officer's Report*.

Challenges ahead

2015-16 has been a highly productive year for the Department. The pace of reform has quickened, with much more remaining to be done. I am confident we are in excellent shape to advance the reform agenda over this coming year, making our quality health and aged care system even better. I thank staff for their on-going commitment to our endeavours and our stakeholders for their continued support.

Martin Bowles PSM
Secretary
September 2016

Chief Medical Officer's **Report**

Managing mosquito-borne disease

Although mosquito-borne diseases such as Zika, malaria, dengue, yellow fever and chikungunya are a risk for overseas travellers, Australia is fortunate in being largely free of local transmission.

There are many species of mosquito in Australia, but only a few that are a concern for human health. The exotic mosquitoes *Aedes aegypti* and *Aedes albopictus* are carriers of dengue, yellow fever, Zika and chikungunya, but are restricted to certain areas of Queensland.

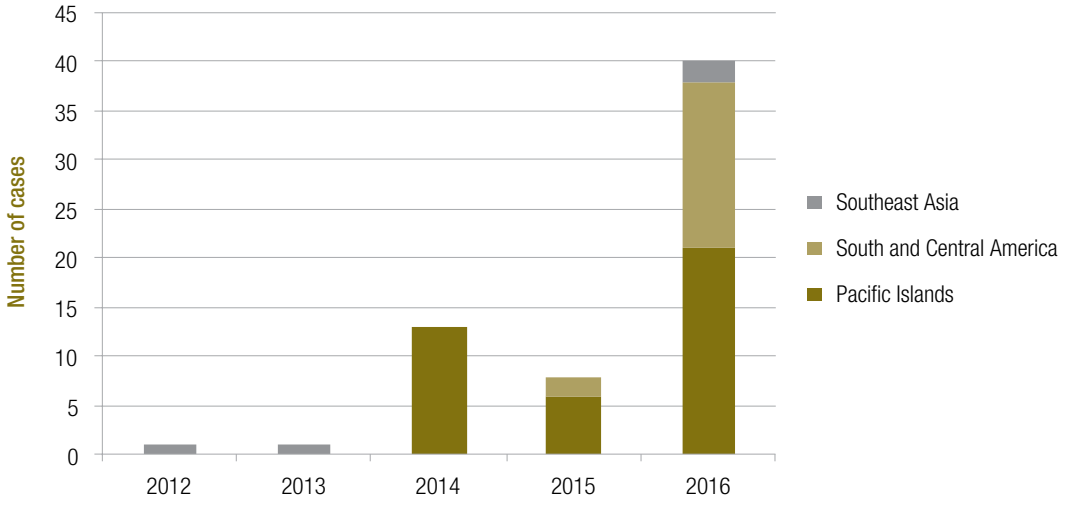
There is a range of mechanisms to manage the risks of importation and spread of exotic mosquito-borne diseases in Australia. The Department continues to work closely with the Queensland Government to monitor and control the spread of *Aedes albopictus* in the Torres Strait. Control mechanisms are proving to be effective, with a reduction in the number of *Aedes albopictus* in the target areas.

Zika has come to recent global attention because of a rapid increase in infection rates in Brazil and other South and Central American countries. In unborn babies, Zika can cause microcephaly, foetal death, or a range of other serious birth defects. As at 30 June 2016, there were 41 confirmed cases identified in Australia, all of which were acquired overseas. There is no evidence of Zika transmission in Australia and there is a very low risk of it becoming established in Australia, as the mosquitoes that can transmit Zika virus are only present in North Queensland in significant numbers.

Preventing local mosquito-borne transmission of Zika and other exotic diseases in North Queensland is a high priority. The Department, in collaboration with the Queensland Government, is working to enhance surveillance efforts and reduce the possibility of Zika transmission.

The Department worked closely with the Department of Foreign Affairs and Trade to provide advice through the Smartraveller website, emphasising the need for all travellers to affected areas to take precautions to prevent mosquito bites. Due to the ever-evolving situation and gaps in surveillance in some of the affected areas, defining the risks for travellers has been a challenge. Guidelines and recommendations are being regularly updated to match the current state of knowledge.

Figure 1: Notifications of Zika infection acquired overseas, 2012 to 30 June 2016 by region of acquisition



Biosecurity is the new quarantine – *Biosecurity Act 2015*

The *Biosecurity Act 2015* (the Act) came into effect on 16 June 2016. As discussed in my report last year, the Act came out of the Beale Review of Biosecurity in 2008, and replaces the *Quarantine Act 1908* in managing biosecurity threats posed by people, goods and conveyances at Australia's international borders and within Australia. The Act is the culmination of many years of effort by a number of teams across the Department, in close partnership with the Department of Agriculture and Water Resources (DAWR).

In the past year, the Department worked closely with our State and Territory counterparts and DAWR on detailed implementation arrangements and subordinate legislation. This included the delivery of a national roadshow to raise awareness of the Act, and training relevant State and Territory officials in their new legislative roles. Post-implementation, the Department continues to liaise with relevant stakeholders to ensure that Australia remains protected from human biosecurity risks.

New treatments for hepatitis C

Hepatitis C is a significant public health issue in Australia. In 2014, it was estimated that there were more than 230,000 Australians living with chronic hepatitis C. Hepatitis C can lead to a variety of serious liver diseases and conditions and is the most common reason for liver transplants in Australia.

Recent advances in antiviral treatment have led to the development of new medicines for treating hepatitis C, which are much better tolerated than previous therapy. From 1 March 2016, these new medicines were listed on the Pharmaceutical Benefits Scheme (PBS). All adult Australians with chronic hepatitis C have access to these new breakthrough treatments through the PBS – a change that could see the disease all but eradicated as a public health threat in this country within a generation.

With a treatment success rate of more than 90 per cent, these medicines will enable most patients to be free of the disease within months. Australia is one of the first countries in the world to publicly subsidise these treatments for every person living with hepatitis C, no matter what the severity of their condition or how they contracted it.

In the first three months after listing the new treatments on the PBS, more than 11,000 patient prescriptions were processed for PBS reimbursement. This is nearly four times the number of people estimated to have received treatment for hepatitis C in 2014. The availability of these new treatments is an important step towards achieving the objectives of the *Fourth National Hepatitis C Strategy* (the National Strategy), to reduce the transmission of, and morbidity and

mortality caused by, hepatitis C, and to minimise the personal and social impact of the epidemic.

The Australian Government is also funding a number of hepatitis C prevention and education programs in line with the priority actions and targets set out in the National Strategy. This includes providing targeted information to priority populations, in particular people who inject drugs, about the new hepatitis C treatments and encouraging these people to know their hepatitis C status; establishing links into care so that people living with hepatitis C can access the new treatments; and encouraging the use of Needle and Syringe Program services for prevention and safe injecting practices.

Looking at tick-borne disease

The Department is concerned about hundreds of Australians presenting with a chronic debilitating illness manifesting as a constellation of multiple non-specific symptoms. Some health care practitioners have ascribed this as chronic Lyme disease or a Lyme disease-like illness. To date, there remains no evidence of classical Lyme disease in Australia. The diagnosis of chronic Lyme disease is disputed by conventional medicine.

In November 2015, an inquiry into the *Growing evidence of an emerging tick-borne disease that causes a Lyme like illness for many Australian patients* was established under the Senate's Community Affairs Reference Committee. Over 1,200 submissions were lodged, including a submission from the Department. An interim report was published by the committee, recommending: the continuation of the inquiry; further consultation with patients and health practitioners; and increased community education and awareness.

The Department has funded the National Serology Reference Laboratory to evaluate the different serological tests used to diagnose Lyme disease in Australian patients. We also developed a diagnostic guideline to assist Australian doctors to diagnose overseas acquired Lyme disease, and a tick bite prevention document to educate the public and medical authorities on tick bite prevention and first aid. During 2015-16, Professor Peter Irwin from Murdoch University published a number of research papers describing new tick-borne bacteria. Whether these bacteria can cause multiple non-specific chronic debilitating symptoms in humans and the implications for human health have yet to be determined. Attributing disease causation requires more research and epidemiological studies. This highlights the need to target the national health and medical research effort to address gaps in health and medical research, such as this tick-borne illness.

The Department will continue its role to find and disseminate information on Australian research relevant to this tick-borne chronic debilitating illness and to coordinate dialogue with patients, their supporters and health care professionals.

Combatting antimicrobial resistance

Antimicrobial resistance (AMR) was a highlight in my report last year. In 2015-16, AMR continued to be a significant global health priority. AMR occurs when microorganisms, such as bacteria, become resistant to medicines to which they were originally susceptible.

Following the release of Australia's first *National Antimicrobial Resistance Strategy 2015-2019* in June 2015, our efforts this year have been focussed on developing a detailed implementation plan that outlines specific focus areas for action, and highlights activities that are being undertaken by stakeholders across all sectors to minimise the development of antimicrobial resistance and ensure the continued availability of effective antimicrobials. The implementation plan has been developed in consultation with stakeholders from the Australian Government, State and Territory Governments, non-government organisations, professional bodies and research organisations.

A major achievement this year has been the establishment of the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System by the Australian Commission on Safety and Quality in Health Care. The AURA Surveillance System collates data from a range of sources and allows integrated analysis and reporting of antimicrobial resistance and antimicrobial use at a national level. The first AURA report was released in June 2016, and was well received by all stakeholders. The data provided in the report will inform immediate actions and provides evidence to evaluate and set priorities.

Given that research shows AMR is largely driven by the misuse of antibiotics, improving antimicrobial stewardship across all sectors and settings is critical to ensure appropriate use of antimicrobials. This year, the Department engaged a consortium

led by the University of Queensland to develop and pilot an integrated, multifaceted package of interventions to reduce antibiotic prescribing in general practice. The results from the General Practitioners Antimicrobial Stewardship Programme Study will be made publicly available on the Department's website in August 2016 and will inform broader implementation of antimicrobial stewardship initiatives in general practice.

Planning is also underway to develop a dedicated national AMR website to provide a central repository of trusted information for professionals and consumers. The website will be critical in achieving a collaborative approach to responding to AMR and is intended to support whole-of-society awareness and participation in the implementation of the *National Antimicrobial Resistance Strategy 2015–2019.*

Implementing Optimal Cancer Care Pathways

The diagnosis and treatment of cancer continues to be challenging. One in two Australian men and one in three Australian women will develop cancer before the age of 85. An ageing population means that new cancer cases will continue to rise, and it is anticipated that over 130,000 Australians will be diagnosed with cancer in 2016. Though challenging, outcomes for Australian cancer patients have improved dramatically over the past 30 years, reflecting strong public awareness of cancer prevention, participating in cancer screening, and acting on early diagnosis.[2]

During 2015-16, the National Cancer Expert Reference Group (NCERG) endorsed the Optimal Cancer Care Pathways (OCPs) and national agreement to pilot the adoption of several of these pathways into our health services. The Department provides the secretariat support to the NCERG. The secretariat will assist national promotion of the OCPs in 2016-17.

OCPs are national guides to promote the best cancer care for specific tumour types. They describe the key steps in a patient's cancer journey and expected standards of care at each stage. They aim to improve patient outcomes by promoting quality cancer care and ensuring that all people diagnosed with cancer receive the best care, regardless of where they live or receive their treatment.

Looking ahead, the NCERG's major focus will be reducing the variation in rates and outcomes across geographical locations, socioeconomic status and the Indigenous population.

Improving immunisation rates across Australia

The Department continues to prioritise preventing vaccine preventable diseases, especially in vulnerable populations, including young children, pregnant women, Aboriginal and Torres Strait Islander people and the elderly.

Of these, influenza causes the greatest burden of disease in Australia[3] and continued significant effort is required to address this. Key achievements in 2015-16 included the move to provide quadrivalent influenza vaccines (QIVs) under the National Immunisation Program (NIP), for the 2016 seasonal influenza season. The Department also re-introduced a pertussis (whooping cough) booster vaccine for toddlers at 18 months of age. The QIV provides added protection to the previously supplied trivalent influenza vaccine, while the 18 month whooping cough booster dose aims to reduce whooping cough notifications and reduce transmission of the disease in babies too young to be immunised.

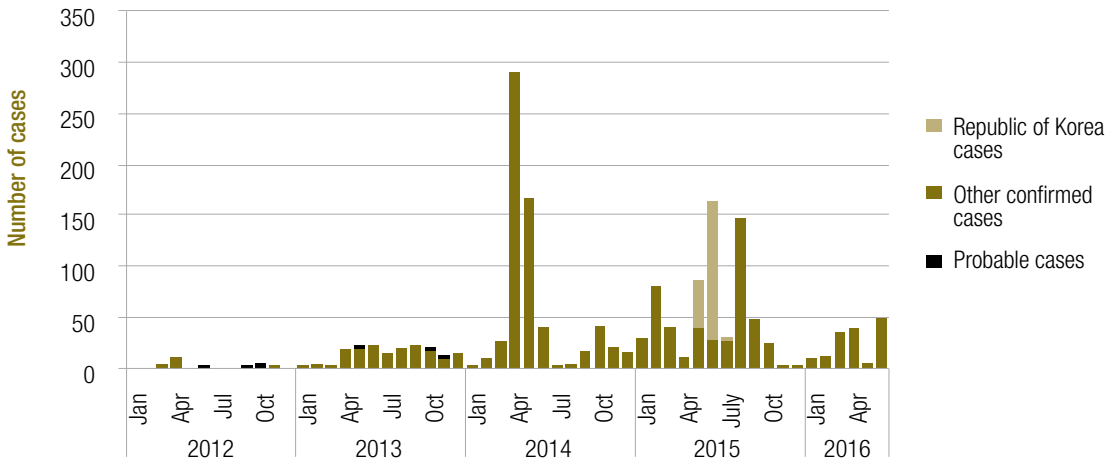
Australia has high childhood immunisation rates, with over 90 per cent of children fully immunised at one, two and five years of age. However, we need to stay vigilant to improve this rate to achieve community immunity, especially amongst vulnerable populations. The Department's performance against immunisation is discussed further in Program 1.3: Immunisation, on page 60.

Looking ahead, in collaboration with Chief Health Officers from all States and Territories, we have set an aspirational target of 95 per cent immunisation coverage. This target provides sufficient herd immunity to prevent transmission of vaccine preventable diseases, and provides the community with the best possible protection.

[2] Australian Institute of Health and Welfare 2014. *Cancer in Australia: an overview 2014.* Cancer series no.90. Cat. no. CAN88. Canberra: AIHW.

[3] AIHW 2016. *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011.* Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: AIHW.

Figure 2: Confirmed and probable MERS-CoV cases by confirmation status, as of 30 June 2016.



Protecting Australia from emerging diseases

Most emerging infectious diseases are of animal origin, and their emergence can be related to sociological, ecological and environmental factors.[4,5]

This has been borne out in recent years by Zika, Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and the Ebola outbreaks.

In my reports for the last three years, I highlighted the risk of MERS-CoV particularly in the context of increasing global travel, and the significant outbreak of MERS-CoV in the Republic of Korea during 2015. There have been no further cases in the Republic of Korea since my last report. While there have been no cases in Australia, I have, through my role as chair of the World Health Organization (WHO) International Health Regulations Emergency Committee on MERS-CoV, been closely monitoring the outbreak overseas. The general risk assessment for MERS-CoV has not changed during the past year: it continues to occur in the Middle East with occasional exportation to other countries resulting in limited transmission; it continues to cause severe human infections resulting in high mortality; and it can transmit between people in health care settings and in the community. As of 30 June 2016, there were 1,769 cases of MERS-CoV including at least 630 deaths world-wide since the outbreak was first reported in September 2012.[6]

The WHO *Public Health Emergency of International Concern* related to Ebola in West Africa was lifted on 29 March 2016. A total of 28,616 confirmed, probable and suspected cases were reported in Guinea, Liberia and Sierra Leone, with 11,310 deaths.[7] While there were cases exported from West Africa to other areas, including the United States and the United Kingdom, there were no cases in Australia. With the reduced risk of importation, border measures for Ebola, highlighted in my report last year, were de-escalated in November 2015.

Supporting Australians with dementia

With an estimated 353,800 Australians currently living with dementia, and a projection of 900,000 by 2050,[8] dementia is one of Australia's national health priorities.

4 Alexander KA, Sanderson CE, Marathe M, Lewis BL, Rivers CM, Shaman J, et al. What factors might have led to the emergence of Ebola in West Africa? *PLoS Negl Trop Dis* 2015;9(6):e0003652.

5 Taylor LH LS, Woolhouse ME. Risk factors for human disease emergence. *Philos Trans R Soc Lond B Biol Sci* 2001;356:983–989.

6 World Health Organization. Middle East Respiratory Syndrome Coronavirus (MERS-CoV). 2016. Accessed on 29 June 2016. Available from: www.who.int/emergencies/mers-cov/en/

7 World Health Organization. Situation Report Ebola Virus Disease 10 June 2016; 2016.

8 Statistic supplied by Australian Institute of Health and Welfare (AIHW)

Approximately 70 per cent of Australians with dementia are living in the community.[9] The *National Framework for Action on Dementia 2015–2019,* published in September 2015*,* identified the need to develop dementia-friendly communities in order to build greater awareness, acceptance and understanding of dementia in the community.

In 2015-16, the Department funded Alzheimer's Australia to support the establishment of 'Dementia Friendly Communities' around the country. As part of this initiative, a National Dementia Friendly Resource Hub will be developed to provide information, resources and best practice guides, as well as opportunities for networking and support for creating local dementia friendly communities.

Dementia is also a key issue in the aged care sector, with over 50 per cent of current aged care residents assessed as having high behavioural needs under the Aged Care Funding Instrument, an indicator of dementia. In November 2015, the Australian Government held the second Ministerial Dementia Forum to engage with key stakeholders on how people with dementia and their carers can be better supported. These forums are a valuable mechanism to consult with health care professionals, aged care providers, peak bodies, individuals with dementia, family carers and other stakeholders.

Severe Behaviour Response Teams commenced operation nationally in November 2015, and act as a top tier support to complement the long standing Dementia Behaviour Management Advisory Service. The establishment of the teams followed the 2014 Ministerial Dementia Forum, which recommended that a mobile workforce of clinical experts be established to assist residential aged care providers to manage clients with severe behavioural and psychological symptoms of dementia.

The National Health and Medical Research Council is also delivering a series of initiatives to prioritise and fund vital new dementia research projects and translate research to improve prevention, diagnosis, treatment and care for dementia patients, their carers and communities.

Internationally, Australia actively participates in global action against dementia through the Organisation of Economic Co-operation and Development and the WHO, and also holds an associate membership on the World Dementia Council.

[9] AIHW Dementia in Australia Report, 2011, available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422943

Farewelling the Department

2015-16 is the final year of my tenure as Australia's Chief Medical Officer. Taking over the reins will be Professor Brendan Murphy from October 2016.

I would like to take this opportunity to thank all my colleagues in the Department of Health for their support, their dedication and the value they add to our health system. I would also wish to pay tribute to all State and Territory Chief Health Officers who ensure public health is delivered to a very high standard in their jurisdictions. Our cooperative and collaborative efforts serve Australia well.

Professor Chris Baggoley AO
Chief Medical Officer
July 2016

Chief Operating Officer's **Report**

Chief Operating Officer's Group Operating Model

At the Department of Health we have refreshed our approach to the way we deliver corporate services across the organisation. The Chief Operating Officer's (COO) Group Operating Model, released in December 2015, provides a new framework for designing and delivering corporate services that are customer-focused, cost-effective and professional.

Our services are diverse and cover everything from human resources, finance, legal and communication advice, to managing grants and IT systems and support. All corporate functions were integrated within the COO Group in early 2016, and up to 40 initiatives to optimise our service offer are under way. To date, we have:

- streamlined our financial processes;
- introduced new self-service tools, and tools to help staff work more collaboratively;
- strengthened the role of State and Territory offices for program delivery and stakeholder engagement; and
- improved our handling of administered funding through new systems.

From July 2016, a corporate front door was introduced to provide easier and faster access to information and contacts. This was supported by a COO group customer service charter and set of principles. A priority for the year ahead will be a continued focus on productivity and providing the best possible service to our customers.

Building Health's capability

We continue to build our organisational capability, so we are best positioned to fulfil Our Purpose in leading and shaping Australia's health outcomes through evidence-based policy and well targeted programs.

In 2015-16, the Department focussed on five themes to build Health's capability:

- leadership and culture;
- strategic capability;
- governance;
- risk; and
- stakeholder engagement.

The Department is currently finalising a review of its organisational capability journey through an independent review process.

Leadership and culture

We continued to build leadership and culture at all levels of the organisation through a range of initiatives including our mentoring program, launch of the *Our Behaviours in Action*, induction and coaching programs, performance and development frameworks, formation of an organisation-wide staff social club, and ongoing staff surveys to assess our progress. For further information on the Department's people management strategies, refer Part 3.4: *People Management*.

Strategic capability

We are transforming our ability to support health policy by encouraging our policy makers to have a greater whole-of-system perspective. As well, we have been shaping an environment in which staff have greater license to explore innovative options and new solutions to keep pace with a constantly evolving health system.

Governance

We have made a number of changes to our senior governance committees to better support the Department's *Strategic Intent 2016–20* and *Corporate Plan 2016-17*. For further information on corporate governance, refer Part 3.1: *Corporate Governance*.

We have been working to improve our systems so we can share and use health data more readily and to better effect. Linking disparate data sources and applying expert analysis will help Government and industry alike to better understand our health system, improve patient care, and inform effective, evidence-based initiatives in the future.

Risk

Enterprise risk remains a strong pillar of the Department's *Strategic Intent 2016–20*. Risk management helps protect the integrity of the Department as we continue to be responsible stewards of Australia's health system.

We have been fostering a culture where innovation and creativity is encouraged – and a critical part of this is giving strong support to decision makers as they consider and manage appropriate levels of risk. In building this support, we have developed an Enterprise Risk Framework and Risk Appetite Statement, identified our enterprise level risks, and new decision support tools for staff. These resources will encourage risk conversations, highlight areas where we are more willing to engage with risk for a greater benefit, and to achieve our strategic objectives. In 2016-17, the Department will embed these resources across the organisation throughout our business processes. For further information on risk management strategies, refer Part 3.1: *Corporate Governance*.

Stakeholder engagement

A collaborative and transparent relationship with our stakeholders is central to our ability to lead and shape Australia's future health system. We have introduced a Stakeholder Engagement Framework with supporting tools and resources. These will help us to better identify our stakeholders' needs and ideas so we can incorporate them into policy development and decision-making processes. We are also making a concerted effort to consult early and often.

Health State Network – working together

In 2015-16, the Department adopted a new operating model for our Health State Network. On 1 July 2016, the Health State Network Division came into effect, as we brought together staff across all State and Territory offices as well as program and grant operations staff in Central Office. The new Health State Network:

- brings together the core functions of grants and program delivery in each State under a single State Manager;
- gives State Managers a site leadership role for departmental employees in their State;
- provides a clear role for State offices to engage locally with stakeholders and maintain relationships with State and Territory Governments; and
- improves links between the Health State Network, grant operations, and policy and program areas while developing and implementing a nationally consistent grants management framework.

Working closely with policy and program areas, the Health State Network brings local intelligence and location-specific needs to help shape the development and delivery of our policies and programs to serve all Australians, regardless of where they live.

People Strategy – our greatest asset

The Department is investing in our people – our greatest asset. We are promoting a culture that rewards and recognises staff performance, where people are engaged and empowered to do their best work.

The *People Strategy 2016–20* (the Strategy) outlines the way we are achieving this. Through the Strategy and our workforce planning, staff are encouraged to be adaptable, flexible, empowered and motivated. The Strategy outlines how we attract and keep the highest performing staff as we become an employer of choice.

With strong ties to *Our Behaviours in Action*, our Strategy provides a blueprint for shaping an organisation in which people work together, embrace new ideas, nurture talent and invest in high performance, trust and empower one another, listen with intent, value contribution, lead by example and embrace change.

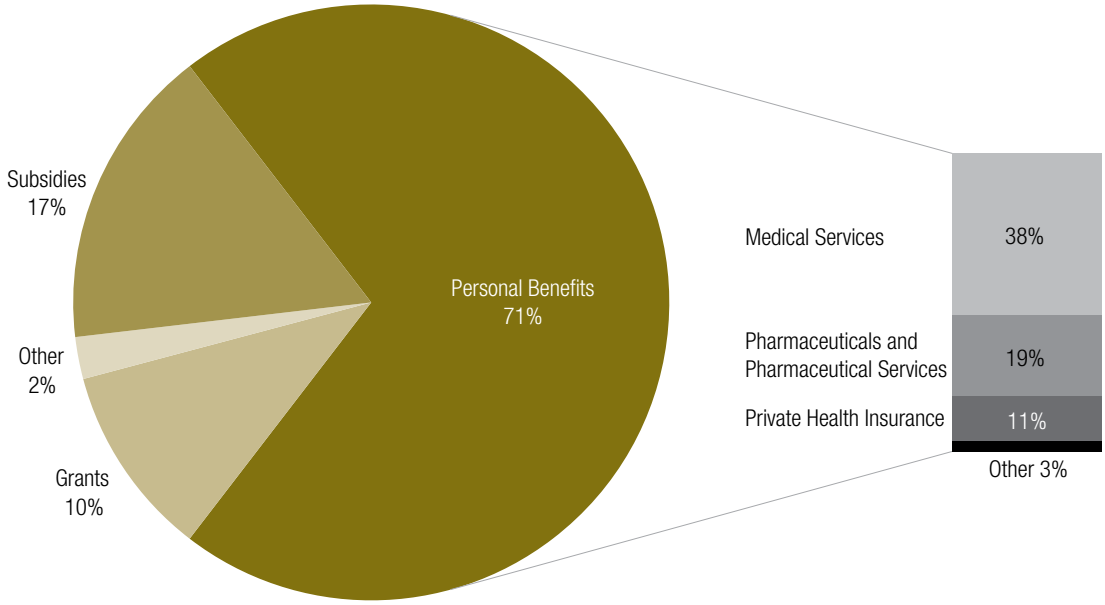
With an ever-increasing complexity in our environment, the Department's workforce planning will see new approaches to the way we recruit, upskill and rotate staff throughout the organisation. It will ensure we are resourced to be at the top of our game when facing new challenges and opportunities. For more information on our people management strategies, refer Part 3.4: *People Management*.

Improved grants management

In 2015-16, we improved our grants processes, including better risk management as a central part of grant administration. We have changed the way we publish grant program guidelines to make it easier for people to apply. The Indigenous Australians Health Programme has been the first program to benefit from this approach. In collaboration with the Indigenous health sector, we have developed grant program guidelines that enable us to fund outcomes for Indigenous health initiatives nationally. Five grants rounds, distributing more than $35 million of Indigenous Australians Health Programme funding to more than 100 organisations around the country, have been successfully delivered since February 2016.

The Department utilises the community hub, provided by the Department of Social Services, to manage its grant programs.

Figure 3: Breakdown of administered expenses during 2015-16



2015-16 Financial year
Total expenses administered by the Department of Health: $55.8 billion

Property review

A review of the Department's property locations across Australia has led the Department to consolidate our properties nationally to one per State and Territory, except in Sydney and Canberra where there will be two locations each. This review accommodates the inclusion of the Health State Network, Health Products Regulatory Group, Health Provider Compliance Division and other out-posted staff of the Department.

2015-16 financial results

In 2015-16, the Department administered 37 programs on behalf of Government, including six aged care programs transferred to the Department under the Administrative Arrangements Order issued on 30 September 2015. Administered expenses totalled $55.8 billion, comprised primarily of payments for personal benefits of $39.6 billion (71 per cent of the total), including those for medical services, pharmaceutical services and private health insurance rebates. Subsidies, predominantly for aged care, amounted to $9.3 billion (17 per cent of the total), and grants expenditure was $5.8 billion (10 per cent of the total) — the majority of which was paid to non-profit organisations.

As at 30 June 2016, the Department's administered assets totalled $2.1 billion, including investments in health related entities and inventories held under the National Medical Stockpile. Administered liabilities were $3.3 billion, which included provisions for personal benefits, grants and subsidies.

Key administered expenditure is illustrated in Figures 3 (refer previous page) and 4 below.

The Department incurred an operating loss, prior to unfunded depreciation, of $5.5 million for the year. This loss was a consequence of payments associated with the Administrative Arrangements Order for aged care programs. The Department remains in a positive net asset position as at 30 June 2016.

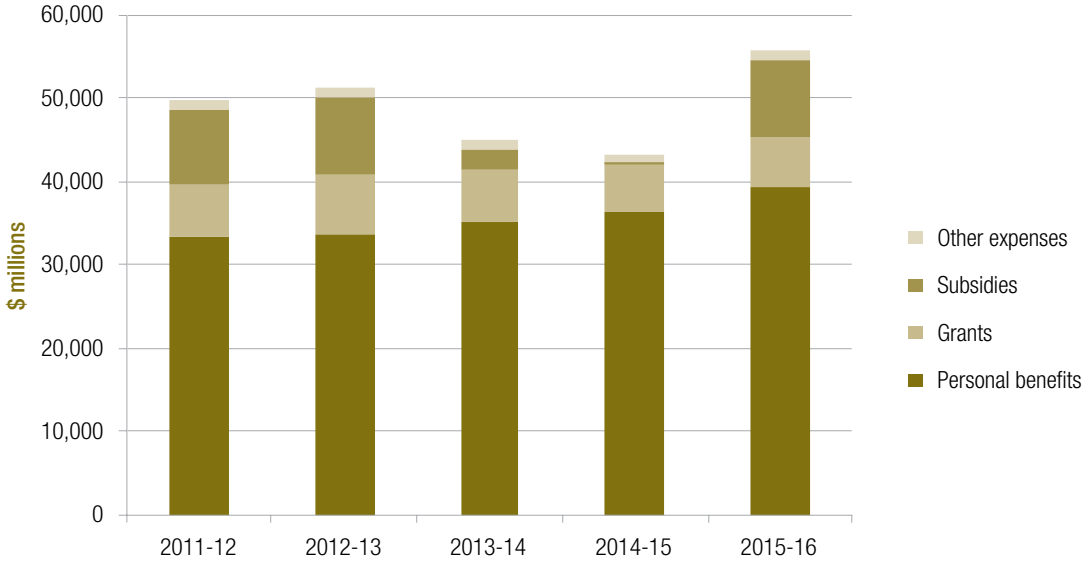
2015-16 financial statements

The Auditor-General has provided the Department with an unmodified audit opinion for the 2015-16 financial statements, noting that we have in place appropriate and effective financial controls.

Part 4: *Financial Statements* contains the Department's financial statements which include information on the financial performance of the Department over the financial year.

Matt Yannopoulos
Acting Chief Operating Officer
July 2016

Figure 4: Administered expenditure by category 2011-12 to 2015-16



PART 1

About the Department

1.1 Executive as at 30 June 2016

From left to right

Andrew Stuart, Matthew (Matt) Yannopoulos, Dr Wendy Southern, Professor Chris Baggoley AO, Secretary Martin Bowles PSM, Mark Cormack, Dr Margot McCarthy, Paul Madden, Adjunct Professor John Skerritt.

The Department's Executive was current at 30 June 2016. For up-to-date details, refer to the Department's website at: www.health.gov.au/internet/main/publishing.nsf/Content/health-executive.htm

Martin Bowles PSM
Secretary

Martin Bowles was appointed Secretary of the Department of Health in 2014.

As lead policy adviser to Government, Martin is responsible for ensuring the Department achieves the Australian Government's priorities for health. Martin is also responsible for the overall management and operation of the Department.

Previously, Martin was Secretary of the Department of Immigration and Border Protection, overseeing the management of migration, humanitarian, citizenship and visa policy and programs. Martin has also held Deputy Secretary positions in the Department of Climate Change and Energy Efficiency and the Department of Defence, and senior executive positions in the education and health portfolios in the Queensland and New South Wales public sector.

Martin has a Bachelor of Business, a Graduate Certificate of Public Sector Management, and is a Fellow of the Australian Society of Certified Practicing Accountants.

Professor Chris Baggoley AO
Chief Medical Officer

Professor Chris Baggoley AO was the Chief Medical Officer for the Australian Government and principal medical adviser to the Minister and the Department of Health. Chris also had responsibility for the Department's Health Protection Group and attended the World Health Assembly and represented Australia on the International Agency for Cancer Research Council. Professor Baggoley chairs the World Health Organization International Health Regulations Emergency Committee concerning Middle East Respiratory Syndrome Coronavirus (MERS-CoV).

Prior to his appointment as Chief Medical Officer in 2011, Chris was the Chief Executive of the Australian Commission on Safety and Quality in Health Care. He is a former Chief Medical Officer and Executive Director with the South Australian Department of Health. His clinical career has been in emergency medicine.

In addition to his medical degrees, Chris holds a degree in Social Administration from Flinders University, an Honours degree in Veterinary Science from the University of Melbourne, and has been awarded the Order of the International Federation for Emergency Medicine. Chris was made an Officer of the Order of Australia (AO) in 2013.

Chris retired as Chief Medical Officer on 15 July 2016.

Professor Brendon Murphy has accepted the role of Chief Medical Officer and will commence with the Department in October 2016.

Mark Cormack
Deputy Secretary, Strategic Policy and Innovation

Mark Cormack is responsible for Health Systems Policy, including portfolio engagement and coordination, international strategies, best practice regulation and strategic policy. Mark is also responsible for Health programs including primary health care, hospitals, mental health and dental. Mark is co-chair of the Department's Strategic Policy Committee.

Prior to joining the Department, Mark held the position of Deputy Secretary in the Department of Immigration and Border Protection, and was the Department's senior executive responsible for implementation of Operation Sovereign Borders. Mark has also held the role of Chief Executive Officer of Health Workforce Australia and Chief Executive, ACT Health.

Mark has worked in and for the public health care sector for over 30 years in various capacities as a health professional, senior manager, policy maker, planner, agency head and industry advocate, and has held a number of senior roles in the public health care system.

Matthew (Matt) Yannopoulos
Acting Chief Operating Officer, Acting Deputy Secretary, COO Group

Matt Yannopoulos joined the Department in July 2015. Matt assumed the role of Acting Chief Operating Officer from May to July 2016. During this period Matt was responsible for the Department's corporate and enabling areas that support the Department in meeting its purpose. Responsibilities included finance, legal, corporate services, the Health State Network and information communication technology (ICT). Matt co-chaired the Department's Strategic Policy Committee and was deputy chair of the Finance and Resources Committee and the People, Values and Capability Committee.

Previously, Matt held the roles of the First Assistant Secretary of Portfolio Investment Division, and the Chief Information Officer (CIO) responsible for the management and operation of ICT functions.

Prior to joining the Department, Matt was the Portfolio CIO of the Department of Immigration and Border Protection, where he was accountable for ICT across the Department and the Australian Customs and Border Protection Service. Matt has also held the roles of Chief Design Officer for the Australian Taxation Office, the Department of Defence's first Chief Technology Officer with responsibility for Enterprise Architecture, ICT standards, and ICT Strategy and Futures.

Paul Madden
Special Adviser, Strategic Health Systems and Information Management

Paul Madden holds the position of Deputy Secretary/Special Adviser, Strategic Health Systems and Information Management. His role includes supporting the Government in leading the national rollout of Digital Health initiatives including: foundation technologies and related services across Australia; the continued and improved operation of the My Health Record; and the opt-out trials. He is also responsible for setting and operation of governance policies and processes for data and information management.

He is chair of the Department's My Health Record Operations Management Committee, a member of the Australian Digital Health Agency Board, and the Australian Institute of Health and Welfare Board.

Prior to joining the Department, Paul was Program Director of the Standard Business Reporting Program led from the Australian Treasury from 2007 to 2010.

Dr Margot McCarthy
Deputy Secretary, Ageing and Aged Care Group

Dr Margot McCarthy joined the Department in November 2015 as Deputy Secretary of the Ageing and Aged Care Group[10] and is responsible for overseeing policy, funding, and a range of regulatory activities for the ageing and aged care system.

Margot has held a number of senior positions in the Department of Defence, the Department of the Prime Minister and Cabinet (PM&C) and the Department of Social Services.

In February 2013, she was appointed as an Associate Secretary in PM&C, leading the National Security and International Policy Group, which provided advice to the Prime Minister, and whole-of-government coordination on national security matters.

Margot is a graduate of Oxford University (D.Phil. in English Literature) and the London School of Economics and Political Science (MSc in Management). She completed her undergraduate studies at the University of New England in Armidale, Australia.

[10] Responsibility for the Ageing and Aged Care functions transferred to the Department of Health from the Department of Social Services as part of the Machinery of Government changes announced in September 2015.

Adjunct Professor John Skerritt
Deputy Secretary, Health Products Regulation Group

Adjunct Professor John Skerritt is responsible for Health Products Regulation including medicines regulation, medical devices, blood and tissue products, and product quality and regulatory practice. He is also responsible for drug control, including dealings with controlled drugs, and development and implementation of the new regulatory framework for medicinal cannabis.

John was a Deputy Secretary in the Victorian Government, and has extensive experience in medical, agricultural and environmental policy, regulation, research management, technology application and commercialisation. He is the former Deputy Chief Executive Officer of the Australian Centre for International Agricultural Research, and a former Ministerial appointee on the Gene Technology Technical Advisory Committee.

John is an Adjunct Full Professor of the Universities of Queensland and Canberra, has a PhD in Pharmacology from the University of Sydney, and is a graduate of the Senior Executive Programs of London Business School and of IMD Business School, Switzerland. He is also a Fellow of the Academy of Technological Sciences and Engineering and a Fellow of the Institute of Public Administration of Australia (Victoria).

Dr Wendy Southern PSM
Deputy Secretary, National Programme Delivery Group

Dr Wendy Southern is responsible for national delivery of population health (including sport), Indigenous health, and health workforce programs and initiatives. Wendy is Chair of the People, Values and Capability Committee.

Prior to joining the Department, Wendy held the position of Deputy Secretary in the Department of Immigration and Border Protection, leading the development and delivery of policy advice and program management across the Department. Wendy has also previously worked for the Department of the Prime Minister and Cabinet.

Before joining the Australian Public Service, Wendy worked in various research, teaching and consultancy positions at the Australian National University, Monash University and the University of the South Pacific.

Andrew Stuart
Deputy Secretary, Health Benefits Group

Andrew Stuart has had an extensive career in the Department of Health spanning across Ageing and Aged Care, Population Health, Primary Care and corporate affairs.

Currently, Andrew leads the Health Benefits Group, ensuring existing and innovative medicines and medical devices, procedures and services are accessible to all Australians, used appropriately, at a cost the individual and community can afford.

Andrew's responsibilities include the Pharmaceutical Benefits Division, the Health Provider Compliance Division and the Medical Benefits Division including Private Health Insurance and the Office of Hearing Services. Andrew also oversees the Office of Chemical Safety.

In a previous Deputy Secretary role at Health, Andrew led the Department's Strategic Review and internal change management program to downsize the Department, realign the corporate functions, reform grant management and promote deregulation.

1.2 Department **Overview**

This annual report is for the 2015-16 financial year, based on the Department of Health's structure as at 30 June 2016, and reports on the Department's activities during 2015-16.

The Department of Health is a Department of State. In 2015-16 we operated under the *Public Service Act 1999* and the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

Our History

The Commonwealth Department of Health was established in 1921, in part as a response to the devastating effects of the Spanish influenza pandemic of 1919, and through the vision of Dr J H L Cumpston, the first head of the Department.

The Department of Health has continued to evolve over the last 95 years, and has undergone a number of changes in name, function and structure.

Our Vision

Better health and wellbeing for all Australians, now and for future generations.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.[11]

Our Strategic Priorities

Better health and ageing outcomes and reduced inequality through:

- An integrated approach that balances prevention, primary, secondary and tertiary care;
- Promoting greater engagement of individuals in their health and healthcare; and
- Enabling access for the most disadvantaged including Aboriginal and Torres Strait Islander people, people in rural and remote areas and people experiencing socio-economic disadvantage.

Affordable, accessible, efficient, and high quality health and aged care system through:

- Partnering and collaborating with others to deliver health and aged care programs;
- Better, more cost-effective care through innovation and technology; and
- Regulation that protects the health and safety of the community, while minimising unnecessary compliance burdens.

Better sport outcomes through:

- Boosting participation opportunities for all Australians;
- Optimising international performance; and
- Safeguarding integrity in sport.

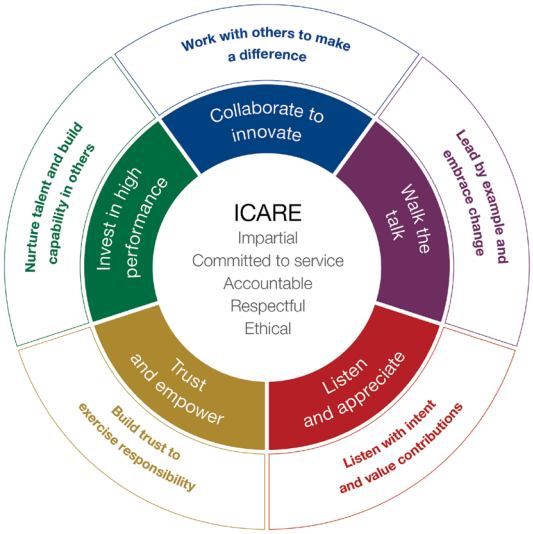
[11] Department of Health Corporate Plan 2016-17 available at: www.health.gov.au/internet/publications/publishing.nsf/content/corporate-plan-2016-17-toc

Our Capabilities

- We build leadership at all levels.
- We think strategically and make evidence-based choices.
- We strengthen our key relationships.
- We embed innovation in our work.
- We manage cost and invest in long term sustainability.

Our Values and Behaviours

The Department of Health adheres to the APS ICARE principles, which are central to *Our Behaviours in Action*. The Department has continued to champion *Our Behaviours in Action* through 2015-16, with a particular emphasis on leadership modelling these behaviours.



Machinery of Government changes

On 13 February 2016, the Prime Minister, the Hon Malcolm Turnbull MP announced changes to the Machinery of Government. The Hon Sussan Ley MP continued in her role as Minister for Health, Minister for Aged Care and Minister for Sport. Senator the Hon Fiona Nash continued to be the Minister with responsibility for Rural Health. To reflect his existing responsibilities, the Hon Ken Wyatt AM, MP added Aged Care to his title, becoming Assistant Minister for Health and Aged Care (for further information refer Ministerial Responsibilities page 32).[12]

The Administrative Arrangements Order issued on 30 September 2015 included the following changes to the Portfolio's responsibilities:

- Ageing and Aged Care functions returned to the Health Portfolio from the Social Services Portfolio, including the Australian Aged Care Quality Agency;
- The statutory offices of the Aged Care Commissioner and the Aged Care Pricing Commissioner transferred to the Department of Health; and
- Medicare Provider Compliance for the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and allied health services transferred to the Department of Health from the Department of Human Services.

There were no changes to the Portfolio as a result of the Administrative Arrangements Order issued on 18 February 2016.

[12] On 19 July 2016, the Prime Minister, the Hon Malcolm Turnbull MP's new Ministry was sworn in. The current Health Portfolio Ministers and their responsibilities are available at: www.health.gov.au/internet/main/publishing.nsf/Content/Ministers-1

Portfolio structure

In 2015-16, the Health Portfolio consisted of:

- the Department of Health (refer Structure Chart on page 29)
- 17 Portfolio entities (refer Portfolio Entity-Specific Outcomes on page 36)
- five statutory office holders:
  - Aged Care Complaints Commissioner
  - Aged Care Pricing Commissioner
  - Gene Technology Regulator
  - Director, National Industrial Chemicals Notification Assessment Scheme
  - National Health Funding Pool Administrator.

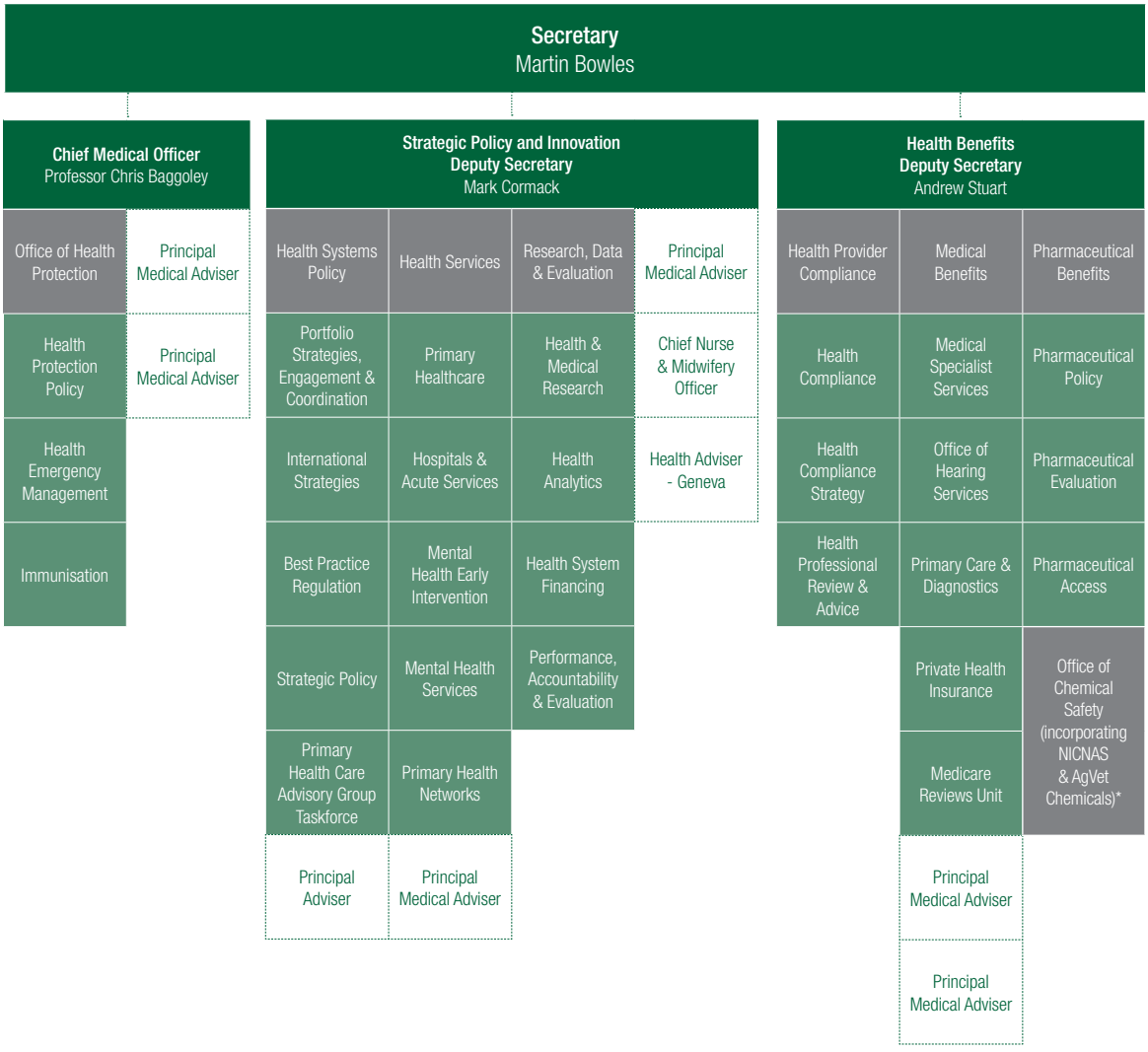
Changes to Portfolio entities

In 2015-16, the Australian Government continued to reduce the size and complexity of Government through the Smaller Government reforms. These reforms, which include further reducing the number of Government bodies in the Health Portfolio, reduce overlap, streamline services and improve efficiency.

- From 1 July 2015, the functions of the Private Health Insurance Administration Council were transferred to the Australian Prudential Regulation Authority.
- From 1 July 2015, the responsibilities of the Private Health Insurance Ombudsman were transferred to the Office of the Commonwealth Ombudsman.
- From 30 June 2016, the National Health Performance Authority was abolished, with its functions transferring to the Australian Institute of Health and Welfare, the Australian Commission on Safety and Quality in Health Care, and the Department of Health.
- From 1 July 2016, the operational functions of the Independent Hospital Pricing Authority transferred to the Department of Health, with the Board, Chief Executive Officer and associated functions retained.
- From 1 July 2016, the Australian Digital Health Agency commenced operation, replacing the National eHealth Transition Authority. The Agency will manage governance, operation and ongoing delivery of digital health.

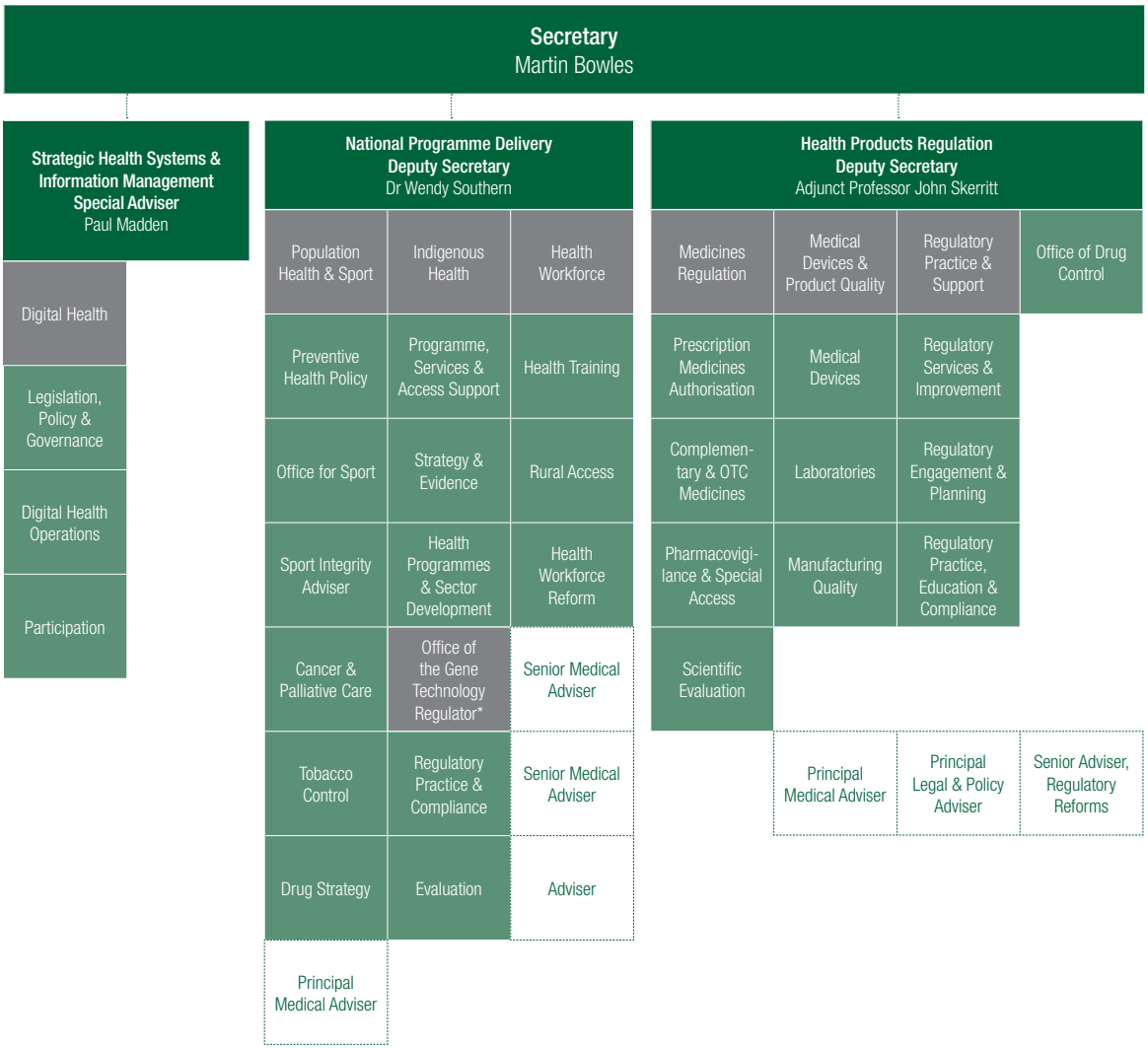
1.3 Structure **Chart** as at 30 June 2016

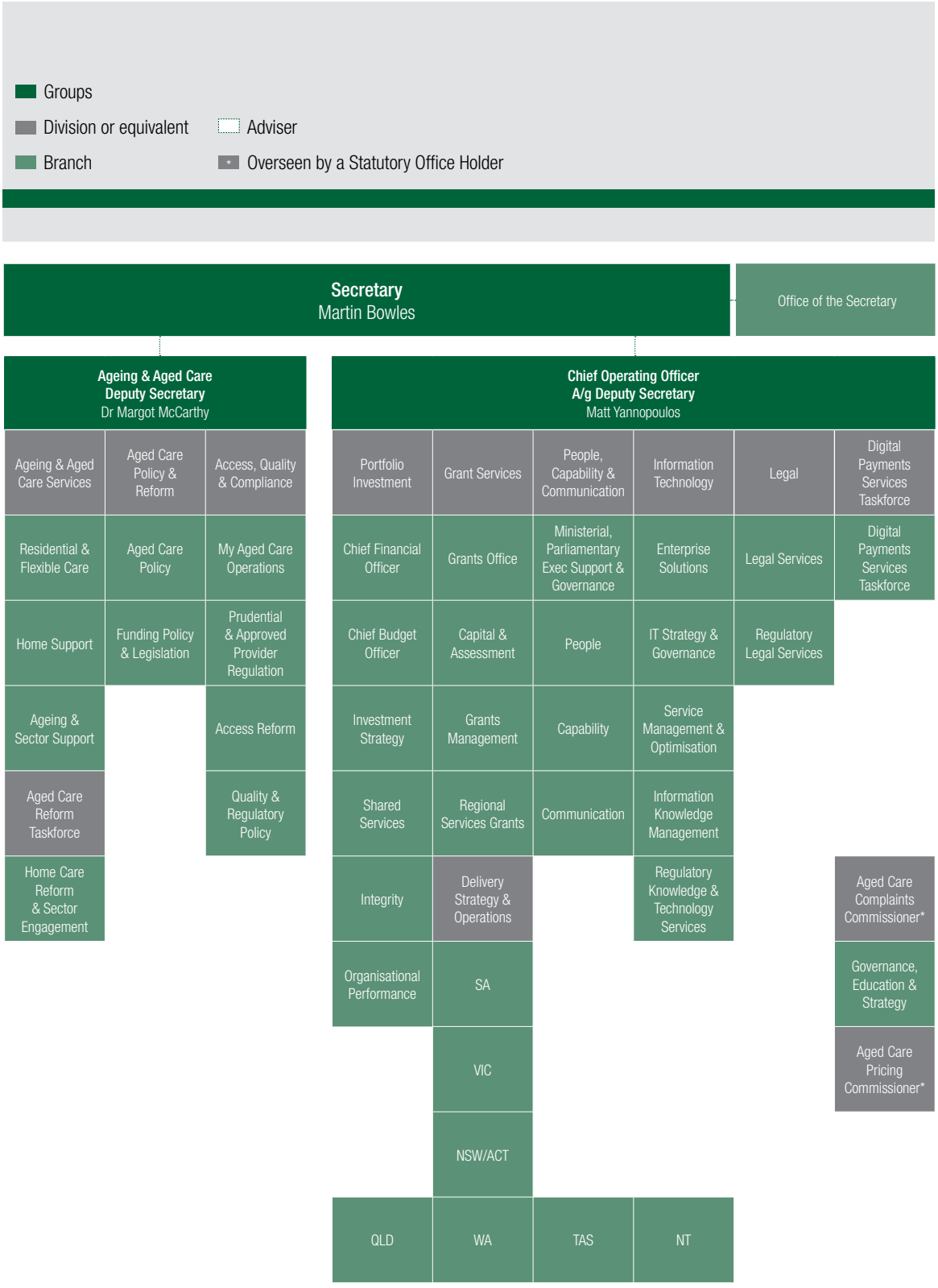
The Department's current structure chart is available at:
www.health.gov.au/internet/main/publishing.nsf/Content/health-struct.htm



1.3 Structure

Chart as at 30 June 2016




Groups
Division or equivalent
Adviser
Branch
Overseen by a Statutory Office Holder
Secretary
Martin Bowles
Office of the Secretary
Ageing & Aged Care
Deputy Secretary
Dr Margot McCarthy
Ageing & Aged Care Services
Aged Care Policy & Reform
Access, Quality & Compliance
Residential & Flexible Care
Aged Care Policy
My Aged Care Operations
Home Support
Funding Policy & Legislation
Prudential & Approved Provider Regulation
Ageing & Sector Support
Access Reform
Aged Care Reform Taskforce
Quality & Regulatory Policy
Home Care Reform & Sector Engagement
Chief Operating Officer
A/g Deputy Secretary
Matt Yannopoulos
Portfolio Investment
Grant Services
People, Capability & Communication
Information Technology
Legal
Digital Payments Services Taskforce
Chief Financial Officer
Grants Office
Ministerial, Parliamentary Exec Support & Governance
Enterprise Solutions
Legal Services
Digital Payments Services Taskforce
Chief Budget Officer
Capital & Assessment
People
IT Strategy & Governance
Regulatory Legal Services
Investment Strategy
Grants Management
Capability
Service Management & Optimisation
Shared Services
Regional Services Grants
Communication
Information Knowledge Management
Integrity
Delivery Strategy & Operations
Regulatory Knowledge & Technology Services
Aged Care Complaints Commissioner*
Organisational Performance
SA
Governance, Education & Strategy
VIC
Aged Care Pricing Commissioner*
NSW/ACT
QLD
WA
TAS
NT

1.4 Ministerial Responsibilities as at 30 June 2016

The Hon Sussan Ley MP Minister for Health, Minister for Aged Care and Minister for Sport

As senior Minister and the Portfolio's Cabinet member, Minister Ley held overall responsibility for the Portfolio, its entities and programs with specific responsibility for:

- Medicare benefits
- pharmaceutical benefits
- hospitals policy and implementation of funding reforms
- private health insurance
- health workforce
- primary health care
- digital health
- mental health policy
- health protection
- aged care policy and funding
- sport
- Therapeutic Goods Administration
- palliative care

Senator the Hon Fiona Nash Minister for Rural Health

Senator the Hon Fiona Nash had responsibility for:

- rural and regional health
- rural health workforce
- Indigenous health services
- tobacco
- illicit drugs including National Drug Strategy
- National Ice Action Strategy
- alcohol
- food policy and regulation
- oversight of the following Portfolio entities:
  - Food Standards Australia New Zealand

On 19 July 2016, the Prime Minister, the Hon Malcolm Turnbull MP's new Ministry was sworn in. The current Health Portfolio Ministers and their responsibilities are available at: www.health.gov.au/internet/main/publishing.nsf/Content/Ministers-1

The Hon Ken Wyatt AM, MP Assistant Minister for Health and Aged Care

Assistant Minister Wyatt had responsibility for:

- aged care service delivery and implementation
- dementia
- multipurpose services
- Office of Chemical Safety
- Office of the Gene Technology Regulator
- National Industrial Chemicals Notification and Assessment Scheme
- hearing services
- oversight of the following Portfolio entities:
  - Australian Radiation Protection and Nuclear Safety Agency
  - National Blood Authority
  - Australian Organ and Tissue Donation and Transplantation Authority (Organ and Tissue Authority)

1.5 Department-Specific **Outcomes**

Outcomes are the Government's intended results, benefits or consequences for the Australian community. The Government requires entities, 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.

Listed below are the outcomes relevant to the Department and the programs managed under each outcome in 2015-16.

Outcome 1
Population Health

1.1: Public Health, Chronic Disease and Palliative Care

1.2: Drug Strategy

1.3: Immunisation

Outcome 2
Access to Pharmaceutical Services

2.1: Community Pharmacy and Pharmaceutical Awareness

2.2: Pharmaceuticals and Pharmaceutical Services

2.3: Targeted Assistance – Pharmaceuticals

2.4: Targeted Assistance – Aids and Appliances

Outcome 3
Access to Medical and Dental Services

3.1: Medicare Services

3.2: Targeted Assistance – Medical

3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology

3.4: Medical Indemnity

3.5: Hearing Services

3.6: Dental Services

Outcome 4
Acute Care

4.1: Public Hospitals and Information

Outcome 5
Primary Health Care

5.1: Primary Care Financing, Quality and Access

5.2: Primary Care Practice Incentives

5.3: Aboriginal and Torres Strait Islander Health

5.4: Mental Health

5.5: Rural Health Services

Outcome 6
Private Health

6.1: Private Health Insurance

Outcome 7
Health Infrastructure, Regulation, Safety and Quality

7.1: eHealth

7.2: Health Information

7.3: International Policy Engagement

7.4: Research Capacity and Quality

7.5: Health Infrastructure

7.6: Blood and Organ Donation

7.7: Regulatory Policy

Outcome 8
Health Workforce Capacity

8.1: Workforce and Rural Distribution

8.2: Workforce Development and Innovation

Outcome 9
Biosecurity and Emergency Response

9.1: Health Emergency Planning and Response

Outcome 10
Sport and Recreation

10.1: Sport and Recreation

Outcome 11
Ageing and Aged Care

11.1: Access and Information

11.2: Home Support

11.3: Home Care

11.4: Residential and Flexible Care

11.5: Workforce and Quality

11.6: Ageing and Service Improvement

1.6 Portfolio Entity-Specific **Outcomes**

In 2015-16 the Health Portfolio consisted of the Department and 17 Portfolio entities. Each entity has its own specific outcome(s), with performance against their outcome(s) reported in their respective annual reports.

Portfolio entity	Outcome
Australian Aged Care Quality Agency	High-quality care for persons receiving Australian Government subsidised residential aged care and aged care in the community through the accreditation of residential aged care services, the quality review of aged care services including services provided in the community, and the provision of information, education and training to the aged care sector.
Australian Commission on Safety and Quality in Health Care	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.
Australian Institute of Health and Welfare	A robust evidence-base for the health, housing and community sectors, including through developing and disseminating comparable health and welfare information and statistics.
Australian Organ and Tissue Donation and Transplantation Authority (Organ and Tissue Authority)	Improved access to organ and tissue transplants, including through a nationally coordinated and consistent approach and system.
Australian Radiation Protection and Nuclear Safety Agency	Protection of people and the environment through radiation protection and nuclear safety research, policy, advice, codes, standards, services and regulation.
Australian Sports Anti-Doping Authority	Protection of the health of athletes and the integrity of Australian sport, including through deterrence, detection and enforcement to eliminate doping.
Australian Sports Commission	**Outcome 1** Improved participation in structured physical activity, particularly organised sport, at the community level, including through leadership and targeted community-based sports activity. **Outcome 2** Excellence in sports performance and continued international sporting success, by talented athletes and coaches, including through leadership in high performance athlete development, and targeted science and research.

Portfolio entity	Outcome
Australian Sports Foundation Limited	Improved Australian sporting infrastructure through assisting eligible organisations to raise funds for registered sporting projects.
Cancer Australia	Minimised impacts of cancer, including through national leadership in cancer control with targeted research, cancer service development, education and consumer support.
Food Standards Australia New Zealand	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.
Independent Hospital Pricing Authority	Promote improved efficiency in, and access to, public hospital services primarily through setting efficient national prices and levels of block funding for hospital activities.
National Blood Authority	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.
National Health Funding Body	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.
National Health and Medical Research Council	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.
National Health Performance Authority	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.
National Mental Health Commission	Provide expert advice to the Australian Government and cross-sectoral leadership on the policy, programs, services and systems that support mental health in Australia, including through administering the Annual National Report Card on Mental Health and Suicide Prevention, undertaking performance monitoring and reporting, and engaging consumers and carers.
Professional Services Review	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.

PART 2

Annual Performance Statements

2.1 2015-16 Annual Performance Statements

The 2015-16 Annual Performance Statements are in accordance with s39(1)(a) of the PGPA Act for the 2015-16 financial year. The Annual Performance Statements accurately present the Department of Health's performance in accordance with s39(2) of the PGPA Act.

Introduction

As required under the *Public Governance, Performance and Accountability Act 2013*, this report contains the Department of Health's Annual Performance Statements for 2015-16. The Annual Performance Statements detail results achieved against the planned performance criteria set out in the *2015-16 Health Portfolio Budget Statements*, the Department's *2015-16 Corporate Plan* and the *2015-16 Health Portfolio Additional Estimates Statements*.

Structure of the Annual Performance Statements

The Annual Performance Statements demonstrate the direct link between each Outcome and its contribution to achieving the Department's Purpose. The Annual Performance Statements follow the following structure – each Outcome contains:

- analysis of the Department's performance against the objective of the Outcome;
- key community benefits delivered through the Outcome;
- graphical representation of performance criteria results for the Outcome;
- key activities planned for 2016-17;
- analysis of the Department's performance against the objectives of the program(s) for the Outcome; and
- results and discussion against each performance criteria.

The page overleaf provides an outline of how the Department's 11 Outcomes contribute to the Department's broader Vision, Purpose and Strategic Priorities.

Results key

Met

100% of the target for 2015-16 has been achieved.

Substantially met

75–99% of the target for 2015-16 has been achieved.

Not met

Less than 75% of the target for 2015-16 has been achieved.

Data not available

Data is not available to report for the 2015-16 reporting year. Associated performance criteria are not included in the graphical representation of results.

N/A

The use of N/A in performance trend boxes indicates that data was not published in the relevant year for that performance criterion. Associated performance criteria are not included in the graphical representation of results.

Our Vision

Better health and wellbeing for all Australians, now and for future generations.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.

Strategic Priorities

Better health outcomes and reduced inequality through:

- An integrated approach that balances prevention, primary, secondary and tertiary care;
- Promoting greater engagement of individuals in their health and healthcare; and
- Enabling access for the most disadvantaged, including Aboriginal and Torres Strait Islander people, people in rural and remote areas, and people experiencing socio-economic disadvantage.

Affordable, accessible, efficient, and high quality health and aged care system through:

- Partnering and collaborating with others to deliver health and aged care programs;
- Better, more cost-effective patient care through innovation and technology; and
- Regulation that protects the health and safety of the community, while minimising unnecessary compliance burdens.

Better sport outcomes through:

- Boosting participation opportunities for all Australians;
- Optimising international performance; and
- Safeguarding integrity in sport.

We will achieve this through our Department's Outcomes

Outcome 1. Population Health

- Program 1.1: Public Health, Chronic Disease and Palliative Care
- Program 1.2: Drug Strategy
- Program 1.3: Immunisation

Outcome 2. Access to Pharmaceutical Services

- 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

Outcome 3. Access to Medical and Dental Services

- Program 3.1: Medicare Services
- Program 3.2: Targeted Assistance – Medical
- Program 3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology
- Program 3.4: Medical Indemnity
- Program 3.5: Hearing Services
- Program 3.6: Dental Services

Outcome 4. Acute Care

- Program 4.1: Public Hospitals and Information

Outcome 5. Primary Health Care

- Program 5.1: Primary Care Financing, Quality and Access
- Program 5.2: Primary Care Practice Incentives
- Program 5.3: Aboriginal and Torres Strait Islander Health
- Program 5.4: Mental Health
- Program 5.5: Rural Health Services

Outcome 6. Private Health

- Program 6.1: Private Health Insurance

Outcome 7. Health Infrastructure, Regulation, Safety and Quality

- Program 7.1: eHealth
- Program 7.2: Health Information
- Program 7.3: International Policy Engagement
- Program 7.4: Research Capacity and Quality
- Program 7.5: Health Infrastructure
- Program 7.6: Blood and Organ Donation
- Program 7.7: Regulatory Policy

Outcome 8. Health Workforce Capacity

- Program 8.1: Workforce and Rural Distribution
- Program 8.2: Workforce Development and Innovation

Outcome 9. Biosecurity and Emergency Response

- Program 9.1: Health Emergency Planning and Response

Outcome 10. Sport and Recreation

- Program 10.1: Sport and Recreation

Outcome 11. Ageing and Aged Care

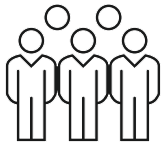
- Program 11.1: Access and Information
- Program 11.2: Home Support
- Program 11.3: Home Care
- Program 11.4: Residential and Flexible Care
- Program 11.5: Workforce and Quality
- Program 11.6: Ageing and Service Improvement

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 1

Outcome 1
Population Health



A reduction in the incidence of preventable mortality and morbidity, including through national public health initiatives, promotion of healthy lifestyles, and approaches covering disease prevention, health screening and immunisation

Analysis of performance – **Outcome 1** Population Health

In 2015-16, the Department implemented key public health initiatives that contributed to the reduction of the incidence of chronic disease and encouraged Australians to lead healthier and more active lifestyles. These included the development of strategies for asthma, diabetes and chronic conditions. In addition, continuation and expansion of the national cervical, bowel and breast screening programs will ensure more Australians are screened, increasing the chances of detecting cancers early and saving more lives.

The Department also continued to deliver programs and communication campaigns aimed at discouraging the use and misuse of alcohol, tobacco, prescription and illicit drugs. Through the delivery of the National Immunisation Program, childhood immunisation rates continued to be high, indicating a high level of protection in the Australian community.

These activities have contributed to the Department's achievement of the objectives under Outcome 1 and Our Purpose.

Key community benefits for **Outcome 1** in 2015-16

Improved detection and survival outcomes for people with cancer

The National Bowel Cancer Screening Program expanded to include 64 and 72 year olds. When fully implemented in 2020, four million Australians aged 50–74 will be invited to participate every two years.

Continued to reduce tobacco use in the community through education

On 1 May 2016, a new national media campaign targeting Aboriginal and Torres Strait Islander smokers was launched. The campaign, *Don't Make Smokes Your Story*, encourages smokers to make a serious quit attempt, not just for themselves but also for the health and wellbeing of their families.

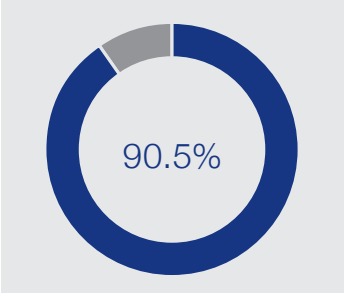
Increased national immunisation coverage rates and improved the efficiency of the National Immunisation Program

Childhood vaccination coverage rates have been maintained or improved in 2015-16, particularly among Aboriginal and Torres Strait Islander children.

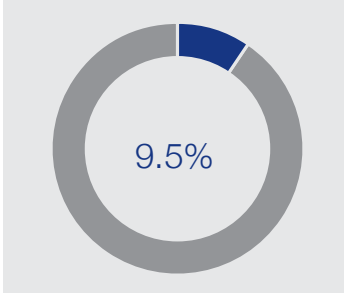
Combatted the decline in physical activity among young women aged 12—19 years

The *Girls Make Your Move* campaign was launched to increase positive attitudes among young women towards being physically active and provide information about different ways to participate in physical activity and sport. In particular, there have been improvements in perceptions about the importance of being active for young women, that activity is good for both mental and physical health and that it is fun.

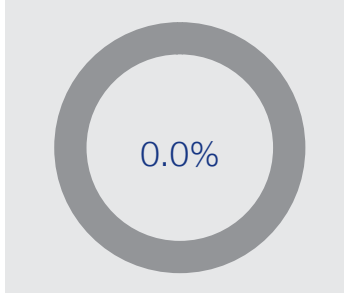
Summary of performance criteria results for **Outcome 1**



Met



Substantially met



Not met

Looking ahead

- In 2016-17, the Department will support the renewal of the National Cervical Screening Program and expansion of the National Bowel Cancer Screening Program. Implementation of the National Cancer Screening Register is expected to commence in early 2017.
- The next Australian National Drug Strategy Household Survey will be conducted in 2016-17.
- From September 2016, the Australian Childhood Immunisation Register will expand to become the Australian Immunisation Register, and will collect immunisation data for all Australians where vaccinations have been provided through general practice and community clinics.
- In 2016-17, an evaluation of the ongoing effectiveness of the current suite of health warnings on tobacco products will be initiated.

Programs and program objectives contributing to **Outcome 1**

Program 1.1: Public Health, Chronic Disease and Palliative Care

- Reduce the incidence of chronic disease and promote healthier lifestyles
- Support the development and implementation of evidence-based food regulatory policy
- Improve detection, treatment and survival outcomes for people with cancer
- Reduce the incidence of blood-borne viruses and sexually transmissible infections
- Improve access to high quality palliative care services

Program 1.2: Drug Strategy

- Reduce harm to individuals and communities from misuse of alcohol, pharmaceuticals and use of illicit drugs
- Reduce the harmful effects of tobacco use

Program 1.3: Immunisation

- Increase national immunisation coverage rates and improve the efficiency of the National Immunisation Program

Analysis of performance – Program 1.1: Public Health, Chronic Disease and Palliative Care

The Department has met all performance targets for Program 1.1: Public Health, Chronic Disease and Palliative Care, for criteria for which data is currently available.

Chronic diseases are the leading cause of preventable death and disease in Australia, presenting a major challenge to Australia's health care system. In 2015-16, the Department continued efforts to reduce the incidence of chronic disease in the community, through the finalisation of the *Australian National Diabetes Strategy 2016–2020*, and the development of a National Asthma Strategy, and the National Strategic Framework for Chronic Conditions. A cross-jurisdictional working group comprising State and Territory health department representatives will develop an Implementation Plan for the Australian National Diabetes Strategy.

In 2015-16, the Department continued efforts to maintain and increase cancer screening rates for eligible Australians. Recognising the importance of cancer screening in the early detection and treatment of cancer, the Department continued expansion of the National Bowel Cancer Screening Program and BreastScreen Australia, and commenced implementing changes to the National Cervical Screening Program. Continuing to actively invite Australians to participate in cancer screening programs will ensure that more Australians are screened, increasing the chances of detecting cancer early and saving more lives. In some cases, early detection also means less invasive treatment.

A key challenge to increasing participation in cancer screening programs is effectively and efficiently supporting equitable access, particularly for harder to reach groups, including Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse people. In 2015-16, the Department implemented communication strategies to improve participation in cancer screening.

In 2015-16, the Department continued to implement priority actions of the National Blood-borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategies 2014–2017. Although these actions focus on a reduction in transmission of BBV and STI in priority populations, the flow-on effect is a decreased risk of transmission in the broader community. Through regular progress reporting, the Department ensures a comprehensive approach to increasing BBV and STI testing and treatment, helping to identify and respond to any gaps that increase the risk of transmission in the community.

Through development and implementation of evidence-based food regulatory policy, the community continues to benefit from confidence in the safety of the food supply chain, and consumers are able to make informed choices about food.

Girls Make Your Move – inspiring, energising and empowering young women to be more active

Launched in February 2016, the *Girls Make Your Move* campaign is about inspiring, energising and empowering young women and girls aged 12–19 years to be more active. It reinforces the many benefits of an active life, whether through recreation, incidental physical activity or sport.

The campaign was in response to 2014-15 research that identified 55.9% of girls aged 15–17 years reported no or low exercise levels, compared to boys at 38.3%. Young women also tend to reduce their participation in sport and physical activity levels at a faster rate than boys.

The campaign addresses this by encouraging young girls' participation in physical activity and sport by reducing perceived barriers, generating positive perceptions towards exercise and generating intentions to be more active.

The campaign encourages sport and physical activity to be a natural part of young women's lives – it's about having fun and feeling good:

"…it makes me feel good about myself, and being active and not just going home and watching T.V., and being proud of what I've done or accomplished." – Selam, 16 years

"…it helps with my mental state as well as my physical. I feel like it's a big achievement in my life." – Taesha, 17 years

This campaign encourages young women in their teenage years to lay down the foundations for the rest of their lives as they are setting up good habits and their muscles and bones are growing.

Being active has many physical, social, emotional and economic benefits for individuals and the community. Regular physical activity can help with managing stress, alleviating depression and anxiety, strengthening self-esteem, enhancing mood and boosting mental alertness. It also provides social benefits through increased social interaction and integration.

Comprising a website,[13] Instagram presence with over 7,000 followers, advertising across traditional and social media, events and public relations, the campaign has reached over 80% of girls aged 12–19 years. The campaign has been positively received, with more than one in five (23%) girls surveyed indicating they had done more physical activity or sport as a result of the campaign.

[13] Available at: www.health.gov.au/internet/girlsmove/publishing.nsf/content/home

Reduce the incidence of chronic disease and promote healthier lifestyles

New National Diabetes Strategy in place to support better prevention and management of diabetes.

Source: 2015-16 Health Portfolio Budget Statements, p. 43

2015-16 Target	2015-16 Result
National Diabetes Strategy finalised and publicly released.	The *Australian National Diabetes Strategy 2016–2020* (the Strategy) was publicly released on 13 November 2015. **Result: Met** ✓

The Strategy is a high-level document that contains seven goals and potential areas for action. It identifies the most effective and appropriate interventions to reduce the impact of diabetes in the community and lead the way internationally in diabetes prevention, management and research. The Strategy is available on the Department's website at: www.health.gov.au/internet/main/publishing.nsf/Content/nds-2016-2020

The Commonwealth, State and Territory Governments will each have a role in supporting strategic investments that enable development and delivery of policies, programs and initiatives to address diabetes and support the goals of the Strategy.

Key chronic disease policy activities (National Strategic Framework for Chronic Conditions and National Asthma Strategy) are informed by appropriate expertise, knowledge and evidence.

Source: 2015-16 Health Portfolio Budget Statements, p. 44

2015-16 Target	2015-16 Result
Experts and the public are consulted through a variety of means, including: working groups, focussed workshops, and online processes.	Experts and the public were consulted in the development of chronic disease policies and strategies. **Result: Met** ✓

The development of the National Strategic Framework for Chronic Conditions has been informed by a variety of means, including: a Jurisdictional Working Group; relevant external experts; a Roundtable Workshop; and targeted and public consultation processes. These processes have provided opportunities for feedback from a range of stakeholders including peak bodies, key stakeholders including State Government representatives, clinical experts, health professionals, academics and consumer representatives. Thirteen targeted consultations were held in nine locations across Australia between September to November 2015 and a six-week online public consultation process concluded in June 2016 with 159 submissions received.

The development of a National Asthma Strategy has been informed by: an Advisory Group; a roundtable of experts and interested persons/organisations; and an online public consultation process. The Strategy is being managed by the National Asthma Council with funding from the Australian Government, and is expected to be completed in 2017.

Support the development and implementation of evidence-based food regulatory policy

Develop advice and policy for the Australian Government on food regulatory issues.
Source: 2015-16 Health Portfolio Budget Statements, p. 43

2015-16 Target	2015-16 Result
Relevant, evidence-based advice produced in a timely manner.	Relevant, evidence-based advice was produced in a timely manner. **Result: Met** ✓

The Department provided advice to the Australian Government in relation to food regulation issues such as country of origin labelling, maternal and infant nutrition, front-of-pack labelling, low tetrahydrocannabinol hemp in food, and labelling of food including health claims.

Promote a nationally consistent, evidence-based approach to food policy and regulation.
Source: 2015-16 Health Portfolio Budget Statements, p. 44 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Develop and implement nationally agreed evidence-based policies and standards.	A consistent regulatory approach was applied across Australia through nationally agreed evidence-based policies and standards. **Result: Met** ✓

In 2015-16, the Department continued to work with the Australia and New Zealand Ministerial Forum on Food Regulation, the Food Regulation Standing Committee and the Implementation Subcommittee for Food Regulation to develop and implement consistent food policies and regulations.

Improve detection, treatment and survival outcomes for people with cancer

Implement the expansion of the National Bowel Cancer Screening Program to a biennial screening interval.
Source: 2015-16 Health Portfolio Budget Statements, p. 43

2015-16 Target	2015-16 Result
Commencement of invitations to 64 and 72 year olds in 2016 and the continued delivery of communication and program enhancement activities.	64 and 72 year olds are being invited as scheduled. Phase two of the Communications Campaign and associated public relations activities supporting the National Bowel Cancer Screening Program was also undertaken in March 2016. **Result: Met** ✓

As a consequence of expanding the National Bowel Cancer Screening Program to include 64 and 72 year olds, around 40,000 invitations per week are being sent out. By 2020, when the expanded program is fully implemented, it is anticipated that around four million invitations will be sent out each year.

In addition to the Communications Campaign, additional promotional activities, such as an event with Culturally and Linguistically Diverse (CALD) clinicians was held in Sydney, hosted by Anton Enus, from the SBS television network. A regional radio promotional activity was also undertaken.

Other program enhancement activities are progressing well. These activities include a strategy and plan focussing on GP engagement to support increased participation and confidence in the program, and an Alternative Pathways Pilot to support increased participation of Aboriginal and Torres Strait Islander people.

Percentage of people invited to take part in the National Bowel Cancer Screening Program who participated.
Source: 2015-16 Health Portfolio Budget Statements, p. 45

2015-16 Target	2015-16 Result	Jan 2013 – Dec 2014	Jan 2012 – Dec 2013
41.0%	Data not available	37.0%[14]	36.0%

As there is a time lag between an invitation being sent, test results and collection of data from the cancer registry, participation rates for 2015 and 2016 will not be available until mid-2017.

A participation rate of 37% has been recorded for January 2013 to December 2014, an increase from 36% for January 2012 to December 2013.

To date, program participation has been hindered by the difficulty in promoting regular screening as the program moves from a five year to a two year screening interval. With the program on track to be fully implemented by 2020, when all eligible people aged 50–74 years will be invited to screen every two years, participation is expected to increase noticeably. A range of measures are being implemented to help increase program participation.

[14] AIHW 2016. National Bowel Cancer Screening Program: monitoring report 2016. Cancer series no. 98. Cat. no. CAN 97. Canberra: AIHW.

Support the expansion of BreastScreen Australia to invite Australian women 70-74 years of age through the implementation of a nationally consistent communication strategy.

Source: 2015-16 Health Portfolio Budget Statements, p. 43

2015-16 Target	2015-16 Result
Delivery of communication activities such as print, radio and online promotion.	Phase two of communication activities to support the expansion of BreastScreen Australia was launched in February 2016. **Result: Met** ✓

In February 2016, the Australian Government launched phase two of the campaign *An invitation that could save your life*, to support the expansion of the BreastScreen Australia program target age to include women aged 70–74.

Media activities included print (national, regional, community press and consumer magazines), radio (metro and regional), and out-of-home and online media activities. Media activities were also adapted for Aboriginal and Torres Strait Islander and CALD audiences by specialist agencies.

Number of breast care nurses employed through the McGrath Foundation.

Source: 2015-16 Health Portfolio Budget Statements, p. 44

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
57	57 **Result: Met** ✓	57	53	44	30

There are 57 Commonwealth-supported breast care nurses located across Australia, with around 86% of these nurses situated in regional and remote communities. Breast care nurses funded through the McGrath Foundation provide vital information, care and support to women diagnosed with breast cancer and their families.

In 2015-16, 4,286 women diagnosed with breast cancer, and their families, were supported by the McGrath Foundation breast care nurses.

Percentage of women 50-69 years of age participating in BreastScreen Australia.

Source: 2015-16 Health Portfolio Budget Statements, p. 45

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
55.0%	Data not available	54.0%	53.7%	54.4%	54.6%

In 2015-16, the Australian Government continued to work with the States and Territories to provide free screening to ensure more Australian women participate in the BreastScreen program.

As there is a time lag between an invitation being sent, test results and collection of data from registries, participation rates for 2015 and 2016 are not yet available. These participation rates will not be available until 2017.

From 2014 to 2015, 54.0% of women aged 50–69 years participated in the program. This compares to 53.7% in 2013 and 2014, and 54.4% in 2012 and 2013.

Age is the biggest risk factor in developing breast cancer, with most breast cancers occurring in women over the age of 50.

Percentage of women 70–74 years of age participating in BreastScreen Australia.
Source: 2015-16 Health Portfolio Budget Statements, p. 45

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
51.0%	Data not available	48.7%	N/A	N/A	N/A

In 2015-16, BreastScreen Australia continued to actively invite women 70–74 years of age to participate in the program.

As there is a time lag between an invitation being sent, test results and collection of data from registries, participation rates for 2015 and 2016 are not yet available. These participation rates will not be available until 2017.

From 2014 to 2015, 48.7% of women aged 70–74 years participated in the program.

Percentage of women in the target age group participating in the National Cervical Screening Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 46

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
57.0%	Data not available	56.9%	57.0%	57.7%	57.3%

As there is a time lag between reminders being sent, test results and collection of data from registries, participation rates for 2015-16 are not yet available. In 2014 and 2015, 56.9% of women aged 20–69 participated in the National Cervical Screening Program (NCSP).

In 2014 and 2015, more than 3.83 million women participated in the NCSP. Currently 56.9% of women participate in the NCSP every two years, which increases to 70.2% every three years and 83.0% every five years.

The Australian Government has now accepted the evidence-based recommendations of the Medical Services Advisory Committee (MSAC) that a five-yearly primary human papillomavirus (HPV) test should replace the current biennial Pap test for cervical screening. This will ensure Australian women will have access to a cervical screening program that is safe, effective, efficient, and is based on current evidence.

The renewed NCSP will commence on 1 May 2017 when the HPV screening test will become available on the Medicare Benefits Schedule and the National Cancer Screening Register will be in place to support the renewed clinical pathway.

Reduce the incidence of blood-borne viruses and sexually transmissible infections

Implement priority actions contained in the National BBV and STI Strategies 2014–17.
Source: 2015-16 Health Portfolio Budget Statements, p. 44

2015-16 Target	2015-16 Result
Ongoing implementation of programs which support delivery of priority action areas to reduce BBV and STI.	Implementation of priority programs continued through 2015-16. **Result: Met** ✓

Priority actions contained in the National BBV and STI Strategies 2014–2017 and the Implementation Plan continued throughout 2015-16. To achieve this goal, the Department worked with non-Government organisations representing and targeting communities affected by HIV, hepatitis B, hepatitis C and sexually transmissible infections.

Support programs which are effective in reducing the spread of communicable disease and working towards the national strategy targets.
Source: 2015-16 Health Portfolio Budget Statements, p. 45 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Reporting on progress of programs that support the National BBV and STI Strategies 2014–2017 is undertaken according to the evaluation framework in the Implementation and Evaluation Plan.	Reporting against the progress of programs is being undertaken in accordance with the Implementation Plan. **Result: Met** ✓

The Commonwealth, together with partners to the National BBV and STI Strategies 2014–2017, reports regularly on progress of programs. This process is ongoing through the life of the strategies.

Improve access to high quality palliative care services

Implement national palliative care quality improvement activities consistent with the National Palliative Care Strategy 2010.
Source: 2015-16 Health Portfolio Budget Statements, p. 44

2015-16 Target	2015-16 Result
Implementation of national projects that support quality improvement in palliative care priority areas including education, training, quality standards and advance care planning.	Implementation of all national projects that support quality improvement in palliative care continued in 2015-16. **Result: Met** ✓

National palliative care projects continued to be implemented in 2015-16. These projects continued to be consistent with the National Palliative Care Strategy 2010 and the objective of assisting Australians to live well at the end of life.

Support effective quality improvements to palliative care priority areas through funding of national projects.

Source: 2015-16 Health Portfolio Budget Statements, p. 45

2015-16 Target	2015-16 Result
Progress reports from contracted organisations indicate that activities are being implemented in accordance with contractual arrangements and are achieving expected outcomes.	All progress reports from contracted organisations indicate that national palliative care projects are achieving expected outcomes in 2015-16. **Result: Met**

National palliative care projects continue to submit progress reports that indicate activities are being implemented in accordance with contractual arrangements. These national projects address three key objectives:

- improve access to high quality palliative care for all Australians as they require it;
- enhance the quality of palliative care service delivery; and
- provide support for people who are dying, their families and carers.

Analysis of performance – Program 1.2: Drug Strategy

The Department has met all performance targets for Program 1.2: Drug Strategy, for criteria for which data is currently available. In December 2015, the Department launched the Positive Choices web portal. The web portal provides a national access point for evidence-based information, tools, and school-based programs on illicit drugs and related harms. It is targeted at teachers, parents and students. It raises awareness about harms associated with illegal drug use, and improves access to evidence-based drug prevention resources.

In response to the National Ice Taskforce Final Report, the new National Ice Action Strategy was agreed at the 11 December 2015 meeting of the Council of Australian Governments. The National Ice Action Strategy includes funding targeted at strengthening education, prevention, treatment, support and community engagement. The Strategy includes a range of achievable actions that will help governments, service providers and communities to work together to reduce the use and supply of ice in Australia, and the harm it causes.

Tobacco smoking is one of the leading causes of preventable death and disease in Australia. The Department continues efforts to reduce the harmful effects of tobacco use among Australians. In 2015-16, this included a new media campaign, *Don't Make Smokes Your Story*, which encourages Aboriginal and Torres Strait Islander smokers to quit, but is also resonating well with non-Indigenous smokers. For more information about initiatives targeted at reducing smoking rates among Aboriginal and Torres Strait Islander people, see Program 5.3: Aboriginal and Torres Strait Islander Health and the case study below.

The Department also concluded a Post-Implementation Review (PIR) of tobacco plain packaging, which became fully effective on 1 December 2012. The PIR concluded that the tobacco plain packaging measure is achieving its public health objectives of reducing smoking and exposure to tobacco smoke in Australia, and it is expected to continue to do so into the future.

An expert analysis commissioned by the Department found that tobacco plain packaging, in combination with updated and enlarged graphic health warnings (the 2012 packaging changes), was associated with a statistically significant estimated decline in smoking prevalence. The analysis estimated that the 2012 packaging changes accounted for about one quarter of the total drop in smoking prevalence, during the 34 month post-implementation period from 1 December 2012 to 30 September 2015, which equates to more than 108,000 fewer smokers.

The Government continued to fund the defence of legal challenges to tobacco plain packaging in two international fora. On 18 December 2015, the arbitral tribunal that heard Philip Morris Asia's (PM Asia) claim regarding Australia's tobacco plain packaging measure, unanimously agreed with the Australian Government's position that the tribunal had no jurisdiction to hear the merits of PM Asia's claim.

In 2015-16, compliance and enforcement activities under the *Tobacco Plain Packaging Act 2011* (the Act) continued. The Department is required to report on contraventions of the Act. The 2015-16 report is included under Part 3.2: *External Scrutiny* of this Annual Report.

Working towards a tobacco-free future

Australia's smoking rates are among the lowest in the world, but this is by no means due to chance.

Over the last few decades, the Australian Government has worked hard to reduce Australia's smoking rates. We have introduced tobacco plain packaging; new and larger graphic health warnings on tobacco products; increased tobacco taxes; restricted tobacco advertising and promotion, including on the internet; continued developing new anti-smoking social marketing campaigns to educate Australians about the health impacts of smoking; and subsidised smoking aids and nicotine replacement therapies through the Pharmaceutical Benefits Scheme.

In 2014-15, 14.5% of adults aged 18 years and over smoked daily (approximately 2.6 million smokers), a decrease from 16.1% in 2011-2012.[15] In April 2016, the Australian Bureau of Statistics released the 2014-15 National Aboriginal Torres Islander Social Survey, which showed that 40.6% of Aboriginal and Torres Strait Islanders aged 18 years and over were daily smokers, down from 44.4% in 2012-13.[16]

The Council of Australian Governments target is that by 2018, the adult daily smoking rate will be reduced to 10%, and the Aboriginal and Torres Strait Islander adult daily smoking rate will be halved from 47.7% within the same period.

Don't Make Smokes Your Story is the latest phase of the National Tobacco Campaign which uses an empowering and positive approach to encourage quit attempts among Aboriginal and Torres Strait Islander smokers.

The campaign tells the story of a young dad, "Ted", played by a former smoker alongside his real family. The storyline tells how Ted quits smoking for his family - two young children, his pregnant wife, mum and aunties. He has lost his father to smoking-related illnesses and has experienced his own health scares. A range of extension videos demonstrate Ted's quitting journey, including Ted actively refusing smokes in common trigger environments and accessing a range of support services such as speaking to an Aboriginal counsellor from the Quitline and using the *My QuitBuddy* mobile app.

This story ran alongside the other existing advertisements, *Break the Chain* and *Quit for You, Quit for Two*, as part of an integrated strategy utilising mainstream mass media, local and targeted channels, digital and social media, and below the line activities.

Quitting resources available include – *My QuitBuddy* and *Quit for You, Quit for Two* mobile phone apps, that are free and can be downloaded to an iPhone or iPad from the Apple iTunes online store[17] or an android phone from Google Play store.[18]

15 ABS, National Health Survey: First Results 2014-15. Released 8 December 2015. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument

16 ABS, National Aboriginal and Torres Strait Islander Social Survey, 2014-15 – Australia. Released 28 April 2016. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02014-15?OpenDocument

17 Available at: itunes.apple.com/au/app/quit-for-you-quit-for-two/id549772042

18 Available at: play.google.com/store/apps/details?id=au.com.bcm.quitfortwo

Reduce harm to individuals and communities from misuse of alcohol, pharmaceuticals and use of illicit drugs

Provide up-to-date information to young people on the risks and harms of illicit drug use.
Source: 2015-16 Health Portfolio Budget Statements, p. 47

2015-16 Target	2015-16 Result
Continue dissemination of materials and delivery of the National Drugs Campaign including provision of resources for parents, teachers and students.	Material continued to be disseminated supporting the National Drugs Campaign, including the launch of the Positive Choices web portal in December 2015. **Result: Met** ✓

The Positive Choices web portal was developed to provide curriculum-specific materials aimed at preventing drug and alcohol harms, which can be used by schools in an Australian context. It raises awareness about harms associated with illegal drug use, and improves access to evidence-based drug prevention resources and programs. The website includes a menu of age-appropriate options for school teachers, students and their parents. It enables parents and teachers to provide their children and students with credible and up-to-date information.

The web portal and any related materials developed are promoted on the National Drugs Campaign website.[19]

While the portal has only been accessible since December 2015, there are early indications that it is being accessed regularly and visitor numbers are growing.

Availability of prevention and early intervention substance misuse resources for teachers, parents and students.
Source: 2015-16 Health Portfolio Budget Statements, p. 48

2015-16 Target	2015-16 Result
Increasing access to new material through the National Drugs Campaign website as measured by an increase in site visits.	2015-16 saw a 9.9% increase in the number of visitors to the National Drugs Campaign website. **Result: Met** ✓

The National Drugs Campaign website was updated during 2015-16 to include information on activities relating to:

- the National Ice Taskforce, including promotion of the final report of the Taskforce and the National Ice Action Strategy; and
- promotion of links for the Positive Choices web portal and state-based help and support services.

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

Percentage of population 14 years of age and older recently (in the last 12 months) using an illicit drug.
Source: 2015-16 Health Portfolio Budget Statements, p. 48 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result	2013	2010	2007	2004
<13.4%	Data not available	15.0%	14.7%	13.4%	15.3%

The National Drug Strategy Household Survey (NDSHS) is undertaken every three years and is the primary data source used to report on this criterion.

The most recent NDSHS undertaken in 2013 found that the prevalence of recent use of illicit drugs was relatively stable between 2004 and 2013. The next NDSHS will be conducted during 2016, and results for the 2016 NDSHS will be available in 2017.

NDSHS data is available at: www.aihw.gov.au/alcohol-and-other-drugs/ndshs/

Reduce the harmful effects of tobacco use

Implement social marketing campaigns to raise awareness of the dangers of smoking and encourage and support attempts to quit.
Source: 2015-16 Health Portfolio Budget Statements, p. 47

2015-16 Target	2015-16 Result
Deliver a campaign within agreed timeframes.	National Tobacco Campaign launched 1 May 2016. **Result: Met** ✓

A new national campaign primarily targeting Aboriginal and Torres Strait Islander smokers 18–40 years of age was launched on 1 May 2016. The campaign, *Don't Make Smokes Your Story*, included media placement across television, print, radio, cinema, out-of-home and digital/social media channels, as well local level community activities.

During the campaign period of 1 May to 18 June 2016 there were 32,760 downloads of the *My Quit Buddy* mobile phone app and a total of 234,698 visits to the QuitNow website. During 2015-16, there were 48,487 calls to Quitline counsellors.

Percentage of population 18 years of age and over who are daily smokers.
Source: 2015-16 Health Portfolio Budget Statements, p. 48 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result	2014-15	2011-12	2007-08
12.6%	Data not available	14.5%	16.1%	18.9%

In December 2015, the Australian Bureau of Statistics (ABS) released the *National Health Survey: First Results, 2014-15*, which showed that 14.5% of adults aged 18 years and over were daily smokers (2.6 million adults), down from 16.1% in 2011-12. The report also showed that a further 1.5% of adults smoked less often than daily, 31.4% were ex-smokers, and just over half, 52.6%, had never smoked. The ABS National Health Survey is undertaken every three years, therefore updated information from this survey will be available in 2018.

Analysis of performance – Program 1.3: Immunisation

The Department has either met or substantially met all performance targets for Program 1.3: Immunisation.

High immunisation rates were maintained in 2015-16, with over 90 per cent of children fully immunised at one, two and five years of age. High coverage rates indicate a high level of protection against vaccine preventable diseases for individuals, which reduces transmission of infection within the Australian community, resulting in fewer outbreaks and stronger protection for those unable to immunise.

However, the rate achieved is below the aspirational target of 95 per cent set by the Chief Medical Officer and the State and Territory Chief Health Officers in 2014. During the previous 12 months of reporting, immunisation coverage rates have continued to increase. This trend is expected to continue towards the 95 per cent target. The Department will continue to work with States and Territories to achieve this target over coming years, noting that geographic variation in coverage will need to be addressed to achieve this aspirational target.

Local level analysis has found significant regional variation in coverage rates, which can create vulnerability to local outbreaks. The Department is conducting further work to address this, including investigating the immunisation information needs of Australians, and options for addressing vaccine hesitancy.[20]

In 2015-16, the Department completed four tenders under the Essential Vaccines Procurement Strategy. Sourcing vaccines under this strategy enables the Department to continue working with States and Territories to secure the continual supply of high quality, safe and efficacious vaccines at value for money for the Australian community.

Increase national immunisation coverage rates and improve the efficiency of the National Immunisation Program

Key actions of the National Immunisation Strategy 2013-2018 (NIS) are implemented.
Source: 2015-16 Health Portfolio Budget Statements, p. 51

2015-16 Target	2015-16 Result
NIS actions to improve vaccination coverage rates are undertaken in accordance with the NIS Implementation Plan.	Implementation of key actions under priority one of the NIS was ongoing in 2015-16. Vaccine coverage rates for human papilloma virus improved amongst girls and boys (currently 77% and 66% respectively in 2015, up from 73% and 61% in 2014). **Result: Substantially met** ✓

Key activities in 2015-16 include provision of free catch up vaccines for children aged 10 to 19 years of age, additional incentives for vaccination providers to catch up children more than two months overdue for vaccines, and dissemination of materials to support vaccination providers engaging with parents with concerns about vaccination.

In 2015-16, phased expansion of the Australian Childhood Immunisation Register to the whole-of-life Australian Immunisation Register (AIR) commenced. From 1 January 2016, immunisation data collection was expanded to include individuals up to 20 years of age (up from 7 years of age).

From September 2016, the AIR will collect immunisation data for all Australians where vaccinations have been provided through general practice and community clinics. This improved data capture will, for the first time, enable understanding of immunisation rates in adolescents and adults at the national level.

[20] Vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy is complex and context specific varying across time, place and vaccines. It includes factors such as complacency, convenience and confidence. Further information is available at: www.who.int/immunization/programmes_systems/vaccine_hesitancy/en/

Number of completed tenders under the National Partnership Agreement on Essential Vaccines (Essential Vaccines Procurement Strategy).
Source: 2015-16 Health Portfolio Budget Statements, p. 51

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
2	4 **Result: Met** ✓	1	0	3	1

As part of the Department's transition to centralised purchasing arrangements for essential vaccines funded under the National Immunisation Program (NIP), four tenders were completed in the 2015-16 financial year for the supply of:

- human papillomavirus (HPV) vaccine to adolescents aged 12 to 13 years;
- hepatitis A vaccine to Aboriginal and Torres Strait Islander children in high risk areas;
- diphtheria-tetanus-acellular-pertussis (DTPa) vaccine to infants aged 18 months; and
- pneumococcal vaccine to medically at risk four year olds, medically at risk Aboriginal and Torres Strait Islander people aged 15 years and over, Aboriginal and Torres Strait Islander people aged 50 years and over, and people aged 65 years and over.

During 2015-16, the Department also procured catch-up vaccines for the *No Jab, No Pay* Budget measure to enable adolescents aged 10–19 years in receipt of family payments to access free catch up vaccines.

States and Territories meet the requirements of the National Partnership Agreement on Essential Vaccines (NPEV).
Source: 2015-16 Health Portfolio Budget Statements, p. 51

2015-16 Target	2015-16 Result
Analysis of data from the Australian Childhood Immunisation Register confirms that the performance benchmarks to improve vaccination coverage rates are achieved in the NPEV.	Preliminary analysis of State and Territory performance for 2015-16 shows that States and Territories have met the required NPEV benchmarks. **Result: Met** ✓

Childhood vaccination coverage rates have been maintained or improved in 2015-16.

- All States and Territories met benchmark 1 – maintain or increase coverage rates for Indigenous Australian children registered aged: 12–15 months; 24–27 months; and 60–63 months.
- All States and Territories met benchmark 2 – maintain or increase coverage in areas of low immunisation.
- All States and Territories met benchmark 3 – maintain or decrease vaccine wastage and leakage to 10% or below.
- All States and Territories met benchmark 4 – maintain or increase coverage rates for four year olds.

Increase the immunisation coverage rates among children 12–15 months of age.
Source: 2015-16 Health Portfolio Budget Statements, p. 52 & 2015-16 Corporate Plan, p. 15 (aggregated performance criteria)

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
91.5%	93.0% **Result: Met** ✓	91.3%	90.4%	91.3%	91.8%

Increase the immunisation coverage rates among children 24–27 months of age.
Source: 2015-16 Health Portfolio Budget Statements, p. 52 & 2015-16 Corporate Plan, p. 15 (aggregated performance criteria)

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
91.5%	90.7% **Result: Substantially met** ✓	89.2%	92.4%	92.4%	92.6%

Increase the immunisation coverage rates among children 60–63 months of age.
Source: 2015-16 Health Portfolio Budget Statements, p. 52 & 2015-16 Corporate Plan, p. 15 (aggregated performance criteria)

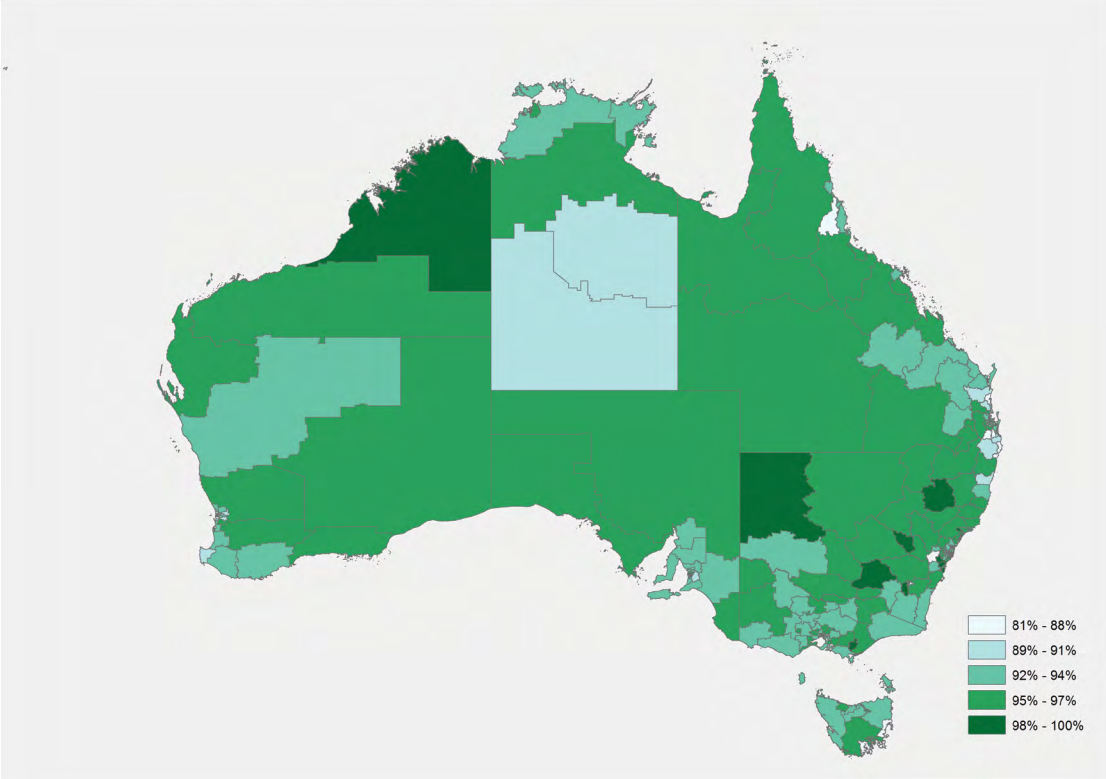
2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
92.0%	92.9% **Result: Met** ✓	92.3%	92.0%	91.5%	90.0%

In December 2014, the definition of fully immunised was updated to include meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months). This caused a drop in the 24–27 month coverage rates. The more vaccines that are included in the assessment of full immunisation, the higher the likelihood of reduced coverage rates. This usually resolves over time, as the changes become routine.

While there was a drop in coverage rates after December 2014, coverage rates have recently been increasing, and it is expected that coverage for 2015-16 will come closer to meeting the target.

Exceeding the national target is a good outcome, and all States and Territories experienced increased immunisation rates for children 12–15 months and 60–63 months of age.

Figure 1.1: Percentage of five year olds fully immunised by Statistical Area Level 3 (1 July 2015 – 30 June 2016)[21]



Increase the immunisation coverage rates among 12–15 months of age Aboriginal and Torres Strait Islander children.

Source: 2015-16 Health Portfolio Budget Statements, p. 52

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
87.0%	89.8% **Result: Met** ✓	N/A	N/A	N/A	N/A

Exceeding the national target is a good outcome, and all States and Territories experienced increased immunisation rates.

By five years of age Aboriginal and Torres Strait Islander children have very high vaccination rates, with coverage at 94.2%. The lower rates at one year of age (89.8%) show that these children are getting vaccinated but are doing so late. The Department will continue to work with States and Territories to improve vaccination timeliness in this cohort.

These high coverage rates provide Aboriginal and Torres Strait Islander children better protection against vaccine preventable diseases circulating within the community.

[21] Data source: Australian Childhood Immunisation Register. Statistical Area Level 3 is a designated reporting level that provides a geographic breakdown of Australia. It generally contains a population of between 20,000 and 130,000 people.

Outcome 1 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 1.1: Public Health, Chronic Disease and Palliative Care[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	165,074	155,205	(9,869)
Special appropriations			
Public Governance, Performance and Accountability Act 2013 s77 - repayments	2,000	8,107	6,107
Departmental expenses			
Departmental appropriation[3]	23,369	26,196	2,827
Expenses not requiring appropriation in the current year[4]	609	1,724	1,115
Total for Program 1.1	**191,052**	**191,232**	**180**
Program 1.2: Drug Strategy[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	122,232	121,806	(426)
Departmental expenses			
Departmental appropriation[3]	18,101	18,536	435
Expenses not requiring appropriation in the current year[4]	467	1,197	730
Total for Program 1.2	**140,800**	**141,539**	**739**
Program 1.3: Immunisation[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	53,696	42,590	(11,106)
to Australian Childhood Immunisation Register Special Account	(5,858)	(7,270)	(1,412)
Special appropriations			
National Health Act 1953 - essential vaccines	240,150	234,738	(5,412)
Special account			
Australian Childhood Immunisation Register Special Account	9,563	9,712	149
Departmental expenses			
Departmental appropriation[3]	9,960	9,862	(98)
Expenses not requiring appropriation in the current year[4]	257	614	357
Total for Program 1.3	**307,768**	**290,246**	**(17,522)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Outcome 1 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	341,002	319,601	(21,401)
to Special accounts	(5,858)	(7,270)	(1,412)
Special appropriations	242,150	242,845	695
Special accounts	9,563	9,712	149
Departmental Expenses			
Departmental appropriation[3]	51,430	54,594	3,164
Expenses not requiring appropriation in the current year[4]	1,333	3,535	2,202
Total expenses for Outcome 1	**639,620**	**623,017**	**(16,603)**
Average staffing level (number)	**309**	**325**	**16**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.
3 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
4 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 2

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

Analysis of performance – **Outcome 2** Access to Pharmaceutical Services

In 2015-16, the Department continued to support the Pharmaceutical Benefits Scheme (PBS), ensuring the efficiency and cost-effectiveness of the PBS, and supporting a viable effective community pharmacy sector. Access to a contemporary range of effective medicines is integral to improving health outcomes in Australia.

The Department managed the ongoing application of price disclosure policy which continues to reduce the price of many medicines for consumers and taxpayers.

The Department also continued to review medicines that are listed on the PBS to ensure that they remain clinically and cost effective. This helps to ensure that Australians have access to innovative and affordable medicines. In 2015-16, there were 370 new and amended PBS listings. This included high cost medicines for the treatment of cancers such as trastuzumab, pertuzumab and trastuzumab emtasine for the treatment of metastatic breast cancer, and pembrolizumab and trametinib for the treatment of melanoma.

The Department continued to support the integrity of the PBS by delivering on health provider compliance activities. Refer Program 3.1: Medicare Services and Appendix 3: *Health Provider Compliance Report*.

These activities have contributed to the Department's achievement of objectives under Outcome 2 and Our Purpose.

Key community benefits for **Outcome 2** in 2015-16

Ensured access to cost-effective, innovative and clinically effective medicines

The Department worked with the Pharmaceutical Benefits Advisory Committee and product sponsors to ensure the Australian community has access to contemporary, high quality and affordable medicines. 370 new and amended medications were listed on the PBS in a timely manner at a cost of $2.1 billion (including revenue).

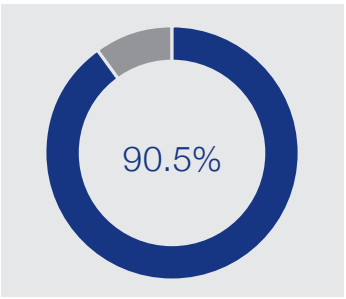
Provided access to expensive and lifesaving drugs for rare and life threatening medical conditions through the Life Saving Drugs Program

71 new patient applications to access medicines listed on the Life Saving Drugs Program were approved within 30 days, giving these patients access to critical medication.

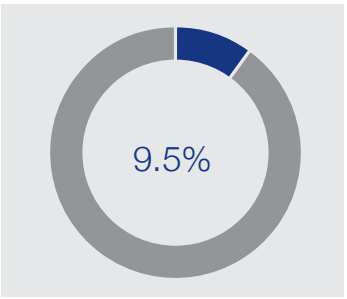
PBS subsidy for break-through drugs to cure chronic hepatitis C from 1 March 2016

Over 230,000 Australians living with chronic hepatitis C will benefit from having access to new medicines that cure this potentially fatal disease.

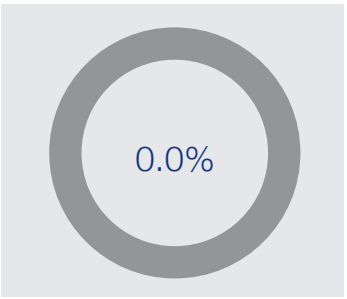
Summary of performance criteria results for **Outcome 2**



Met



Substantially met



Not met

Looking ahead

- The Department will implement the Pharmacy Trial Program during 2016-17. This program will test new approaches to providing primary care services to Australians through pharmacies.
- In 2016-17, the Australian Government will continue to consider new listings as recommended by the Pharmaceutical Benefits Advisory Committee.
- The Australian Government will continue to support the PBS by:
  - looking at ways to reduce the cost of medicines for taxpayers and consumers;
  - bringing new and innovative medicines on to the PBS in a timely way; and
  - ensuring efficiency in the pharmaceutical supply chain.
- The Department implemented the first phase of the Hospital Medication Chart on 1 July 2016, with electronic Hospital Medication Charts to be implemented by March 2017. The Hospital Medication Chart aims to improve the efficiency and safety of medication management in Australian hospitals, leading to improved quality use of medicines outcomes.

Programs and program objectives contributing to **Outcome 2**[22]

Program 2.1: Community Pharmacy and Pharmaceutical Awareness

- Support timely access to medicines and pharmacy services

Program 2.2: Pharmaceuticals and Pharmaceutical Services

- Increase the sustainability of the PBS[23]
- List cost-effective, innovative, clinically effective medicines on the PBS
- Post-market surveillance

Program 2.3: Targeted Assistance – Pharmaceuticals

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

Program 2.4: Targeted Assistance – Aids and Appliances

- To improve health outcomes for people with diabetes across Australia through the provision of subsidised products and self-management services
- Assist people with a stoma by providing stoma related products
- Improve the quality of life for people with Epidermolysis Bullosa
- Access to aids and appliances

[22] Revised performance information for Outcome 2 was published in the *2015-16 Portfolio Additional Estimates Statements*, replacing the performance information published in the *2015-16 Health Portfolio Budget Statements* and the Department's *2015-16 Corporate Plan*.

[23] Sustainability of the PBS refers to the ability of the Government to continue to fund medicines over the longer term given increasing demand for and costs of medicines and related services, e.g. dispensing.

Analysis of performance – Program 2.1: Community Pharmacy and Pharmaceutical Awareness

The Department has met all performance targets for Program 2.1: Community Pharmacy and Pharmaceutical Awareness. Access to pharmacy services is key to improving the health of all Australians. The Department has worked with key stakeholders, including consumer organisations and industry groups, to ensure access to community pharmacies.

The Department implemented new and continuing measures such as the pharmacy Administration, Handling and Infrastructure fee, the Co-payment $1 discount measure and the continuation of existing pharmacy programs. These have enhanced the timely and affordable access to PBS medicines and professional services, through community pharmacies, for all Australians.

In 2015-16, the Department also commenced developing a Pharmacy Trial Program which will trial new and expanded community pharmacy programs with the aim of improving clinical outcomes for consumers. This included work to develop trial protocols for three trials and a 'call for ideas' which generated 108 ideas for future trials.

The aim of the Community Services Obligation (CSO) Funding Pool is to ensure there are arrangements in place for all Australians to have timely access to PBS medicines, via their community pharmacy, regardless of where they live and usually within 24 hours. The CSO financially supports pharmaceutical wholesalers to supply the full range of PBS medicines and diabetes products under the National Diabetes Services Scheme to pharmacies across Australia, regardless of pharmacy location, within agreed timeframes.

Support timely access to medicines and pharmacy services

Maintenance of PharmCIS and delivery of an increased suite of reporting and data related to pharmacy and PBS funded medicine access and cost made available to Parliament, consumers, business.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 42

2015-16 Target	2015-16 Result
Periodically increase the volume and nature of data on the Department of Health website during the course of 2015-16.	The target was achieved with the ongoing publication of regular PBS schedules and data sets, and an increased range of data published. **Result: Met** ✓

In addition to the regular PBS data that is published and made available to the public, in 2015-16 there was an increase in the range and availability of data captured and the level of breakdown that is publicly available. For example, the Date of Supply and Under Co-payment PBS datasets are now updated and available monthly. This provides a complete picture of the PBS data to allow researchers and stakeholders the capability to perform more detailed analysis. The pbs.gov.au website was updated on 4 May 2016 to include additional data on Fifth Community Pharmacy Agreement expenses in 2014-15. This can be found in tables 21, 22, 23 and 24 of the publication *Expenditure and prescriptions twelve months to 30 June 2015*.[24]

From 1 January 2016, under the Sixth Community Pharmacy Agreement, the Department commenced capturing point of sale data from community pharmacy and patient payments for medicines. Opportunities to publish this data will be available in PBS data releases as the data set grows.

The Department has a contract in place to maintain the PharmCIS application. The PharmCIS application is used to support the efficient management of the PBS listing process. The Department continues to manage a formal change control process to modify the PharmCIS application to accommodate policy, legislative and PBS listing changes as required.

[24] Available at: www.pbs.gov.au/statistics/2014-2015-files/exp-prs-book-01-2014-15.pdf

Providing transparency of PBS expenditure data provides the Australian community with an understanding of the costs to Government associated with the PBS supply chain, including pharmaceutical manufacturers, pharmaceutical distributors and community pharmacies, as a result of providing Australians with access to necessary medicines.

Percentage of urban centres/localities in Australia with a population in excess of 1,000 people with a resident community pharmacy or approved supplier of PBS medicines.[25]

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 42

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
>90%	91.8% **Result: Met** ✓	N/A	N/A	N/A	N/A

91.8% of communities with a population of at least 1,000 people have timely access to PBS subsidised medicines from a community pharmacy or approved supplier when needed. Approved suppliers can be a pharmacy, a medical practitioner (in rural/remote locations where there is not access to a pharmacy) or an Aboriginal Health Service, approved to supply PBS medicines to the community.

Percentage of urban centres/localities in Australia with a population in excess of 1,000 people with a resident service provider of, or recipient of, Medscheck, Home Medicines Review, Residential Medication Management Review or Clinical Intervention.[26]

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 42

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
>80%	97% **Result: Met** ✓	N/A	N/A	N/A	N/A

97% of communities with a population of at least 1,000 people, have access to advice and reviews when needed.

Medication Management Review services include the following programs:

- *Clinical Intervention* – the process of a pharmacist identifying, and making a recommendation to prevent or resolve a drug-related problem; for example, a change in the patient's medication therapy, means of administration or medication-taking behaviour;
- *Medscheck/Diabetes Medscheck* – a structured pharmacy service, which takes place in the pharmacy, involving face-to-face consultations between the pharmacist and consumer, with the aim to improve medicine use through education, self-management and medication adherence strategies;
- *Home Medicines Review* – a comprehensive clinical review of a patient's medicines in their home by an accredited pharmacist on referral from the patient's general practitioner (GP). An assessment is undertaken to identify, resolve and prevent medication-related problems and a report is provided to the patient's GP; and

[25] The *2015-16 Health Portfolio Additional Estimates Statements* indicated that this performance criterion would report against urban centres/localities (UC/Ls) in Australia with a population in excess of 1,000 people. In determining the result for 2015-16 only Urban Centres (UCs) with a population in excess of 1,000 people were utilised, consistent with the Australian Bureau of Statistics definition of an urban centre.

[26] Ibid.

- *Residential Medication Management Review* – a service provided to a permanent resident of an Australian Government funded aged care facility. It is conducted by an accredited pharmacist when requested by a resident's GP. An assessment is undertaken to identify, resolve and prevent medication-related problems and a report is provided to the resident's GP.

Percentage of subsidised PBS units delivered to community pharmacy within agreed requirements of the Community Service Obligation.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 42

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
>95%	96% **Result: Met** ✓	N/A	N/A	N/A	N/A

Communities have timely access to subsidised medicines from community pharmacies within specified timeframes. The timely supply of PBS medicines is secured under the Community Services Obligations (CSO) Funding Pool. Wholesalers engaged under the CSO are contractually required to deliver medicines within the guaranteed supply period of 72 hours for medicines in the Top 1,000 Brands list and 24 hours for all other medicines.

Average cost per subsidised script funded by the PBS.[27]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 43

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
$30.04	$27.37 **Result: Met** ✓	N/A	N/A	N/A	N/A

In 2015-16, the average cost of subsidised scripts under the PBS was $27.37. This includes PBS prescriptions that are subsidised (cost above the patient co-payment) and unsubsidised (those below general patient co-payment).

Average cost per subsidised script paid by consumers for subsidised medicines.[28]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 43

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
$9.76	$9.27 **Result: Met** ✓	N/A	N/A	N/A	N/A

In 2015-16, the average cost of subsidised scripts paid by consumers under the PBS was $9.27. This includes PBS prescriptions that are subsidised (cost above the patient co-payment) and unsubsidised (those below general patient co-payment).

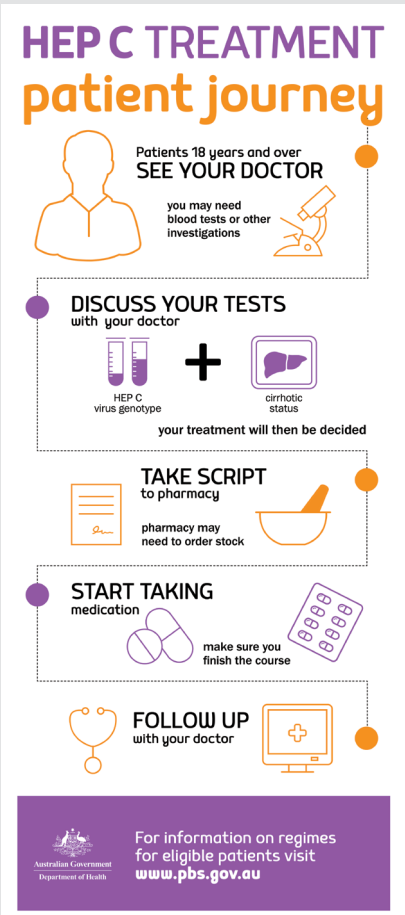
27 This is the average across all PBS prescriptions, including under co-payment prescriptions.
28 This is the average across all PBS prescriptions for the period 1 January 2016 – 30 June 2016 to allow for the inclusion of actual under co-payment patient payment amounts.

Analysis of performance – Program 2.2: Pharmaceuticals and Pharmaceutical Services

The Department has met majority of the performance targets for Program 2.2: Pharmaceuticals and Pharmaceutical Services. The PBS has continued to be managed in a fiscally responsible way which has ensured that all Australians have had access to new, innovative and affordable medicines, such as the new generation of hepatitis C medicines. Pressure is still expected to continue on the PBS growth rate due to factors such as an increase in the prevalence of chronic disease, the ageing population and the listing of specialised new and expensive medicines in Australia.

The Department has undertaken reviews of medicines to ensure the appropriateness and quality of medicines to help improve health outcomes for patients and to ensure value for money for taxpayers.

A new generation of hepatitis C medicines



Hepatitis C is an infectious, blood-borne virus that attacks the liver, causing inflammation and in some cases leading to cirrhosis, end-stage liver disease, liver cancer or death. Approximately 230,000 Australians are living with this disease.

On 1 March 2016, a breakthrough of new generation hepatitis C medicines was listed on the Pharmaceutical Benefits Scheme (PBS), at a total cost to Government of over $1 billion dollars.

So far, approximately 20,000 Australians have begun treatment to cure their hepatitis C. About 5,000 of these Australians have already completed their course of treatment. At this rate, Australia is on track to eliminate hepatitis C within a generation.

The new drugs cure hepatitis C in over 90% of patients, after just 12 weeks of treatment, making them significantly more effective than previous treatment options. They are also less complex to administer and have fewer side effects than other hepatitis C medications.

The new direct-acting antiviral medicines are available through the PBS for use by all Australians over the age of 18 who suffer from chronic hepatitis C. Eligible patients pay the normal PBS co-payment for a prescription – currently $6.20 for concessional patients and $38.30 for general patients for a treatment, which would otherwise cost more than $20,000.

Increase the sustainability of the PBS[29]

Estimated savings to Government from Price Disclosure.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 43

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
$2,429.7m	$2,258.4m **Result: Substantially met** ✓	N/A	N/A	N/A	N/A

The save in 2015-16, from all rounds, was $2,258.4 million, which is $171.3 million, or 7.1%, below the target. The savings are driven by market behaviour, and while the savings to Government are below estimates, price disclosure is still producing significant savings to consumers as the price of most medicines subject to price disclosure reductions are below the general co-payment of $38.30.

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

Percentage of submissions for new medicines for listing that are considered by PBAC within 17 weeks of lodgement.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 44

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	N/A	N/A	N/A	N/A

The Pharmaceutical Benefits Advisory Committee (PBAC) met on five occasions in 2015-16, including two special meetings in August 2015 and April 2016.[30]

The PBAC consistently met to consider recommendations within the specified 17 week timeframe from lodgement of submissions. Approved medications were made publicly available in timeframes consistent with long standing arrangements agreed with the pharmaceutical industry.

All PBAC assessments are based on the clinical and cost effectiveness of the medicine.

Percentage of submissions for new medicines that are recommended for listing by PBAC, that are listed on the PBS within six months of agreement of Budget impact and price.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 44

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
80%	92% **Result: Met** ✓	N/A	N/A	N/A	N/A

Negotiations with product sponsors and listing activities for new listings of medicines on the PBS were completed in a timely manner, with 92% being listed on the PBS within six months of agreement on price, and the overall cost to Government (Budget impact), meeting the performance target.

[29] Sustainability of the PBS refers to the ability of the Government to continue to fund medicines over the longer term given increasing demand for and costs of medicines and related services e.g. dispensing.

[30] Refer Appendix 1: *Processes Leading to PBAC Consideration – Annual Report for 2015-16* for more information.

Post-market surveillance

Percentage of post-market reviews completed within scheduled timeframes.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 44

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
90%	100% **Result: Met** ✓	N/A	N/A	N/A	N/A

Post-market reviews enable the systematic review of Government funded medicines against agreed objectives including improved patient safety, achievement of intended clinical benefits, ongoing viability of the PBS and improvements to the quality use of medicines and education for patients and prescribers.

The Post-market Review of the Life Saving Drugs Program, which sought to ensure Australians with very rare conditions continue to have subsidised access to much needed, expensive medicines, was completed and the report finalised.

The Post-market Review of Authority Required PBS Listings (Authority Review), which sought to reduce administrative burden on prescribers and dispensers of PBS listed medicines, has been completed.

Percentage of Government-accepted recommendations from post-market reviews that have been implemented within six months.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 44

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
80%	80% **Result: Met** ✓	N/A	N/A	N/A	N/A

All Government accepted recommendations arising from the Post-market Authority Review were implemented through core PBS listing processes. Implementation of the remaining Review recommendations continue to be processed.

To date, the Authority Review has produced total savings of approximately $6,308,862, and an expected $7 million per year in red tape reduction once implementation of Authority Review recommendations is completed. The following savings have been reported:

- 2014-15: savings of approximately $935,612 (57 recommendations) in regulatory burden were reported;
- 1 September 2015: 30 recommendations were implemented saving approximately $1,470,250 in regulatory burden; and
- 1 June 2016: a further 73 recommendations were implemented, saving approximately $3,903,000 in regulatory burden.

Some recommendations required IT system changes, and/or further policy development work, which are being progressed.

Analysis of performance – Program 2.3: Targeted Assistance – Pharmaceuticals

The Department has met the majority of performance targets for Program 2.3: Targeted Assistance – Pharmaceuticals. The Department, through the Life Saving Drugs Program (LSDP), has continued to ensure access to expensive and life saving drugs to eligible patients, for rare and life threatening medical conditions.

During 2015-16, the Department undertook a review of the LSDP to ensure it continued to provide Australians with access to much needed and very expensive medications for rare conditions. The review has been completed.

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

Number of patients assisted through the LSDP.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 45

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
287	335 **Result: Met** ✓	278	257	228	215

The LSDP is a demand-driven program based on assessment of patients against set eligibility criteria.

Percentage of Government-accepted recommendations from LSDP post-market reviews that are implemented.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 45

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	N/A	N/A	N/A	N/A	N/A

There were no Government-accepted recommendations to implement in 2015-16.

Eligible patients have timely access to the LSDP.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 45

2015-16 Target	2015-16 Result
Patient applications are processed within 30 calendar days of receipt of the complete data package to support the application.	All patient applications were processed within 30 calendar days of receipt of the complete data package to support the application. **Result: Met** ✓

All 72 new patient applications received this financial year were processed within 30 calendar days of receipt of the complete data package to support the application, with 71 being approved.

Percentage of eligible patients with access to fully subsidised medicines through the LSDP.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 45

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

The Australian Government provides fully subsidised access for eligible patients to expensive drugs for rare and life threatening medical conditions through the LSDP.

Twelve drugs are currently funded through the program to treat eight serious and rare medical conditions. These conditions are: Fabry disease, Gaucher disease, Mucopolysaccharidosis Types I, II and VI, Pompe disease (Infantile-onset, Juvenile-onset or Adult Late-onset), Paroxysmal Nocturnal Haemoglobinuria, and Hereditary Tyrosinaemia Type I.

Analysis of performance – Program 2.4: Targeted Assistance – Aids and Appliances

The Department has met the majority of performance targets for Program 2.4: Targeted Assistance – Aids and Appliances. Diabetes is a serious complex condition that can have a significant impact on quality of life. Through the National Diabetes Services Scheme (NDSS), the Department ensures the provision of timely, reliable and affordable access to products and services to help people effectively self-manage their condition.

In 2015-16, the Department also continued to assist people with stomas by ensuring access to stoma-related products, with a greater choice of new improved products.

In addition, the Department continues to support access to clinically appropriate dressings and education on best treatment practices to improve the quality of life for people with Epidermolysis Bullosa.

The NDSS, Stoma Appliance Scheme, Insulin Pump Program and Epidermolysis Bullosa Dressing Scheme were established as a result of Government decisions to subsidise the supply of products. As the products supplied in these programs are aids and appliances and not medicines, they do not fit within the PBS.

To improve health outcomes for people with diabetes across Australia through the provision of subsidised products and self-management services

Number of people with diabetes receiving benefit from the NDSS.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 46[31]

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
1,326,000[32]	1,320,328 **Result: Met** ✓	1,259,203	1,133,412	1,086,860	1,037,621

The NDSS is a demand-driven program. In 2015-16, the number of people with type 1, type 2 and gestational diabetes receiving benefit from the NDSS was 1,211,251.

There were also a further 109,077 people registered on the post-gestational diabetes register who were also eligible to receive services (but not products) from the NDSS. All eligible individuals were provided access throughout the financial year.

The NDSS meets the needs of stakeholders.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 46

2015-16 Target	2015-16 Result
Annual survey of registrants demonstrates that the needs of stakeholders are being met.	Approximately 70% of surveyed registrants indicated that the NDSS improved their knowledge and understanding of diabetes and helped them manage their condition more effectively. **Result: Met** ✓

Since 2012, Diabetes Australia has been required to undertake an annual customer satisfaction and awareness survey. The results for the 2015-16 survey indicate that overall satisfaction with the NDSS ranged from 63% to 79% nationally.

31 An identical performance criterion to this was reported in error on page 47 of the *2015-16 Health Portfolio Additional Estimates Statements*.
32 The 2015-16 target has been revised. The target of 1,526,000 published in the *2015-16 Health Portfolio Additional Estimates Statements* was incorrect.

Number of people with access (through the program) to insulin pumps and associated consumables for children under 18 years of age with Type 1 diabetes.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 47

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
68	66 **Result: Substantially met**	65	204	76	178

Funding for insulin pump subsidies is capped and provided on a sliding scale with those on lower incomes being provided greater subsidy. The 2015-16 target was set based on the expectation that families on incomes across the range would receive subsidies. The fact that the target was not fully met indicates that higher subsidies were provided to less people, thus assisting those families in greater need.

The performance result of 'substantially met' is based on meeting 97% of the target.

Assist people with a stoma by providing stoma related products

Number of people receiving stoma related products.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 47

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
43,250	43,767 **Result: Met**	42,678	42,228	N/A	N/A

In 2015-16, 64 new products were listed on the Stoma Appliance Scheme Schedule. These provided people with stomas with greater choice of new improved products which could lead to improved health outcomes.

Improve the quality of life for people with Epidermolysis Bullosa

Number of people with Epidermolysis Bullosa receiving subsidised dressings.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 47

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
135	185 **Result: Met**	179	136	99	81

The Epidermolysis Bullosa Dressing Scheme is demand-driven and more people were provided with access to dressings in 2015-16 than originally anticipated.

Access to aids and appliances

Average time from receipt of an approved claim to delivery of aids and appliances.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 48

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
No increase on prior year.	Average one business day - no increase. **Result: Met** ✓	N/A	N/A	N/A	N/A

In 2015-16, new patients accepted to participate in the Epidermolysis Bullosa Dressing Scheme received their first order within one business day, in comparison to one business day on average in 2014-15.

Average cost per aid and appliance delivered to eligible persons.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 48

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
Increase at a rate less than CPI.	$2.52 **Result: Met** ✓	N/A	N/A	N/A	N/A

In 2015-16, the average cost per aid and appliance for the Stoma Appliance Scheme remained the same as the average cost in 2014-15 of $2.52.

Outcome 2 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 2.1: Community Pharmacy and Pharmaceutical Awareness			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	298,350	276,960	(21,390)
Departmental expenses			
Departmental appropriation[2]	11,583	13,481	1,898
Expenses not requiring appropriation in the budget year[3]	197	639	442
Total for Program 2.1	**310,130**	**291,080**	**(19,050)**
Program 2.2: Pharmaceuticals and Pharmaceutical Services			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	202,161	201,078	(1,083)
Special appropriations			
National Health Act 1953 - pharmaceutical benefits	9,735,781	10,837,986	1,102,205
Departmental expenses			
Departmental appropriation[2]	36,116	37,444	1,328
Expenses not requiring appropriation in the budget year[3]	2,293	3,229	936
Total for Program 2.2	**9,976,351**	**11,079,737**	**1,103,386**
Program 2.3: Targeted Assistance - Pharmaceuticals			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	126,084	106,828	(19,256)
Departmental expenses			
Departmental appropriation[2]	12,138	11,673	(465)
Expenses not requiring appropriation in the budget year[3]	105	337	232
Total for Program 2.3	**138,327**	**118,838**	**(19,489)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 2.4: Targeted Assistance - Aids and Appliances			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	593	572	(21)
Special appropriations			
National Health Act 1953 - aids and appliances	336,427	301,104	(35,323)
Departmental expenses			
Departmental appropriation[2]	3,162	3,104	(58)
Expenses not requiring appropriation in the budget year[3]	77	186	109
Total for Program 2.4	**340,259**	**304,966**	**(35,293)**
Outcome 2 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	627,188	585,438	(41,750)
Special appropriations	10,072,208	11,139,090	1,066,882
Departmental expenses			
Departmental appropriation[2]	62,999	65,702	2,703
Expenses not requiring appropriation in the budget year[3]	2,672	4,391	1,719
Total expenses for Outcome 2	**10,765,067**	**11,794,621**	**1,029,554**
Average staffing level (number)	**255**	**260**	**5**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
3 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 3

Outcome 3

Access to Medical and Dental Services

Access to cost-effective medical, dental, allied health and hearing services, including through implementing targeted medical assistance strategies, and providing Medicare subsidies for clinically relevant services and hearing devices to eligible people

Analysis of performance – **Outcome 3** Access to Medical and Dental Services

In 2015-16, the Department continued working with our partners, including the Department of Human Services, to provide Australians with access to high quality and clinically relevant medical, dental, hearing and associated services.

The Department has continued to look at ways to improve the effectiveness and efficiency of a range of medical services including through a number of major reviews. The reviews include the Medicare Benefits Schedule Review and Diagnostic Imaging Accreditation Scheme Review, which are discussed later in this chapter.

These activities have contributed to the Department's achievement of objectives under Outcome 3 and Our Purpose.

Key community benefits for **Outcome 3** in 2015-16

The Medicare Benefits Schedule (MBS) continued to provide high quality and cost-effective access to professional health services

All Australians benefit from an MBS that supports high value care in line with current clinical evidence, and is affordable over the long term.

The Department delivers this through supporting the Medical Services Advisory Committee in assessing the safety, clinical effectiveness and cost effectiveness of any new or existing MBS item.

The Department is also supporting the work of the clinician-led MBS Review Taskforce in reviewing the entire MBS with over 5,700 items describing medical services and procedures to ensure items are aligned with contemporary clinical evidence and practice and improve health outcomes for patients.

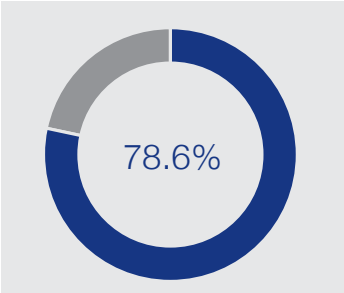
324,797 hearing services vouchers were issued

These vouchers enable eligible people to access subsidised hearing services and devices. Improved management of hearing loss assists eligible people to have better quality of life and to be able to better engage with the community.

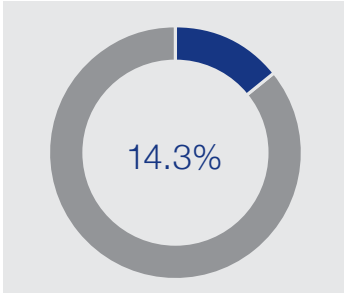
Over 400,000 additional dental services were provided under the National Partnership Agreement on Treating More Public Dental Patients

More public dental patients received services and experienced shorter waiting periods.

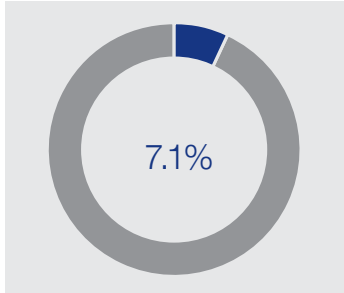
Summary of performance criteria results for **Outcome 3**



Met



Substantially met



Not met

Looking ahead

- The Department will be working closely with the health sector to implement Government policies including:
  - access to affordable diagnostic imaging for all Australians;
  - access to affordable pathology for all Australians; and
  - new magnetic resonance imaging (MRI) machines in Frankston and Maroondah.
- The Department will continue to support the clinician-led MBS Review, to better align services with contemporary clinical evidence, and identify waste and inefficiencies.
- The Department will continue to support the work of the Medical Services Advisory Committee (MSAC) in assessing the strength of evidence behind new or existing medical services or technology.
- The Department will continue to liaise with stakeholders on the transition of the Hearing Services Program to the National Disability Insurance Scheme.
- The Department will also continue to implement a new Child and Adult Public Dental Scheme, through a National Partnership Agreement with States and Territories to ensure that eligible children and adults receive improved access to public dental services.

Programs and program objectives contributing to **Outcome 3**

Program 3.1: Medicare Services
• Improve the sustainability of the Medicare system[33]
• Supporting the integrity of health provider claiming
Program 3.2: Targeted Assistance – Medical
• Provide medical assistance to Australians who travel overseas
• Support access to necessary medical services which are not available through mainstream mechanisms
• Provide medical assistance following overseas disasters
• Improve access to prostheses for women who have had a mastectomy as a result of breast cancer
Program 3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology
• Improve the provision of safe and effective diagnostic imaging services
• Expert stakeholder engagement in pathology, diagnostic imaging and radiation oncology
• Improve access to pathology services
• Improve access to quality radiation oncology services

[33] Sustainability of the Medicare system refers to the ability of the Government to continue to fund services over the longer term given increasing demand for and costs of services.

Program 3.4: Medical Indemnity
• Ensure the stability of the medical indemnity insurance industry • Ensure that insurance products for medical professionals and midwives are available and affordable
Program 3.5: Hearing Services
• Support access to a range of subsidised hearing services to eligible Australians to manage their hearing loss and improve their engagement with the community • Support research into hearing loss prevention and management
Program 3.6: Dental Services
• Improve access to dental services for children • Improve access to public dental services

Analysis of performance – Program 3.1: Medicare Services

The Department met, or substantially met, all the performance targets for Program 3.1: Medicare Services. In 2015-16, the Department continued work to improve the sustainability of Medicare[34] to ensure that all Australians have continued access to high quality and cost-effective professional health services.

The Medicare Benefits Schedule (MBS) Review Taskforce was established in 2015-16, as part of the Government's Medicare reform agenda. The Department is supporting the Taskforce in its work to review more than 5,700 items on the MBS to align with contemporary clinical evidence and practice and improve health outcomes for patients.

The clinician-led Taskforce has engaged over 300 leading clinicians to contribute to its clinical sub-committees and undertaken extensive consultation with stakeholders, including consumers. There has been strong support and commitment to participate in the Review process from professionals and consumers. The initial round of consultations on obsolete items received 63 submissions to an online survey that was conducted between 21 December 2015 and 8 February 2016. The Department will continue to support the Taskforce through further rounds of review.

The Department supported the Medical Services Advisory Committee (MSAC) to continue to evaluate the clinical effectiveness and cost-effectiveness of any new or existing medical services or technology, and the circumstances under which public funding should be supported. The Department also reviewed the MSAC arrangements to streamline processes, improve timeliness and transparency. This work contributes to the sustainability of the Medicare system.

The Department also continued to support the integrity of the Medicare program by delivering health provider compliance activities encouraging appropriate claiming by health professionals. During 2015-16, the Department completed 3,912 Medicare audit and review cases, exceeding the KPI of 2,500 cases. Of these cases, 35 were referred to the Commonwealth Director of Public Prosecutions for prosecution and 80 requests for review were made to the Director of Professional Services Review. $9.9 million in associated debts was recovered in the 2015-16 financial year.

[34] Sustainability of the Medicare system refers to the ability of the Government to continue to fund services over the longer term given increasing demand for and costs of services.

Improve the sustainability of the Medicare system[35]

Preliminary review of the Medicare Benefits Schedule with development of priority action plan.
Source: 2015-16 Health Portfolio Budget Statements, p. 72

2015-16 Target	2015-16 Result
Priorities and action plan to be provided to Government by 31 December 2015.	Priorities and action plan provided to Government in January 2016. **Result: Substantially met**

The MBS Review Taskforce's interim report to the Minister for Health set out the Review methodology, including the key issues to be addressed, a committee structure to undertake review of all aspects of the MBS, and a stakeholder consultation strategy.

Due to the extensive consultation process and the high level of stakeholder feedback, the interim report was provided to Government in January 2016.

Medicare Benefits Schedule Review Taskforce delivers relevant and high quality advice to Government.
Source: 2015-16 Health Portfolio Budget Statements, p. 72

2015-16 Target	2015-16 Result
Committees established and engage constructively with professional and community stakeholders.	12 Clinical Committees and a 'Principles and Rules Committee' were established and extensive stakeholder consultation undertaken. **Result: Met**

In 2015-16, the MBS Review Taskforce provided recommendations to Government on the priorities and processes going forward, as well as removal of obsolete items from the MBS. These recommendations were subject to public consultation, conducted through an online survey and submission process, a series of stakeholder forums and targeted meetings with specific organisations and groups. The obsolete items were removed from the MBS on 1 July 2016.

Continuation of MSAC process improvement to ensure ongoing improvement in rigour, transparency, consistency, efficiency and timeliness.
Source: 2015-16 Health Portfolio Budget Statements, p. 72

2015-16 Target	2015-16 Result
Greater stakeholder engagement and improved timeliness of the MSAC application assessment process.	Public consultation was conducted from 1 December 2015 to 12 February 2016 on proposed improvements to the MSAC process. The Department received a total of 44 submissions. **Result: Met**

These improvements aim to streamline the MSAC process. The transition into new MSAC arrangements commenced in July 2016.

[35] Sustainability of the Medicare system refers to the ability of the Government to continue fund to services over the longer term given increasing demand for and costs of services.

Supporting the integrity of health provider claiming

Achievement of payment integrity standards. Medicare: Completed audit and review cases.
Source: 2015-16 Human Services Portfolio Budget Statements, p. 39

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
≥2,500	3,912[36] **Result: Met** ✓	3,680	3,544	2,819	3,439

In total, 3,912 audits and reviews were completed in 2015-16. This includes practitioner reviews and criminal investigations.

Compliance activities are focussed on all health programs and include health professionals, practice staff or health related businesses receiving payments from the Medicare program.

Analysis of performance – Program 3.2: Targeted Assistance – Medical

The Department met all the performance targets for Program 3.2: Targeted Assistance – Medical. The aim of Program 3.2 is to provide targeted financial assistance to eligible Australians to enable access to necessary medical treatment, either overseas or in Australia.

Reciprocal Health Care Agreements enable access to local health services for Australians travelling overseas in 11 countries. The Agreements also enable access to public health services in Australia for visitors from those countries. The Medical Treatment Overseas program provides access to approved medical treatments overseas for life threatening illness, that are not currently available in Australia.

The Government also provides financial assistance to eligible Australian victims of disasters occurring overseas, including acts of terrorism, civil disturbances or natural disasters. Through the Disaster Health Care Assistance Schemes, assistance is provided in the form of ex-gratia payments to victims and their families covering out-of-pocket expenses for health care delivered in Australia for injury or ill health arising from specific disasters. There are currently six active schemes covering events such as the Bali bombings and the Asian tsunami.

In addition, the Government provides financial support to women who have undergone a mastectomy as a result of breast cancer, through the reimbursement for the cost of external breast prostheses.

Each of these programs and schemes support Australians in receiving the medical services and assistance they need.

[36] This figure includes 164 criminal investigation cases involving members of the public connected to health professionals (e.g. employees such as receptionists, practice managers, or medical business owners). Those cases were transferred to the Department as part of the Machinery of Government changes announced in September 2015.

Provide medical assistance to Australians who travel overseas

Ensure that the Reciprocal Health Care Agreements are supporting Australians when they travel overseas.
Source: 2015-16 Health Portfolio Budget Statements, p. 74

2015-16 Target	2015-16 Result
Timely resolution of issues encountered by Australians attempting to access health services in reciprocal countries.	No major issues were encountered by Australians which prevented access to health services in countries with Reciprocal Health Care Agreements. **Result: Met** ✓

The Australian Government has Reciprocal Health Care Agreements with New Zealand, United Kingdom, Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway.

In 2015-16, 120,597 MBS services were provided to visitors to Australia under the Reciprocal Health Care Agreements with a total of $8,050,829 paid in benefits.

Support access to necessary medical services which are not available through mainstream mechanisms

Financial assistance is provided to eligible applicants through the Medical Treatment Overseas Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 74

2015-16 Target	2015-16 Result
Assessments of applications for medical treatment are managed in accordance with program guidelines.	All applications for financial assistance were assessed in accordance with the established program guidelines. **Result: Met** ✓

In 2015-16, the Department received eight applications for financial assistance.

Six individuals requiring care received funding to undergo treatment overseas. These applicants were supported by independent expert advice from medical craft groups.

Authorisation of payments to successful patients within agreed timeframes.
Source: 2015-16 Health Portfolio Budget Statements, p. 75

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
90%	100% **Result: Met** ✓	N/A	N/A	N/A	N/A

All payments were made within the timeframes required.

Provide medical assistance following overseas disasters

Facilitate health care assistance to eligible Australians in the event of overseas disasters.
Source: 2015-16 Health Portfolio Budget Statements, p. 74

2015-16 Target	2015-16 Result
Ensure appropriate assistance is provided through timely policy advice to the Department of Human Services.	The Department continued to provide policy advice to the Department of Human Services, ensuring health care assistance was provided to eligible Australians. **Result: Met** ✓

In 2015-16, the Department of Human Services paid $477,660 for 2,209 claims on behalf of the Department of Health.

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 2015-16, all reimbursements were provided in a timely manner.

Improve access to prostheses for women who have had a mastectomy as a result of breast cancer

Percentage of claims by eligible women under the national External Breast Prostheses Reimbursement Program processed within ten days of lodgement.
Source: 2015-16 Health Portfolio Budget Statements, p. 75

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
90%	98% **Result: Met** ✓	98%	98%	98%	99.8%

14,550 reimbursements were processed under the program. Of the 14,550 eligible claims made, 98% were processed within 10 days of lodgement.

Analysis of performance – Program 3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology

The Department met, or substantially met, most of the performance targets for Program 3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology. This Program aims to ensure that pathology, diagnostic imaging and radiation oncology services are accessible, safe, effective and responsive to the needs of health care consumers.

In working to achieve this, during 2015-16, the Department completed a major review of the Diagnostic Imaging Accreditation Scheme (DIAS). Changes made to the DIAS to strengthen standards and streamline processes, have been well received by practices and accreditors.

The systematic review of the pathology services listed on the Medicare Benefits Schedule (MBS) is now being undertaken as part of the MBS Review. Progress is discussed in the performance criteria below.

Access to pathology services continues at a high level. The Department has been actively engaging with the pathology sector during 2015-16, concerning the cost of rent paid by some pathology collection centres located within medical practices. The Department will continue to work with the sector to implement changes in line with the direction set by Government.

The Department improves access to high quality radiation oncology services by funding approved equipment, quality programs and initiatives to support the radiation oncology workforce. The Radiation Oncology Health Program Grants Scheme reimburses service providers for the cost of approved equipment used to provide treatment services. These payments ensure that equipment is replaced at the end of its lifespan so that treatment is delivered with up-to-date technology.

Improve the provision of safe and effective diagnostic imaging services

Undertake a major review of the Diagnostic Imaging Accreditation Scheme to strengthen the standards and streamline processes.
Source: 2015-16 Health Portfolio Budget Statements, p. 78

2015-16 Target	2015-16 Result
Review of Diagnostic Imaging Accreditation Scheme to be completed by June 2016.	The Review of the Diagnostic Imaging Accreditation Scheme has been completed and recommendations implemented. **Result: Met** ✓

As part of the Review, the Practice Accreditation Standards were reviewed in 2015. Changes to the accreditation standards came into effect on 1 January 2016. This included revised accreditation documentation to assist practices with the evidentiary requirements.

An expert committee will be established in 2016-17 to oversee a more systematic review of the current accreditation arrangements, including alternative conformity assessment options.

Diagnostic radiology services are effective and safe.
Source: 2015-16 Health Portfolio Budget Statements, p. 78

2015-16 Target	2015-16 Result
Patients have access to diagnostic imaging services that are performed by a suitably qualified professional.	All practitioners providing Medicare-funded diagnostic radiology services met minimum formal qualification requirements. **Result: Met** ✓

Radiologists need to meet minimum formal qualification requirements, including the quality standards under the DIAS.

Expert stakeholder engagement in pathology, diagnostic imaging and radiation oncology

Undertake systematic reviews of the pathology services listed on the Medicare Benefits Schedule (MBS) to ensure they are safe, effective, and cost-effective.
Source: 2015-16 Health Portfolio Budget Statements, p. 78

2015-16 Target	2015-16 Result
The Pathology Services Advisory Committee (PSAC) will consider evidence from six systematic reviews of pathology services and make recommendations for change to the MBS listings where required.	In 2015-16, as part of the work of the MBS Review Taskforce, the PSAC was replaced by the Pathology Clinical Committee (PCC) which was established as a sub-committee of the MBS Review Taskforce. **Result: Not met**

The PCC is continuing the ongoing systematic review of all pathology MBS items with recommendations to be forwarded to the MBS Review Taskforce.

The PCC has set up six working groups (Anatomical and Cytology, Chemical, Genetics, Haematology, Immunology and Microbiology) to review pathology.

The Taskforce will publish and invite public feedback on the PCC's recommendations, prior to the recommendations being provided to the Minister.

Stakeholder engagement in program and/or policy development.
Source: 2015-16 Health Portfolio Budget Statements, p. 79

2015-16 Target	2015-16 Result
Conduct two formal meetings with the pathology sector to discuss pathology policy and sector interests.	More than two formal meetings were conducted with the pathology sector. **Result: Met**

The Department formally met with stakeholders, through individual discussions and group forums to discuss issues related to the pathology sector. The focus of these meetings was the issue of the cost of rent paid by pathology collection centres, particularly where they are co-located within a general practice. Additional issues raised included the 2015-16 Mid-Year Economic and Fiscal Outlook measure to remove the bulk billing incentives and other changes to the MBS subsidies for pathology services. The Department is continuing to consult with the sector to resolve these issues.

Improve access to pathology services

Number of new and/or revised national accreditation standards produced for pathology laboratories.
Source: 2015-16 Health Portfolio Budget Statements, p. 78

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
4	3 **Result: Substantially met** ✓	4	13	0	4

The National Pathology Accreditation Advisory Council (NPAAC) published three revised standards during 2015-16. NPAAC focussed on several comprehensive document reviews and strategic accreditation issues. Due to the complexity of some of the document reviews, not all revised standards were able to be completed during 2015-16 and will be published as soon as practicable.

The performance result of 'substantially met' is based on meeting 75% of the target.

Percentage of Medicare-eligible pathology laboratories meeting accreditation standards.
Source: 2015-16 Health Portfolio Budget Statements, p. 79

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

An Approved Pathology Laboratory must apply for accreditation from the National Association of Testing Authorities, Australia before applying for accreditation from the Department of Human Services.

Improve access to quality radiation oncology services

The number of sites delivering radiation oncology.
Source: 2015-16 Health Portfolio Budget Statements, p. 79

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
71	80 **Result: Met** ✓	75	69	66	63

The Department exceeded its target in 2015-16 and continues to improve access to high quality radiation oncology services by funding approved equipment, quality programs and initiatives to support the radiation oncology workforce. These payments ensure that equipment is replaced at the end of its lifespan so that treatment is delivered with up-to-date technology. The payments complement Medicare benefits payable to patients under Program 3.1: Medicare Services.

Analysis of performance – Program 3.4: Medical Indemnity

The Department has met all the performance targets for Program 3.4: Medical Indemnity.

The Department works with the Department of Human Services to administer schemes that support the medical indemnity industry and ensure it is stable and secure. These schemes make medical indemnity affordable and stable to allow the medical workforce to focus on the delivery of high quality medical services.

The schemes include the High Cost Claims Scheme (HCCS) and the Exceptional Claims Scheme (ECS). The HCCS subsidises claims over $300,000, and the ECS further assists by providing a guarantee to cover claims above the limit of doctors' medical indemnity contracts of insurance, so doctors are not personally liable for very high claims.

The Department also administers the Midwife Professional Indemnity Scheme for eligible midwives in private practice. The Scheme allows private midwives to access professional indemnity insurance and provides financial assistance for eligible claims.

Ensure the stability of the medical indemnity insurance industry

Percentage of medical indemnity insurers who have a Premium Support Scheme contract with the Commonwealth that meets the Australian Prudential Regulation Authority's Minimum Capital Requirement.

Source: 2015-16 Health Portfolio Budget Statements, p. 81

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

In 2015-16, all medical indemnity insurers who have a Premium Support Scheme contract with the Commonwealth met the Minimum Capital Requirement as set by the Australian Prudential Regulation Authority.

Ensure that insurance products for medical professionals and midwives are available and affordable

Percentage of eligible applicants receiving a premium subsidy through the Premium Support Scheme.

Source: 2015-16 Health Portfolio Budget Statements, p. 81

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

The Premium Support Scheme assists eligible doctors to meet the cost of their medical indemnity insurance by reducing their medical indemnity costs, when their gross indemnity premium exceeds 7.5% of their income. The subsidy is paid via the doctor's medical indemnity insurer.

All eligible applicants received a premium subsidy through the Premium Support Scheme in 2015-16.

Number of doctors that receive a premium subsidy support through the Premium Support Scheme.
Source: 2015-16 Health Portfolio Budget Statements, p. 82

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
2,000	1,237 **Result: Met** ✓	1,400	1,613	1,847	2,106

The 2015-16 estimate of doctors requiring subsidisation of their insurance premium costs through the Premium Support Scheme was 2,000. However, due to the increasing affordability of medical indemnity insurance premiums, only 1,237 doctors required assistance under the Scheme.

Percentage of eligible midwife applicants covered by the Midwife Professional Indemnity Scheme.
Source: 2015-16 Health Portfolio Budget Statements, p. 81

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

The Midwife Professional Indemnity Scheme provides professional indemnity insurance to private midwives who are found to be eligible by the Nursing and Midwifery Board of Australia. For eligible claims the Government contributes 80% to the costs of claims above $100,000 and 100% of costs above $2 million.

All eligible private midwives who applied for Commonwealth-supported professional indemnity insurance through Medical Insurance Group Australia (MIGA) were offered cover.

The continued availability of professional indemnity insurance for eligible midwives.
Source: 2015-16 Health Portfolio Budget Statements, p. 81

2015-16 Target	2015-16 Result
Maintain contract with Medical Insurance Group Australia to provide professional indemnity insurance to eligible midwives.	Contract maintained with an insurer (MIGA) to provide professional indemnity insurance to eligible midwives. **Result: Met** ✓

Eligible private midwives were able to purchase Commonwealth-supported professional indemnity insurance from MIGA.

Analysis of performance – Program 3.5: Hearing Services

During 2015-16 the Department has either met or substantially met all of the performance targets for Program 3.5: Hearing Services. The Hearing Services Program (the Program) established in 1997, provides a range of fully or partially subsidised hearing services to eligible Australians to manage their hearing loss and improve their engagement with the community.

In 2015-16, the Department continued to support hearing research through the Hearing Loss Prevention Program (HLPP). The HLPP is managed through the National Health and Medical Research Council. The research focuses on ways to reduce the impact of hearing loss and the incidence and consequence of avoidable hearing loss in the Australian community.

The Program will transition (in part) to the National Disability Insurance Scheme by 2019-20. The Program has undertaken, and will continue to undertake, broad stakeholder consultation to develop a National Disability Insurance Scheme Transition Plan.

Support access to a range of subsidised hearing services to eligible Australians to manage their hearing loss and improve their engagement with the community

Quality service provision and client outcomes supported through a risk-based audit framework.
Source: 2015-16 Health Portfolio Budget Statements, p. 83

2015-16 Target	2015-16 Result
Audit outcomes support a risk-based approach to identification of service provider compliance with contractual and legislative obligations.	Detailed audits were undertaken of specific service provider sites based on risk profiles. **Result: Met** ✓

The annual provider self-assessment process was managed and completed in accordance with contractual requirements.

Detailed audits were undertaken based on risk profiles including results of the self-assessment, new provider status, irregular claiming patterns and/or complaints.

Participating service providers have an opportunity to provide feedback to support continuous improvement.

Policies and program improvements are developed and implemented in consultation with consumers and service providers.
Source: 2015-16 Health Portfolio Budget Statements, p. 83

2015-16 Target	2015-16 Result
Opportunity for stakeholders to participate in consultations.	Broad stakeholder consultation was undertaken around Australia to support the development of the National Disability Insurance Scheme Transition Plan for eligible hearing services clients. **Result: Met** ✓

A proposed Service Delivery Framework for hearing services was developed with input from key stakeholders to support stronger self-regulation. Documents consulted on, to date, include the Quality Principles for Hearing Care and the National Practice Standards for Hearing Care Practitioners.

Further consultations on elements of the Transition Plan are expected for the coming financial year.

Number of people who receive voucher services nationally.
Source: 2015-16 Health Portfolio Budget Statements, p. 84

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
774,000	692,283 **Result: Substantially met**	669,793	647,545	636,389	616,639

The voucher component of the program is client demand-driven, and the projected target is an estimation based on population trends. The performance result of 'substantially met' is based on meeting 89.4% of the target.

Proportion of claims for a hearing aid fitting that relate to voucher clients who have a hearing loss of greater than 23 decibels.
Source: 2015-16 Health Portfolio Budget Statements, p. 84

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
95%	93.7% **Result: Substantially met**	94%	94%	95%	96%

There are legislated exceptions which constrain a 100% compliance with this target. As this is a demand-driven program the target is an annual estimate. The performance result of 'substantially met' is based on meeting 98.6% of the target.

Support research into hearing loss prevention and management

Implementation of hearing health research projects in accordance with program objectives.
Source: 2015-16 Health Portfolio Budget Statements, p. 83

2015-16 Target	2015-16 Result
Funded research projects meet NHMRC research protocols.	100% of funded research projects met NHMRC protocols. **Result: Met**

In 2015-16, the NHMRC managed nine hearing research related projects for the Department.

The National Acoustic Laboratories operates in accordance with the guidelines provided in the NHMRC documents, the *Australian Code for the Responsible Conduct of Research* and *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.*

Analysis of performance – Program 3.6: Dental Services

The Department met the majority of the performance targets for Program 3.6: Dental Services.

In March 2016, the Minister for Health tabled in Parliament the *Report on the Third Review of the Dental Benefits Act 2008*. The review supported the effective operation of the Child Dental Benefits Schedule which provides low to middle income families with financial assistance to help meet the costs of their children's dental care.

The Department also conducted a review of the National Partnership Agreement on Treating More Public Dental Patients (the Agreement). The review found there was a positive impact on the community. The target of 400,000 additional services was exceeded by the end of the Agreement, meaning that more eligible public dental patients received services.

The introduction of the new Child and Adult Public Dental Scheme, in 2016-17, will improve access to public dental services. More consumers on concession cards will benefit from the scheme. State and Territory Governments will have greater funding certainty to improve waiting times and help more eligible people.

Improve access to dental services for children

Complete independent review of the operation of the *Dental Benefits Act 2008.*
Source: 2015-16 Health Portfolio Budget Statements, p. 85

2015-16 Target	2015-16 Result
Review findings are provided for tabling in Parliament.	The review's report was provided to the Minister for Health on 17 December 2015. **Result: Met** ✓

The Minister for Health tabled the *Report on the Third Review of the Dental Benefits Act 2008* in Parliament on 3 March 2016.

Number of children accessing the Child Dental Benefits Schedule.
Source: 2015-16 Health Portfolio Budget Statements, p. 86

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
2,400,000	1,007,258 **Result: Not met**	988,963	N/A	N/A	N/A

The Child Dental Benefits Schedule is a demand-driven, calendar year program. Utilisation of the program was lower than expected in 2015-16. Under utilisation is being addressed through the 2016-17 Budget measure *Child and Adult Public Dental Scheme*.

Improve access to public dental services

Improve access to dental services for public dental patients.
Source: 2015-16 Health Portfolio Budget Statements, p. 86 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Evaluation of the National Partnership Agreement on Treating More Public Dental Patients and associated data, to determine if increased access to dental services has occurred following the conclusion of the Agreement (June 2015).	By the Agreement's conclusion, more people had received public dental services and the waiting time to receive those services had decreased significantly. **Result: Met** ✓

The Department evaluated performance and targets under the Agreement through data and performance reports obtained from the States and Territories. The findings were positive and showed that with the increase in Commonwealth funding for public dental services, a higher volume of services was provided and waiting times decreased. The key performance indicator under the Agreement, as measured in Dental Weight Activity Units, is included in the *Council of Australian Governments Report on Performance 2015*, which is published on the COAG website.[37]

[37] Available at: www.coag.gov.au/node/528

Outcome 3 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 3.1: Medicare Services			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	13,288	7,455	(5,833)
Special appropriations			
Health Insurance Act 1973 - medical benefits	21,080,530	21,115,085	34,555
Departmental expenses			
Departmental appropriation[2]	72,955	66,002	(6,953)
Expenses not requiring appropriation in the budget year[3]	1,952	4,313	2,361
Total for Program 3.1	**21,168,725**	**21,192,855**	**24,130**
Program 3.2: Targeted Assistance - Medical			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	11,943	10,728	(1,215)
Departmental expenses			
Departmental appropriation[2]	782	797	15
Expenses not requiring appropriation in the budget year[3]	22	53	31
Total for Program 3.2	**12,747**	**11,578**	**(1,169)**
Program 3.3: Pathology and Diagnostic Imaging Services and Radiation Oncology			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	72,483	69,705	(2,778)
Departmental expenses			
Departmental appropriation[2]	5,237	5,385	148
Expenses not requiring appropriation in the budget year[3]	145	353	208
Total for Program 3.3	**77,865**	**75,443**	**(2,422)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 3.4: Medical Indemnity			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	150	150	-
Special appropriations			
Medical Indemnity Act 2002	88,700	81,517	(7,183)
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	3,904	-	(3,904)
Departmental expenses			
Departmental appropriation[2]	1,813	1,603	(210)
Expenses not requiring appropriation in the budget year[3]	44	99	55
Total for Program 3.4	**94,611**	**83,369**	**(11,242)**
Program 3.5: Hearing Services			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	498,892	475,908	(22,984)
Departmental expenses			
Departmental appropriation[2]	10,078	9,639	(439)
Expenses not requiring appropriation in the budget year[3]	229	1,841	1,612
Total for Program 3.5	**509,199**	**487,388**	**(21,811)**
Program 3.6: Dental Services[4]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	-	-	-
Special appropriations			
Dental Benefits Act 2008	313,741	312,669	(1,072)
Departmental expenses			
Departmental appropriation[2]	1,757	1,490	(267)
Expenses not requiring appropriation in the budget year[3]	44	96	52
Total for Program 3.6	**315,542**	**314,255**	**(1,287)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Outcome 3 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	596,756	563,946	(32,810)
Special appropriations	21,486,875	21,509,271	22,396
Departmental expenses			
Departmental appropriation[2]	92,622	84,916	(7,706)
Expenses not requiring appropriation in the budget year[3]	2,436	6,755	4,319
Total expenses for Outcome 3	**22,178,689**	**22,164,888**	**(13,801)**
Average staffing level (number)	**527**	**522**	**(5)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
3 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.
4 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 4

Outcome 4
Acute Care

Improved access to, and efficiency of, public hospitals, acute and subacute services, including through payments to state and territory governments

Analysis of performance – **Outcome 4** Acute Care

In 2015-16, the Government continued to improve access to, and the efficiency of, public hospitals through the provision of $17.2 billion of funding to State and Territory Governments.

On 1 April 2016, the Council of Australian Governments' (COAG) agreed a Heads of Agreement for public hospital funding from 1 July 2017 to 30 June 2020 ahead of consideration of longer term arrangements.

The Department supported the Government through the provision of timely and effective policy advice on public hospital funding matters. The Department also supported the implementation of state-wide elective surgery reform activities in Tasmania.

These activities have contributed to the Department's achievement of objectives under Outcome 4 and Our Purpose.

Key community benefits for **Outcome 4** in 2015-16

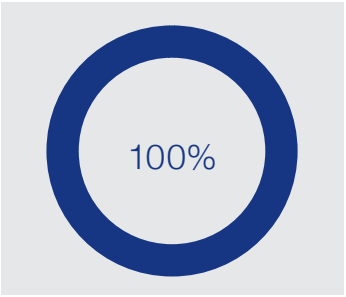
Supported the delivery of efficient public hospital services

The Government provided funding of $17.2 billion to the States and Territories to improve public hospital service delivery for the benefit of all Australians.

Improved health services in Tasmania

State-wide elective surgery reform has meant that Tasmania has delivered additional surgeries to patients who have been waiting for longer than the clinically recommended time.

Summary of performance criteria results for **Outcome 4**



Met

Substantially met

Not met

Looking ahead

- The Australian Government will increase its funding contribution to public hospital services from $17.2 billion in 2015-16 to $17.9 billion in 2016-17. The funding will support the efficient pricing, delivery and accountability of public hospital services.

Programs and program objectives contributing to **Outcome 4**

Program 4.1: Public Hospitals and Information

- Support States to deliver efficient public hospital services
- Mersey Community Hospital
- Improve health services in Tasmania

Analysis of performance – Program 4.1: Public Hospitals and Information

The Department has met all its performance targets under Program 4.1: Public Hospitals and Information, and continues to work with State and Territory Governments, and relevant national agencies to support the efficient pricing, delivery and accountability of public hospital services.

On 1 April 2016, the COAG agreed a Heads of Agreement for public hospital funding from 1 July 2017 to 30 June 2020 ahead of consideration of longer term arrangements. Commonwealth funding to States and Territories for this period includes an estimated additional $2.9 billion in funding for public hospital services.

In addition, implementation of state-wide elective surgery activities have supported Tasmania to provide cost-effective surgery to patients who have been waiting for longer than clinically recommended times. The Department also continues to provide evidence-based policy advice to the Minister to better inform policy decisions to support States and Territories to deliver efficient public hospital services.

Support States to deliver efficient public hospital services

Provide accurate advice to the Minister on public hospital funding policy.
Source: 2015-16 Health Portfolio Budget Statements, p. 90

2015-16 Target	2015-16 Result
Relevant advice produced in a timely manner.	Relevant advice to the Minister on public hospital funding matters was provided within agreed timeframes, consistent with Government agreed processes. **Result: Met** ✓

The Minister was provided with the information and advice required to better inform policy decisions to improve the Australian community's wellbeing.

Mersey Community Hospital

Ensure that residents of north-west Tasmania have ongoing access to hospital services.
Source: 2015-16 Health Portfolio Budget Statements, p. 90

2015-16 Target	2015-16 Result
Agreement reached with the Tasmanian Government on the arrangements for the Mersey Community Hospital.	On 28 August 2015, a new two year Heads of Agreement was reached between the Australian Government and the Tasmanian Government for the continued management and operation of the Mersey Community Hospital from 1 September 2015 until 30 June 2017. **Result: Met** ✓

Funding supports continuation of a mix of general hospital and 24-hour emergency services to the local community, as well as specialising in elective surgery and subacute care. The two year period also allows both Governments sufficient time to work together to develop an appropriate long term arrangement for the hospital.

Improve health services in Tasmania

Implementation of state-wide elective surgery reform activities. Source: 2015-16 Health Portfolio Budget Statements, p. 90	
2015-16 Target	2015-16 Result
Reform activities, including tendering for elective surgery, commenced.	All reform activities have commenced, with tendering for elective surgery completed. **Result: Met** ✓

Elective surgery tendering was completed with the panel of private providers announced by the Tasmanian Government on 1 October 2015. Elective surgery procedures have commenced under this process.

Outcome 4 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 4.1: Public Hospitals and Information[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	92,639	89,854	(2,785)
Non cash expenses - depreciation[3]	963	963	-
Departmental expenses			
Departmental appropriation[4]	29,615	29,251	(364)
Expenses not requiring appropriation in the current year[5]	4,028	5,976	1,948
Total for Program 4.1	**127,245**	**126,044**	**(1,201)**
Outcome 4 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	92,639	89,854	(2,785)
Non cash expenses - depreciation[3]	963	963	-
Departmental expenses			
Departmental appropriation[4]	29,615	29,251	(364)
Expenses not requiring appropriation in the current year[5]	4,028	5,976	1,948
Total expenses for Outcome 4	**127,245**	**126,044**	**(1,201)**
Average staffing level (number)	**47**	**45**	**(2)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.
3 'Non cash expenses relate to the depreciation of buildings.
4 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
5 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 5

Outcome 5
Primary Health Care

Access to comprehensive primary and mental health care services, and health care services for Aboriginal and Torres Strait Islander peoples and rural and remote populations, including through first point of call services for the prevention, diagnosis and treatment of ill-health and ongoing services for managing chronic disease

Analysis of performance – **Outcome 5** Primary Health Care

In 2015-16, the Department continued working towards providing all Australians with access to cost-effective primary and mental health care including those who live and work in regional, rural and remote areas. The establishment of innovative service and funding models has increased the efficiency and effectiveness of primary health care services and improved the coordination of care for patients.

The Department has continued its commitment to Closing the Gap by improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples through the delivery of high quality essential services. The Department also continued to have a strong focus on improving the prevention, detection and management of chronic disease to improve health outcomes for all Australians.

The Department continued to support the integrity of primary health care by delivering on health provider compliance activities. Refer Program 3.1: Medicare Services and Appendix 3: *Health Provider Compliance Report*.

These activities have contributed to the Department's achievement of objectives under Outcome 5 and Our Purpose.

Key community benefits for **Outcome 5** in 2015-16

The Practice Incentives Program (PIP) After Hours Incentive ensured that all Australians had access to high quality after-hours primary health care

Australians can access 4,680 eligible general practices for after-hours primary care.

Further progress has been achieved to help close the gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians

The Aboriginal and Torres Strait Islander child mortality rate has declined and is on track to meet COAG's Closing the Gap targets.

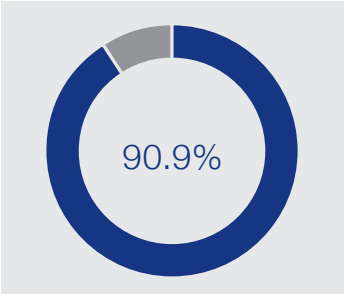
Increased access to essential health care services for Australians living and working in remote areas

The Rural Health Outreach Fund and Royal Flying Doctors Service provided access to support and services which would otherwise not have been available.

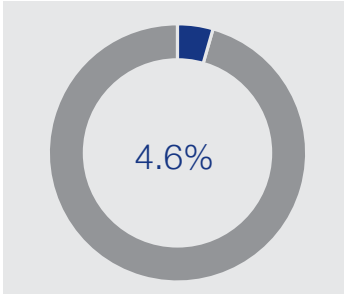
Primary Health Care Advisory Group completed its review of the primary health care system

The Group's core recommendation, the establishment of Health Care Homes in Australia which will benefit people with complex and chronic disease, was accepted by the Australian Government and work has begun on its implementation.

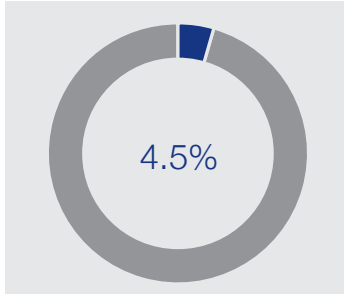
Summary of performance criteria results for **Outcome 5**



Met



Substantially met



Not met

Looking ahead

- Changes to the Practice Incentives Program (PIP) to include a new quality improvement incentive payment will streamline and simplify current PIP payments to help general practices achieve high quality health care and improved patient outcomes.
- In 2016-17, the Department will establish a new digital mental health gateway which will improve access to existing evidence-based information, advice and digital mental health treatment, and will connect people to services through a centralised telephone and web portal.
- The Department will design and develop the necessary infrastructure and supporting mechanisms needed to enable the rollout of Health Care Homes, and the commencement of services from 1 July 2017.

Programs and program objectives contributing to **Outcome 5**

Program 5.1: Primary Care Financing, Quality and Access
• Focus investment in frontline medical services for patients through Primary Health Networks
Program 5.2: Primary Care Practice Incentives
• Provide general practice incentive payments
Program 5.3: Aboriginal and Torres Strait Islander Health
• Improve access to Aboriginal and Torres Strait Islander health care in areas of need • Reduce chronic disease • Improve child and maternal health
Program 5.4: Mental Health
• Invest in more and better coordinated services for people with mental illness
Program 5.5: Rural Health Services
• Improve access to primary health care and specialist services • Improve access to health information services in regional, rural and remote areas

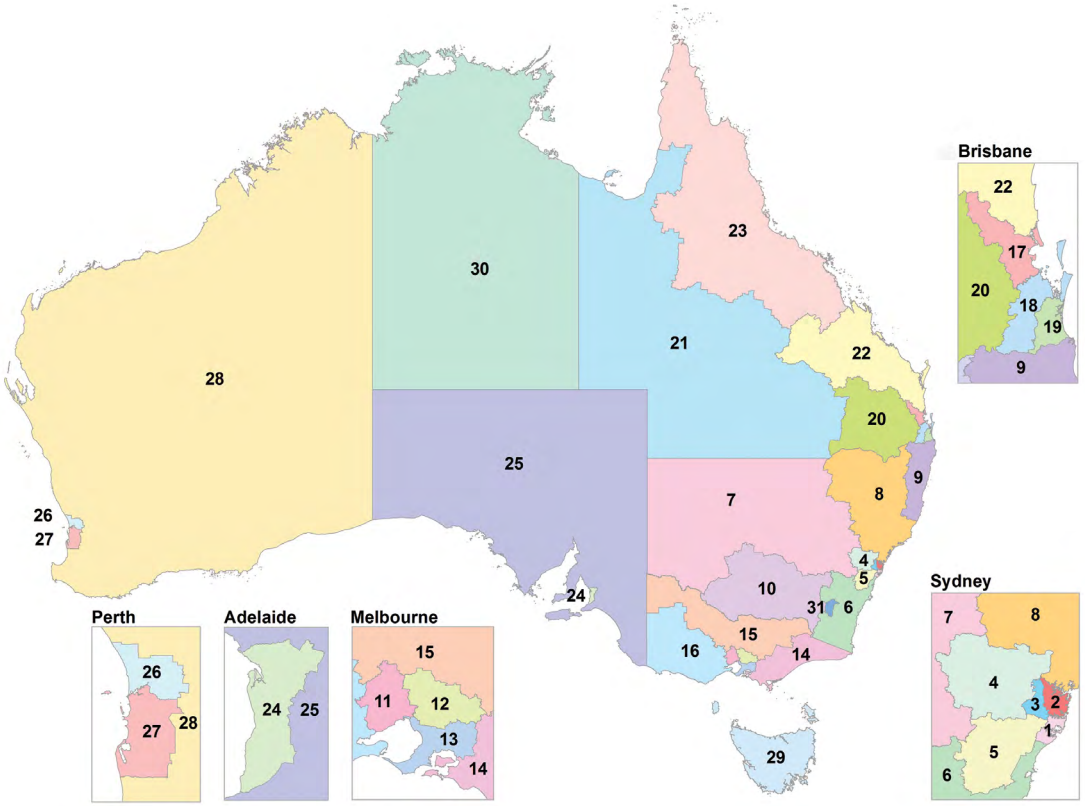
Analysis of performance – Program 5.1: Primary Care Financing, Quality and Access

The Department met all the performance targets for Program 5.1: Primary Care Financing, Quality and Access.

In 2015-16, the Department continued to focus investment in frontline medical services through Primary Health Networks (PHNs). PHNs are primary health care organisations established to increase the efficiency and effectiveness of primary health care services for patients, particularly those at risk of poor health outcomes; and improve coordination of care to ensure patients receive the right care in the right place at the right time. On 1 July 2015, 31 PHNs came into operation. Each PHN is a locally run, independent organisation that is responsive to the local health care needs of its population.

The Department has continued to focus investment in local health services through the expansion of the PHNs' responsibilities in commissioning primary mental health services and drug and alcohol treatment services.

Figure 5.1: Map of Primary Health Network boundaries



New South Wales (NSW)

1. Central and Eastern Sydney
2. Northern Sydney
3. Western Sydney
4. Nepean Blue Mountains
5. South Western Sydney
6. South Eastern NSW
7. Western NSW
8. Hunter, New England and Central Coast
9. North Coast
10. Murrumbidgee

Victoria

11. North Western Melbourne
12. Eastern Melbourne
13. South Eastern Melbourne
14. Gippsland
15. Murray
16. Western Victoria

Queensland

17. Brisbane North
18. Brisbane South
19. Gold Coast
20. Darling Downs and West Moreton
21. Western Queensland
22. Central Queensland, Wide Bay, Sunshine Coast
23. North Queensland

South Australia (SA)

24. Adelaide
25. Country SA

Western Australia (WA)

26. Perth North
27. Perth South
28. Country WA

Tasmania

29. Tasmania

Northern Territory

30. Northern Territory

Australian Capital Territory

31. Australian Capital Territory

Focus investment in frontline medical services for patients through Primary Health Networks

Primary Health Networks operational.
Source: 2015-16 Health Portfolio Budget Statements, p. 95

2015-16 Target	2015-16 Result
Primary Health Networks (PHNs) operating from 1 July 2015.	All 31 PHNs were fully operational on 1 July 2015. **Result: Met** ✓

2015-16 was an establishment year for PHNs as they prepared to become commissioners. Whilst maintaining continuity of service for existing programs transferred to PHNs, they focussed on the following:

- establishing GP-led Clinical Councils and Community Advisory Committees to ensure a clinically and regionally focussed approach;
- building effective local relationships with primary health care providers and other providers within the broader health system, including Local Hospital Networks and Aboriginal and Torres Strait Islander health providers to support local service integration; and
- preparing for the move to commissioning models, which involved a more strategic approach to the procurement of health services, informed by local health needs assessment, market analysis of local health care supply, and ongoing monitoring and evaluation of service quality and performance.

Percentage of PHNs with completed baseline needs assessments and strategies for responding to identified service gaps.
Source: 2015-16 Health Portfolio Budget Statements, p. 95

2015-16 Target	2015-16 Result
100% completed by PHNs by 30 June 2016.	100% of PHNs completed baseline needs assessments and developed strategies for responding to identified service gaps by 30 June 2016. **Result: Met** ✓

Needs assessments and activity work plans for all 31 PHNs were completed by 30 June 2016.

The needs assessment process supports PHNs in working towards improving patient health outcomes. It identifies and prioritises the health and service needs of the community within their regions. The work plans describe the activities to be undertaken from 1 July 2016 to 30 June 2018 in response to local needs. These plans also outline how Commonwealth funding will be distributed against these activities.

Analysis of performance – Program 5.2: Primary Care Practice Incentives

The Department met all the performance targets for Program 5.2: Primary Care Practice Incentives.

In 2015-16, the Department continued to fund the Practice Incentives Program (PIP) to support general practice activities by encouraging continuous improvement, increased quality of care, enhanced capacity, and improved access and health outcomes for patients.

In 2015-16, the PIP After Hours Incentive was implemented with a higher than projected participation rate from all eligible general practices across the country. The PIP After Hours Incentive supports general practices to provide their patients with access to after-hours primary health care through a more streamlined, flexible and nationally consistent model of after-hours service provision.

The Government took important steps towards addressing the growing rates of chronic disease in the community. In April 2015, the Minister for Health established the Primary Health Care Advisory Group (Advisory Group) to examine opportunities for reform of primary health care in improving the management of people with complex and chronic disease. The Advisory Group examined national and international evidence relating to innovative service and funding models in primary health care, and undertook a comprehensive national consultation process to inform its deliberations. The core recommendation of the Advisory Group's final report was the establishment of Health Care Homes to provide patients with continuity of care, coordinated services and a team-based approach according to the needs and wishes of the patient. The Government has accepted the outcomes of the Advisory Group's final report and the Department will establish Health Care Homes through a staged rollout process, with services commencing from 1 July 2017.

Provide general practice incentive payments

Percentage of GP patient care provided by PIP practices.[38]
Source: 2015-16 Health Portfolio Budget Statements, p. 97

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
84.1%	86.0% **Result: Met** ✓	85.0%	84.7%	84.4%	84.0%

The Department continued to provide incentive payments to support general practice activities through the PIP, encouraging continuing improvement, increased quality of care, enhanced capacity, and improved access and health outcomes for patients.

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

Implement the PIP After Hours Incentive.
Source: 2015-16 Health Portfolio Budget Statements, p. 97

2015-16 Target	2015-16 Result
Provide general practices with access to the PIP After Hours Incentive from 1 July 2015.	Access to the PIP After Hours Incentive was available to all eligible PIP practices on 1 July 2015. **Result: Met** ✓

The PIP After Hours Incentive was introduced in response to the Review of after-hours primary health care which involved extensive nationwide stakeholder consultation. The Department worked closely with the primary care sector to ensure a smooth transition to the new arrangements.

The PIP After Hours Incentive has been implemented successfully and 85% of practices were registered for the incentive at May 2016. The incentive comprises five different payment levels, which provides both national consistency and flexibility for participating practices.

Number of general practices participating in the PIP After Hours Incentive.
Source: 2015-16 Health Portfolio Budget Statements, p. 97

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
4,600	4,680 **Result: Met** ✓	N/A	N/A	N/A	N/A

The PIP After Hours Incentive supports practices to provide their patients with access to after-hours primary care. It consists of five levels that allow practices flexibility to select the level of after-hours coverage that best suits their business needs.

Investigate innovative primary health care funding models.
Source: 2015-16 Health Portfolio Budget Statements, p. 97

2015-16 Target	2015-16
Provide advice to Government through the Primary Health Care Advisory Group, in relation to innovative primary health care funding models. Report due by late 2015.	The Advisory Group provided its final report to Government in December 2015. **Result: Met** ✓

The Advisory Group made a number of recommendations, the core of which was the establishment of the Health Care Homes Program. In March 2016, the Government announced stage one of the establishment of Health Care Homes in Australia. Health Care Homes are general practices or Aboriginal Medical Services which will provide a patient with a 'home base' for the ongoing coordination, management and support of their conditions.

Analysis of performance – Program 5.3: Aboriginal and Torres Strait Islander Health

The Department met the majority of performance targets for Program 5.3: Aboriginal and Torres Strait Islander Health. The Department is committed to closing the gap by improving the health and wellbeing of Aboriginal and Torres Strait Islander Australians through the delivery of high quality essential services.

In 2015-16, the Department released the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 Implementation Plan in partnership with the National Health Leadership Forum for Aboriginal and Torres Strait Islander peak organisations that provide advice on health. The Implementation Plan articulates the overarching vision of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 by progressing strategies and actions that improve health outcomes for Aboriginal and Torres Strait Islander peoples. The Implementation Plan incorporates actions across the life course and is across seven domains including: maternal health and parenting; childhood development; adolescents and youth; healthy adults; healthy ageing; health systems effectiveness; and the social and cultural determinants of health.

In 2015-16, the Department continued to fund a range of activities through the Indigenous Australians' Health Programme to improve the health of Aboriginal and Torres Strait Islander peoples, with over 60 per cent of the program's funding going directly to Indigenous organisations.

In 2015-16, the Department has continued to focus on improving the prevention, detection and management of chronic disease to improve health outcomes. The 2015-16 Closing the Gap Report indicated that the Department is on track to achieve the target of halving the gap in mortality rates for Indigenous children under five by 2018.

In keeping with previous years, in 2015-16 the Department funded more health checks for Indigenous adults and children than expected. Designed especially for Indigenous peoples, the health checks support early intervention initiatives and are contributing to closing the gap.

Trachoma, an eye infection that can lead to blindness, still occurs in a number of communities in Australia, primarily rural and remote Indigenous communities. In 2015-16, the Department continued to work with State and Territory Governments through the Project Agreement on Improving Trachoma Control Services for Indigenous Australians to provide trachoma screening and treatment in affected communities. Good progress has been made, with the national prevalence rate for trachoma decreasing from 14 per cent in 2009 to 4.6 per cent in 2015.

In 2015-16, the Department also reformed and improved the Tackling Indigenous Smoking program, with a focus on evidence-based approaches being delivered at multiple levels, including: health service funding; workforce training and organisational support; and support for smokers through Quitline funding. The program uses proven approaches to change smoking behaviours within Aboriginal and Torres Strait Islander communities, and alongside broader tobacco control measures, is contributing to a steady decline in Indigenous smoking rates. These initiatives have contributed to the national daily smoking rate declining from 49 per cent in 2002 to 39 per cent in 2014-15, while the number of Aboriginal and Torres Strait Islander people who have never smoked continues to increase. This positive downwards trend shows that the Department's comprehensive and multi-faceted approach to tobacco control is working. For further information on tobacco control, refer Program 1.2: Drug Strategy, on page 56.

Improve access to Aboriginal and Torres Strait Islander health care in areas of need

Implement the National Aboriginal and Torres Strait Islander Health Plan 2013—2023.
Source: 2015-16 Health Portfolio Budget Statements, p. 100

2015-16 Target	2015-16 Result
Commence actions in the Implementation Plan.	Implementation of activities in accordance with the Implementation Plan are underway. **Result: Met** ✓

Work on a range of milestones has included the following:

- the Indigenous Australians' Health Programme guidelines have been completed and are being used as a basis for the program's funding decisions;
- the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families is with the Australian Health Ministers' Advisory Council for final endorsement; and
- five per cent of National Health and Medical Research Council funding is directed to Aboriginal and Torres Strait Islander health.

Performance against the Implementation Plan goals will be measured through the Health Performance Framework 2017, led by the Department of the Prime Minister and Cabinet. This report measures progress on Indigenous health outcomes, health system performance and determinants of health (such as employment, education and safety).

Number of Indigenous adult and child health checks completed.
Source: 2015-16 Health Portfolio Budget Statements, p. 100

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
164,476	196,759 **Result: Met** ✓	171,786	150,534	122,161	96,579

The Council of Australian Governments' 2008 Closing the Gap reforms included a commitment to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. Ensuring access to the health check is an important part of achieving this commitment, as it has both direct benefits and also provides access to targeted follow-up measures. Health assessments are available to Aboriginal and Torres Strait Islander people of all ages.

Reduce chronic disease

Percentage of regular Aboriginal and/or Torres Strait Islander clients with type 2 diabetes that have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.[39]
Source: 2015-16 Health Portfolio Budget Statements, p. 100

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
60–65%	Data not available	N/A	N/A	N/A	N/A

Data to support this performance criterion will be available in late 2016. At this stage, initial reports indicate this target is likely to have been exceeded.

[39] A regular client is defined as an Aboriginal and/or Torres Strait Islander person who has an active medical record (attendance at least 3 times in the last 2 years) with a primary health care organisation that receives funding from the Australian Government Department of Health to provide primary care services primarily to Aboriginal and Torres Strait Islander peoples.

Chronic disease related mortality rate per 100,000:[40]
Source: 2015-16 Health Portfolio Budget Statements, p. 101 & 2015-16 Corporate Plan, p. 15

	2014 Target[41]	2014 Result	2013	2012	2011	2010
Aboriginal and Torres Strait Islander	603-642	756.5 **Result: Not met**	784	898	N/A	897
Non-Aboriginal and Torres Strait Islander[42]	435-441	447.4	449	451	N/A	469
Rate difference[43]	165-204	309.1	335	447	N/A	428

The 2014 Aboriginal and Torres Strait Islander chronic disease mortality rate (756.5 per 100,000) was not within the target range (603-642 per 100,000). Although there has been a statistically significant decline in Aboriginal and Torres Strait Islander rates over the period 1998-2014, there has been no statistically significant change in the gap between the two populations. This is because the non-Indigenous rates in chronic disease mortality have declined faster than Indigenous rates.

Improve child and maternal health

Number of services funded to provide New Directions: Mothers and Babies Services.
Source: 2015-16 Health Portfolio Budget Statements, p. 101

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
110	110 **Result: Met**	85	85	85	85

The Department continued working towards the goal of funding a total of 136 services by 2018. The Department is on track to meet this target with the funding of 25 additional services in 2015-16, bringing the current total to 110 services. The New Directions: Mothers and Babies Services program provides Aboriginal and Torres Strait Islander families with young children access to: antenatal care, standard information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring developmental milestones, immunisation status and infections; and health checks for Aboriginal and Torres Strait Islander children before starting school.

40 Source: AIHW National Mortality Database, calendar years 1998 to 2014 (which is the most up-to-date data available) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined). Note that this data is reported on a calendar year basis, reflecting the ABS mortality data collection and publication processes.
41 2014 data, due to the time lag in ABS mortality data publication.
42 This is contextual data and is listed to provide a comparison.
43 Ibid.

Number of organisations funded to provide Australian Nurse Family Partnership Program Services.[44]

Source: 2015-16 Health Portfolio Budget Statements, p. 101

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
5	5 **Result: Met** ✓	3	N/A	N/A	N/A

The Department continued to support the Australian Nurse Family Partnership Program (ANFPP) with the goal of having a total of 13 sites supported by 2018. An additional two sites (North Brisbane and remote community outreach in the Northern Territory) were funded in 2015-16, bringing the current total to five sites. The ANFPP supports women pregnant with an Aboriginal and/or Torres Strait Islander child to improve their own health and the health of their baby through a nurse-led home visiting program. It 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.

Child 0-4 mortality rate per 100,000:[45]

Source: 2015-16 Health Portfolio Budget Statements, p. 102 & 2015-16 Corporate Plan, p. 15

	2014 Target[46]	2014 Result	2013	2012	2011	2010
Aboriginal and Torres Strait Islander	112-166	159.1 **Result: Met** ✓	185	165	N/A	203
Non-Aboriginal and Torres Strait Islander[47]	80-91	74.4	84	77	N/A	95
Rate difference[48]	27-81	85.7	101	87	N/A	108

The 2014 Aboriginal and Torres Strait Islander child mortality rate (159.1 per 100,000) was within the target range for 2014 (112-166 per 100,000). Over the period 1998 to 2014, Aboriginal and Torres Strait Islander child mortality rates have declined significantly (by 33%), and the gap with non-Indigenous rates has also narrowed significantly (by 34%). The COAG target to halve the gap in mortality rates for Indigenous children under five within a decade (by 2018) is on track.

44 This performance criterion has not previously been published, but monitoring of this activity has occurred, therefore a result for 2014-15 has been included.

45 Source: AIHW National Mortality Database, calendar years 1998 to 2014 (which is the most up-to-date data available) and includes jurisdictions for which data are available and of sufficient quality to publish (NSW, Qld, WA, SA and NT combined). Note that this data is reported on a calendar year basis, reflecting the ABS mortality data collection and publication processes.

46 2014 data, due to the time lag in ABS mortality data publication.

47 This is contextual data and is listed to provide a comparison.

48 Ibid.

Analysis of performance – Program 5.4: Mental Health

The Department met all performance targets for Program 5.4: Mental Health.

The Department has continued to achieve better outcomes for people with mental illness and their carers by supporting better coordination and integration of mental health services.

In November 2015, the Australian Government announced its response to *Contributing Lives, Thriving Communities* – Review of Mental Health Programmes and Services.[49] The reforms aim to achieve a more efficient, integrated and sustainable mental health system to improve mental health services for Australians and help prevent suicide. The Department has worked closely with an expert reference group and key stakeholders resulting in a new stepped care approach to mental health, which will mean better targeting of services to meet individual needs.

The Department has continued to work with key stakeholders, including State and Territory Governments to support better coordination and integration of mental health services. The Fifth National Mental Health Plan (Fifth Plan) is being developed to achieve improved outcomes for people with mental illness and their carers by improving both system and service level integration at the regional level.

In any given year, one in four Australians aged 16–24 years old will experience mental illness, facing challenges including accessibility of services, concerns about confidentiality and stigma. The Department recognises the importance of early intervention in children and young people and continued to provide funding for mental health initiatives such as *headspace* and KidsMatter Primary in 2015-16. The continued investment in youth mental health activities will assist to break down barriers and improve mental health outcomes.

Invest in more and better coordinated services for people with mental illness

Analysis of opportunities for reform arising from the Review of Mental Health Programmes and Services.
Source: 2015-16 Health Portfolio Budget Statements, p. 103

2015-16 Target	2015-16 Result
Options developed for policy and program reform and implementation.	Australian Government Response to the Review of Mental Health Programmes and Services (Review) was announced on 26 November 2015. **Result: Met** ✓

The Department has commenced work on implementation of the nine key action areas identified in the Review.

The Review sets out system reforms in response to the review undertaken by the National Mental Health Commission, as well as advice from the Mental Health Expert Reference Group and the sector more broadly.

[49] Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response

Total number of *headspace* youth-friendly service sites funded.
Source: 2015-16 Health Portfolio Budget Statements, p. 104

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100	100 **Result: Met** ✓	100	85	70	55

As at 30 June 2016, there were 100 *headspace* centres funded, with 95 operational centres providing mental health services to young people.

The transition of funding for *headspace* centres to Primary Health Networks (PHNs) as of 1 July 2016 has impacted implementation of the remaining centres. The Department is working with relevant PHNs and *headspace* National Office to open the remaining centres by February 2017.

Support better coordination and integration of mental health services at a national and regional level to improve consumer outcomes.
Source: 2015-16 Health Portfolio Budget Statements, p. 104 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Initial consultation with States and Territories on the development of a new national mental health plan completed by August 2015.	Initial consultations on the development of the new Fifth Plan were completed by August 2015. **Result: Met** ✓

The Fifth Plan is a joint Commonwealth State Plan that is being progressed by the Mental Health Drug and Alcohol Principal Committee (MHDAPC) Fifth Plan Working Group.

Initial meetings of the MHDAPC Fifth Plan Working Group, comprising of State and Territory representatives, agreed to the scope and objectives of the Fifth Plan.

Increase the number of schools participating in the KidsMatter Primary initiative.
Source: 2015-16 Health Portfolio Budget Statements, p. 104

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
3,000	3,035 **Result: Met** ✓	2,635	2,020	1,352	793

The funded organisation and subcontractors continued to engage with primary schools to encourage participation in KidsMatter. This included organising a series of professional learning events in the form of webinars and face-to-face learning. For more information refer to the following case study.

Growing healthy minds

KidsMatter is all about growing healthy minds and healthy communities. The aim of KidsMatter is to create positive school and early childhood communities, teach children skills for good social and emotional development, work together with families, and recognise and get help for children with mental health problems. KidsMatter is a partnership between education and health sectors and is the first of its kind in Australia, funded by the Department and delivered by *beyondblue*.

KidsMatter was developed by mental health and education professionals in response to a growing recognition of the presence of mental health problems in young children. It provides a broad spectrum of resources, particularly for the important people in a child's life, such as family, peers and teachers.

"Mental wellbeing is really about how you feel, and how others feel," said one student, age 8. Another student, age 10, said: "Mental wellbeing is being healthy with your mind, helps you work out problems."

In addition to focussing on childhood mental health, the initiative also connects parents with the school and broader community. This then feeds into the programs and further encourages the participation of children.

Further information on KidsMatter can be found at: www.kidsmatter.edu.au

Analysis of performance – Program 5.5: Rural Health Services

The Department has met or substantially met all performance targets for Program 5.5: Rural Health Services.

The Department continues to support people living in regional, rural and remote areas as they face greater health care challenges than Australians based in metropolitan areas. In 2015-16, the services of the Rural Health Outreach Fund positively impacted communities with improved access to medical specialists, GPs, allied and other health professionals. Efforts also continued with a focus on the priority areas of chronic disease management, mental health, eye health, and maternity and paediatric health. The Visiting Optometrists Scheme continued to provide greater than expected access to optometry services.

In 2015-16, the Department continued supporting the delivery of essential health services to people in regional, rural and remote areas through support for the Royal Flying Doctors Service (RFDS). The RFDS clinical services are provided to ensure people living and working or travelling in remote areas have access to services which would otherwise not be available. With the implementation of the new funding arrangements, the RFDS has been able to ensure that essential services are maintained including primary aero-medical evacuations, primary and community health clinics, remote consultations (telephone consultations) and medical chests containing pharmaceutical and medical supplies for remote locations.

Improve access to primary health care and specialist services

Number of communities receiving outreach services through the Rural Health Outreach Fund.
Source: 2015-16 Health Portfolio Budget Statements, p. 105

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
350	515 **Result: Met** ✓	483	460	421	384

In total, 515 locations in regional, rural and remote Australia received services under the Rural Health Outreach Fund.

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.
Source: 2015-16 Health Portfolio Budget Statements, p. 106 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Organisations funded to support rural outreach are contractually required to consult with stakeholder groups, and will be guided by existing advisory forums and Indigenous Health Partnership forums, to identify community needs.	Organisations funded through the Rural Health Outreach Fund, undertook comprehensive consultation processes to identify and address community needs. **Result: Met** ✓

Organisations funded through the Rural Health Outreach Fund, undertook needs assessments and planning for outreach health services in consultation with a range of organisations including: local health services; State and Territory health departments; Aboriginal and Torres Strait Islander Health Organisations; and Primary Health Networks and were guided by Advisory Forums and Indigenous Health Partnership Forums to identify community needs.

Number of patient contacts supported[50] through the Rural Health Outreach Fund.[51]
Source: 2015-16 Health Portfolio Budget Statements, p. 106

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
165,000	247,455 **Result: Met** ✓	216,787	190,460	192,985	191,786

In 2015-16, there were 247,455 patient contacts under the Rural Health Outreach Fund.

50 Number of patients seen by participating health practitioners per annum.
51 Targets for this criterion have been revised to reflect the 2014-15 Budget measure *Health Flexible Funds – pausing indexation and achieving efficiencies*.

Number of locations receiving optometry services through the Visiting Optometrists Scheme.
Source: 2015-16 Health Portfolio Budget Statements, p. 105

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
500	526 **Result: Met** ✓	480	N/A	N/A	N/A

The Visiting Optometrists Scheme has improved access to optometrists for people living in regional, rural and remote Australia. The Visiting Optometrists Scheme has played a significant role in detecting the need for prescription glasses, detecting eye disease and ensuring appropriate referral for treatment and ongoing management.

Number of patients attending Royal Flying Doctor Service clinics.
Source: 2015-16 Health Portfolio Budget Statements, p. 106

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
40,000	34,352 **Result: Substantially met** ✓	36,365	42,608	43,142	41,657

In 2015-16, 34,352 patients attended Royal Flying Doctor Service Clinics. The reduction is due to less patient demand as well as improvements in reporting. The performance result of 'substantially met' is based on meeting 85.9% of the target.

Improve access to health information services in regional, rural and remote areas

Accurate, quality place-based information is provided through the Rural and Regional Health Australia website.
Source: 2015-16 Health Portfolio Budget Statements, p. 106

2015-16 Target	2015-16 Result
Regular revision of the Rural and Regional Health Australia website to maintain information accuracy and quality.	The content on the Rural and Regional Health Australia website continued to be updated throughout 2015-16, however the website was decommissioned on 1 July 2016. **Result: Met** ✓

In 2015-16, the Rural and Regional Health Australia website was regularly updated.

A review conducted by the Department in 2015 resulted in the decision to decommission the Rural and Regional Health Australia website on 1 July 2016, and to relocate the relevant information to a dedicated webpage on the Department of Health website. This has removed unnecessary duplication of information and provides a single access point to a comprehensive list of rural health programs and services.

Outcome 5 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 5.1: Primary Care Financing, Quality and Access			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	424,119	419,004	(5,115)
Departmental expenses			
Departmental appropriation[2]	25,427	24,701	(726)
Expenses not requiring appropriation in the budget year[3]	648	1,728	1,080
Total for Program 5.1	**450,194**	**445,433**	**(4,761)**
Program 5.2: Primary Care Practice Incentives			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	357,971	341,993	(15,978)
Departmental expenses			
Departmental appropriation[2]	2,250	2,082	(168)
Expenses not requiring appropriation in the budget year[3]	58	137	79
Total for Program 5.2	**360,279**	**344,212**	**(16,067)**
Program 5.3: Aboriginal and Torres Strait Islander Health[4]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	729,135	726,665	(2,470)
Departmental expenses			
Departmental appropriation[2]	44,581	44,931	350
Expenses not requiring appropriation in the budget year[3]	1,153	2,912	1,759
Total for Program 5.3	**774,869**	**774,508**	**(361)**
Program 5.4: Mental Health[4]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	663,578	648,090	(15,488)
Departmental expenses			
Departmental appropriation[2]	21,407	20,299	(1,108)
Expenses not requiring appropriation in the budget year[3]	779	1,296	517
Total for Program 5.4	**685,764**	**669,685**	**(16,079)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 5.5: Rural Health Services			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	68,074	64,795	(3,279)
Departmental expenses			
Departmental appropriation[2]	2,126	2,559	433
Expenses not requiring appropriation in the budget year[3]	56	164	108
Total for Program 5.5	**70,256**	**67,518**	**(2,738)**
Outcome 5 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	2,242,877	2,200,547	(42,330)
Departmental expenses			
Departmental appropriation[2]	95,791	94,572	(1,219)
Expenses not requiring appropriation in the budget year[3]	2,694	6,237	3,543
Total expenses for Outcome 5	**2,341,362**	**2,301,356**	**(40,006)**
Average staffing level (number)	**572**	**573**	**1**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
3 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.
4 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 6

Outcome 6
Private Health

Improved choice in health services by supporting affordable quality private health care, including through private health insurance rebates and a regulatory framework

Analysis of performance – **Outcome 6** Private Health

In 2015-16, the Government continued to improve choice and reduce the pressure on the public health system by providing the private health insurance rebate to support affordable private health care. The number of people covered by private health hospital insurance continues to rise steadily.

These activities have contributed to the Department's achievement of objectives under Outcome 6 and Our Purpose.

Key community benefits for **Outcome 6** in 2015-16

Reduced pressure on the public hospital system

The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance. Rebates make private health insurance more affordable and provide greater choice.

Ensured access to high quality prostheses

Privately insured Australians are assured of having continuing access to high quality prostheses through regular revisions to the Prostheses List.

Summary of performance criteria results for **Outcome 6**

Looking ahead

- The Australian Government has announced the establishment of the Private Health Ministerial Advisory Committee to provide technical and specialist advice on designing and implementing reforms to private health insurance. The Committee will consider a range of issues including value for money, complexity and transparency of private health insurance products.
- Public confidence in the process for reviewing listed prostheses will be increased by the reconstitution of the Prostheses List Advisory Committee. The Committee will provide revitalised expertise and be able to further develop and advise on changes to the prostheses listing process.

Programs and program objectives contributing to **Outcome 6**

Program 6.1: Private Health Insurance

- Support the affordability of private health insurance through the private health insurance rebate
- Ensure access to safe and effective medical devices through the Prostheses List
- Promote a viable, sustainable and cost-effective private health insurance sector

Analysis of performance – Program 6.1: Private Health Insurance

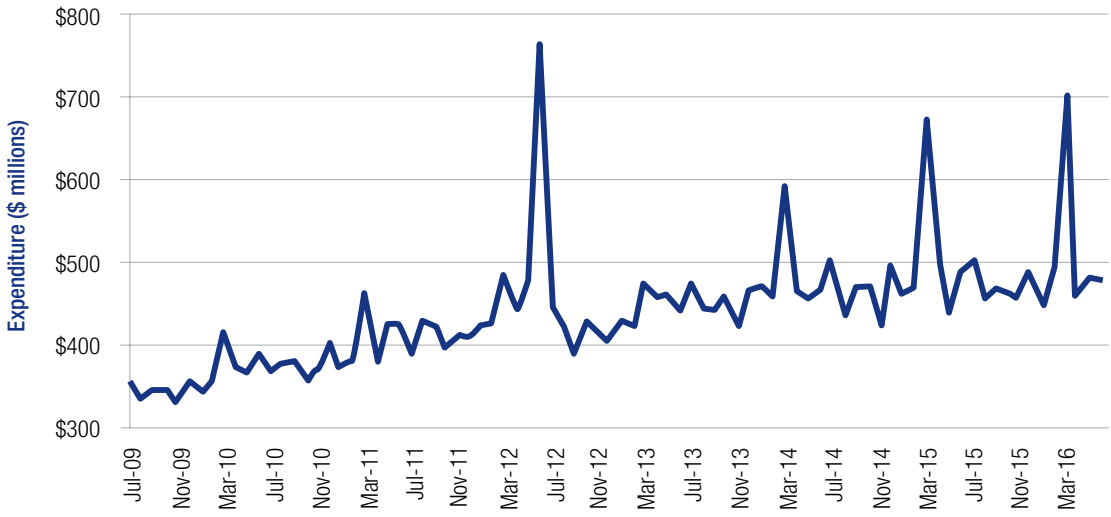
The Department met all performance targets under Program 6.1: Private Health Insurance. Insurers and peak bodies were consulted through individual discussions and forums.

The Department also ensured clinically appropriate and cost-effective prostheses are available to privately insured Australians through the regular revision of the Prostheses List.

The Department undertook a significant consultation process in late 2015. Over 40,000 people completed an online survey, over 100 stakeholders attended eight consultation roundtables, and the Department received over 180 written submissions. The consultations showed that consumers are focussed on value for money, and are concerned about the complexity and transparency of private health insurance products.

Government spending on the private health insurance rebate is being maintained below $6 billion. The number of people with hospital treatment policies has increased by 102,250 from March 2015 to March 2016. Almost half the Australian population is covered by private health insurance. Figure 6.1 below shows private health insurance rebate expenditure from 2009-10 to 2015-16.

Figure 6.1: Private health insurance rebate expenditure, 2009-10 to 2015-16[52]



[52] March increases attributed to annual premium increase at 1 April and reflects some individuals and families choosing to pay in advance.

Support the affordability of private health insurance through the private health insurance rebate

Consultation with stakeholders on ways to ensure that the private health insurance rebate is communicated to policy holders and delivered through private health insurance products.

Source: 2015-16 Health Portfolio Budget Statements, p. 111

2015-16 Target	2015-16 Result
Ongoing stakeholder discussions (a minimum of two stakeholder consultation forums) to assist in the timeliness and streamlining of processes to enable consistent advice to consumers.	Individual discussion and forums in six capital cities were undertaken with insurers and peak bodies to ensure that consistent advice was delivered to all stakeholders, to assist in the timeliness of notifications to consumers. The Department's consultations on private health insurance also covered the appropriate provision of information to consumers. This was in addition to circulars, email advice and clarification. **Result: Met** ✓

Insurers were able to notify policy holders of variations to their private health insurance rebate within acceptable timeframes, before changes were implemented.

Percentage of insurers' average premium increases publicly released in a timely manner.

Source: 2015-16 Health Portfolio Budget Statements, p. 111

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

The Department announced the weighted average premium increase for 2016 premiums on 2 March 2016. The average premium increase was 5.6%.

The number of people covered by private health insurance hospital treatment cover.

Source: 2015-16 Health Portfolio Budget Statements, p. 112 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
10.7m	11.3m **Result: Met** ✓	11.2m	11.1m	10.8m	10.6m

Private health insurance participation rates within the population remained steady over the 12 month period. The uptake of policies with hospital treatment during the same period has increased gradually.

The number of people with hospital treatment policies has increased by 102,250 from March 2015 to March 2016. Almost half the Australian population is covered as a result. Participation rates can be found in the *Australian Prudential Regulation Authority Private Health Insurance Quarterly Statistics March 2016.*[53]

[53] Available at: www.apra.gov.au/PHI/Publications/Pages/Quarterly-Statistics.aspx

Ensure access to safe and effective medical devices through the Prostheses List

Ensure consumers have access to safe and effective surgically implanted prostheses under the Prostheses List.
Source: 2015-16 Health Portfolio Budget Statements, p. 111

2015-16 Target	2015-16 Result
Consumers have access to clinically appropriate and cost-effective surgically implanted prostheses.	Consumers continue to have access to clinically appropriate and cost-effective surgically implanted prostheses. **Result: Met** ✓

There are over 10,000 items on the Prostheses List, providing surgeons with choice to select the most appropriate prosthesis for their patients.

Application processes continue to ensure that new medical devices are assessed as being, at minimum, as clinically effective as prostheses already listed on the Prostheses List or other available health care options.

Percentage of applications to list devices on the Prostheses List completed[54] within 22 weeks.
Source: 2015-16 Health Portfolio Budget Statements, p. 112

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
86.0%	89.7% **Result: Met** ✓	88.89%	N/A	N/A	N/A

The Department continues to review and refine its processes to ensure that as many applications as possible are completed within 22 weeks and listed on the next Prostheses List.

Promote a viable, sustainable and cost-effective private health insurance sector

Ensure that all health funds complete due diligence when assessing the increase in annual premiums.
Source: 2015-16 Health Portfolio Budget Statements, p. 111

2015-16 Target	2015-16 Result
Premium round applications demonstrate sufficient capital adequacy, solvency and prudential viability.	All premium round applications demonstrated sufficient capital adequacy, solvency and prudential viability. **Result: Met** ✓

In 2015-16, the Australian Prudential Regulation Authority (APRA) assumed the regulatory oversight role that was previously undertaken by the Private Health Insurance Administration Council.

The APRA confirmed that all private health insurance insurers met their prudential obligations.

[54] 'Completed' to be interpreted as a decision taken to: 1) recommend to list, or 2) recommend not to list, or 3) recommend to be deferred.

Outcome 6 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 6.1: Private Health Insurance			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	2,328	2,310	(18)
Special appropriations			
Private Health Insurance Act 2007 - incentive payments and rebate	5,953,427	5,887,067	(66,360)
Departmental expenses			
Departmental appropriation[2]	9,069	8,615	(454)
Expenses not requiring appropriation in the budget year[3]	181	449	268
Total for Program 6.1	**5,965,005**	**5,898,441**	**(66,564)**
Outcome 6 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	2,328	2,310	(18)
Special appropriations	5,953,427	5,887,067	(66,360)
Departmental expenses			
Departmental appropriation[2]	9,069	8,615	(454)
Expenses not requiring appropriation in the budget year[3]	181	449	268
Total expenses for Outcome 6	**5,965,005**	**5,898,441**	**(66,564)**
Average staffing level (number)	**43**	**42**	**(1)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
3 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 7

Outcome 7

Health Infrastructure, Regulation, Safety and Quality

Improved capacity, quality and safety of Australia's health care system to meet current and future health needs including through investment in health infrastructure, regulation, international health policy engagement, research into health care, and support for blood and organ donation services

Analysis of performance – **Outcome 7** Health Infrastructure, Regulation, Safety and Quality

In 2015-16, the Department continued to deliver appropriate and effective regulation, safeguarding the health and wellbeing of the community. In working to ensure the health system meets future needs, the Department established the Australian Digital Health Agency, which will lead the ongoing development of the national digital health capability. The Medical Research Future Fund Advisory Board was established in April 2016 and undertook extensive public consultations which will assist in determining the Australian Medical Research and Innovation Strategy and related Priorities.

These activities have contributed to the Department's achievement of objectives under Outcome 7 and Our Purpose.

Key community benefits for **Outcome 7** in 2015-16

Ongoing development of Australia's digital health capability

Work in 2015-16 ensured the commencement of the Australian Digital Health Agency on 1 July 2016. The development of the national digital health capability will allow health care providers, professionals and patients to share health information, improving availability of treatment and health outcomes.

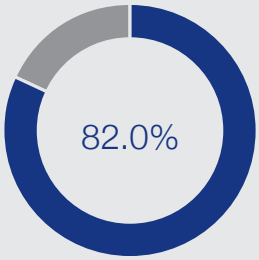
International engagement on global health issues

The Department represented Australia at the 66th Session of the WHO Western Pacific Regional Committee meeting. The Department secured critical outcomes on regional action plans and frameworks on viral hepatitis, tuberculosis, universal health coverage and urban health. This active engagement improves health practice and knowledge internationally, and contributes to better health outcomes for all Australians.

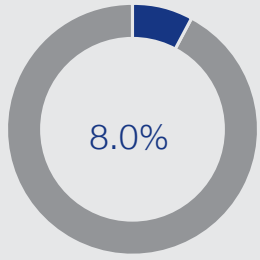
Improvements to Australia's research capacity

Agreement was reached with States and Territories through the *Clinical Trials Framework for Action* to improve the environment for clinical trials. Agreement will ensure a cohesive and strategic national approach across Australia, contributing to long term health care benefits to the Australian community.

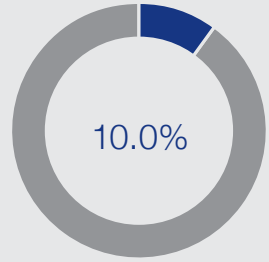
Summary of performance criteria results for **Outcome 7**



Met



Substantially met



Not met

Looking ahead

- Evaluate trials of My Health Record participation arrangements with findings used to inform the development of future strategies.
- Continue to monitor international health policy trends and actively engage in international dialogue on health policy challenges.
- Enhance investment in health and medical research by strategic investment of the Medical Research Future Fund (MRFF), with guidance from the Australian Medical Research Advisory Board.
- Redesign the Rural and Regional Teaching Infrastructure Grants Program to help deliver improved rural health services.
- Continue to promote best practice regulation.

Programs and program objectives contributing to **Outcome 7**

Program 7.1: eHealth

- Redevelop and operate a national shared eHealth record system
- Provide national eHealth leadership

Program 7.2: Health Information

- Provide support to the Council of Australian Governments (COAG) Health Council and the Australian Health Ministers' Advisory Council (AHMAC)
- Support the Australian Government with informed policy advice and facilitate engagement with the health sector

Program 7.3: International Policy Engagement

- Facilitate international engagement on global health issues

Program 7.4: Research Capacity and Quality

- Improve research capacity
- Monitor the use of diagnostics, therapeutics and pathology
- Improve safety and quality in health care

Program 7.5: Health Infrastructure

- Invest in other major health infrastructure
- Improve primary health care infrastructure

Program 7.6: Blood and Organ Donation

- Improve Australians' access to organ and tissue transplants
- Support access to blood and blood products

Program 7.7: Regulatory Policy

- Continue the quality improvement and regulatory reform process

Therapeutic goods

- Regulate therapeutic goods for safety, effectiveness/performance and quality
- Participate in international regulatory convergence and work sharing activities
- Continue the quality improvement and regulatory reform process

Chemical safety

- Aid in the protection of the Australian people and the environment by assessing the risks of chemicals and providing information to promote their safe use

Gene technology regulation

- Protect the health and safety of people and the environment by regulating work with genetically modified organisms (GMOs)

Analysis of performance – Program 7.1: eHealth

The Department met all the performance targets for Program 7.1: eHealth. In 2015-16, the Department implemented key recommendations from the Review of the Personally Controlled Electronic Health Record. The system was renamed to My Health Record and improvements were made to its usability and clinical content. My Health Record enables improved coordination of health care and the ability for consumers to share their health information seamlessly and securely across multiple health care providers.

National Digital Health governance arrangements and My Health Record system operations transitioned from the Department and the National eHealth Transition Authority to the newly established Australian Digital Health Agency (the Agency) on 1 July 2016. The Agency will lead the ongoing evolution of national digital health systems, which will connect and drive efficiencies in the health system and result in better health outcomes for all individuals. For further information about the Agency refer Appendix 5: *Australian Digital Health Agency 2015-16 Annual Report*.

The Department is currently trialling new participation arrangements, including an opt-out system, as well as innovative approaches utilising the current opt-in system. Outcomes from these trials will inform future participation arrangements in the My Health Record system.

My Health Record

In March 2016, My Health Record was launched. This is a secure online summary of a person's medications, diagnosed illnesses, treatments, allergies and tests. More than four million Australians already have a My Health Record and more are registering every day.

Each person can control what goes onto their My Health Record, and who is allowed to see it.

For health care providers, knowing more about a patient's medical history can lead to a better understanding of what is happening, and result in better treatment decisions. In any week, one in three GPs will see a patient for whom they have little or no health information. More than one in five GPs face this situation every day. With My Health Record, registered health care providers can have access to important information about their patient anytime and anywhere they need it.

Pharmacist Shane Jackson recognises the benefits of the My Health Record: "I am absolutely thrilled in the potential of the My Health Record system. More appropriate and timely access to patient information allows me to deliver better clinical care to my patients."

My Health Record enables people to take a more active role in managing their own health – both in preventing lifestyle-related chronic diseases, and managing conditions they already have. It can benefit all Australians, and is particularly helpful for people who have complex health conditions or continuing medical treatments and are being seen by a range of health care providers.

To find out more about the benefits of a My Health Record, and to sign up, visit: www.myhealthrecord.gov.au

Redevelop and operate a national shared eHealth record system

Good practice principles and methods are applied to the operation and support of the My Health Record system.
Source: 2015-16 Health Portfolio Budget Statements, p. 119

2015-16 Target	2015-16 Result
The My Health Record system operations and practices are regularly reviewed to improve performance and usability.	The My Health Record system operations and practices are regularly reviewed to improve performance and usability. Monthly governance meetings have been held throughout 2015-16 to manage the My Health Record program and monitor system operations and performance. These are underpinned by standard system design and operations processes and regular testing and assurance of system functions. **Result: Met** ✓

In applying and developing good practice principles and methods for the operation of the My Health Record system, the Department has taken into consideration expert advice, feedback and recommendations from a range of stakeholders, as well as the Operations Management Committee, Jurisdictional Advisory Committee and the Independent Advisory Council.

A number of improvements, informed by user research, have been made to the My Health Record system in order to improve the system operations and useability for individuals and providers.

Trials of new participation arrangements are undertaken, including for an opt-out system.
Source: 2015-16 Health Portfolio Budget Statements, p. 119

Participation trial findings inform future planning to increase participation in, and meaningful use of, the My Health Record.[55]
Source: 2015-16 Health Portfolio Budget Statements, p. 119 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Trials to commence in 2016.	Opt-out trials commenced in March 2016. Opt-in trials commenced in July 2016. **Result: Met** ✓

On 28 October 2015, the Minister for Health announced that the opt-out trial sites would cover the Northern Queensland and Nepean Blue Mountains Primary Health Network regions. These trials commenced in March 2016, following the Ministerial launch of the My Health Record on 4 March 2016.

In April 2016, two trials of innovative approaches to increasing participation and use of the My Health Record system utilising the current opt-in registration arrangements were announced. These two trials are taking place in Western Australia, and Ballarat in western Victoria.

As a result of the opt-out trials in Northern Queensland and the Nepean Blue Mountains, over 970,000 new My Health Records have been created.

The Ballarat trial will seek to register patients being admitted to the Ballarat hospital for a My Health Record. It is estimated that 27,000 individuals will register over the 6 month period of the trial.

[55] This performance criterion was originally published under the 'Provide national eHealth leadership' program objective.

The Western Australia trial will seek to increase registration of chronically ill patients when they establish a care plan with their doctor. It is estimated that 15,000 chronically ill patients will register as part of the trial.

The relative effectiveness of an opt-out system to increase participation and use of the system by consumers and health care providers is being assessed against the outcomes from the two trials of innovative opt-in approaches and the current national opt-in system, to inform future strategies for bringing forward the benefits of the My Health Record nationally.

The Department has engaged an independent evaluator to assess the outcomes of the trials. The independent evaluator's findings, which will be presented in a final report at the end of November 2016, will inform the Department's report to the Government. The Department's report will inform the Government's decisions on the future direction for the My Health Record system.

Provide national eHealth leadership

System availability.
Source: 2015-16 Health Portfolio Budget Statements, p. 120

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
99% of the time (excluding planned outages)	99.38% of the time (excluding planned outages) **Result: Met** ✓	99.86% (excluding planned outages)	N/A	N/A	N/A

The Department worked with its partner organisation to improve My Health Record system availability. This work included continued improvements to system monitoring tools for early detection of technical issues, and implementation of infrastructure failover capability, to ensure system availability in the event of equipment failure.

New eHealth governance arrangements are implemented, including establishment of the Australian Commission for eHealth.[56]
Source: 2015-16 Health Portfolio Budget Statements, p. 119

2015-16 Target	2015-16 Result
The Commission is operational from 1 July 2016.	The Australian Digital Health Agency was established in law on 30 January 2016 and commenced operations on 1 July 2016. **Result: Met** ✓

The Australian Digital Health Agency commenced operating on 1 July 2016 and will lead the ongoing development and delivery of the national digital health capability, which will allow health care providers, professionals and patients to seamlessly share health information.

The Intergovernmental Agreement which commits funding to the Australian Digital Health Agency was approved and executed by the COAG Health Council on 8 April 2016.

The Minister for Health appointed the Chair and Board members on 20 April 2016, after agreement from State and Territory health ministers. An acting CEO was appointed on 4 May 2016 pending the appointment of a permanent CEO.

[56] The Australian Commission for eHealth was renamed the Australian Digital Health Agency in November 2015 by the Minister for Health, to better address the long term digital transformation of health care and provide a simple title for the health consumer.

Analysis of performance – Program 7.2: Health Information

The Department met all the performance targets for Program 7.2: Health Information. In 2015-16, the Department continued to work with the States and Territories through the Council of Australian Governments' (COAG) Health Council to improve health outcomes of all Australians, through a coordinated and collaborative approach to health policy development. Health services are delivered more efficiently through a coordinated approach, which in turn contributes to the sustainability of the health system.[57]

The Department also continued to seek advice from peak and advisory bodies. This advice is considered as part of the development of policies and programs that directly improve health outcomes.

Provide support to the COAG Health Council and AHMAC

Australian Government initiated activities undertaken by AHMAC and its Principal Committees support the COAG Health Council in providing leadership on national health issues.
Source: 2015-16 Health Portfolio Budget Statements, p. 121

2015-16 Target	2015-16 Result
Relevant Australian Government priorities are highlighted and progressed in the activities of the COAG Health Council.	Priorities were agreed and progressed by Australian Health Ministers' Advisory Council (AHMAC) and endorsed by the COAG Health Council. **Result: Met** ✓

The Commonwealth, State and Territory Governments have a shared intention to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.[58]

The COAG Health Council, supported by AHMAC, focussed on a broad range of issues in 2015-16 including: long term future of the health system; hospital and health service delivery; establishment and integration of primary care networks; coordination of care for people with chronic and complex conditions; Aboriginal and Torres Strait Islander Health; digital health; health workforce; mental health; safety and quality; aged care; and health promotion and prevention.

Support the Australian Government with informed policy advice and facilitate engagement with the health sector

Advice obtained from national peak and advisory bodies informs policy and programme development.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 75

2015-16 Target	2015-16 Result
Funding agreements with a range of national peak and advisory bodies commencing from 1 January 2016.	Funding agreements commenced from 1 January 2016. **Result: Met** ✓

An approach to market was undertaken and finalised prior to 31 December 2015. Funding agreements commenced from 1 January 2016.

[57] Sustainability of the health system refers to the ability of the Government to continue to fund services over the longer term given increasing demand for and costs of services.

[58] Ibid.

Analysis of performance – Program 7.3: International Policy Engagement

The Department met all the performance targets for Program 7.3: International Policy Engagement. Responding to global health security threats, building effective health systems, and preventing and treating disease, including non-communicable disease, are global challenges that require global solutions.

In 2015-16, the Department continued to provide leadership in international health fora, promoting international best practice and sharing its technical and policy expertise, focussing on regional and global health priorities.

The Department also continued to host overseas delegations to share information and experiences in different aspects of health systems. The learnings from these delegations continue to assist the Department in the ongoing development of a more affordable, accessible, efficient, and high quality health system.

Facilitate international engagement on global health issues

Number of international health delegation visits facilitated by the Department.
Source: 2015-16 Health Portfolio Budget Statements, p. 123

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
15-20	16 **Result: Met** ✓	20	20	25	35

Incoming visits from overseas delegations that are interested in learning more about various parts of Australia's health system, are an important means of engaging with other countries: to build networks and professional linkages between individuals and organisations; exchange ideas and experience; and facilitate international discussions on health issues.

Australia's interests secured at relevant meetings of key international health bodies and organisations.

Source: 2015-16 Health Portfolio Budget Statements, p. 123 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Departmental representatives will have actively engaged in meetings of the WHO governing bodies, OECD Health Committee, APEC Health Working Group and other international fora.	The Department provided leadership in international health fora, promoting and learning from international best practice and sharing its technical and policy expertise focussing on domestic regional and global health priorities. **Result: Met** ✓

The Department pursued meaningful governance reform of the World Health Organization (WHO), and was active at the World Health Assembly, where countries achieved positive outcomes including reaching agreement on: the WHO's new health emergency program and global health security issues more broadly; the first ever Global Strategy and Plan of Action on Ageing and Health; access to medicines; and new global health sector strategies on HIV, viral hepatitis and sexually transmitted infections. The Department also represented Australia at the 66th Session of the WHO's Western Pacific Regional Committee Meeting securing critical outcomes on regional action plans and frameworks on viral hepatitis, tuberculosis, universal health coverage and urban health.

The Department actively engaged with the OECD Health Committee and participated in a number of expert group meetings and committee projects, including supporting a comprehensive review of Australia's health system.

Through the Asia-Pacific Economic Cooperation (APEC) Health Working Group, the Department worked to improve health security preparedness through improved capacity and better cooperation across sectors. The Department led Australia's delegations to the Pacific Heads of Health Meeting, contributing to strategic policy objectives for Pacific health ministries, in particular in the area of non-communicable diseases.

Analysis of performance – Program 7.4: Research Capacity and Quality

The Department met the majority of the performance targets for Program 7.4: Research Capacity and Quality. There were some challenges in achieving all performance targets, which are discussed in the performance criteria below.

Health and medical research over the medium to longer term is vital to the future of the health system. All Australians stand to benefit from ongoing investments in research through the Medical Research Future Fund (MRFF), either directly through improved health, or indirectly by supporting improved system productivity and economic growth.

The first disbursements from the MRFF were scheduled to be made during 2015-16. The legislation that underlies the MRFF requires the Australian Medical Research Advisory Board to undertake consultation prior to determining the Australian Medical Research and Innovation Strategy and related Priorities. Consultations commenced in May 2016. First disbursements from the MRFF are expected to be made in early 2017.

Improve research capacity

Stakeholders are engaged in developing strategies to improve clinical trials processes.
Source: 2015-16 Health Portfolio Budget Statements, p. 125

2015-16 Target	2015-16 Result
Agreement reached by jurisdictions on strategies to improve clinical trials processes.	Jurisdictions and key stakeholder representatives endorsed a *Clinical Trials Framework for Action*. Key stakeholders engaged in investigation into recruitment and retention barriers in Australian clinical trials. **Result: Met** ✓

The endorsed *Clinical Trials Framework for Action* will ensure a cohesive and strategic national approach and improve the clinical trials environment in Australia.

The Department funded a systematic review of barriers and enablers to clinical trials recruitment in Australia, to inform future strategies for improvement. Project consultations included jurisdictional representatives and key stakeholders from across the clinical trials sector, as well as consumers.

Clinical trials reform continues to deliver improved processes and drive further investment.
Source: 2015-16 Health Portfolio Budget Statements, p. 126

2015-16 Target	2015-16 Result
Adoption of national metrics system by all jurisdictions as a mechanism for quality improvement.	*Framework for National Aggregate Statistics for Clinical Trials* was implemented by jurisdictions. Work in 2015-16 ensured that the first activity report was provided to Australian Health Ministers' Advisory Council (AHMAC) in May 2016. **Result: Met** ✓

Health Ministers endorsed a *Framework for National Aggregate Statistics for Clinical Trials* in April 2015. In 2015-16, jurisdictions reported data for initial metrics and delivered the *First Activity Report on Commercially Sponsored Clinical Trials in Australian Public Health Organisations* to AHMAC in May 2016.

The report (which will be refined over time) provides a national picture of number, phase and timelines for clinical trials in Australia, to evaluate the success of efforts to improve the clinical trials environment, and to inform future quality and performance improvement.

Investment in medical research supports sustainability for the health system and drives innovation.

Source: 2015-16 Health Portfolio Budget Statements, p. 126 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result
Strategic investment of total available funding in 2015-16.	First disbursements under the Medical Research Future Fund will be made in 2016-17. **Result: Not met**

The *Medical Research Future Fund Act 2015* (MRFF Act) was passed by Parliament in August 2015, with the Australian Medical Research Advisory Board (Advisory Board) established in April 2016.

The MRFF Act requires the Advisory Board to consult and develop the Australian Medical Research and Innovation Strategy and related Priorities to be considered by Government in making decisions on fund disbursements. The MRFF Act requires that stakeholder consultation and engagement occurs before the Advisory Board determines the Strategy and Priorities. A public consultation process, including a public call for submissions finished on 31 August 2016.

The passage of the enabling MRFF legislation (an interdepartmental effort led by the Department of Finance) and subsequent appointment of the Advisory Board, impacted on the ability to make disbursements in 2015-16.

It is anticipated the delivery of Strategy and Priorities will now occur in October 2016, allowing the first disbursements to be made in early 2017.

The movement of 2015-16 funds to 2016-17 has been agreed by Government and is published in the 2016-17 Budget.

The Biomedical Translation Fund (BTF) was announced as part of the National Innovation and Science Agenda in December 2015. The BTF will provide funding to private fund managers for investment into biomedical discoveries. Funds intended for the capital base of the MRFF have been diverted to form the BTF, which will allow for the fast tracking of investments into biomedical start-ups. A BTF Committee was established under Innovation Australia to guide the appointment of fund managers. The Committee's first meeting was held in June 2016. The call for fund managers closed on 14 September 2016 and it is expected that fund managers will be appointed in late 2016. Fund managers are expected to identify investees and commence the drawdown of matched funds in early 2017.

Monitor the use of diagnostics, therapeutics and pathology

Information regarding quality use of medicines newly listed on the PBS is provided to health professionals where appropriate.

Source: 2015-16 Health Portfolio Budget Statements, p. 125

2015-16 Target	2015-16 Result
The Department will provide funding for the provision of quality use of medicines information to be available in a variety of formats throughout the year, designed to support clinicians and consumers.	The Department supported NPS MedicineWise to produce its scheduled publications which provide evidence-based information on therapeutics, including new and revised listings of medicines on the PBS, for health professionals and consumers. **Result: Met**

NPS MedicineWise publications include the *Rational Assessment of Drugs and Research (RADAR)*, *Australian Prescriber* and an annual evaluation report of all NPS MedicineWise programs.

The Department also continued to support NPS MedicineWise through the Quality Use of Diagnostics, Therapeutics and Pathology Flexible Fund, to provide information and support to consumers and health professionals on quality use of medicines and medical testing.

Education was provided to health professionals in the form of one-on-one education visits, clinical e-Audits, peer group sessions, online modules and publications. Information was provided to health consumers through targeted campaigns (including on the appropriate use of antibiotics) and through various therapeutic topics accessible through the NPS MedicineWise website.[59]

Improve safety and quality in health care

Relevant evidence-based resources are available to help reduce unwarranted healthcare variation by changing clinical practice.
Source: 2015-16 Health Portfolio Budget Statements, p. 126

2015-16 Target	2015-16 Result
Tools are available to consumers, clinicians and health services to promote adoption of clinical best practice.	Information is available to reduce variation in 36 health care interventions. **Result: Met** ✓

The first Australian Atlas of Healthcare Variation (the Atlas) points to actions clinicians and health services can take to address health care variation.

Identification of potential unwarranted healthcare variation.
Source: 2015-16 Health Portfolio Budget Statements, p. 126

2015-16 Target	2015-16 Result
Agreement with relevant stakeholders on unwarranted healthcare variation for further investigation.	Agreement pending. Stakeholders currently considering the incidence of healthcare variation revealed in the Atlas. **Result: Not met**

The Atlas contains 67 recommendations directed to multiple stakeholders across the health care system. The suggested actions are designed to improve equity and efficiency, as well as the safety and quality of health care. Twelve recommendations are directed to the Department and have been considered in the context of broader health reform.

[59] Available at: www.nps.org.au

Analysis of performance – Program 7.5: Health Infrastructure

The Department substantially met two of the three performance targets for Program 7.5: Health Infrastructure.

Investment in health infrastructure will improve access to essential health services for people living in rural, remote and very remote communities. The Department continues to monitor the progress of infrastructure projects, taking remedial action where required.

The Department has not achieved the target of providing 75 Rural and Regional Teaching Infrastructure Grants (RRTIGs). RRTIGs work in partnership to stimulate the bringing forward of capital expenditure for upgrades of private health infrastructure in rural and regional Australia.

While the Department made 74 offers to successful applicants, not all RRTIGs offers were accepted. In seeking feedback, the Department understood offers were declined due to the amount of the grant offered and the limitations on how grant money could be spent by applicants. The Department has worked to reduce the administration burden on applicants as a result of this feedback.

Invest in other major health infrastructure

Funding arrangements in place for all successful projects under the 2010 and 2011 Regional Priority Round of Health and Hospitals Fund (HHF) grants.
Source: 2015-16 Health Portfolio Budget Statements, p. 127

2015-16 Target	2015-16 Result
Remaining six funding agreements signed by 31 December 2015.	One of the funding agreements was signed by 31 December 2015 and a further four funding agreements were signed by 18 February 2016. The remaining funding agreement is expected to be finalised by 30 September 2016. **Result: Not met**

The outstanding funding agreements all involved complex negotiations to ensure the agreed outputs for the projects would be achieved within the approved scope and budget.

Effective monitoring of HHF projects for compliance with agreed outputs.
Source: 2015-16 Health Portfolio Budget Statements, p. 128

2015-16 Target	2015-16 Result
Reports are received for all projects in the required timeframe and remedial action taken as required.	357 reports were due during the period. 304 reports were submitted in the required timeframe, remedial action was taken for the 53 reports which have now been submitted. **Result: Substantially met**

The majority of HHF funding recipients were compliant in providing project reports and achieving agreed project outputs within the required timeframes. Where projects were found to be non-compliant, the Department undertook remedial action in a timely manner.

This performance result of 'substantially met' is based on meeting 85% of the target.

Improve primary health care infrastructure

Number of grants to support the provision of additional space for teaching and training to strengthen the rural workforce.
Source: 2015-16 Health Portfolio Budget Statements, p. 128

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
75	43 **Result: Not met**	10	N/A	N/A	N/A

The Department has 43 RRTIGs funding agreements in place.

The Department made 74 grant funding offers to applicants, of which 20 applicants decided to withdraw from contract negotiations. The main reasons cited for withdrawal were the amount of the grant to be awarded and limitations in how the grant funds could be utilised. The Department is continuing negotiations to finalise the remaining offers.

The RRTIGs program has been streamlined to reduce administrative burden on applicants.

Analysis of performance – Program 7.6: Blood and Organ Donation

The Department met all performance targets for Program 7.6: Blood and Organ Donation.

In 2015-16, the Department continued to ensure there was sufficient blood and blood products available to support Australian patients. Governments endorsed the 2016–18 Jurisdictional Blood Committee Strategic Plan which incorporates a range of activities to improve the efficiency of the national blood arrangements and ensure its financial sustainability. Embedded within the Strategic Plan are eight policy priority areas for action over the life of the Plan, covering topics such as appropriateness of use and sustainability of Immunoglobulin; blood product use and wastage within the private sector; and harmonising the provisions of the National Blood Agreement with that of the broader health sector.

The Department continued to support the Organ and Tissue Authority in implementing, coordinating and monitoring a national approach to organ and tissue donation, with the aim of increasing Australians' access to life-saving and life-transforming transplants. This included activities in relation to the implementation of the 2014-15 Budget measure – *Accelerating Growth in Organ and Tissue Donation for Transplantation.*

On 1 July 2015, the Department assumed responsibility for the administration of the Supporting Leave for Living Organ Donors (SLLOD) Program, for which funding is provided until 30 June 2017. The SLLOD Program provides a financial contribution, via the donor's employer, to alleviate the financial burden for leave taken during the living donation process and recovery period. The Department also continued to provide policy oversight and support to the Department of Human Services in administering the Australian Organ Donor Register which enables Australians to register their decision about becoming an organ and/or tissue donor for transplantation after death.

The Department continued to ensure Australian patients are able to access Australian donors/cord blood units, or matched international donors/cord blood units, for stem cell transplant purposes, as part of life-saving treatment for cancer and other serious conditions.

Improve Australians' access to organ and tissue transplants

Support the Australian Bone Marrow Donor Registry and the National Cord Blood Collection Network to identify matched donors and stem cells for transplant.
Source: 2015-16 Health Portfolio Budget Statements, p. 130

2015-16 Target	2015-16 Result
Increased diversity of tissue types of donors and cord blood units available for transplant.	Diversity of donors and cord blood units available for transplant has increased. **Result: Met** ✓

The Australian Bone Marrow Donor Registry and the National Cord Blood Collection Network have been supported, and continue to identify matched donors and cord blood units for patients requiring them for transplantation. Donors from ethnically diverse backgrounds are required to increase the chance of a match being found in the Australian registry, as the Australian population profile is ethnically diverse. While the diversity of cord blood units has increased, a new donor recruitment strategy is being assessed to substantially improve the diversity of the stem cell donor pool. At present the donor pool is ageing and predominantly of north-west European descent, and needs younger donors from other backgrounds. This issue is being considered in the context of meeting the needs of Australian patients into the future.

Number of banked cord blood units.
• Total • Indigenous
Source: 2015-16 Health Portfolio Budget Statements, p. 130

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
Total 1,600 Indigenous 50	Total 1,700 Indigenous 60 **Result: Met** ✓	1,765 119	1,957 101	523 64	810 94

Cord blood units continue to be collected and banked in the three public cord blood banks in Australia, which now have more units per head of population banked than most other countries. A review of cord blood banking in Australia has recently been completed and will inform the future direction of the cord blood banking sector in Australia.

Support provided to the Australian Bone Marrow Donor Registry to search for (and transport) matched donors and stem cells internationally, when a domestic match is unavailable for transplant.
Source: 2015-16 Health Portfolio Budget Statements, p. 131

2015-16 Target	2015-16 Result
Funding is provided to meet the Commonwealth's agreement with the Australian Bone Marrow Donor Registry.	Funding was provided as agreed. **Result: Met** ✓

The Australian Bone Marrow Donor Registry has been fully funded as per the Agreement, and stem cells from matched international donors have been transported for transplantation for Australian patients.

Demand for stem cell transplants continues to increase and international currency fluctuations impact on the cost of sourcing and transporting matched cells donated internationally.

Support access to blood and blood products

Effective planning of the annual blood supply through the National Supply Plan and Budget.
Source: 2015-16 Health Portfolio Budget Statements, p. 130

2015-16 Target	2015-16 Result
Implementation of the 2015-16 National Supply Plan and Budget that was agreed by all Health Ministers in 2014-15.	The 2015-16 National Supply Plan and Budget was agreed by all Health Ministers on 17 April 2015 and has been implemented. **Result: Met** ✓

The Commonwealth's contribution in 2015-16, based on the national cost-sharing arrangements, was expected to be up to $721.3 million.[60]

The supply of blood and essential blood products are effectively supported in order to meet Australia's clinical need.
Source: 2015-16 Health Portfolio Budget Statements, p. 131

2015-16 Target	2015-16 Result
Funding is provided to meet the Commonwealth's contribution under the National Blood Agreement.	Funding has been provided as agreed. **Result: Met** ✓

The supply of blood and essential blood products have been fully-funded as per the National Blood Agreement to ensure that there is a sufficient supply of blood and blood products and services in all the States and covered Territories.

This funding ensured Australians had access to blood and blood products required for treatment of numerous medical conditions in 2015-16. Conditions include cancer, heart, stomach, bowel, liver and kidney diseases. Blood and/or blood products are predominantly provided during and after surgery, for treatment of traumatic injury or burns, and for chronic conditions including blood disorders (e.g. haemophilia) and immunodeficiency conditions.

[60] The Commonwealth's contribution in 2015-16 will be reconciled approximately in December 2016 to reflect actual expenditure.

Analysis of performance – Program 7.7: Regulatory Policy

The Department met, or substantially met, the majority of performance targets for Program 7.7: Regulatory Policy.

The Department has continued to contribute significantly to the Government's regulatory reform agenda with the aim to reduce the red tape burden on businesses, community organisations and individuals. The focus of the reforms has been on ensuring delivery of appropriate and effective regulation which maintains desired health outcomes, upholds public health and safety protections, and implements effective compliance regimes while reducing unnecessary regulatory and red tape burden.

The Department has been at the forefront of implementing regulatory reform initiatives such as the Regulator Performance Framework (RPF) and the adoption of international standards and risk assessment under the Government's Industry Innovation and Competitiveness Agenda. In 2015-16, the first year of RPF implementation, departmental and portfolio regulators worked closely to develop and publish evidence metrics under the RPF. These will be used to assess regulators' performance through annual self-assessments.

In 2015-16, to protect the health, safety and wellbeing of the Australian community, the Department continued to provide national leadership in regulatory policy in the areas of therapeutic goods, industrial chemicals and gene technology.

The Department has contributed to the achievement of significant reductions in red tape burden. The Portfolio has reported red tape reduction savings worth $249 million since September 2013.

Continue the quality improvement and regulatory reform process

Contribute to the Government's deregulation and red tape reduction agenda by identifying and progressing opportunities to reduce red tape.
Source: 2015-16 Health Portfolio Budget Statements, p. 133

2015-16 Target	2015-16 Result
Opportunities to reduce regulatory and red tape burden are identified and contribute to the Government's $1 billion per annum regulation reduction target.	In 2015, the Department made 40 regulatory savings decisions worth a combined total net saving of $96.8 million. **Result: Met** ✓

The Government's red tape reduction outcomes are reported on a calendar year basis. For 2015, the Department reported gross savings decisions of $100.4 million and net savings decisions worth $96.8 million, contributing to the whole-of-government net outcome of $2.5 billion for that year. Details of specific regulatory reform activities undertaken by the Department are published in the *2015 Annual Red Tape Reduction Report*.[61]

Further opportunities for regulatory reform have been identified, and the Department and wider portfolio will continue to promote regulatory reform, encouraging best practice in regulation and minimising unnecessary compliance burden in 2016-17 and beyond.

[61] Available at: www.cuttingredtape.gov.au/annual-red-tape-reduction-report-2015

The Department is currently putting in place a detailed regulatory framework, enabling applications for licences and permits for the cultivation, production and manufacture of medicinal cannabis products.

Medicinal cannabis scheme to ease pain of suffering Australians

Amendments to the *Narcotic Drugs Act 1967*, passed by Parliament in February 2016, will allow the domestic cultivation and manufacture of medicinal cannabis products and related research purposes after 30 October 2016. The medicinal cannabis scheme will allow medical professionals to prescribe medicinal cannabis products where appropriate and aims to help Australians who suffer from illnesses including nausea associated with cancer treatment, childhood epilepsy, multiple sclerosis and to assist those in end of life palliative care.

The Department has been working closely with State and Territory Governments to form relevant regulations and guidelines, as well as holding public consultations around the country.

The medicinal cannabis scheme has been met with enthusiasm by many who attended the information and consultation sessions with a number of attendees believing this has been a long time coming. The scheme will not only help Australians who suffer from a range of illnesses that might benefit from medicinal cannabis, but potentially give those who have turned to illegal sources in a desperate attempt to find relief an alternative, legal option.

The medicinal cannabis scheme is expected to start accepting and reviewing licence and permit applications to cultivate and manufacture after 30 October 2016, with the aim of having domestically grown products available for patients by mid-2017.

The Department, through the Therapeutic Goods Administration (TGA), continued to safeguard and enhance the health of the Australian community through effective and timely regulation of therapeutic goods, while ensuring that the goods available in Australia are safe and fit for their intended purpose. These include goods Australians rely on every day, such as vitamin tablets and sunscreens, through to goods used to treat serious conditions, such as prescription medicines, vaccines, blood products and surgical implants.

Further to publication on 24 June 2015 of the 32 recommendations in the first report of the Expert Panel Review of Medicines and Medical Devices Regulation (the Review), on 20 November 2015 the second and final report was published. This report looked at the regulatory framework for complementary medicines and the advertising of therapeutic goods and made a further 26 recommendations.

Advice to the Government in response to the recommendations of the Review was provided. Work is currently underway on implementation of the 2016-17 Budget measure – *Improving the Regulation of Therapeutic Goods in Australia*.

The National Industrial Chemicals Notification Assessment Scheme (NICNAS), administered by the Department, continued to aid in the protection of the Australian people and the environment. In 2015-16, NICNAS continued to disseminate high quality assessment reports that inform workers, governments, industry and community about the risks and safe use of new and existing industrial chemicals. Reports cover chemicals used in solvents, adhesives, plastics, paints, inks, fuels, or laboratory reagents, as well as in refrigeration, cosmetics and household cleaning. The Department also commenced work on the implementation of the reforms to NICNAS that had been announced by the Government in the context of the 2015-16 Budget. The Department published a series of consultation papers and convened a series of workshops to better understand and (to the extent possible within the policy parameters decided by the Government) accommodate the divergent views of different stakeholder groups in preparing advice for the Government on the practical details of a reformed scheme.

The Gene Technology Regulator, supported by the Department, administers the national gene technology regulatory scheme. In 2015-16, the Regulator continued to protect the health and safety of people, and to protect the environment, by identifying risk posed by or as a result of gene technology, and by managing those risks through regulating certain dealings with genetically modified organisms (GMOs).

There have been significant technological advances in recent years, including the development of a range of novel techniques for making precise changes to genes. Regulatory frameworks across the world were developed prior to the existence of these new technologies. The Gene Technology Regulator is working to address the challenges of keeping pace with the new techniques and their regulation.

Therapeutic goods

Regulate therapeutic goods for safety, effectiveness/performance and quality

Continue to regulate therapeutic goods for safety, effectiveness/performance and quality.
Source: 2015-16 Health Portfolio Budget Statements, p. 133

2015-16 Target	2015-16 Result
Effective pre-market evaluation and post-market monitoring and assessment of therapeutic goods, as required under the *Therapeutic Goods Act 1989* and associated regulations.	The TGA continued to undertake pre-market and post-market monitoring and assessment of therapeutic goods as required under the *Therapeutic Goods Act 1989* and associated regulations. **Result: Substantially met** ✓

Through the TGA, the Department demonstrates regulatory performance through its reporting framework. The framework consists of various reports that focus on its performance as a regulator and engagement with stakeholders, as well as more detailed information about regulatory and corporate activities.

Performance measures surrounding pre-market application processing and post-market activities are reported below.

In addition, detailed information regarding pre and post-market statistics are reported in the TGA's Performance Statistics Report and published on the TGA website annually.

Performance result of 'substantially met' is based on meeting 99.1% of the targeted 100% of Category 3 applications for prescription medicines processed within legislated timeframes.

Update and maintain the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) for medicines.
Source: 2015-16 Health Portfolio Budget Statements, p. 133

2015-16 Target	2015-16 Result
SUSMP is amended as soon as practicable after the Secretary's delegate's final decision under the *Therapeutic Goods Regulations 1990*.	The SUSMP was amended as soon as practicable after the Secretary's delegate's final decision. In all, there were 6 updates to the SUSMP during 2015-16. **Result: Met** ✓

All required SUSMP legislative instruments were amended as soon as practicable after the Secretary's delegate's final decision during 2015-16 and all are available on the Federal Register of Legislation (FRL) website for June 2015, July 2015, October 2015, February 2016, March 2016 and June 2016. This result represents an increase in SUSMP publication of 100% during the financial year to meet demand.

Percentage of applications for the import, export, and manufacture of controlled substances that are assessed and processed within agreed timeframes.
Source: 2015-16 Health Portfolio Budget Statements, p. 134

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
95%	99% **Result: Met** ✓	N/A	N/A	N/A	N/A

During 2015-16, 99% of applications were completed within the requisite timeframe due to improvements to internal workflow processes.

In 2015-16, the Office of Drug Control (ODC) issued a total of 7,002 licences and permits authorising the import, export and manufacture of controlled drugs. This represents a decrease of 6% compared to 2014-15.

The ODC also provided 230 basic checks and statements to law enforcement.

Percentage of evaluations/assessments completed within legislated timeframes:[62]
a) Applications lodged under prescription medicines registration (Category 1 applications) processed within 255 working days;
b) Quality related evaluations of prescription medicines (Category 3 applications) processed within 45 working days; and
c) Conformity assessments for medical devices processed within 255 working days.
Source: 2015-16 Health Portfolio Budget Statements, p. 135

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	a) 100% b) 99.1% c) 100% **Result:** **a) Met** ✓ **b) Substantially met** ✓ **c) Met** ✓	a) 99.7% b) 98% c) 100%	a) 99.8% b) 100% c) N/A	a) 99.7% b) 100% c) N/A	a) 99.5% b) 99.4% c) N/A

Category 1 applications are for new medicines, presentations and indications. Category 3 applications are initiated by sponsors for manufacturing and quality changes and are usually to an existing, marketed medicine.

380 of 380 (100%) Category 1 evaluations for prescription medicines, 1,390 of 1,403 (99.1%) Category 3 evaluations and 186 of 186 (100%) of conformity assessment applications for medical devices were processed within legislated timeframes.

As a result of business improvement processes, all conformity assessments for medical devices have been processed in less than 200 working days throughout the reporting period.

[62] Once an application has been accepted by the TGA, the approval time is defined as the number of TGA working days until a decision is made. This timeframe is underpinned by legislation and excludes public holidays, weekends, the time allocated to the applicant to provide responses to requests for information and 'mutual clock stop' periods agreed with the applicant. In accordance with the *Therapeutic Goods Regulations 1990*, a 'submission' may include a number of applications submitted at the one time. The data presented relate to submissions as this best reflects the evaluation and decision-making processes.

Percentage of alleged breaches of the *Therapeutic Goods Act 1989* received that are assessed within 10 working days and an appropriate response initiated.
Source: 2015-16 Health Portfolio Budget Statements, p. 135

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

Complaints are triaged in a risk-based regulatory compliance framework and against the scope of jurisdictional reach of Commonwealth law to determine the appropriate response in relation to risks posed by breaches of the TGA's regulatory scheme.

Percentage of licensing and surveillance inspections closed out within target timeframes.
Source: 2015-16 Health Portfolio Budget Statements, p. 135

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
85%	87% **Result: Met** ✓	N/A	N/A	N/A	N/A

The Department reviewed the process for conducting post-inspection activities to allow a more efficient resolution of deficiencies and close-out of inspections and to align with international practice. Following a trial of the modified process, in addition to consultation with the Technical Industry Working Group on Good Manufacturing Practice, changes have been made to:

- deficiencies reported to manufacturers after the inspection in place of the inspection report;
- requirements for objective evidence required under certain circumstances e.g. critical deficiencies, initial inspection or recurring deficiencies;
- the inspection report issued to the manufacturer after the responses to the deficiencies have been addressed and closed; and
- the format and content of the inspection report.

External guidance material is available on the TGA website and continues to be updated.

Participate in international regulatory convergence and work sharing activities

Implement international harmonisation and work sharing activities with comparable international regulators.
Source: 2015-16 Health Portfolio Budget Statements, p. 133

2015-16 Target	2015-16 Result
Enhanced cooperation and work sharing, including increased reliance on medicines evaluation and facilities inspection information from international regulators, as outlined in TGA's *International Engagement Strategy 2013–2015.*	The Department successfully continued collaboration activities with comparable international regulators through international fora as outlined in the TGA's *International Engagement Strategy 2013–15*. **Result: Met** ✓

The Department promoted enhanced cooperation and work sharing, and influenced international regulatory policy, in relation to therapeutic goods, through its continued participation in fora such as the International Coalition of Medicines Regulatory Authorities and the International Medical Devices Regulators' Forum.

Percentage of good manufacturing practice clearances of overseas manufacturers that take into account approvals by equivalent international regulators.
Source: 2015-16 Health Portfolio Budget Statements, p. 134

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
85%	95% **Result: Met** ✓	N/A	N/A	N/A	N/A

New processes have led to improvements in the TGA's ability to issue Good Manufacturing Practice clearances in a shorter timeframe.

Continue the quality improvement and regulatory reform process

Implement reforms that enhance TGA's current regulatory processes and are consistent with the Government's deregulation and red tape reduction agenda.
Source: 2015-16 Health Portfolio Budget Statements, p. 133

2015-16 Target	2015-16 Result
Begin implementation of the Government's response to the Review of Medicines and Medical Devices Regulation.	Changes to the Medicines and Medical Devices Regulation in response to the Review were funded in the 2016-17 Budget and are in the process of being implemented. **Result: Met** ✓

These reforms, when fully implemented, are estimated to save around $75 million annually through removing unnecessary duplication, cutting red tape and easing the regulatory burden on the pharmaceutical and medical device industries.

Number of reforms implemented to enhance TGA's regulatory processes.
Source: 2015-16 Health Portfolio Budget Statements, p. 134

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
9[63]	2 **Result: Not met**	1	9	28	N/A

In December 2011, the Government released its response, *TGA Reforms: a blueprint for the TGA's future* (the Blueprint), to a number of reviews undertaken of therapeutic goods regulation. It was agreed that the reforms and recommendations contained in the Blueprint would be implemented over a four year period.

To date, 40 of 48 Blueprint reference targets have been met. Implementation of a small number of recommendations was put on hold pending the Expert Panel Review of Medicines and Medical Devices Regulation. A plan to ensure information on the TGA website is current, accurate, relevant and up to date and meets the needs of its audiences has been developed.

Chemical safety

Aid in the protection of the Australian people and the environment by assessing the risks of chemicals and providing information to promote their safe use

Scientifically robust assessments of new and existing industrial chemicals.
Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
Peer review and stakeholder feedback support assessment outcomes.	Peer review and stakeholder feedback supported assessment outcomes. **Result: Met**

In 2015-16, NICNAS published assessment reports for 196 new chemicals, one Priority Existing Chemical, and published three reports following secondary notifications of previously assessed chemicals and one secondary notification of a new chemical. All of these reports were peer reviewed, and stakeholder feedback was considered prior to finalising the reports. No reviews of NICNAS's chemical assessments were conducted by the Administrative Appeals Tribunal.

NICNAS aids in the protection of the Australian people and the environment by disseminating high quality assessment reports that inform workers, governments, industry and community about the risks and safe use of new and existing industrial chemicals.

[63] This target does not include one uncompleted reform from 2014-15. As at 30 June 2016, eight reforms are still to be implemented.

High quality assessment outcomes are produced through effective use of the Inventory Multi-tiered Assessment and Prioritisation (IMAP) framework.
Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
The IMAP framework will be reviewed to inform future assessment approaches for industrial chemicals already in use.	The IMAP framework was internally reviewed and found to be a suitable basis for future assessment approaches under reformed chemical assessment arrangements. **Result: Met** ✓

The IMAP framework was established in 2012 and is being implemented in a staged manner to accelerate the assessment of previously unassessed chemicals listed on the Australian Inventory of Chemical Substances (AICS).

By the end of the four years of Stage One of the application of the IMAP framework (30 June 2016), NICNAS had made 2,705 recommendations to manage newly identified risks associated with the industrial use of 2,135 unique chemicals assessed under the IMAP framework.

This includes 194 recommendations made during 2015-16. In all cases, interested parties were given the opportunity to comment on those recommendations. NICNAS staff engaged with stakeholders, and met with key Australian risk management agencies to promote the uptake of recommendations.

NICNAS staff, in consultation with Australian and international stakeholders, undertook a review of Stage One of the implementation of the IMAP program, which found that the IMAP framework is very effective overall in accelerating high quality assessment outputs for chemicals. The review found that recommendations contained in IMAP assessment reports have been taken up by relevant regulatory agencies to improve the safe use of chemicals already in use in Australia, and that more effective management of risks associated with the use of these chemicals will further aid in the protection of the Australian people and the environment. The review concluded that the tools and approaches used in the IMAP framework were aligned with international best practice and were fit for purpose.

Following this review, the Assistant Minister for Health and Aged Care approved the commencement of the second stage of implementing the IMAP framework.

Contribution to the international harmonisation of regulatory approaches and methodologies for assessing industrial chemicals by reviewing Australian processes.
Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
Regulatory approaches are reviewed and methodologies developed by the Organisation for Economic Co-operation and Development (OECD) Chemicals Committee and its key sub-committees for their application to NICNAS assessments of industrial chemicals.	Continued collaborative activities through the reviewing and consulting on international methodologies, guidance and regulation for their application to NICNAS assessments of industrial chemicals. **Result: Met** ✓

In 2015-16, NICNAS participated in the OECD Chemicals Committee and its key subsidiary committees (the Task Force on Hazard Assessment; Clearing House on New Chemicals; Working Party on Manufactured Nanomaterials) and presented a Metals Risk Assessment workshop at the Asia-Pacific Economic Cooperation (APEC) Chemical Dialogue forum in the Philippines.

NICNAS also engaged with other regulators on a bilateral and multilateral basis to further facilitate international harmonisation of NICNAS assessment methods.

Increased international harmonisation of chemical regulation reduces the regulatory burden on industry, which facilitates the availability of newer and safer chemicals in Australia.

All introducers of industrial chemicals are aware of their legal obligations.
Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
Identified introducers are registered and provided with regular information updates.	NICNAS uses a variety of means to identify chemical importers and manufacturers to promote their awareness of legal obligations, and to provide relevant information updates. **Result: Met** ✓

At the end of 2015-16, there were 6,144 companies registered with NICNAS, which is 99.7% of identified introducers. Thirteen information sessions were delivered to over 600 attendees in major capital cities and regional areas, with positive feedback received. An online questionnaire was developed to prioritise companies for further assessment of their compliance with new chemical obligations.

Update and maintain the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) for chemical poisons.
Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
SUSMP is amended as soon as practicable after the Secretary's delegate's final decision under the *Therapeutic Goods Regulations 1990.*	The SUSMP was amended as soon as practicable after the Secretary's delegate's final decision. In all, there were 6 updates to the SUSMP during 2015-16. **Result: Met** ✓

All required SUSMP legislative instruments were amended as soon as practicable after the Secretary's delegate's final decision during the 2015-16 financial year and all are available on the Federal Register of Legislation (FRL) website for June 2015, July 2015, October 2015, February 2016, March 2016 and June 2016. This result represents an increase in SUSMP publication of 100% during this financial year to meet demand.

The costs associated with the regulation of industrial chemicals are adequately balanced against the benefits to worker health and safety, public health and the environment.

Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
Reforms to NICNAS more efficiently and effectively achieve the objects of the *Industrial Chemicals (Notification and Assessment) Act 1989*.	NICNAS published three consultation papers on the implementation of the NICNAS reforms, and sought input from stakeholders including international regulators and technical experts. **Result: Met** ✓

119 submissions were received in response to the three consultation papers published in 2015-16. In addition, a total of 301 people attended six stakeholder workshops to discuss the reform proposals.

Stakeholder views obtained through written submissions and workshops will be taken into account in finalising the regulatory model for industrial chemicals submitted to Government for agreement.

The NICNAS reforms will reduce regulatory burden on industry and promote the availability of safer chemicals by streamlining assessment approaches and refocussing regulatory effort on higher risk industrial chemicals, while ensuring Australia's robust safety standards are maintained.

Effective use of international information.

Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
In order to better utilise and increase the acceptance of international risk assessment materials, the Office of Chemical Safety will work with trusted overseas regulators to harmonise assessment approaches.	Continued collaborative activities with trusted international regulators to harmonise assessment approaches. **Result: Met** ✓

Departmental regulatory scientists continued to use information on the hazards of chemicals obtained from a range of international sources in conducting assessments of the risks of the use of these chemicals in Australia. Departmental scientists engaged with their counterparts in comparable international regulatory agencies and global industry associations to obtain and review relevant information, and received ongoing professional development in a range of assessment-focussed areas. In addition, internal databases were updated with new internationally validated testing guidelines and assessment methods, to enable assessors to effectively interpret the latest information. Nineteen assessments from comparable international agencies were incorporated in NICNAS new chemicals assessments.

Effective use of international information reduces regulatory duplication, and considers relevant information in the Australian context. This reduces the regulatory burden on industry and promotes the availability of safer chemicals for use in Australia.

Human health risk assessments for agricultural and veterinary chemicals are performed in a timely manner.

Source: 2015-16 Health Portfolio Budget Statements, p. 137

2015-16 Target	2015-16 Result
Chemical assessments and public health regulation completed in accordance with the service level agreement between Health and the Australian Pesticides and Veterinary Medicines Authority (APVMA).	Human health risk assessments for agricultural and veterinary chemicals were performed in accordance with the service level agreement. **Result: Met** ✓

Human health risk assessments for agricultural and veterinary chemicals are performed by the Department in accordance with the service level agreement between the Department and the APVMA. The service level agreement specified the timeframes and cost recovery arrangements and quality assurance criteria for the various assessment categories.

In 2015-16, the Department continued to undertake human health risk assessments for the APVMA. The Department completed 114 assessments and the overall timeframe compliance increased to 76.3%, which is the highest timeframe compliance rate since 2009-10.

The Department recommended against granting some applications based on the potential for these chemicals to cause adverse health impacts.

Percentage of new industrial chemical assessments completed within legislated timeframes.

Source: 2015-16 Health Portfolio Budget Statements, p. 138 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
96%	99% **Result: Met** ✓	98%	96%	95%	95%

NICNAS completed 292 certificate and permit assessments for new industrial chemicals, with 289 of these completed within legislated timeframes.

Timely assessment of new chemicals ensures timely access to safer and innovative chemical products for the Australian community. New chemical assessment reports, certificate and permit details are published on the NICNAS website to increase public confidence on the chemicals introduced into the country.

Cumulative percentage of Stage One industrial chemicals assessed through effective application of IMAP framework.
Source: 2015-16 Health Portfolio Budget Statements, p. 138

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
95%	97.3%[64] **Result: Met** ✓	93%	56%	24%	N/A

By the end of Stage One (30 June 2016) of implementation of the IMAP Framework, NICNAS completed 5,114 human health and/or environment assessments for 3,419 unique chemicals in 2015-16 for chemicals that may already be in use in Australia. This includes 909 assessments completed in 2015-16.

Percentage of Level C and D introducers of industrial chemicals assessed for compliance with their new chemicals obligations under the *Industrial Chemicals (Notification and Assessment) Act 1989*.
Source: 2015-16 Health Portfolio Budget Statements, p. 138

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
45%	45% **Result: Met** ✓	40%	35%	30%	25%

During 2015-16, 45% of registrants that had introduced relevant industrial chemicals with a value above $500,000 were screened for evidence of compliance with new chemicals obligations. This resulted in 103 organisations being selected for further risk assessment. Fifty-five of these registrants were required to provide NICNAS with further information with regard to their new chemicals obligations via an online questionnaire.

Ongoing compliance monitoring raises awareness among the regulated community of their obligations under the Act and identifies non-compliance.

Gene technology regulation

Protect the health and safety of people and the environment by regulating work with genetically modified organisms (GMOs)

Commence technical review of the *Gene Technology Regulations 2001*.
Source: 2015-16 Health Portfolio Budget Statements, p. 139

2015-16 Target	2015-16 Result
Review undertaken in consultation with relevant stakeholders.	A technical review of the *Gene Technology Regulations 2001* commenced. **Result: Substantially met** ✓

In 2015-16, a technical review of the *Gene Technology Regulations 2001* commenced. Due to complexity of the new technologies, a discussion paper was prepared on options for a review of the regulations. During this period, the Department through the OGTR liaised with other regulatory agency stakeholders. A full consultation with all stakeholders will commence in 2016-17.

[64] This total included 515 chemicals that were not on the Stage One list, that were able to be efficiently assessed due to their close similarity to chemicals already being assessed.

Provide open, effective and transparent regulation of GMOs.
Source: 2015-16 Health Portfolio Budget Statements, p. 139

2015-16 Target	2015-16 Result
Risk assessments and risk management plans prepared for 100% of applications for licensed dealings and made publicly available. Stakeholders, including the public, consulted on all assessments for proposed release of GMOs into the environment. Record of GMO dealings and maps of all field trial sites maintained and made publicly available on the OGTR website.	Risk assessments and risk management plans prepared for 100% of licence applications for release of GMOs into the environment. Stakeholders, including the public, consulted on all assessments of these applications. Record of GMO dealings and maps of all field trial sites maintained and made publicly available on the OGTR website. **Result: Met** ✓

The Gene Technology Regulator prepared comprehensive risk assessments and risk management plans and consulted with stakeholders, including the public, on nine GMO licence applications for intentional release into the environment (three field trials, two clinical trials, two commercial GM canola, one commercial GM cut flower and a commercial GM cancer treatment). The Regulator also prepared risk assessments and risk management plans for six licence applications for work in contained facilities. The Regulator maintained a record of approved GMOs and maps of all field trial sites, and made them available on the OGTR website.

Percentage of field trial sites and higher level containment facilities inspected.
Source: 2015-16 Health Portfolio Budget Statements, p. 139

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
≥20%	46% of field trial sites 21% of higher level containment facilities **Result: Met** ✓	44% 29%	40% 25%	42% 25%	44% 33%

In 2015-16, 46% of GM field trial sites across the country were inspected to monitor compliance with licence conditions ensuring risks to human health and the environment were minimised. Sites were inspected in New South Wales, Northern Territory, Queensland, Victoria and Western Australia. Inspections included GM banana, barley, canola, cotton, safflower, sugarcane and wheat.

The Department through the OGTR also inspected 21% of higher level containment facilities to ensure compliance with certification conditions. These inspections focussed on the integrity of the physical structure of the facility and on the general laboratory practices followed.

Protect people and environment through identification and management of risks from GMOs.
Source: 2015-16 Health Portfolio Budget Statements, p. 140

2015-16 Target	2015-16 Result
Comprehensive and effective risk assessment and risk management of GMOs. High level of compliance with the gene technology legislation and no adverse effect on human health or environment from authorised GMOs.	No adverse effect on human health or environment from authorised GMOs. **Result: Met** ✓

Routine monitoring of the regulated community found a high level of compliance with the gene technology legislation.

Facilitate cooperation and provision of advice between relevant regulatory agencies with responsibilities for GMOs and /or genetically modified products.
Source: 2015-16 Health Portfolio Budget Statements, p. 140

2015-16 Target	2015-16 Result
High degree of cooperation with relevant regulatory agencies and provision of timely advice.	Maintained high degree of cooperation with relevant regulatory agencies. **Result: Met** ✓

In 2015-16, the Regulator continued cooperative arrangements with other Australian Government regulators to enhance coordinated decision-making and avoid duplication in regulation of GMOs and genetically modified products.

The Department through the OGTR engaged in international fora relevant to GMO regulation including the OECD Working Group on the Harmonisation of Regulatory Oversight in Biotechnology. Regulators from other countries continued to seek input from the OGTR because the Australian scheme is considered a model for robust, practical and efficient regulation of GMOs. The OGTR also provided technical support to Australian engagement for meetings under the United Nations Convention on Biological Diversity and Cartagena Protocol on Biosafety.

Percentage of licence decisions made within statutory timeframes.
Source: 2015-16 Health Portfolio Budget Statements, p. 140

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	95%	100%	100%	100%

Fifteen licence decisions were made, all within the applicable statutory timeframes.

Outcome 7 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 7.1: eHealth[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	129,182	116,697	(12,485)
Non cash expenses[3]	21,662	19,420	(2,242)
Departmental expenses			
Departmental appropriation[4]	17,488	18,361	873
Expenses not requiring appropriation in the current year[5]	289	964	675
Total for Program 7.1	**168,621**	**155,442**	**(13,179)**
Program 7.2: Health Information			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	18,296	19,428	1,132
Departmental expenses			
Departmental appropriation[4]	4,040	4,060	20
Expenses not requiring appropriation in the current year[5]	105	264	159
Total for Program 7.2	**22,441**	**23,752**	**1,311**
Program 7.3: International Policy Engagement			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	14,412	14,412	-
Departmental expenses			
Departmental appropriation[4]	6,021	6,529	508
Expenses not requiring appropriation in the current year[5]	151	366	215
Total for Program 7.3	**20,584**	**21,307**	**723**
Program 7.4: Research Capacity and Quality[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	79,217	78,543	(674)
Special accounts			
Medical Research Future Fund	-	-	-
Departmental expenses			
Departmental appropriation[4]	10,957	9,698	(1,259)
Expenses not requiring appropriation in the current year[5]	250	630	380
Total for Program 7.4	**90,424**	**88,871**	**(1,553)**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 7.5: Health Infrastructure[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	11,380	9,590	(1,790)
Special appropriations	54,984	24,787	(30,197)
Special accounts			
Health and Hospital Fund Health Portfolio Special Account	33,197	52,484	19,287
Departmental expenses			
Departmental appropriation[4]	5,261	5,061	(200)
Expenses not requiring appropriation in the current year[5]	133	320	187
Total for Program 7.5	**104,955**	**92,242**	**(12,713)**
Program 7.6: Blood and Organ Donation[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	23,084	19,509	(3,575)
Special appropriations			
National Health Act 1953 - Blood Fractionation, Products and Blood Related Products - to National Blood Authority	645,262	718,382	73,120
Departmental expenses			
Departmental appropriation[4]	4,345	4,221	(124)
Expenses not requiring appropriation in the current year[5]	118	277	159
Total for Program 7.6	**672,809**	**742,389**	**69,580**

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 7.7: Regulatory Policy			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	256	39	(217)
Departmental expenses			
Departmental appropriation[4]	13,089	14,119	1,030
to Special accounts	(11,612)	(11,247)	365
Expenses not requiring appropriation in the current year[5]	-	191	191
Special accounts			
OGTR Special Account[6]	7,882	7,599	(283)
NICNAS Special Account[7]	18,532	15,873	(2,659)
TGA Special Account[8]	138,876	133,749	(5,127)
Expense adjustment[9]	(5,215)	(6,288)	(1,073)
Expenses not requiring appropriation in the current year[5]	-	5	5
Total for Program 7.7	**161,808**	**154,040**	**(7,768)**
Outcome 7 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	275,827	258,218	(17,609)
Non cash expenses[3]	21,662	19,420	(2,242)
Special accounts	33,197	52,484	19,287
Special appropriations	700,246	743,169	42,923
Departmental expenses			
Departmental appropriation[4]	61,201	62,049	848
to Special accounts	(11,612)	(11,247)	365
Expenses not requiring appropriation in the current year[5]	1,046	3,012	1,966
Special accounts	160,075	150,938	(9,137)
Total expenses for Outcome 7	**1,241,642**	**1,278,043**	**36,401**
Average staffing level (number)	**1,049**	**1,039**	**(10)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.
3 'Non cash expenses' relates to the depreciation of computer software.
4 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
5 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.
6 Office of the Gene Technology Regulator Special Account.
7 National Industrial Chemicals Notification and Assessment Scheme Special Account.
8 Therapeutic Goods Administration Special Account.
9 Special accounts are reported on a cash basis. The adjustment reflects the difference between cash and expenses.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 8

Outcome 8
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

Analysis of performance – **Outcome 8** Health Workforce Capacity

In 2015-16, the Department continued working to improve the capacity, quality and mix of Australia's health workforce. The Department has had a major focus on addressing the ongoing challenge of workforce distribution.

Through a commitment to training programs, scholarships, incentive programs and other initiatives the Department continued to encourage health practitioner students and graduates to provide services to the community with an emphasis on rural, regional and remote areas.

In addition, the Department showed its commitment to best practice and innovation, by making changes to programs to provide maximum community impact.

These activities have contributed to the Department's achievement of objectives under Outcome 8 and Our Purpose.

Key community benefits for **Outcome 8** in 2015-16

Supported medical practitioners to ensure the right mix of skills are available in the health workforce into the future

The Department continued to support registrars and medical students across Australia by providing over 1,500 General Practice (GP) training places and 900 specialist training places, ensuring a continued supply of qualified practitioners to provide services to the Australian community.

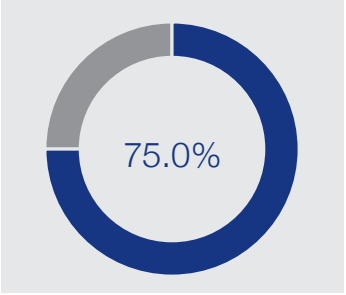
Supported service delivery to rural, regional and remote communities

The number of medical practitioners servicing rural, regional and remote communities was bolstered by departmental programs and incentives, resulting in more Australians having access to medical services.

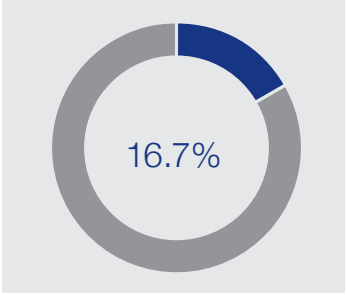
Invested in broadening nurse capabilities

The Practice Nurse Incentive Program continues to broaden the roles of nurses working in general practice, with just over 4,500 practices participating in the program. The program allows for the professional development of nurses and for GPs to focus on more complex care, improving access and health outcomes for patients.

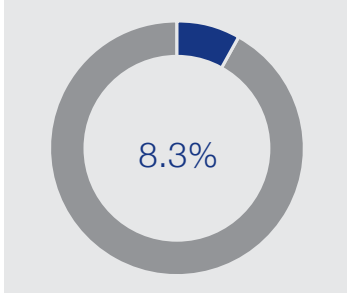
Summary of performance criteria results for **Outcome 8**



Met



Substantially met



Not met

Looking ahead

- Establish a Rural Health Commissioner to support program delivery and policy development to best meet the health needs of rural Australians.
- Establish a national rural generalist pathway to improve access to highly skilled doctors in rural, regional and remote Australia and examine existing workforce incentives and levers to ensure support is being directed to areas of highest need.
- Expand support for the Rural Health Multidisciplinary Training Program, including establishing an additional three University Departments of Rural Health to increase clinical training capacity for nursing, midwifery, and allied health students in rural areas.
- Implement the *Integrated Rural Training Pipeline Initiative*, which will help retain medical graduates in rural areas.
- From 2016-17, the Department's funding for health workforce capacity will be combined with funding for Primary Health Care (Rural Health Services) in a new Health Workforce Program. This consolidation will allow better consideration of the Government's access, quality and health workforce distribution programs and support the role of the Rural Health Commissioner.

Programs and program objectives contributing to **Outcome 8**

Program 8.1: Workforce and Rural Distribution

- Redesign the supply of, and support for, health professionals in rural, regional and remote Australia
- Increase the effectiveness of medical training and education

Program 8.2: Workforce Development and Innovation

- Improve the distribution of the dental workforce
- Develop the workforce through clinical training

Analysis of performance – Program 8.1: Workforce and Rural Distribution

The Department met the majority of performance targets in Program 8.1: Workforce and Rural Distribution, with one indicator not met.

The Department continued to support health practitioners in rural, regional and remote Australia, with participation in rural health workforce initiatives surpassing targets. The Department met all targets relating to increasing the effectiveness of medical training and education, with all related initiatives reporting an increase in uptake.

Workforce incentive programs designed to increase availability of services have had a notable impact over the last decade, with recent data showing that compared to ten years ago, access to services in inner and outer regional areas are now comparable to those in the major city areas of Australia.

In addition to this, workforce training programs continue to support distribution, providing opportunities for medical students, interns and registrars to experience rural practice early in their careers.

The Department will continue to monitor the distribution of the health workforce and the effectiveness of its programs, to ensure support and incentives are targeted appropriately.

Redesign the supply of, and support for, health professionals in rural, regional and remote Australia

Consolidate Health portfolio scholarships into a streamlined Health Workforce Scholarship Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 144

2015-16 Target	2015-16 Result
Conduct open tender process to identify a provider to administer the Health Workforce Scholarship Program, to be completed by 31 March 2016.	Tender process on hold. **Result: Not met**

The open tender process has been delayed while the Department conducts further consultation to ensure appropriate targeting of the program to areas with the most need.

The Department has continued to manage the Bonded Medical Program (BMP) and the Medical Rural Bonded Scholarship Scheme (MRBS). The 100 MRBS places have rolled into the BMP from 2016 onwards.

Scholarships were not awarded for the mid-year 2016 scholarships intake. Current scholarship holders continue to receive their benefits.

Continuation of administrative arrangements have been put in place to meet Government commitments where multi-year scholarships have been awarded.

Percentage of medical students participating in the Rural Clinical Training and Support Program – 1 year rural clinical placement.
Source: 2015-16 Health Portfolio Budget Statements, p. 145

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
≥25%	33% **Result: Met** ✓	33%	33%	32%	37%

The Rural Clinical Training and Support Program, a component of the Rural Health Multidisciplinary Training Program, provided funding to participating universities for the establishment and support of medical student training in rural areas, supporting 17 rural clinical schools nationally. In the 2015 academic year, 893 medical students spent a year at a rural clinical school, equating to 33% of graduating medical students.

Number of weeks of rural multidisciplinary placements supported through the Rural Health Multidisciplinary Training Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 145

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
18,113	24,290 **Result: Met** ✓	N/A	N/A	N/A	N/A

In the 2015 academic year, 11 University Departments of Rural Health, under the Rural Health Multidisciplinary Training Program, supported 5,141 undergraduate students to undertake rural clinical placements (two weeks or longer). This equates to a total of 24,290 placement weeks across rural settings.

Number of practices supported through the Practice Nurse Incentive Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 146 & 2015-16 Corporate Plan, p. 15

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
4,100	4,594 **Result: Met** ✓	4,338	4,236	3,978	3,571

The Department continued support of expanded and enhanced roles for nurses working in general practices. Uptake for this demand-driven program has increased from 4,338 participating practices in 2014-15 to a total of 4,594 participating practices in 2015-16.

Number of doctors supported by the General Practice Rural Incentives Program in rural and remote areas.
Source: 2015-16 Health Portfolio Budget Statements, p. 146

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
6,500	6,696 **Result: Met** ✓	N/A	N/A	N/A	N/A

A redesign of the General Practice Rural Incentives Program (GPRIP) was announced in the 2015-16 Budget. The transition to the new geographical classification system (the Modified Monash Model) and updated eligibility criteria work more effectively to target financial incentives to doctors in areas experiencing greater difficulty attracting and retaining general practitioners. From August 2016, 6,696 eligible doctors received their first payments for 2015-16 under the redesigned GPRIP. An additional 150-200 doctors who provide eligible GPRIP services outside of the Medicare billing system (via the Flexible Payment System) are expected to receive their first payments by the end of 2016.

Increase the effectiveness of medical training and education

Number of commencing GP trainees funded through the Australian General Practice Training Program (AGPT).
Source: 2015-16 Health Portfolio Budget Statements, p. 145

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
1,500	1,500 **Result: Met** ✓	1,192	1,108	1,000	900

In total, 1,500 new GP registrars commenced training across Australia with at least 50% of all Australian General Practice Training Program training activity being undertaken in rural, regional and remote locations.

Number of training positions funded through the Specialist Training Program.
Source: 2015-16 Health Portfolio Budget Statements, p. 145

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
900	900 **Result: Met** ✓	900	750	600	518

The Department continued to support the delivery of specialist training, in expanded settings outside traditional public hospital teaching environments, such as rural, regional and remote areas. Agreements with 12 specialist medical colleges provide support for 900 (full time equivalent) training posts. In the 2015 academic year, 44% of the posts involved some training in rural and regional areas and 42% in private settings.

Number of medical internship positions funded through the Commonwealth Medical Internships Program.

Source: 2015-16 Health Portfolio Budget Statements, p. 145

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
84	100 **Result: Met** ✓	N/A	N/A	N/A	N/A

The Commonwealth Medical Internships (CMI) Program supported 100 junior doctors to start work as medical interns in Australia in 2016.

All CMI doctors complete a minimum of one rotation in a rural or regional location. Of the 100 places, 26 are full regional internships, delivered in Townsville, Bundaberg and Mackay.

Analysis of performance – Program 8.2: Workforce Development and Innovation

The Department met or substantially met all performance targets in Program 8.2: Workforce Development and Innovation.

The Department realigned the Dental Relocation Infrastructure Support Scheme (DRISS) to provide greater support to those relocating to rural areas, which will improve distribution of the dental workforce.

The Department continued to manage graduate programs for both dentists and oral health therapists until the cessation of the programs at the end of 2015, through the 2015-16 Budget Measure, *Rationalising and streamlining health programs*.

The 2015-16 Mid-Year Economic and Fiscal Outlook measure, *Streamlining Health and Aged Care Workforce Programme Funding*, announced the cessation of the Clinical Training Funding program from 1 January 2016. Funding is being redirected to better target priority areas that support the future and current rural and regional health workforce.

Improve the distribution of the dental workforce

Redesign of the Dental Relocation Infrastructure Support Scheme to better match demand, and align with the new Modified Monash Model classification system.
Source: 2015-16 Health Portfolio Budget Statements, p. 147

2015-16 Target	2015-16 Result
New program guidelines developed in consultation with stakeholders.	Guidelines were developed in January 2016. **Result: Met** ✓

Program guidelines have been revised to realign the program with the Modified Monash Model, and in consultation with stakeholders.

Changes to the Scheme are aimed at providing improved access to dental services for people living in rural, regional and remote communities.

Number of dental graduates participating in the Voluntary Dental Graduate Year Program.[65]
Source: 2015-16 Health Portfolio Budget Statements, p. 148

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
50	48 **Result: Substantially met** ✓	49	N/A	N/A	N/A

In 2015, 50 graduates commenced participation on the Voluntary Graduate Year Program, with two withdrawing prior to completion.

Approximately 84% of placements were in major metropolitan and inner regional areas. Of the 48, 26.25 placements were in metropolitan areas; 14 were in inner regional; four were in outer regional; two in remote Australia; and 1.75 were placed into very remote locations.

The performance result of 'substantially met' is based on meeting 96% of the target.

[65] The 2015-16 Budget Measure, *Rationalising and streamlining health programmes*, announced the cessation of this program at the end of the 2015 cohort.

Number of oral health therapist graduates participating in the Oral Health Therapist Graduate Year Program.[66]
Source: 2015-16 Health Portfolio Budget Statements, p. 148

Academic Year 2015 Target	Academic Year 2015 Result	2014	2013	2012	2011
50	49 **Result: Substantially met**	49	N/A	N/A	N/A

In 2015, 50 graduates commenced participation on the Oral Health Therapist Graduate Year Program, with one withdrawing prior to completion.

Approximately 82% of placements were in major metropolitan or inner regional areas. Of the 49, 23 placements were in metropolitan areas; 17 were placed into inner regional areas; 4.5 in outer regional; 0.5 in remote areas; and four placements took place across multiple areas.

The performance result of 'substantially met' is based on meeting 98% of the target.

Develop the workforce through clinical training

The number of universities providing students with clinical training placements in priority settings.
Source: 2015-16 Health Portfolio Budget Statements, p. 148

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
38	38 **Result: Met**	N/A	N/A	N/A	N/A

The Clinical Training Funding program aims to assist in balancing the distribution of students and clinical placements in underserviced areas, by subsidising clinical placements and student numbers in specific health disciplines and priority settings.

[66] The 2015-16 Budget Measure, *Rationalising and Streamlining health programmes*, announced the cessation of this program at the end of the 2015 cohort.

Outcome 8 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 8.1: Workforce and Rural Distribution			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	1,173,829	1,135,665	(38,164)
Departmental expenses			
Departmental appropriation[2]	37,256	35,620	(1,636)
Expenses not requiring appropriation in the current year[3]	976	2,356	1,380
Total for Program 8.1	**1,212,061**	**1,173,641**	**(38,420)**
Program 8.2: Workforce Development and Innovation			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	46,379	19,445	(26,934)
Departmental expenses			
Departmental appropriation[2]	5,946	5,924	(22)
Expenses not requiring appropriation in the current year[3]	159	390	231
Total for Program 8.2	**52,484**	**25,759**	**(26,725)**
Outcome 8 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	1,220,208	1,155,110	(65,098)
Departmental expenses			
Departmental appropriation[2]	43,202	41,544	(1,658)
Expenses not requiring appropriation in the current year[3]	1,135	2,746	1,611
Total expenses for Outcome 8	**1,264,545**	**1,199,400**	**(65,145)**
Average staffing level (number)	**257**	**259**	**2**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
3 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 9

Outcome 9
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

Analysis of performance – **Outcome 9** Biosecurity and Emergency Response

In 2015-16, the Department continued its commitment to Biosecurity and Emergency Response. Working in collaboration with stakeholders, the Department led Australia's preparedness measures to effectively respond to the Zika virus outbreak and supported Australia's response to Tropical Cyclone Winston in Fiji. The Department also continued working with stakeholders to prevent the introduction of mosquito-borne illnesses borne by exotic mosquitoes. The Department continued to lead the charge against antimicrobial resistance (AMR), within Australia and significantly contributing to the international effort.

These activities have contributed to the Department's achievement of objectives under Outcome 9 and Our Purpose.

Key community benefits for **Outcome 9** in 2015-16

Ensured the Australian public is well protected from international outbreaks and disasters

Maintained Australia's readiness to respond to national health emergencies.

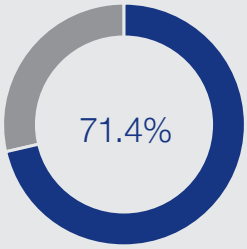
Protected the public from mosquito-borne illness

Intensive control and monitoring of exotic mosquito *Aedes albopictus* in the Torres Strait ensured that it did not spread to the mainland of North Queensland.

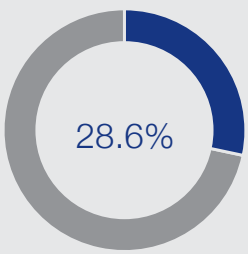
Australia led the way in addressing antimicrobial resistance

Monitoring AMR allowed health system stakeholders to continue to minimise the development and spread of AMR and its impact on the health of Australians.

Summary of performance criteria results for **Outcome 9**



Met



Substantially met

Not met

Looking ahead

- The focus on combatting AMR will continue in 2016-17. The Department will continue to work with national and international stakeholders to monitor levels of resistance, identify emerging issues, and collaborate to implement effective solutions.
- In 2016-17, the Government will continue to prioritise readiness to respond to national health emergencies, by providing $25.5 million for the National Medical Stockpile, ensuring it holds the necessary reserve of essential pharmaceuticals and protective equipment, and $15.7 million for the National Critical Care and Trauma Response Centre.

Programs and program objectives contributing to **Outcome 9**

Program 9.1: Health Emergency Planning and Response

- Provide a comprehensive and effective response to a national health emergency
- Improve biosecurity and minimise the risks posed by communicable diseases
- Replenishment and reform of the National Medical Stockpile

Analysis of performance – Program 9.1: Health Emergency Planning and Response

The Department met or substantially met all its performance targets for Program 9.1: Health Emergency Planning and Response. Working with other Commonwealth entities and State and Territory counterparts, the Department undertook several activities to strengthen preparedness for a national health emergency. In addition to emergency response activities, the Department invested significantly in the replenishment and reform of the National Medical Stockpile, a key component of ensuring an effective response to health emergencies.

The Department also continued to focus on improvements to biosecurity and minimising risks posed by communicable diseases.

In addition to working with key stakeholders at the National AMR Forum and with the Australian Strategic and Technical Advisory Group on AMR, the Department is finalising the National AMR Implementation Plan which is expected to be available in September 2016. Further to this, the national surveillance system for AMR and antimicrobial usage in human health released its first annual report in June 2016. The report provides an important baseline measure of AMR in Australia, as well as providing international comparisons and identifies priority areas for future action.

Combatting antimicrobial resistance

Antimicrobial resistance (AMR) is one of the main global health challenges facing our generation, according to the World Health Organization (WHO). AMR occurs when a microorganism develops resistance to an antimicrobial (such as an antibiotic) that was previously an effective treatment. Resistant infections can have serious consequences for human health, as well as for animal health and agriculture.

To guide Australia's response, the Government has released its first *National AMR Strategy 2015-2019*. This strategy draws upon expert views across animal and human health, food and agriculture sectors, and outlines how best to combat AMR in Australia. Secretaries of the Departments of Health and Agriculture and Water Resources, the Chief Medical Officer and Chief Veterinary Officer all form part of a group that oversees the implementation of the AMR strategy.

Surveillance is recognised as a critical element of any effective response to AMR. Surveillance is necessary to understand the magnitude, distribution and impact of resistant organisms and antimicrobial usage, and identifying emerging resistance and trends. The Australian Commission on Safety and Quality in Health Care, through funding provided by the Government, established a National AMR and Antimicrobial Usage surveillance system (referred to as the AURA Surveillance System). *AURA 2016: first Australian report on antimicrobial use and resistance in human health* was released in June 2016, and provides the most comprehensive picture of AMR, antimicrobial usage and appropriateness of prescribing in Australia to date.

Increasing globalisation provides opportunities for AMR to spread faster and further than ever before. Given this, no country can act in isolation and significant momentum is building through international fora to ensure a coordinated global response to AMR. The Australian Government is working with the international community to reduce the spread of AMR globally. We are actively involved in the WHO Global Action Plan, the Global Health Security Agenda Action Package on AMR and the Ministerial-level Alliance of Champions on AMR.

Provide a comprehensive and effective response to a national health emergency

Develop, exercise and refine national health emergency policy under the National Health Emergency Response Arrangements.
Source: 2015-16 Health Portfolio Budget Statements, p. 153

2015-16 Target	2015-16 Result
National Health Emergency Response Arrangements will be exercised and revised and an emergency response plan for communicable diseases and environmental health threats of national significance will be developed.	Two pillars of the National Health Emergency Response Arrangements were exercised and significant work was undertaken in progressing the communicable disease and the chemical, biological, radiological and nuclear response plans. **Result: Substantially met**

In July 2015, the Department brought together stakeholders from Commonwealth, State and Territory Government entities for a discussion exercise – Exercise CURIEosity. This Exercise was used to increase preparedness for a radiological emergency and to contribute to the review of the Domestic Health Response Plan for Chemical, Biological, Radiological and Nuclear Incidents of National Consequence.

The Department also participated in a national maritime counter-terrorism exercise, whole-of-government and jurisdictional exercises to manage food incident emergencies and a jurisdictional mass casualty exercise designed to evaluate notification, escalation and response to an emergency of state significance.

The Department is currently finalising a plan to guide the health sector response to a communicable disease incident of national significance. The plan is expected to be available by December 2016.

The Department's Smallpox Plan provides guidance in relation to the national health sector response on the management of a deliberate release of smallpox and outlines the role of the Department and the States and Territories in the emergency. A review of the Smallpox Plan has commenced.

The Abrin and Ricin Plan will provide guidance in relation to the national health sector response to a bioterrorism event involving these toxins and the clinical management of cases if poisoning occurs. Development of the Abrin and Ricin Plan has commenced.

In February 2016, the Department contracted a Prime Vendor to manage the National Medical Stockpile. Under this contract the Prime Vendor must conduct a minimum of two deployment drills per year. The first deployment drill was conducted in July 2016.

Containment of national health emergencies through the timely engagement of national health coordination mechanisms and response plans.
Source: 2015-16 Health Portfolio Budget Statements, p. 154

2015-16 Target	2015-16 Result
National responses to health emergencies are successfully managed.	Responded to 150 health-related incidents and established effective responses to significant international incidents of concern, including Middle Eastern Respiratory Syndrome (MERS-CoV) and Zika virus. **Result: Met** ✓

The Department has continued to fulfil Australia's obligations under the International Health Regulations through the maintenance of the National Focal Point in the National Incident Room (NIR), with the NIR responding to 150 health-related incidents in 2015-16. The most frequent type of response was to assist States and Territories and other National Focal Points conduct contact tracing of travellers exposed to disease through contact with an infected person. Tuberculosis was the most common disease that triggered contact tracing in 2015-16, followed by measles.

The Department continues to closely monitor international and national health emergencies such as MERS-CoV and Zika virus. The Department is working with the World Health Organization and Australian Government entities to ensure appropriate action is taken, including the development of effective public communications campaigns to reduce the risk of infection from communicable diseases.

Improve biosecurity and minimise the risks posed by communicable diseases

Collect and disseminate data in the National Notifiable Diseases Surveillance System and monitor data quality in accordance with the *National Health Security Act 2007*.
Source: 2015-16 Health Portfolio Budget Statements, p. 153

2015-16 Target	2015-16 Result
Data is collected and available for regular reporting by the Commonwealth and ad hoc requests by stakeholders, including publishing in the Department's journal *Communicable Diseases Intelligence*.	The National Notifiable Diseases Surveillance System received notifications of 326,395 cases of diseases diagnosed in 2015-16. Data was collected on a daily basis and made available to the public via the Department of Health's website, through 22 data requests from stakeholders and in four issues of *Communicable Diseases Intelligence.* **Result: Met** ✓

Quality data is provided regularly to the National Notifiable Diseases Surveillance System from States and Territories. Throughout 2015-16, this data was made available to stakeholders upon request and published in *Communicable Diseases Intelligence*. Enhanced data sets for Invasive Pneumococcal Disease, Influenza and Meningococcal disease were also made publicly available.

In March 2016, *Australia's notifiable disease status, 2014: Annual Report of the National Diseases Surveillance System* was published in *Communicable Diseases Intelligence.*

Manage and control exotic mosquito populations to reduce the risk of disease transmission in the Torres Strait and mainland Australia.

Source: 2015-16 Health Portfolio Budget Statements, p. 153

2015-16 Target	2015-16 Result
Regular mosquito surveillance to indicate whether the mosquito population has reduced in the target areas in the Torres Strait and not spread to the mainland.	Regular surveillance was maintained. **Result: Met** ✓

Results continued to demonstrate the effectiveness of ongoing State and Territory control strategies as comprehensive surveillance detected only one adult *Aedes albopictus* on each of Thursday and Horn islands up to the end of April 2016. There has been no detection of *Aedes albopictus* in surveys conducted on the mainland of North Queensland.

Commence implementation of actions under the National Antimicrobial Resistance (AMR) Strategy.

Source: 2015-16 Health Portfolio Budget Statements, p. 153

2015-16 Target	2015-16 Result
National AMR Implementation Plan is developed by 30 June 2016.	The Implementation Plan was developed by 30 June 2016, and will be provided to the Minister for Health and the Minister for Agriculture and Water Resources for noting in August 2016. **Result: Met** ✓

The National AMR Forum was held in November 2015 with over 170 stakeholders from human and animal health, food and agriculture, academic sectors and all levels of government in attendance.

Stakeholder consultation through the National AMR Forum and the Australian Strategic and Technical Advisory Group on AMR has informed the development of the Implementation Plan for the National AMR Strategy.

The Implementation Plan for the National AMR Strategy will be provided to the Australian Government in August 2016.

The national surveillance system for AMR and antimicrobial usage has been established and the first annual national report was released in June 2016.

The development and spread of antimicrobial resistance (AMR) is minimised.
Source: 2015-16 Health Portfolio Budget Statements, p. 154

2015-16 Target	2015-16 Result
Progress reports indicate that actions to minimise the development and spread of AMR are being implemented in accordance with the National AMR Implementation Plan.	The development of the Implementation Plan has included a comprehensive review of current activities being undertaken by both government and non-government stakeholders to support the achievement of the National AMR Strategy. The national surveillance system for AMR and antimicrobial usage (through the Antimicrobial Use and Resistance in Australia surveillance project) was established, and the first comprehensive surveillance report published in June 2016. **Result: Substantially met** ✓

The development of the Implementation Plan confirmed that Australia has a significant number of initiatives that are supporting efforts to minimise the development and spread of AMR, providing a good foundation for the future.

The first national comprehensive surveillance report released by the Antimicrobial Use and Resistance in Australia surveillance project in June 2016 highlights where further effort is needed to minimise the development and spread of AMR in Australia. These results will be used to target future initiatives in line with the National AMR Strategy.

Percentage of designated points of entry into Australia capable of responding to public health events, as defined in the *International Health Regulations (2005)*.
Source: 2015-16 Health Portfolio Budget Statements, p 154

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

Australia has eight international airports and six international seaports that are compliant with the International Health Regulations. The Regulations require designated ports and airports to have a range of capabilities to ensure safe transit of travellers and the ability to respond to public health events, including health emergencies.

A desktop review of designation status is scheduled for completion in 2016.

Replenishment and reform of the National Medical Stockpile

There were no performance criteria for this program objective in 2015-16.

Outcome 9 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 9.1: Health Emergency Planning and Response[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	79,951	53,070	(26,881)
Non cash expenses - write down of assets[3]	105,379	105,319	(60)
Special accounts			
Human Pituitary Hormone Special Account	160	105	(55)
Departmental expenses			
Departmental appropriation[4]	22,110	20,811	(1,299)
Expenses not requiring appropriation in the current year[5]	694	1,456	762
Total for Program 9.1	**208,294**	**180,761**	**(27,533)**
Outcome 9 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	79,951	53,070	(26,881)
Non cash expenses	105,379	105,319	(60)
Special accounts	160	105	(55)
Departmental expenses			
Departmental appropriation[4]	22,110	20,811	(1,299)
Expenses not requiring appropriation in the current year[5]	694	1,456	762
Total expenses for Outcome 9	**208,294**	**180,761**	**(27,533)**
Average staffing level (number)	**105**	**103**	**(2)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.
3 'Non cash expenses' relate to the write down of the drug stockpile inventory due to expiration, consumption and distribution.
4 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
5 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 10

Outcome 10
Sport and Recreation

Improved opportunities for community participation in sport and recreation, and excellence in high-performance athletes, through initiatives to help protect the integrity of sport, investment in sport infrastructure, coordination of Commonwealth involvement in major sporting events, and research and international cooperation on sport issues

Analysis of performance – **Outcome 10** Sport and Recreation

In 2015-16, the Department continued to work closely with the Australian Sports Commission, Australian Sports Foundation, Australian Sports Anti-Doping Authority (ASADA) and States and Territories to ensure a coordinated, whole-of-government approach to sports policy. The Department supported strategies, policies and projects that: boost opportunities for all Australians to participate in sport and physical activity; optimise the performance of Australia's elite athletes; and deliver successful major sporting events.

The Department also worked to safeguard the integrity of sport domestically and on an international scale.

These activities have contributed to the Department's achievement of objectives under Outcome 10 and Our Purpose.

Key community benefits for **Outcome 10** in 2015-16

Ensured the safe and successful delivery of the 2015 INF Netball World Cup

Over 100,000 spectators safely enjoyed the 2015 INF Netball World Cup.

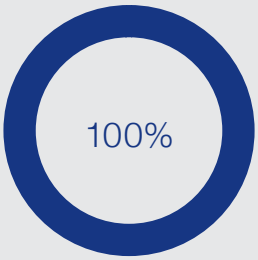
Improved the safety of water and snow activities through education

Parents and communities are better placed to prevent drowning and minimise snow injuries.

Fulfilled Australia's international anti-doping obligations, helping to safeguard the integrity of sport in Australia and internationally

Safeguarding the integrity of Australian sport has health, economic, cultural and social benefits which flow to the community.

Summary of performance criteria results for **Outcome 10**



Met

Substantially met

Not met

Looking ahead

- In 2016-17, the Department will contribute to the staging of upcoming major international sporting events to be held in Australia, including:
  - the 2017 RLIF Rugby League World Cup (co-hosted with New Zealand);
  - the 2018 Gold Coast Commonwealth Games; and
  - the 2020 ICC World Cup Twenty 20.
- The Department will continue to develop and implement water and snow safety initiatives to support a 50 per cent reduction in drowning deaths by 2020.
- The Department will support Australia's participation on the World Anti-Doping Agency Executive Committee and Foundation Board.

Programs and program objectives contributing to **Outcome 10**

Program 10.1: Sport and Recreation

- Increase participation in sport and recreation
- Support for upcoming major sporting events
- Improve water and snow safety
- Protect the integrity of sport

Analysis of performance – Program 10.1: Sport and Recreation

The Department met all performance targets for Program 10.1: Sport and Recreation.

In 2015-16, the Department continued to work closely with other Government entities, including the Australian Sports Commission and Australian Sports Foundation, to implement initiatives to improve participation in sport and physical activity. The Department aims to encourage Australian adults and children to participate in sport and connect with community sport. Challenges to increasing participation include: the increase in sedentary behaviours and competition with other types of recreation; demographic changes, particularly an ageing population; improving the status of sport in education; changes in the sport consumer market; and funding for community sport and recreation facilities.

The Department coordinated and worked closely with organisers and other Government entities to ensure the 2015 INF Netball World Cup was delivered safely and securely. The same collaborative approach continues to be implemented in preparation for upcoming sporting events held in Australia – the 2017 RLIF Rugby League World Cup and 2018 Gold Coast Commonwealth Games. Safe and successful major sporting events provide the community with social benefits and enhance Australia's reputation as a host of major sporting events.

The Department continued to deliver initiatives to protect the integrity of sport, working closely with the States and Territories, sporting organisations, the Australian Sports Anti-Doping Authority, Australian Sports Commission and international partners. Improved sports integrity capacity provides a protective function against integrity compromises, maintains community confidence in Australian sport, and ensures Governments are better able to confront modern sports integrity threats, such as criminal infiltration of sport and increased sophistication of doping activity.

Increase participation in sport and recreation

Coordination across Government to support the development, implementation and promotion of strategies, policies and projects to support increased participation in sport and physical activity.

Source: 2015-16 Health Portfolio Budget Statements, p. 159

2015-16 Target	2015-16 Result
Strategies, policies and projects are implemented in consultation with relevant Australian Government agencies, the Australian Sports Commission, the States and Territories and other relevant stakeholders. Strategies, policies and projects support increased participation, encompass health outcomes and deliver whole-of-government objectives.	The Department continued to work closely with the Australian Sports Commission and States and Territories to ensure a coordinated, whole-of-government approach to the implementation of strategies, policies and projects that support the increased participation in sport and physical activity. **Result: Met** ✓

The Department worked with relevant Australian Government entities, including the Australian Sports Commission and the Australian Sports Foundation. This work included continuing to implement the *Play.Sport.Australia* strategy which is the Australian Sports Commission's blueprint to drive increased participation, and the Sporting Schools program.

The Department also worked closely with States and Territories through the Committee of Australian Sport and Recreation Officials, which reports to the Meeting of Sport and Recreation Ministers, to increase participation under the auspices of the National Sport and Active Recreation Policy Framework.

Support the development and implementation of strategies and policies to increase participation in sport at a community to elite level, and improve safety and health outcomes for people involved in sport through the provision of advice to Government entities and delivery of sport infrastructure projects.

Source: 2015-16 Health Portfolio Budget Statements, p. 160 & 2015-16 Corporate Plan, p. 16 (abridged)

2015-16 Target	2015-16 Result
Participation strategies, policies and projects reflect whole-of-government and broader health objectives. Strategic policy advice provided to Government on matters relating to participation in sport, physical activity and recreation. Sport infrastructure projects deliver on the Government's objectives around increasing participation in sport, physical activity and recreation.	At the community level, programs were implemented to increase participation, including Sporting Schools. At the elite level, Australia's Winning Edge continues to guide our approach to high performance. The Department provided $70,000 to support a joint initiative between the Australian Institute of Sport and the Australian Medical Association on sport-related concussion. One-off sport infrastructure projects continued to be delivered to provide high quality, accessible community sport and recreation facilities. **Result: Met** ✓

The Concussion in Sport website brings together contemporary evidence-based information for athletes, parents, teachers, coaches and medical practitioners and seeks to ensure that all members of the public have rapid access to information to increase their understanding of sport-related concussion and to assist in the delivery of best practice medical care.

The Department manages funding agreements for a small number of one-off sport and recreation infrastructure projects. Funded projects range from small community facilities in regional and urban areas, to major sporting venues. Projects are located throughout Australia and directly benefit those involved in a range of sports including hockey, swimming, soccer, netball, tennis, softball and rugby league.

Support for upcoming major sporting events

Coordination across Government entities to facilitate the implementation of strategies and policies which support the hosting of major international sporting events in Australia, including the 2015 INF Netball World Cup, the 2017 RLIF Rugby League World Cup and the 2018 Gold Coast Commonwealth Games.

Source: 2015-16 Health Portfolio Budget Statements, p. 159

2015-16 Target	2015-16 Result
Strategies and policies are implemented in consultation with stakeholders, including State and Territory Governments, the New Zealand Government and event organising committees. Strategies and policies contribute to the Australian Government's security plan to deliver a safe and secure event environment for athletes and spectators.	The Department worked closely with organisers, State Governments, and Commonwealth entities to develop strategies and implement arrangements for the safe and secure delivery of the 2015 INF Netball World Cup, and is continuing preparations for the 2017 RLIF Rugby League World Cup (joint hosted with New Zealand) and 2018 Gold Coast Commonwealth Games. **Result: Met** ✓

Policies and strategies covered a wide array of activity: customs, immigration, biosecurity and aviation screening at airports; the importation of medical kits; the registration of team medical professionals; intellectual property rights protection; legacy, trade and tourism; and security.

Well-coordinated preparation for the safe and successful delivery of the 2015 INF Netball World Cup, the 2017 RLIF Rugby League World Cup and the 2018 Gold Coast Commonwealth Games.

Source: 2015-16 Health Portfolio Budget Statements, p. 160

2015-16 Target	2015-16 Result
Safe and secure delivery of the 2015 INF Netball World Cup. Continued preparation to support planning for the 2017 RLIF Rugby League World Cup and 2018 Gold Coast Commonwealth Games. Post event analysis of completed major events including analysis on whether trade, tourism, diplomatic and community objectives were achieved.	The Department supported the safe and secure delivery of the 2015 INF Netball World Cup. The Department continued to support preparation for the 2017 RLIF Rugby League World Cup and 2018 Gold Coast Commonwealth Games. **Result: Met** ✓

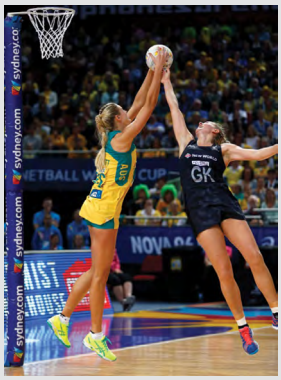
In the lead up to the 2015 INF Netball World Cup, the Department worked in collaboration with organisers, State Governments, and Australian Government entities to develop strategies and implement activities to ensure the delivery of a safe and secure event.

In August 2015, Netball Australia, with the assistance of the Australian and New South Wales Governments, staged a highly successful tournament at Sydney Olympic Park. 2015 INF Netball World Cup matches were attended by 102,674 spectators, and the final broke the world record for a crowd at a netball match (16,849).

With financial assistance from the Australian Government, tourism objectives were achieved through the 2015 INF Netball World Cup hosting the world's largest netball clinic during the tournament, which saw over 550 primary school children from across New South Wales participate in fun netball based drills and exercises led by the Australian Diamonds.

Additionally, diplomatic objectives were achieved through the Australian Government funding $300,000 to ensure the participation of Zambia, Uganda, Sri Lanka, Malawi, Papua New Guinea and Botswana. These nations were at risk of not being able to attend the 2015 INF Netball World Cup due to funding constraints.

The Australian Government is continuing to support preparations for the 2017 RLIF Rugby League World Cup and 2018 Gold Coast Commonwealth Games.



The 2015 INF Netball World Cup shoots for healthy living

The 2015 INF Netball World Cup was an outstanding success, both on the court and off it. Over 100,000 spectators from around Australia and the world converged on Sydney Olympic Park for the ten day tournament. In the final, a world record sell-out crowd of 16,849 witnessed the Australian Diamonds win their eleventh (and third consecutive) world title.

Netball has one of the highest participation rates in Australia amongst women, particularly girls. The 2015 INF Netball World Cup was the ideal opportunity to communicate effectively to this demographic. With funding from the Department of Health, Netball Australia not only delivered a memorable world cup, but also staged the *World's Biggest Netball Clinic* on day four of the tournament. Over 550 primary school students from all over New South Wales attended the event which included participation in netball related drills, discussions regarding healthy and active living, and a Q&A session with the Australian Diamonds.

The *World's Biggest Netball Clinic* combined with fan engagement activities led International Netball Federation President Molly Rhone to comment that, "Sydney organisers took the whole fan experience to another level."

Activities such as the *World's Biggest Netball Clinic* effectively complement other Departmental initiatives, most notably the *Girls Make Your Move* Campaign and the Australian Sports Commission's *Sporting Schools* program that aim to educate and inspire young Australians to be more active, more often, developing healthy habits for life.

Image credit: David Callow

Improve water and snow safety

Develop and implement water and snow safety strategies, programs and projects to support a 50% reduction in drowning deaths by 2020.
Source: 2015-16 Health Portfolio Budget Statements, p. 160

2015-16 Target	2015-16 Result
Water and snow safety programs and projects reflect whole-of-government and broader health objectives. Strategic policy advice provided to Government on matters relating to water and snow safety. Increased water and snow safety awareness, as reported by water and snow safety organisations.	Policy advice provided to Government on water and snow safety matters. An independent review was undertaken on the National Recreation Safety Program and Saving Lives in the Water Element 1 which advised that these programs are an efficient and effective use of Government funding. **Result: Met** ✓

Throughout 2015-16, the Department continued to support key participation initiatives and strategies, including: water and snow safety organisations and projects through the National Recreation Safety Program; the Savings Lives in the Water (Element 1 and Element 2) initiative; and the Water Safety: Reduce Drownings program.

Protect the integrity of sport

Implement initiatives and facilitate stakeholder interaction with Government entities to build resilience of sporting organisations and their capacity to deliver integrity measures.

Source: 2015-16 Health Portfolio Budget Statements, p. 159

2015-16 Target	2015-16 Result
Regular Australian and Jurisdictional Sports Integrity Network meetings are initiated and convened with sporting organisations, State and Territory Governments, industry stakeholders, and relevant entities. Sports integrity education platforms are developed and supported.	Five Sports Integrity Network meetings were held during 2015-16. A new Illicit Drugs in Sport online education program, specifically designed for athletes and sports officials, was developed and launched in April 2016. The program has over 250 registered sports users, with component modules accessed over 400 times. **Result: Met** ✓

The Australian and Jurisdictional Sports Integrity Network meetings provided regular collaborative fora for Governments, national and jurisdictional sporting organisations, and relevant stakeholders to coordinate responses to key sport integrity threats.

Australia's sports integrity effort was further strengthened through ongoing usage of the 'Keep Sport Honest' match-fixing online education module, with over 9,000 registered users, and the April 2016 launch of the Illicit Drugs in Sport online education program.

Implement an Australian anti-doping legislative framework that fulfils Australia's international anti-doping obligations.

Source: 2015-16 Health Portfolio Budget Statements, p. 159

2015-16 Target	2015-16 Result
Australian anti-doping arrangements are compliant with the World Anti-Doping Code. Participation in the 5th Conference of Parties on the UNESCO International Convention against Doping in Sport is supported.	WADA identifies Australia as operating a Code-compliant anti-doping framework. Australian officials attended the 5th Conference of Parties on the UNESCO International Convention against Doping in Sport. **Result: Met** ✓

Australia tabled a key resolution to improve harmonisation of the UNESCO International Convention against Doping in Sport and the revised World Anti-Doping Code, to support a more effective global anti-doping effort. This was endorsed in 2015.

Increased capacity of Australian sporting organisations to address sports integrity issues.
Source: 2015-16 Health Portfolio Budget Statements, p. 161 & 2015-16 Corporate Plan, p. 16

2015-16 Target	2015-16 Result
Ongoing assessment of integrity vulnerabilities of priority national sporting organisations and delivery of support for relevant sports integrity initiatives.	Five individual Sports Integrity Threat Assessments were undertaken in 2015-16. Two Probity Checking training courses were delivered. Ongoing advice and support was provided for national sporting organisations on integrity matters. **Result: Met** ✓

In 2015-16, the Department undertook five individual integrity assessments of sports organisations. Assessments informed specific funding initiatives with individual sports to address vulnerabilities.

Specialised training courses to improve probity checking arrangements were conducted for national sporting organisations.

Delivery of internationally compliant Australian anti-doping arrangements.
Source: 2015-16 Health Portfolio Budget Statements, p. 161 & 2015-16 Corporate Plan, p. 16

2015-16 Target	2015-16 Result
Effective operation of Australian anti-doping arrangements to address doping in the contemporary sports environment.	WADA identifies Australia as operating a Code-compliant anti-doping framework. A revised National Anti-Doping Framework was endorsed. **Result: Met** ✓

The revised National Anti-Doping Framework[67] was endorsed 1 October 2015 by Commonwealth, State and Territory Ministers responsible for Sport. The Framework now provides for cooperation between jurisdictions on performance and image enhancing drugs; and supplements.

[67] Available at: www.health.gov.au/internet/main/publishing.nsf/Content/anti-doping-framework

Outcome 10 – Budgeted expenses and resources

	Budget Estimate[1] 2015-16 $'000 (A)	Actual 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 10.1: Sport and Recreation[2]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	21,948	20,617	(1,331)
Special accounts			
Sport and Recreation Special Account	378	421	43
Departmental expenses			
Departmental appropriation[3]	9,906	9,252	(654)
Expenses not requiring appropriation in the current year[4]	275	617	342
Total for Program 10.1	**32,507**	**30,907**	**(1,600)**
Outcome 10 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	21,948	20,617	(1,331)
Special accounts	378	421	43
Departmental expenses			
Departmental appropriation[3]	9,906	9,252	(654)
Expenses not requiring appropriation in the current year[4]	275	617	342
Total expenses for Outcome 10	**32,507**	**30,907**	**(1,600)**
Average staffing level (number)	**59**	**55**	**(4)**

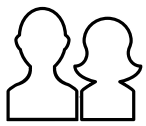
1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.
3 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)' and 'Revenue from independent sources (s74)'.
4 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Our Purpose

Lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation

In 2015-16, we undertook activities which contributed to achieving Our Purpose, including under Outcome 11

Outcome 11
Ageing and Aged Care



Improved wellbeing for older Australians through targeted support, access to quality care and related information services

Analysis of performance – **Outcome 11** Ageing and Aged Care

In 2015-16, the Department has continued to improve the access to and choice of aged care services for older Australians, their families and carers. This was achieved through the provision of: a range of targeted support services and programs to help older people stay independent and in their own homes longer; a range of quality care options; and accommodation for older people who are unable to continue to live independently in their own homes.

These activities have contributed to the Department's achievement of objectives under Outcome 11 and Our Purpose.

Key community benefits for **Outcome 11** in 2015-16

Improved access to aged care services and information through the My Aged Care initiative

The My Aged Care system has enabled older people, their families, and carers to access consistent information on aged care service. This has assisted people needing services to locate and access appropriate assessment and service options.

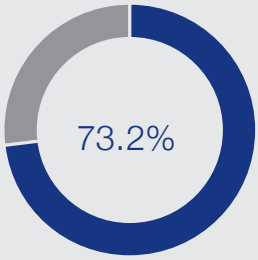
Greater power to influence design and delivery of services

Consumer-directed care has provided increased choice and control for consumers by allowing them to decide what type of care and services they can access and how they're delivered.

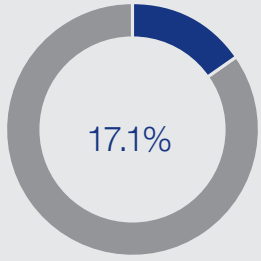
Streamlined home support services into a single program

Families and individuals now receive a range of entry-level support services from a single support program. The reduction in complexity helps people get the support they need to remain independent at home.

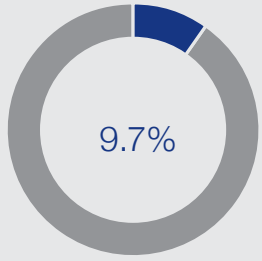
Summary of performance criteria results for **Outcome 11**



Met



Substantially met



Not met

Looking ahead

- In 2016-17, the Australian Government will further enhance services and programs to help older people stay independent and in their own homes longer.
- The Victorian Home and Community Care (HACC) services for Victorians aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander peoples) will become part of the Commonwealth Home Support Program (CHSP).
- From 1 July 2016, the CHSP and Multi-Purpose Services will start to be offered to all eligible residents on Norfolk Island.
- Increasing Choice in Home Care will allow funding to follow eligible consumers, and enable consumers to choose their service provider. Portable packages will allow the consumer to change their provider, including when the consumer moves to another location.

Programs and program objectives contributing to **Outcome 11**

Program 11.1: Access and Information

- Provide equitable and timely access to aged care assessments and make it easier for older people to find aged care services and information

Program 11.2: Home Support

- Provide high quality support, at a low intensity on a short-term or on-going basis, or higher intensity services delivered on a short term episodic basis to frail older people (65 years and over or 50 years and over for Aboriginal and Torres Strait Islander people) to maximise their independence at home and in the community for as long as they choose or are able to do so

  Support frail older people through the delivery of planned respite activities which allow carers to take a break from their usual caring responsibilities

Program 11.3: Home Care

- Provide coordinated packages of services tailored to meet individuals' specific care needs including care services, support services, clinical services and other services to support older people to remain living at home

Program 11.4: Residential and Flexible Care

- Residential aged care provides a range of care options and accommodation for older people who are unable to continue living independently in their own homes
- Flexible care caters to the needs of older people, in either a residential or home care setting, who may require a different approach than that provided through mainstream residential and home care options

Program 11.5: Workforce and Quality

- To ensure the availability of a skilled workforce, empower consumers and ensure a high quality of care to recipients of aged care services

Program 11.6: Ageing and Service Improvement

- To enable the Australian Government to better support activities that promote healthy and active ageing, to better respond to existing and emerging challenges including dementia care and to better support services targeting Aboriginal and Torres Strait Islander peoples and people from diverse backgrounds

Analysis of performance – Program 11.1: Access and Information

The Department met the majority of performance targets for Program 11.1: Access and Information. In 2011, the Productivity Commission identified the need for an improved entry point to the aged care system and the need for an independent assessment service. On 1 July 2015, with the introduction of the Commonwealth Home Support Program, My Aged Care was expanded to become the single entry point to the aged care system in Australia. Services were significantly enhanced to include: a central client record to facilitate the collection and sharing of client information; the Regional Assessment Service to conduct face-to-face assessments of people seeking entry-level support at home; the National Screening and Assessment Form to ensure a nationally consistent and holistic screening and assessment process; and the provision of web-based portals for clients, assessors and service providers.

Moving to a new system has taken time and 2015-16 has been a transitional year for the sector. There were some initial challenges in terms of stabilising the ICT platform, and the contact centre, assessors and providers had to adapt to new processes.

Over 3,000 aged care service providers across the nation were transitioned into My Aged Care, enabling them to directly and flexibly manage their own service information and receive client referrals.

To help ensure My Aged Care was working as it should, the Department conducted a mid-point review and enhanced a number of operational and system processes that further supported the full transition of the Aged Care Assessment Teams onto My Aged Care.

Provide equitable and timely access to aged care assessments and make it easier for older people to find aged care services and information

Establishment and operation of My Aged Care systems and workforce capable of providing aged care information, conducting needs based assessments and making referrals for services.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 93

2015-16 Target	2015-16 Result
Expanded functionality of My Aged Care systems and improved assessor training.	Functionality of My Aged Care systems and improved assessor training was delivered. **Result: Met** ✓

From 1 July 2015, My Aged Care expanded from an information service to include the creation of a client record, enhanced service finder functionality, consistent needs based home support and comprehensive assessments, and referrals to appropriate Commonwealth aged care services.

Training for the My Aged Care assessment workforce was coordinated and delivered appropriately at each transition point and is now embedded into the ongoing workforce management structure.

Number of calls made to the My Aged Care Contact Centre.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 93

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
382,600	634,060 **Result: Met** ✓	161,448	146,439	223,502	N/A

The number of calls[68] made to the My Aged Care Contact Centre Consumer line exceeded initial forecasts following the My Aged Care functionality expansion on 1 July 2015. In addition, the contact centre received over 150,000 calls from assessors and service providers for system and process support; they also received a further 293,000 webforms and faxes, the majority being referrals for aged care services.

A proportion of this increased demand can be attributed to transition impacts as the community, providers and assessors progressively adopted the reforms.

The Department actively engaged with the sector on capacity issues experienced by the contact centre with a focus on enhancing the quality of services delivered.

Average number of unique visitors per month to the My Aged Care website.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 93

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
121,000	203,045 **Result: Met** ✓	116,366	56,000	N/A	N/A

The increase in website demand is reflective of the increased use of the enhanced Service Finder functionality. The My Aged Care website and Contact Centre numbers have been promoted through the year via: the distribution of printed materials such as My Aged Care branded brochures and postcards; videos played in GP surgeries; and search engine marketing.

Extent of consumer satisfaction with My Aged Care website service.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 94

2015-16 Target	2015-16 Result
Maintaining over 60% of surveyed consumers satisfied with the service provided by My Aged Care Website during the first year of operation.[69]	59% **Result: Substantially met** ✓

The My Aged Care website is designed to provide consumers with plain English information on ageing and aged care services to help them navigate the system. The website also includes useful tools such as service finders and fee estimators to assist consumers to find and compare services. The Department has made a number of enhancements to the usability of the website over the past 12 months to support the expansion of My Aged Care functionality and is committed to continuing to improve the user experience.

[68] Number of calls to the My Aged Care Consumer and Provider lines for 2015-16.
[69] HealthDirect Australia Contact Centre and Website Customer Satisfaction Survey Report.

Extent of consumer satisfaction with My Aged Care Contact Centre service.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 94

2015-16 Target	2015-16 Result
Maintaining over 90% of surveyed consumers are satisfied with the service provided by My Aged Care Contact Centre during the first year of operation.[70]	97% **Result: Met** ✓

Satisfaction surveys for callers (both consumers and the sector) to the My Aged Care Contact Centre are performed by Australian Market Research. Callers are asked at the end of calls if they would like to be transferred to complete a survey. They are also given an option of being called back at a later point in time to undertake the survey.

My Aged Care assessment workforce (Contact Centre, Regional Assessment Service organisations and Aged Care Assessment Teams (ACATs)) to complete mandatory training prior to undertaking screening and assessment through My Aged Care.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 94

2015-16 Target	2015-16 Result
100% of the My Aged Care assessment workforce completes the mandatory training for their screening, assessment or delegate roles.	The requirement for mandatory training is included in the Department's agreements with all contracted assessment workforce organisations. **Result: Met** ✓

Contracted organisations report to the Department on their compliance against My Aged Care program requirements. The Department is establishing a routine method to validate this based on reports provided by the Registered Training Organisation and users within the My Aged Care system.

Number of new client registrations.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 95

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
183,800	288,649 **Result: Met** ✓	N/A	N/A	N/A	N/A

The number of new My Aged Care client registrations is greater than originally forecast, demonstrating the higher than expected demand for My Aged Care services since 1 July 2015. The benefit of the client registration process is clients no longer need to tell their story multiple times as My Aged Care builds on their individual record at each stage of the client journey.

[70] HealthDirect Australia Contact Centre and Website Customer Satisfaction Survey Report.

Number of assessments completed on My Aged Care.[71]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 95

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
459,300	183,887 **Result: Not met**	N/A	N/A	N/A	N/A

The Aged Care Assessment Teams (ACATs) transitioned to full use of the My Aged Care system during February/March 2016. The ACATs were originally scheduled to transition in late 2015, however, the decision was made to delay the transition to early 2016 to ensure system capability. The timing of the transition impacted the number of ACAT assessments being conducted on My Aged Care in 2015-16 as the majority were conducted on the former legacy system. Regional Assessment Services (RAS) were introduced as part of the expansion of My Aged Care to conduct nationally consistent and holistic assessments for clients seeking to access entry-level home support services. As a new service, assessment numbers indicated for 2015-16 were based on forecast, not previous year assessment numbers. RAS assessment numbers were below this forecast for 2015-16.

Aged Care Assessment Program (ACAP) and Regional Assessment Service organisations training resources reflect current program operation and enable consistent decision making.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 93

2015-16 Target	2015-16 Result
All ACAP training reflects the current program operation model, with six monthly reviews of all training resources to ensure currency is maintained.	During the 2015-16 implementation period, a six monthly review of all training material was substituted with: system changes; communications; factsheets; and frequently asked questions as changes have occurred. **Result: Substantially met**

Updated information is regularly provided to assessment organisations to ensure internal training material is kept up to date. A full review of Statement of Attainment training for My Aged Care assessors commenced in early 2016 and will be finalised by the end of July 2016.

[71] Includes ACAT and Regional Assessment Service organisation assessments.

ACAP data is maintained to a high level of accuracy and is provided within the specified timeframe by the State and Territory Governments to the Australian Government.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 94

2015-16 Target	2015-16 Result
State and Territory Governments successfully upload data files into the Aged Care Data Warehouse in the required timeframe and format with an error rate not exceeding 0.1%.	All States and Territories have met this target. **Result: Met** ✓

Under a new agreement with the Australian Government, the State and Territory Governments transitioned their Aged Care Assessment Teams onto the My Aged Care System from February to March 2016. This involved transition from legacy reporting systems to My Aged Care.

Percentage of high priority ACAT assessments completed within 48 hours of referral.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 95

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
85.0%	96.9% **Result: Met** ✓	94.8%	89.0%	88.0%	85.0%

ACATs provide first intervention of a clinical nature within 48 hours of a referral for assessment being received.

Analysis of performance – Program 11.2: Home Support

The Department met all performance targets for Program 11.2: Home Support, for criteria for which data is currently available. The Australian Government is committed to providing a range of services and programs to help older people stay independent and in their homes and communities for longer. The commencement of the Commonwealth Home Support Program (CHSP) in 2015 saw four programs being consolidated into one, which were the:

- Commonwealth Home and Community Care (HACC) Program;
- planned respite from the National Respite for Carers Program (NRCP);
- Day Therapy Centres (DTC) Program; and
- Assistance with Care and Housing for the Aged (ACHA) Program.

The CHSP benefits frail older people and carers by providing streamlined access to entry-level support services and a standardised national assessment process and entry point through My Aged Care. Continuity of service was achieved, ensuring minimal disruption to clients.

The CHSP ensures that all clients have equity of access to services that are socially and culturally appropriate and free from discrimination. Aboriginal and Torres Strait Islander people may be eligible for the CHSP from 50 years of age and over, whereas for non-Indigenous people, it is 65 years and over.

In 2016, a one-off grant was allocated to CHSP providers to contribute towards costs incurred to align their businesses to the new program taxonomy and comply with new reporting requirements. A total of 1,149 providers have received the one-off grant, totalling $18 million.

Provide high quality support through the Commonwealth Home Support Program[72]

Continuity of services in programs being incorporated into the CHSP.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 96

2015-16 Target	2015-16 Result
New CHSP Agreements with service providers established by 1 November 2015 to maintain continuity of service.	All Agreements were with service providers by 1 November 2015. **Result: Met** ✓

The CHSP delivers entry level care to frail, older Australians living in their homes. The term 'entry level' refers to home support services provided at a low intensity on a short-term or ongoing basis, or higher intensity services delivered on a short-term episodic basis. Service providers continued to provide services to clients throughout the transition period.

Regular stakeholder consultation on the management of the new CHSP through formal and informal mechanisms.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 96

2015-16 Target	2015-16 Result
Timely contact and consultation with key stakeholders.	Regularly contacted and consulted with key stakeholders. **Result: Met** ✓

The Department conducted consultations and communications through various mediums including bulk emails, webinars and media releases to engage with stakeholders including consultation with the National Aged Care Alliance sub-group – the CHSP Advisory Group.

Funding agreements established with providers for the delivery of CHSP services.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 96

2015-16 Target	2015-16 Result
New CHSP Agreements with service providers established by 1 November 2015.	All Agreements were offered to service providers by 1 November 2015. **Result: Met** ✓

The establishment of funding agreements was achieved through regular consultation and communication with stakeholders, including the transitioning of service providers, and effective internal communication and governance.

[72] Program objective has been simplified. Refer 'Programs and program objectives contributing to Outcome 11' on page 196.

Commonwealth Home Support services delivered by contracted service providers to support frail older people and their carers to get the services they need to remain at home.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 97

2015-16 Target	2015-16 Result
Regular reporting on key milestones from contracted service providers indicate that activities are being implemented according to contractual arrangements.	Service providers are reporting on contracted activities, recognising that some service providers are still receiving support to transition to new reporting arrangements. **Result: Met** ✓

The Department supported contracted service providers, through webinars, bulk emails, training and direct engagement, to manage and report on Commonwealth Home Support service activities in line with contractual arrangements.

Number of older people receiving Commonwealth Home Support services.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 96

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
556,136	Data not available	N/A	N/A	N/A	N/A

In line with funding agreements, data collection for the CHSP commenced on 1 November 2015 and only eight months of client data was captured from 1 November to 30 June 2016. This data has not been compiled at the time of publishing. In 2016-17 a full set of the CHSP client data will be available.

Number of Commonwealth Home Support older clients receiving services as a percentage of the target population.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 97

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
≥ 87%	Data not available	N/A	N/A	N/A	N/A

In line with funding agreements, data collection for the CHSP commenced on 1 November 2015 and only eight months of client data was captured from 1 November to 30 June 2016. This data has not been compiled at the time of publishing. In 2016-17, the CHSP will report on the target population.

Analysis of performance – Program 11.3: Home Care

The Department met or substantially met all performance targets for Program 11.3: Home Care. This program assists older Australians to remain living in their own home by providing a coordinated package of service, tailored to meet individual specific care needs. During 2015-16, the Department worked towards transitioning all Home Care Packages to a consumer-directed care basis, giving consumers more choice and flexibility in the types of care and services they access and on the delivery of those services.

Delivering the Home Care Package on a consumer-directed care basis, in line with the Home Care Agreement developed between the provider and the consumer, provides greater transparency about what funding is available under their package and how those funds are spent through the use of an individualised budget and monthly statement.

Adapting administrative systems and establishing an organisational culture that supports the consumer-directed care focus of service delivery, has been a complex process for some providers, especially smaller providers.

In 2016, a one-off grant was allocated to home care providers for the costs incurred in 2014-15 for retraining and reskilling the workforce for the transition to the consumer-directed care service delivery model. The payments were finalised in January 2016. A total of 462 home care package providers have received the one-off grant, totalling $19.7 million.

Smaller providers, including those in rural and remote areas, have required a range of support to assist with the transition. Work is continuing to support those providers in 2016-17.

Consumer-directed care

In 2015-16, home care packages moved towards a consumer-directed care (CDC) model. There are four levels of home care packages, ranging from level 1 for support of people with basic needs to level 4 for people with high care needs. The CDC model puts the consumer at the centre of their care, and builds a more flexible aged care system.

CDC empowers consumers to influence the delivery of the services they receive and allows them to exercise a greater degree of choice in what services are delivered, where and when. This results in a particularly positive effect on consumers with diverse needs. Emily's story is an example of CDC in action.

It was important for Emily to stay independent and active as she got older. Emily has been able to do this with the help of her home care package. Emily realised that she was becoming isolated after the passing of her partner, Joan. She worked with her service provider to review her care plan to fix the situation. Her service provider had their staff undergo lesbian, gay, bi sexual, transgender and intersex (LGBTI) awareness training, to broaden their understanding of potential issues Emily may face.

The service provider contacted an LGBTI group, connecting her with community in her area.

During their discussions, Emily told her case manager that she used to go swimming, but had stopped going when Joan passed away. Emily's case manager found a local swimming group, and if Emily wanted to go swimming again, transport could be organised through her home care package.

Emily has been very satisfied with the care and services, and has been spending time with the swimming group. Since she started swimming with the group, she has become stronger and has reconnected with her community.

Emily is just one of many aged care consumers who have been empowered to direct their own care and needs with the CDC model.

For more information about home care packages delivered on a CDC basis, visit: www.myagedcare.gov.au

Provide coordinated packages of services tailored to meet individuals' specific care needs including care services, support services, clinical services and other services to support older people to remain living at home

All Home Care Packages are delivered on a consumer-directed care basis.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 97

2015-16 Target	2015-16 Result
All Home Care Packages are transitioned to a consumer-directed care basis by 1 July 2015.	On 1 July 2015, some providers were still receiving support to fully transition to consumer-directed care, due to a need to adapt administrative systems and organisational culture to support operational elements of the transition. **Result: Substantially met**

The majority of providers are delivering services on a consumer-directed care basis. Approximately 7.5% of home care providers are still receiving support to transition to consumer-directed care.

Consumers and providers are supported to adopt consumer-directed care approaches.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 97

2015-16 Target	2015-16 Result
All consumers and providers have access to information and material to support their adoption of consumer-directed care approaches for Home Care Packages.	All consumers and providers have access to information and material to support their adoption of consumer-directed care. **Result: Met**

The Department has undertaken a strategic communication and engagement approach to ensure providers have access to information on aged care reform. The Department has funded a number of capacity building projects to develop tools and resources to support operational change required for adoption of consumer-directed care in business as usual operations.

Consumers have been provided access to a comprehensive range of materials through My Aged Care and the Department's website. Key documents such as the Charter of Rights and Responsibilities have been translated into 18 languages, ensuring equity of access. The Department has funded project partners to provide a range of educational services. This support assists the consumer to understand the legislation that the provider operates under and also their rights and responsibilities. It enables the consumer to make fully informed choices about their care and services.

The Department has contracted Taylor Nelson Sofres (TNS) Pty Limited, an international research company with expertise in social research. TNS will conduct research on home care providers and consumers to understand their knowledge of consumer-directed care, satisfaction with the approach and perceptions of support and information provided. The results of this research will be available to the Department in August 2016, and will provide an analysis of the effectiveness of support and information provided by the Department to support delivery of consumer-directed care.

Number of new Home Care Packages allocated.[73]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 98

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
6,045	6,445 **Result: Met** ✓	6,653	0[74]	5,835	1,724

The Minister for Aged Care varied the original Ministerial Determination in January 2016 to make available an additional 400 Level 4 Home Care Packages for allocation in 2015-16.

A key focus in 2015 was the release of significantly higher level Home Care Packages (i.e. Level 3 and Level 4) relative to lower level packages, in recognition of consumer demand for higher level home care.

There are four levels of a Home Care Package. Home care levels range from Level 1, for the support of people with basic care needs; to Level 2, for low level care needs; Level 3 for intermediate care needs; and Level 4, for people with high care needs. A consumer can be eligible for either low-level care (Level 1 or 2 package) or high-level care (Level 3 or 4 package). An Aged Care Assessment Team undertakes the assessment and approval of the level of care that a consumer is eligible for. The increase in level of Home Care Package is related to a person's assessed need, level of frailty and need for more complex care services.

Home Care providers continue to deliver services.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 98

2015-16 Target	2015-16 Result
All Home Care Packages allocated are operational.	78,956 out of 79,313 allocated packages were operational at 30 June 2016. 357 allocated packages were not operational. **Result: Substantially met** ✓

Number of operational Home Care Packages at end of financial year.[75]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 98

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
78,747	78,956 **Result: Met** ✓	72,702	66,149	60,308	59,201

The utilisation of Home Care Packages is dependent upon geographical demand and required level of care, resulting in under-utilisation in some locations of lower level packages.

A greater than estimated number of Home Care Packages were required to meet the needs of aged Australians.

[73] As part of the aged care reforms announced by the Government in the 2015-16 Budget, from 2016-17, home care packages will no longer be allocated to providers through the Aged Care Approvals Round.
[74] There was no allocation of Home Care Packages in 2013-14.
[75] The total number of Home Care Packages each year is determined following the previous year's stocktake of places.

Analysis of performance – Program 11.4: Residential and Flexible Care

The Department met or substantially met the majority of performance targets for Program 11.4: Residential and Flexible Care. Residential aged care provides accommodation and care for older Australians who are unable to remain living in their own homes, either permanently or on a respite basis. In 2015-16, the Australian Government funded an additional 10,940 new residential aged care places.

In 2015-16, the Government allocated $67 million in capital grants from the Rural, Regional and Other Special Needs Building Fund to 22 providers for capital works projects. This funding will support the development of 297 new residential aged care places and the upgrade of facilities to accommodate 270 existing residential aged care places. The funded projects included works to improve access to residential aged care for people from special needs groups and works to address fire safety.

In 2015, the Government announced the new Short-Term Restorative Care (STRC) Program building on the success of the existing Transition Care Program. Unlike Transition Care, STRC will be available to people without requiring a hospital stay, assisting to help older Australians live longer in their own homes. Significant progress has been made in implementing STRC Program, including an extensive stakeholder consultation process held in October 2015 and regular briefings and updates provided to interested stakeholder groups over the course of the financial year. From 2016-17, new STRC places will progressively become available with at least 2,000 places available by 2021.

The Department continued to improve access to culturally appropriate aged care services for Indigenous Australians with the establishment of a service in Kintore, Northern Territory, under the Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Providing a range of residential and flexible care options and accommodation for older people who are unable to continue living independently in their own homes[76]

Competitive Aged Care Approvals Round.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 99

2015-16 Target	2015-16 Result
Competitive Aged Care Approvals Round undertaken with outcomes to be announced by April 2016.	Outcomes of the Competitive Aged Care Approvals Round were announced on 18 March 2016. **Result: Met** ✓

The 2015 Competitive Aged Care Approvals Round application process allowed prospective and existing approved providers of aged care to apply for a range of new Australian Government funded aged care places and financial assistance in the form of a capital grant.

[76] Program objective has been simplified. Refer 'Programs and program objectives contributing to Outcome 11' on page 196.

All new residential Aged Care Places allocated.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 100

2015-16 Target	2015-16 Result
All new residential Aged Care Places are allocated by 30 June 2016.	All new residential Aged Care Places were allocated by 30 June 2016. **Result: Met** ✓

Through the 2015-16 Aged Care Approvals Round 10,940 new residential aged care places were allocated across Australia by 30 June 2016.

Number of operational Residential Aged Care places at end of financial year.[77]
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 100

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
198,259	199,449 **Result: Met** ✓	195,953	192,834	189,761	187,941

A number of red tape reduction measures have been implemented to make it easier for approved providers to operationalise provisionally allocated places. This was achieved by reducing the associated regulatory burden, enabling approved providers to focus less on administrative processes and more on the timely delivery of care to older Australians who require it.

Expansion of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 99

2015-16 Target	2015-16 Result
Conduct a funding round to expand existing services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, with places allocated by 31 May 2016.	A funding round is planned to occur in 2016, with places being made operational in the first half of 2017. **Result: Not met** ●

[77] The total number of Residential Aged Care places each year is determined following the previous year's stocktake of places.

Number of flexible places available for Aboriginal and Torres Strait Islander peoples through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 99[78]

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
820	820 **Result: Met** ✓	802	739	679	675

All new flexible places for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program allocated.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 100

2015-16 Target	2015-16 Result
All new flexible places for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program are allocated by 31 May 2016.	173 of the 200 new flexible places have been allocated. **Result: Substantially met** ✓

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide culturally appropriate residential and/or community care to older Aboriginal and Torres Strait Islander people.

Funding provides access to aged care services through 32 aged care facilities. Services are delivered to meet the aged care needs of this community, allowing older Aboriginal and Torres Strait Islander people to live close to home and community.

The Department did not meet its target to conduct a funding round to expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The scope of the funding round is under consideration by the Government, with a funding round expected to occur in 2016.

In December 2015, a new flexible aged care service was established in Kintore, Northern Territory (NT). The provider was allocated 18 home care packages to deliver aged care services in a remote, Indigenous community.

In 2012-13 funding was provided to expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This funding provided approximately 200 additional places over a five year period commencing in 2012-13. To date, 173 places have been allocated via inviting expressions of interest for new and additional services from communities identified through comprehensive consultation processes and departmental resources.

In addition, the Department is currently working with key partners to establish a new flexible aged care service in Nhulunbuy, NT. Up to 30 places will be made available for the establishment of this service.

[78] The same performance criterion was reported in error on page 100 of the *2015-16 Portfolio Additional Estimates Statements*.

Number of operational Short-Term Restorative Care places (including Transition Care Places). Source: 2015-16 Health Portfolio Budget Additional Estimates Statements, p. 99[79]					
2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
4,000	4,000 **Result: Met** ✓	4,000	4,000	4,000	4,000

As at 30 June 2016, 4,000 Transition Care Places were in operation. These places are administered through State and Territory health departments. On average the Transition Care Program had a 88.1% occupancy rate during the 2015-16 financial year. The Commonwealth invested more than $254 million in transition care.

New Short-Term Restorative Care places are scheduled to be allocated as part of the 2016 Aged Care Approvals Round, and will commence operation in 2016-17.

Number of operational Multi-Purpose Services places at end of financial year. Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 100					
2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
3,695	3,592 **Result: Substantially met** ✓	3,545	3,525	3,483	3,337

Due to the changes implemented in home care and further planning required to implement changes that will take effect from February 2017, home care places were not allocated to Multi-Purpose Services (MPS) in 2015-16. There are 33 provisionally allocated MPS places which are yet to be made operational. A further funding round will be conducted in 2016-17 to allocate additional MPS places.

The performance result of 'substantially met' is based on meeting 97% of the target.

Analysis of performance – Program 11.5: Workforce and Quality

The Department met the majority of performance targets for Program 11.5: Workforce and Quality. Australia's aged care system has a strong quality framework, appropriately skilled and qualified workforce, and empowers consumers. The Australian Government continued to support the Community Visitors Scheme, providing one-on-one visits in residential care and home visits for those clients receiving home care packages, with a focus on special needs groups.

The Department continued to take a risk-based regulatory approach to identified non-compliance to protect the health, safety and wellbeing of care recipients. Appropriate and proportionate compliance action was undertaken to bring providers back into compliance.

[79] The same performance criterion was reported in error on page 100 of the *2015-16 Portfolio Additional Estimates Statements*.

To ensure the availability of a skilled workforce, empower consumers and ensure high quality of care to recipients of aged care services

Continuing uptake of new models of the Community Visitors Scheme.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 101

2015-16 Target	2015-16 Result
Increase uptake of new models of the Community Visitors Scheme.	2015-16 data indicates an increased uptake of the new models of the Community Visitors Scheme, including one-on-one home care visits and group visits in residential care. **Result: Met**

Continued support for the Community Visitors Scheme to provide one-on-one visits in residential care, home visits for people receiving home care packages and group visits (groups of two or more residents) in residential aged care settings.

This included a focus on targeting special needs groups (people from culturally and linguistically diverse backgrounds and Lesbian, Gay, Bisexual, Transexual and Intersex people).

Number of annual reviews of Aged Care Funding Instrument funding claims to ensure residents are correctly funded.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 102

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
20,000	15,763 **Result: Substantially met**	20,587	20,349	21,426	18,735

Fewer reviews were conducted in 2015-16. Improved targeting and the increased use of more labour intensive comprehensive reviews resulted in a greater proportion of incorrect Aged Care Funding Instrument claims being identified.

The performance result of 'substantially met' is based on meeting 79% of the target.

Percentage of General Purpose Financial Reports submitted by approved providers reviewed to assess financial risk.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 102

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met**	100%	100%	100%	100%

Risk profiling was applied across all who submitted a General Purpose Financial Report, and a detailed risk assessment was undertaken on all those identified as being at the highest level of risk.

Percentage of detailed risk assessments completed for residential aged care approved providers assessed as having a financial risk at the highest level.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 102

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	N/A	N/A	N/A	N/A

Detailed risk assessments were undertaken on all approved providers assessed at the highest financial risk level. Compliance approaches were identified to bring those providers into compliance if required.

Extent to which the Department has taken appropriate action to identify and respond to provider financial risks where those risks have been assessed as being at the highest level.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 103

2015-16 Target	2015-16 Result
Action taken by the Department is proportionate to the level of risk and in accordance with the *Aged Care Act 1997*.	The Department has taken appropriate action to identify and respond to all providers assessed as being at the highest level of financial risk in accordance with the Act. **Result: Met** ✓

Following a detailed risk assessment, proportionate regulatory action is taken in accordance with the *Aged Care Act 1997.*

Extent to which the Department has taken appropriate action against approved providers to address serious non-compliance that threatens the health, welfare or interests of care recipients.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 103

2015-16 Target	2015-16 Result
Action taken by the Department is proportionate to the level of risk and in accordance with the *Aged Care Act 1997*.	The Department has taken appropriate action to respond to all providers to address serious non-compliance in accordance with the Act. **Result: Met** ✓

All instances of identified serious non-compliance were responded to appropriately and proportionately. Sanctions were imposed on all approved providers where an immediate and severe risk to the safety, health or wellbeing of care recipients was identified. Where there is identified non-compliance, the Department applies a risk based approach and following a detailed assessment, appropriate and proportionate regulatory action is taken in accordance with the *Aged Care Act 1997*.

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.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 103

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
100%	100% **Result: Met** ✓	100%	100%	100%	100%

In 2015-16, the Department imposed four sanctions on two approved providers following identification of an immediate and severe risk to the safety, health or welfare of care recipients.

Aged Care Complaints Commissioner

From 1 January 2016, the Aged Care Complaints Scheme moved to the Aged Care Complaints Commissioner (Complaints Commissioner). For results on the four performance criteria below and information on complaints, please refer to the Complaints Commissioner's 2015-16 Annual Report.

Percentage of complaints finalised by the Aged Care Complaints Scheme within 90 days.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 102

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
80%	Refer to Complaints Commissioner's 2015-16 Annual Report.	87%	84%	85%	83%

Percentage of complaints resolved by the Aged Care Complaints Scheme at early resolution.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 102

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
64%	Refer to Complaints Commissioner's 2015-16 Annual Report.	81%	78%	72%	61%

Timely and effective resolution of complaints through the Aged Care Complaints Scheme.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 101

2015-16 Target	2015-16 Result
Majority of complaints are resolved within 90 days, with over 64 per cent finalised at the early resolution stage.	Refer to Complaints Commissioner's 2015-16 Annual Report.

Satisfaction with the operation of the Aged Care Complaints Scheme. Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 103	
2015-16 Target	2015-16 Result
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.	Refer to Complaints Commissioner's 2015-16 Annual Report.

Analysis of performance – Program 11.6: Ageing and Service Improvement

The Department met the majority of performance targets for Program 11.6: Ageing and Service Improvement. Dementia continues to be a challenge for the health and aged care system, with the prevalence of dementia predicted to rise significantly. The current suite of dementia support programs funded by the Australian Government will not be sufficient to deliver the same quality of service to an ever-growing client base. For this reason, during 2015-16, the Department analysed its dementia support programs and began developing improved, streamlined national services.

An element of this has been a process to establish a single national Dementia Behaviour Management Advisory Service and the new Dementia Training Program, to be launched in October 2016. These new programs will achieve efficiencies, allowing a greater number of people to access the services they need, as well as allow expansion into new services. The new programs will be available to an array of health professionals and care staff in all health and aged care settings.

A key challenge faced by residential aged care providers is the management of behavioural and psychological symptoms of dementia. The national launch of the Severe Behaviour Response Teams on 2 November 2015 created a new tier of support for residential aged care providers to manage severe and extreme cases of behavioural and psychological symptoms of dementia. While Severe Behaviour Response Teams have not been operational for a full year, feedback to date has been positive and data indicates that referrals will continue to grow to meet future targets.

To enable the Australian Government to better support activities that promote healthy and active ageing, to better respond to existing and emerging challenges including dementia care and to better support services targeting Aboriginal and Torres Strait Islander peoples and people from diverse backgrounds

Funding will be available under the Dementia and Aged Care Services Fund.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 104

2015-16 Target	2015-16 Result
An open grant funding round is advertised in 2016.	An open funding round was advertised in April 2016 to seek a national provider for the Dementia Behaviour Management Advisory Service, and a national provider to deliver a suite of dementia training and education activities. **Result: Met** ✓

The national provider for the Dementia Behaviour Management Advisory Service and dementia training programs will commence by October 2016.

Activities and projects that improve the lives of people with dementia are delivered, including as part of Severe Behaviour Response Teams.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 104

2015-16 Target	2015-16 Result
Continued Government funding of a number of programs which provide additional support for people with dementia.	Funding of $52.1 million in 2015-16 was provided for a range of existing dementia programs. **Result: Met** ✓

During 2015-16, the following activities continued to receive funding to support people living with dementia:

- Dementia Behaviour Management Advisory Service;
- Dementia Training Study Centres;
- Dementia Care Essentials;
- National Dementia Support Program;
- a number of smaller one-off projects; and
- Severe Behaviour Response Teams.

Number of service episodes delivered by Severe Behaviour Response Teams.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 105

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
550	319 **Result: Not met**	N/A	N/A	N/A	N/A

The Severe Behaviour Response Teams program commenced national service delivery on 2 November 2015, so has not been operational for the full 2015-16 financial year.

As part of the referrals received, there have been a total of 13,157 service activities, with an average of 42 service activities per service episode.

Feedback on the service delivery received through the program's performance reporting and independently provided to the Department has been positive.

Number of service episodes delivered by Dementia Behaviour Management Advisory Services clinicians that support aged care staff, healthcare professionals and family carers to improve their care of people with behavioural and psychological symptoms of dementia.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 105

2015-16 Target	2015-16 Result	2014-15	2013-14	2012-13	2011-12
6,800	7,941 **Result: Met**	7,323	N/A	N/A	N/A

Performance data for the program indicates that targets for the Dementia Behaviour Management Advisory Services are being met, and in some instances exceeded. Feedback on the program indicates a high level of satisfaction with the care being delivered.

Projects to support older Aboriginal and Torres Strait Islander people and services that provide care to this group are delivered, including grants of capital assistance.
Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 104

2015-16 Target	2015-16 Result
An open grant funding round is advertised in 2016.	An open grant funding round was not held in 2015-16. **Result: Not met**

Funding continues to be made available under the Dementia and Aged Care Services Fund for one-off activities such as capital funding, or under programs such as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Service Development Assistance Panel.

Remote Indigenous communities continued to be supported through one-off grants for items including capital assistance, security upgrades, and purchase of equipment necessary for the delivery of high quality aged care.

Extent of implementation of service system improvement initiatives to better support older people from diverse backgrounds and with special needs.

Source: 2015-16 Health Portfolio Additional Estimates Statements, p. 104

2015-16 Target	2015-16 Result
Continued Government funding of Partners In Culturally Appropriate Care to support and promote understanding of cultural issues and accessibility of services through My Aged Care.	Seven Partners In Culturally Appropriate Care (PICAC) organisations, one in each State and Territory (including one organisation for both NSW and ACT), continue to be funded to equip aged care providers to deliver culturally appropriate care to older people from culturally and linguistically diverse (CALD) backgrounds. A project to investigate My Aged Care accessibility for these communities commenced in 2015-16. **Result: Met**

PICAC organisations are funded to improve partnerships between aged care providers and CALD communities, develop and disseminate information and translated aged care resources to CALD communities, and provide culturally appropriate training to staff of aged care services. In 2015-16, one of the PICAC organisations was engaged to support and promote an understanding of cultural issues and CALD communities' accessibility of services through My Aged Care. The organisation will continue to consult with My Aged Care and CALD communities until the project's completion on 30 June 2017.

Outcome 11 – Budgeted expenses and resources

	Budget Estimate[1,2] 2015-16 $'000 (A)	Actual[2] 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 11.1: Access and Information			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	86,897	87,327	430
Departmental expenses			
Departmental appropriation[3]	16,085	23,013	6,928
Expenses not requiring appropriation in the current year[4]	505	1,033	528
Total for Program 11.1	**103,487**	**111,373**	**7,886**
Program 11.2: Home Support[5]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	1,091,321	1,064,310	(27,011)
Departmental expenses			
Departmental appropriation[3]	23,582	16,505	(7,077)
Expenses not requiring appropriation in the current year[4]	525	1,076	551
Total for Program 11.2	**1,115,428**	**1,081,891**	**(33,537)**
Program 11.3: Home Care[5]			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	1,216	898	(318)
Special appropriations			
Aged Care Act 1997 - home care packages	1,103,461	1,134,595	31,134
Departmental expenses			
Departmental appropriation[3]	14,207	14,230	23
Expenses not requiring appropriation in the current year[4]	421	852	431
Total for Program 11.3	**1,119,305**	**1,150,575**	**31,270**

	Budget Estimate[1,2] 2015-16 $'000 (A)	Actual[2] 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Program 11.4: Residential and Flexible Care			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	93,954	60,844	(33,110)
Zero real interest loans[6]			
- appropriation	68,451	22,289	(46,162)
- expense adjustment	(63,749)	(18,037)	45,712
Special appropriations			
Aged Care Act 1997 - residential care	7,643,190	7,690,942	47,752
Aged Care Act 1997 - flexible care	329,144	333,891	4,747
Aged Care (Accommodation Payment Security Act 2006)	718	718	-
Departmental Expenses			
Departmental appropriation[3]	26,781	26,452	(329)
Expenses not requiring appropriation in the current year[4]	756	1,592	836
Total for Program 11.4	**8,099,245**	**8,118,691**	**19,446**
Program 11.5: Workforce and Quality			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	9,953	12,965	3,012
Departmental expenses			
Departmental appropriation[4]	35,068	39,296	4,228
Expenses not requiring appropriation in the current year[4]	1,112	2,262	1,150
Total for Program 11.5	**46,133**	**54,523**	**8,390**
Program 11.6: Ageing and Service Improvement			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	84,540	71,536	(13,004)
Special appropriations			
- continence aids payments	35,815	17,202	(18,613)
Departmental expenses			
Departmental appropriation[3]	23,358	21,877	(1,481)
Expenses not requiring appropriation in the current year[4]	685	1,341	656
Total for Program 11.6	**144,398**	**111,956**	**(32,442)**

	Budget Estimate[1,2] 2015-16 $'000 (A)	Actual[2] 2015-16 $'000 (B)	Variation $'000 (B) - (A)
Outcome 11 Totals by appropriation type			
Administered expenses			
Ordinary annual services (Appropriation Act No. 1)	1,367,881	1,302,132	(65,749)
Special appropriations	9,112,328	9,177,348	65,020
Departmental expenses			
Departmental appropriation[3]	139,081	141,373	2,292
Expenses not requiring appropriation in the current year[4]	4,004	8,156	4,152
Total expenses for Outcome 11	**10,623,294**	**10,629,009**	**5,715**
Average staffing level (number)	**777**	**766**	**(11)**

1 Budgeted appropriation taken from the *2016-17 Health Portfolio Budget Statements* and re-aligned to the 2015-16 outcome structure.
2 The ageing and aged care functions transferred from the Department of Social Services under the Administrative Arrangements Order issued on 30 September 2015.
3 Departmental appropriation combines 'Ordinary annual services (Appropriation Act No. 1)', 'Revenue from independent sources (s74)' and an expense adjustment due to Machinery of Government changes.
4 'Expenses not requiring appropriation in the budget year' is made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.
5 This Program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations Framework.
6 'Ordinary annual services (Bill 1)' against program 11.4 excludes amounts appropriated in Bill 1 for Zero Real Interest Loans as this funding is not accounted for as an expense.

2.2 Entity Resource Statement 2015-16

		Actual available appropriation 2015-16 $'000 (A)	Payments made 2015-16 $'000 (B)	Balance remaining 2015-16 $'000 (A) - (B)
Ordinary annual services[1]				
Departmental appropriation				
Prior year departmental appropriation		99,489	59,709	39,780
Departmental appropriation[2]		590,444	527,148	63,296
Departmental capital budget[3]		12,174	11,858	316
s74 relevant agency receipts		56,407	56,407	-
Total		**758,514**	**655,122**	**103,392**
Administered expenses				
Outcome 1		325,211	295,830	
Outcome 2		627,188	578,039	
Outcome 3		596,756	544,411	
Outcome 4		91,927	89,178	
Outcome 5		2,201,777	2,200,534	
Outcome 6		2,328	2,302	
Outcome 7[4]		296,080	248,700	
Outcome 8		1,220,208	1,199,681	
Outcome 9		57,558	35,747	
Outcome 10[5]		26,948	19,900	
Outcome 11		1,436,646	1,294,757	
Payments to corporate entities		346,502	328,658	
Total		**7,229,129**	**6,837,737**	
Total ordinary annual services	**A**	**7,987,643**	**7,492,859**	
Other services[6]				
Departmental non-operating				
Prior year departmental appropriation		7,231	7,231	-
Equity injections[7]		32,290	20,110	12,180
Total		**39,521**	**27,341**	**12,180**
Administered non-operating				
Prior year administered appropriation		18,548	3,482	
Administered assets and liabilities		156,741	29,720	
Total		**175,289**	**33,202**	
Total other services	**B**	**214,810**	**60,543**	
Total available annual appropriations and payments		**8,202,453**	**7,553,402**	

		Actual available appropriation 2015-16 $'000 (A)	Payments made 2015-16 $'000 (B)	Balance remaining 2015-16 $'000 (A) - (B)
Special appropriations				
Special appropriations limited by criteria/entitlement				
Aged Care Act 1997			9,831,715	
Health Insurance Act 1973			21,167,610	
National Health Act 1953			11,798,076	
Medical Indemnity Act 2002			69,264	
Dental Benefits Act 2008			312,724	
Private Health Insurance Act 2007			5,896,162	
Public Governance, Performance and Accountability Act 2013 – s77[8]			7,926	
Total special appropriations	**C**		**49,083,477**	
Special accounts[9]				
Opening balance		84,794		
Appropriation receipts[10]		23,055		
Non-appropriation receipts to special accounts		210,381		
Payments made			222,443	
Total special accounts	**D**	**318,230**	**222,443**	**95,787**
Total resourcing and payments[11]	**A+B+C+D**	**8,520,683**	**56,859,322**	
Less appropriations drawn from annual or special appropriations above				
and credit to special accounts		23,055		
and credit to corporate entities		346,502	328,658	
Total net resourcing and payments for the Department of Health		**8,151,126**	**56,530,664**	

1 Appropriation Act (No.1) 2015-16, Appropriation Act (No.3) 2015-16.
2 This includes an amount of $132,036,000 s75 transfer under the Administrative Arrangements Order issued on 30 September 2015. This also includes an amount of $42,000 appropriated in the 2016-17 Budget relating to 2015-16.
3 For accounting purposes this amount has been designated as 'contributions by owners'. This includes an amount of $965,000 s75 transfer under the Administrative Arrangements Order issued on 30 September 2015
4 This balance includes a temporarily quarantined amount of $20,253,000.
5 This balance includes a temporarily quarantined amount of $5,000,000.
6 Appropriation Act (No.2) 2015-16, Appropriation Act (No.4) 2015-16.
7 This includes an amount of $12,174,000 s75 transfer under the Administrative Arrangements Order issued on 30 September 2015.
8 This includes an amount of $7,825,174.24 transferred to Department of Human Services to refund a portion of recoveries from the Compensation for Health Care and Other Services Special Account previously returned to the Official Public Account.
9 Does not include 'Relevant Public Money' held in Services for Other Entities and Trust Moneys special account (SOETM).
10 Appropriation receipts from the Department of Health and special appropriations for 2015-16 included above.
11 Total resourcing excludes the actual available appropriation for all Special Appropriations.

PART 3

Management & Accountability

3.1 Corporate Governance

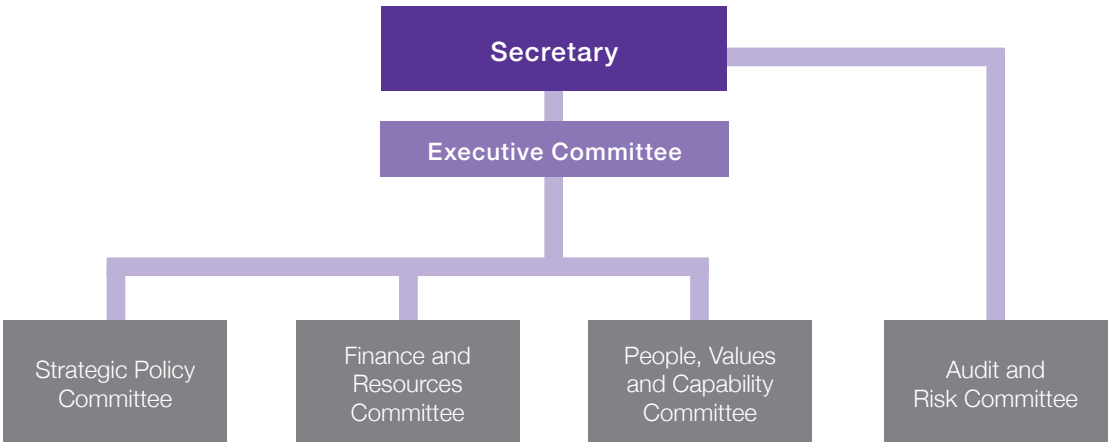
Five senior governance committees supported the Department to achieve Our Purpose and Strategic Priorities

We continue to encourage staff to positively engage with risk and to make decisions using a risk-based approach

The senior governance committees provide advice and recommendations to the Executive to support organisational performance.

The Department's governance committee structure is:

Figure 3.1.1: Governance committee structure



Executive Committee

The Executive Committee provides strategic, whole-of-organisation advice to the Secretary and the Department's leaders to ensure effective decision-making, management and oversight of the Department's operations and performance. It is the key forum to guide cross-portfolio issues in the Department.

The Executive Committee met 11 times in 2015-16 and comprises the Secretary, Deputy Secretaries, the Chief Medical Officer, General Counsel and the First Assistant Secretaries of the Portfolio Investment Division and the People, Capability and Communication Division. Biographies for the Senior Executive members of the Committee are located within Part 1.1: *Executive*.

The Department will be supported to deliver on its core business through a contemporary governance model and continued investment in corporate services that are client focussed, professional and cost effective.

Strategic Policy Committee

The Strategic Policy Committee is co-chaired by two Deputy Secretaries with members chosen from the Senior Executive Service (SES). It makes recommendations to the Secretary and Executive Committee on shaping and supporting the strategic policy directions of the organisation, consistent with the Department's Strategic Intent 2015–19.

The Committee met ten times in 2015-16. Its scope includes:

- improving organisational policy capabilities required to deliver against current and future requirements;
- providing strategic oversight and advice on the development and implementation of innovative major health policy and reform;
- enabling cross-departmental dialogue on consideration of key policy issues and projects;
- overseeing the Portfolio's Budget strategy; and
- promoting external collaboration and coordination between the Department, other agencies and stakeholders.

Finance and Resources Committee

The Finance and Resources Committee is chaired by a Deputy Secretary with members chosen from the SES. It makes recommendations to the Secretary and the Executive Committee on strategic financial and security (IT, physical and information) management policy initiatives and issues, and advises on the allocation of resources including budget adjustments.

The Committee met 11 times in 2015-16. Its scope includes:

- overseeing the development of strategies to improve the Department's financial management framework and financial performance;
- monitoring the Department's annual departmental capital and operating budget process and ensuring its alignment to the Department's corporate plan and priorities;
- providing advice to the Executive Committee on forecast revenue and expenditure, budget adjustments and reallocation of resources that meet the Department's budget appropriations;
- overseeing the planning of multi-year operating budgets consistent with the Department's corporate plan and priorities; and
- overseeing the development and implementation of the Department's ICT projects (including change releases) and other strategically significant projects.

People, Values and Capability Committee

The People, Values and Capability Committee is chaired by a Deputy Secretary with members chosen from the SES, and a representative of the Australian Public Service Commission (APSC). It makes recommendations to the Secretary and the Executive Committee on strategies to:

- embed the Department's values;
- ensure the Department has the people and capability it needs;
- ensure the Department's workforce is sustainable to maintain and increase productivity and efficiency; and
- support staff health and wellbeing.

The Committee met 11 times in 2015-16, and considered the practices and policies of the Department which affect staff health and wellbeing, values and/or ethical standards, to ensure that they:

- contribute to an ethical culture;
- are consistent with the Australian Public Service Values and Code of Conduct;
- are consistent with Australian Government objectives and the Department's Corporate Plan; and
- comply with the APSC Model of Capability and advance the overall capability of the organisation.

Audit and Risk Committee

The Audit and Risk Committee comprises five members; three of whom are independent external members, including the Chair, and two SES members. It provides independent advice and assurance to the Secretary on the appropriateness of the Department's accountability and control framework, including independently verifying and safeguarding the integrity of financial and performance reporting.

The Committee met seven times in 2015-16.

The Secretary authorises the Committee, within its responsibilities, to:

- obtain any information it requires from any employee and/or external party (subject to any legal obligation to protect information);
- discuss any matters with the external auditor, or other external parties (subject to confidentiality considerations);
- request the attendance of any employee, including the Secretary, at Committee meetings; and
- obtain external legal or other professional advice, as considered necessary to meet its responsibilities, with the approval of the Secretary.

Audit and Risk Committee Membership

As at 30 June 2016, membership of the Audit Committee comprised:

- Ms Kathleen Conlon, independent external Chair;
- Ms Jenny Morison, independent external member;
- Mr Steve Peddle, independent external member;
- Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division; and
- Adjunct Professor John Skerritt, Deputy Secretary, Health Products Regulation Group.

Kathleen Conlon – Independent External Chair

Kathleen Conlon commenced as the Chair of the Department's Audit and Risk Committee on 3 June 2015. Kathleen is a professional non-executive director, with 20 years' experience at the Boston Consulting Group (BCG), including seven years as a partner. During her time at BCG, Kathleen led BCG's Asia Pacific operational effectiveness practice area, health care practice area, and the Sydney office.

Kathleen is a member of Chief Executive Women, and a non-executive Director of the REA Group Limited, Lynas Corporation Limited, Aristocrat Leisure Limited and The Benevolent Society. As a member of these boards, Kathleen currently chairs and serves on a number of committees. She has also previously served on the NSW Better Services and Value Taskforce, and was a senior reviewer for the Department of Communication's Capability Review.

Jenny Morison – Independent External Member

Jenny Morison is a Fellow Chartered Accountant of Australia and New Zealand, with 34 years of broad experience in accounting and commerce, including audit, taxation, management consulting, corporate advisory and consulting to Government. Jenny has held numerous board positions, and is one of the longest standing independent member and chair of Audit Committees in the Australian Government. Her experience encompasses both large Departments and smaller entities.

Since 1996, Jenny has run her own business, providing strategic financial management, governance and risk advice within the Government sector. Jenny has a Bachelor of Economics and is a Fellow of the Australian Institute of Management.

Steve Peddle – Independent External Member

Steve Peddle has more than 20 years senior management experience as a Chief Information Officer (CIO), Chief Technology Officer and General Manager, covering information and communication technology service delivery and senior general management.

Steve has gained experience in private, Government and Defence industries in the areas of computer design and engineering, applications development, strategic planning, outsourcing contract management, housing management services, digital broadcast video services, network security and operations service delivery. Steve is currently the CIO for the Australian Maritime Safety Authority.

Penny Shakespeare – Internal Member

Penny Shakespeare is the First Assistant Secretary of the Department's Pharmaceutical Benefits Division, which works to provide all Australians with access to high quality, affordable and cost-effective medicines and pharmaceutical services. She has worked in the Department since 2006, previously in health workforce, Medicare benefits and private health insurance areas.

Prior to joining the Department, Penny worked as an industrial relations lawyer in the Department of Employment and Workplace Relations, and in regulatory policy roles, including as head of the ACT Office of Industrial Relations.

Penny has a Bachelor of Laws degree and a Masters in International Law, and is admitted as a Barrister and Solicitor of the ACT Supreme Court.

Adjunct Professor John Skerritt – Internal Member

Adjunct Professor John Skerritt is the Deputy Secretary with responsibility for the Department's Health Products Regulation Group. Refer Part 1.1: *Executive* for Adjunct Professor Skerritt's full profile.

Accountability and risk management

Corporate Plan

The Corporate Plan is the primary planning document of the Department.

The Department's *Corporate Plan 2015-16* released in August 2015, was the first Corporate Plan prepared in accordance with the requirements of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and will be replaced by the *Corporate Plan 2016-17*.

The four-year horizon for the Corporate Plan allows the Department to outline our medium-term direction to deliver on the Government's health agenda, including detail about significant activities, capability and risks. While the Corporate Plan spans four reporting periods, it will be reviewed and updated annually.

Figure 3.1.2 outlines the Department's business planning and performance reporting framework.

Figure 3.1.2: Business planning and performance reporting framework

- **Government Priorities** - Portfolio Budget Statements (PB Statements)
- **Strategic Intent** - Defines Our Vision, Our Purpose and Strategic Priorities
- **Corporate Plan** - Builds on the Strategic Intent and outlines how we will achieve our purpose, strategic priorities, build organisational capability, manage risk and performance
- **Business Planning** - Group, Division and Branch business plans, risk management and workforce planning
- **Individual Development Plans** - Identifies immediate development needs against the capabilities of the role

- **Performance Measures** - Outlined in PB Statements & Corporate Plan
- **Performance Framework** - Informed by our People Strategy, Our Behaviours in Action, APS Values and Code of Conduct
- **Performance Development Scheme** - Setting performance expectations and development opportunities for individuals

- **Annual Report** - Informs the performance of entities in relation to activities undertaken
- **Annual Performance Statements** - Reporting against non-financial performance criteria included in PB Statements and Corporate Plans

Risk management

The Department encourages staff to positively engage with risk and to make decisions using a risk-based approach.

During 2015-16, the Department identified 11 Enterprise Level Risks, developed an Enterprise Risk Appetite Statement, and updated the Risk Management Framework and Risk Management Policy to support our changing environment. In 2016-17, the Department will embed the suite of updated risk management documentation into the primary business planning process (Refer Figure 3.1.2).

The improved Risk Management Framework will assist the Department to make well-informed risk-based decisions on all aspects of business, including budget and resourcing allocations. A key focus will be the integration of risk management with our planning processes by identifying the key risks associated with our strategic objectives.

The Department has ensured that all risk documents comply with the PGPA Act, and the international standard *AS/NZS ISO 3100:2009 Risk Management – Principles and Guidelines,* and aligns with the *Commonwealth Risk Management Policy*.

In 2016, the Department saw an improvement against the Comcover Risk Management Benchmarking Survey. The Department moved to an 'Integrated' level of maturity, with greatest improvements related to the positive risk culture plus reviewing and continually improving the management of risk.

The decisions we make will be underpinned by a greater understanding of our risk appetite and organisational risk management approach to support innovative approaches to addressing complex issues within the health system.

Compliance reporting

There have been no significant breaches of finance law by the Department during 2015-16. The Department maintains a risk-based approach to compliance with a combination of self-reporting and focussed review. Any changes to this methodology are reviewed and endorsed by the Audit and Risk Committee. All instances of non-compliance are reported to the Audit and Risk Committee.

The Department minimises non-compliance through training and publication of legislation and rules, delegation schedules and Accountable Authority Instructions, which are available to staff to inform decision-making.

Internal audit arrangements

Audit and fraud control

During 2015-16, the Department strengthened its corporate governance arrangements by implementing a new structure for the provision of assurance services while maintaining audit and fraud control programs of work. With oversight by the Audit and Risk Committee, and working closely with the Australian National Audit Office, the Department:

- completed seven audits. The audits covered and supported compliance with the Department's control frameworks for budgeting, entitlements and payments, personnel security, grants and contract management, and program performance measurement and evaluation activities; and
- received 64 fraud allegations. The Department investigated seven of these allegations, while a further 11 were referred to the Australian Federal Police or other agencies for investigation. No matters were referred for prosecution during 2015-16.

Fraud minimisation strategies

During 2015-16, the Department continued to deliver the whole-of-government fraud awareness eLearning package and deliver fraud awareness presentations to staff. The program of presentations was delivered across a range of health functions.

The enterprise level fraud risk assessment was updated to reflect structure and function changes in the Department, and inform updates to the Fraud and Corruption Plan. Additionally, the Department implemented new internal and external accesses for integrity, public interest disclosure and fraud concerns.

Certification of departmental fraud control arrangements

I, Martin Bowles, certify that:

- the Department has prepared fraud risk assessments and fraud control plans;
- the Department has in place appropriate fraud prevention, detection, investigation, and reporting mechanisms that meet the specific needs of the Department; and
- I have taken all reasonable measures to appropriately deal with fraud relating to the Department.

Martin Bowles PSM
Secretary
September 2016

3.2 External Scrutiny

The Department continues to build organisational capability to achieve Our Purpose and Strategic Priorities

The Department continues to develop and implement supporting systems to enable coordinated engagement with all stakeholders to meet our legislative requirements

External scrutiny of the Department provides independent assurance that the Department's systems, processes and controls are effective.

This section provides information on the most significant developments in external scrutiny of the Department during 2015-16.

Australian National Audit Office audits

The Department works closely with the Australian National Audit Office (ANAO) to provide responses to proposed audit findings and recommendations prior to the Auditor-General presenting his reports to Parliament.

During 2015-16, the ANAO tabled four audits that involved the Department:

- Administration of the Radiation Oncology Health Program Grants Scheme;[80]
- Administration of the Child Dental Benefits Schedule;[81]
- Records Management in Health;[82] and
- Implementing the Deregulation Agenda: Cutting Red Tape.[83]

The other entities involved in the Cutting Red Tape audit with the Department were the Department of the Prime Minister and Cabinet, the Department of Communication and the Arts, and the Department of Industry, Innovation and Science.

The Department agreed to all audit recommendations with relevant implementation activities either underway or completed.

80 Available at: www.anao.gov.au/work/performance-audit/administration-radiation-oncology-health-program-grants-scheme
81 Available at: www.anao.gov.au/work/performance-audit/administration-child-dental-benefits-schedule
82 Available at: www.anao.gov.au/work/performance-audit/records-management-health
83 Available at: www.anao.gov.au/work/performance-audit/implementing-deregulation-agenda-cutting-red-tape

Audits specific to the Department

Audit:	Administration of the Radiation Oncology Health Program Grants Scheme Audit Report No.35 of 2015-16, tabled 5 May 2016
Objective:	The audit assessed the effectiveness of the Department of Health's and the Department of Human Services' administration of the Radiation Oncology Health Program Grants Scheme.
Recommendations:	The ANAO made two recommendations: • periodically review and document reimbursement rates and the underlying variables, publish the areas of need analysis to inform stakeholder investment decisions and clarify guidance for Scheme applicants; and • as part of a planned review of the Scheme, review the underlying program design, including mechanisms to improve pricing transparency.

Audit:	Administration of the Child Dental Benefits Schedule Audit Report No.12 of 2015-16, tabled 3 December 2015
Objective:	The audit assessed the effectiveness of the Department of Health's and the Department of Human Services' management and administration of the Child Dental Benefits Schedule (CDBS).
Recommendations:	The ANAO made four recommendations: • identify and treat risks to the administration of the CDBS; • evaluate the approach to program communications, and develop and promulgate a revised communications strategy; • improve performance measurement and reporting, and provide assurance on the quality of manual data matching processes under the CDBS; and • assist in assessing the achievement of program objectives.

Audit:	Records Management in Health Audit Report No.10 of 2015-16, tabled 1 December 2015
Objective:	The audit assessed the effectiveness of the Department's records management arrangements, including the progress in transitioning to digital records management. To assess the status of the Department's information and records management framework and governance arrangements, and its progress towards implementing the Australian Government's Digital Transition Policy, the ANAO examined records management (and relevant information management strategies), policies and guidelines, as well as systems and training materials relating to the creation, maintenance and destruction of records.
Recommendations:	The ANAO made four recommendations: • improve the governance of information and records management; • place the TRIM Electronic Document and Records Management System remediation project on a sound footing; • require preparation of guidelines for sentencing digital records upon record creation; and • strengthen the management and control framework for the finalisation, deletion and destruction of records.

Audit:	Implementing the Deregulation Agenda: Cutting Red Tape Audit Report No.29 of 2015-16, tabled 4 May 2016
Objective:	The audit assessed the effectiveness of selected Departments' implementation of deregulation initiatives.
Recommendation:	No recommendations were made in relation to the Department.

Joint Committee of Public Accounts and Audit reviews

During 2015-16, the Joint Committee of Public Accounts and Audit (JCPAA) tabled one review that relates to the ANAO's audit of the Administration of the Fifth Community Pharmacy Agreement (5CPA) tabled on 5 March 2015.

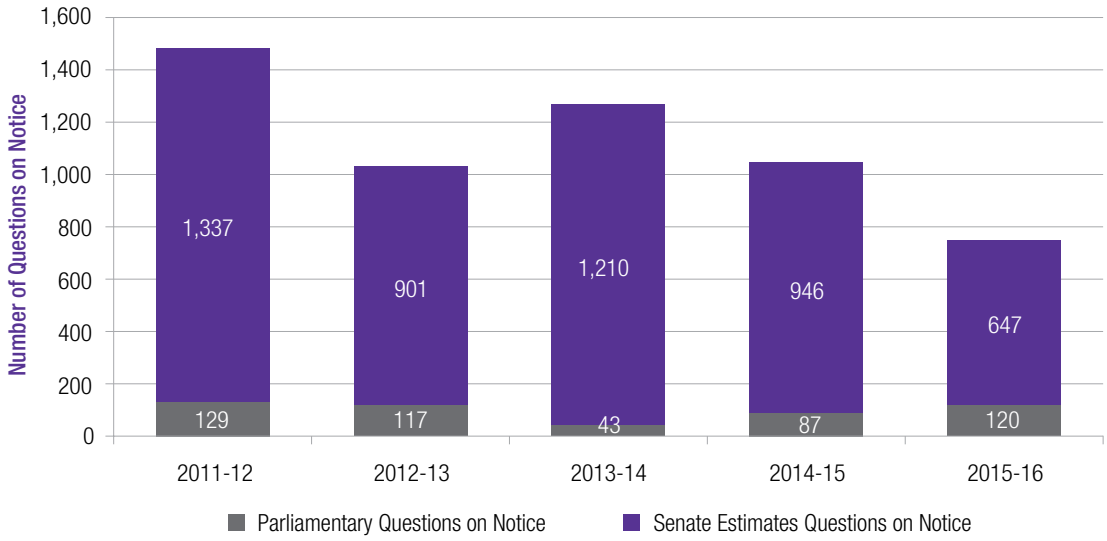
Audit:	Community Pharmacy Agreements Report 451, tabled 23 November 2015
Terms of reference:	The JCPAA resolved to review the ANAO's Audit Report No.25 (2014-15) Administration of the 5CPA.
Recommendations:	The JCPAA made three recommendations, requesting: • a progress and final report on the Department's review of remuneration and regulation of the Sixth Community Pharmacy Agreement (6CPA); • a report on the Department's final key performance indicators for the 6CPA; and • that the ANAO conduct a follow-up audit on the 6CPA.

Other parliamentary scrutiny

The Department appears before a number of parliamentary committees to answer questions about our administration of the health and ageing system.

During 2015-16, the Department received a total of 120 Parliamentary Questions on Notice from the House of Representatives and the Senate, and 647 Senate Estimates Questions on Notice.

Figure 3.2.1: 2011-12 to 2015-16 Questions on Notice



Attendance at Senate Estimates hearings

Senate Standing Committees on Community Affairs

The Department appeared before the Community Affairs Legislation Committee (Senate Estimates) on three occasions during 2015-16 for a total of five days.

- Supplementary Budget Estimates – 21 October 2015.
- Additional Budget Estimates – 10 February, 3 March and 16 March 2016.
- Budget Estimates – 6 May 2016.

Senate Standing Committees on Finance and Public Administration

The Department appeared before the Finance and Public Administration Legislation Committee on two occasions for a total of two days.

- Supplementary Budget Estimates – 23 October 2015.
- Additional Budget Estimates – 12 February 2016.

Parliamentary Committee inquiries

The Department provided evidence and/or submissions to Parliamentary Committee inquiries on the following occasions.

Senate Standing Committee on Community Affairs

Legislation Committee

- Social Services Legislation Amendment (No Jab, No Pay) Bill 2015.
- Inquiry into the Health Legislation Amendment (eHealth) Bill 2015.
- Health Insurance Amendment (Safety Net) Bill 2015.
- Inquiry into the Food Standards Australia New Zealand Amendment (Forum of Food Regulation and Other Measures) Bill 2015.
- Australian Radiation Protection and Nuclear Safety Amendment Bill 2015.
- Medical Research Future Fund Bill 2015 and Medical Research Future Fund (Consequential Amendments) Bill 2015.

References Committee

- Inquiry into the growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients.
- Inquiry into medical complaints process in Australia.
- Inquiry into the future of Australia's aged care sector workforce.

Senate Standing Committee on Economics

References Committee

- Inquiry into the third party certification of food.
- Inquiry into personal choice and community impacts.

Senate Standing Committee on Legal and Constitutional Affairs

References Committee

- Inquiry into the need for a nationally consistent approach to alcohol-fuelled violence.

Senate Select Committee on Health

The Department appeared before the Committee on five separate occasions during 2015-16: 10 July, 26 August, 8 October, 11 December 2015 and 3 February 2016.

Senate Select Committee on Unconventional Gas Mining

- Inquiry into the adequacy of Australia's legislative, regulatory and policy framework for unconventional gas mining including coal seam gas and shale gas mining.

Senate Standing Committee on Foreign Affairs, Defence and Trade

References Committee

- Inquiry into contamination caused by fire-fighting foams at RAAF Base Williamstown and other sites.

House of Representatives Standing Committee on Health

- Inquiry into chronic disease prevention and management in primary health care.

House of Representatives Standing Committee on Social Policy and Legal Affairs

- Inquiry into surrogacy.

House of Representatives Standing Committee on Agriculture and Industry

- Inquiry into agricultural innovation.

Parliamentary Joint Committee on Law Enforcement

- Inquiry into Crystal Methamphetamine.
- Inquiry into illicit tobacco.

Parliamentary Joint Standing Committee on Foreign Affairs, Defence and Trade

- Inquiry into the role of development partnership in agriculture and agribusiness in promoting prosperity, reducing poverty and enhancing stability in the Indo-Pacific region.

Judicial Decisions and Decisions of Administrative Appeals Tribunals

During 2015-16, the Department was involved in four matters in the High Court, two matters in the Full Federal Court, 11 matters in the Federal Court and 25 matters in the Administrative Appeals Tribunal. Two important decisions that affected the Department during 2015-16 are summarised below.

Judicial Decision

Commonwealth v Sanofi and Wyeth [2015] FCAFC 172

The Commonwealth is seeking compensation from two pharmaceutical companies arising from increased subsidies paid under the Pharmaceutical Benefits Scheme (PBS), when court injunctions stopped certain generic drugs being listed on the PBS during patent proceedings. The companies had given undertakings to the court to pay damages to anyone affected by the injunctions if the patents were found to be invalid, which they ultimately were. However, the companies argued the Commonwealth could not claim under the undertakings because of provisions in the *Therapeutic Goods Act 1989.* The Full Federal Court disagreed and leave to appeal to the High Court was refused, removing a potential barrier to the Commonwealth's cases.

International Body Decision

PCA Case No. 2012-12 Philip Morris Asia Limited (Hong Kong) v The Commonwealth of Australia

In 2011, Philip Morris Asia (PM Asia) initiated arbitration against Australia under the Australia-Hong Kong Bilateral Investment Treaty (BIT) challenging Australia's tobacco plain packaging measures. PM Asia claimed that Australia's measures amounted to a deliberate destruction of its highly valuable portfolio of brands by arbitrary government action, which would permanently damage its investment in Australia. The Tribunal arbitrating the proceedings bifurcated (split) the proceedings into a preliminary jurisdictional phase and subsequent merits phase.

On 18 December 2015, the Tribunal arbitrating the proceedings handed down its decision, unanimously finding that it lacked jurisdiction to hear PM Asia's claim. On 17 May 2016, the Tribunal published its reasons for the decision, finding that PM Asia's claim was an abuse of process because PM Asia acquired an Australian subsidiary, Philip Morris (Australia) Limited, for the purpose of initiating arbitration under the BIT. Because Australia was successful in arguing that PM Asia's claims were outside the jurisdiction of the Tribunal, the Tribunal did not consider the merits of PM Asia's claims.

Freedom of Information

The Information Publication Scheme requires all entities subject to the *Freedom of Information Act 1982* (FOI Act), under Part II, to publish information about what is available to the public. The Department's plan showing the information published in accordance with this Act can be found at: www.health.gov.au/internet/main/publishing.nsf/Content/foi-doh-pub-scheme-agency-plan

In 2015-16, the Department received 272 FOI requests.

Documents that the Department has released in response to FOI requests during 2015-16 can be found on the Disclosure Log at: www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2015-16

Decisions of the Australian Information Commissioner

All requests finalised in 2015-16 by the Australian Information Commissioner (AIC) for reviews of departmental decisions were concluded by either the AIC exercising discretion under s54W of the FOI Act to cease the review, or the applicant withdrawing their application.

Reports on the operations of the Department by the Commonwealth Ombudsman

The Department continues to liaise with the Commonwealth Ombudsman on complaints relating to aspects of the Department's administrative activities.

Anyone with concerns about the Department's actions or decision-making is entitled to make a complaint with the Commonwealth Ombudsman to determine whether the Department was wrong, unjust, discriminatory or unfair. Further information on the role of the Commonwealth Ombudsman is available at: www.ombudsman.gov.au

During 2015-16, the Commonwealth Ombudsman investigated ten complaints against the Department's administrative practices. Three of the ten complaints investigations were concluded as at 30 June 2016. None of the concluded complaints investigations resulted in a finding of administration deficiency. No investigations were carried over from 2014-15.

The Commonwealth Ombudsman's Office did not release any reports regarding the Department during 2015-16.

Reporting Requirements under section 108 of the *Tobacco Plain Packaging Act 2011*

The Department pursuant to section 108 of the *Tobacco Plain Packaging Act 2011* (the Act) reports that 210 potential contraventions of the Act were investigated in 2015-16. The majority of these matters were continuing investigations from the previous year. In 2015-16, one infringement notice and 60 warning letters were issued. The failure of one supplier to take appropriate action following the receipt of a warning letter resulted in the infringement notice being issued.

A copy of this report has been provided to the Minister for Health.

3.3 Financial Management

27 new contracts with Indigenous enterprises compared to ten in 2014-15

510 contracts with Small Business Enterprises compared to 430 contracts in 2014-15 and 459 contracts in 2013-14

Financial accountability responsibilities

The Department's financial accountability responsibilities are set out in the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). These responsibilities form the basis of transparent processes for efficient, effective, economical and ethical use of Commonwealth resources and related policies. The Department's activities during 2015-16 aligned with the financial framework and ensured the efficient processing and recording of financial transactions, including the production of audited financial statements.

The reporting and analysis of financial information for each outcome supports the enhanced Commonwealth performance framework under the PGPA Act. The complete set of financial statements for the Department is provided in Part 4: *Financial Statements*. Refer *Chief Operating Officer's Report* for an overview of the Department's financial results for 2015-16.

The Department's Finance and Resources Committee provides advice and makes recommendations to the Executive Committee on financial management, and oversees the development and implementation of the Department's ICT projects and other strategically significant projects. Further detail on the Department's governance committees is provided in Part 3.1: *Corporate Governance*.

This section provides information on how the Department managed its financial management obligations during 2015-16.

Asset management

The Department holds financial and non-financial assets. Financial assets include cash and receivables, which are subject to strong controls and reconciliations. The non-financial asset base consists primarily of computing software and hardware, building fit-out, and furniture and fittings. The non-financial asset portfolio is small in comparison with the Department's operating budget.

The Department's asset management strategy encompasses whole-of-life asset management including planning, capital budgeting, acquisition, accounting, management and disposal. Decisions about asset management are undertaken in the context of broader departmental strategic planning to ensure investment in assets supports the achievement of the Department's outcomes.

Discussion relating to the assets administered by the Department in 2015-16 can be found in Part 4: *Financial Statements*.

To support effective management of the Department's assets, several key processes are in operation:

- funding for significant new assets including property fit-out and computing applications is considered by the Department's Finance and Resources Committee;
- stocktakes of physical assets are undertaken regularly; and
- a review of the useful lives and ongoing operation of assets is undertaken annually.

Consultants

The Department engages consultants when specialist expertise or independent research, review or assessment are required. Consultants are typically engaged to:

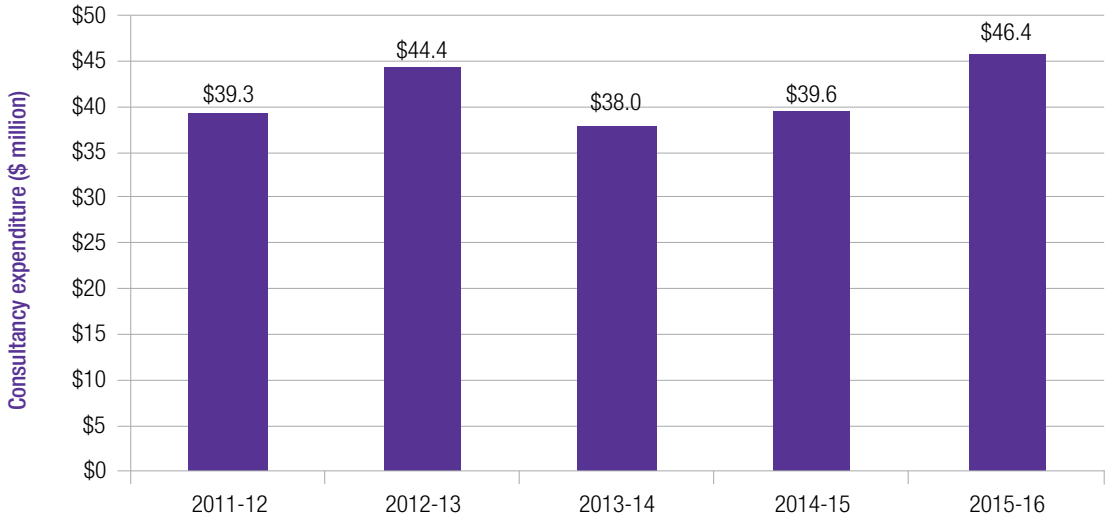
- investigate or diagnose a defined issue or problem;
- carry out defined reviews or evaluations; or
- provide independent advice, information or creative solutions to assist in the Department's decision-making.

Prior to engaging consultants, the Department takes into account the skills and resources required for the task, the skills available internally and the cost-effectiveness of engaging external expertise.

Decisions to engage consultants are made in accordance with the PGPA Act and related regulations including the Commonwealth Procurement Rules and other internal policies.

During 2015-16, 421 new consultancy contracts were entered into involving total actual expenditure of $22.6 million. In addition, 327 ongoing consultancy contracts were active during 2015-16 involving total actual expenditure of $23.8 million.

Figure 3.3.1: Comparison of consultancy expenditure between 2011-12 and 2015-16



The increase in consultancy expenditure in 2015-16 can be attributed to the following functions being transferred to the Department from 5 November 2015 as a result of Machinery of Government changes:

- Ageing and Aged Care from the Department of Social Services; and
- Medicare Provider Compliance for the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, and allied health services from the Department of Human Services.

Annual reports contain information about actual expenditure on contracts for consultancies. Information on the value of contracts and consultancies is available on the AusTender website at www.tenders.gov.au

Grants

Information on grants awarded by the Department during the period 1 July 2015 to 30 June 2016 is available at: www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting

Procurement

Purchasing

The Department's approach to procurement is drawn from the core principles of the Commonwealth's financial framework, which encourages competition, value for money, transparency and accountability as well as the efficient, effective, ethical and economical use of Commonwealth resources. The Department complied with the purchasing policies in the Commonwealth Procurement Rules, with the exception of those instances reported in the Department's 2015-16 Compliance Report, such as non-compliance with AusTender reporting requirements and the correct procurement method.

The Department is currently revising its processes to ensure improved compliance with the Commonwealth Procurement Rules. This includes updating training material to ensure it meets departmental objectives.

Australian National Audit Office access clauses

In 2015-16, no contracts were exempt from the standard clauses granting the Auditor-General access to contractor premises.

Exempt contracts

In 2015-16, 207 contracts were exempt from reporting on AusTender on the basis that publishing contract details would disclose exempt matters under the *Freedom of Information Act 1982*. The increase of 200 contracts compared to 2014-15 figures is due to the inclusion of contracts entered into by the Therapeutic Goods Administration, which had previously been excluded.

Procurement initiatives to support small business

The Department supports small business participation in the Commonwealth Government procurement market. Small and Medium Enterprises (SME) and Small Enterprise participation statistics are available on the Department of Finance's website: www.finance.gov.au/procurement/statistics-on-commonwealth-purchasing-contracts/

The Department's measures to support SMEs include:

- implementation of the Indigenous Procurement Policy (IPP), which supports supplier diversity to create opportunities for Indigenous businesses to grow and employ more people, noting that the Indigenous business sector is dominated by SMEs;
- Small Business Engagement Principles clearly communicated in simple language and in an accessible format as outlined in the Government's Industry Innovation & Competitiveness Agenda;
- use of the Commonwealth Contracting Suite (CCS) implemented by the Department of Finance, which is designed to minimise the burden on businesses contracting with the Commonwealth Government; and
- internal guidance and advice providing end users with information relating to the IPP, Small Business Engagement Principles and the CCS.

The Department recognises the importance of ensuring that small businesses are paid on time. The results of the Survey of Australian Government Payments to Small Business are available on the Department of the Treasury's website: www.treasury.gov.au

Indigenous procurement policy

The Department also continues to be a Supply Nation member, supporting Supply Nation-listed Indigenous enterprises to achieve success and build vital businesses. The Department has entered into new contracts with Indigenous enterprises and receives Supply Nation self-reports regarding purchases and contracts with their listed suppliers. In 2015-16, the Department entered into 27 new contracts with Indigenous enterprises at a total value of $3.5 million compared to ten contracts valued at $630,000 entered into during 2014-15. For further information on Indigenous enterprises refer to: www.dpmc.gov.au/indigenous-affairs/economic-development/indigenous-procurement-policy-ipp

The Department is currently undertaking a series of workshops to develop an IPP Strategy to meet and exceed our targets, and it will be finalised following the endorsement of the Department's Reconciliation Action Plan. Refer Part 3.4 *People Management* for details of the Reconciliation Plan.

3.4 People Management

21 Indigenous trainees – an increase of 19 trainees in the Indigenous Entry Level Program from 2014-15

Additional 698 training places, representing an increase of 29% from 2014-15

Developed the People Strategy 2016–20 with an emphasis on better quality workforce data as an integral part of workforce planning

People Strategy

The Department has developed a new People Strategy 2016–20 (Strategy) to replace the People Strategy 2010–15. In developing the Strategy, the Department considered both recent organisational reviews and conducted extensive staff consultation.

We will foster leadership through all levels and invest in a capable, agile and productive workforce, supported through the Department's People Strategy 2016–20.

The new Strategy, endorsed by the Executive Committee on 29 June 2016, has four areas of focus:

- **Managing workforce composition and agility** – Evidence-based planning decisions will ensure our workforce meets the needs of the Department, remaining flexible and adaptable, by attracting and retaining the right people.
- **Building the right capability** – People are supported to drive their own capability development through role clarity, effective performance feedback, and flexibility in making arrangements.
- **Continuing to improve our leadership and culture** – We promote a culture where everyone understands how their work contributes to the strategic direction; where high performance is enabled, risk is engaged with, and diversity and innovation are respected and celebrated.
- **Investing in career and succession** – We actively plan for the succession of critical roles, promoting career development through innovative pathways, collaboration and sharing of professional expertise.

Managing performance

The Department is committed to a culture of high performance and all staff engage in a formal Performance Development Scheme (PDS) process twice a year to discuss their achievements, work responsibility and development.

The Department is improving the process and systems that support staff to achieve the Department's, and their own, performance goals. Improvements during 2015-16 include:

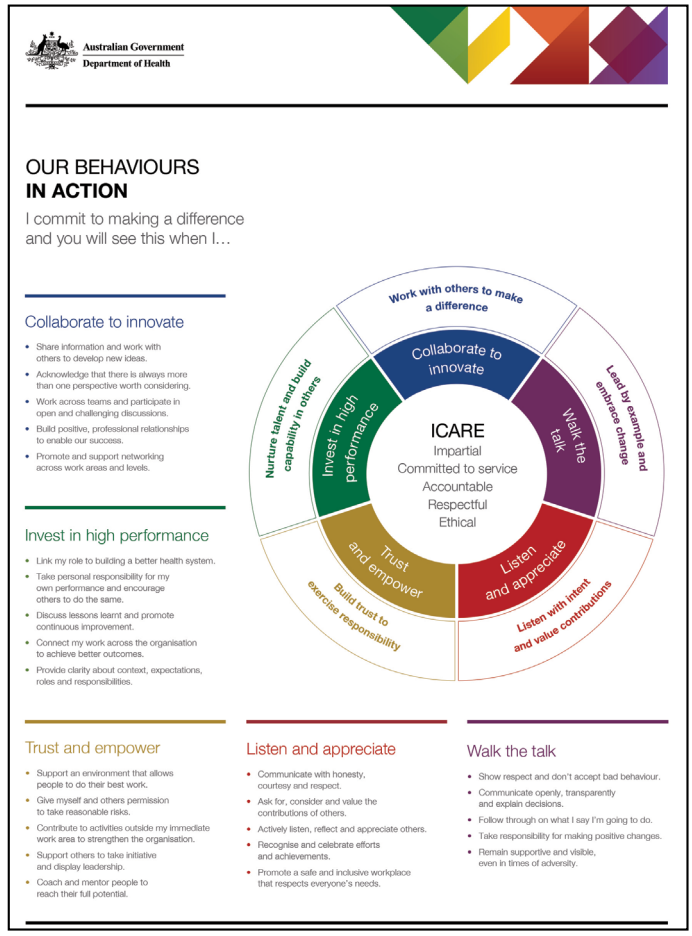
- enhancement of supporting IT systems;
- development of performance conversation tools and training; and
- implementation of targeted managing team performance training for supervisors.

The Department will continue to monitor and evaluate the impact of these initiatives, with new initiatives developed as the need is identified.

Creating a culture of high performance and an environment that provides both job satisfaction and opportunities for career growth are a continuing focus for the Department. Investing in high performance is central to the Department's *Our Behaviours in Action* principles, with nurturing talent and building capability fundamental to this investment.

The five key leadership behaviours are:

- collaborate to innovate;
- invest in high performance;
- trust and empower;
- listen and appreciate; and
- walk the talk.



Workforce inclusivity

The Department is committed to building an inclusive culture and to acknowledging and celebrating the diversity and differences of all staff. We appreciate how these differences contribute to our capacity to deliver health outcomes.

In 2015-16, the Department continued to undertake a number of projects to promote an inclusive workplace, including:

- Aboriginal and Torres Strait Islander workforce initiatives;
- the development of a Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Workforce Action Plan; and
- a rewrite of the Accessibility Action Plan.[84]

The Department undertook a comprehensive consultation approach to ensure these plans are reflective of staff views.

The Department also held three Multicultural Forums in July 2015, December 2015 and June 2016. These forums are an opportunity for staff to have a say on issues such as retention of multicultural staff, and to hear from senior staff in the Department who are from non-English speaking backgrounds. Staff who attended the forums noted their interest in:

- exploring mentoring;
- aged care in culturally and linguistically diverse communities; and
- intranet resources for managers and staff from multicultural backgrounds.

In May 2016, the Australian Public Service Commission (APSC) launched the *APS Gender Equality Strategy: Balancing the Future* (APS Strategy). The Department will continue to work with the APSC to align our work practices with the recommendations from the APS Strategy.

Reconciliation Action Plan

The Department is redeveloping its Reconciliation Action Plan to focus more on individual connection to reconciliation within the Department. We are also developing the following corporate strategies designed to improve the workplace experience for Aboriginal and Torres Strait Islander employees:

- Aboriginal and Torres Strait Islander Employment and Retention Strategy;
- Aboriginal and Torres Strait Islander Cultural Capability Strategy; and
- Aboriginal and Torres Strait Islander Procurement Strategy.

Our efforts will only see us gain ground if we at Health genuinely exercise a commitment to the principles of reconciliation, in our work and in our organisation. Reconciliation is a shared journey and we are committed to walk alongside each other embracing our diversity and together achieving our goal for a more inclusive Australia.

To increase engagement at all levels with Health's reconciliation journey, the Department held the inaugural Senior Executive Service (SES) Roundtable on Reconciliation and Respect, where the SES workshopped the Department's Statement of Commitment and Vision for Reconciliation that will be published in 2016-17. A key highlight of the SES Roundtable was to hear from Aboriginal and Torres Strait Islander staff about their experiences and the barriers they have faced in their working lives.

[84] Previously known as the Disability Workforce Action Plan. For further information on the Accessibility Action Plan, refer Part 3.7: *Addressing Disability and Carer Recognition.*

Supporting staff from Aboriginal and Torres Strait Islander backgrounds

During 2015-16, the Department increased its Indigenous Entry Level Program (IELP) participation across the APS and recruited 21 Indigenous trainees through the Department of Human Services Indigenous Apprenticeship Programme, the Shared Services Centre Indigenous Australian Government Programme and the APSC Indigenous Pathways Program.

During 2015-16, the Department also increased support to IELP participants including the delivery of Indigenous leadership and mentoring training, and the launch of BlakChat.

The Department is committed to building a **culturally safe workplace** and increasing our cultural capability. As part of this commitment, the Australian Indigenous Leadership Centre's BlakChat Cultural Advice Line, and face-to-face visits, have been made available for all departmental staff.

BlakChat aims to deliver practical culturally appropriate solutions to build employer cultural capability to engage effectively with Aboriginal and Torres Strait Islander staff members and communities.

The service is a new initiative and over time will provide practical **solutions** to building retention initiatives and improving the Department's appreciation and understanding of Aboriginal and Torres Strait Islander cultures.

Email: BlakChat@ailc.org.au
Freecall: 1800927643 or 1800YARN43

The Department has an active National Aboriginal and Torres Strait Islander Staff Network, and associate memberships are available for non-Indigenous staff in the Friends of the Network. Associate members support the Network in delivering major cultural events including National Reconciliation Week and National Aborigines and Islanders Day Observance Committee (NAIDOC) Week events and promote reconciliation in the Department. The Network also has the support of three Senior Executive Champions, who actively advocate on behalf of Aboriginal and Torres Strait Islander staff, chair key governance committees, attend and support cultural activities and celebrations, as well as representing the Department in external forums.

Senior Executive Champion, Wendy Southern's pledge:

I pledge that as the Department's Aboriginal and/or Torres Strait Islander Champion, as a Deputy Secretary responsible for the Indigenous Health Division and as a member of the Executive, to work with others right across the Department and in other entities to ensure that when we develop and implement health priorities in Australia we recognise and act upon the health needs of Aboriginal and/or Torres Strait Islander peoples, so that we can Close the Gap.

During the year, the Department recognised days of significance for Aboriginal and Torres Strait Islander peoples, including National Apology Day, National Reconciliation Week and NAIDOC Week. Highlights of the Department's NAIDOC Week celebrations included:

- the annual Secretary's NAIDOC Week Awards;
- a cultural activity where staff learnt about traditional art symbols and their meanings;
- the annual NAIDOC Cook-up Competition;
- film screenings; and
- poetry workshops.

Staff participation and engagement in activities in 2015-16 has raised awareness and appreciation of Aboriginal and Torres Strait Islander cultures.

Supporting lesbian, gay, bisexual, transgender and intersex (LGBTI) staff

Two Senior Executive Pride Champions, who actively participate in and raise awareness of Health Pride events, support the Department's Health Pride Network for LGBTI staff and their allies.

On 28 August 2015, we celebrated Wear It Purple Day, which aims to raise awareness of the challenges faced by LGBTI youth and the need to eradicate bullying based on sexuality and gender diversity. Staff were invited to a forum with guest speakers from *headspace*, Safe Schools Coalition ACT, ACT Sexual Health and Family Planning.

On 20 November 2015, we acknowledged International Transgender Awareness Week, which celebrates diversity and aims to educate and broaden the understanding of gender non-conforming people and the issues they face.

On 17 May 2016, we celebrated the International Day Against Homophobia, Biphobia and Transphobia. To recognise this year's theme of 'mental health and wellbeing' we welcomed staff to hear from speakers from TranzAustralia and the AIDS Action Council who discussed mental health in the LGBTI community.

The Department is an ongoing member of Pride in Diversity, a member based organisation that supports the Department to meet its responsibilities to staff, by assisting them to conduct training and awareness sessions for all staff. The Department will work closely with Pride in Diversity to conceptualise its LGBTI workforce action plan, which will formalise the ways in which the Department supports its LGBTI staff and makes the workplace inclusive and equitable. In addition to consulting with Pride in Diversity, the Department will seek input from all staff through focus groups and network participation.

Championing diversity

The Department is committed to reflecting the diversity of the Australian community in its workforce to build an inclusive culture. The Department acknowledges the differences in every employee and acknowledges that diversity in our backgrounds, skills, talents and views enrich our working environment and quality of work.

Champions have a range of roles including the promotion of diversity in the workplace, raising awareness and understanding, and educating colleagues within their areas and across the Department. They are available to meet with staff networks and individuals to support their work, and advocate where required in relation to diversity issues.

Champions also ensure there is a strong awareness and consideration of diversity and inclusion across the Senior Executive to ensure its importance, impact and value is recognised across the Department.

As part of this commitment, a number of SES officers have volunteered to undertake the role of Diversity Champions and Champions of our staff networks including the Staff with Disability Network, the Health Pride Network and the National Aboriginal and Torres Strait Islander Staff Network.

Recognising staff

The Department recognises and rewards individual, team or entity performance and achievements that contribute to a productive workplace. The benefits include:

- greater job satisfaction;
- increased staff motivation;
- increased creativity and productivity; and
- improved attraction and retention rates.

The Department actively participates in the Australia Day Achievement Awards, offered by the National Australia Day Council. The awards aim to promote a sense of national pride, and a commitment to our country and its future among all Australians. In 2016, eight individual and 13 team awards were presented across the Department.

2016 Australia Day Award winner: relationships

Kassmena Birch, Acting Assistant Manager

Kassmena Birch was awarded the 2016 Australia Day Award in the relationships category after representing the Department at a Prime Ministerial visit to the Torres Strait and Northern Peninsula Region in 2015.

Over the three-week trip, Kassmena demonstrated her resilience, responsiveness and ability to work collaboratively in a team under high pressure. Organising and managing over 15 stakeholder meetings across various remote locations, her excellent work was acknowledged by our Ministers, our Secretary – Martin Bowles (pictured), and the Department of the Prime Minister and Cabinet senior officials.

Employment arrangements in the Department

The Department's practices for making employment arrangements with its staff are consistent with the requirements of the Workplace Bargaining Policy 2015 (the 'Bargaining Policy') and the *Fair Work Act 2009*. The types and main features of employment arrangements either in operation or available to departmental staff during 2015-16 are outlined below.

Enterprise Agreement

The terms and conditions of employment for non-SES staff are provided through the Department's Enterprise Agreement 2016–2019, which began on 3 February 2016 and will nominally expire on 26 January 2019.

The Agreement contains an individual flexibility arrangement term, which enables the Department to vary the operation of specified terms and conditions provided under the Agreement for individual non-SES staff where necessary and appropriate. Refer Part 3.5: *Staffing Information* for details of the non-salary benefits and individual agreements provided to non-SES staff.

Individual determinations under the *Public Service Act 1999*

Comprehensive terms and conditions of employment for new departmental SES staff are provided via individual determinations made under section 24(1) of the *Public Service Act 1999*. The determinations are made following negotiations between the staff member and the Department. Refer Part 3.5: *Staffing Information* for more information on individual determinations for SES staff and equivalents.

Australian Workplace Agreements

The Department does not have any Australian Workplace Agreements in place.

Common law contracts

The Department does not generally use common law contracts. However, they may be used where necessary to establish and/or supplement conditions and entitlements.

Remuneration for senior officials

The Department maintained a remuneration position consistent with equivalent public sector entities during 2015-16. Base salaries and inclusions, such as the allowance paid in lieu of a motor vehicle, complied with Government policy and guidelines. Individual salaries are negotiated on commencement and reviewed annually by the Department's Executive Committee. Total remuneration for SES staff may have included non-monetary inclusions or reimbursements for mobile phones and laptops/tablets. For further details on remuneration for SES staff, refer Part 3.5: *Staffing Information*.

Performance pay

From 1 July 2014, the Department undertook a process to remove access to performance pay for all staff in receipt of the payment (including SES staff) and no longer offers performance pay to new staff. For further details on existing performance payments for non-SES staff, refer Part 3.5: *Staffing Information*.

Learning and development

The Department has developed a new Learning and Development Strategy 2016–2019 (Strategy) that includes three Strategic Priorities:

- Core Skills;
- Professional Capabilities and Corporate Knowledge; and
- Leadership, Culture and Talent.

The aim of the Strategy is to create a diverse learning environment that builds a capable workforce to achieve departmental outcomes. The Strategy also identifies a number of key drivers and learning principles, recognising the different influences, learning methods and future staff challenges the Department faces.

In 2015-16, the Department delivered a number of new learning and development initiatives including a monthly induction package, stakeholder engagement, mentoring and coaching programs. The monthly face-to-face induction presentation started in late February 2016 and has now been delivered to over 200 new starters. The Stakeholder Engagement Program has been delivered in capital city offices, and was attended by over 230 staff.

The Department remains committed to the expansion of evidence-based learning and development activities that address areas of business need. In early 2016, a departmental wide Capability Needs Analysis was conducted with the goal of gaining a deeper understanding of the capability gaps and barriers across the Department in order to better address development needs and priorities.

The Department continued to deliver essential corporate training using the APSC fundamental programs. In total, 3,086 training places were filled by staff across the following subject areas:

- 1,016 staff members attended information technology training; and
- 434 staff members attended writing and communications skills training.

Online learning programs were accessed 4,567 times by staff during 2015-16, encompassing subjects such as fraud awareness; APS Values; cultural awareness; work health and safety; financial management; and knowledge management.

The Department continued to build leadership and management capability of staff during 2015-16. The existing Middle Manager Development Programs for APS, EL1 and EL2 staff were redesigned to reflect the development of *Our Behaviours in Action*. The programs were also offered in the Department's Sydney and Melbourne offices for the first time to support the development of managers outside of Canberra. The programs continue to be positively evaluated and valued by participants as an important capability development opportunity.

In addition, a number of new leadership development initiatives were piloted including coaching, mentoring and change programs. A training catalogue to build diversity competence and awareness was also developed. These initiatives were positively received and will continue in 2016-17.

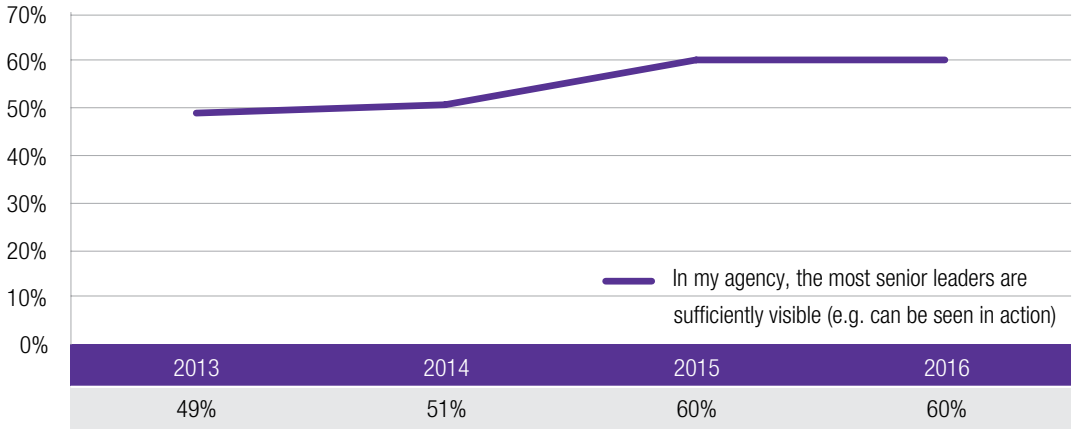
The Department also increased its obligation to developing the leadership capability of SES staff. SES staff participated in 360 degree feedback and new SES Development Guidelines were launched. SES staff were also supported by an expanded range of capability development options including learning circles for SES Band 1 and SES Band 2 staff, and short lunchtime sessions on key topics.

Staff Survey

The Staff Survey (APS State of the Service Employee Census) continues to provide valuable insight into staff views. Seventy-four per cent of staff participated in the Survey between 9 May and 10 June 2016, compared to 73 per cent in 2015.

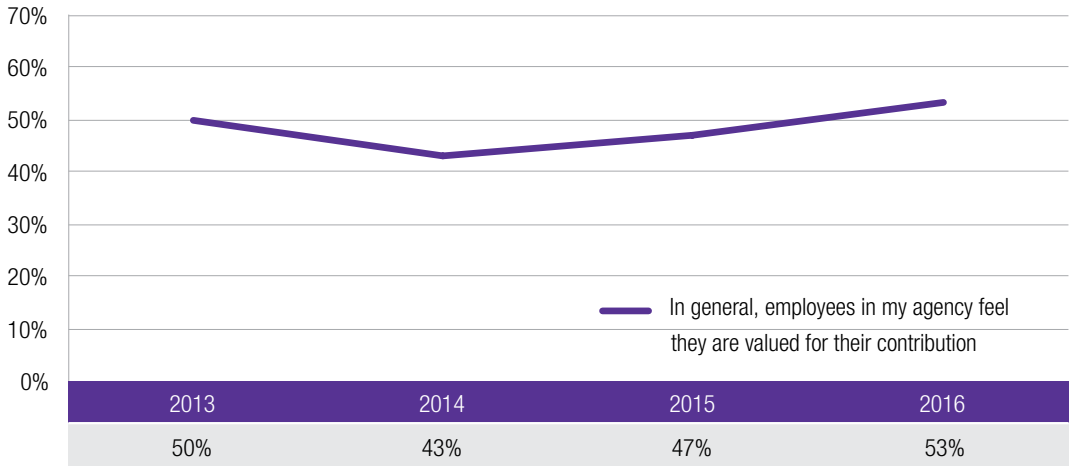
The Department's average staff engagement results (job, team, supervisor and agency) increased in 2016, with a score of 6.8 compared with an APS average of 6.6 out of 10. Overall, staff's perceptions of senior leadership are significantly above the APS average for quality (12 per cent above), visibility (12 per cent above), communication (13 per cent above) and acting in accordance with the APS Values (8 per cent above) (Refer Figure 3.4.1).

Figure 3.4.1: Visibility of Senior Leaders – percentage comparison between 2013 and 2016



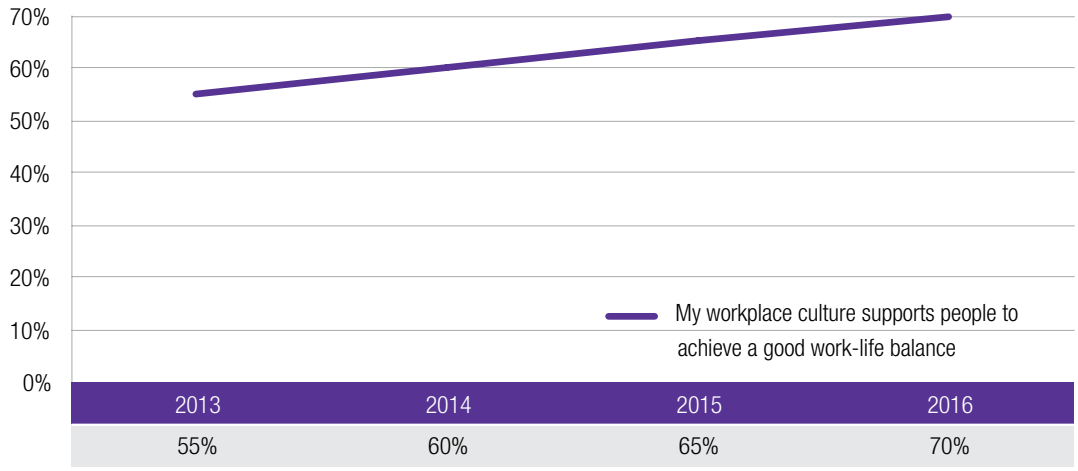
The Staff Survey results show the Department's leadership and culture continues to improve, and is well placed to achieve its objectives and meet future challenges.

Figure 3.4.2: Staff feeling valued for their contribution – percentage comparison between 2013 and 2016



Compared to the 2015 survey results, more staff are satisfied with the recognition they receive for doing a good job (five per cent increase from 2015) and feel valued for their contribution (six per cent increase from 2015) (Refer Figure 3.4.2). More staff also agree that people in the Department are expected to admit to mistakes and learn from them (6 per cent increase from 2015).

Figure 3.4.3: Work-life balance – percentage comparison between 2013 and 2016



Ethical standards

During 2015-16, the Department continued its commitment to ensuring the highest ethical standards. This included the provision of a range of behavioural and ethical education and training opportunities aimed at embedding staff knowledge and understanding of their responsibilities, and emphasising the workplace behaviours expected of all staff.

The Department takes all alleged breaches of the APS Code of Conduct seriously and manages these in accordance with best practice. The majority of complaints received were handled through local management action or preliminary investigation. The Department finalised eight Code of Conduct investigations during 2015-16 resulting in seven breaches of the APS Code of Conduct being determined.

Productivity gains

In accordance with the Government's Workplace Bargaining Policy 2015, the salary increases delivered to staff by the Department's new Enterprise Agreement (EA) are funded by a range of productivity improvements. While the majority of savings are achieved through corporate initiatives, such as property and ICT efficiencies, the EA does deliver productivity improvements through the streamlining of content and removal of restrictive and/or inefficient work practices. This includes changes to the operation of the Department's peak consultative body, the National Staff Participation Forum, which has resulted in the Department being able to update key employment guidelines and policies in a more efficient manner, while maintaining the key principle of consultation with staff regarding potential changes to their terms and conditions of employment.

3.5 Staffing Information

108 staff identified as Aboriginal and Torres Strait Islander people representing 2.1% of our total workforce

20.5% increase in female Senior Executive Service staff compared to 2014-15

Our workforce

The Department values its staff, and continues to prioritise developing and maintaining high performing leadership, culture and capability. In 2015-16, we developed a People Strategy identifying four focus areas:

- managing workforce composition and agility;
- building the right capability;
- continuing to improve our leadership and culture; and
- investing in career and succession.

Refer Part 3.4: *People Management* for more information on the Department's People Strategy 2016–20.

The following section provides details on workforce demographics, such as staff numbers, locations, and aggregate information on salary, performance pay and non-salary benefits provided to staff during 2015-16.

Staffing

As at 30 June 2016, the Department employed 5,037 staff, 21 per cent on a part-time basis. This figure compares with 3,598 as at 30 June 2015, and includes employees on leave and secondment.

Of the total 5,037 employees, 4,620 were ongoing and 417 were non-ongoing (Refer Table 3.5.1).

The following functions were transferred to the Department from 5 November 2015 as a result of Machinery of Government changes:

- Ageing and Aged Care from Department of Social Services; and
- Medicare Provider Compliance for the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, and allied health services, from the Department of Human Services.

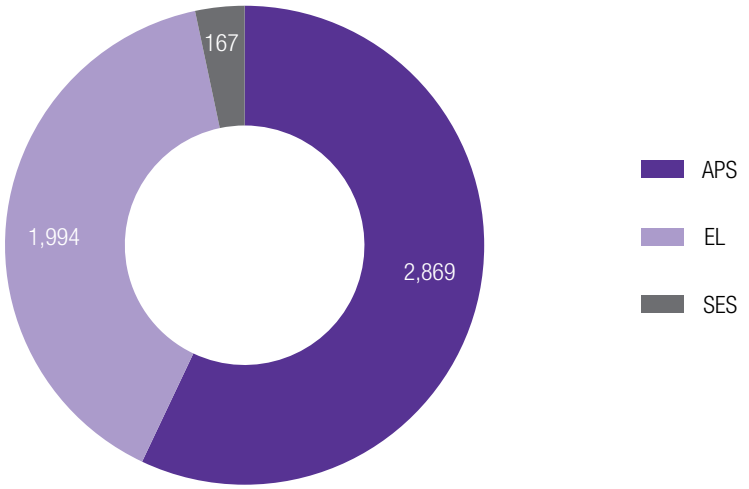
Staffing retention

The ongoing employee retention rate in 2015-16 was 88 per cent. This is a decrease from 91 per cent in 2014-15.

Staff turnover

The ongoing staff turnover rate in 2015-16 was 12 per cent, an increase from 9 per cent in 2014-15. The increase in staff turnover rate was due to the recruitment controls in place across the Australian Public Service (APS) during 2014-15 being lifted in 2015-16, which in turn increased the mobility of staff between agencies.

Figure 3.5.1: Staff profile as at 30 June 2016[85]



[85] Excludes the Secretary, Holder of Public Office and the Chief Medical Officer. Senior Executive Service (SES) staff and equivalent comprise SES Band 1-3 and Medical Officers 5-6. Executive Level (EL) staff and equivalent comprise EL 1-2, Medical Officers 2-4, Legal 1-2, Public Affairs 3, Senior Principal Research Scientist and Principal Research Scientist.

Figure 3.5.2: Comparison of gender profile at 30 June 2016[86]

Table 3.5.1: Staff numbers by classification at 30 June 2016

Classification	Female		Male		2015-16 Total	2014-15 Total
	Full-time	Part-time	Full-time	Part-time		
Secretary	-	-	1	-	1	1
Holder of Public Office	2	-	3	-	5	2
Senior Executive Band 3	2	-	5	-	7	6
Senior Executive Band 2	17	-	13	-	30	24
Senior Executive Band 1	66	3	38	-	107	95
Executive Level 2	271	54	232	8	565	491
Executive Level 1	578	288	428	33	1,327	954
APS 6	765	309	332	23	1,429	907
APS 5	415	117	179	15	726	468
APS 4	288	80	86	6	460	329
APS 3	59	24	27	7	117	110
APS 2	15	14	11	17	57	40
APS 1	1	3	6	3	13	12

[86] Excludes the Secretary, Holder of Public Office and the Chief Medical Officer, Senior Executive Service (SES) staff equivalent comprise SES Band 1-3 and Medical Officers 5-6. Executive Level (EL) staff and equivalent comprise EL 1-2, Medical Officers 2-4, Legal 1-2, Public Affairs 3, Senior Principal Research Scientist and Principal Research Scientist.

Table 3.5.1 continued

Classification	Female		Male		2015-16 Total	2014-15 Total
	Full-time	Part-time	Full-time	Part-time		
Health Entry-Level Broadband	33	-	19	-	52	40
Legal 2	12	4	6	2	24	25
Legal 1	7	4	9	-	20	17
Chief Medical Officer	-	-	1	-	1	1
Principal Medical Consultant	-	-	-	-	-	1
Medical Officer 6	1	1	3	2	7	6
Medical Officer 5	8	-	6	2	16	16
Medical Officer 4	4	4	10	1	19	17
Medical Officer 3	6	9	8	6	29	8
Medical Officer 2	6	4	1	1	12	17
Public Affairs 3	4	2	1	-	7	7
Public Affairs 2	1	-	1	-	2	-
Professional 1	1	-	-	-	1	1
Senior Principal Research Scientist	-	-	1	1	2	2
Principal Research Scientist	-	-	1	-	1	1
Department total	2,562	920	1,428	127	5,037	3,598

This table includes:

- head count figures of departmental staff as at 30 June 2016; and
- staff on leave and secondment.

Note: The majority of the 2015-16 increase in staffing numbers from 2014-15 can be attributed to the 2015 Machinery of Government changes.

Table 3.5.2: Comparison of Indigenous staff by employment status between 30 June 2015 and 30 June 2016

Employment Status	Indigenous Staff	
	30 June 2015	30 June 2016
Ongoing	58	102
Non-ongoing	6	6
Total Indigenous staff	64	108
Percentage of Indigenous staff in the Department	1.8%	2.1%

Table 3.5.3: Distribution of staff at 30 June 2016

Unit	Female		Male		Total
	Ongoing	Non-ongoing	Ongoing	Non-ongoing	
Access, Quality and Compliance	98	16	42	4	160
Aged Care Complaints Commissioner	119	6	43	3	171
Aged Care Policy and Reform	45	1	33	1	80
Aged Care Reform Taskforce	26	-	8	-	34
Ageing and Aged Care Services	108	13	33	3	157
Delivery Strategy and Operations	258	15	66	7	346
Executive	30	-	10	1	41
Digital Health	32	4	15	2	53
Digital Payments Services Taskforce	15	1	5	-	21
Grant Services	273	7	85	4	369
Health Provider Compliance	198	5	128	6	337
Health Services	147	7	22	2	178
Health Systems Policy	114	7	46	2	169
Health Workforce	114	12	45	8	179
Indigenous Health	87	3	30	-	120
Information Technology	86	4	92	1	183

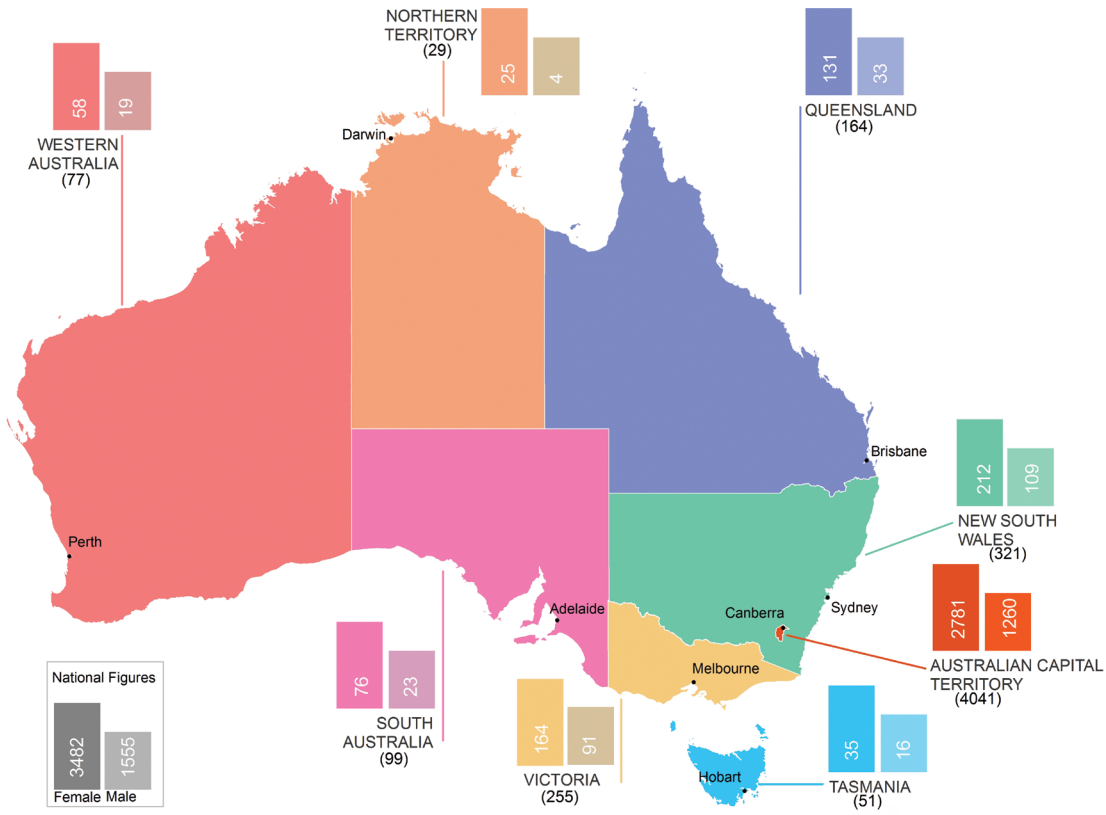
Table 3.5.3 continued

Unit	Female		Male		Total
	Ongoing	Non-ongoing	Ongoing	Non-ongoing	
Legal	28	3	12	-	43
Medical Benefits	152	19	73	6	250
Medical Devices Product Quality	150	9	90	6	255
Medicines Regulation	155	12	92	12	271
Office of Chemical Safety	59	5	30	1	95
Office of Drug Control	8	-	10	-	18
Office of Health Protection	97	5	27	3	132
Office of the Gene Technology Regulator	27	1	21	1	50
People, Capability and Communication	159	25	46	20	250
Pharmaceutical Benefits	132	32	59	11	234
Population Health and Sport	159	14	46	2	221
Portfolio Investment	157	42	91	28	318
Pricing Commissioner	2	3	-	-	5
Regulatory Practice and Support	110	7	80	-	197
Research Data and Evaluation	55	4	40	1	100
Department total	3,200	282	1,420	135	5,037

This table includes:

- head count figures of all staff by unit as at 30 June 2016, including staff on leave and secondment; and
- non-ongoing figures include casual staff.

Figure 3.5.3: Distribution of staff and gender by State and Territory at 30 June 2016



Note: These figures include the head count figures of all staff by State and Territory as at 30 June 2016, including staff on leave and secondment.

Table 3.5.4: Senior Executive Service staff and equivalent staff with Individual Agreements at 30 June 2016

	Number of staff with Approved Individual Agreements		
Nominal Classification	Female	Male	Total
Senior Executive Band 3	2	4	6
Senior Executive Band 2	15	10	25
Senior Executive Band 1	55	35	90
Chief Medical Officer	-	1	1
Medical Officer 6	2	4	6
Medical Officer 5	8	8	16

Table 3.5.5: Non-Senior Executive Service staff covered by Individual Flexibility Arrangements and Enterprise Agreement at 30 June 2016

Level	Number of staff covered by Enterprise Agreement
Non-Senior Executive Service staff	4,887[87]

Table 3.5.6: EL and APS levels salary structure

Classification	Salary ranges at 30 June 2016 $
Executive Level 2	136,453
	129,902
	125,705
	115,252
Executive Level 1	110,173
	105,813
	100,804
	96,599
APS 6	88,682
	86,740
	82,421
	78,608
APS 5	75,940
	72,130
	70,220
APS 4	69,222
	67,316
	65,514
APS 3	64,094
	61,187
	59,462
	57,825

[87] This includes 414 staff covered by Enterprise Agreement and an approved Individual Flexibility Arrangement.

Table 3.5.6 continued

Classification	Salary ranges at 30 June 2016 $
APS 2	54,604
	53,086
	51,539
	50,037
APS 1	48,083
	45,846
	44,327
	42,813
Staff at 20 years of age	38,961
Staff at 19 years of age	34,680
Staff at 18 years of age	29,970
Staff under 18 years of age	25,689

Table 3.5.7: Health Entry-Level Broadband

Local title	APS classification	Salary ranges at 30 June 2016 $
Health Entry-Level (T, I, A or G)	APS 4	69,222
		67,316
		65,514
Health Entry-Level (T, I, A, or G)	APS 3	64,094
		61,187
		59,462
		57,825
Health Entry-Level (T, I, A, or G)	APS 2	54,604
		53,086
		51,539
		50,037

Table 3.5.7 continued

Local title	APS classification	Salary ranges at 30 June 2016 $
Health Entry-Level (T, I, A, or G)	APS 1 (adult)	48,083
		45,846
		44,327
		42,813
	Staff at 20 years of age	38,961
	Staff at 19 years of age	34,680
	Staff at 18 years of age	29,970
	Staff under 18 years of age	25,689

Note:

- Trainees = (T)
- Indigenous Australian Government Development Program participants = (I)
- Indigenous Apprenticeship Programme = (A)
- Graduates = (G)

Table 3.5.8: Professional 1 salary structure

Local title	APS classification	Salary ranges at 30 June 2016 $
Professional 1	APS 5	75,940
	APS 5	72,130
	APS 4	67,316
	APS 4[88]	65,514
	APS 3[89]	61,187
	APS 3	59,462

[88] Salary on commencement for a professional with a four year degree (or higher).
[89] Salary on commencement for a professional with a three year degree.

Table 3.5.9: Medical Officer salary structure

Local title	Salary ranges at 30 June 2016 $
Medical Officer Class 4	163,905
	154,710
	148,909
Medical Officer Class 3	142,968
	136,548
Medical Officer Class 2	128,673
	122,121
Medical Officer Class 1	111,598
	101,097
	93,935
	86,712

Table 3.5.10: Legal salary structure

Local title	APS classification	Salary ranges at 30 June 2016 $
Legal 2	Executive Level 2	141,229
		135,099
		130,732
Legal 1	Executive Level 1	119,539
		110,046
		100,804
	APS 6	86,740
		82,421
		78,608
	APS 5	72,758
	APS 4	68,209

Table 3.5.11: Public Affairs salary structure

Local title	APS classification	Salary ranges at 30 June 2016 $
Senior Public Affairs 2	Executive Level 2	141,912
		136,396
Senior Public Affairs 1	Executive Level 2	129,902
Public Affairs 3	Executive Level 1	118,436
		112,691
		105,842
Public Affairs 2	APS 6	88,774
		82,421
		78,608
	APS 5	75,940
		72,130
	APS 4	69,222
	APS 4[90]	65,514

[90] This level is generally reserved for staff with less than two years' experience.

Table 3.5.12: Research Scientist salary structure

Local title	APS classification	Salary ranges at 30 June 2016 $
Senior Principal Research Scientist	Executive Level 2	173,295
		155,885
Principal Research Scientist	Executive Level 2	152,827
		148,090
		142,046
		138,301
		133,172
Senior Research Scientist	Executive Level 2	138,773
		129,902
		125,705
		115,252
Research Scientist	Executive Level 1	103,803
		96,599
	APS 6	82,573
		78,261
		76,133

Table 3.5.13: Senior Executive Service staff and Senior Medical Officer indicative salary bandwidths[91]

Classification	Minimum $	Maximum $
Senior Executive Band 3	270,000	330,000
Senior Executive Band 2	214,200	265,200
Senior Executive Band 1	165,240	204,000
Medical Officer Class 6	224,400	265,200
Medical Officer Class 5	195,840	224,400

[91] These are indicative as the Secretary may approve salary rates outside these bandwidths.

Table 3.5.14: Non-salary benefits

Non-Senior Executive Service staff
Access to engage in private medical practice for Medical Officers
Access to Individual Flexibility Arrangements (IFA)
Access to negotiated discount registration/membership fees to join a fitness or health club
Access to paid leave at half pay
Access to remote locality conditions
Access to the Employee Assistance Program
Additional cultural and ceremonial Aboriginal and Torres Strait Islander employee's leave
ADF Reserve, full-time service or cadet leave
Annual close down and early stand down at Easter and Christmas Eve
Annual influenza vaccinations for staff
Annual leave
Bereavement and compassionate leave
Breastfeeding facilities
Community service leave
Family care rooms
Financial assistance to access financial advice for staff 54 years and older
Flexible working locations and home-based work including, where appropriate, access to laptop computers, dial-in facilities, and mobile phones
Flextime (not all non-SES employees) and time in lieu
Hepatitis B vaccinations for staff who are required to come into regular contact with members of the community classified as at increased risk with regard to hepatitis B
Miscellaneous leave with or without pay, including leave for personal compelling reasons and exceptional circumstances

Table 3.5.14 continued

Non-Senior Executive Service staff
Parental leave - includes maternity, adoption and partner leave
Personal/carers leave
Provision of eyesight testing and reimbursement of prescribed eyewear costs specifically for use with screen based equipment
Public Transport Loan Scheme
Purchased and extended purchased leave
Recognition of travel time
Reflection room
Study assistance
Support for professional and personal development
Senior Executive Service staff
All the benefits of non-SES staff except flextime
Airport lounge membership
Car parking
IT Reimbursement Scheme
Motor vehicle allowance or private use of motor vehicle

Table 3.5.15: Non-Senior Executive Service staff, performance payments, 1 July 2015 to 30 June 2016

Level	Number	Aggregated amount $	Average $	Minimum $	Maximum $
Non-Senior Executive Service staff	13	44,906	3,454	552	10,272

This table includes figures of non-Senior Executive Service staff who received performance pay. Payments have been aggregated to preserve employees' privacy. The majority of performance payments made in 2015-16 relate to assessments for the 2014-15 cycle. A small number relate to assessments for the 2015-16 cycle. Performance bonus payments paid in 2015-16 relates to staff entitlements covered under section 72, of the *Public Service Act 1999* Machinery of Government moves from the former Department of Regional Australian, Local Government, Arts and Sports.

From 1 July 2014, the Department removed access to performance pay for all staff (including Senior Executive Service staff).

3.6 Work Health and Safety

21% workers' compensation premium reduction when compared to Commonwealth average of 7%. This follows a 42% reduction in 2014-15

87 staff have received assistance to return to work/ remain at work under the Early Intervention policy

848 ergonomic assessments were conducted between September 2015 and June 2016

Improving work health and safety (WHS) in the workplace

The Department acknowledges its responsibilities under the *Work Health and Safety Act 2011* (WHS Act) and the *Safety, Rehabilitation and Compensation Act 1988* to ensure the health and safety of its workforce, and to assist ill and injured workers. The Department maintains a strong commitment to the health and wellbeing of all staff.

In 2015-16, new initiatives such as the in-house ergonomic team, targeted risk assessment workshops, Guardian Break software and triaging systems continued to strengthen our WHS policies, procedures and practices. The Department's Health and Wellbeing Framework (the Framework) was developed in 2015-16 and was launched in July 2016. The Framework provides strategies for promoting wellbeing and good health.

This section details the WHS initiatives undertaken by the Department during 2015-16.

Evaluation of the Department's WHS performance

In June 2016, Comcare conducted a Work Health and Safety Management System (WHSMS) audit of the Department. The audit assessed the Department's WHS legislative compliance and effectiveness of our health and safety policy, health and safety procedures, and health and safety management systems. The audit verifies that management systems are in place and evaluates the implementation and effectiveness of those systems. The Department's conformance rating against the Comcare audit was 58 per cent in 2015-16.

Further work is required before the WHSMS can be regarded as fully effective. The Department will progress outcomes of the WHSMS audit during 2016-17 focussing on the key risks identified, with the aim of increasing the conformance rating.

Achievements

In 2015-16, the Department revised the terms of reference for its National Work Health Safety Committee to elevate the level of senior management representatives and to ensure a more strategic approach to WHS in the Department.

Work in 2016-17 will include:

- a program of discussions across the Department to better understand the nature of work, risk profile, peaks and troughs, and what WHS assistance is required to meet business objectives. These discussions in conjunction with priorities established from the Comcare audit findings will inform the Executive in setting objectives and performance criteria for the 2017–21 WHS strategy; and
- establishing a taskforce consisting of representatives from across the Department to assist in ensuring that line managers are well aware of, and active in progressing, WHS objectives in their areas.

Initiatives taken during the year to ensure the health, safety and welfare of workers who carry out work for the Department

Significant work has been undertaken throughout 2015-16, with a focus on prevention and early intervention. The following initiatives have been implemented to improve the Department's WHS performance:

- collaboration with the Australian Taxation Office and eleven other Commonwealth entities to undertake a cooperative procurement for the selection and management of rehabilitation providers and medical services;
- continued support for work capacity certification from treating doctors with an emphasis on work capability rather than incapacity;
- introduction of a triage system for handling enquiries to improve front-end response to injuries and incidents;
- introduction of professional in-house ergonomic assessment capability through the engagement of a qualified occupational therapist and an exercise physiologist:
  - 848 ergonomic assessments have been performed between September 2015 and June 2016;
  - of these, 181 were related to new injury symptoms, 514 were for pre-existing injuries and 153 people were without symptoms;
- completion of best practice trials of rehabilitation case management;
- implementation of review mechanisms for monitoring the performance of long-term claims; and
- introduction of Guardian Break software across the Department to address overuse and postural injury risks.

Health and Wellbeing Framework

In 2015-16, the Department developed the Health and Wellbeing Framework (the Framework).

In July 2016, the Health and Wellbeing Program and Framework was launched. The Program is available to staff irrespective of their physical location, and is designed to accommodate staff disability and diversity.

HEALTH & WELLBEING PROGRAM

The goals of the Framework are to:

- encourage a culture that focuses on supporting employees to develop good work and personal health habits;
- improve knowledge and change attitudes to an employee's own health; and
- improve employee engagement and productivity through the provision of activities that promote healthy practices.

The Health and Wellbeing Program and Framework forms part of the Department's broader organisational business plan, risk management framework, People Strategy and early intervention (EI) strategies. It takes a holistic approach encompassing physical and mental health and wellbeing, prevention and early intervention, and workplace support.

In 2015-16, the Department also developed an EI policy to support early access to appropriate treatment and reduce severity of personal and business impacts. This included the successful development and piloting of an EI training program, which is recommended to become part of the Department's learning and development core curriculum in 2016-17. This will be available as part of the Department's Learning Management System.

Health and safety outcomes (including the impact on injury rates of workers) achieved as a result of initiatives

The Department's strong rehabilitation performance has been achieved through the effective implementation of WHS measures, with a further workers' compensation premium reduction of 21 per cent in 2015-16 compared with the Commonwealth average of seven per cent. These figures include staff that have entered and exited the Department in the 2015 Machinery of Government changes. The reduction in the premium has been attributed to the effective implementation of WHS measures and previous year's initiatives, as well as a strong focus on active claims management by the Department and Comcare.

Since 2012-13, the number of accepted claims for the Department has been consistently declining. In 2013-14 there were 58 claims, in 2014-15 there were 30 and there have been 23[92] accepted claims for 2015-16.

[92] Claims may have been submitted and not yet determined. It is also possible that claims with a date of injury that fall in this period are yet to be determined. If liability is accepted for these claims, they will be attributed to the 2015-16 injury experience year.

Statistics of any notifiable incidents of which the Department became aware of during 2015-16 that arose out of the conduct of business or undertakings by the Department

During 2015-16 there were three dangerous incidents including one serious personal injury notified to Comcare with respect to the Department's statutory obligation under section 35 of the WHS Act. The serious personal injury resulted from a vehicle incident during the journey home from work, with the other two incidents being a laboratory fire and the discovery of asbestos material. A review of the asbestos incident and the laboratory fire concluded that there were no resulting injuries. A review of causative factors has been undertaken, with the primary factor for the fire being the age of the equipment. A program of removal of all legacy equipment has been implemented. A system review of response to the laboratory fire was undertaken with improvements made to information available for emergency services during an incident.

Any investigations conducted during 2015-16 that relate to businesses or undertakings conducted by the Department, including details of all notices given to the Department during 2015-16 under Part 10 of the WHS Act

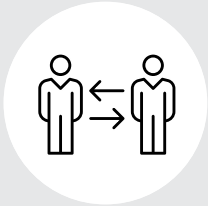
No notices were issued to the Department in 2015-16 and no investigations were initiated.

Such other matters as required by guidelines approved on behalf of the Parliament by the Joint Committee of Public Accounts and Audit

No matters to report for 2015-16.

3.7 Addressing Disability and Recognising Carers

The Department held its inaugural Carers Week event in October — guest speakers shared their personal stories of caring for a family member to raise awareness about unpaid carers, and to recognise the outstanding contribution they make to our nation



590 new People Assist referrals were received through the Employee Assistance Program, with over 1,416 hours accessed

Increasing recognition and awareness

The Department has a responsibility to create an accessible and attractive workplace for staff with disability, and carers of people with disability. Through this commitment, the Department's Staff with Disability Network provides support and advocacy services to staff, and raises awareness of disability matters.

The Disability Network is supported by Disability Champions. These Champions represent the Network to the Department's Executive and engage with the wider Australian Public Service (APS) through the APS Disability Champions Network.

The Department is committed to increasing awareness of the vital role that staff who are also unpaid carers play in providing daily care and support to people with disability, medical conditions, mental illness or who are frail and aged, through its obligations under the *Carer Recognition Act 2010* (the Act) and the Statement for Australia's Carers.[93]

The Act places a range of reporting and consultation obligations on those APS entities that have responsibility for the development, implementation, provision or evaluation of policies, programs or services directed to carers or the persons for whom they care.

The criteria in this section measures the Department's obligations under the Act and the responses provide an overall assessment of performance in 2015-16.

[93] Available at: www.legislation.gov.au/Details/C2010A00123

Supporting staff with disability

The Department is committed to increasing the accessibility and attractiveness for staff with disability, and will work closely with the Australian Public Service Commission (APSC) to implement the *As One: Australian Public Service Disability Employment Strategy* launched in May 2016.

The Department's Accessibility Action Plan (the Plan) is in consultation phase with an expected launch in late 2016.[94] The Plan has been created in conjunction with input from staff across the Department and the Australian Network on Disability, of which the Department continues to be a gold member. The Plan focuses on creating an accessible workplace for staff with disability, and carers for people with disability.

The Department has two Senior Executive Service (SES) Disability Champions who participate in the APS Disability Champion Network. They also support the Staff with Disability Network in actively promoting awareness and inclusion events in the Department. Having Champions at the SES level demonstrates departmental support to our diversity groups.

Disability Champion's personal story

On 28 October 2015, as Disability Champion for the Department, I attended the APS 'Ten plus Ten' meeting at the APSC along with nine other APS Disability Champions. This was the second 'Ten plus Ten' run by the APSC, and involved ten APS employees with disability sharing their personal stories. I attended along with a Health employee with a disability. The experience of listening to people sharing the highs and lows of their lived experience was powerful and inspiring. Ten courageous people with a range of disabilities shared details of their lives and the ways that they not only manage their disability, but flourish and contribute in the workplace. I felt very privileged to be able to listen and participate. A number of people shared their experience with mental health issues, which are not often well understood or well managed in the workplace. I was impressed by the self-awareness and frankness of these participants regarding an issue that is often considered taboo. The meeting only enhanced my conviction of the value of diversity in the workplace, and my commitment to my role as Disability Champion.

Dr Jenean Spencer
Disability Champion

On 3 December 2015, the Department celebrated International Day of People with Disability, which had a theme this year of 'Inclusion matters: access and empowerment for people of all abilities'. Staff were invited to attend and the Secretary encouraged staff to show their support by participating in 'Walk4Ability' to help raise funds for Boundless Canberra – ACT's first inclusive playground.

In line with the Department's commitment to increasing accessibility and attractiveness for staff with disability, the Department now applies the RecruitAbility Scheme to all advertised vacancies, with justification required if areas wish to opt out.

[94] Previously known as the Disability Workforce Action Plan.

The National Disability Strategy

Since 1994, non-corporate Commonwealth entities have reported on their performance as policy adviser, purchaser, employer, regulator and provider under the Commonwealth Disability Strategy. In 2007-08, reporting on the employer role was transferred to the annual APSC's State of the Service Report and the APS Statistical Bulletin. These reports are available at: www.apsc.gov.au. From 2010-11, entities have no longer been required to report on these functions.

The Commonwealth Disability Strategy has been overtaken by the National Disability Strategy 2010–2020 (Strategy), which sets out a ten-year national policy framework to improve the lives of people with disability, promote participation and create a more inclusive society. A high-level two-yearly report will track progress against each of the six outcome areas of the Strategy and present a picture of how people with disability are faring. Reports can be found at: www.dss.gov.au

Access and Equity

The National Disability Strategy 2010–2020 (Strategy) requires all levels of Government to work collaboratively with people with disability in the development of programs, policies and systems that affect people with disabilities. This includes engaging with representative organisations, families and carers, community service providers, advocacy and other organisations.

Under the Strategy, all Australian Government entities agreed to develop protocols for engaging with people with disability in the development of policy and programs. The Department has developed a protocol for this purpose that guides the delivery of Department business. The protocol outlines the Department's obligations under the Strategy, and identifies and promotes activities that improve accessibility and responsiveness of our policies, programs and services. The protocol includes relevant internal and external policy considerations and case studies to demonstrate the application of health programs to people with disability. The protocol also includes guidance for engaging with Indigenous Australians with disability.

As part of the Strategy, the Department contributed to the development of a Commonwealth Action Plan by the Department of Social Services. The Department reports against its activities in the Action Plan, which will be available to staff during 2016-17.

Compliance with the *Carer Recognition Act 2010*

Measures taken by the Department to ensure employees and agents are aware of and understand the Statement for Australia's Carers [Part 3 section 7(1)]

As the Department's Staff with Disability Network has many members who care for family with disability, a carers group was initiated to connect employees who are also carers with each other. To demonstrate their support and ensure these staff feel welcome and represented, and to better reflect the intent of the Network, the Network committee is proposing to change its name to the Disability and Carers Network.

The Department conducts awareness initiatives including all staff messages and an event during National Carers Week. During the week of 11–17 October 2015, staff were invited to a seminar to raise community awareness about unpaid carers, and to recognise the outstanding contribution they make to our nation. Guest speakers including the Secretary and members of staff shared their personal stories of caring for a family member. The event opened the eyes of many who have yet to be in a position of caring for someone else – whether it be a disabled child, an elderly parent or a close friend. Regulatory Services Group also held an event with employees from the Department, the Department of Social Services, the Australian Bureau of Statistics and the Department of the Prime Minister and Cabinet. Three guest speakers shared their personal experiences as carers.

Department's internal human resource policies, so far as they may significantly affect an employee's caring role, are to be developed having due regard to the Statement for Australia's Carers [Part 3 section 7(2)]

The Department's human resource policies and guidelines comply with the principles expressed in the Statement for Australia's Carers. The Department offers staff members a range of provisions to assist them with their caring responsibilities, including:

- access to flexible working arrangements, such as part-time employment, flex-time and home-based work;
- an Employee Assistance Program, which offers free counselling for staff and their family to assist with work or personal issues;
- paid and unpaid carers leave for various reasons, such as meeting family responsibilities and providing care and support to family or household members;
- the ability to purchase up to six weeks additional leave per calendar year;
- access to family care rooms in the workplace to enable staff to carry out work while caring for dependants, as an alternative to taking personal/carers leave; and
- providing appropriate facilities to enable mothers returning to work after maternity leave to undertake breastfeeding, lactation and associated activities.

Measures taken to ensure that employees and agents take action to reflect the principles of the Statement for Australia's Carers in developing, implementing, providing or evaluating care supports [Part 3 section 8(1)]

The Department's commitment to the Statement for Australia's Carers is reflected through its ongoing review process of initiatives that support carers.

The Department has established a carers group to actively promote carer issues to all staff, and works with key carer groups to improve access to carer services. Further details on the Department's carer programs and services are identified below.

Consult carers or bodies that represent carers when developing or evaluating care supports [Part 3 section 8(2)]

The Department recognises the contribution that carers make to the community by providing unpaid care and support to family and friends who are diagnosed with a life-limiting condition and require palliative care, and to clients receiving aged care services.

In 2015-16, the Department continued to consult with individual carers and representatives of carer organisations, including those with special needs, when developing support mechanisms, and implementing reforms, to ensure programs and services continue to meet the requirements of the *Carer Recognition Act 2010*.

Below are some examples of where the Department has worked with carer organisations:

Palliative care services

- The Department sourced an external evaluation of the *National Palliative Care Strategy 2010* (the Strategy).[95] The evaluation commenced in 2015-16 and will analyse the goals, action areas and measures of the Strategy to determine relevance and useability. It also includes national consultation with palliative care stakeholders, including carers, and will be finalised by September 2016.
- The Department provided funding to Carers Australia to deliver a series of workshops to train counsellors and other people to better support carers who are caring for someone with palliative care needs. Over 95 per cent of participants surveyed said the workshops improved or significantly improved their knowledge and skills in advance care planning, interdisciplinary approach to palliative care services, understanding grief and loss, carer's experience after the death of the person for whom they were caring, understanding the caring experience, and challenges carers face and strategies to support carers.

[95] The *National Palliative Care Strategy 2010 – Supporting Australians to Live Well at the End of Life* represents the combined commitments of the Australian, State and Territory Governments, palliative care service providers and community based organisations. It guides the development and implementation of palliative care policies, strategies and services across Australia. The Strategy is available at: www.health.gov.au/palliativecare

Supporting aged care services

- The Department supported training for the My Aged Care[96] workforce in 2015-16 to help identify the needs of older people and their carers, and to assess the type of support provided by carers, the sustainability of the caring relationship and any ongoing support that is required to maintain the caring relationship.[97]
- The Department established two stakeholder working groups in April 2015 and has held two meetings for each working group in 2015-16 to guide future implementation of Culturally and Linguistically Diverse, and Lesbian, Gay, Bisexual, Transgender and Intersex strategies. The working groups facilitated the development of new, and strengthening of existing, relationships with key stakeholders within the aged care sector, including representatives of carer organisations.

Dementia support programs

- In response to feedback from a range of stakeholders, the Australian Government announced in January 2016 the redesign and streamlining of dementia programs to ensure a nationally consistent approach to support for people with dementia.
- As part of this, a new national Dementia Behaviour Management Advisory Service and national Dementia Training Program will commence from 1 October 2016. In addition, the Department is redesigning existing consumer and carer support programs, and will further consult with stakeholders, including carers, on the design of these in 2016-17.

Review of Mental Health Programmes and Services

- The Australian Government response to the *Contributing Lives, Thriving Communities* – Review of Mental Health Programmes and Services was informed by consultation with stakeholders, including consumers, carers and peak bodies.
- The mental health system changes being implemented will benefit consumers and their carers through locally commissioned and integrated mental health services that are planned around individual and community needs. The Department will implement these mental health system changes from 2016-17 onwards.

[96] Available at: www.myagedcare.gov.au

[97] Refer Part 2.1: *2015-16 Annual Performance Statements*, Outcome 11: Ageing and Aged Care for more information on aged care services.

3.8 Ecologically Sustainable Development and Environmental Performance

187.6 tonnes of recycled waste produced – 6% increase compared to 2014-15

National Australian Built Environment Rating Scheme rating of 6 out of 6 stars for the Sirius building

Ecologically sustainable practices

The Department is committed to fulfilling its obligations under section 516A of the *Environment Protection and Biodiversity Conservation Act 1999* through the ongoing review and administration of appropriate legislation and activities that minimise our environmental footprint.

In 2015-16, the Department continued to administer initiatives that considered the short and long-term environmental affects, while according with the principles of ecologically sustainable development (ESD).

Compliance with the *Environment Protection and Biodiversity Conservation Act 1999*

Activities of, and the administration of legislation by the Department during 2015-16 accorded with ecologically sustainable development principles [section 516A(6)(a)]

The Department administers legislation that is relevant to, and meets the principles of, ESD. These include the *Gene Technology Act 2000* and the *Industrial Chemicals (Notification and Assessment) Act 1989*.

The National Industrial Chemicals Notification and Assessment Scheme (NICNAS), administered by the Department, aids in the protection of the Australian people and the environment by assessing the risks of industrial chemicals and providing information to promote their safe use.

NICNAS operates within an agreed framework for chemical management that is consistent with the National Strategy for ESD, its principles and policies. This framework aligns with the United Nations Conference on Environment and Development Agenda 21 (Rio Declaration), of which Chapter 19 relates to the environmentally sound management of toxic chemicals. Activities are aligned with a series of ESD principles and decision-making processes that effectively integrate both long-term and short-term environmental, social and equity-supporting considerations. Environmental risk assessments are conducted under a service level agreement with the Department of the Environment and Energy.

The Gene Technology Regulator (the Regulator) within the Office of the Gene Technology Regulator (OGTR) administers the *Gene Technology Act 2000*. The Act aims to protect the health and safety of people and the environment by identifying risks posed by gene technology and managing those risks through regulating activities with genetically modified organisms (GMOs).

Outcome contribution to ecologically sustainable development [section 516A(6)(b)]

In 2015-16, the Department continued its commitment to ESD by ensuring that it effectively delivered corporate strategic priorities while minimising environmental impact. This included a methodical approach to planning, implementing and monitoring the Department's environmental performance through programs and policies that are in accordance with current legislation, whole-of-government requirements and environmental best practice.

Through NICNAS, new industrial chemicals entering Australia (by manufacturing and/or importing) continued to be assessed for health and environmental risks. Administration of NICNAS also supported the Department's contribution to ESD by assessing chemicals already in commerce, based on environmental and/or health concerns.

OGTR continued to support the Regulator in regulating activities involving live and viable GMOs. These activities ranged from contained work in certified laboratories to releases of GMOs into the environment. The Regulator imposed licence conditions to protect the environment, and used extensive powers to monitor and enforce those conditions.

The effect of departmental activities on the environment [section 516A(6)(c)]

In 2015-16, the Department continued implementing its key environmental management issues that were aimed at reducing the consumption of energy, maintaining recycling efforts to minimise landfill and maximising the efficient use of resources by continuing the second-hand stationery store.

The Department is committed to making a positive contribution to sustainable practices and using whole-of-government benchmark indicators and targets to assess and monitor environmental performances.

The Department works closely with the respective building owners and managing agents for the properties we occupy to implement and manage schemes that will have a positive impact on the environment. This collaboration has seen the Sirius building achieve a 6 star National Australian Built Environment Rating Scheme (NABERS)[98] rating and receive national and international recognition.

Measures the Department is taking to minimise the impact of activities on the environment [section 516A(6)(d)]

During 2015-16, the Department continued to maintain an environmental management system (EMS) in accordance with the International Standard ISO 14001:2004. The EMS tool assists the Department with monitoring and managing its environmental performance impact, and complying with legal and whole-of-government requirements.

Mechanisms for reviewing and increasing the effectiveness of those measures that minimise the impact of the Department on the environment [section 516A(6)(e)]

Energy performance standards

The Energy Efficiency in Government Operations (EEGO) Policy contains minimum energy performance standards for Australian Government office buildings as a strategy for achieving energy targets. This ensures that entities progressively improve their performance through the procurement and ongoing management of energy efficient office buildings and environmentally sound equipment and appliances.

The Department, as part of its strategic accommodation planning, undertakes to meet the requirements of the Green Lease Schedule; that is for tenancies of greater than 2,000m^2 with a lease term greater than two years, accommodation will meet the 'A' grade standard of the Building Owners and Managers Association International guidelines and meet a minimum NABERS rating of 4.5 stars.

The table below details the Department's occupied buildings during 2015-16 that achieved the recommended base building NABERS ratings.

Table 3.8.1: NABERS energy rating

Property	Rating
Canberra Central Office (Sirius building)	6
Canberra Central Office (Scarborough House)	4.5
Victorian State Office	4.5
Queensland State Office	4.5

Energy saving initiatives in the Department's leased property portfolio includes T5 fluorescent and movement activated sensor lighting, double glazed windows and energy efficient heating, ventilation and air-conditioning systems.

[98] NABERS measures the environmental performance of Australian buildings, tenancies and homes.

Energy consumption and efficiency

The Department's 2015-16 energy consumption rates against the core performance indicators established under the EEGO Policy are identified below.

During 2015-16, a Machinery of Government change saw the Department assigned eight properties in the States and Territories, effective 1 January 2016. This resulted in an increase in the overall energy consumption for the Department for 2015-16.

Electricity consumption

The Department's electricity consumption during 2015-16 was 36,229 gigajoules. This figure includes the properties that were assigned to the Department in the 5 November 2015 Machinery of Government change.

Table 3.8.2: Electricity consumption (gigajoules) 2015-16[99]

	Gigajoules
Department total	36,229[100]

Office tenant light and power

The Department is required to meet the target of no more than 7,500 megajoules (MJ) per person, per annum, for office tenant light and power under the EEGO Policy.

In 2015-16, the Department more than met this requirement with only 3,649 MJ used per person, per annum, as detailed in the below table.

Table 3.8.3: Office tenant light and power 2015-16

	Energy (MJ)	Area (m^2)	MJ/m^2	People	MJ/ person
Department total[101]	18,380,604	89,536	205	5,037	3,649[102]

[99] The 2015-16 gigajoules figure includes the eight properties that were assigned to the Department (effective 1 January 2016).
[100] The figures include 10 Rudd St Canberra tenancy, which is majority sub-leased to National Health Funding Body.
[101] Total MJ/m^2 (205) represents the energy consumption in the Department's office tenancies (18,380,604) divided by the entire office floor space measured in square metres (89,536).
[102] Total MJ/person (3,649) represents the energy consumption by the Department (18,380,604) divided by the total number of people (5,037).

Non-office buildings: electricity

The Department occupies a number of sites used for a purpose other than office space, these properties include testing laboratories, workshop and storage facilities. There is no target for electricity consumption for properties that fall under this category. The Department, as part of its commitment to reducing its impact on the environment, monitors the usage in these facilities and in the 2015-16 period had a further decrease in consumption of 3.6 per cent from 2014-15.

Table 3.8.4: Non-office buildings – electricity consumption 2015-16

	2015-16		
	Energy (MJ)	Area (m^2)	MJ/m^2
Department total	17,847,898	19,574	912

Non-office buildings: natural gas

One of the Department's non-office buildings uses natural gas (Symonston complex). While there is no gas consumption target for properties that fall under this category, the Department, as part of its commitment to reducing its impact on the environment, monitors the usage in the facility and in 2015-16 there was a further decrease in consumption in the order of 17 per cent from 2014-15.

Table 3.8.5: Non-office buildings – natural gas 2015-16

	2015-16		
	Energy (MJ)	Area (m^2)	MJ/m^2
Department total	14,668,170	18,524	792

Sustainable energy initiatives

The Department accessed the whole-of-government electricity supply contract for the majority of its sites within the ACT and NSW, which includes 10 per cent green power.

In 2015-16, the Department improved the Information and Communication Technology (ICT) Sustainability Plan end user target of 400kWh per user per annum by implementing ICT energy saving measures that resulted in the reduction to 250kWh per user per annum. The Department will continue to investigate further opportunities to improve usage.

The Department installed and commissioned a new Building Management System. This installation has shown a significant decrease in both electricity and gas consumption at the Symonston complex.

The Department participated in Earth Hour 2016 by switching off building lights, thin terminals, monitors and office equipment for all its sites around Australia.

Waste management

The Department is committed to protecting the environment through the implementation of efficient and effective waste management programs.

In the majority of the Department's offices, waste management initiatives include segregated waste streams to improve management of general waste, commingled recycling, organic recycling, and paper and cardboard recycling. Further recycling efforts include the recycling of printer and toner cartridges, batteries and mobile phones to ensure these items are diverted from landfill and used in sustainable programs.

In 2015-16, the Department continued to recycle over half of its total waste produced with 187.6 tonnes of the total 309 tonnes (up by six per cent on 2014-15) of waste recycled, with a 20 per cent increase in paper and cardboard recycling. The general waste increased by just over four per cent and this was reflected in the slight decreases in the commingled and organic recycling streams. The Department will continue to educate staff on the importance of recycling waste.

Table 3.8.6: Waste reporting (tonnes) from 2011-12 to 2015-16[103]

	General waste	Commingled recycling	Paper & cardboard recycling	Organic recycling	Total
2011-12	108	12	81	3	203
2012-13	145	42	125	3	315
2013-14	123	41	81	3	249
2014-15	125	90	73	4	291
2015-16	130	88	88	3	309

[103] Waste reports provided for Canberra sites only.

Vehicle fleet management

The Department pre-Machinery of Government change relinquished a number of vehicles after a review of the actual vehicle usage in the State and Territory offices and found that it was not value for money to retain the vehicles. As part of the Machinery of Government change, Ageing and Aged Care was transitioned to the Department. To meet the ongoing requirements of the positions transferred to the Department, 28 vehicles were transferred to Health. As at 30 June 2016, the Department had 34 vehicles.

The Department is committed to working towards meeting the Australian Government's Green Car Challenge which states that by 2020, 50 per cent of the Government fleet's passenger vehicles will be Australian-made, value for money and environmentally friendly. Additionally, the Australian Government Fleet requires Australian Government entities to work towards a voluntary target of 28 per cent of their leased/pool vehicles to meet the Green Vehicles Guide[104] score of at least 10.5 out of 20.

The emissions of the Department's 2015-16 fleet vehicles are reported, in accordance with the EEGO Policy (Refer Table 3.8.7).

Table 3.8.7: Fleet vehicle emissions 2015-16

	Number of vehicles	Diesel oil (L)	E-10 (biofuel) (L)	Petroleum (unleaded and premium) (L)	Total (MJ)	Distance travelled (km)	Total MJ/ km[105]	CO_2 emissions (Tonnes)
Department total	30[106]	4,801	3,249	11,220	772,711	364,038	2.12	48

The Department has installed video conferencing facilities nationally and within the NICNAS office to reduce the need for travel. Teleconferencing is also used as an alternative to travel where video conferencing facilities are not available.

Follow-me printing

In March 2016, the Department commenced the rollout of the follow-me printing solution that allows staff to securely release print jobs to any multi-function device within the Department.

With follow-me printing, unwanted print jobs are not automatically printed and can be deleted, and any print jobs left in the queue for more than 12 hours are deleted. This benefits the environment as less ink cartridges, toner and paper are consumed.

This paper saving initiative will continue to be rolled out incrementally through to the end of 2016.

104 Available at: www.industry.gov.au/Energy/EnergyEfficiency/Documents/energy-efficiency/FactSheet-5-GVG-survey.pdf

105 Total MJ/km (2.12) represents the Department's total fleet vehicle emissions (772,711) divided by the total distance travelled (364,038).

106 This data has been provided by SG Fleet. The relevant report and data from LeasePlan is unavailable at time of publication. The Department had four cars provided by LeasePlan (not included in the above total).

Water conservation

During 2015-16, the Department continued with the modifications introduced in the 2014-15 financial year.

The Department occupies buildings that are fitted with a range of water-saving technologies including low-flow taps and showers, dual-flush cisterns, waterless or low-flow urinals and grey water systems.

The Department's national office (Sirius building) has a NABERS water rating[107] of 6 stars, which reflects the building's high level of water efficiency. This is well above the current market average of two and a half stars.

The implementation of the water usage timers has shown an active decrease in the consumption of water during 2015-16.

[107] NABERS water rating measures the water consumption of an office building on a scale of one to six stars reflecting the performance of the building relative to the market, from least efficient (one star) to market leading (six stars).

3.9 Advertising and Market Research

Prompted awareness of the Health Star Rating system reached 60% in its second year of implementation

The *Girls Make Your Move* campaign was successfully launched in February 2016. The campaign aims to encourage young women aged 12 to 19 years old to be more active

In 2015-16, the Department is required to report on all payments over $12,700 (GST inclusive) to advertising agencies, market research organisations, polling organisations, direct mail organisations and media advertising organisations.

This section details these payments, along with the names of advertising campaigns conducted by the Department during 2015-16.

Advertising campaigns

During 2015-16, the Department conducted the following advertising campaigns:

- BreastScreen Australia campaign;
- Girls Make Your Move campaign;
- Health Star Rating system campaign;
- National Bowel Cancer Screening Program campaign;
- National Drugs campaign; and
- National Tobacco campaign.

Further information on these advertising campaigns is available at www.health.gov.au, and in the reports on Australian Government advertising prepared by the Department of Finance and published at www.finance.gov.au/advertising/

Particulars of payments

Table 3.9.1: Advertising, market research, direct mail and media advertising payments for 2015-16

Organisation	Service provided	Amount paid (GST incl)
Advertising agencies (creative advertising agencies which have developed advertising campaigns)		
303 MullenLowe	Health Star Rating system campaign	$174,116
AJF Partnership	Girls Make Your Move campaign	$828,850
Carbon Media	National Tobacco campaign	$285,730
The Trustee for the Knowles Bristow Trust trading as BCM Partnership	National Drugs campaign	$117,740
Total		$1,406,436
Market research		
Cultural and Indigenous Research Centre Australia	Consumer research to understand Aboriginal and Torres Strait Islander community health service needs and preferences in the western Sydney and Nepean Blue Mountains regions	$75,986
GfK Australia	Evaluation research services for the Girls Make Your Move campaign	$183,500
Hall & Partners Open Mind	Consumer research for the Health Star Rating system campaign	$52,060
Latitude Insights	Palliative Care - Consumer Research	$330,000
National Heart Foundation of Australia	Consumer research for the Health Star Rating System	$52,800
ORC International	Consumer research for the National Tobacco campaign	$558,985
ORC International	Market research (qualitative) to support the Biosimilar Awareness Initiative	$243,054
Pollinate	Consumer research for the Health Star Rating System	$24,500
Pollinate	Evaluation research services for the Health Star Rating system campaign	$21,900
Snapcracker Research and Strategy	Immunisation Research	$416,350

Table 3.9.1 continued

Organisation	Service provided	Amount paid (GST incl)
Social Research Centre	Evaluation research services for the 2015 National Tobacco campaign	$36,052
Stancombe Research & Planning	Evaluation research services for the National Drugs campaign	$111,331
Taylor Nelson Sofres Australia	Consumer research for aged care	$185,900
Taylor Nelson Sofres Australia	Consumer research for development of a physical activity and sports participation campaign	$367,403
Taylor Nelson Sofres Australia	Evaluation research services for the National Bowel Cancer Screening Program campaign	$74,250
ThinkPlace	User research and usability testing with consumers, health professionals and industry (7 projects over two websites)	$201,654
WhereTo	Palliative Care - GPs Research	$330,000
Total		$3,265,726
Direct mail organisations[108] (includes organisations which handle the sorting and mailing out of information material to the public)		
National Mailing and Marketing	Early advice on 2016 National Influenza Vaccine mail out	$55,890
National Mailing and Marketing	Immunisation requirements for Family Assistance Payments mail out	$20,502
National Mailing and Marketing	National Diabetes Services Scheme mail out	$178,100
National Mailing and Marketing	National Influenza Vaccine resources mail out	$95,307
National Mailing and Marketing	No Jab No Pay mail out	$47,189
National Mailing and Marketing	Whooping cough 18 month booster and schedule resources mail out	$86,211
Total		$483,199

[108] The costs reported cover only the amount paid to the organisation and not the cost of postage or production of the material sent out. Where a creative agency or direct marketing agency has been used to create the direct mail materials, the amount paid to the agency is reported here.

Table 3.9.1 continued

Organisation	Service provided	Amount paid (GST incl)
Media advertising organisations (the master advertising agencies which place Government advertising in the media – this covers both campaign and non-campaign advertising)		
Dentsu Mitchell	Media buying for the Australian General Practice Training Program	$29,176
Dentsu Mitchell	Media buying for the BreastScreen Australia campaign	$1,186,956
Dentsu Mitchell	Media buying for the Girls Make Your Move campaign	$7,505,947
Dentsu Mitchell	Media buying services for the Health Star Rating System campaign	$1,749,000
Dentsu Mitchell	Media buying services for the National Tobacco campaign	$7,425,000
Dentsu Mitchell	Media buying services for the National Drugs campaign	$4,378,568
Dentsu Mitchell	Media buying for the National Bowel Cancer Screening Program campaign	$1,881,543
Dentsu Mitchell	Placing advertisements regarding regulatory activities	$20,210
Total		$24,176,400
Grand total		$29,331,761

PART 4

Financial Statements

2015-16 Financial Statements

Financial statements process

In accordance with the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), the Department is required to prepare annual financial statements. The statements must be prepared in accordance with the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR) and Australian Accounting Standards. Additional financial reporting requirements are detailed in Resource Management Guide No. 125 released by the Department of Finance.

The FRR applicable to 2015-16 does not mandate separate preparation of financial statements for the Therapeutic Goods Administration (TGA) special account, in addition to the financial statements of the Department. In previous years separate disclosure was required. The Department has provided additional disclosure for the TGA special account in the notes to the Department's financial statements provided for the consolidated entity.

In preparing the 2015-16 financial statements, the Department applied professional judgement to ensure that the financial statements fairly present the financial position, financial performance and cash flows. The Department developed formal position papers to detail issues where professional judgement was required.

Detailed cross references have been provided to guide readers to other relevant disclosures within the financial statements.

The Department's quality assurance framework applied to the financial statements includes independent advice from the Audit and Risk Committee to the Secretary on the preparation and review of the financial statements. The financial statements are audited by the Australian National Audit Office.

For further information, refer to the *Chief Operating Officer's Report*, which contains a summary of the Department's 2015-16 financial results.

Department of Health

Independent Auditor's Report

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Aged Care

I have audited the accompanying annual financial statements of the Department of Health for the year ended 30 June 2016, which comprise:

- Statement by the Secretary and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement;
- Administered Schedule of Comprehensive Income;
- Administered Schedule of Assets and Liabilities;
- Administered Reconciliation Schedule;
- Administered Cash Flow Statement; and
- Notes comprising a Summary of Significant Accounting Policies and other explanatory information.

Opinion

In my opinion, the financial statements of the Department of Health:

(a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Department of Health as at 30 June 2016 and its financial performance and cash flows for the year then ended.

Accountable Authority's Responsibility for the Financial Statements

The Secretary of the Department of Health is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards and the rules made under that Act. The Secretary is also responsible for such internal control as the Secretary determines is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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Phone (02) 6203 7300 Fax (02) 6203 7777

Department of Health
Independent Auditor's Report

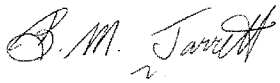
An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Australian National Audit Office



Brandon Jarrett

Executive Director

Delegate of the Auditor-General

Canberra

31 August 2016

Department of Health

Statement by the Secretary and Chief Financial Officer

DEPARTMENT OF HEALTH
STATEMENT BY THE SECRETARY AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2016 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Department of Health will be able to pay its debts as and when they fall due.

Signed.....

Martin Bowles PSM
Secretary
Department of Health

31 August 2016

Signed.....

Craig Boyd
Chief Financial Officer
Department of Health

31 August 2016

Department of Health

Statement of comprehensive income

for the period ended 30 June 2016

	Notes	ACTUAL 2016 $'000	ACTUAL 2015 $'000	BUDGET ESTIMATE Original 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000	BUDGET ESTIMATE Revised 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000
NET COST OF SERVICES							
EXPENSES							
Employee benefits	2A	**464,527**	373,865	419,648	44,879	520,497	(55,970)
Suppliers	2B	**304,416**	252,073	181,675	122,741	238,010	66,406
Depreciation and amortisation	2C	**23,984**	43,953	31,143	(7,159)	21,851	2,133
Write-down and impairment of assets	2D	**2,745**	3,268	-	2,745	252	2,493
Other expenses	2E	**1,105**	11,531	2,856	(1,751)	4,054	(2,949)
Total expenses		**796,777**	684,690	635,322	161,455	784,664	12,113
OWN-SOURCE INCOME							
Own-source revenue							
Sale of goods and rendering of services	3A	**174,561**	165,362	160,884	13,677	171,211	3,350
Other revenue	3B	**2,063**	2,226	15,004	(12,941)	2,407	(344)
Total own-source revenue		**176,624**	167,588	175,888	736	173,618	3,006
Gains							
Sale of assets	3C	**78**	-	-	78	-	78
Other gains	3D	**370**	3	1,050	(680)	-	370
Total gains		**448**	3	1,050	(602)	-	448
Total own-source income		**177,072**	167,591	176,938	134	173,618	3,454
Net cost of services		**619,705**	517,099	458,384	161,321	611,046	8,659
Revenue from Government	3E	**594,997**	479,885	433,784	161,213	594,997	-
Surplus/(Deficit) attributable to the Australian Government		**(24,708)**	(37,214)	(24,600)	(108)	(16,049)	(8,659)
OTHER COMPREHENSIVE INCOME							
Items not subject to subsequent reclassification to net cost of services							
Changes in asset revaluation surplus		**-**	16,395	-	-	-	-
Total other comprehensive income		**-**	16,395	-	-	-	-
Total comprehensive surplus/(loss) attributable to the Australian Government		**(24,708)**	(20,819)	(24,600)	(108)	(16,049)	(8,659)

The above statement should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

Department of Health

Statement of financial position

as at 30 June 2016

		ACTUAL		BUDGET ESTIMATE		BUDGET ESTIMATE	
				Original	Variance	Revised	Variance
	Notes	**2016**	2015	2016	2016	2016	2016
		$'000	$'000	$'000	$'000	$'000	$'000
ASSETS							
Financial assets							
Cash and cash equivalents	5A	**90,672**	79,631	71,089	19,583	82,989	7,683
Trade and other receivables	5B	**137,120**	120,769	116,122	20,998	139,713	(2,593)
Accrued revenue		**8,649**	5,505	6,173	2,476	5,257	3,392
Total financial assets		**236,441**	205,905	193,384	43,057	227,959	8,482
Non-financial assets							
Land and buildings	6A	**53,278**	53,027	32,321	20,957	58,139	(4,861)
Property, plant and equipment	6A	**6,316**	7,065	6,085	231	9,058	(2,742)
Intangibles	6A	**106,146**	91,405	94,389	11,757	121,664	(15,518)
Other non-financial assets	6C	**11,729**	3,804	7,796	3,933	5,288	6,441
Total non-financial assets		**177,469**	155,301	140,591	36,878	194,149	(16,680)
Assets held for sale		**-**	9,131	-	-	-	-
Total assets		**413,910**	370,337	333,975	79,935	422,108	(8,198)
LIABILITIES							
Payables							
Suppliers	7A	**61,620**	61,882	61,801	(181)	75,737	(14,117)
Other payables	7B	**45,196**	51,409	69,445	(24,249)	46,611	(1,415)
Total payables		**106,816**	113,291	131,246	(24,430)	122,348	(15,532)
Provisions							
Employee provisions	8A	**152,143**	115,972	106,786	45,357	146,963	5,180
Other provisions	8B	**28,560**	22,017	23,272	5,288	28,244	316
Total provisions		**180,703**	137,989	130,058	50,645	175,207	5,496
Total liabilities		**287,519**	251,280	261,304	26,215	297,555	(10,036)
Net assets		**126,391**	119,057	72,671	53,720	124,553	1,838
EQUITY							
Parent entity interest							
Contributed equity		**246,925**	217,325	236,944	9,981	263,746	(16,821)
Asset revaluation reserve		**30,436**	30,507	14,112	16,324	30,507	(71)
Accumulated deficit		**(150,970)**	(128,775)	(178,385)	27,415	(169,700)	18,730
Total parent entity interest		**126,391**	119,057	72,671	53,720	124,553	1,838
Total equity		**126,391**	119,057	72,671	53,720	124,553	1,838

The above statement should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

Department of Health

Statement of changes in equity

for the period ended 30 June 2016

		ACTUAL		BUDGET ESTIMATE		BUDGET ESTIMATE	
				Original	Variance	Revised	Variance
	Notes	2016	2015	2016	2016	2016	2016
		$'000	$'000	$'000	$'000	$'000	$'000
ACCUMULATED DEFICIT							
Opening balance							
Balance carried forward from previous period		**(128,775)**	(116,440)	(153,785)	25,010	(153,651)	24,876
Adjustments for errors		**-**	24,879	-	-	-	-
Adjusted opening balance		**(128,775)**	(91,561)	(153,785)	25,010	(153,651)	24,876
Comprehensive income							
Deficit for the period		**(24,708)**	(37,214)	(24,600)	(108)	(16,049)	(8,659)
Total comprehensive income		**(24,708)**	(37,214)	(24,600)	(108)	(16,049)	(8,659)
Transfers between equity components		**2,513**	-	-	2,513	-	2,513
Closing balance as at 30 June		**(150,970)**	(128,775)	(178,385)	27,415	(169,700)	18,730
Closing balance attributable to the Australian Government		**(150,970)**	(128,775)	(178,385)	27,415	(169,700)	18,730
ASSET REVALUATION RESERVE							
Opening balance							
Balance carried forward from previous period		**30,507**	14,112	14,112	16,395	30,507	-
Adjusted opening balance		**30,507**	14,112	14,112	16,395	30,507	-
Comprehensive income							
Other comprehensive income		**-**	16,395	-	-	-	-
Total comprehensive income		**-**	16,395	-	-	-	-
Transfers between equity components		**(71)**	-	-	(71)	-	(71)
Closing balance as at 30 June		**30,436**	30,507	14,112	16,324	30,507	(71)
Closing balance attributable to the Australian Government		**30,436**	30,507	14,112	16,324	30,507	(71)
CONTRIBUTED EQUITY							
Opening balance							
Balance carried forward from previous period		**217,325**	202,477	217,325	-	223,835	(6,510)
Adjusted opening balance		**217,325**	202,477	217,325	-	223,835	(6,510)
Transfers between equity components		**(2,442)**	-	-	(2,442)	-	(2,442)
Transactions with Owners							
Contributions by owners							
Equity injection - appropriations		**20,034**	8,820	8,410	11,624	32,290	(12,256)
Equity injection - restructuring[2]		**12,256**	-	-	12,256	-	12,256
Departmental capital budget		**6,656**	6,028	11,209	(4,553)	7,621	(965)
Departmental capital budget - restructuring[2]		**965**	-	-	965	-	965
Restructuring[3]		**(7,869)**	-	-	(7,869)	-	(7,869)
Total transactions with owners		**32,042**	14,848	19,619	12,423	39,911	(7,869)
Closing balance as at 30 June		**246,925**	217,325	236,944	9,981	263,746	(16,821)
Closing balance attributable to the Australian Government		**246,925**	217,325	236,944	9,981	263,746	(16,821)

Department of Health

Statement of changes in equity

for the period ended 30 June 2016

		ACTUAL		BUDGET ESTIMATE		BUDGET ESTIMATE	
				Original	Variance	Revised	Variance
	Notes	2016	2015	2016	2016	2016	2016
		$'000	$'000	$'000	$'000	$'000	$'000
TOTAL EQUITY							
Opening balance							
Balance carried forward from previous period		**119,057**	100,149	77,652	41,405	100,691	18,366
Adjustments for errors[1]		**-**	24,879	-	-	-	-
Adjusted opening balance		**119,057**	125,028	77,652	41,405	100,691	18,366
Comprehensive income							
Other comprehensive income		**-**	16,395	-	-	-	-
Deficit for the period		**(24,708)**	(37,214)	(24,600)	(108)	(16,049)	(8,659)
Total comprehensive income		**(24,708)**	(20,819)	(24,600)	(108)	(16,049)	(8,659)
Transactions with Owners							
Contributions by owners							
Equity injection - appropriations		**20,034**	8,820	8,410	11,624	32,290	(12,256)
Equity injection - restructuring[2]		**12,256**	-	-	12,256	-	12,256
Departmental capital budget		**6,656**	6,028	11,209	(4,553)	7,621	(965)
Departmental capital budget - restructuring[2]		**965**	-	-	965	-	965
Restructuring[3]		**(7,869)**	-	-	(7,869)	-	(7,869)
Total transactions with owners		**32,042**	14,848	19,619	12,423	39,911	(7,869)
Closing balance as at 30 June		**126,391**	119,057	72,671	53,720	124,553	1,838
Closing balance attributable to the Australian Government		**126,391**	119,057	72,671	53,720	124,553	1,838

The above statement should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

[1] For adjustments for errors in refer to Note 1: Overview (1.7 Transactions with the Australian Government as Owner).

[2] This relates to Appropriation Receivable transferred under the *Administrative Arrangements Order* issued on 30 September 2015 from the Department of Social Services and Department of Human Services through Appropriation Acts No. 3 and 4. Refer to Note 9: Restructuring for details.

[3] This relates to the residual assets and liabilities assumed/relinquished under the *Administrative Arrangements Order* issued on 30 September 2015. Refer to Note 9: Restructuring for details. The Restructuring net assets/(liabilities) figure differs from the Statement of changes in equity, as this has been adjusted for appropriations received through the budgetary process and inter-agency transfers for which a formal agreement has not yet been approved 'under section 75 of the PGPA Act'.

Department of Health

Cash flow statement

for the period ended 30 June 2016

	Notes	ACTUAL 2016 $'000	ACTUAL 2015 $'000	BUDGET ESTIMATE Original 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000	BUDGET ESTIMATE Revised 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000
OPERATING ACTIVITIES							
Cash received							
Appropriations		**678,390**	545,728	532,479	145,911	609,225	69,165
Sale of goods and rendering of services		**161,373**	210,257	188,519	(27,146)	210,972	(49,599)
Net GST received		**25,816**	24,518	19,946	5,870	24,946	870
Other		**2,063**	1,176	11,790	(9,727)	1,085	978
Total cash received		**867,642**	781,680	752,734	114,908	846,228	21,414
Cash used							
Employees		**(471,954)**	(372,598)	(433,472)	(38,482)	(463,516)	(8,438)
Suppliers		**(339,331)**	(318,939)	(204,756)	(134,575)	(305,461)	(33,870)
Net GST paid		**-**	-	(20,113)	20,113	(4,349)	4,349
Section 74 receipts transferred to OPA		**(58,550)**	(69,808)	(76,558)	18,008	(63,558)	5,008
Other		**(1,105)**	(11,531)	(6,046)	4,941	(1,095)	(10)
Total cash used		**(870,940)**	(772,876)	(740,945)	(129,995)	(837,979)	(32,961)
Net cash from operating activities	10	**(3,298)**	8,804	11,789	(15,087)	8,249	(11,547)
INVESTING ACTIVITIES							
Cash received							
Proceeds from sales of property, plant and equipment		**9,210**	-	-	9,210	9,200	10
Total cash received		**9,210**	-	-	9,210	9,200	10
Cash used							
Purchase of property, plant, equipment and intangibles		**(35,438)**	(30,137)	(35,289)	(149)	(54,002)	18,564
Total cash used		**(35,438)**	(30,137)	(35,289)	(149)	(54,002)	18,564
Net cash used by investing activities		**(26,228)**	(30,137)	(35,289)	9,061	(44,802)	18,574
FINANCING ACTIVITIES							
Cash received							
Appropriations - Equity injection		**27,341**	15,757	19,619	7,722	39,911	(12,570)
Appropriations - Departmental capital budget		**13,226**	2,215	-	13,226	-	13,226
Total cash received		**40,567**	17,972	19,619	20,948	39,911	656
Net cash received from financing activities		**40,567**	17,972	19,619	20,948	39,911	656
Net increase in cash held		**11,041**	(3,361)	(3,881)	14,922	3,358	7,683
Cash and cash equivalents at the beginning of the reporting period		**79,631**	82,992	74,970	4,661	79,631	-
Cash and cash equivalents at the end of the reporting period	5A	**90,672**	79,631	71,089	19,583	82,989	7,683

The above statement should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

Department of Health

Administered schedule of comprehensive income

for the period ended 30 June 2016

	Notes	ACTUAL 2016 $'000	ACTUAL 2015 $'000	BUDGET ESTIMATE Original 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000	BUDGET ESTIMATE Revised 2016 $'000	BUDGET ESTIMATE Variance 2016 $'000
NET COST OF SERVICES							
Expenses							
Suppliers	17A	**676,768**	453,604	497,579	179,189	506,481	170,287
Subsidies	17B	**9,290,201**	126,703	104,067	9,186,134	9,189,162	101,039
Personal benefits	17C	**39,507,641**	36,560,965	39,124,195	383,446	38,582,700	924,941
Grants	17D	**5,818,319**	5,412,211	5,971,750	(153,431)	6,163,976	(345,657)
Depreciation and amortisation	17E	**20,383**	19,272	19,272	1,111	22,625	(2,242)
Write-down and impairment of assets	17F	**107,326**	3,858	101,656	5,670	105,379	1,947
Payments to corporate Commonwealth entities	17G	**328,658**	300,847	346,502	(17,844)	346,502	(17,844)
Other expenses	17H	**10,149**	450,900	-	10,149	4,702	5,447
Total expenses		**55,759,445**	43,328,360	46,165,021	9,594,424	54,921,527	837,918
Income							
Revenue							
Taxation revenue							
Other taxes	18A	**17,799**	16,906	26,036	(8,237)	15,000	2,799
Total taxation revenue		**17,799**	16,906	26,036	(8,237)	15,000	2,799
Non-taxation revenue							
Interest		**4,757**	-	-	4,757	5,839	(1,082)
Recoveries	18B	**2,556,834**	781,007	1,013,159	1,543,675	1,591,786	965,048
Other revenue	18C	**252,222**	1,375,055	913,627	(661,405)	82,305	169,917
Total non-taxation revenue		**2,813,813**	2,156,062	1,926,786	887,027	1,679,930	1,133,883
Total income		**2,831,612**	2,172,968	1,952,822	878,790	1,694,930	1,136,682
Net cost of services		**52,927,833**	41,155,392	44,212,199	8,715,634	53,226,597	(298,764)
Deficit		**(52,927,833)**	(41,155,392)	(44,212,199)	(8,715,634)	(53,226,597)	298,764
OTHER COMPREHENSIVE INCOME							
Items not subject to subsequent reclassification to net cost of services							
Changes in asset revaluation reserves		**9,692**	-	-	9,692	-	9,692
Changes in administered investment reserves		**(9,906)**	(134,806)	-	(9,906)	-	(9,906)
Total other comprehensive income		**(214)**	(134,806)	-	(214)	-	(214)
Total comprehensive loss		**(52,928,047)**	(41,290,198)	(44,212,199)	(8,715,848)	(53,226,597)	298,550

The above schedule should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

Department of Health

Administered schedule of assets and liabilities

as at 30 June 2016

		ACTUAL		BUDGET ESTIMATE		BUDGET ESTIMATE	
				Original	Variance	Revised	Variance
	Notes	**2016**	2015	2016	2016	2016	2016
		$'000	$'000	$'000	$'000	$'000	$'000
ASSETS							
Financial assets							
Cash and cash equivalents	20A	**171,579**	336,648	13,312	158,267	336,648	(165,069)
Personal benefits receivable	20B	**748,121**	148,511	183,131	564,990	148,511	599,610
Trade and other receivables	20C	**625,396**	171,851	383,661	241,735	891,227	(265,831)
Other investments	20D	**380,117**	390,024	342,124	37,993	512,249	(132,132)
Total financial assets		**1,925,213**	1,047,034	922,228	1,002,985	1,888,635	36,578
Non-financial assets							
Land and buildings	21	**33,197**	24,468	23,505	9,692	23,505	9,692
Computer software	21	**48,823**	36,617	43,125	5,698	39,772	9,051
Inventories held for distribution		**111,265**	210,005	117,148	(5,883)	111,550	(285)
Total non-financial assets		**193,285**	271,090	183,778	9,507	174,827	18,458
Total assets administered on behalf of Government		**2,118,498**	1,318,124	1,106,006	1,012,492	2,063,462	55,036
LIABILITIES							
Payables							
Suppliers	22A	**9,881**	7,110	12,071	(2,190)	7,110	2,771
Subsidies - external parties		**263,538**	2,708	2,634	260,904	154,334	109,204
Personal benefits - indirect		**898,425**	915,091	1,173,946	(275,521)	942,069	(43,644)
Grants	22B	**378,070**	375,162	232,586	145,484	370,716	7,354
Total payables		**1,549,914**	1,300,071	1,421,237	128,677	1,474,229	75,685
Provisions							
Subsidies - external parties	22C,D	**425,000**	413,000	359,787	65,213	406,975	18,025
Personal benefits - indirect		**1,280,045**	1,011,494	1,027,297	252,748	1,011,494	268,551
Total provisions		**1,705,045**	1,424,494	1,387,084	317,961	1,418,469	286,576
Total liabilities administered on behalf of Government		**3,254,959**	2,724,565	2,808,321	446,638	2,892,698	362,261
Net liabilities		**1,136,461**	1,406,441	1,702,315	(565,854)	829,236	307,225

The above schedule should be read in conjunction with the accompanying notes.

For budgetary reporting information refer to Note 29. The original budget is the budget published in the 2015-16 Portfolio Budget Statements and the revised budget is the estimated actuals from the 2016-17 Portfolio Budget Statements. The budget statement information has been reclassified and presented on a consistent basis with the corresponding financial statement.

Department of Health

Administered reconciliation schedule

	2016	2015
	$'000	$'000
Opening assets less liabilities as at 1 July	**(1,406,441)**	(1,381,555)
Adjusted opening assets less liabilities	**(1,406,441)**	(1,381,555)
Net cost of services		
Income	**2,831,612**	2,172,968
Expenses		
Payments to entities other than corporate Commonwealth entities	**(55,430,787)**	(43,027,513)
Payments to corporate Commonwealth entities	**(328,658)**	(300,847)
Other comprehensive income		
Revaluations transferred from reserves	**(214)**	(134,806)
Net assets assumed from portfolio agencies	**-**	484
Transfers (to)/from Australian Government		
Appropriation transfers from OPA		
Administered assets and liabilities appropriations	**33,202**	3,713
Annual appropriations		
Payments to entities other than corporate Commonwealth entities	**6,619,347**	5,341,376
Payments to corporate Commonwealth entities	**328,658**	300,847
Special appropriations (unlimited)		
Payments to entities other than corporate Commonwealth entities	**48,149,354**	36,638,318
Payments to corporate Commonwealth entities	**-**	445,538
Special appropriations (limited)		
Refund of receipts (section 77 of the *PGPA Act*)	**7,926**	737
Net GST appropriations	**25,875**	9,644
Appropriation transfers to OPA		
Transfers to OPA	**(2,135,107)**	(1,475,345)
Restructuring	**168,773**	-
Closing assets less liabilities as at 30 June	**(1,136,461)**	(1,406,441)

Department of Health

Administered cash flow statement

for the period ended 30 June 2016

	Note	2016 $'000	2015 $'000
OPERATING ACTIVITIES			
Cash received			
Interest		**3,130**	-
Taxes		**17,799**	16,906
Net GST received		**359,467**	315,084
Health and hospital fund receipts		**54,984**	716,916
Recoveries		**2,301,933**	784,495
Transfers from Private Health Insurance Administration Council		**-**	445,538
Other		**117,687**	237,123
Total cash received		**2,855,000**	2,516,062
Cash used			
Grants		**(6,204,054)**	(5,642,752)
Subsidies		**(9,180,995)**	(108,669)
Personal benefits		**(39,613,098)**	(36,497,460)
Suppliers		**(684,997)**	(462,230)
Payments to corporate Commonwealth entities		**(328,658)**	(300,847)
Transfers to Private Health Insurance Administration Council		**-**	(445,538)
Total cash used		**(56,011,802)**	(43,457,496)
Net cash used by operating activities	23	**(53,156,802)**	(40,941,434)
INVESTING ACTIVITIES			
Cash received			
Repayments of advances and loans		**16,402**	-
Total cash received		**16,402**	-
Cash used			
Advances and loans made		**(22,298)**	-
Purchase of intangible assets		**(31,626)**	-
Total cash used		**(53,924)**	-
Net cash used by investing activities		**(37,522)**	-
Net decrease in cash held		**(53,194,324)**	(40,941,434)

Department of Health

Administered cash flow statement

for the period ended 30 June 2016

	Note	2016	2015
		$'000	$'000
Cash and cash equivalents at the beginning of the reporting period		**336,648**	13,254
Cash from Official Public Account			
Appropriations		**55,105,285**	42,726,816
Special Accounts		**10,093**	5,345
Capital appropriations		**33,202**	3,713
Administered GST appropriations		**380,296**	328,505
Total cash from Official Public Account		**55,528,876**	43,064,379
Cash to Official Public Account			
Special Accounts		**(10,093)**	(5,345)
Private Health Insurance Administration Council transfers		**-**	(445,538)
Return of GST appropriations to the Official Public Account		**(354,421)**	(318,861)
Other		**(2,135,107)**	(1,029,807)
Total cash to Official Public Account		**(2,499,621)**	(1,799,551)
Cash and cash equivalents at the end of the reporting period	20A	**171,579**	336,648

This statement should be read in conjunction with the accompanying notes.

Department of Health

Table of contents – notes to and forming part of the financial statements

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

1.1 Objectives of the Department of Health

The Department of Health (the Department) is an Australian Government controlled entity which is a not-for-profit entity. The objective of the Department to lead and shape Australia's health system and sporting outcomes through evidence based policy, well targeted programs and best practice regulation and in 2016 was structured to meet the following 11 outcomes:

Outcome 1	Population Health;
Outcome 2	Access to Pharmaceutical Services;
Outcome 3	Access to Medical and Dental Services;
Outcome 4	Acute Care;
Outcome 5	Primary Health Care;
Outcome 6	Private Health;
Outcome 7	Health Infrastructure, Regulation, Safety and Quality;
Outcome 8	Health Workforce Capacity;
Outcome 9	Biosecurity and Emergency Response;
Outcome 10	Sport and Recreation; and
Outcome 11	Ageing and Aged Care.

Outcome 11: Ageing and Aged Care is included in 2015-16 as the result of the transfer of the function to the Department under the *Administrative Arrangement Order* issued on 30 September 2015. The Medicare Provider Compliance function was transferred into Outcome 3. Refer to Note 9: Restructuring.

The continued existence of the Department in its present form and with its present programs is dependent on Government policy and on continuing funding by Parliament for the Department's administration and programs.

Department activities contributing toward these outcomes are classified as either departmental or administered. Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by the Department in its own right. Administered activities involve the management or oversight by the Department, on behalf of the Government, of items controlled or incurred by the Government.

The Department is responsible for the following administered activities on behalf of the Government:

- payment of subsidies for residential, aged care and community programs;
- payment of personal benefits for Medicare services, pharmaceutical services and affordability, and choice of health care initiatives; and
- payment of grants, with the majority of these made to non-profit organisations.

1.2 Basis of Preparation of the Financial Statements

The financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

The financial statements and notes have been prepared in accordance with:

- *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015* (the FRR); and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements and notes have been prepared on an accrual basis and are in accordance with the historical cost convention, except for certain assets at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian Dollars.

Administered revenues, expenses, assets, liabilities and cash flows reported in the administered schedules and related notes are accounted for on the same basis and using the same policies as for Departmental items, except as otherwise stated in Note 1.18.

The Department's financial statements include the financial statements of the Department of Health and three Departmental special accounts, the Therapeutic Goods Administration (TGA), the Office of the Gene Technology Regulator (OGTR) and the National Industrial Chemicals Notification and Assessment Scheme (NICNAS).

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

All transactions between the Department and the special accounts have been eliminated from the departmental financial statements.

Comparative Figures

Comparative figures have been adjusted, where required, to conform to changes in presentation of the financial statements.

1.3 New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

The Department adopted all new, revised and amending standards and interpretations that were issued by the Australian Accounting Standards Board (AASB) prior to the sign-off date and are applicable to the current reporting period. The adoption of these standards and interpretations did not have a material effect, and are not expected to have a future material effect on the Department's financial statements.

During the period, the department adopted early AASB 2015-7 *Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-for-Profit Public Sector Entities*. The result of this early adoption of the standard has had an immaterial effect on the fair value disclosures included in the financial statements.

Future accounting standard requirements

The following new, revised and amending standards and interpretations were issued by the AASB prior to the signing of the statement by the Accountable Authority and Chief Financial Officer, for which the Department is still assessing the potential impact on the financial statements:

- AASB 15 *Revenue from Contracts with Customers*
- AASB 16 *Leases*
- AASB 124 *Related Party Disclosures*

All other new, revised, and amending standards or interpretations that have been issued by the AASB prior to sign off date that are applicable to the future reporting period(s) are not expected to have a future material financial impact on the Department's financial statements.

1.4 Significant Accounting Judgements and Estimates

Departmental

In the process of applying the accounting policies listed in this note, the Department has determined that no accounting assumptions and estimates have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next accounting period.

Administered

The following assumptions and estimates have been identified that may have a significant risk of causing material adjustments to the carrying amounts of administered assets and liabilities within the next accounting period.

Medical Indemnity

Medical indemnity schemes are administered by the Department under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*. The Department administers the following medical indemnity schemes:

- Incurred But Not Reported Scheme (IBNRS);
- High Cost Claims Scheme (HCCS);
- Exceptional Claims Scheme (ECS);
- Run-Off Cover Scheme (ROCS);
- Premium Support Scheme (PSS);
- Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS); and
- Midwife Professional Indemnity Run-off Cover Scheme (MPIRCS).

Further detail on each of these schemes is provided at Note 22D.

The payments for medical indemnity are managed by the Department of Human Services (DHS), the service delivery entity, on behalf of the Department through its Medicare program.

The Australian Government Actuary (AGA) estimated the provision for future payments for the medical indemnity schemes administered by the Department. At the reporting date, provision for future payment was recognised for IBNRS, HCCS, and ROCS. No provision was recognised for ECS, MPIS or MPIRCS as, to date, no payment has been made against these schemes and

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

they could not be reliably measured and are reported as a contingent liability in Note 24. No provision was recognised for the PSS as the nature and timing of payments associated with this scheme are based on a relatively predictable pattern of annual payments that must be settled within 12 months of the end of a premium period.

The nature of the medical indemnity liability estimates is inherently, and unavoidably uncertain.

The uncertainty arises for the following reasons:

- it is not possible to precisely model the claim process, and random variation both in past and future claims have or will have adverse consequences on the model;
- there can be a long delay between incident occurrences, to notification and to settlement, making the projection of timing very uncertain;
- the nature and cause of injury is difficult to determine and prove;
- the claims experience can be very sensitive to the surrounding factors such as technology, legislation, attitudes and the economy; and
- in general, these schemes have a small number of large claims which account for a substantial part of the overall cost. This is associated with large expected random variation. It follows that a wide range of results can be obtained with equal statistical significance which differs materially in the context of a Schedule of Assets and Liabilities. This is a common situation with liabilities of this nature.

The methods used by the AGA to estimate the liability under the different schemes are as follows:

- General:

The AGA has relied on projections that have been prepared by the appointed actuaries to the five medical indemnity insurers (MIIs) and provided to the Commonwealth under the relevant provisions of the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*. Payment information from the Medicare program complemented the projection. Where appropriate, adjustments have been made to those projections as described below.

- IBNRS:

The AGA has carried out chain ladder modelling using the payments data. The results of this analysis have been compared to the projections prepared by the industry actuaries. The results closely match and as a result, the AGA has largely relied on industry projections to estimate the liability.

- ROCS:

The AGA has developed an independent ROCS actuarial model which estimates the total annual accruing ROCS cost to the Australian Government. The model output is used to check against industry actuaries' projections. For the estimate of the outstanding ROCS liability as at 30 June 2016, the AGA has relied on the projections from the actuary of each of the MIIs, but has adjusted the IBNRS component on comparison with the projections from its own ROCS internal model. Given that the majority of the claims anticipated under this scheme have not yet made, the AGA noted a relatively high level of uncertainty in the estimate.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

- HCCS:

The AGA has relied on the projections of the industry actuaries but has made adjustments in respect of claims which are also eligible for the IBNRS and/or ROCS to ensure overall consistency of the estimates.

The experience of the medical indemnity claims cycle indicates that claims and subsequent payments can take a number of years to mature and settle. The Department has used a 1.7% per annum discount rate in the calculation of the estimate for the current year. This discount rate was derived from the Commonwealth bonds yield curve based on the revised average observed liability duration of 5 years for the medical indemnity payments. This discount rate is deemed to be more appropriate than the 10 year bond yield at 30 June 2016, which was 2%. A discount rate of 2.4% was used last year, which was derived using the same method.

A sensitivity analysis was undertaken by moving the discount rate either up or down to the nearest full percentage point. Increasing the discount rate to 2% would result in a discounted liability estimate which is about 1.9% ($8m) less than the base estimate. On the other hand, decreasing the discount rate to 1% would result in a discounted liability estimate which is about 3.5% ($15m) higher than base estimate.

	2015-16			2014-15
	discounted	discounted	discounted	discounted
	1%	1.7%[1]	2%	2.4%
	$'m	$'m	$'m	$'m
Incurred But Not Reported	29	28	27	34
High Cost Claims Scheme	325	316	311	300
Run-Off Cover Scheme	86	81	79	79
Total	**440**	**425**	**417**	**413**

[1] 1.7% was used as the basis of estimation in 2015-16, see note 22D.

Medicare Outstanding Claims

Medicare payments processed by the DHS on behalf of the Department are either reimbursement to patients, made after medical services have been received from a doctor, or payments made directly to doctors through the bulk billing system. At any point in time, there are thousands of cases where a medical service has been rendered, but the Medicare payment has not yet been made. The DHS has been using the 'Winters' methodology to estimate the value of these outstanding claims.

Under the Winters methodology, a number of models are used to estimate the outstanding Medicare claims liabilities. The model preferred by the industry, and consistently applied in past financial statements of the Department, is Model 5. Model 5 comprises two major components: chain ladder modelling and time series modelling.

Under Model 5, user defined parameters are applied to smooth the time series observations and make predictions about future payment values. As the parameters are user defined it is reasonable to assume that different users of the model may make different choices, and therefore arrive at different estimates of the outstanding liability. In order to validate the parameters used, actual payment data has been compared to previous estimates using various parameters to predict the liability. The model weight recent payment experience more heavily and is therefore self adjusting for emerging trends.

The AGA was engaged to analyse the monthly Medicare payment data from June 2015 to June 2016 across a range of reasonable choices for the smoothing parameters. A range of estimated liabilities from these scenarios, for each month, was then compared with the estimated liability under the Model 5 smoothing parameters. This sensitivity analysis indicates that under a reasonable range of smoothing parameter scenarios, the estimated liabilities vary by up to plus or minus 5%.

1.5 Revenue

Revenue from the sale of goods is recognised when:

- the risks and rewards of ownership have been transferred to the buyer;
- the Department retains no managerial involvement or effective control over the goods;
- the revenue and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the Department.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when the:

- amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- probable economic benefits associated with the transaction will flow to the Department.

Receivables for goods and services, which have 30 day terms (note the TGA operates on terms in accordance with the *Therapeutic Goods Regulations 1990*), are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

On 1 July 2015 TGA introduced a new scheme to provide relief from annual charges for products with low value turnover. The scheme, which is detailed in the regulations covering therapeutic goods, allows for charges in respect of 2016 to be determined after 1 July 2016. This introduces a level of uncertainty into the revenue calculation for the financial year, the uncertainty will reduce in subsequent years as data about the uptake of the scheme is accumulated.

Revenue from Government

Amounts appropriated for Departmental appropriations for the year (adjusted for any formal additions and reductions) are recognised as Revenue from Government when the Department gains control of the appropriation, except for certain amounts that relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned. Appropriations receivable are recognised at their nominal amounts.

1.6 Gains

Resources Received Free of Charge

Resources received free of charge are recognised as gains when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Resources received free of charge are recorded as either revenue or gains depending on their nature.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government entity as a consequence of a restructuring of administrative arrangements (refer to Note 1.7).

Sale of Assets

Gains from disposal of non-current assets are recognised when control of the asset has passed to the buyer.

1.7 Transactions with the Australian Government as Owner

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) and Departmental Capital Budgets (DCBs) are recognised directly in contributed equity in that year.

Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Government entity under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

Under the *Administrative Arrangements Order* issued on 30th September 2015:

- responsibility for aged care programs and functions was transferred to the Department from the Department of Social Services (DSS). This included the Australian Aged Care Quality Agency;
- the statutory offices of the Aged Care Commissioner and the Aged Care Pricing Commissioner transferred to the Department; and
- Medicare Provider compliance for the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule and allied health services transferred to the Department from the Department of Human Services (DHS).

Refer to Note 9: Restructuring for the details of assets and liabilities transferred between the affected agencies which occurred in 2015-16.

In addition, following the passing of required legislation, the Private Health Insurance Administration Council and the Private Health Insurance Ombudsman, entities within the Health Portfolio, were closed and their functions transferred to the Department and other Australian Government entities.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Independent Reviews Prior Year Funding

During the current period, the Department identified a prior period error. The error has been corrected by retrospectively restating the affected comparative items in the current year. It was identified that certain unspent departmental funding, appropriated between 2005-06 and 2013-14 was recognised as a liability payable to the Department of Finance (Finance). In 2015-16, the Department determined that there was no obligation to return the unspent funding to Finance. No transactions have impacted the liability reported in error since 2013-14. The effect of derecognising the liability to comparative amounts for 2015-16 has reduced Suppliers by $24.879m in the Statement of Financial Position. The effect of recognising the accumulated funding between 2005-06 and 2013-14 to comparative amounts for 2015-16 has reduced the Accumulated Deficit by $24.879m within the Statement of Financial Position and the Statement of Changes in Equity.

Other Distributions to Owners

The FRR requires that any distribution to owners be debited to contributed equity unless it is in the nature of a dividend.

1.8 Employee Benefits

Liabilities for 'short-term employee benefits' (as defined in *AASB 119 Employee Benefits*) and termination benefits due within twelve months of the end of reporting period are measured at their nominal amounts.

Other long-term employee benefits are measured as net total of the present value of the defined benefit obligation at the end of the reporting period minus the fair value at the end of the reporting period of plan assets (if any) out of which the obligations are to be settled directly.

Leave

The liability for employee benefits includes provisions for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the Department is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the Department's employer superannuation contribution rates to the extent that leave is likely to be taken during service rather than paid out on termination. The liability for long service leave and annual leave expected to be settled outside of 12 months of the balance date has been determined by reference to the work of an actuary as at June 2016. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Separation and Redundancy

Provision is made for separation and redundancy benefit payments, as shown at Note 8A: Employee Provisions. The Department recognises a provision for termination when it has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

Superannuation

Under the *Superannuation Legislation Amendment (Choice of Funds) Act 2004*, staff of the Department are able to become a member of any complying superannuation fund. A complying superannuation fund is one that meets the requirements under the *Income Tax Assessment Act (1997)* and the *Superannuation Industry (Supervision) Act 1993*.

The Department's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), the PSS accumulation plan (PSSap) or other compliant super funds with the rates of contribution being set by the Department of Finance on an annual basis.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap and other compliant superannuation funds are defined contribution schemes.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

The Department makes employer contributions to the employee superannuation schemes at rates determined by an actuary to be sufficient to meet the current cost to the Government. The Department accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the number of days between the last pay period in the financial year and 30 June.

1.9 Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased assets. An operating lease is a lease that is not a finance lease. In operating leases, the lessor effectively retains substantially all such risks and benefits.

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Surplus Lease Space

Future net outlays in respect of surplus space under non-cancellable lease agreements are expensed in the period in which the spaces are identified as becoming surplus.

Lease Incentives

Lease incentives taking the form of 'free' leasehold improvements and rent holidays are recognised as liabilities. These liabilities are reduced on a straight-line basis by allocating lease payments between rental expense and reduction of the lease incentive liability.

Provision for Restoration Obligation

Where the Department has a contractual obligation to undertake remedial work upon vacating leased properties, the estimated cost of that work is recognised as a liability. An equal value asset is created at the same time and amortised over the life of the lease of the underlying leasehold property.

1.10 Cash

Cash and cash equivalents include:

- cash on hand;
- demand deposits in bank accounts with an original maturity of three months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value; and
- cash in special accounts includes amounts that are banked in the Australian Government's Official Public Account.

Overdrafts

An overdraft occurs when the amount withdrawn from the Department's administered bank account by the DHS, due to an agreed sweeping arrangement, is greater than the original estimated payments. A debit balance of the bank account as a result of an inaccurate estimate is authorised by the Finance Minister's delegations under section 53 (2) of the *PGPA Act*.

1.11 Financial assets

The Department classifies its financial assets in the following categories:

- available-for-sale financial assets; and
- loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon trade date.

Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

Available-for-Sale Financial Assets

Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories.

Available-for-sale financial assets are recorded at fair value. Gains and losses arising from changes in fair value are recognised directly in the reserves (equity) with the exception of impairment losses. Interest is calculated using the effective interest method and foreign exchange gains and losses on monetary assets are recognised directly in profit or loss. Where the asset is disposed of, or is determined to be impaired, part (or all) of the cumulative gain or loss previously recognised in the reserve is included in surplus and deficit for the period.

Loans and Receivables

Trade receivables, loans and other receivables that have fixed or determinable payments that are not quoted in an active market are classified as 'loans and receivables'. Loans and receivables are measured at amortised cost using the effective interest method less impairment. Interest is recognised by applying the effective interest rate.

Impairment of Financial Assets

Financial assets are assessed for impairment at the end of each reporting period.

Financial assets held at amortised cost - if there is objective evidence that an impairment loss has been incurred for loans and receivables, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Statement of comprehensive income.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Available-for-sale financial assets - if there is objective evidence that an impairment loss on an available-for-sale financial asset has been incurred, the amount of the difference between its cost, less principal repayments and amortisation, and its current fair value, less any impairment loss previously recognised in expenses, is transferred from equity to the Statement of comprehensive income.

1.12 Financial Liabilities

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or 'other financial liabilities'. Financial liabilities are recognised and derecognised upon trade date.

The Department does not hold any financial liabilities at 'fair value through profit and loss'.

Other financial liabilities are initially measured at fair value, net of transaction costs. These liabilities are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective yield basis.

Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

1.13 Contingent Liabilities and Contingent Assets

Contingent liabilities and contingent assets are not recognised in the Statement of financial position but are reported in the relevant notes. They may arise from uncertainty as to the existence of a liability or asset, or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not certain, and contingent liabilities are disclosed when settlement is greater than remote.

1.14 Acquisition of Assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor's accounts immediately prior to the restructuring, refer also Note 1.7.

1.15 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of financial position, except for information technology equipment purchases costing less than $500 (TGA $2,000), leasehold improvements costing less than $50,000 (TGA $10,000), and all other purchases costing less than $2,000, which are expensed in the year of acquisition (other than when they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in property leases taken up by the Department where there exists an obligation to restore the property to prescribed conditions. These costs are included in the value of the Department's leasehold improvements with a corresponding provision for the 'make good' recognised.

Revaluations

Following initial recognition at cost, property, plant and equipment are carried at latest value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations depends upon the volatility of movements in market values for the relevant assets.

An independent valuation of all property, plant and equipment was carried out by Australian Valuation Solutions Pty Ltd on 30 June 2015. The desktop review of assets undertaken as at 30 June 2016 indicated that the carrying value of departmental assets did not materially differ from fair value.

Revaluation adjustments are made on a class basis. Any revaluation increment was credited to equity under the heading of asset revaluation reserve except to the extent that it reversed a previous revaluation decrement of the same class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset is restated to the revalued amount.

Any class of asset not formally revalued in a given year has been subject to a management assessment (or a desktop review) to ensure the carrying value does not materially differ to its fair value.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

An independent valuation of administered land and buildings was carried out by Australian Valuation Solutions Pty Ltd on 30 June 2014. The 2016 desktop valuation of administered buildings indicated that a revaluation as at 30 June 2016 was required to align the carrying value with the fair value. Refer also Note 19.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Department using, in all cases, the straight-line method of depreciation. Leasehold improvements are depreciated on a straight-line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease, including any applicable lease options available.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are made in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2016	2015
Buildings on freehold land	20 to 25 years	20 to 25 years
Leasehold improvements	The lower of the lease term or the estimated useful life	The lower of the lease term or the estimated useful life
Plant and equipment	3 to 20 years	3 to 20 years

Impairment

All assets were assessed for impairment at 30 June 2016. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

1.16 Intangibles

The Department's intangibles comprise internally developed software for internal use and purchased software. These assets are carried at cost less accumulated amortisation and accumulated impairment losses. The Department recognises internally developed software costing more than $100,000 and purchased software costing more than $500 (TGA $100,000.)

Software is amortised on a straight-line basis over its anticipated useful life.

The useful lives of the Department's software are:

	2016	2015
Internally developed software	2 to 10 years	2 to 10 years
Purchased software	2 to 7 years	2 to 7 years

All software assets were assessed for indications of impairment as at 30 June 2016.

1.17 Taxation

The Department is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office; and for receivables and payables.

1.18 Reporting of Administered Activities

Administered revenues, expenses, assets, liabilities and cash flows are disclosed in the administered schedules and related notes.

Except where otherwise stated below, administered items are accounted for on the same basis and using the same policies as for departmental items, including the application of Australian Accounting Standards.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Administered Cash Transfers to and from the Official Public Account

Revenue collected by the Department for use by the Government rather than the Department is administered revenue. Collections are transferred to the Official Public Account (OPA) maintained by the Department of Finance. Conversely, cash is drawn from the OPA to make payments under Parliamentary appropriation on behalf of Government. These transfers to and from the OPA are adjustments to the administered cash held by the Department on behalf of the Government and are reported as such in the Administered cash flow statement and in the Administered reconciliation schedule.

Revenue

All administered revenues are revenues relating to the course of ordinary activities performed by the Department on behalf of the Australian Government. As such, administered appropriations are not revenues of the individual entity that oversees distribution or expenditure of the funds as directed.

Recoveries are recognised on an accrual basis and relate to:

- recoveries under the Medical Benefits, Pharmaceutical Benefits and Health Rebate schemes after settlement of personal injury claims;
- recoveries for services provided under the National Disability Insurance Scheme and for young people in residential care;
- rebates associated with high cost drug recoveries; and
- recoveries from the DHS Recovery of Compensation for Health Care and Other Services Special Account.

Inventories

The Department's inventories relate to the National Medical Stockpile (the Stockpile). The Stockpile is a strategic reserve of medicines, vaccines, antidotes and protective equipment available for use as part of the national response to a public health emergency. It is intended to augment state and territory government reserves of key medical items in a health emergency, which could arise from terrorist activities or natural causes.

Inventories held for distribution are valued at cost, adjusted for any loss of service potential. Not all inventories are expected to be distributed in the next 12 months.

Costs incurred in bringing each item of the Stockpile to its present location and condition include purchase cost plus other reasonably attributable costs, such as overseas shipping and handling and import duties, less any bulk order discounts and rebates received from suppliers.

During 2016, $105.4m of inventory held for distribution was recognised as an expense (2015: $5.1m) of which $105.4m was obsolete stock (2015: $3.2m).

Administered Investments

Administered investments represent Corporate Commonwealth entities within the Health portfolio. Administered investments in subsidiaries, joint ventures and associates are not consolidated because their consolidation is only relevant at the Whole of Government level.

Administered investments other than those held for sale are classified as available-for-sale and are measured at their fair value as at 30 June 2016. Fair value has been taken to be the Australian government's proportional interest in the net assets of each organisation as at the end of the reporting period.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

Personal Benefits

Personal benefits are the current transfers for the benefit of individuals or households, directly or indirectly, that do not require any economic benefit to flow back to Government. The Department administers a number of personal benefits programs on behalf of the Government that provide a range of health care entitlements to individuals. These include, but are not limited to:

- Pharmaceutical Benefits (the primary means through which the Australian Government ensures Australians have timely access to pharmaceuticals);
- Medical Benefits (provide high quality and clinically relevant medical and associated services through Medicare);
- Private Health Insurance Rebate (helps make private health insurance more affordable, provides greater choice and accessibility to access private health care options, and reduces pressure on the public hospital system);
- Primary Care Practice Incentives (support activities that encourage continuing improvements, increase quality of care, enhance capacity, and improve access and health outcomes for patients);
- Targeted Assistance (support the provision of relevant pharmaceuticals, aids and appliances); and
- Hearing Services (reduce the incidence and consequences of avoidable hearing loss in the community by providing access to high quality hearing services and devices).

Personal benefits are assessed, determined and paid by DHS in accordance with provisions of the relevant legislation under delegation from the Department. Unless stated otherwise, all personal benefits liabilities are expected to be settled within 12 months of the balance date.

In the majority of cases the above payments are initially based on the information provided by customers and providers. Both the Department and DHS have established review mechanisms to identify overpayments made under various schemes. The recognition of receivables and recovery actions take place once the overpayments are identified.

Refer to Note 1.4 for significant accounting judgements and estimates relating to personal benefits.

Grants and Subsidies

The Department administers a number of grant and subsidy schemes on behalf of the Government.

Grant and subsidy liabilities are recognised to the extent that (i) the services required to be performed by the grantee have been performed or (ii) the grant eligibility criteria have been satisfied, but payments due have not been made. A commitment is recorded when the Government enters into an agreement to make these grants but services have not been performed or criteria satisfied. Unless stated otherwise, all grants and subsidies liabilities are expected to be settled within 12 months of the balance date.

Refer to Note 1.4 for significant accounting judgements and estimates relating to subsidies.

Payments to corporate Commonwealth entities

Payments to corporate Commonwealth entities from amounts appropriated for that purpose are classified as administered expenses, equity injections or loans to the relevant portfolio entity. The appropriation to the Department is disclosed in Table A of Note 26A. Payments to corporate Commonwealth entities are disclosed in Note 17G.

1.19 Events After the Reporting Period

TGA special account annual charges 2015-16

Sponsors of certain products on the Australian Register of Therapeutic Goods during 2015-16 have until 15 September 2016 to apply for exemption for 2015-16 annual charges. The amounts recognised as revenue in these financial statements may be subject to change should sponsors successfully apply for reinstatement of exempt status.

Outcome restructure

Effective 1 July 2016, the Department's Outcome and Program structure has been revised and the number of Outcomes has been reduced from 11 to 6. Details of the revised Outcome and Program structure are included in the 2016-17 Health Portfolio Budget Statements.

Administered Inventory

$10.117m of Administered inventory held in the National Medical Stockpile will pass its expiry date during the period July to September 2016 (2015: $20.703m).

Portfolio Agencies

The National Health Performance Authority has closed and its activities and capabilities transferred to the Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Health Care on 1 July 2016.

Department of Health

Notes to and forming part of the financial statements

Note 1: Overview

The functions of the Independent Hospital Pricing Authority (IHPA) have been transferred to the Department effective 1 July 2016, with the Board, Chief Executive Officer and associated functions retained. The Department will provide all support for IHPA from 1 July 2016.

Digital Health

The Government announced in the 2015-16 Budget that in response to the Review of the Personally Controlled Electronic Health Record (PCEHR) it would redevelop the system to improve its usability and clinical utility, strengthen digital health governance and operations, and trial new participation arrangements. The PCEHR was then renamed to become the *My Health Record* and the Australian Digital Health Agency (ADHA) was established during 2016 to manage the governance, operation and ongoing delivery for digital health with the transfer date of 1 July 2016. *My Health Record* software will be transferred to ADHA with an effective date of 1 July 2016.

Department of Health

Notes to and forming part of the financial statements

Note 2: Expenses

	2016 $'000	2015 $'000
Note 2A: Employee benefits		
Wages and salaries	**321,540**	258,503
Superannuation:		
Defined contribution plans	**27,876**	20,979
Defined benefit plans	**39,785**	34,137
Leave and other entitlements	**71,506**	55,209
Separation and redundancies	**3,820**	5,037
Total employee benefits	**464,527**	373,865
Note 2B: Suppliers		
Goods and services supplied or rendered		
Contractors and consultants	**84,532**	59,236
Information technology costs	**79,888**	53,798
Contracted services	**25,478**	10,064
Property	**11,195**	6,922
Travel	**9,577**	7,107
Training and other staff related expenses	**6,646**	5,826
Legal	**5,920**	4,455
Committees	**3,967**	3,363
Other	**17,788**	16,965
Total goods and services supplied or rendered	**244,991**	167,736
Other suppliers		
Operating lease rentals in connection with		
Minimum lease payments	**49,146**	71,402
Contingent rentals	**3,257**	3,061
Workers compensation premiums	**7,022**	9,874
Total other suppliers	**59,425**	84,337
Total suppliers	**304,416**	252,073
Note 2C: Depreciation and amortisation		
Depreciation		
Property, plant and equipment	**2,259**	8,371
Buildings - leasehold improvements	**7,269**	9,648
Total depreciation	**9,528**	18,019
Amortisation		
Computer software - internally developed	**14,216**	25,400
Computer software - purchased	**240**	534
Total amortisation	**14,456**	25,934
Total depreciation and amortisation	**23,984**	43,953
Note 2D: Write-down and impairment of assets		
Impairment on financial instruments	**366**	2,019
Impairment of property, plant and equipment	**28**	238
Impairment on intangibles	**2,351**	1,011
Total write-down and impairment of assets	**2,745**	3,268

Department of Health

Notes to and forming part of the financial statements

Note 2: Expenses

	2016 $'000	2015 $'000
Note 2E: Other expenses		
Payments made on behalf of Portfolio agencies [1]	**1,077**	1,150
Act of Grace payments	**28**	31
Other	**-**	10,350
Total other expenses	**1,105**	11,531

[1] Payments made on behalf of Portfolio agencies are recovered, refer Note 3B.

Note 2F: Lease Commitments		
Operating leases[2]	**345,780**	610,528
Total leases	**345,780**	610,528
Minimum lease payments expected to be settled		
Within 1 year	**53,296**	100,361
Between 1-5 years	**188,734**	355,425
More than 5 years	**103,750**	154,742
Total leases	**345,780**	610,528

[2] The operating lease commitments relates to property lease payments.
Note: Commitments disclosed for Financial year 2014-15 are inclusive of all operating expense lease commitments.

Department of Health

Notes to and forming part of the financial statements

Note 3: Income

	2016 $'000	2015 $'000
OWN-SOURCE REVENUE		
Note 3A: Sale of goods and rendering of services		
Sale of goods in connection with		
Sale of goods	**1,449**	1,716
Rendering of services	**173,112**	163,647
Total sale of goods and rendering of services	**174,561**	165,363
Note 3B: Other revenue		
Recoveries received from Portfolio agencies[1]	**1,077**	1,150
Resources received free of charge		
Remuneration of auditors	**975**	1,050
Other revenue	**11**	26
Total other revenue	**2,063**	2,226

[1] For payments made on behalf of Portfolio agencies refer Note 2E.

GAINS		
Note 3C: Gains from sale of assets		
Infrastructure, Plant and Equipment		
Proceeds from sale	**9,209**	-
Less: Carrying value of assets sold	**9,131**	-
Total gain from sale of assets	**78**	-
Note 3D: Other gains		
Other gains	**370**	3
Total other gains	**370**	3
Note 3E: Revenue from Government		
Appropriations		
Departmental appropriations	**594,997**	479,885
Total revenue from Government	**594,997**	479,885

Department of Health

Notes to and forming part of the financial statements

Note 4: Operating Result Reconciliation

	2016	2015
	$'000	$'000
Total comprehensive loss - as per the Statement of Comprehensive Income	**(24,708)**	(37,214)
Plus: depreciation/amortisation expenses previously funded through revenue appropriation[1]	**19,177**	38,015
Total comprehensive profit/(loss) less depreciation/amortisation expenses previously funded through revenue appropriations [2]	**(5,531)**	801

Included in the **Total comprehensive loss - as per the Statement of Comprehensive Income** are the following:

A significant element of supplier expenses includes an amount of $12.315m paid to the Department of Social Services for the continued development of information technology systems utilised by the Department's ageing and aged care functions. The amount had been transferred to the Department as an equity contribution via the Machinery of Government changes for the financial year. The transfer of the amount as an equity contribution through capital rather than revenue therefore did not compensate the Department for the additional expense incurred.

In addition, the application of prevailing bond rates to the Department's employee provisions also contributed a further $2.881m in expenses for the year.

[1] Depreciation/amortisation expense for NICNAS and the TGA have been excluded where assets have been acquired from Industry funds.

[2] From 2010-11, the Government introduced net cash appropriation arrangements, where revenue appropriations for depreciation/amortisation expenses ceased. Entities now receive a separate capital budget provided through equity appropriations. Capital budgets are to be appropriated in the period when cash payment for capital expenditure is required.

Department of Health

Notes to and forming part of the financial statements

Note 5: Financial Assets

	2016 $'000	2015 $'000
Note 5A: Cash and cash equivalents		
Special accounts	**5,574**	7,459
Cash on hand or on deposit	**1,854**	762
Cash in special accounts	**83,244**	71,410
Total cash and cash equivalents	**90,672**	79,631
Note 5B: Trade and other receivables		
Receivables in connection with:		
Goods and services receivable	**16,242**	10,963
Appropriations receivables		
Existing programs	**103,076**	93,132
Undrawn equity injection	**12,180**	9,673
Departmental capital budget	**316**	5,922
Total appropriations receivable	**115,572**	108,727
Other receivables		
GST receivable from the Australian Taxation Office	**5,974**	2,584
Total other receivables	**5,974**	2,584
Total trade and other receivables (gross)	**137,788**	122,274
Less impairment allowance		
Goods and services	**(668)**	(1,505)
Total impairment allowance	**(668)**	(1,505)
Total trade and other receivables (net)	**137,120**	120,769
Trade and other receivables (net) are expected to be recovered		
No more than 12 months	**136,651**	120,213
More than 12 months	**469**	556
Total trade and other receivables (net)	**137,120**	120,769
Trade and other receivables are aged as follows		
Not overdue	**130,013**	120,078
Overdue by		
0 to 30 days	**5,747**	595
31 to 60 days	**1,048**	94
61 to 90 days	**458**	153
More than 90 days	**522**	1,354
Total trade and other receivables (gross)	**137,788**	122,274
The impairment allowance aged as follows		
Not overdue	**-**	(67)
Overdue by:		
0 to 30 days	**(20)**	(52)
31 to 60 days	**(28)**	(24)
61 to 90 days	**(98)**	(117)
More than 90 days	**(522)**	(1,245)
Total impairment allowance	**(668)**	(1,505)

Department of Health

Notes to and forming part of the financial statements

Note 5: Financial Assets

Credit terms for goods and services were within: the Department 30 days (2015: 30 days), TGA 28 days (2015: 28 days). Appropriations receivable undrawn, are appropriations controlled by the Department but held in the Official Public Account under the Government's just-in-time drawdown arrangement.

The impairment allowance for amounts not overdue related to the TGA for disputed debts.

Reconciliation of the impairment allowance

Movements in relation to 2016

	Goods and services	**Total**
	$'000	**$'000**
Opening balance	**(1,505)**	**(1,505)**
Amounts written off	**584**	**584**
Amounts recovered and reversed	**803**	**803**
Increase recognised in net surplus	**(550)**	**(550)**
Closing balance	**(668)**	**(668)**

Movements in relation to 2015

	Goods and services	Total
	$'000	$'000
Opening balance	(3,460)	(3,460)
Amounts written off	2,063	2,063
Amounts recovered and reversed	806	806
Increase recognised in net surplus	(914)	(914)
Closing balance	(1,505)	(1,505)

Note 6: Non-Financial Assets including Fair Value Measurements

Note 6A: Reconciliation of the opening and closing balances of land and buildings and property, plant, equipment and intangible for 2016

	Land and buildings	Property, plant and equipment	Computer Software - Internally Developed	Computer Software - Purchased	Total Intangibles
	$'000	**$'000**	$'000	$'000	**$'000**
As at 1 July 2015					
Gross book value	**53,196**	**7,065**	194,072	5,867	**199,939**
Accumulated depreciation/amortisation and impairment	**(169)**	**-**	(103,268)	(5,266)	**(108,534)**
Total as at 1 July 2015	**53,027**	**7,065**	90,804	601	**91,405**
Additions					
Purchase or internally developed	**2,143**	**1,001**	31,790	-	**31,790**
Acquisitions of entities or operations (including restructuring)	**6,240**	**50**	-	-	**-**
Depreciation/Amortisation	**(7,269)**	**(2,259)**	(14,216)	(240)	**(14,456)**
Reclassification	**(245)**	**487**	(157)	(85)	**(242)**
Assets held for sale	**-**	**9,131**	-	-	**-**
Disposals					
From disposal of entities or other operations (including restructuring)	**(618)**	**-**	-	-	**-**
Other	**-**	**(9,159)**	-	-	**-**
Impairment	**-**	**-**	(2,351)	-	**(2,351)**
Total as at 30 June 2016	**53,278**	**6,316**	105,870	276	**106,146**
Total as at 30 June 2016 represented by					
Gross book value[1]	**60,676**	**8,564**	221,220	4,652	**225,872**
Accumulated depreciation/amortisation and impairment	**(7,398)**	**(2,248)**	(115,350)	(4,376)	**(119,726)**
Total as at 30 June 2016	**53,278**	**6,316**	105,870	276	**106,146**

[1] Closing gross book value includes Work in Progress of Leasehold Improvement of $1.170m and Intangible Work in Progress of $49.695m.

Department of Health

Notes to and forming part of the financial statements

Note 6: Non-Financial Assets including Fair Value Measurements

Note 6A: Reconciliation of the opening and closing balances of land and buildings and property, plant, equipment and intangible for 2015

	Land and buildings	Property, plant and equipment	Computer Software - Internally Developed	Computer Software - Purchased	Total Intangibles
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2014					
Gross book value	67,772	27,424	180,072	6,145	186,217
Accumulated depreciation/amortisation and impairment	(21,347)	(12,622)	(82,707)	(5,009)	(87,716)
Total as at 1 July 2014	46,425	14,802	97,365	1,136	98,501
Additions					
Purchase or internally developed	721	2,396	26,592	-	26,592
Revaluations recognised in other comprehensive income	16,169	224			-
Depreciation/Amortisation	(9,648)	(8,371)	(25,400)	(534)	(25,934)
Reclassification	-	6,743	(6,742)	(1)	(6,743)
Disposals					-
From disposal of entities or other operations (including restructuring)	(454)	(8,677)	-	-	-
Impairment	(186)	(52)	(1,011)	-	(1,011)
Total as at 30 June 2015	53,027	7,065	90,804	601	91,405
Total at 30 June 2015 represented by					
Gross book value[1]	53,196	7,065	194,072	5,867	199,939
Accumulated depreciation/amortisation and impairment	(169)	-	(103,268)	(5,266)	(108,534)
Total as at 30 June 2015	53,027	7,065	90,804	601	91,405

[1] Closing gross book value includes Work in Progress of Leasehold Improvement of $1.173m and Intangible Work in Progress of $56.019m.

Note 6: Non-Financial Assets including Fair Value Measurements

Note 6B: Fair Value Measurements

The following tables provide an analysis of assets and liabilities that are measured at fair value.
The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
Level 3: Unobservable inputs for the asset or liability.

Note 6B(i): Fair Value Measurements, Valuation Techniques and Inputs Used

	Fair value measurements at the end of the reporting period using			For Levels 2 and 3 fair value measurements	
	2016	2015	Category	Valuation	Inputs used
	$'000	$'000	(Level 1, 2 or 3[4])*	technique(s)[2]	
Non-financial assets[3]					
Leasehold Improvements	**1,169**	-	Level 2	Replacement Cost	
	63	80	Level 2	Market Approach	Adjusted market
	52,046	51,773	Level 3	Depreciated Replacement Cost (DRC)	Replacement Cost New (price per square metre) Consumed economic benefit / Obsolescence of asset
Property, plant and equipment	**2,757**	2,362	Level 2	Market Approach	Adjusted market transactions
	58	69	Level 3	Market Approach	Adjusted market transactions
	3,501	4,635	Level 3	Depreciated Replacement Cost (DRC)	Replacement Cost New Consumed economic benefit / Obsolescence of asset
Total non-financial assets	**59,594**	58,919			
Total fair value measurements of assets in the statement of financial position	**59,594**	58,919			

Department of Health

Notes to and forming part of the financial statements

Note 6: Non-Financial Assets including Fair Value Measurements

Assets not measured at fair value in the statement of financial position:		
Intangibles	**56,451**	35,386
Asset Under Construction - Intangibles	**49,695**	56,020
- Leasehold Improvement	**-**	1,173
Assets held for sale	**-**	9,131
Total assets not measured at fair value in the statement of financial position	**106,146**	101,710
Total non-financial assets (excluding prepayments) stated in the statement of financial	**165,740**	160,629

[1] The Department measured non-financial assets at fair value as at March 2015 on non-recurring assets held for sale.

[2] There has been changes to the valuation techniques for assets in the property, plant and equipment class. In instances where sufficient observable inputs, such as market transactions of similar assets, were (not) identified in this financial year, the valuation technique was changed from a DRC (Market) approach to a Market (DRC) approach.

[3] Fair value measurements - highest and best use differs from current use for non-financial assets (NFAs)

The Department of Health's assets are held for operational purposes and not held for the purposes of deriving a profit. The current use of all NFAs is considered their highest and best use.

[4] Recurring and non-recurring Level 3 fair value measurements - valuation processes

The Department tests the procedures of the valuation model as an asset materiality review at least once every 12 months (with a formal revaluation undertaken once every three years). If a particular asset class experiences significant and volatile changes in fair value (i.e. where indicators suggest that the value of the class has changed materially since the previous reporting period), that class is subject to specific valuation in the reporting period, where practicable, regardless of the timing of the last specific valuation. The Department engaged Australian Valuation Solutions (AVS) to undertake a full revaluation and confirm that the models developed comply with AASB 13.

The weighted average is determined by assessing the fair value measurement as a proportion of the total fair value for the class against the total useful life of each asset.

[5] Significant Level 3 inputs utilised by the entity are derived and evaluated as follows:

Property, Plant & Equipment - Adjusted Market Transactions

The significant unobservable inputs used in the fair value measurement of PPE assets relates to the market demand and valuers judgement to determine the fair value measurement of these assets. A significant increase (decrease) in this input would result in a significantly higher (lower) fair value measurement.

Leasehold Improvements, Property, Plant and Equipment - Consumed economic benefit / Obsolescence of asset

Assets that do not transact with enough frequency or transparency to develop objective opinions of value from observable market evidence have been measured utilising the cost (Depreciated Replacement Cost or DRC) approach. Under the DRC approach the estimated cost to replace the asset is calculated and then adjusted to take into account its consumed economic benefit / asset obsolescence (accumulated depreciation). Consumed economic benefit / asset obsolescence has been determined based on professional judgement regarding physical, economic and external obsolescence factors relevant to the asset under consideration. For all Leasehold Improvement assets, the consumed economic benefit/ asset obsolescence deduction is determined based on the term of the associated lease.

Note 6: Non-Financial Assets including Fair Value Measurements

Note 6B(ii): Level 1 and Level 2 transfers for recurring fair value measurements

There have been no transfers of NFAs between level 1 and 2 of the hierarchy during the year.

Note 6B(iii): Reconciliation for recurring Level 3 fair value measurements

Recurring Level 3 fair value measurements - reconciliation for assets

	Non-financial assets					
	Leasehold Improvements		Property, Plant and Equipment		Total	
	2016 $'000	2015 $'000	**2016 $'000**	2015 $'000	**2016 $'000**	2015 $'000
Opening balance[1]	**51,773**	45,736	**4,704**	6,726	**56,476**	52,462
Total gains/(losses) recognised in net cost of services	**(7,252)**	(9,825)	**(1,394)**	(1,645)	**(8,646)**	(11,471)
Total gains/(losses) recognised in other comprehensive income[2]	**-**	16,167	**-**	320	**-**	16,487
Purchases	**91**	148	**-**	1,520	**91**	1,668
Transfers to Assets Held for Sale	**-**	(453)	**-**	(2,218)	**-**	(2,671)
Transfers/operations including restructuring	**5,621**	-	**4**	-	**5,625**	-
Reclassification	**1,813**	-	**245**	-	**2,058**	-
Transfers into Level 3[3]	-	-	-	115	-	115
Transfers out of Level 3[4]	-	-	-	(115)	-	(115)
Closing balance	**52,046**	51,773	**3,559**	4,704	**55,604**	56,476
Changes in unrealised gains/(losses) recognised[5]	**-**	-	**-**	-	**-**	-

[1] Open balance as determined in accordance with AASB 13

[2] The presentation of these gains/(losses) in the Statement of Comprehensive Income will depend on the entity.

[3] There have been transfers of property, plant and equipment asset fair value measurements into level 3 during the year due to changes in the valuation technique from a market approach to DRC.

[4] There have been transfers of property, plant and equipment asset fair value measurements out of level 3 during the year due to changes in the valuation technique from DRC to a market approach. Fair value measurements have been determined without the use of significant unobservable inputs.

[5] The presentation of unrealised gains/(losses) in the Statement of Comprehensive Income will depend on the entity.

Department of Health

Notes to and forming part of the financial statements

Note 6: Non-Financial Assets including Fair Value Measurements

	2016	2015
	$'000	$'000
Note 6C: Other non-financial assets		
Prepayments	**11,729**	3,804
Total other non-financial assets	**11,729**	3,804
Other non-financial assets are expected to be recovered		
No more than 12 months	**11,668**	3,651
More than 12 months	**61**	153
Total other non-financial assets	**11,729**	3,804

No indicators of impairment were found for other non-financial assets.

Note 7: Payables

Note 7A: Suppliers		
Trade creditors and accruals	**61,620**	61,882
Total suppliers	**61,620**	61,882

Settlement is usually made within 30 days.

Note 7B: Other payables		
Wages and salaries	**2,926**	11,248
Superannuation	**187**	2,086
Other employee payables	**74**	73
Lease incentives	**23,656**	16,998
Unearned income	**18,353**	21,004
Total other payables	**45,196**	51,409
Total other payables		
Other payables expected to be settled		
No more than 12 months	**25,382**	36,217
More than 12 months	**19,814**	15,192
Total other payables	**45,196**	51,409

Department of Health

Notes to and forming part of the financial statements

Note 8: Provisions

	2016	2015
	$'000	$'000
Note 8A: Employee provisions		
Leave	**151,721**	110,972
Separations and redundancies	**422**	5,000
Total employee provisions	**152,143**	115,972
Employee provisions expected to be settled		
No more than 12 months	**43,133**	38,430
More than 12 months	**109,010**	77,542
Total employee provisions	**152,143**	115,972
Note 8B: Other provisions		
Provision for surplus lease space[1]	**-**	1,000
Provision for restoration[2]	**3,079**	598
Provision for lease straightlining[3]	**25,481**	20,419
Total other provisions	**28,560**	22,017
Other provisions expected to be settled		
No more than 12 months	**1,647**	7,830
More than 12 months	**26,913**	14,187
Total other provisions	**28,560**	22,017

	Provision for surplus lease space[1]	Provision for restoration[2]	Provision for lease straightlining[3]	Total
	$'000	$'000	$'000	$'000
As at 1 July 2015	**1,000**	**598**	**20,419**	**22,017**
Additional provisions made	**-**	**2,716**	**6,152**	**8,868**
Amounts used	**1,000**	**235**	**1,090**	**2,325**
Total as at 30 June 2016	**-**	**3,079**	**25,481**	**28,560**

[1] The Department took up a provision for surplus lease space on Anne St, Brisbane in the 2013-14 financial year for a two year period. This space will be occupied by the Aged Care staff during the 2016-17 financial year.

[2] The Department currently has 7 (2015: 3) agreements for the leasing of premises which have provisions requiring the entity to restore the premises to their original condition at the conclusion of the lease. The Department has made a provision to reflect the present value of this obligation.

[3] The Department holds a provision for lease straightlining on the existing 11 leases.

Department of Health

Notes to and forming part of the financial statements

Note 9: Restructuring

Note 9: Restructuring - Machinery of Government Changes

Functions in relation to:	2016 Aged Care and Population Ageing, Department of Social Services[1] $'000	2016 Medicare Provider Compliance, Department of Human Services[2] $'000	2016 (Administered) Ageing and Aged Care, Department of Social Services[1] $'000
FUNCTIONS ASSUMED			
Assets recognised			
Appropriation receivable	25,973	8,814	-
Departmental Capital Budget (DCB) receivable[4]	639	326	-
Equity injection[4]	12,256	-	-
Other Receivable		-	-
Prepayments	6	-	-
Receivables	-	-	63,801
Advances and loans	-	-	268,008
Other non-financial assets	-	-	1,324
Property, plant and equipment	14	36	-
Leasehold improvements	6,240	-	-
Total assets recognised	**45,128**	**9,176**	**333,133**
Liabilities recognised			
Trade creditors and accruals	175	-	-
Provisions for make-good, lease incentives and straightlining	9,759	-	-
Employee provisions	27,282	11,118	-
Supplier payable	-	-	3,405
Subsidies payable	-	-	149,514
Grants payable	-	-	11,441
Total liabilities recognised	**37,216**	**11,118**	**164,360**
Net assets/(liabilities) recognised[3]	**7,912**	**(1,942)**	**168,773**
Income assumed			
Recognised by the receiving entity	-	-	921,950
Recognised by the losing entity	509	-	1,425
Total income assumed	**509**	**-**	**923,375**
Expenses assumed			
Recognised by the receiving entity	95,734	27,269	10,478,225
Recognised by the losing entity	32,354	15,826	3,668,712
Total expenses assumed	**128,088**	**43,095**	**14,146,937**
FUNCTIONS RELINQUISHED			
Assets relinquished			
Leasehold improvements[5]	618	-	-
Total assets relinquished	**618**	**-**	**-**
Net assets/(liabilities) relinquished	**618**	**-**	**-**

[1] Responsibility for Ageing and Aged care functions was assumed from the DSS under the *Administrative Arrangements Order* issued on 30 September 2015.

[2] Responsibility for Medicare provider compliance functions was assumed from the DHS under the *Administrative Arrangements Order* issued on 30 September 2015.

[3] The net assets assumed from Department of Social Service (DSS) is $168.000m for Adminstered and $6.588m for Departmental.

[4] Appropriation received amounting to $12.175m as Bill 2 and $0.139m as Departmental Capital Budget were paid to DSS, refer also Note 4.

[5] Leasehold improvement relinquished relate to the property at 2 Lonsdale Street, Melbourne being transferred back from DSS.

Note:
In respect of functions assumed, the net book values of assets and liabilities were transferred to the entity for no consideration.
By agreement, the transfer of leases from DSS was effective from 1 January 2016.
By agreement, staff transferred from DSS and DHS on 5 November 2015.
No comparatives are detailed given that no Machinery of Government changes were made during the 2014-15 year.

Department of Health

Notes to and forming part of the financial statements

Note 10: Cash Flow Reconciliation

	2016	2015
	$'000	$'000
Reconciliation of cash and cash equivalents as per Statement of Financial Position to Cash Flow Statement		
Report cash and cash equivalents as per		
Cash Flow Statement	**90,672**	79,631
Statement of Financial Position	**90,672**	79,631
Discrepancy	**-**	-
Reconciliation of net cost of services to net cash from operating activities		
Net cost of services	**(619,705)**	(517,099)
Add revenue from Government	**594,997**	479,885
Adjustment for non-cash items		
Gain on sale of assets /Net loss from sale of assets and Other gains	**(448)**	-
Depreciation/amortisation	**23,984**	43,953
Net write-down of non-financial assets	**28**	3,269
Decrease in net assets from restructure	**(13,541)**	15,743
Movements in assets and liabilities		
Assets		
Decrease/(increase) in net receivables	**(19,218)**	(673)
Decrease/(increase) in other financial assets	**(3,144)**	(83)
Decrease/(increase) in other non-financial assets	**(7,925)**	3,992
Liabilities		
Increase/(decrease) in employee provisions/payables	**30,972**	4,158
Increase/(decrease) in supplier payables	**152**	(2,014)
Increase/(decrease) in other payables	**4,007**	(19,947)
Increase/(decrease) in other provisions	**6,543**	(2,379)
Net cash from operating activities	**(3,298)**	8,804

Department of Health

Notes to and forming part of the financial statements

Note 11: Contingent Assets and Liabilities

	Guarantees		Claims for damages or costs		Total	
	2016	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000
Contingent assets						
Balance from previous period	**-**	-	**238**	238	**238**	-
New contingent assets recognised	**-**	-	**9**	-	**9**	238
Re-measurement	**-**	-	**(178)**	-	**(178)**	-
Rights expired	**-**	-	**(50)**	-	**(50)**	-
Total contingent assets	**-**	-	**19**	238	**19**	238
Contingent liabilities						
Balance from previous period	**5,000**	27,600	**4,630**	1,768	**9,630**	29,368
New	**-**	-	**-**	2,630	**-**	2,630
Re-measurement	**-**	(22,600)	**550**	232	**550**	(22,368)
Obligations expired	**-**	-	**(170)**	-	**(170)**	-
Total contingent liabilities	**5,000**	5,000	**5,010**	4,630	**10,010**	9,630
Net contingent liabilities	**(5,000)**	(5,000)	**(4,991)**	(4,392)	**(9,991)**	(9,392)

Department of Health

Notes to and forming part of the financial statements

Note 11: Contingent Assets and Liabilities

Quantifiable Contingencies

Quantifiable Contingent Assets

The Department has a quantifiable contingent asset as at 30 June 2016 of $0.190m (2015: $0.240m).

Quantifiable Contingent Liabilities

Claims for damages and costs

The Schedule of Contingencies reports contingent liabilities in respect of claims for damages/costs of $5.010m (2015: $4.630m). The amount represents an estimate of the Department's liability based on precedent cases. The Department is defending the claims.

Guarantees

The Schedule of Contingencies reports a contingent liability in respect of claims for payments made for Price Disclosure Services of $5.000m (2015: $5.000m). This represents the maximum exposure to the Commonwealth in the event that the current contractor is unable to deliver.

Unquantifiable Contingencies

Unquantifiable Contingent Assets

At 30 June 2016, the Department was involved in a number of litigation cases before the courts. The Department has been advised by its solicitors that it is not possible to quantify amounts relating to these cases. Therefore, in accordance with Accounting Standard AASB 137 *Provisions, Contingent Liabilities and Contingent Assets,* the information is not required by the Standard on the grounds that it may seriously prejudice the outcomes of these cases.

Unquantifiable Contingent Liabilities

At 30 June 2016, the Department was involved in a number of litigation cases before the courts. The Department has been advised by its solicitors that it is not possible to quantify amounts relating to these cases. Therefore, in accordance with Accounting Standard AASB 137 *Provisions, Contingent Liabilities and Contingent Assets,* the information is not required by the Standard on the grounds that it may seriously prejudice the outcomes of these cases.

The Department has provided an indemnity to its transactional bankers in relation to any claims made against the bank resulting from errors in the Department's payment files. There were no claims made during the year.

Significant Remote Contingencies

The Department did not have any significant remote contingencies in either reporting year.

Department of Health

Notes to and forming part of the financial statements

Note 12: Senior Management Personnel Remuneration

	2016 $	2015 $
Short-term employee benefits:		
Salary	**27,196,217**	22,647,935
Performance bonuses	**1,618**	-
Allowances	**4,732,175**	4,017,741
Total short-term employee benefits	**31,930,010**	26,665,676
Post-employment benefits:		
Superannuation	**5,191,049**	4,314,012
Total post-employment benefits	**5,191,049**	4,314,012
Other long-term employee benefits:		
Annual leave	**2,414,887**	2,191,540
Long service leave	**977,524**	963,072
Total other long-term employee benefits	**3,392,411**	3,154,612
Termination benefits		
Voluntary redundancy payments	**1,549,881**	854,629
Total senior executive remuneration expenses	**42,063,351**	34,988,929

Notes:

The total number of senior management personnel that are included in the above table is 195 (2015:164) and represents the nominal positions for the current year. The current year number has been impacted by the transfers of SES positions which took place during the year as a consequence of the Machinery of Government. Average Staffing Levels (ASL) for the current year is 154 (2015:128).

Department of Health

Notes to and forming part of the financial statements

Note 13: Financial Instruments

	2016 $'000	2015 $'000
Note 13A: Categories of financial instruments		
Financial Assets		
Loans and receivables		
Cash and cash equivalents	**90,672**	79,631
Goods and services receivable	**15,574**	9,458
Accrued revenue	**8,649**	5,505
Total loans and receivables	**114,895**	94,594
Total financial assets	**114,895**	94,594
Financial Liabilities		
Financial Liabilities measured at amortised cost		
Trade creditors	**61,620**	(61,882)
Total financial liabilities measured at amortised cost	**61,620**	(61,882)
Total financial liabilities	**61,620**	(61,882)
Note 13B: Net income and expenses from financial instruments		
Loans and receivables:		
Impairment expense	**366**	2,019
Net expense from loans and receivables	**366**	2,019
Net expense from financial assets	**366**	2,019

There was no interest income from financial assets not at fair value through profit or loss in the year ending 2016(2015: $NIL).

Note 13C: Liquidity risk

The Department's financial liabilities are payables. The exposure to liquidity risk is based on the notion that the Department will encounter difficulty in meeting its obligations associated with financial liabilities.

This is highly unlikely due to appropriation funding and mechanisms available to the Department (e.g. Advance to the Finance Minister) and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations. The Department has no prior experience of default.

The maturities for non-derivative financial liabilities amount to $61.620m (2014-15: $86.758m).

The Department has no derivative financial liabilities in both the current and prior year.

Note 13D: Market risk

The Department's financial instruments are of a nature that does not expose the Department to certain market risks.

The Department is not exposed to 'currency risk' or 'other price risk'.

The Department has no interest bearing items on the Statement of Financial Position.

Department of Health

Notes to and forming part of the financial statements

Note 13: Financial Instruments

Note 13E: Credit risk

The Department was exposed to minimal credit risk as loans and receivables are cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. The amount was equal to the total amount of trade receivables of $24.891m in 2016 (2015: $16.468m). The entity managed its credit risk by establishing policies and procedures with regard to debt management and recovery techniques that were to be applied.

The following table illustrates the Department's maximum exposure to credit risk (excluding any collateral or credit enhancements).

	2016	2015
	$'000	$'000
Financial assets carried amount not best representing maximum exposure to credit risk		
Goods and services receivable	**16,242**	10,963
Accrued revenue	**8,649**	5,505
Total financial assets carried at amount not best representing maximum exposure to credit risk	**24,891**	16,468

The Department holds no collateral to mitigate against risk.

Credit quality of financial assets not past due or individually determined as impaired

	Not past due nor impaired	Not past due nor impaired	**Past due or impaired**	Past due or impaired
	2016	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000
Loans and receivables				
Goods and services receivable	**8,467**	8,443	**7,775**	2,263
Accrued revenue	**8,649**	5,505	**-**	-
Total	**17,116**	13,948	**7,775**	2,263

Ageing of financial assets that were past due but not impaired in 2016

	0 to 30 days	**31 to 60 days**	**61 to 90 days**	**90+ days**	**Total**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Loans and receivables					
Goods and services receivable	**5,727**	**1,020**	**360**	**-**	**7,107**
Total	**5,727**	**1,020**	**360**	**-**	**7,107**

Ageing of financial assets that were past due but not impaired for 2015

	0 to 30 days	31 to 60 days	61 to 90 days	90+ days	Total
	$'000	$'000	$'000	$'000	$'000
Loans and receivables					
Goods and services receivable	543	70	36	109	758
Total	543	70	36	109	758

Department of Health

Notes to and forming part of the financial statements

Note 14: Therapeutic Goods Administration

Note 14A: Objective

The Therapeutic Goods Administration (TGA) is a part of the Department of Health, which is an Australian Government controlled not for profit entity. The TGA contributes to Outcome 7 of the Department of Health – health infrastructure, regulation, safety and quality. The Australian Government, through Outcome 7, aims to support a sustainable world class health system in Australia through support for deregulation, effective regulation, quality and safety, and strategic investments in health infrastructure and research.

Pursuant to Division 3 of the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR), the TGA is not an applicable entity within the Department and as such is not deemed to be a reporting entity. TGA operates via a special account. Included below is financial information for the TGA. The balance of the special account represents a standing appropriation from which payments are made for the purposes of the special account. As a significant part of the Department, the TGA accounts are subject to annual audit by the Australian National Audit Office.

Therapeutic goods are regulated to ensure that medicinal products and medical devices in Australia meet standards of safety, quality and efficacy at least equal to that of comparable countries. These products and devices should be made available in a timely manner and the regulatory impact on business kept to a minimum. This is achieved through a risk management approach to pre-market evaluation and approval of therapeutic products intended for supply in Australia, licensing of manufacturers and post market surveillance.

The continued existence of the TGA in its present form and with its present priorities is dependent on Government policy. The TGA is reflected as a departmental special account in the Department of Health's statements.

TGA receives payment for evaluation services in advance of service delivery, which can extend across financial years. TGA estimates the stage of service completion and recognises the matching revenue. Revenue reported for 2016 includes an estimate for annual charges, refer Note 1.5.

The TGA recovers the cost of all activities undertaken within the scope of the *Therapeutic Goods Act 1989* from industry through fees and charges.

	2016 **$'000**	2015 $'000
Note 14B: Comprehensive Income		
Expenses		
Employee benefits	**79,193**	84,612
Consultants and Contractors	**16,940**	14,154
Property (including lease payments)	**14,906**	14,391
Other	**12,967**	13,923
Depreciation and amortisation	**4,672**	5,620
Write-down and impairment of assets	**105**	2,205
Total expenses	**128,783**	134,905
Sale of goods and rendering of services	**141,539**	130,764
Other revenue and gains	**148**	200
Total own-source revenue	**141,687**	130,964
Revenue from Government	**3,177**	8,579
Surplus on continuing operations	**16,081**	4,638
Changes in asset revaluation surplus	**-**	824
Total comprehensive income	**16,081**	5,462

Department of Health

Notes to and forming part of the financial statements

Note 14: Therapeutic Goods Administration

	2016	2,015
	$'000	$'000
Note 14C: Financial Position		
Assets		
Financial assets[1]	**78,142**	67,272
Non-financial assets	**25,022**	21,846
Total assets	**103,164**	89,118
Liabilities		
Payables	**(24,457)**	(24,353)
Provisions	**(23,781)**	(25,917)
Total liabilities	**(48,237)**	(50,270)
Equity		
Contributed equity	**2,029**	2,029
Asset revaluation reserve	**4,217**	4,217
Retained surplus	**48,680**	32,602
Total Equity	**54,926**	38,848
Note 14D: Commitments		
Capital Commitments		
Property, Plant and Equipment	**(72)**	(1,652)
Other Commitments		
Operating Leases	**(9,405)**	(20,084)
Total Capital and Lease Commitments [2]	**(9,477)**	(21,736)

[1] Cash balance is disclosed in Note 27 Special Accounts

[2] Included in Note: 2B Suppliers.

Department of Health

Notes to and forming part of the financial statements

Note 15: Remuneration of Auditors

	2016 $'000	2015 $'000
Financial statement audit services were provided free of charge to the Department by the Australian National Audit Office (ANAO).		
Fair value of services received		
Financial statement audit services - Department	**827**	1,303
Financial statement audit services - TGA	**148**	200
Total fair value of services received	**975**	1,503

No other services were provided by the auditors of the financial statements.

Department of Health

Notes to and forming part of the financial statements

Note 16: Regulatory Charging Summary

	2016 $'000	2015 $'000
Amounts applied		
Departmental		
Annual appropriations	**2,141**	23,376
Special appropriations (including special account)	**-**	141,226
Own source revenue	**165,882**	-
Administered		
Annual appropriations	**2,243**	2,594
Total amounts applied	**170,266**	167,196
Expenses		
Departmental	**164,874**	166,796
Administered	**2,250**	2,592
Total expenses	**167,124**	169,388
Revenue		
Departmental	**164,367**	150,159
Administered	**14,906**	16,213
Total external revenue	**179,273**	166,372
Amounts written off		
Departmental	565	3,723
Administered	**58**	-
Total amounts written-off	**623**	3,723

Regulatory charging activities:

Therapeutic Goods Administration (TGA)

TGA undertakes cost recovered activities to evaluate the safety, quality and efficacy of medicines, medical devices and biologicals available for supply in, or export from Australia. Regulation activities include:
- Pre-market assessments
- Post-market monitoring and enforcement of standards
- Licensing of Australian manufacturers and verifying overseas manufacturers' compliance with the same standards as their Australian counterparts.

Further details regarding TGA cost recovery arrangements are available at http://www.tga.gov.au/cost-recovery-implementation-statements.

National Industrial Chemicals Notification and Assessment Scheme (NICNAS)
Registration levies charged for registration of chemicals across Australia.
Assessment fees charged on assessment of chemicals.
https://www.nicnas.gov.au/about-nicnas/cost-recovery/cost-recovery-impact-statement

Department of Health

Prostheses List: The prostheses listing arrangements refer to the activities involved in listing prostheses and their benefits for the purposes of private health insurance reimbursement.

Private Health Insurance Ombudsman Levy - Administered Revenue only.

Listing of medicines on the Pharmaceutical Benefits Scheme and designated vaccines on the National Immunisation Program.

Private Health Insurance Ombudsman Levy - Administered Revenue only.

http://www.health.gov.au/internet/main/publishing.nsf/Content/phib-njrr

http://www.pbs.gov.au/publication/factsheets/shared/cost-recovery-implementation-statement-2015-2016.pdf

Department of Health

Notes to and forming part of the financial statements

Note 17: Administered - Expenses

	2016 $'000	2015 $'000
Note 17A: Suppliers		
Services rendered		
Consultants	**16,034**	13,984
Contract for services	**606,068**	385,993
Travel	**653**	485
Communications and publications	**26,831**	24,776
Committee related expenses	**2,366**	1,450
Other	**24,816**	26,916
Total services rendered	**676,768**	453,604
Note 17B: Subsidies		
Subsidies in connection with		
Aged care	**9,161,229**	-
Medical indemnity	**81,517**	83,920
Mental health	**33,897**	32,735
Other	**13,558**	10,048
Total subsidies	**9,290,201**	126,703
Note 17C: Personal benefits		
Indirect		
Medical services	**21,428,064**	20,470,868
Pharmaceuticals and pharmaceutical services	**10,832,702**	9,072,126
Private health insurance	**5,887,067**	5,804,467
Primary care practice incentives	**340,120**	228,069
Hearing services	**475,905**	443,628
Targeted assistance	**405,287**	441,984
Other	**138,496**	99,823
Total personal benefits	**39,507,641**	36,560,965
Note 17D: Grants		
Public sector		
Australian government entities (related entities)	**730,250**	672,200
Health and hospital fund	**44,391**	661,980
Private sector		
Profit and non-profit organisations	**5,025,630**	4,000,865
Health and hospital fund	**8,201**	57,436
Overseas	**9,847**	19,730
Total grants	**5,818,319**	5,412,211

Department of Health

Notes to and forming part of the financial statements

Note 17: Administered - Expenses

	2016	2015
	$'000	$'000
Note 17E: Depreciation and amortisation		
Depreciation		
Buildings	**963**	963
Total depreciation	**963**	963
Amortisation		
Intangibles	**19,420**	18,309
Total amortisation	**19,420**	18,309
Total depreciation and amortisation	**20,383**	19,272
Note 17F: Write-down and impairment of assets		
Impairment on financial instruments	**1,950**	626
Write-off of inventories	**105,376**	3,232
Total write-down and impairment of assets	**107,326**	3,858
Note 17G: Payments to corporate Commonwealth entities		
Australian Institute of Health and Welfare	**15,625**	15,800
Food Standards Australia New Zealand	**17,257**	17,479
Australian Sports Commission	**253,646**	267,568
Independent Hospital Pricing Authority	**25,877**	-
National Health Performance Authority	**16,253**	-
Total payments to corporate entities	**328,658**	300,847
Note 17H: Other expenses		
Act of Grace payments	**50**	12
Foreign exchange losses (net) - non-speculative	**1**	-
Cost of inventory distributed	**5**	5
Transfers to Private Health Insurance Administration Council	**-**	445,538
Payments to Special Accounts	**10,093**	5,345
Total other expenses	**10,149**	450,900

Department of Health

Notes to and forming part of the financial statements

Note 18: Administered - Income

	2016 $'000	2015 $'000
Revenue		
Taxation revenue		
Note 18A: Other taxes		
Medical indemnity levy	**15,561**	14,744
Other	**2,238**	2,162
Total other taxes	**17,799**	16,906
Non-taxation revenue		
Note 18B: Recoveries		
Medical and pharmaceutical benefits and health rebate schemes	**72,904**	59,793
High cost drug recoveries	**1,576,230**	721,214
Aged care recoveries, cross-billings and budget neutrality adjustments	**907,700**	-
Total recoveries	**2,556,834**	781,007
Note 18C: Other revenue		
Transfers from Private Health Insurance Administration Council	**-**	445,538
Health and hospital fund	**54,984**	716,916
Other	**197,238**	212,601
Total other revenue	**252,222**	1,375,055

Department of Health

Notes to and forming part of the financial statements

Note 19: Administered - Fair Value Measurements

The following tables provide an analysis of assets and liabilities that are measured at fair value.
The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
Level 3: Unobservable inputs for the asset or liability.

Note 19A: Fair value measurements, valuation techniques and inputs used

	Fair value measurements at the end of the reporting period			For Level 2 and 3 fair value measurements	
	2016	2015	**Category (Level 1, 2 or 3[2])**	**Valuation technique(s)**	**Inputs used**
	$'000	$'000			
Financial assets[3]					
Other investments	**380,117**	390,024	Level 3	Net assets	Net assets position of each entity
Total financial assets	**380,117**	390,024			
Non-financial assets[1]					
Land	**605**	605	Level 2	Market approach	Adjusted market transactions
Land	**1,290**	1,290	Level 3	Market approach	Adjusted market transactions
Buildings	**690**	677	Level 2	Market approach	Adjusted market transactions
Buildings	**30,612**	21,896	Level 3	Depreciated Replacement Cost (DRC)	Current costs per square metre of floor relevant to the location of the asset, adjusted for the estimated rate of physical depreciation and obsolescence
Total non-financial assets	**33,197**	24,468			
Total fair value measurements of assets in the administered schedule of assets and liabilities	**413,314**	414,492			

Note 19: Administered - Fair Value Measurements

Note 19A: Fair value measurements, valuation techniques and inputs used (continued)

1. Fair value measurements - highest and best use differs from current use for non-financial assets (NFAs)
The highest and best use of all non-financial assets is the same as their current use.

2. Recurring and non-recurring Level 3 fair value measurements - valuation process
Land and Buildings - general
The Department engages an independent valuer to undertake valuations of Administered land and buildings. The Department tests the procedures of the valuation model as an internal management review at least once every 12 months, with a formal revaluation undertaken once every three years. If a particular asset class experiences significant and volatile changes in fair value (i.e. where indicators suggest that the value of the class has changed materially since the previous reporting period), that class is subject to specific valuation in the reporting period, where practical, regardless of the timing of the last specific valuation. The Department procured services of the Australian Valuation Solutions Pty Ltd (AVS) to undertake a valuation of Administered land and buildings as at 30 June 2014. However, sufficient evidence was available during the 2016 desktop valuation, such as the recent hospital construction contracts across Australia, to warrant further quantitative analysis to be carried out and a subsequent revaluation of the buildings to be recognised. AVS provided written assurance to the Department that the valuation models developed are in compliance with AASB 13.

Land and buildings - Adjusted market transactions
The Department controls land and buildings assets situated in Latrobe, Tasmania. Reference was made to available sales evidence together with other relevant information related to local economic and property market conditions. Market transactions for the main hospital site and ancillary car parks (CP zoned) had been scarce, and the valuer has used significant professional judgement in determining the fair value measurements.

Buildings - Consumed economic benefit / Obsolescence of asset
Mersey Community Hospital is an asset that is held to provide health-related services to the Northern Region of Tasmania. Assets of this nature are not transacted with by market participants with sufficient frequency or transparency to develop objective opinions of value from observable market evidence. Therefore, value has been measured utilising the cost (Depreciated Replacement Cost or DRC) approach. Under the DRC approach the estimated cost to replace the asset is calculated and then adjusted to take into account its consumed economic benefit / asset obsolescence. Consumed economic benefit / asset obsolescence has been determined based on professional judgement regarding physical, economic and external obsolescence factors relevant to the asset under consideration.

Other investments - Net assets
The value of investments is estimated annually on the basis of net asset position of each entity, as obtained from management accounts.

3. Recurring and non-recurring Level 3 fair value measurements - sensitivity analysis for financial assets and liabilities
Other investments - Net assets
Significant unobservable inputs used in the fair value measurement of other investments relate to the assets and liabilities reported in the management accounts of each entity. A significant increase / (decrease) in this input would result in a significantly lower / (higher) fair value measurement.

4. The remaining assets and liabilities reported by the Department in the Administered Schedule of Assets and Liabilities are not measured at fair value.

Department of Health

Notes to and forming part of the financial statements

Note 19: Administered - Fair Value Measurements

Note 19B: Reconciliation for recurring Level 3 fair value measurements

Recurring Level 3 fair value measurements - reconciliation for assets

	Financial assets		Non-financial assets	
	Other investments		Land and buildings	
	2016	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000
As at 1 July	**390,024**	524,830	**23,186**	24,121
Total gains recognised in other comprehensive income[1]	**-**	-	**9,651**	-
Total losses recognised in other comprehensive income[2]	**(9,906)**	(134,806)	**-**	-
Total losses recognised in net cost of services[3]	**-**	-	**(935)**	(935)
Total as at 30 June	**380,117**	390,024	**31,902**	23,186

[1] Gains recognised in 2016 relate to the revaluation of Mersey hospital buildings as at 30 June 2016.

[2] Losses recognised in 2016 relate to the elimination of investment in PHIAC following its merger with the Australian Prudential Regulation Authority effective 1 July 2015 and the annual revaluation of other investments. Of the total losses recognised in 2015, $184.200m is the result of elimination of investments in HWA and GPET following the abolition of these agencies. The remainder is the result of revaluation of administered investments as at 30 June 2015. The full value of losses has been taken to the Administered Schedule of Comprehensive Income.

[3] These losses are presented in the Administered Schedule of Comprehensive Income under depreciation and amortisation (Note 17E).

Department of Health

Notes to and forming part of the financial statements

Note 20: Administered - Financial Assets

	2016 $'000	2015 $'000
Note 20A: Cash and cash equivalents		
Cash on hand or on deposit	**164,509**	331,001
Cash in special accounts	**7,070**	5,647
Total cash and cash equivalents	**171,579**	336,648
Note 20B: Personal benefits receivable		
Pharmaceutical benefits	**712,796**	97,236
Medicare benefits	**34,828**	51,258
Other personal benefits	**497**	17
Total personal benefits receivable	**748,121**	148,511
Note 20C: Trade and other receivables		
Goods and services receivable		
Subsidies		
Medical indemnity	**10,933**	11,187
Aged care	**78,117**	-
Other	**49**	-
Other - recoveries and miscellaneous receivables	**210,582**	127,168
Total goods and services receivables	**299,681**	138,355
Advances and loans		
Aged care facilities	**271,352**	-
Total advances and loans	**271,352**	-
Advances and loans represented by		
Nominal value	**306,696**	-
Less: Unexpired discount	**(35,344)**	-
Carrying amount	**271,352**	-

Loans were made to approved providers under the *Aged Care Act 1997* for an estimated period of 12 years. No security is generally required. Interest rates are linked to the Consumer Price Index. Interest payments are due on the 21st day of each calendar month. These loans were transferred to the Department from the DSS during 2016 for no consideration under the Administrative Arrangements Order issued on 30th September 2015.

Other receivables		
GST receivable from the Australian Taxation Office	**62,000**	41,171
Total other receivables	**62,000**	41,171
Total trade and other receivables (gross)	**633,033**	179,526
Less impairment allowance		
Goods and services	**(7,637)**	(7,675)
Total impairment allowance	**(7,637)**	(7,675)
Total trade and other receivables (net)	**625,396**	171,851
Trade and other receivables (net) expected to be recovered		
No more than 12 months	**347,166**	171,851
More than 12 months	**278,230**	-
Total trade and other receivables (net)	**625,396**	171,851

Department of Health

Notes to and forming part of the financial statements

Note 20: Administered - Financial Assets

	2016 $'000	2015 $'000
Trade and other receivables (gross) aged as follows		
Not overdue	**605,413**	165,140
Overdue by:		
0 to 30 days	**5,797**	4,606
31 to 60 days	**8,596**	134
61 to 90 days	**2,774**	134
More than 90 days	**10,453**	9,512
Total trade and other receivables (gross)	**633,033**	179,526

The entire impairment allowance relates to debts aged more than 90 days.

Credit terms for goods and services were net 30 days (2015: 30 days).

Reconciliation of the Impairment Allowance

Movement in relation to 2016

	Goods and Services Receivable $'000
As at 1 July 2015	**(7,675)**
Amounts written off	**1,760**
Amounts recovered and reversed	**362**
Increase recognised in net cost of services	**(2,084)**
Total as at 30 June 2016	**(7,637)**

Movement in relation to 2015

	Goods and Services Receivable $'000
As at 1 July 2014	(11,132)
Amounts written off	222
Amounts recovered and reversed	3,951
Increase recognised in net cost of services	(716)
Total as at 30 June 2015	(7,675)

Department of Health

Notes to and forming part of the financial statements

Note 20: Administered - Financial Assets

		2016	2015
		$'000	$'000
Note 20D: Other investments			
Equity interest - Australian Institute of Health and Welfare	(i)	**6,723**	5,880
Equity interest - Food Standards Australia New Zealand	(ii)	**7,745**	7,592
Equity interest - Private Health Insurance Administration Council		**-**	2,774
Equity interest - Australian Commission on Safety and Quality in Health Care	(iii)	**2,136**	1,774
Equity interest - Australian Sports Commission	(iv)	**310,208**	315,108
Equity interest - Australian Sports Foundation Ltd	(v)	**4,375**	15,889
Equity interest - Independent Hospital Pricing Authority	(vi)	**24,125**	17,500
Equity interest - National Health Performance Authority	(vii)	**24,805**	23,507
Total other investments		**380,117**	390,024

None of the investments are expected to be recovered within 12 months.
The Department classifies these investments as 'available for sale' and they were measured at fair value as at 30 June 2016. Fair value has been taken to be the unaudited net assets of the entity as at the end of the reporting period.

(i) The Australian Institute of Health and Welfare informs community discussion and decision making through national leadership and collaboration in developing and providing health and welfare statistics and information.

(ii) The Food Standards Australia New Zealand protects and informs consumers through the development of effective food standards, in a way that helps stimulate and support growth and innovation in the food industry.

(iii) The Australian Commission on Safety and Quality in Health Care works to lead and coordinate national improvements in safety and quality in health care across Australia.

(iv) The Australian Sports Commission manages, develops and invests in sport at all levels. It works closely with a range of national sporting organisations, state and local governments, schools and community organisations to ensure sport is well run and accessible.

(v) The Australian Sports Foundation Ltd assists sporting, community, educational and other government organisations to raise funds for the development of sports infrastructure.

(vi) The Independent Hospital Pricing Authority was established on 1 July 2014 to contribute to significant reforms to improve Australian public hospitals. A major component of these reforms is the implementation of national Activity Based Funding (ABF) for Australian public hospitals. The implementation of ABF provides incentives for efficiency and increases transparency in the delivery and funding of public hospital services across Australia.

(vii) The National Health Performance Authority was established on 1 July 2014 to monitor and report on the performance of local health care organisations including Local Hospital Networks, public and private hospitals, and primary health care organisations such as Medicare Locals and other organisations that provide health care services to the community. It provides nationally consistent, locally relevant and comparable information about Australia's health system to inform consumers, stimulate and inform improvements and increase transparency and accountability.

Transferred entities

The Private Health Insurance Administration Council regulates the financial performance of the private health industry, calculates the reinsurance pool, reviews pricing applications, registers health insurance organisations, and provides information relating to membership in private health insurance and the benefits paid by the industry. Private Health Insurance Administration Council was merged with the Australian Prudential Regulation Authority effective 1 July 2015, and the value of investment was reduced to nil.

Department of Health

Notes to and forming part of the financial statements

Note 21: Administered - Non-Financial Assets

Reconciliation of the opening and closing balances of property, plant and equipment and intangibles for 2016

	Land	Buildings	Total land and buildings	Computer Software	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2015					
Gross book value	**1,895**	**23,536**	**25,431**	**91,544**	**116,975**
Accumulated depreciation, amortisation and impairment	**-**	**(963)**	**(963)**	**(54,927)**	**(55,890)**
Total as at 1 July 2015	**1,895**	**22,573**	**24,468**	**36,617**	**61,085**
Additions					
Internally developed	**-**	**-**	**-**	**31,626**	**31,626**
Revaluations and impairments recognised in other comprehensive income	**-**	**9,692**	**9,692**	**-**	**9,692**
Depreciation and amortisation	**-**	**(963)**	**(963)**	**(19,420)**	**(20,383)**
Total as at 30 June 2016	**1,895**	**31,302**	**33,197**	**48,823**	**82,020**
Total as at 30 June 2016 represented by					
Gross book value	**1,895**	**31,302**	**33,197**	**123,170**	**156,367**
Accumulated depreciation, amortisation and impairment	**-**	**-**	**-**	**(74,347)**	**(74,347)**
Total as at 30 June 2016 represented by	**1,895**	**31,302**	**33,197**	**48,823**	**82,020**

No indications of impairment were found for land, buildings and software.

No land and buildings are expected to be sold or disposed of within the next 12 months. All of the computer software balance (comprising *My Health Record*) will be transferred to the Australian Digital Health Agency at cost, effective 1 July 2016.

Reconciliation of the opening and closing balances of property, plant and equipment and intangibles for 2015

	Land	Buildings	Total land and buildings	Computer Software	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2014					
Gross book value	1,895	23,536	25,431	91,544	116,975
Accumulated depreciation, amortisation and impairment	-	-	-	(36,618)	(36,618)
Total as at 1 July 2014	1,895	23,536	25,431	54,926	80,357
Depreciation and amortisation	-	(963)	(963)	(18,309)	(19,272)
Total as at 30 June 2015	1,895	22,573	24,468	36,617	61,085
Total as at 30 June 2015 represented by					
Gross book value	1,895	23,536	25,431	91,544	116,975
Accumulated depreciation, amortisation and impairment	-	(963)	(963)	(54,927)	(55,890)
Total as at 30 June 2015 represented by	1,895	22,573	24,468	36,617	61,085

Department of Health

Notes to and forming part of the financial statements

Note 22: Administered - Payables and Provisions

	2016	2015
	$'000	$'000
Note 22A: Suppliers		
Trade creditors and accruals	**9,881**	7,110
Total suppliers	**9,881**	7,110

All suppliers payable are expected to be settled within 12 months.

Settlement is usually made within 30 days.

	2016	2015
	$'000	$'000
Note 22B: Grants		
Australian Government entities (related entities)	**32,244**	15,101
Profit and non-profit organisations	**345,826**	360,061
Total grants	**378,070**	375,162

All grants payable are expected to be settled within 12 months.

Settlement is made according to the terms and conditions of each grant. This is usually within 30 days of performance or eligibility.

	Notes	2016	2015
		$'000	$'000
Note 22C: Subsidies - external parties			
Medical Indemnity provision			
Incurred But Not Reported Scheme	22D	**28,000**	34,000
High Cost Claims Scheme	22D	**316,000**	300,000
Run-Off Cover Scheme	22D	**81,000**	79,000
Total subsidies		**425,000**	413,000
Subsidies expected to be settled			
No more than 12 months		**61,438**	51,363
More than 12 months		**363,562**	361,637
Total subsidies		**425,000**	413,000

The reconciliation of this provison is disclosed in 22D.

Department of Health

Notes to and forming part of the financial statements

Note 22: Administered - Provisions

Note 22D: Medical Indemnity Provision

The table below provides a summary of the movement of medical indemnity provisions in the Department's Administered Schedule of Assets and Liabilities for the financial year ended 30 June 2016.

	Balance as at 30 June 2015	Claims paid	Administered Schedule of Comprehensive Income Impact	Balance as at 30 June 2016
	$'000	$'000	$'000	$'000
Medical Indemnity Liabilities				
Incurred But Not Reported Scheme	**34,000**	**(5,907)**	**(93)**	**28,000**
High Cost Claims Scheme	**300,000**	**(49,911)**	**65,911**	**316,000**
Run-Off Cover Scheme	**79,000**	**(4,123)**	**6,123**	**81,000**
Total	**413,000**	**(59,941)**	**71,941**	**425,000**

Medical Indemnity is administered by the Department under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* . The Department administers the following medical indemnity schemes:

- Incurred But Not Reported Scheme (IBNRS);
- High Cost Claims Scheme (HCCS);
- Exceptional Claims Scheme (ECS);
- Run-Off Cover Scheme (ROCS);
- Premium Support Scheme (PSS);
- Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS); and
- Midwife Professional Indemnity Run-off Cover Scheme (MPIRCS).

In accordance with Note 1.4, a liability can only be recognised for IBNRS, HCCS and ROCS.

A summary of each of the schemes is provided below:

Incurred But Not Reported Scheme (IBNRS)

The IBNRS provides for payments to Avant Mutual Group for claims made in relation to its IBNR liability at 30 June 2002. Some claims that will be payable under the IBNRS may also be eligible for payment under the HCCS.

High Cost Claims Scheme (HCCS)

Under HCCS, the Government pays 50% of the cost of claims made to all Medical Indemnity Insurers (MIIs) that exceed a specified threshold, up to the limit of the practitioner's insurance. The threshold to be applied depends on the date of notification of the claim, as follows:

- from 1 January 2003 to 21 October 2003 - $2m;
- from 22 October 2003 to 31 December 2003 - $0.500m; and
- on or after 1 January 2004 - $0.300m.

Exceptional Claims Scheme (ECS)

The ECS provides coverage for practitioners for the cost of medical indemnity claims that exceed the limit of their contract of insurance. To be covered by the ECS, the practitioner must have medical indemnity insurance cover to at least $15m for the period 1 January to 30 June 2003 and $20m from 1 July 2003.

Run-Off Cover Scheme (ROCS)

ROCS provides free run-off cover for specific groups of medical practitioners including those retired and over 65, on maternity leave, retired for more than three years, retired due to permanent disability or the estates of those that have died. This scheme is funded through the collection of support payments imposed as a tax on MIIs.

Premium Support Scheme (PSS)

The PSS helps eligible doctors with the costs of their medical indemnity insurance. Under this scheme, if a doctor's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a subsidy towards the cost of the premium beyond that threshold limit.

Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)

Under this scheme, Medical Insurance Australia Pty Ltd (MIGA) is reimbursed for part of the costs of claims notified to MIGA on or after 1 July 2010. MIGA will pay the first $0.100m of each eligible claim, plus 20 cents in the dollar for claims costs between $0.100m and $2m. The Government will contribute the remaining 80 cents in the dollar for claims costs between $0.100m and $2m (i.e. Level 1 Commonwealth contributions) and will meet 100% of that part of the cost of any claim which exceeds the $2m threshold (i.e. Level 2 Commonwealth contributions).

Midwife Professional Indemnity Run-off Scheme (MPIRCS)

Under this scheme, MIGA is fully reimbursed for the costs of claims made by midwives who have ceased practice. The MPIRCS applies to claims (including incidents) notified to MIGA on or after 1 July 2010 by midwives.

Department of Health

Notes to and forming part of the financial statements

Note 23: Administered - Cash Flow Reconciliation

	2016 $'000	2015 $'000
Reconciliation of cash and cash equivalents as per Administered Schedule of Assets and Liabilities to Administered Cash Flow Statement		
Cash and cash equivalents as per:		
Administered Cash Flow Statement	**171,579**	336,648
Administered Schedule of Assets and Liabilities	**171,579**	336,648
Discrepancy	**-**	-
Reconciliation of net cost of services to net cash used by operating activities		
Net cost of services	**(52,927,833)**	(41,155,392)
Adjustment for non-cash items		
Depreciation and amortisation	**20,383**	19,272
Net write-down of assets	**107,326**	3,858
Inventory adjustments	**5**	5
Foreign exchange losses (net)	**1**	-
Concessional loans discount and unwinding	**2,552**	-
Movements in assets and liabilities		
Assets		
Decrease/(increase) in net receivables	**(718,628)**	34,419
Decrease/(increase) in inventories	**(6,642)**	(5,373)
Liabilities		
Increase/(decrease) in suppliers payable	**(634)**	(3,082)
Increase/(decrease) in subsidies payable	**111,316**	74
Increase/(decrease) in personal benefits payable	**(16,666)**	64,363
Increase/(decrease) in grants payable	**(8,533)**	98,225
Increase/(decrease) in subsidies provision	**12,000**	18,000
Increase/(decrease) in personal benefits provision	**268,551**	(15,803)
Net cash used by operating activities	**(53,156,802)**	(40,941,434)

Department of Health

Notes to and forming part of the financial statements

Note 24: Administered - Contingent Assets and Liabilities

Contingent Assets

There were no quantifiable administered contingent assets as at 30 June 2016 (2015: Nil).

	Indemnities		Claims for costs		Aged Care Accommodation Bond Guarantee Scheme		Total	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Contingent liabilities								
Balance from previous period	**52,000**	53,000	**81**	263	**-**	-	**52,081**	53,263
New contingent liabilities recognised	**-**	-	**22**	50	**208**	-	**230**	50
Re-measurement	**8,000**	(1,000)	**(13)**	-	**-**	-	**7,987**	(1,000)
Liabilities recognised	**-**	-	**-**	(4)	**-**	-	**-**	(4)
Obligations expired	**-**	-	**-**	(228)	**-**	-	**-**	(228)
Restructure	**-**	-	**-**	-	**-**	-	**-**	-
Total contingent liabilities	**60,000**	52,000	**90**	81	**208**	-	**60,298**	52,081
Net contingent liabilities	**60,000**	52,000	**90**	81	**208**	-	**60,298**	52,081

Department of Health

Notes to and forming part of the financial statements

Note 24: Administered - Contingent Assets and Liabilities

Quantifiable Contingent Liabilities

Indemnities
The table on the previous page reports a contingent liability in respect of medical indemnity payments under the High Cost Claims Scheme of up to $60m (2015: $52m).

Claims for Costs
The table also reports a contingent liability in respect of claims for costs payments related to medical benefits of up to $0.090m (2015: $0.081m).

Aged Care Accommodation Bond Guarantee Scheme
The Department is currently aware of the potential for the accommodation bond scheme to be activated. If this occurs, the maximum payments required to be made by the Commonwealth under the scheme is estimated at $0.208m.

Unquantifiable Contingent Assets

Compensation from Sanofi
The Department has initiated legal action to seek compensation from Sanofi, the original patent owner of clopidogrel (Plavix®), for additional costs to the Pharmaceutical Benefits Scheme (PBS) resulting from a delay in listing a generic version of clopidogrel. Listing a generic form of clopidogrel on the Australian market in 2008 would have triggered an automatic reduction to the price paid by the Government for clopidogrel through the PBS and is likely to have resulted in a Price Disclosure reduction in 2010. The first generic version of this medicine was listed in 2010 and the first Price Disclosure reduction occurred in 2012.

Compensation from Wyeth
The Department has initiated legal action to seek compensation from Wyeth, the original patent owner of venlafaxine (Efexor®), for additional costs to the Pharmaceutical Benefits Scheme (PBS) resulting from a delay in listing a generic version of venlafaxine. Listing a generic form of venlafaxine on the Australian market in 2009 would have triggered an automatic reduction to the price paid by the Government for venlafaxine through the PBS. The first generic version of this medicine was listed in 2012.

Unquantifiable Contingent Liabilities

Tobacco plain packaging litigation
The Australian Government will continue to fund the defence of legal challenges to the tobacco plain packaging legislation in international forums. Further information about these cases has not been disclosed on the grounds that it may prejudice the outcomes of these cases or may relate to commercial information.

Aged Care Accommodation Bond Guarantee Scheme
A Guarantee Scheme has been established through the *Aged Care (Accommodation Payment Security) Act 2006* and *Aged Care (Accommodation Payment Security) Levy Act 2006* . Under the Guarantee Scheme, if a provider becomes insolvent or bankrupt and is unable to repay outstanding bond balances to aged care residents, the Australian Government will step in and repay the bond balances owing to each resident. In return, the residents' rights to pursue the defaulting provider to recover the accommodation bond money transfer to the Government. In the event the Government cannot recover the full amount from the defaulting provider, it may levy all providers holding accommodation bonds to recoup the shortfall. It is not possible to quantify the Australian Government's contingent liability in the event that the Guarantee Scheme is activated. The Department has implemented risk mitigation strategies which should reduce the risk of default and thereby activation of the Guarantee Scheme.

From the latest available information, the maximum contingent liability, in the unlikely event that all providers defaulted, is $18.340 billion. Since the scheme was introduced it has been activated nine times requiring payment of $41.045m. It is difficult to predict if the past patterns of payments are indicative of future payments. The scheme was activated during the period ended 30 June 2016, with $0.125m refunded and another $0.593m accrued as at 30 June 2016.

Responsibility for the Guarantee Scheme was transferred to the Department from DSS during 2016 under the Administrative Arrangements Order issued on 30th September 2015

Diagnostic Products Agreement
The Australian Government has provided an indemnity to a review of certain matters in relation to the Diagnostics Products Agreement. The indemnity provides certain specified members of the review the same level of indemnity as Australian Government officers for the purpose of the review. For the period ended 30 June 2016 no claims have been made (2015: Nil).

Department of Health

Notes to and forming part of the financial statements

Note 24: Administered - Contingent Assets and Liabilities

Medical Indemnity

DHS delivers the Incurred But Not Reported Scheme (IBNRS) on behalf of the Australian Government. Eligibility for claim payments under this scheme is dependent on whether the Medical Indemnity Insurer (MII) is deemed to be a participating Medical Defence Organisation under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* .

DHS also delivers the Exceptional Claims Scheme (ECS) on behalf of the Australian Government. Under this scheme, the Australian Government will be liable for the cost of medical indemnity claims that exceed certain thresholds. The Consolidated Revenue Fund is appropriated to make payments under this scheme. To be covered by the ECS, practitioners must have medical indemnity insurance cover to at least a threshold of $15m for claims arising from incidents notified between 1 January to 30 June 2003 and $20m for claims notified from 1 July 2003. At 30 June 2015, the Department had received no notification of any incidents that would give rise to claims under this scheme. However, the nature of these claims is such that there is usually an extended period between the date of the medical incident and notification to the insurer. For the period ended 30 June 2016 no claims have been made or notified (2015: Nil).

CSL Ltd

Under existing agreements, the Australian Government has indemnified CSL Ltd for certain existing and potential claims made for personal injury, loss or damage suffered through therapeutic and diagnostic use of certain products manufactured by CSL Ltd. For the period ended 30 June 2016 no claims have been made (2015: Nil).

The Australian Government has indemnified CSL Ltd for a specific range of events that occurred during the Plasma Fractionation Agreement from 1 January 1994 to 31 December 2004, where alternative cover was not arranged by CSL Ltd. For the period ended 30 June 2016 no claims have been made (2015: Nil).

Australian Red Cross Blood Service

The Deed of Agreement between the Commonwealth and the Australian Red Cross Society (ARCS) and the National Blood Authority (NBA) in relation to the operations of the Blood Service, includes certain indemnities and limited liability in favour of ARCS. These cover a defined set of potential business, product and employee risks and liabilities arising from the operation of the Blood Service. The indemnities and limitation of liability only operate in the event of the expiry and non-renewal, or the early termination of the Deed, and only within a certain scope. They are also subject to appropriate limitations and conditions including in relation to mitigation, contributory fault, and the process of handling relevant claims.

Under certain conditions the Australian Government, States and Territories jointly provide indemnity for the Blood Service through a cost-sharing arrangement in relation to the National Managed Fund claims, both current and potential, regarding personal injury and loss or damages suffered by a recipient of certain blood and blood products where other available mitigation or cover is not available. Under a Memorandum of Understanding between governments and the Blood Service, the blood and blood products liability cover for the Blood Service remains in force until all parties agree to terminate the arrangements from an agreed date.

For the period ended 30 June 2016 no claims have been made (2015: Nil).

Vaccines

Under certain conditions the Australian Government has provided an indemnity for the supply of certain vaccines to the suppliers of the vaccines. The contract under which contingent liability is recognised will expire in September 2016. However, until replacement stock is sourced the contingent liability for use of the vaccine currently held remains with the Commonwealth. For the period ended 30 June 2016 no claims have been made (2015: Nil).

Human Pituitary Hormone Program

Under certain conditions the Australian Government has provided indemnity for the supply of growth hormones manufactured from human pituitary glands and human pituitary gonadotrophin manufactured before 31 December 1985. For the period ended 30 June 2016 no claims have been made (2015: Nil).

The Australian Medical Association

This is an agreement between the Australian Medical Association Ltd (AMA), the Commonwealth, Australian Private Hospitals Association Ltd and Private Healthcare Australia for participation in and support of the Private Mental Health Alliance. In respect of identified information collected, held or exchanged by the parties in connection with the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures in Private, Hospital-based Psychiatric Services each party has agreed to indemnify each other in respect of any loss, liability, cost, claim or expense, misuse of Confidential Information or breach of the Privacy Act. The AMA's liability to indemnify the other parties will be reduced proportionally to the extent that any unlawful or negligent act or omission of the other parties or their employees or agents contributed to the loss or damage. For the period ended 30 June 2016 no claims have been made (2015: Nil).

2018 Commonwealth Games

The Australian Government has provided guarantees in support of the Gold Coast bid to host the 2018 Commonwealth Games.

Department of Health

Notes to and forming part of the financial statements

Note 25: Administered - Financial Instruments

	2016 $'000	2015 $'000
Note 25A: Categories of financial instruments		
Financial Assets		
Loans and receivables		
Cash and cash equivalents	**171,579**	336,648
Personal benefits receivable	**741,254**	121,996
Goods and services receivable	**202,945**	119,493
Advances and loans	**271,352**	-
Total loans and receivables	**1,387,130**	578,137
Available-for-sale financial assets		
Equity interest - Australian Institute of Health and Welfare	**6,723**	5,880
Equity interest - Food Standards Australia New Zealand	**7,745**	7,592
Equity interest - Private Health Insurance Administration Council	**-**	2,774
Equity interest - Australian Commission on Safety and Quality in Health Care	**2,136**	1,774
Equity interest - Australian Sports Commission	**310,208**	315,108
Equity interest - Australian Sports Foundation Ltd	**4,375**	15,889
Equity interest - Independent Hospital Pricing Authority	**24,125**	17,500
Equity interest - National Health Performance Authority	**24,805**	23,507
Total available-for-sale financial assets	**380,117**	390,024
Total financial assets	**1,767,247**	968,161
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors	**9,881**	7,110
Grants payable	**378,070**	375,162
Total financial liabilities measured at amortised cost	**387,951**	382,272
Total financial liabilities	**387,951**	382,272
Note 25B: Net gains or losses on financial assets		
Loans and receivables		
Interest revenue	**4,757**	-
Impairment	**(1,950)**	(626)
Net losses on loans and receivables	**2,807**	(626)
Net losses on financial assets	**2,807**	(626)
Note 25C: Net gains or losses on financial liabilities		
Financial liabilities measured at amortised cost		
Exchange loss	**(1)**	-
Net losses on financial liabilities measured at amortised cost	**(1)**	-
Net losses on financial liabilities	**(1)**	-

Department of Health

Notes to and forming part of the financial statements

Note 25: Administered - Financial Instruments

Note 25D: Credit risk

The Administered activities of the Department are not exposed to a high level of credit risk as the majority of financial assets were goods and services receivables and shares in Government controlled and funded entities. The Department has policies and procedures that outline the debt recovery techniques to be applied. The Department has assessed the risk of default on payment and has allocated $7.637m in 2016 (2015: $7.675m) to an impairment allowance account for 'Goods and services receivables'. The Department held no collateral to mitigate against credit risk.

Maximum exposure to credit risk

	2016	2015
	$'000	$'000
Financial assets carried at amount not best representing maximum exposure to credit risk		
Personal benefits receivable	**741,254**	121,996
Goods and services receivable	**210,582**	127,168
Advances and loans	**271,352**	-
Equity interest - Australian Institute of Health and Welfare	**6,723**	5,880
Equity interest - Food Standards Australia New Zealand	**7,745**	7,592
Equity interest - Private Health Insurance Administration Council	**-**	2,774
Equity interest - Australian Commission on Safety and Quality in Health Care	**2,136**	1,774
Equity interest - Australian Sports Commission	**310,208**	315,108
Equity interest - Australian Sports Foundation Ltd	**4,375**	15,889
Equity interest - Independent Hospital Pricing Authority	**24,125**	17,500
Equity interest - National Health Performance Authority	**24,805**	23,507
Total	**1,603,305**	639,188

Department of Health

Notes to and forming part of the financial statements

Note 25: Administered - Financial Instruments

Note 25D (Continued): Credit risk

Credit quality of financial instruments not past due or individually determined as impaired

	Not past due nor impaired 2016 $'000	Not past due nor impaired 2015 $'000	**Past due or impaired 2016 $'000**	Past due or impaired 2015 $'000
Personal benefits receivable	**741,254**	121,996	**-**	**-**
Goods and services receivable	**182,962**	112,782	**27,620**	14,386
Advances and loans	**271,352**	-	-	-
Total	**1,195,568**	234,778	**27,620**	14,386

Ageing of financial assets that were past due but not impaired in 2016

	0 to 30 days $'000	**31 to 60 days $'000**	**61 to 90 days $'000**	**90+ days $'000**	**Total $'000**
Goods and services receivable	**5,797**	**8,596**	**2,774**	**2,816**	**19,983**
Total	**5,797**	**8,596**	**2,774**	**2,816**	**19,983**

Ageing of financial assets that were past due but not impaired in 2015

	0 to 30 days $'000	31 to 60 days $'000	61 to 90 days $'000	90+ days $'000	Total $'000
Goods and services receivable	4,606	134	134	1,837	6,711
Total	4,606	134	134	1,837	6,711

Note 25E: Liquidity risk

The Department's administered financial liabilities are suppliers payable and grants payable. The exposure to liquidity risk is based on the notion that the Department will encounter difficulty in meeting its obligations associated with its administered financial liabilities. This is highly unlikely due to appropriation funding and mechanisms available to the Department (e.g. Advance to the Finance Minister) and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations. The Department has no past experience of default. All liabilities related to suppliers payable and grants payable are expected to be settled within one year.

Note 25F: Market risk

The Department holds financial instruments that are of a nature that do not expose the Department to certain market risks.

Interest rate risk refers to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The only interest bearing items in the Administered Schedule of Assets and Liabilities were zero real interest loans, disclosed as advances and loans. These loans have an interest rate linked to Consumer Price Index and will not fluctuate for changes in market interest rates.

The Department is not exposed to ‘currency risk’ or 'other price risk'.

Department of Health

Notes to and forming part of the financial statements

Note 26A: Appropriations

Table A: Annual Appropriations ('Recoverable GST exclusive')

	2016 $'000	2015 $'000
DEPARTMENTAL		
Ordinary Annual Services		
Annual appropriation[1,2]	**458,366**	480,321
Capital budget	**11,209**	6,028
Receipts retained under PGPA Act - Section 74	**56,407**	50,746
Transfers of appropriations under PGPA Act - Section 75 - annual appropriation	**132,036**	-
Transfers of appropriations under PGPA Act - Section 75 - capital budget	**965**	-
Total appropriation	**658,983**	537,095
Appropriation applied (current and prior years)	**(655,122)**	(546,682)
Variance[3]	**3,861**	(9,587)
Other Services - Equity		
Annual appropriation	**20,034**	8,820
Transfers of appropriations under PGPA Act - Section 75	**12,256**	-
Total appropriation	**32,290**	8,820
Appropriation applied (current and prior years)	**(27,341)**	(15,757)
Variance[3]	**4,949**	(6,937)

[1] There were no amounts temporarily quarantined from 2016 or 2015 departmental appropriations. In administered a total of $25,253,000 has been temporarily quarantined against 2016 ordinary annual services appropriations and another $44,800,000 has been temporarily quarantined against 2015 ordinary annual services appropriations. An additional $3,000,000 has been temporarily quarantined in administered from the 2015 appropriation balances transferred to the Department from the Department of Social Services under the Administrative Arrangements Order issued on 30th September 2015. These amounts have been disclosed as available in Note 26A, Table B.

[2] There were no amounts withheld under section 51 of the *PGPA Act* from 2016 departmental appropriations. In administered a total of $430,172,000 has been permanently quarantined against 2016 appropriations for ordinary annual services. In 2015 appropriations a total of $624,163,183.83 has been permanently quarantined against administered appropriations for ordinary annual services and $436,000 has been permanently quarantined against departmental appropriations for ordinary annual services. These amounts have been witheld under section 51 of the PGPA Act which represents a loss of control. Therefore, these amounts have not been disclosed as available in Note 26A, Table B.

[3] The variance of $3,861,000 for departmental ordinary annual services primarily represents the timing difference of payments to suppliers or employees. The variance of $4,949,000 for departmental equity primarily represents the timing difference of payments on asset acquisition. The administered ordinary annual services items variance of $693,453,000 relates to the utilisation of retained funding from 2015 during 2016 (the former section 11 of the Appropriation Acts). The administered other services payments to corporate Commonwealth entities variance of $17,844,000 relates to the National Health Performance Authority appropriations. The administered other services assets and liabilities variance of $123,539,000 relates to funding for the investment in the Biomedical Translation Fund.

[4] DHS spent money from the CRF on behalf of the Department under a payment authority. The money spent has been included in the table above.

[5] Departmental capital budgets are appropriated through Appropriation Acts (No.1,3). They form part of ordinary annual services and are not separately identified in the Appropriation Acts.

Department of Health

Notes to and forming part of the financial statements

Note 26A: Appropriations

Table A: Annual Appropriations ('Recoverable GST exclusive')

	2016 $'000	2015 $'000
ADMINISTERED		
Ordinary Annual Services - Administered items		
Annual appropriation[1,2]	**5,804,936**	5,837,790
Receipts retained under PGPA Act - Section 74	**107,701**	44,248
Transfers of appropriations under PGPA Act - Section 75	**1,507,863**	-
Total appropriation	**7,420,500**	5,882,038
Appropriation applied (current and prior years)	**(6,727,047)**	(5,385,625)
Variance[3]	**693,453**	496,413
Ordinary Annual Services - Payments to corporate Commonwealth entities		
Annual appropriation	**346,502**	299,363
Total appropriation	**346,502**	299,363
Appropriation applied (current and prior years)	**(328,658)**	(299,347)
Variance	**17,844**	16
Other services - Administered assets and liabilities		
Annual appropriation	**156,741**	5,682
Total appropriation	**156,741**	5,682
Appropriation applied (current and prior years)	**(33,202)**	(3,713)
Variance[3]	**123,539**	1,969
Other Services - Payments to corporate Commonwealth entities		
Annual appropriation	**-**	1,500
Total appropriation	**-**	1,500
Appropriation applied (current and prior years)	**-**	(1,500)
Variance	**-**	-

[1] There were no amounts temporarily quarantined from 2016 or 2015 departmental appropriations. In administered a total of $25,253,000 has been temporarily quarantined against 2016 ordinary annual services appropriations and another $44,800,000 has been temporarily quarantined against 2015 ordinary annual services appropriations. An additional $3,000,000 has been temporarily quarantined in administered from the 2015 appropriation balances transferred to the Department from the Department of Social Services under the Administrative Arrangements Order issued on 30th September 2015. These amounts have been disclosed as available in Note 26A, Table B.

[2] There were no amounts withheld under section 51 of the *PGPA Act* from 2016 departmental appropriations. In administered a total of $430,172,000 has been permanently quarantined against 2016 appropriations for ordinary annual services. In 2015 appropriations a total of $624,163,183.83 has been permanently quarantined against administered appropriations for ordinary annual services and $436,000 has been permanently quarantined against departmental appropriations for ordinary annual services. These amounts have been witheld under section 51 of the *PGPA Act* which represents a loss of control. Therefore, these amounts have not been disclosed as available in Note 26A, Table B.

[3] The variance of $3,861,000 for departmental ordinary annual services primarily represents the timing difference of payments to suppliers or employees. The variance of $4,949,000 for departmental equity primarily represents the timing difference of payments on asset acquisition. The administered ordinary annual services items variance of $693,453,000 relates to the utilisation of retained funding from 2015 during 2016 (the former section 11 of the Appropriation Acts). The administered other services payments to corporate Commonwealth entities variance of $17,844,000 relates to the National Health Performance Authority appropriations. The administered other services assets and liabilities variance of $123,539,000 relates to funding for the investment in the Biomedical Translation Fund.

[4] DHS spent money from the CRF on behalf of the Department under a payment authority. The money spent has been included in the table above.

[5] Departmental capital budgets are appropriated through Appropriation Acts (No.1,3). They form part of ordinary annual services and are not separately identified in the Appropriation Acts.

Department of Health

Notes to and forming part of the financial statements

Note 26A: Appropriations

Table B: Unspent Annual Appropriations ('Recoverable GST exclusive')

	2016	2015
	$'000	$'000
DEPARTMENTAL		
Appropriation Act (No. 2) 2012-13	-	2,919
Appropriation Act (No. 1) 2013-14 - Departmental Capital Budget (DCB)	-	871
Appropriation Act (No. 2) 2013-14	-	1,780
Appropriation Act (No. 3) 2013-14 - Departmental Capital Budget (DCB)	-	585
Appropriation Act (No. 4) 2013-14	-	2,444
Appropriation Act (No. 1) 2014-15[1]	**33,134**	86,922
Appropriation Act (No. 1) 2014-15 - Cash at Bank	-	762
Appropriation Act (No. 1) 2014-15 - Departmental Capital Budget (DCB)	-	4,466
Appropriation Act (No. 2) 2014-15	-	2,530
Appropriation Act (No. 3) 2014-15	**6,646**	6,646
Appropriation Act (No. 1) 2015-16	**38,672**	-
Appropriation Act (No. 1) 2015-16 - Cash at Bank[2]	**1,859**	-
Appropriation Act (No. 1) 2015-16 - Departmental Capital Budget (DCB)	**316**	-
Appropriation Act (No. 2) 2015-16	**556**	-
Appropriation Act (No. 3) 2015-16	**24,624**	-
Appropriation Act (No. 4) 2015-16	**11,624**	-
Total departmental	**117,431**	109,925
ADMINISTERED		
Appropriation Act (No. 1) 2012-13[3]	**3,323**	3,323
Appropriation Act (No. 1) 2013-14[3]	**26,391**	26,391
Appropriation Act (No. 2) 2013-14[3]	**14,226**	14,226
Appropriation Act (No. 1) 2014-15[1,4]	**213,993**	721,216
Appropriation Act (No. 2) 2014-15	**840**	4,322
Appropriation Act (No. 3) 2014-15	**-**	6,168
Appropriation Act (No. 5) 2014-15	**46,689**	-
Appropriation Act (No. 1) 2015-16[1,5]	**366,133**	-
Appropriation Act (No. 2) 2015-16	**2,021**	-
Appropriation Act (No. 3) 2015-16	**7,415**	-
Appropriation Act (No. 4) 2015-16	**125,000**	-
Total administered	**806,031**	775,646

[1] In administered a total of $618,915,913.02 of the *Appropriation Act (No. 1) 2014-15,* $5,247,270.81 of the *Appropriation Act (No. 3) 2014-15* and $430,172,000 of the *Appropriation Act (No. 1) 2015-16* has been permanently quarantined under section 51 of the *PGPA Act*. In departmental a total of $436,000 has been permanently quarantined under section 51 of the *PGPA Act*. This represents a loss of control of the appropriations and therefore these amounts were not reported as available in the above table.

[2] Cash at bank mainly relates to deposits made on 30 June that are subject to Section 74 of the *PGPA Act* (annotated Appropriation Act 1).

[3] These balances have been temporarily quarantined. This does not represent a loss of control of the appropriations and therefore these amounts were reported as available in the above table.

[4] This balance includes temporarily quarantined amounts to the total of $47,800,000. This does not represent a loss of control of the appropriations and therefore these amounts were reported as available in the above table. Of these quarantines, $44,800,000 was in place in 2015, and an additional $3,000,000 applied to the 2015 appropriation balances transferred to the Department from the DSS during 2016 under the Administrative Arrangements Order issued on 30th September 2015.

[5] This balance includes temporarily quarantined amounts to the total of $25,253,000. This does not represent a loss of control of the appropriations and therefore these amounts were reported as available in the above table.

Department of Health

Notes to and forming part of the financial statements

Note 26A: Appropriations

Table C: Special Appropriations Applied ('Recoverable GST exclusive')

	Appropriation applied	
	2016	2015
Authority	**$'000**	$'000
Aged Care (Accommodation Payment Security) Act 2006	**-**	-
Aged Care Act 1997	**9,831,715**	-
Health Insurance Act 1973	**21,167,610**	20,160,432
National Health Act 1953	**11,798,076**	9,989,313
Medical Indemnity Act 2002	**69,264**	66,001
Private Health Insurance Act 2007	**5,896,162**	5,783,998
Dental Benefits Act 2008	**312,724**	311,647
Private Health Insurance Act 2007	**-**	440,874
Private Health Insurance Act 2007	**-**	4,664
Health and Other Services (Compensation) Act 1995	**-**	-
Medical Indemnity Agreement (Financial Assistance - Binding Commonwealth Obligations) Act 2002	**-**	-
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	**-**	-
Public Governance, Performance and Accountability Act 2013 s.77 [1]	**7,926**	737
Total special appropriations applied	**49,083,477**	36,757,666

[1] This amount included $7,825,174.24 transferred to DHS to refund a portion of recoveries from the Compensation for Health Care and Other Services Special Account previously returned to the OPA.

[2] DHS drew money from the CRF on behalf of the Department against the following special appropriations:
Aged Care Act 1997;
Health Insurance Act 1973;
National Health Act 1953;
Medical Indemnity Act 2002;
Dental Benefits Act 2008; and
Private Health Insurance Act 2007.

Table D: Disclosure by Agent in Relation to Annual and Special Appropriations ('Recoverable GST exclusive')

	2016	2015
	$'000	$'000
Department of Social Services		
Total receipts	**6,127**	4,992
Total payments	**(6,127)**	(4,992)

The Department made wage supplementation payments from the Social and Community Services Pay Equity Special Account administered by the Department of Social Services (DSS) to eligible social and community services workers during 2016 and 2015.

Department of Health

Notes to and forming part of the financial statements

Note 26B: Compliance with Statutory Requirements for Payments from the Consolidated Revenue Fund

Section 83 of the Constitution provides that no amount may be paid out of the Consolidated Revenue Fund except under an appropriation made by law.

The Department has primary responsibility for administering legislation related to health care. Payments totalling approximately $49 billion each year are authorised against Special Appropriations by the Department in accordance with a range of frequently complex legislation. Most of the payments are administered by the DHS under the Medicare program, on behalf of the Department. In the vast majority of cases DHS relies on information or estimates provided by customers and medical providers to calculate and pay entitlements. Despite future payments being adjusted to recover any overpayment, a breach of section 83 could nevertheless result. In addition, simple administrative errors can also lead to breaches of section 83.

Due to the number of payments made, the reliance that must be placed on external control frameworks and the complexities of the legislation governing these payments, the risk of a section 83 breach cannot be fully mitigated. However, the reported section 83 breaches represent only a very small portion of payments, both in number and in value, and the Department is committed to implementing measures to ensure that the risk of unintentional breaches of section 83 is as low as possible.

The Department has developed an approach for assessing the alignment of payment processes with legislation. This approach is reviewed annually. During 2015-16, the Department:

- reviewed legislation (including administrative processes) enacted since 1 July 2013 that creates or modifies payment eligibility as to whether processes are in place to minimise the risk of breaches of section 83;
- received assurance from DHS that action has been undertaken to detect and prevent any potential breaches of section 83;
- continued its ongoing reviews of special accounts by internal audit as part of its rolling compliance program;
- obtained legal advice, as appropriate, to resolve questions of potential non-compliance; and
- identified legislative/procedural changes to reduce the risk of non-compliance in the future.

Special Accounts

Currently the Department has nine Special Accounts, as per Note 27. Eight are assessed as low risk and one, the Sport and Recreation Special Account, is assessed as medium risk for non-compliance with section 83.

Special Appropriations

The Department administers 13 pieces of legislation, as disclosed in Note 26A Table C, as having Special Appropriations involving statutory requirements for payments. Of these legislations, some payments under the following legislation have been identified as having either actual or potential breaches of section 83 of the constitution.

Health Insurance Act 1973

In 2015-16, there were 29 cases of non-compliance under the Chronic Disease Dental Scheme totalling $3.536m.

These breaches have been confirmed by the Australian Government Solicitor and the related debts have been waived on the basis that it would be inequitable to recover the debts owed by various patients and providers of medical services, as they received the payments in good faith and would have been eligible for the benefit had the intended amendments to the legislation had been correctly implemented.

Corrective action involving regulatory amendments and the enactment of legislative instruments has been implemented where appropriate.

In addition to the above, DHS has estimated overpayments resulting in potential breaches of the *Health Insurance Act 1973* of $95.254m (or approximately 0.45% of total payments under this Act). These in the main reflect payments made to claimants that have subsequently been found to not meet the definition under section 10AC and 10AD.

DHS have also advised that potential breaches of the *Health Insurance Act 1973* relating to Medicare Easyclaim occur in instances where DHS make payments to financial institutions greater than the amount recorded by DHS as being owed to the financial institutions. The current process is necessitated by the settlement arrangements with the financial institutions which see a $5,000 "difference" cap to cater for 'small' differences which happen regularly and stopping any settlement where a 'larger' difference applied. DHS advised that during 2015-16, 106 instances occurred where such small differences existed totalling $17,627.

Department of Health

Notes to and forming part of the financial statements

Note 26B: Compliance with Statutory Requirements for Payments from the Consolidated Revenue Fund

Continued Focus

The Department will continue to review legislation (including any related administrative processes) that creates or modifies payment eligibility as it is enacted to determine whether process are in place to minimise the risk of breaches of section 83. It will continue with an ongoing review program that involves reviewing legislation, New Policy Proposals, business rules and payment processes. In addition, the Department will continue ongoing reviews of special accounts by internal audit as part of its rolling compliance program.

	Expenditure in 2015-16 $'000	Review complete?[1] (Yes/No)	Breaches identified to date[2]			Potential breaches yet to be resolved (Yes/No)	Remedial action taken or proposed[3]
Appropriation identified as subject to conditions			**Actuals $'000**	**Potential $'000**	**Recovered $'000**		
Special Appropriations							
Health Insurance Act 1973	21,167,610	Yes	3,536	95,271	-	No	Ongoing
	21,167,610		**3,536**	**95,271**			

1. Reviewed legislation (including any administrative processes) enacted since 1 July 2012 that creates or modifies payment eligibility as to whether processes the risk of breaches of section 83.
2. Recoveries can relate to prior periods.
3. Ongoing reviews through payment accuracy reviews.

Department of Health

Notes to and forming part of the financial statements

Note 27: Special Accounts

Note 27: Special Accounts ('Recoverable GST exclusive')

	Services for Other Entities and Trust Moneys Account [1]		Australian Childhood Immunisation Register Account [2]		Human Pituitary Hormones Account [3]		Sport and Recreation Account [4]	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**13,849**	16,246	**2,258**	2,442	**2,675**	2,857	**714**	5,187
Increases								
Appropriation credited to special account	**11,870**	7,340	**7,270**	5,802	**-**	-	**-**	-
Other increases	**12,609**	9,731	**4,060**	3,705	**-**	-	**331**	7,439
Total increases	**24,479**	17,071	**11,330**	9,507	**-**	-	**331**	7,439
Available for payments	**38,328**	33,317	**13,588**	11,949	**2,675**	2,857	**1,045**	12,626
Decreases								
Administered	**-**	-	**9,712**	9,691	**105**	182	**421**	11,912
Total administered decreases	**-**	-	**9,712**	9,691	**105**	182	**421**	11,912
Relevant Money	**19,555**	19,468	**-**	-	**-**	-	**-**	-
Total relevant money decreases	**19,555**	19,468	**-**	-	**-**	-	**-**	-
Total decreases	**19,555**	19,468	**9,712**	9,691	**105**	182	**421**	11,912
Total balance carried to the next period	**18,773**	13,849	**3,876**	2,258	**2,570**	2,675	**624**	714

Note 27: Special Accounts

[1] Establishing Instrument: *Public Governance, Performance and Accountability Act 2013;* section 78
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 78
Purpose: to disburse amounts held on trust or otherwise for the benefit of a person other than the Commonwealth; disburse amounts in connection with services performed on behalf of other government bodies that are not non-corporate Commonwealth entities (formerly FMA Act agencies); to repay amounts where an Act or other law requires or permits the repayment of an amount received; to reduce the balance of the special account (and, therefore the available appropriation for the special account) without making a real or notional payment.
Under the Administrative Arrangements Order issued on 30 September 2015, $3.171m was transferred to Health into the Services for Other Entities and Trust Monies Special Account.

[2] Establishing Instrument: *Public Governance, Performance and Accountability Act 2013;* section 78
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 78
Purpose: for expenditure relating to the operations of the Australian Childhood Immunisation Register, including payments to providers for the provision of information.
The Australian Childhood Immunisation Register Special Account will cease on 1 October 2016 under Part 6 (sunsetting) of the *Legislative Instruments Act 2003* . A new special account will be established to replace it.

[3] Establishing Instrument: *Public Governance, Performance and Accountability Act 2013;* section 78
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 78
Purpose: for expenditure through grants and other payments for:
- counselling and support services to recipients of pituitary-derived hormones and their families; and
- medical and other care to people treated with pituitary-derived hormones should they contract Creutzfeldt-Jakob disease as a result of the treatment; and
- one-off payments for recipients of pituitary-serviced hormones who can demonstrate that they have suffered a psychiatric illness prior to 1 January 1998 due to their having been informed that they are at a greater risk of contracting Creutzfeldt-Jakob disease; and
- one-off payments for the children of recipients of pituitary-derived hormones who can demonstrate that they have suffered a psychiatric illness as a consequence of the death of their parent from Creutzfeldt-Jakob disease.
The Human Pituitary Hormones Special Account ceased on 1 October 2015 under Part 6 (sunsetting) of the *Legislative Instruments Act 2003* . A new special account was established to replace it.

[4] Establishing Instrument: *Public Governance, Performance and Accountability Act 2013;* section 78
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 78
Purpose: to undertake sport and recreation related projects of common interest to the Sport and Recreation Ministers' Council, its successor or subordinate bodies, and that benefit all or a majority of members.
The Sport and Recreation Special Account will cease on 1 October 2016 under Part 6 (sunsetting) of the *Legislative Instruments Act 2003* . A new special account will be established to replace it.

Department of Health

Notes to and forming part of the financial statements

Note 27: Special Accounts

Note 27: Special Accounts ('Recoverable GST exclusive')

	Therapeutic Goods Administration Account [5]		Gene Technology Account [6]		Industrial Chemicals Account [7]		HHF Health Portfolio Account [8]		Local Hospitals Network Account [9]	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**61,059**	63,329	**7,585**	7,042	**10,503**	11,069	**-**	-	**-**	1,261
Increases										
Appropriation credited to special account	**4,177**	8,579	**7,734**	7,814	**3,874**	354	**-**	-	**-**	-
Other increases	**134,552**	126,650	**152**	116	**16,302**	13,433	**54,984**	716,916	**-**	-
Total increases	**138,729**	135,229	**7,886**	7,930	**20,176**	13,787	**54,984**	716,916	**-**	-
Available for payments	**199,788**	198,558	**15,471**	14,972	**30,679**	24,856	**54,984**	716,916	**-**	1,261
Decreases										
Departmental	**133,749**	137,499	**7,599**	7,387	**15,873**	14,353				
Total departmental decreases	**133,749**	137,499	**7,599**	7,387	**15,873**	14,353	**-**	-	**-**	-
Administered							**54,984**	716,916		1,261
Total administered decreases	**-**	-	**-**	-	**-**	-	**54,984**	716,916	**-**	1,261
Total decreases	**133,749**	137,499	**7,599**	7,387	**15,873**	14,353	**54,984**	716,916	**-**	1,261
Total balance carried to the next period	**66,039**	61,059	**7,872**	7,585	**14,806**	10,503	**-**	-	**-**	-

Note 27: Special Accounts

[5] Establishing Instrument*: Therapeutic Goods Act 1989*
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 80
Purpose: The purpose has been set out in section 45 of the *Therapeutic Goods Act 1989* and are:
- to make payments to further the objects of the Act; and
- to enable the Commonwealth to participate in the international harmonisation of regulatory controls on therapeutic goods and other related activities.

[6] Establishing Instrument: *Gene Technology Act 2000*
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 80
Purpose: for the receipt of all moneys and payment of all expenditures and disbursements related to all operations of the Gene Technology Regulator.

[7] Establishing Instrument: *Industrial Chemicals (Notification and Assessment) Act 1989*
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 80
Purpose: for the receipt of all moneys and payment of all expenditures and disbursements related to all operations of the National Industrial Chemicals Notification and Assessment Scheme.

[8] Establishing Instrument: *Nation Building Funds Act 2008*
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 80
Purpose: the main purpose of the Health and Hospitals Fund Special Account is to make payments in relation to the creation or development of health and infrastructure.
The HHF Health Portfolio Special Account ceased from 29 October 2015. Account balance was nil at the time of abolition.

[9] Establishing Instrument: *Public Governance, Performance and Accountability Act 2013;* section 78
Appropriation: *Public Governance, Performance and Accountability Act 2013* ; section 78
Purpose: to make grants of financial assistance to Local Hospital Networks, in accordance with agreements entered into between them and the Commonwealth, for the provision of hospital and pharmaceutical benefits, and medical and dental services.

The Local Hospitals Network Special Account ceased from 1 July 2014. Remaining funds were returned to contributors.

The Medical Research Future Fund Special Account (*Medical Research and Future Fund Act 2015*) was established on 26 August 2015. No financial activity has occurred for the year ended 30 June 2016.

Department of Health

Notes to and forming part of the financial statements

Note 28: Reporting of Outcomes

The Department allocates shared items to outcomes in proportion to the employee costs directly assigned to outcomes in the 2015-16 financial year.

	Outcome 1		Outcome 2		Outcome 3		Outcome 4	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Expenses								
Employee benefits	**36,540**	38,951	**37,110**	29,734	**56,431**	31,541	**5,163**	12,972
Suppliers	**20,267**	22,405	**30,290**	32,061	**31,865**	19,841	**24,419**	28,422
Depreciation and amortisation	**1,061**	3,359	**2,445**	4,026	**2,919**	2,736	**5,620**	13,554
Other	**261**	47	**247**	38	**456**	44	**25**	17
Total expenses	**58,129**	64,762	**70,092**	65,859	**91,671**	54,162	**35,227**	54,965
Own-source income								
Other	**1,554**	2,307	**1,003**	1,604	**1,758**	1,594	**163**	714
Total own-source income	**1,554**	2,307	**1,003**	1,604	**1,758**	1,594	**163**	714
Expenses								
Suppliers	**367,838**	251,718	**15,626**	11,733	**9,232**	7,959	**2,741**	8,636
Subsidies	**9,711**	9,692	**-**	-	**81,517**	83,920	**-**	-
Personal benefits	**8,565**	429	**11,237,989**	9,514,110	**21,970,005**	20,982,489	**-**	-
Grants	**177,797**	176,895	**470,913**	577,661	**10,461**	13,846	**87,113**	86,376
Other	**977**	668	**-**	-	**2,002**	58	**963**	963
Total expenses	**564,888**	439,402	**11,724,528**	10,103,504	**22,073,217**	21,088,272	**90,817**	95,975
Income								
Taxation revenue	**-**	-	**-**	-	**15,561**	14,744	**-**	-
Recoveries	**-**	-	**1,576,230**	721,214	**72,952**	59,753	**-**	-
Other	**8,292**	5,678	**11,828**	37,171	**(13,935)**	15,161	**-**	145
Total income	**8,292**	5,678	**1,588,058**	758,385	**74,578**	89,658	**-**	145
Net cost of outcome delivery	**613,171**	496,179	**10,205,559**	9,409,374	**22,088,552**	21,051,182	**125,881**	150,081
Assets								
Cash and cash equivalents	**-**	-	**-**	-	**-**	-	**-**	-
Trade and other receivables	**1,685**	1,826	**1,326**	1,392	**2,612**	1,485	**242**	665
Land and buildings, property plant and equipment and intangibles	**7,819**	12,230	**10,547**	15,405	**27,670**	27,362	**39,815**	23,735
Other	**1,087**	1,571	**855**	1,195	**1,685**	1,276	**156**	571
Total assets	**10,591**	15,627	**12,728**	17,992	**31,967**	30,123	**40,213**	24,971
Liabilities								
Suppliers	**5,361**	7,944	**4,218**	6,046	**8,313**	6,452	**771**	2,888
Other payables	**2,771**	4,184	**2,181**	3,185	**4,298**	3,399	**398**	1,521
Employee provisions	**10,322**	11,208	**9,274**	9,955	**22,960**	10,496	**1,148**	5,379
Other provisions	**2,881**	3,071	**2,267**	2,336	**4,468**	2,493	**415**	1,116
Total liabilities	**21,335**	26,407	**17,940**	21,522	**40,039**	22,840	**2,732**	10,904
Assets								
Cash and cash equivalents	**3,876**	2,258	**-**	-	**-**	-	**-**	-
Loans and receivables	**1,111**	302	**898,936**	208,039	**44,203**	61,433	**-**	91
Other investments	**-**	-	**-**	-	**-**	-	**48,930**	41,007
Other non-financial assets	**-**	-	**-**	-	**-**	-	**33,197**	24,468
Total assets	**4,987**	2,560	**898,936**	208,039	**44,203**	61,433	**82,127**	65,566
Liabilities								
Suppliers	**1,759**	3,054	**265**	-	**87**	-	**58**	-
Subsidies	**-**	-	**-**	-	**425,000**	413,000	**-**	-
Personal benefits	**-**	-	**624,845**	352,494	**1,016,532**	1,044,205	**-**	-
Grants	**46,080**	30,483	**58,608**	38,252	**3,003**	3,673	**695**	4,250
Total liabilities	**47,839**	33,537	**683,718**	390,746	**1,444,622**	1,460,878	**753**	4,250

Department of Health

Notes to and forming part of the financial statements

Note 28: Reporting of Outcomes

The Department allocates shared items to outcomes in proportion to the employee costs directly assigned to outcomes in the 2015-16 financial year.

	Outcome 5		Outcome 6		Outcome 7		Outcome 8	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Expenses								
Employee benefits	**62,375**	68,529	**4,571**	6,825	**127,437**	136,812	**28,110**	26,314
Suppliers	**36,010**	40,477	**4,323**	5,412	**71,123**	74,867	**15,153**	15,147
Depreciation and amortisation	**1,974**	6,125	**135**	580	**5,844**	9,253	**824**	2,271
Other	**450**	76	**35**	568	**348**	2,450	**203**	31
Total expenses	**100,809**	115,207	**9,064**	13,385	**204,752**	223,382	**44,290**	43,763
Own-source income								
Other	**1,956**	3,452	**4,508**	4,829	**159,300**	146,781	**882**	1,327
Total own-source income	**1,956**	3,452	**4,508**	4,829	**159,300**	146,781	**882**	1,327
Expenses								
Suppliers	**45,006**	35,356	**60**	84	**104,282**	92,968	**4,369**	1,995
Subsidies	**33,897**	32,735	**-**	-	**31**	356	**3,815**	-
Personal benefits	**374,878**	251,221	**5,887,067**	5,804,467	**11,935**	8,249	**-**	-
Grants	**1,742,388**	1,783,782	**2,243**	2,162	**932,999**	1,446,308	**1,146,876**	1,273,786
Other	**4,378**	483	**7**	445,535	**24,044**	22,859	**50**	227
Total expenses	**2,200,547**	2,103,577	**5,889,377**	6,252,248	**1,073,291**	1,570,740	**1,155,110**	1,276,008
Income								
Taxation revenue	**-**	-	**2,238**	2,162	**-**	-	**-**	-
Recoveries	**-**	-	**-**	-	**-**	-	**(48)**	40
Other	**86,337**	21,155	**2,235**	448,130	**132,674**	718,893	**10,982**	119,144
Total income	**86,337**	21,155	**4,473**	450,292	**132,674**	718,893	**10,934**	119,184
Net cost of outcome delivery	**2,213,063**	2,194,177	**5,889,460**	5,810,512	**986,069**	928,448	**1,187,584**	1,199,260
Assets								
Cash and cash equivalents	**-**	-	**-**	-	**88,813**	78,869	**-**	-
Trade and other receivables	**2,903**	3,215	**214**	316	**11,755**	6,369	**1,307**	1,236
Land and buildings, property plant and equipment and intangibles	**13,394**	21,668	**3,670**	2,113	**34,306**	33,316	**6,028**	8,269
Other	**1,873**	2,761	**138**	271	**1,985**	3,333	**844**	1,061
Total assets	**18,170**	27,644	**4,022**	2,700	**136,859**	121,887	**8,179**	10,566
Liabilities								
Suppliers	**9,240**	13,967	**681**	1,372	**13,553**	13,315	**4,165**	5,368
Other payables	**4,776**	7,358	**352**	723	**20,349**	25,824	**2,153**	2,828
Employee provisions	**15,434**	18,676	**1,516**	2,137	**38,509**	40,242	**7,737**	8,161
Other provisions	**4,966**	5,397	**366**	530	**2,725**	3,249	**2,238**	2,074
Total liabilities	**34,416**	45,398	**2,915**	4,762	**75,136**	82,630	**16,293**	18,431
Assets								
Cash and cash equivalents	**-**	-	**-**	-	**-**	-	**-**	-
Loans and receivables	**515**	1,412	**287**	637	**6,073**	6,508	**8,603**	686
Other investments	**-**	-	**-**	2,774	**16,604**	15,246	**-**	-
Other non-financial assets	**-**	-	**-**	-	**48,823**	36,617	**-**	-
Total assets	**515**	1,412	**287**	3,411	**71,500**	58,371	**8,603**	686
Liabilities								
Suppliers	**1,539**	3,941	**-**	-	**502**	79	**-**	-
Subsidies	**4,167**	2,708	**-**	-	**-**	-	**-**	-
Personal benefits	**60,050**	44,007	**476,400**	485,495	**606**	384	**-**	-
Grants	**21,716**	52,691	**-**	-	**29,769**	26,513	**161,749**	194,115
Total liabilities	**87,472**	103,347	**476,400**	485,495	**30,877**	26,976	**161,749**	194,115

Department of Health

Notes to and forming part of the financial statements

Note 28: Reporting of Outcomes

The Department allocates shared items to outcomes in proportion to the employee costs directly assigned to outcomes in the 2015-16 financial year.

	Outcome 9		Outcome 10		Outcome 11		Payments to corporate Commonwealth entities	
	2016	2015	**2016**	2015	**2016**	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Expenses								
Employee benefits	**13,876**	14,616	**6,166**	7,571	**86,748**	-	-	-
Suppliers	**7,780**	8,732	**3,455**	4,709	**59,731**	-	-	-
Depreciation and amortisation	**511**	1,369	**204**	680	**2,447**	-	-	-
Other	**100**	19	**44**	9	**604**	-	-	-
Total expenses	**22,267**	24,736	**9,869**	12,969	**149,530**	-	-	-
Own-source income								
Other	**3,140**	4,127	**189**	856	**2,619**	-	-	-
Total own-source income	**3,140**	4,127	**189**	856	**2,619**	-	-	-
Expenses								
Suppliers	**41,745**	30,994	**939**	12,161	**84,930**	-	-	-
Subsidies	**-**	-	**-**	-	**9,161,230**	-	-	-
Personal benefits	**-**	-	**-**	-	**17,202**	-	-	-
Grants	**11,368**	8,663	**20,099**	42,732	**1,216,062**	-	-	-
Other	**105,381**	3,237	**-**	-	**56**	-	**328,658**	300,847
Total expenses	**158,494**	42,894	**21,038**	54,893	**10,479,480**	-	**328,658**	300,847
Income								
Taxation revenue	**-**	-	**-**	-	**-**	-	-	-
Recoveries	**-**	-	**-**	-	**907,700**	-	-	-
Other	**37**	1,347	**4,278**	8,185	**14,251**	-	-	-
Total income	**37**	1,347	**4,278**	8,185	**921,951**	-	-	-
Net cost of outcome delivery	**177,584**	62,156	**26,440**	58,821	**9,704,440**	-	**328,658**	300,847
Assets								
Cash and cash equivalents	**-**	-	**-**	-	**-**	-	-	-
Trade and other receivables	**643**	687	**281**	356	**3,889**	-	-	-
Land and buildings, property plant and equipment and intangibles	**3,281**	5,020	**1,296**	2,379	**17,914**	-	-	-
Other	**415**	591	**181**	305	**2,510**	-	-	-
Total assets	**4,339**	6,298	**1,758**	3,040	**24,313**	-	-	-
Liabilities							-	-
Suppliers	**2,049**	2,985	**895**	1,545	**12,374**	-	-	-
Other payables	**1,058**	1,573	**463**	814	**6,397**	-	-	-
Employee provisions	**5,393**	7,171	**1,882**	2,547	**37,968**	-	-	-
Other provisions	**1,101**	1,154	**481**	597	**6,652**	-	-	-
Total liabilities	**9,601**	12,883	**3,721**	5,503	**63,391**	-	-	-
Assets								
Cash and cash equivalents	**2,570**	2,675	**624**	714	**-**	-	-	-
Loans and receivables	**-**	-	**2**	45	**352,800**	-	-	-
Other investments	**-**	-	**314,583**	330,997	**-**	-	-	-
Other non-financial assets	**111,265**	210,005	**-**	-	**-**	-	-	-
Total assets	**113,835**	212,680	**315,209**	331,756	**352,800**	-	-	-
Liabilities								
Suppliers	**570**	6	**-**	30	**5,097**	-	-	-
Subsidies	**-**	-	**-**	-	**259,371**	-	-	-
Personal benefits	**-**	-	**-**	-	**37**	-	-	-
Grants	**20,143**	24,175	**324**	928	**35,733**	-	-	-
Total liabilities	**20,713**	24,181	**324**	958	**300,238**	-	-	-

Department of Health

Notes to and forming part of the financial statements

Note 28: Reporting of Outcomes

The Department allocates shared items to outcomes in proportion to the employee costs directly assigned to outcomes in the 2015-16 financial year.

	Not attributed		Total	
	2016	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000
Expenses				
Employee benefits	**-**	-	**464,527**	373,865
Suppliers	**-**	-	**304,416**	252,073
Depreciation and amortisation	**-**	-	**23,984**	43,953
Other	**1,077**	11,500	**3,850**	14,799
Total expenses	**1,077**	11,500	**796,777**	684,690
Own-source income				
Other	**-**	-	**177,072**	167,591
Total own-source income	**-**	-	**177,072**	167,591
Expenses				
Suppliers	**-**	-	**676,768**	453,604
Subsidies	**-**	-	**9,290,201**	126,703
Personal benefits	**-**	-	**39,507,641**	36,560,965
Grants	**-**	-	**5,818,319**	5,412,211
Other	**-**	-	**466,516**	774,877
Total expenses	**-**	-	**55,759,445**	43,328,360
Income				
Taxation revenue	**-**	-	**17,799**	16,906
Recoveries	**-**	-	**2,556,834**	781,007
Other	**-**	46	**256,979**	1,375,055
Total income	**-**	46	**2,831,612**	2,172,968
Net cost of outcome delivery	**1,077**	**11,454**	**53,547,538**	**41,672,491**
Assets				
Cash and cash equivalents	**1,859**	762	**90,672**	79,631
Trade and other receivables	**118,912**	108,727	**145,769**	126,274
Land and buildings, property plant and equipment and intangibles	**-**	-	**165,740**	151,497
Other	**-**	-	**11,729**	12,935
Total assets	**120,771**	109,489	**413,910**	370,337
Liabilities				
Suppliers	**-**	-	**61,620**	61,882
Other payables	**-**	-	**45,196**	51,409
Employee provisions	**-**	-	**152,143**	115,972
Other provisions	**-**	-	**28,560**	22,017
Total liabilities	**-**	-	**287,519**	251,280
Assets				
Cash and cash equivalents	**164,509**	331,001	**171,579**	336,648
Loans and receivables	**60,987**	41,209	**1,373,517**	320,362
Other investments	**-**	-	**380,117**	390,024
Other non-financial assets	**-**	-	**193,285**	271,090
Total assets	**225,496**	372,210	**2,118,498**	1,318,124
Liabilities				
Suppliers	**4**	-	**9,881**	7,110
Subsidies	**-**	-	**688,538**	415,708
Personal benefits	**-**	-	**2,178,470**	1,926,585
Grants	**250**	82	**378,070**	375,162
Total liabilities	**254**	82	**3,254,959**	2,724,565

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

The following provides a comparison of the 2016 final outcome to the 2015-16 Portfolio Budget Statements (PBS) in accordance with Australian Accounting Standard Board (AASB) 1055: *Budgetary Reporting*. Disclosures made in accordance with this standard provide information relevant to assessing performance of the Department, including accountability for resources entrusted to it.

General Commentary

AASB 1055: Budgetary Reporting requires explanations of major variances between the original budget as presented in the 2015-16 PBS and the 2016 final outcome. The information presented below should be read in the context of the following:

1. The 2016 year saw two significant functions transferred to the Department as part of the Machinery of Government (MOG) changes detailed in Note 9. These two functions are:
- Ageing and Aged Care; and
- Health Care Provider Compliance.

The impact on the Department of these transfers was significant in terms of the resources utilised in undertaking its activities. Where those activities are for the Department in its own right, they are reflected in the departmental statements. Where those activities are for the Department to provide management or oversight of, on behalf of the Government, they are reflected in the administered statements.

As a result of the financial significance upon departmental resources of the transfer of these functions, the Department has included the 2015-16 Estimated Actuals in the financial statements to provide a more reflective comparative of the Department and its activities for 2016. While not required by AASB 1055, it is considered appropriate for the additional disclosures to be included.

2. It should be noted that the original Budget was prepared before the 2015 final outcome could be known. As a consequence, the opening balance of the Statement of Financial Position needed to be estimated and in some cases variances between the 2016 final outcome and budget estimates can be at least in part attributed to unanticipated movement in the prior year period figures.

Variances attributable to factors which would not reasonably have been identifiable at the time of the budget preparation, such as revaluation or impairment of assets or reclassifications of asset reporting categories have not been included as part of the analysis.

3. The Department considers that major variances are those greater than 10% of the original estimate. Variances below this threshold are not included unless considered significant by their nature.

Variances relating to cash flows are a result of the factors detailed under expenses, own source income, assets or liabilities. Unless otherwise individually significant or unusual, no additional commentary has been included.

The departmental activities of the Department, net of unfunded depreciation, presumed a balanced operating result in 2016 consistent with the requirement under the Commonwealth budgeting framework to work within the resources provided by Government and revenues received from cost recovered activity.

4. The Budget is not audited.

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

Note 29(i): Major Departmental Budget Variances for 2016

Net cost of services
The total variation in departmental expenses for 2016 was in excess of $160m higher than 2015-16 PBS. As outlined above, the MOG changes were the principal reasons for the significantly higher levels of expenditure, reflective of the additional resources required in undertaking the Department's activities, with employee and supplier expenses being the highest. The increase in supplier expenses was in part a result of an expense incurred for the development of aged care intangibles which would normally have been reflected as an asset to the Department however the nature of the transaction necessitated in the amount being expensed in 2016.

Broadly, the Department received additional appropriation revenue to meet in part the cost of the additional resources utilised.

After making an adjustment for the impact of the MOG, 2016 saw a significant reallocation of resources between employees and suppliers. This reallocation was necessary due to the Department's delay to recruit and higher attrition rate. As a result resources were reallocated into areas such as short term labour contracts as well as other supplier expense categories. The two main factors for the slower than anticipated rate of recruitment were the limitations imposed on the public sector as well as the impact from an organisational perspective as the Department realigned priorities to take account of MOG changes and the resultant structural adjustments.

The other key event occuring during the year was the activity undertaken as part of the reconfiguration of the State/Territory network which also contributed to the higher level of supplier expenses for the year.

While not as significant as the events outlines above, the Department did redirect unfunded resources into areas such as the Cancer Screening Register, which resulted in higher levels of operational expenditure across a range of supplier expenses.

Departmental non-financial assets
The total variation in departmental non-financial assets for 2016 between the original budget estimate and the actual outcome is approximately $37 million or 26%. The main contributor to this variance is the MOG change resulting in the Department assuming assets principally utilised by the Ageing and Aged care function from 1 October 2015, and changes to the 2015 final outcome was after the 2015-16 PBS was finalised. The transfer of these functions resulted in the Department recognising $7.4 million of property, plant and equipment and leasehold improvements for additional intangible assets for information technology systems. The 2015 final outcome included an amount of $16.4 million for an increase in the fair value of land and buildings. This amount was not included in the original budget as it was unknown at the time the budget was prepared.

Departmental payables
The total variation in departmental payables for 2016 between the original estimate published in the 2015-16 PBS and the final outcome resulted in a reduction of approximately 20% and is principally as a result of the change in recognition of amounts previously received for the funding of independent reviews.

Departmental provisions
The total variation in departmental provisions for 2016 between the original budget estimate and the final outcome is $50.6 million or 39%. The main contributor to this variance is the MOG through the transfer of employee provisions and property related provisions which saw the Department recognising $38.4 million of employee provisions for the 1,363 staff transferred to the Department as well as provisions for make-good, leases incentive and straightlining to the value of $9.7 million.

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

Departmental cash flows

The Department makes payments when due and obtains funds from the Official Public Account in a just-in-time manner to make these payments as they fall due. Cash receipts and payments are therefore similar. The timing of payments, particularly for suppliers, will be dependent on the receipt of the goods and services and their related invoices and so can vary between reporting periods. The variation between the initial budget estimate for operating activities is an increase in cash received and paid. This increase is attributable to the MOG which resulted in additional cash transactions for the Department.

Cash flows from investing activities includes a cash inflow of $9.2 million that was not included in the original 2015-16 PBS. This inflow is attributable to a transaction that occurred after the original budget was developed. It relates to the sale of the Department's information technology assets to the new service provider for the 2016 year. The cash flows from investing activities included outflows relating to the purchase of intangible assets.

Actual cash flows from financing activities are higher then the original 2015-16 PBS. This increase is attributable to additional equity injections and Departmental Capital Budgets being utilised by the Department as a result of the MOG.

Note 29 (ii): Major Administered Budget Variances for 2016

Administered expenses

Total administered expenses for 2016 were approximately $9,594m higher than the original budget. This variance was driven by a significant overspend in subsidies ($9,186m), relating to the Residential and Flexible Care and Home Care subsidies. Responsibility for the aged care program subsidies was transferred to Health from the DSS during 2016, and the original budget for these subsidies against Health was nil.

This overspend was contributed to by overspends in personal benefits ($383m) and suppliers ($179m). Personal benefits expenses relate to a range of program groups, most of which are funded by significant special appropriations, including but not limited to the Pharmaceutical Benefits Scheme, Medicare Benefits Scheme, Dental Benefits and Private Health Insurance Rebate. The most significant elements of the 2016 overspend were:

- Pharmaceuticals and Pharmaceutical Services: overspending by $1,062m; and
- Ageing and Service Improvement: overspending by $17m.

Conversely, the following program groups reported underspends against the original budget:

- Dental Services: underspending by $293m;
- Private Health Insurance: underspending by $235m;
- Hearing Services: underspending by $56m;
- Targeted Assistance – Aids and Appliances: underspending by $48m; and
- Primary Care Practice Incentives: underspending by $28m.

The core reason for the overspend in personal benefits was the high demand for new Hepatitis C drugs since their introduction in March 2016. Expenditure for these drugs has exceeded $1 billion during the first four months, while only $282m was budgeted for 2016.

The overspend in suppliers was largely attributable to the aged care programs ($85m), which were not included in the original budget, and eHealth ($60m) which related to the non-capital portion of work carried out on enhancements to the *My Health Record* software. These variances remained consistent when measured against the revised budget as well.

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

The above overspends were reduced by a range of underspends in grants ($153m), comprised of overspends across the Aged Care program groups ($1,212m) and underspends across most of the other grants-based program groups. The biggest contributors to the underspends included:

- Private Health Insurance – Transfers to PHIAC: underspending by $563m due to PHIAC being merged into the Australian Prudential Regulation Authority (APRA) effective 1 July 2015, with the entire budget for transfers to PHIAC being reported as a variance;
- Health Infrastructure: underspending by $249m, largely due to the abolition of the Health and Hospitals Fund (HHF) Health Special Account early in the year;
- Workforce Development and Innovation: underspending by $199m, largely due to a range of savings across the clinical training programs within this program group, as well as withholding of payments to the recipients holding surplus funds;
- Community Pharmacy and Pharmaceutical Awareness: underspending by $123m, due to better targeting of premium free dispensing (a component of the 6CPA), which led to a reduction of expenditure against this program; and
- eHealth: underspending by $79m, due to the classification difference between grants and suppliers, with this program group reporting a large overspend against supplier expenses.

The remainder of the grants underspend against the original budget was spread across most grants-based program groups, and was due to savings delivered, new measures implemented and grant programs reduced or terminated post budget.

Concerning the revised budgets, personal benefits expenses reported an even larger overspend ($925m), which is consistent with a substantial overspend in the Pharmaceuticals and Pharmaceutical Services program group in connection with Hepatitis C drugs and relatively minor underspends across a number of other program groups.

For grants, whilst the overall grants budget has increased, this was represented by an increase in aged care program grants and a substantial decrease in grants across other program groups – taking into account the abolition of the HHF special account, the merger of PHIAC into APRA and other large underspends against the original budget. As a result, the most significant contributors to the grants underspend against the revised budget were:

- eHealth: underspending by $73m, due to the classification difference between grants and suppliers, with this program group reporting a large overspend against supplier expenses;
- Workforce and Rural Distribution: underspending by $45m, largely in relation to the Australian General Practice Training Program, which was due to a combination of recovery of surplus funds from training providers no longer continuing on the program, withholding of payments from organisations holding surplus funds, and lower agreement values following negotiations with providers; and
- Workforce Development and Innovation: underspending by $28m, largely in relation to the Dental Relocation Incentive Support Scheme, which was due to a combination of withholding of payments from recipients holding surplus funds, savings delivered for a number of clinical training programs within this program group, and some slippage in rolling out the new measures.

The remainder of the grants underspend against the revised budget was spread across a range of program groups, and was due to a range of factors, including but not limited to the deliverables not being completed or accepted for payment prior to year-end, delays in contract negotiations, and the general slowing down of the grants activity during the caretaker period of Government.

Administered revenues

Total administered revenue for 2016 was $887m (45%) above the original budget. The two key contributors to this result were recoveries ($1,544m over budget) and other revenue ($661m under budget).

The main driver behind the increase in recoveries was the value of aged care recoveries from the States and Territories for the Younger People in Residential and Home Care as well as the cross-billings and budget neutrality recoveries from the States and Territories in connection with implementation of the National Disability Insurance Scheme (NDIS). In aggregate such recoveries reached $908m during the year, with the entire amount reported as a variance, as the relevant functions were transferred to Health from the DSS during 2016 and did not form part of the original budget for 2016.

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

Another key contributor to the overall increase in recoveries was the value of high cost drugs recoveries ($588m of the variance), which are collected in accordance with cost-sharing agreements between the Commonwealth and pharmaceutical companies, with the latter required to contribute to the cost of providing certain listed drugs when specified conditions are met. Furthermore, the thresholds which must be reached before the pharmaceutical companies are liable to contribute to the costs also vary for different listed drugs and between the different agreements. As a result, actual recoveries in a given year fluctuate with no predictable patterns. However, a significant contributor to the increase in 2016 was the high demand for the new Hepatitis C drugs following their introduction in March 2016.

The most significant contributors to the decrease in other revenue were:

- the merger of PHIAC into APRA, resulting in nil transfers from PHIAC to Health during 2015-16 (budgeted at $557m); and
- the abolition of the Health and Hospital Fund (HHF) Health Special Account early in the year, resulting in only $52.6m worth of transfers from this account to Health during 2015-16 (budgeted at $240m).

Both the merger of PHIAC and the abolition of the HHF Health Special Account were incorporated in the revised budget, eliminating these variances. The value of both the aged care and high cost drugs recoveries were still substantially higher than the budgeted amounts. Other revenue exceeded the revised budget, largely due to a one-of receipt of $76m from the National Blood Authority following completion of the 2015 Annual Supply Plan reconciliation.

Administered assets

Total assets administered on behalf of the Commonwealth at 30 June 2016 were $1,012m (92%) greater than the original budget estimate.

The highest contributors to this variance were personal benefits receivable ($565m), relating to the High Cost Drugs recoveries. Due to the nature of these recoveries, the value of these receivables can fluctuate with no predictable pattern from one year to another. A significant contributor to the increase in 2016 was the high demand for the new Hepatitis C drugs following their introduction in March 2016.

This was followed by the increase in the value of trade and other receivables ($242m), due largely to the value of aged care concessional loans receivable transferred to Health from the DSS during 2016.

Cash and cash equivalents also reported a significant increase ($158m). This mainly related to the cash balances from the banking arrangements for the Pharmaceutical Benefits Scheme, the Medicare Benefits Scheme and the aged care subsidy programs. While a balance of around $150m is maintained to facilitate the timely payment of benefits and subsidies, the actual balance of this account fluctuates from month to month and year to year.

Other notable variances in assets included:

- investments held in corporate entities, being adjustments relating to the inclusion, exclusion and revaluation of portfolio entities; the revised budget also incorporated $125m relating to the value of expected investment in the Biomedical Translation Fund, which did not eventuate;
- increase in computer software, relating to the additional releases capitalised for the *My Health Record* software; and
- increase in land and buildings, following a revaluation of Mersey community hospital at the end of the year.

Department of Health

Notes to and forming part of the financial statements

Note 29: Explanation of Budget Variances

Administered liabilities

Total liabilities administered on behalf of the Commonwealth at 30 June 2016 were $447m (15.9%) higher than the original budget estimate. Subsidies payable were the biggest contributor to this variance ($261m), largely driven by the value of Home Care subsidies outstanding at the end of the year. This was followed by an increase in grants payable ($145m), brought about by the value of additional payables relating to the aged care programs and an overall increase in grant expenditure this year. As both of these items related to the aged care functions transferred to Health from the DSS during 2016, they did not form part of the original budget for 2016. Subsidies provisions, which relate entirely to the Medical Indemnity schemes, were also substantially in excess of the original budget due to the value of actuarial adjustments following a review by the Australian Government Actuary at the end of the year.

When measured against the revised budget, grants payable reported only a minor variance, whilst subsidies payable still showed a significant increase. Additionally, combined personal benefits liabilities (payables and provisions) were substantially higher than the revised budget, driven by the increase in the value of outstanding claims provisions for the Pharmaceutical Benefits Scheme. The increase in the provision is consistent with the increase in personal benefits expenditure described earlier. It should also be noted that the value of subsidies and personal benefits liabilities has been calculated and assured during the biannual sign-off process between Health and DHS and does not appear unreasonable in light of actual monthly expenditure during 2016.

The remaining variances represent normal fluctuations in payables, provisions and accruals and are not considered significant.

Appendices

Appendix 1
Processes Leading to PBAC Consideration – Annual Report for 2015-16

Introduction

This is the seventh annual report to the Parliament on the processes leading to the consideration by the Pharmaceutical Benefits Advisory Committee (PBAC) of applications for recommendation for listing of items on the Pharmaceutical Benefits Scheme (PBS). This report covers the 2015-16 financial year.

This annual report has been prepared pursuant to subsection 99YBC(5) of the *National Health Act 1953* (the Act), under which it is required that:

> *The Secretary must, as soon as practicable after June 30 each year, prepare an annual report on the processes leading up to Pharmaceutical Benefits Advisory Committee consideration, including:*
>
> *a) the extent and timeliness with which responsible persons are provided copies of documents relevant to their submissions to the Pharmaceutical Benefits Advisory Committee;*
>
> *b) the extent to which responsible persons exercise their right to comment on these documents, including appearing at hearings before the Pharmaceutical Benefits Advisory Committee; and*
>
> *c) the number of responsible persons seeking a review of the Pharmaceutical Benefits Advisory Committee recommendation.*

PBAC Cost Recovery Reform

Cost recovery for processes leading to PBAC consideration commenced on 1 January 2010.

Background

Cost recovery policy is administered by the Department of Finance and is outlined in the Australian Government Cost Recovery Guidelines. The underlying principle of the policy is that entities should set charges to recover all the costs of products or services where it is efficient and effective to do so, where services will be provided to an identified group and where charging is consistent with Australian Government policy objectives.

PBS Cost Recovery Regulations

Section 140 of the Act provides in part, that the:

> *Governor-General may make regulations, not inconsistent with the Act, prescribing all matters which by this Act are required or permitted to be prescribed, or which are necessary or convenient to be prescribed for carrying out or giving effect to the Act.*

Division 4C of Part VII of the Act enables fees to be charged for certain services provided by the Australian Government in order to recover the cost to the Commonwealth of providing those services. Those services relate to the exercise of certain powers of the Minister for Health under section 9B of the Act (which relates to the National Immunisation Program (NIP)) and under Part VII of the Act (which relates to the PBS). The services include the functions of PBAC and its sub-committees; and related functions performed by officers, administrative staff, contractors and sub-contractors of the Department.

Section 99YBA of the Act provides for regulations to set out the fees that are payable for those services, as well as other matters relating to the payment of those fees and the provision of those services, including some consequences of failing to pay a fee.

The regulations prescribe application categories, fees and application procedures to applicants seeking a new or amended inclusion in the PBS or NIP. The regulations also provide for the exemption from fees, waiver of fees, and for review rights and procedures. The fees and procedures are administered by the Department of Health.

PBAC

The PBAC is established under section 100A of the Act and is an independent expert body appointed by the Australian Government. Members include doctors, health professionals, health economists and a consumer representative. In 2015, provision was made for appointment of an industry representative and additional consumer representative. Its primary role is to recommend new medicines for listing on the PBS and the inclusion of vaccines on the NIP. No new medicine can be listed unless the committee makes a positive recommendation to the Minister for Health. The PBAC holds three scheduled meetings each year, usually in March, July and November.

When recommending a medicine for listing, the PBAC takes into account the medical condition(s) for which the medicine was registered for use in Australia and its clinical effectiveness, safety and cost-effectiveness ('value for money') compared with other treatments, including non-medical treatments.

The PBAC has two sub-committees to assist with analysis and advice in these areas. They are:

- **The Economics Sub-Committee (ESC)** which assesses clinical and economic evaluations of medicines submitted to the PBAC for listing, and advises the PBAC on the technical aspects of these evaluations; and
- **The Drug Utilisation Sub-Committee (DUSC)** which assesses estimates on projected usage and the financial cost of medicines. It also collects and analyses data on actual use (including in comparison with different countries), and provides advice to the PBAC.

Roles of the PBAC

The PBAC performs the following roles:

- recommends medicines and medicinal preparations to the Minister for Health for funding under the PBS;
- recommends vaccines to the Minister for funding under the NIP (since 2006);
- advises the Minister and Department about cost-effectiveness;
- recommends maximum quantities and repeats on the basis of community use, and any restrictions on the indications where PBS subsidy is available;
- regularly reviews the list of PBS items; and
- advises the Minister about any other matters relating to the PBS, including on any matter referred to it by the Minister.

Requirements of section 99YBC of the Act

a) Extent and timeliness of the provision of relevant documents to responsible persons

Subsection 99YBC(5)(a) of the Act requires that the Minister report to the Parliament on the extent and timeliness of the provision of relevant documents to responsible persons. The PBAC provides responsible persons with documents relevant to their submissions in an orderly, timely and transparent fashion. This is achieved through the well-established practice of providing responsible persons with documents relevant to their submissions six weeks before the applicable PBAC meeting. These documents are referred to as 'commentaries'.

Applicants' pre-sub-committee response(s) are received by the PBAC Secretariat five weeks before the relevant PBAC meeting. Following the meeting of PBAC sub-committees, the PBAC Secretariat provides relevant sub-committee papers to responsible persons two weeks before the relevant PBAC meeting. Sponsors then provide their responses to the PBAC Secretariat one week before the PBAC meeting.

Following the PBAC meeting the PBAC Secretariat provides verbal advice on the outcomes of PBAC consideration to the relevant sponsor half a week after the meeting, with written advice provided three weeks (positive recommendations) and five weeks (all other recommendations) after the relevant PBAC meeting.

Where requested, the PBAC Secretariat, the PBAC and its sub-committees provide informal access to departmental officers and formal access to the PBAC for responsible persons or their representative, including the option for the sponsor to appear before the PBAC in person.

b) Extent to which responsible persons comment on their commentaries

Subsection 99YBC(5)(b) of the Act requires that the Minister report to the Parliament on the:

> *'…extent to which responsible persons exercise their right to comment on these documents, including appearing at hearings before the Pharmaceutical Benefits Advisory Committee;'*

During 2015-16, the PBAC held three ordinary meetings (as is usual practice) and considered a total of 97 major submissions. For the:

- **July 2015 PBAC meeting**, 27 responsible persons lodged major submissions. 27 sponsors responded to their commentaries.
- **November 2015 PBAC meeting**, 34 responsible persons lodged major submissions. 34 sponsors responded to their commentaries.
- **March 2016 PBAC meeting**, 36 responsible persons lodged major submissions. 35 sponsors responded to their commentaries and one sponsor withdrew its submission before responding to its commentary.

Consequently, of the 96 major submissions considered by PBAC in 2015-16, 96 responsible persons exercised their right to respond to their commentaries.

c) Number of responsible persons seeking a review of PBAC recommendations

Subsection 99YBC(5)(c) of the Act requires that the Minister report to the Parliament on the:

> *'…number of responsible persons seeking a review of the Pharmaceutical Benefits Advisory Committee recommendation.'*

During the 2015-16 financial year, there were no requests to the PBAC for an Independent Review.

Number and category of applications for each PBAC meeting in 2015-16

July 2015 PBAC Meeting

Category	Number	Comments
Major	27	–
Minor	26	Included 1 secretariat listing

November 2015 PBAC Meeting

Category	Number	Comments
Major	34	–
Minor	43	Included 4 secretariat listings

March 2016 PBAC Meeting

Category	Number	Comments
Major	36	–
Minor	38	Included 2 secretariat listings

Secretariat listings are not considered as a separate agenda item at a meeting of the Committee as they are very minor amendments to existing listings. However, all secretariat listings are still decided by the Committee on the merit of each application based on the papers provided to the Committee.

Withdrawn applications for each PBAC meeting in 2015-16 by category and reasons for withdrawal of applications for each meeting

July 2015 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	0	–
Minor	1	Decision by applicant – no reason provided

November 2015 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	0	–
Minor	2	Decision by applicants – no reason provided

March 2016 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	1	Decision by applicant – no reason provided
Minor	1	Decision by applicant – no reason provided

Number of responsible persons that responded to their commentaries, including appearing before PBAC meetings

All of the responsible persons who submitted a major submission to PBAC during 2015-16 responded to their commentary.

July 2015 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
27	27	6

November 2015 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
34	34	9

March 2016 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
36 (1 subsequently withdrawn)	35	16

Number of pre-submission meetings held in 2015-16

Pre-submission meetings per month	Meetings held
2015	
July	0
August	10
September	6
October	2
November	0
December	5
2016	
January	4
February	2
March	2
April	6
May	7
June	3
Total	47

Figures do not take into account extended meetings where two or more drugs are discussed within one meeting date.

Appendix 2
Report from the Director of the National Industrial Chemicals Notification and Assessment Scheme

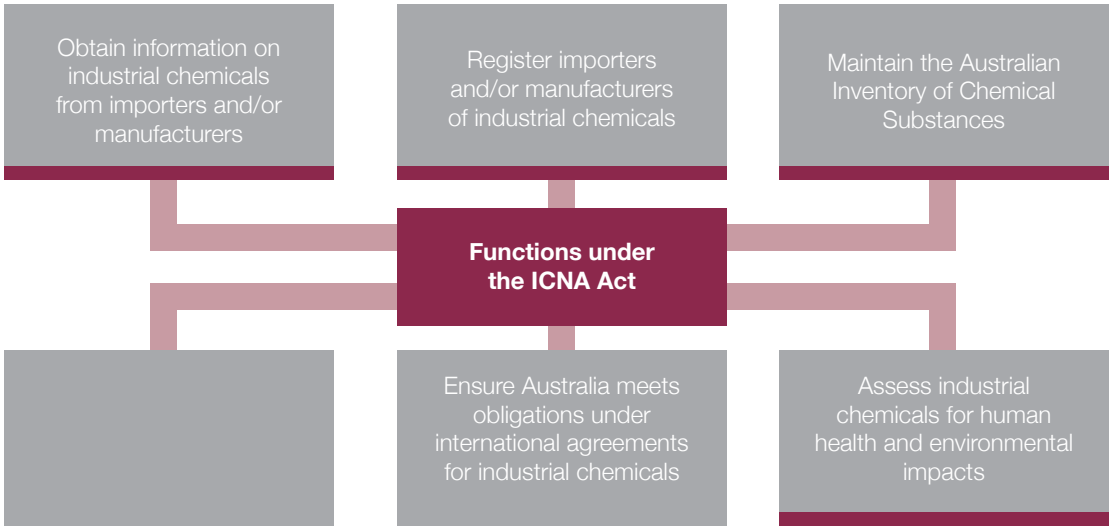
About NICNAS

The National Industrial Chemicals Notification and Assessment Scheme (NICNAS) is established by the *Industrial Chemicals (Notification and Assessment) Act 1989* (the ICNA Act). The scheme aids in the protection of the Australian people and the environment by assessing the risks of industrial chemicals and providing information to promote their safe use.

NICNAS assessment reports are used by a range of Government entities that regulate the control, use, release and disposal of industrial chemicals. NICNAS also informs workers, industry and the community about the safe use of industrial chemicals.

NICNAS achieved all of its key performance targets for 2015-16 within the available budget, as detailed in Part 2.1: *2015-16 Annual Performance Statements*, pages 153–158.

Figure 1: Description of functions under the ICNA Act



Registration of importers and/or manufacturers of industrial chemicals

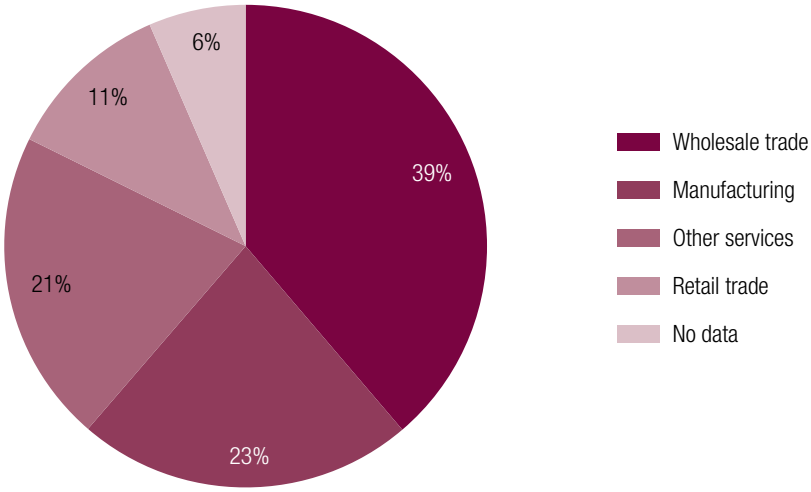
The registration of importers and/or manufacturers of industrial chemicals helps NICNAS to monitor the introduction of industrial chemicals in Australia, communicate effectively with the regulated industry and maintain public confidence that the chemical industry is aware of and complying with its regulatory obligations.

There are four different registration levels (Levels A to D) with levies for each level set according to the value of relevant industrial chemicals introduced.

Key registration statistics during 2015-16:

- 6,144 businesses were registered with NICNAS.
- Over 300 new businesses registered as a result of compliance monitoring activities.
- More than 600 people attended 13 NICNAS education and outreach sessions.

Figure 2: Registered businesses by industry sector (2015-16)



Source: NICNAS internal data

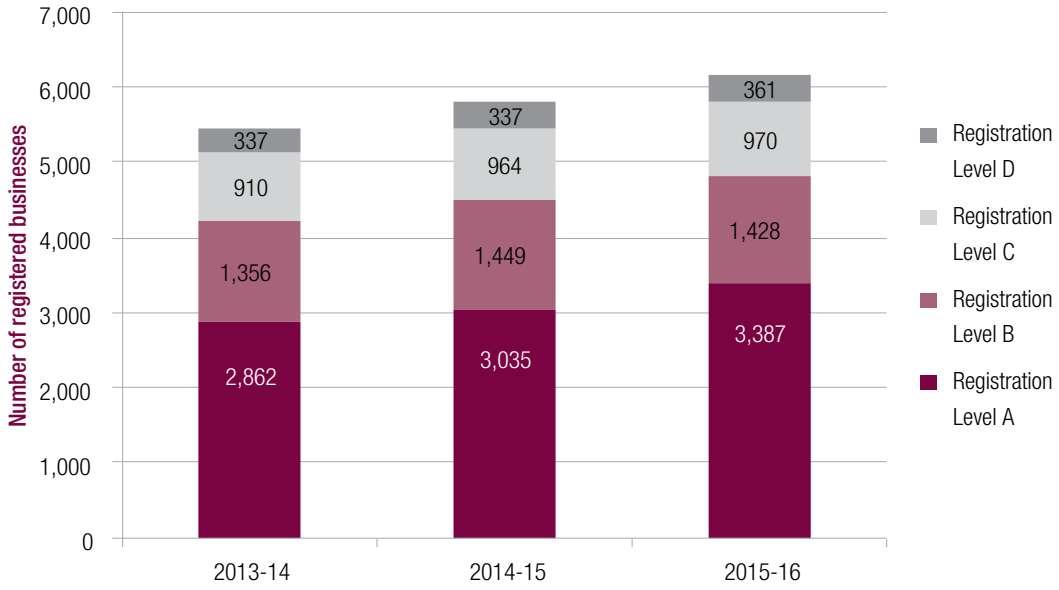
Compliance monitoring

NICNAS undertakes a range of compliance monitoring activities to assist importers and manufacturers of industrial chemicals to be aware of and comply with their obligations under the ICNA Act.

Key compliance statistics during 2015-16:

- 45% of all high volume importers and/or manufacturers were surveyed, with 55 businesses required to provide further information to NICNAS for potential non-compliance.
- 80 cases of potential non-compliance were identified, with 54 cases resolved within the financial year.
- As a result of resolved non-compliance:
  - 12 new industrial chemicals were notified or reported.
  - Introduction of 8 chemicals ceased.

Figure 3: Three-year trend data for NICNAS registrations



Source: NICNAS Annual Reports and internal data

Australian Inventory of Chemical Substances

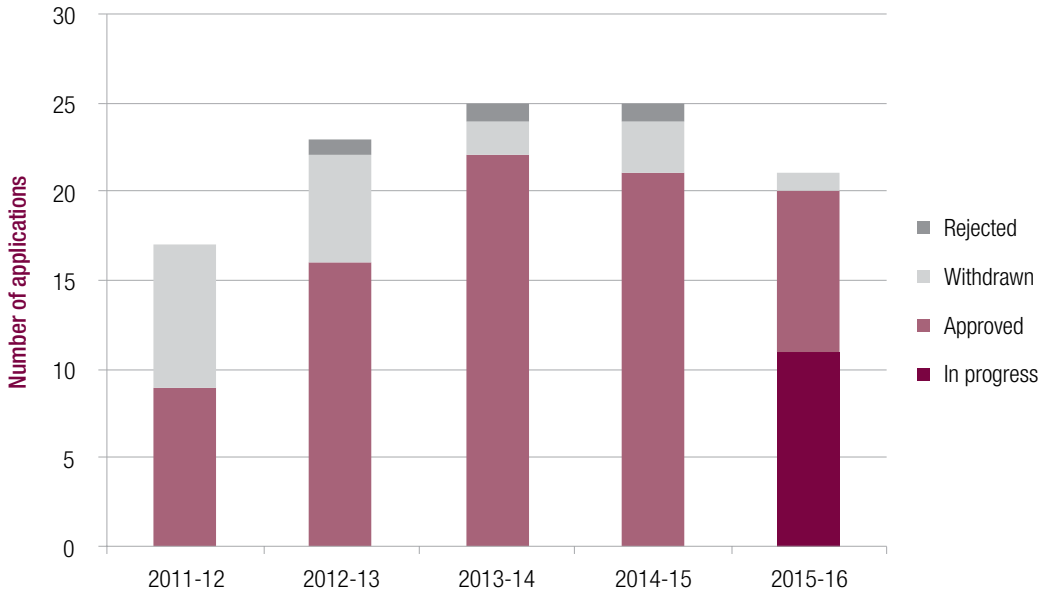
The Australian Inventory of Chemical Substances (AICS) lists industrial chemicals that may be manufactured and/or imported in Australia without notification to NICNAS. Chemicals on the AICS are known as 'existing' industrial chemicals. If a chemical is not listed on the AICS, it is considered to be a 'new' industrial chemical. New industrial chemicals assessed by NICNAS are listed on the AICS five years after an assessment certificate has been issued.

The AICS consists of a non-confidential (public) and confidential section. Applications for confidential listing are subject to a statutory public interest test. A chemical that satisfies this test is listed on the confidential AICS for five years, after which time the chemical is transferred to the public AICS unless another application is received, which again satisfies the public interest test.

Key AICS statistics during 2015-16:

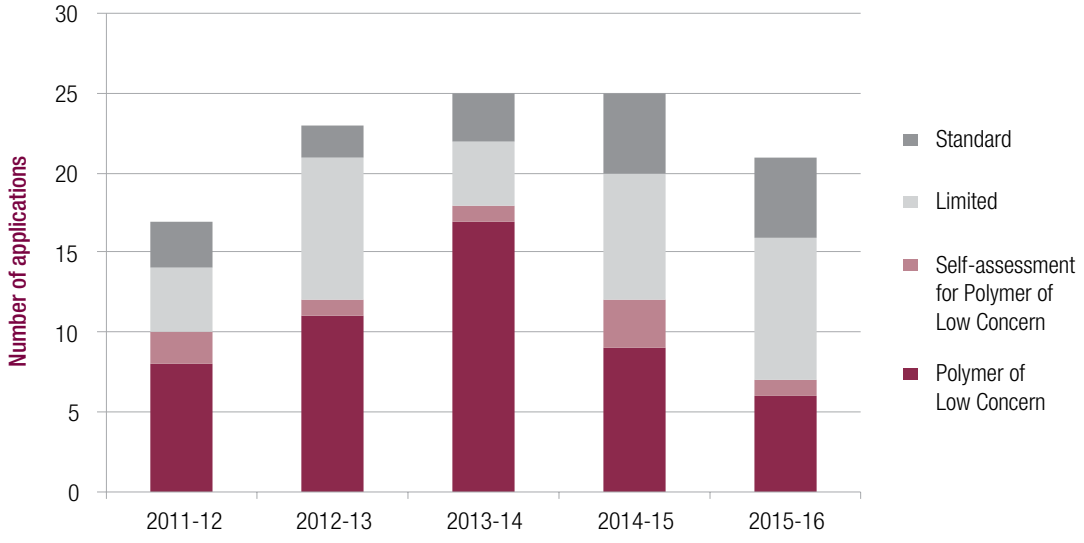
- 40,061 chemicals were on the public AICS, with 81 chemicals on the confidential AICS.
- 138 chemicals for which an assessment certificate had been issued five years previously, or had been listed on the confidential AICS for five years, were due to transfer to the public AICS.
- 21 of these chemicals were considered for confidential listing/re-listing: nine chemicals were approved for confidential listing, one was withdrawn by the applicant and 11 remained under consideration at the end of the financial year.
- 56% of approved applications for confidential listing were for polymers of low concern.
- 222 requests were received from bona fide introducers for a search of the confidential section of the AICS.

Figure 4: Outcomes of applications for confidential listing on the AICS received from 2011-12 to 2015-16



Source: NICNAS internal data

Figure 5: The original assessment categories for confidential listing applications from 2011-12 to 2015-16



Source: NICNAS internal data

New imported and/or manufactured industrial chemicals

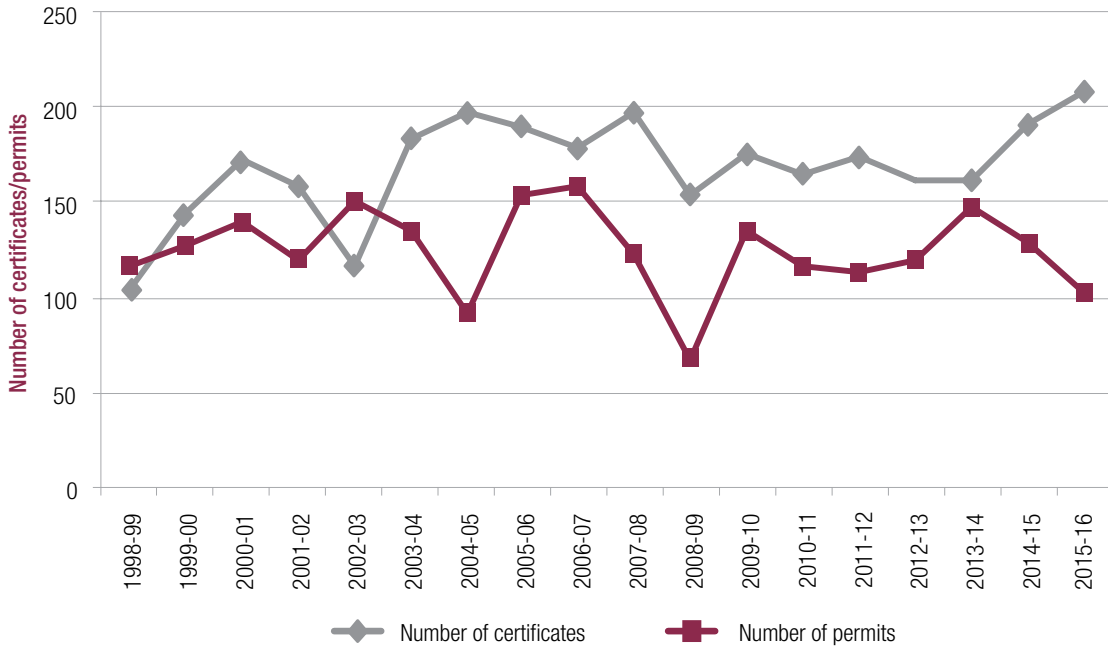
Unless a chemical is eligible under the ICNA Act for an exemption, all new industrial chemicals must be notified for assessment by NICNAS for risks to human health and the environment before they can be manufactured or imported into Australia. NICNAS assessments of new industrial chemicals lead to the issuing of permits and certificates. Chemicals introduced under a permit are not eligible for listing on AICS.

Key assessment statistics during 2015-16:

- 11,688 new industrial chemicals introduced under exemptions were reported by 208 introducers.
- 311 new industrial chemicals were assessed prior to introduction into Australia.

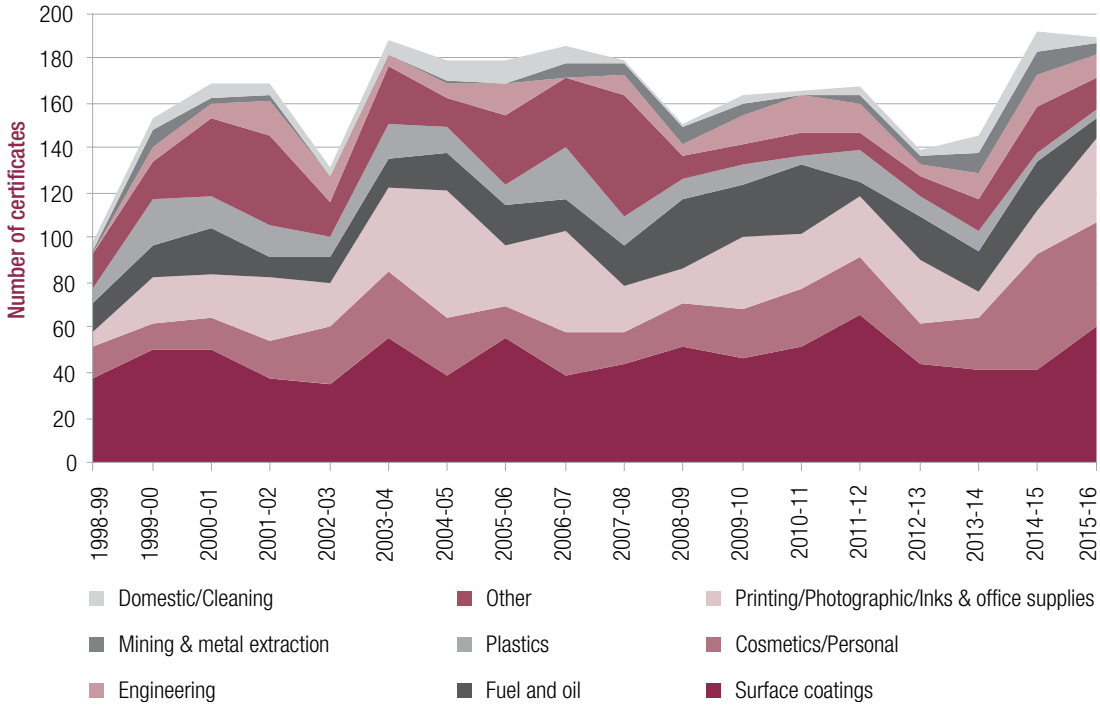
The following figures describe trends in the assessment of new chemicals notified by industry:

Figure 6: Certificates and permits issued 1998-99 to 2015-16



Source: NICNAS Annual Reports and internal data

Figure 7: Standard, Limited and Polymer of Low Concern Certificates issued by use category from 1998-99 to 2015-16



Note: The areas display trends over time and are stacked so that each series adjoins but does not overlap the preceding series.

Source: NICNAS Annual Reports and internal data

Assessment of existing industrial chemicals

On 30 June 2016, NICNAS completed Stage One of the application of the Inventory Multi-tiered Assessment and Prioritisation (IMAP) framework, which had commenced 1 July 2012. The application of the IMAP framework increased the availability of chemical safety information, leading to improved advice to risk management agencies about the measures that should be undertaken to help protect the Australian people and the environment.

By 30 June 2016, NICNAS had completed 5,114 human health and environment assessments for 3,419 unique industrial chemicals, exceeding the target of 2,850 chemicals set at the start of the program (95 per cent of the 3,000 chemicals prioritised for assessment in Stage One). This total includes 909 assessments completed in 2015-16. Greater program efficiency was gained by assessing 515 chemicals that were not included on the Stage One list, due to chemical similarities with other chemicals under assessment.

2,705 recommendations for 2,135 unique chemicals (including 194 for 2015-16) were identified for risk management or further assessment by NICNAS. NICNAS collaborated with its international counterparts, Australian risk management agencies (such as Safe Work Australia, the Chemicals Scheduling Delegate for the Poisons Standard and the Australian Competition and Consumer Commission), industry bodies and community groups to enable accurate and relevant information to be considered in undertaking IMAP assessments.

1,019 chemicals were recommended for classification for carcinogenicity, mutagenicity or toxicity to reproduction (CMR) – 71 per cent of these chemicals did not have equivalent classification overseas. 258 new entries or amendments to the Poisons Standard were recommended, with 40 per cent now aligned with international regulatory authorities. No direct equivalent restriction internationally was available for the remainder.

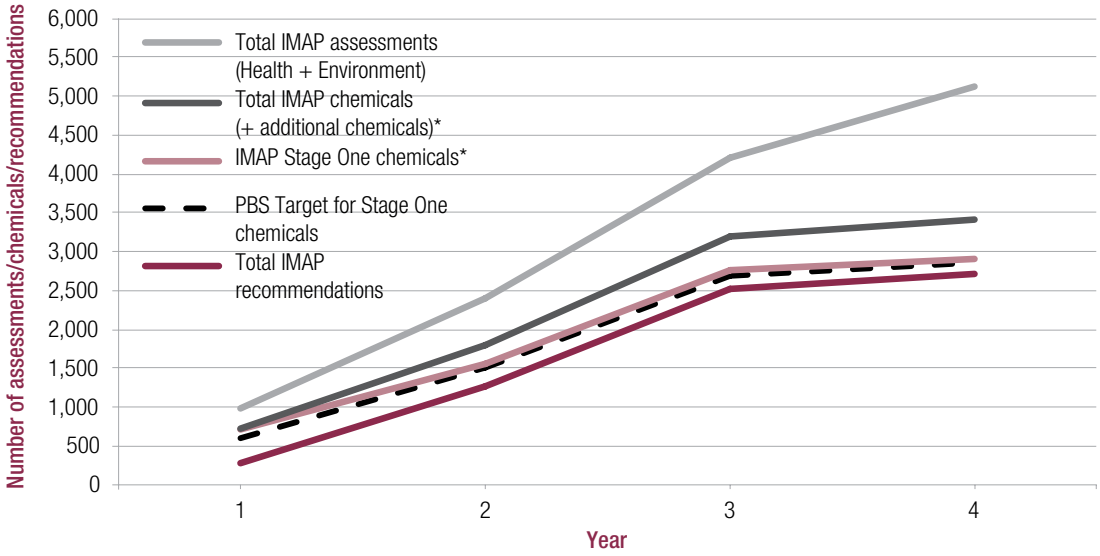
A six-to-eight week public comment period after the publication of each tranche of assessment reports enabled the provision of further information that added important value to the assessment reports.

A review of Stage One of the IMAP framework was completed in 2016, which identified opportunities to enhance the IMAP framework and adapt it to support assessments under the NICNAS reforms. The outcomes of the review have been published on the NICNAS website.[109]

IMAP review findings:

- The IMAP framework is very effective in accelerating high quality assessment outputs for existing chemicals.
- Tools and approaches used in the IMAP framework are aligned with international best practice and are fit for purpose.
- Data from international sources are fundamental to IMAP's success. Significant diversity in the scope of international data demonstrated the important role of the framework in identifying potential risks associated with the use of industrial chemicals in Australia.

Figure 8: Outcomes of IMAP Stage One



*Assessed for human health and/or environment
Source: NICNAS Annual Reports, internal data and *2015-16 Health Portfolio Budget Statements*

NICNAS reforms

The reforms to NICNAS aim to streamline assessment processes, focus regulatory effort on higher risk chemicals, and maintain Australia's robust health, safety and environmental standards.

The implementation of the reforms is being developed in consultation with industry, community and government stakeholders.

Stakeholder views will be considered in finalising the regulatory model submitted to Government for introduction into Parliament, with a view to full implementation by July 2018.

[109] Available at: www.nicnas.gov.au/chemical-information/imap-assessments/imap-review-2016

Key NICNAS reform statistics during 2015-16:

- Three public consultation papers were released, with 119 written submissions received in response.
- Over 300 people attended six stakeholder workshops.
- Over 100 organisations were consulted.

Stakeholder advice

The NICNAS Strategic Consultative Committee (SCC) first met in August 2015. The SCC has representation from peak industry and community groups, is chaired by the Director of NICNAS, and its membership and Terms of Reference were approved by the (then) Assistant Minister for Health.

The SCC held four meetings in 2015-16 (August, November, March and May), and two working groups were convened to consider the approaches proposed under the NICNAS reforms to introduce new chemicals at a concentration of up to one per cent in formulated products, and to implement transitional arrangements.

The SCC was consulted in advance of the publication of the three consultation papers describing the proposed approach to implementing the NICNAS reforms. The Committee also discussed:

- the management of Confidential Commercial Information by NICNAS;
- chemicals introduced under exemptions from notification and assessment;
- tattoo inks;
- the review of the IMAP framework;
- NICNAS involvement in the Organisation for Economic Co-operation and Development (OECD) Working Party on Manufactured Nanomaterials; and
- NICNAS regulatory and financial performance results.

Digital services

A review of the NICNAS website was completed in 2015-16 to explore options for improving navigation, usability and design. An upgrade of the website's search engine saw the introduction of an improved search results display and ability to search both the AICS and website content.

International engagement

NICNAS contributes to and benefits from international collaboration through increased understanding and agreement on international risk assessment approaches, principles and practices.

In 2015-16, NICNAS maintained its active engagement with trusted international regulators. The OECD Chemicals Committee and its key subsidiary committees are the main mechanisms through which NICNAS engages multilaterally.

Engagement with regional jurisdictions through the Asia Pacific Economic Cooperation Chemical Dialogue continued. Ongoing dialogue between NICNAS and its Canadian, European and US counterparts through existing cooperative arrangements was valuable, as this facilitated access to scientific expertise, assessment tools and methodologies, enabling Australian industrial chemicals regulation to remain at world's best practice.

Financial performance

Table 1: Five year comparison of NICNAS revenue and expenses

	2011-12 $'000	2012-13 $'000	2013-14 $'000	2014-15 $'000	2015-16 $'000
Industry cost recovered revenue	9,014	11,089	12,819	13,045	16,324
Other revenue	836	2,809	2,094	1,023	493
Total revenue	9,850	13,898	14,913	14,068	16,817
Total expenses	10,004	13,074	13,906	13,764	14,602
Operating surplus/(deficit)	(154)	824	1,007	304	2,215

Compared with 2014-15, total revenue and expenses have increased by $2.749 million and $0.838 million, respectively.

Industry cost recovered revenue was $16.324 million, which is $3.279 million higher than the previous year. 2015-16 revenue was affected by changes to registration fees and charges, which were increased to fund the implementation of the NICNAS reforms in accordance with the NICNAS Cost Recovery Implementation Statement.

Net revenue from other sources was $0.493 million, which is $0.530 million lower than the previous year, due to the completion of an external project.

Total expenses were $14,602 million, which is $0.838 million higher than the previous year. This result is due to operational costs associated with the NICNAS reforms, net of a $0.502 million decrease in costs of an external project.

The NICNAS final net result for 2015-16 was a surplus of $2.215 million, which will be retained in the NICNAS Special Account to provide for business continuity requirements, future capital projects and to fund staff entitlements, in accordance with relevant Government policies.

Acknowledgements

NICNAS is administered by highly skilled and dedicated staff in both the Department of Health and the Department of the Environment and Energy, with advice from the NICNAS Strategic Consultative Committee and its working groups. Many stakeholders provided thoughtful and constructive input into the implementation of the reforms to NICNAS that were announced in the context of the 2015-16 Budget. I sincerely appreciate the efforts of staff and stakeholders in the work of the scheme.

Dr Brian Richards

Director of NICNAS

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Appendix 3
Health Provider Compliance Report

Machinery of Government change

On 30 September 2015, the Prime Minister, the Hon Malcolm Turnbull MP, announced that a Machinery of Government transfer would occur, with responsibility for the Medicare Provider Compliance function transferring from the Department of Human Services to the Department of Health. The transfer was recommended by the Health Functional and Efficiency Review.

Achievements

The Department of Health continues to achieve results with several matters referred to the Commonwealth Director of Public Prosecutions. The following three cases, amongst others, were finalised in the courts during 2015-16:

- 13 November 2015, a health professional was convicted and sentenced to three years imprisonment for fraudulently obtaining Medicare benefits of $854,188. The health professional had submitted false claims for over 14,000 services that were not provided to patients in Victoria between December 2006 and September 2013.
- 15 January 2016, a former medical receptionist was convicted and sentenced to three years imprisonment for fraudulently obtaining Medicare benefits of $189,316. The medical receptionist had submitted 771 false claims for services which were not provided to patients at two medical practices in Queensland between May 2011 and November 2012.
- 22 March 2016, a former medical receptionist was convicted and sentenced to six months imprisonment for fraudulently obtaining Medicare benefits of $44,134. The former medical receptionist had submitted 345 false claims for services not provided to patients at a medical centre in New South Wales between December 2008 and May 2013.

Improve billing practices within public hospitals

The *Fraud Prevention and Compliance — improve billing practices within public hospitals* measure, which concluded in 2015-16, identified further areas for education about Medicare billing practices within public hospitals. Information was published on the Department's website to help health professionals and hospital administrators understand their legal responsibilities and requirements when billing under Medicare in public hospitals.

Looking ahead

Enhanced compliance Budget measure

The *Healthier Medicare — enhanced Medicare compliance program* will enhance health provider compliance with funding of $48 million over four years. Efficiencies will be achieved by introducing an advanced data analytics capability to better target providers who make Medicare claims that are inconsistent with existing rules and introducing changes to improve low rates of debt recovery from providers. The savings of $66.2 million over four years from this measure will be redirected by the Government to fund Health policy priorities.

Education and stakeholder engagement

Education and engagement assists health professionals meet their compliance obligations through a range of activities and information.

General education and targeted feedback letters

In 2015-16, 417 general education and targeted feedback letters were sent to health professionals covering a range of issues, such as checking concession entitlement of patients when claiming bulk bill incentive items.

Health Professional Guidelines

Developed in consultation with peak bodies, Health Professional Guidelines (HPGs) help educate regarding the documents that can be used to substantiate services. At 30 June 2016 there were 19 HPGs published on the Department of Health website.

Health compliance professionalism survey

The professionalism survey invites health professionals to provide feedback about their experience during Health Provider Compliance audits. The survey is sent following the completion of an audit and feedback guides training initiatives and improvements to business processes. In 2015-16 the Department received completed surveys from 409 health professionals, showing an overall satisfaction level of 91.1 per cent.

Audit and review activities

Audits and reviews are planned compliance activities on individuals or businesses that support payment integrity. They include general audits, practitioner review or criminal investigation.

Table 1: Completed health compliance audits and reviews

Programs/groups	2015-16
Medicare Benefits Schedule	3,399
Pharmaceutical Benefits Scheme	291
Health support programs	66
Child Dental Benefits Schedule	156
Total	3,912

The 2015-16 work program focussed on priority risks in the following areas:

Pharmaceutical Benefits Scheme (PBS)

- **Unapproved pharmacies:** reviewed claims from approved pharmacies when allegations were made that they had claimed for medicines supplied by another pharmacy not approved to supply under the PBS.
- **Multiple payments:** reviewed approved suppliers when claims are made more than once for the same authorised supply of a PBS medicine or when claims are made for the supply of two identical prescriptions where only one is valid for PBS subsidy.

Medicare Benefits Schedule (MBS)

- **GPs bulk billing incentive payments:** recovered benefits from GPs who continued to claim incorrectly after receiving targeted letters in 2014-15 about claiming for patients who did not have a valid concession card on the date of service.
- **Specialists-referred consultations:** audited specialists' claiming of referred consultations to determine if they had a valid referral before claiming the consultation.
- **Specialists-assisted reproductive technology:** audited specialists to determine if they have incorrectly claimed Medicare benefits for services related to Assisted Reproductive Technology) treatment cycles.
- **Pathology services:** carried out an end-to-end audit of selected approved pathology authorities to ensure that pathology tests/services requested were the tests performed and claimed by the approved pathology practitioner.
- **Diagnostic imaging:** audited computed tomography and/or diagnostic radiology services to ensure that the services requested were performed and claimed by the billing practitioner.

Incentive programs

- **Practice Incentives Program and Practice Nurse Incentive Program:** activities in 2015-16 focused on redrafting of the guidelines for the programs to provide increased clarity for practices and better support for future compliance activity.

Child Dental Benefit Schedule (CDBS)

- **Targeted audits:** identified dental practitioners for audit through analysis of CDBS claims data to ensure all requirements for payment of benefits had been met.
- **Education:** provided education material to all dental practitioners eligible to claim under the CDBS.
- **Voluntary acknowledgements:** processed repayments of debts from incorrect claiming that were acknowledged voluntarily by dental practitioners.
- **Monitoring:** reviewed the claims data of all dental practitioners who provided services under the CDBS.

Practitioner Review Program

The Department monitors Medicare claims to identify medical practitioners whose servicing or ordering of tests, or prescribing under the PBS, appears abnormal when compared with their peers. Whilst this may reflect the nature of the practice, it may also indicate inappropriate practice. When the Department has concerns about a practitioner's Medicare claims the practitioner is reviewed under the Department's Practitioner Review Program. At interview with one of the Department's health professional advisers, the practitioner is provided with an opportunity to explain why their profile is different to that of their peers. If concerns remain, including after a possible period of review, the Department may request the Director of

Professional Services Review (PSR) to review the practitioner's provision of services.

During 2015-16, 80 such requests were made to the Director of PSR.

During 2015-16, issues discussed during practitioner interviews included, but were not limited to:

- daily servicing;
- prescribing of drugs of addiction under the PBS; and
- initiation of pathology or diagnostic imaging.

During 2015-16, 472 practitioners were interviewed by professional advisers.

Under the *Health Insurance Act 1973* (the Act) general practitioners or other medical practitioners who render 80 or more professional attendances on 20 or more days in a 12 month period (a prescribed pattern of services) are deemed to have engaged in inappropriate practice (the 80/20 rule) and must be reviewed by the Director of PSR. During 2015-16, the Director of PSR was requested to review the provision of services of five practitioners who breached the 80/20 rule.

Practitioners identified as approaching the 80/20 service level without yet breaching the rule were reminded of their obligations by letter, or at a Practitioner Review Program interview. During 2015-16, 77 practitioners were advised in writing to review their Medicare servicing levels.

Internal reviews

In 2015-16, the Department completed 69 reviews of decisions, including 44 legislative reviews and 25 administrative reviews. The original decision was upheld in approximately 39 per cent of cases. Of those cases where the original decision was varied or revoked, 85 per cent involved consideration of new evidence.

Table 2: Health internal reviews

	2015-16	2014-15	2013-14
Allied health providers	4	6	12
Pharmacies	1	1	0
Dentists	6	2	2
General practitioners and specialists	39	42	9
Incentive payments	19	12	3
Total	69	63	26

Debts

Health programs debt

In 2015-16, the Department worked with the Department of Human Services to raise debts of more than $18.6 million in incorrect MBS and other health support payments. This was through:

- identifying recoverable amounts from audits and investigations;
- practitioners acknowledging incorrect billing at a Practitioner Review Program interview or during an audit;
- payment orders resulting from successful prosecutions or from determinations under the Professional Services Review scheme; and
- penalties, including civil, criminal and administrative.

Table 3: Debts raised for recovery of benefits incorrectly paid

Program	2015-16		2014-15		2013-14	
	Number	$ million	Number	$ million	Number	$ million
Medicare Benefits Schedule	1,924	16.3	1,760	61.4	970	9.8
Pharmaceutical Benefits Scheme	222	1.6	211	1.2	146	0.7
Health support programs	39	0.74	39	1.3	35	0.2
Total	2,185	18.6	2,010	64.0[110]	1,151	10.7

Fraud

Fraud investigations

The Department investigates fraud and refers matters to the Commonwealth Director of Public Prosecutions (CDPP) where appropriate relating to PBS, MBS, and other Health support programs. The Department's fraud control processes are deliberately focused on the most serious cases of non-compliance, not on people making honest mistakes.

In 2015-16, the Department conducted 190 investigations into fraud compared to 169 investigations in 2014-15.

[110] Total has been rounded to the nearest decimal point.

Tip-offs

In February 2016, the Department launched the Health Provider Compliance Hotline. Previously tip-offs associated with claiming by health providers were managed through the Australian Government Fraud Tip-off Line in the Department of Human Services. Since February 2016, the Department has received approximately 850 tip-offs from members of the public and health providers about potential provider non-compliance or fraud. Tip-offs can be lodged by:

- telephoning the Provider Compliance Hotline on 1800 314 808;
- email at health.provider.compliance@health.gov.au; and
- web form under the 'reporting suspected fraud' quick link on the home page of the Department's website: www.health.gov.au

Referrals

Medicare Participation Review Committees

Medicare Participation Review Committees (MPRCs) are independent statutory committees established on a case-by-case basis under Part VB of the *Health Insurance Act 1973.* They make determinations about whether to disqualify practitioners from participating in the Medicare program for a period up to five years.

Practitioners are referred to MPRCs following: the making of pecuniary penalty orders in respect of civil contraventions of the legislation; the commission of relevant criminal offences; or, breaches of a pathology undertaking. No practitioners were referred to MPRCs in 2015-16.

Table 4: Cases referred to MPRCs

	2015-16	2014-15	2013-14[111]
Open matters at start of year	0	1	7
Matters referred	0	0	0
Determinations finalised	0	1	6
Open matters at end of year	0	0	1
Hearings conducted	0	0	6

Commonwealth Director of Public Prosecutions

The Department and the Commonwealth Director of Public Prosecutions (CDPP) continued to work together to respond to fraud against health programs. The Department detects and investigates potential fraud and refers matters involving criminal offences relating to the MBS, PBS, or other related Health support programs to the CDPP, which decides whether to prosecute in line with the Prosecution Policy of the Commonwealth.

In 2015-16, the Department referred 35 matters to the CDPP including:

- 3 matters relating to health professionals;
- 1 matter relating to pharmacists; and

[111] Since December 2013, practitioners who have been referred to the Director of Professional Services Review on two or more occasions are no longer referred to MPRCs.

- 31[112] matters relating to corporate entities/employers, employees (such as receptionists), or their associates.

This compares to 94 such matters referred to the CDPP in 2014-15.

- 46[113] cases had a successful prosecution outcome during 2015-16. These outcomes included:
  - 36 reparation orders for the repayment of $1,462,706 in funds;
  - 12 custodial sentences ranging from one month to three years;
  - 24 orders relating to good behaviour and community service; and
  - 10 fines issued by the court.

[112] This includes two matters that were referred to the CDPP prior to Machinery of Government changes that have since been referred to the Department of Human Services, Business Integrity Branch for management.

[113] This includes eight public fraud matters that were finalised by the CDPP prior to Machinery of Government changes.

Appendix 4
Australian National Preventive Health Agency Financial Statements

Essential functions of the Australian National Preventive Health Agency (ANPHA) transferred to the Department of Health from 1 July 2014.

Appendix 4 contains the complete set of financial statements for ANHPA.

Contents

Australian National Preventive Health Agency

Independent Auditor's Report

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Aged Care

I have audited the accompanying annual financial statements of the Australian National Preventive Health Agency for the year ended 30 June 2016, which comprises the Statement by the Secretary and Chief Financial Officer, Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, Cash Flow Statement; Administered Schedule of Assets and Liabilities, Administered Reconciliation Schedule, Administered Cash Flow Statement and Notes to and forming part of the financial statements, comprising significant accounting policies and other explanatory information.

Opinion

In my opinion, the financial statements of the Australian National Preventive Health Agency:

(a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian National Preventive Health Agency as at 30 June 2016 and its financial performance and cash flows for the year then ended.

Accountable Authority's Responsibility for the Financial Statements

The Secretary of the Department of Health is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards and the rules made under that Act. The Secretary is also responsible for such internal control as the Secretary determines is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the

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Australian National Preventive Health Agency

Independent Auditor's Report

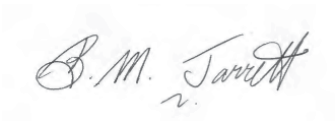
entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Australian National Audit Office



Brandon Jarrett

Executive Director

Delegate of the Auditor-General

Canberra

31 August 2016

Australian National Preventive Health Agency

Statement by the Secretary and Chief Financial Officer

AUSTRALIAN NATIONAL PREVENTIVE HEALTH AGENCY
STATEMENT BY THE SECRETARY AND CHIEF FINANCIAL OFFICER

The Secretary of the Department of Health pursuant to Section 31 of the *Public Governance, Performance and Accountability Act 2013* required by Section 31 and subsection 17A(3) of the *Public Governance, Performance and Accountability Rule 2014* is the accountable authority responsible to prepare the financial statements of the Australian National Preventive Health Agency for the period ended 30 June 2016.

In our opinion the attached financial statements for the period 1 July 2015 to 30 June 2016:
a) comply with subsection 42(2) of the *Public Governance, Performance and Accountability (PGPA) Act 2013;*
b) have been prepared based on properly maintained financial records as per subsection 41(2) of the PGPA Act; and
c) when this statement was made, there are reasonable grounds to believe that the Australian National Preventive Health Agency will be able to pay its debts as and when they fall due.

Signed.....

Martin Bowles PSM
Secretary
Department of Health

31 August 2016

Signed.....

Craig Boyd
Chief Financial Officer
Department of Health

31 August 2016

Australian National Preventive Health Agency

Statement of comprehensive income

for the period ended 30 June 2016

	Notes	2016 $'000	2015 $'000
NET COST OF SERVICES			
EXPENSES			
Employee benefits		-	171
Supplier		20	57
Impairment of other Commonwealth entity travel debts		18	-
Total expenses		38	228
OWN-SOURCE INCOME			
Gains			
Other Gains - FBT refund		15	-
Total own-source revenue		15	-
Other revenue			
Resources received free of charge		19	65
Total other revenue		19	65
Total own-source income		34	65
Net (cost of) services		(4)	(163)
Surplus (Deficit)		(4)	(163)
Surplus (Deficit) attributable to the Australian Government	1.3	(4)	(163)

The above statement should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Statement of financial position

as at 30 June 2016

	Notes	2016	2015
		$'000	$'000
ASSETS			
Financial assets			
Cash and cash equivalents	1.3	**18**	2
Departmental appropriation receivable		**1,347**	1,347
Other receivables to Commonwealth entities		**-**	20
Total financial assets		**1,365**	1,369
Total assets		**1,365**	1,369
LIABILITIES			
Total liabilities		**-**	-
Net assets		**1,365**	1,369
EQUITY			
Accumlated surplus		**1,365**	1,369
Total equity		**1,365**	1,369

The above statement should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Statement of changes in equity

for the period ended 30 June 2016

	Retained earnings		Total equity	
	2016	2015	**2016**	2015
	$'000	$'000	**$'000**	$'000
Opening balance				
Balance carried forward from previous period	**1,369**	1,532	**1,369**	1,532
Opening balance	**1,369**	1,532	**1,369**	1,532
Comprehensive income				
Deficit for the period	**(4)**	(163)	**(4)**	(163)
Total comprehensive income	**1,365**	1,369	**1,365**	1,369
Closing balance as at 30 June	**1,365**	1,369	**1,365**	1,369

The above statement should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Cash flow statement

for the period ended 30 June 2016

	Notes	2016 $'000	2015 $'000
OPERATING ACTIVITIES			
Cash received			
Prepayment paid back from Department of Health		-	379
Net GST received		1	47
FBT Refund		15	31
Total cash received		16	457
Cash used			
Employees		-	510
Suppliers		-	24
Total cash used		-	534
Net cash from operating activities	1.3	16	(77)
Net (decrease) in cash held		16	(77)
Cash and cash equivalents at the beginning of the reporting period		2	79
Cash and cash equivalents at the end of the reporting period	1.3	18	2

The above statement should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Administered schedule of assets and liabilities

as at 30 June 2016

	2016 $'000	2015 $'000
ASSETS		
Financial assets		
Trade and other receivables	**12,383**	12,383
Total financial assets	**12,383**	12,383
Total assets administered on behalf of Government	**12,383**	12,383
Net assets	**12,383**	12,383

Australian National Preventive Health Agency

Administered reconciliation schedule

as at 30 June 2016

	2016	2015
	$'000	$'000
Opening administered assets less administered liabilities as at 1 July	**12,383**	12,894
Surplus (deficit) items:		
Transfers to OPA	-	(511)
Administered assets and liabilities appropriations	-	-
Closing administered assets less administered liabilities as at 30 June	**12,383**	12,383

The above schedule should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Administered cash flow statement

for the period ended 30 June 2016

	2016 $'000	2015 $'000
OPERATING ACTIVITIES		
Cash received		
Sale of goods and rendering of services	-	-
Net GST received	-	511
Other	-	-
Total cash received	-	511
Cash to Official Public Account:		
- Appropriations	-	511
Total cash to official public account	-	511
Cash and cash equivalents at the end of the reporting period	-	-

This schedule should be read in conjunction with the accompanying notes.

Australian National Preventive Health Agency

Overview

Abolition of the Australian National Preventive Health Agency

In the 2014-15 Budget papers the Australian Government announced as part of its Smaller Government initiative that it would abolish the Australian National Preventive Health Agency (ANPHA) and integrate its ongoing functions into the Department of Health, including the administration of social marketing activities and the provision of grants to third parties for preventive health activities.

A bill to abolish ANPHA was introduced to Parliament on the 15 May 2014 by the Australian Government. The bill was referred to the Senate Community Affairs Committee on the 15 May and on the 14 July 2014, the Committee recommended that the Bill be passed. The House of Representatives passed the bill on the 3 June 2014 and the bill was introduced to the Senate on the 16 June 2014 and was negatived by the Senate on the second reading on the 25 November 2014. There is currently no bill before Parliament to abolish ANPHA.

The Department of Health was provided funding in the 2014-15 Budget to integrate and transition the ongoing functions of ANPHA into the Department of Health. All ongoing administered grants to third parties are being managed by the Department of Health.

ANPHA was not provided any annual appropriations in 2014-15, 2015-16 or 2016-17, Appropriation Acts. At 30 June 2016, ANPHA's total financial assets are in excess of its total liabilities as reported in the statement of financial position and ANPHA has no debts. At 30 June 2016, ANPHA has no employees. The Chief Executive Officer was the only employee of ANPHA during 2014-15 financial year and resigned effective 5 January 2015.

The Secretary of the Department of Finance, pursuant to subsection 17A(3) of the *Public Governance, Performance and Accountability Rule 2014* has instructed the Secretary of the Department of Health to produce the financial statements for ANPHA as would have been required by the accountable authority.

ANPHA is an Australian Government Agency and does not have a separate legal personality to the Australian Government.

Objectives of the Australian National Preventive Health Agency

ANPHA is listed as a non-corporate Commonwealth entity under the *Public Governance, Performance and Accountability (PGPA) Act 2013*, and its role and functions are set out in the *Australian National Preventive Health Agency Act 2010*.

The Australian Government established ANPHA on 1 January 2011 to provide a new national capacity to drive preventive health policy and programs.

ANPHA will not continue to exist in its present form and will not continue its programs. Government policy is to abolish ANPHA and funding has not been provided by Parliament for ANPHA's administration and programs.

ANPHA was structured to meet one outcome:

Outcome 1: 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.

ANPHA activities that contributed toward this outcome are classified as either departmental or administered. Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by ANPHA in its own right. Administered activities involve the management or oversight by ANPHA, on behalf of the Government, of items controlled or incurred by the Government.

Basis of Preparation of the Financial Statements

The financial statements are general-purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

The financial statements have been prepared in accordance with:

a) Financial Reporting Rule (FRR) for reporting periods ending on or after 1 July 2015; and
b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value.

The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars unless otherwise specified.

Unless an alternative treatment is specifically required by an accounting standard or the FRR, assets and liabilities are recognised in the statement of financial position when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executory contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the contingencies note.

ANPHA had no departmental or administered commitments or contingencies as at 30 June 2015 or 30 June 2016.

Unless alternative treatment is specifically required by an accounting standard, income and expenses are recognised in the Statement of Comprehensive Income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

Significant Accounting Judgements and Estimates

No accounting assumptions or estimates have been identified that have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next reporting period.

Australian National Preventive Health Agency
Overview

New Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

No accounting standard has been adopted earlier than the application date as stated in the standard.

Revised standards that were issued prior to the sign-off date and are applicable to the current reporting period did not have a financial impact, and are not expected to have a future financial impact on the Agency. AASB 1055 '*Budgetary Reporting*' has no impact on ANPHA's reporting requirements, as ANPHA did not receive any budget for the 2014-15 financial year or beyond and did not present a budget to Parliament.

Future Australian Accounting Standard Requirements

No new standards, revised standards, interpretations and amending standards that were issued by the Australian Accounting Standards Board prior to the sign-off date, are expected to have a material financial impact on the Agency for future reporting periods.

Revenue

Resources Received Free of Charge

Resources received free of charge are recognised as revenue when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense. Resources received free of charge are recorded as either revenue or gains depending on their nature.

Revenue from Government

Amounts appropriated for departmental appropriations for the year (adjusted for any formal additions and reductions) are recognised as Revenue from Government when ANPHA gains control of the appropriation, except for certain amounts that relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned. Appropriations receivable are recognised at their nominal amounts.

Employee Benefits

There were no person's engaged or reportable to ANPHA as at 30 June 2016.

Cash

Cash is recognised at its nominal amount. Cash and cash equivalents include:

a) cash on hand, and
b) cash in special accounts.

Financial Assets

Loans and Receivables

Impairment of Financial Assets

Financial assets are assessed for impairment at the end of each reporting period.

Financial assets held at cost - If there is objective evidence that an impairment loss has been incurred, the amount of the impairment loss is the difference between the carrying amount of the asset and the present value of the estimated future cash flows discounted at the current market rate for similar assets.

Contingent Liabilities and Contingent Assets

As at 30 June 2016 and at 30 June 2015, there were no contingent assets or liabilities.

Property, Plant and Equipment

ANPHA has no Property, Plant or Equipment.

Taxation / Competitive Neutrality

ANPHA is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses and assets are recognised net of GST except:

a) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
b) for receivables and payables.

Events after the Reporting Period

Departmental

There was no subsequent event that had the potential to significantly affect the ongoing structure and financial activities of the entity.

Administered

There was no subsequent event that had the potential to significantly affect the ongoing structure and financial activities of the entity.

Reporting of Administered Activities

There were no Administered activities to report during 2015-16 in relation to ANPHA.

Australian National Preventive Health Agency

Notes to and forming part of the financial statements

Note 1.1: Appropriations

Unspent Annual Appropriations ('Recoverable GST exclusive')

	2016	2015
Authority	**$**	**$**
DEPARTMENTAL		
Appropriation Act (No.1) 2013-2014	**1,347**	1,347
Total departmental	**1,347**	1,347

Note 1.2: Special Accounts

Special Accounts (Recoverable GST exclusive)

	The Australian National Preventive Health Agency Special Account (Administered)[1]	
	2016	2015
	$'000	$'000
Balance brought forward from previous period	**12,383**	12,383
Available for payments	**12,383**	12,383
Total balance carried to the next period	**12,383**	12,383

Notes:

1. Appropriation: *Public Governance, Performance and Accountability Act 2013* , Section 80.

2. Establishing Instrument: *Australian National Preventive Health Agency Act 2010* , Section 50.

3. Purposes of the Account:

(a) paying or discharging the costs, expenses and other obligations incurred by the Commonwealth in the performance of the CEO's functions;

(b) paying any remuneration and allowances payable to any person under the *Australian National Preventive Health Agency Act 2010* ; and

(c) meeting the expenses of administering the Account.

Note 1.3: Cash Flow Reconciliation

	2016	2015
	$'000	$'000
Reconciliation of cash and cash equivalents as per Statement of Financial Position to Cash Flow Statement		
Cash and cash equivalents as per:		
Cash flow statement	**-**	2
Statement of financial position	**-**	2
Difference	**-**	-
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	**-**	(163)
Revenue from Government	**-**	-
Adjustment for non cash items		
Depreciation / amortisation		-
Net write down of non-financial assets	**-**	-
Movement in assets / liabilities		
Assets		
(Increase) / decrease in net receivables	**20**	26
(Increase) / decrease in prepayments received	**-**	379
Liabilities		
Increase / (decrease) in employee provisions	**-**	(292)
Increase / (decrease) in supplier payables	**-**	(16)
Increase / (decrease) in other payable	**-**	(10)
Net cash from operating activities	**20**	(77)

Appendix 5
Australian Digital Health Agency 2015-16 Annual Report

Australian Government
Australian Digital Health Agency

Level 25, 56 Pitt Street
Sydney NSW 2000
Telephone: (02) 8298 2600
Facsimile: (02) 8298 2666
www.digitalhealth.gov.au

13 September 2016

The Hon Sussan Ley MP
Minister for Health and Aged Care
Minister for Sport
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the board of the Australian Digital Health Agency (the Agency), I am pleased to present our annual report for the period 1 July 2015 to 30 June 2016.

The Agency was established on 30 January 2016, following registration of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2016, and commenced operations on 1 July 2016. The report addresses the requirements of section 46 of the *Public Governance, Performance and Accountability Act 2013* and includes audited financial statements as required by subsection 43(4) of that Act.

This annual report was approved for presentation to you in accordance with a resolution of the board on 13 September 2016.

In compliance with sections 68 and 69 of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule* 2016, the Agency will notify each State and Territory Health Minister of the availability of the report, and provide a copy on request.

Yours sincerely

Jim Birch AM
Chair
Australian Digital Health Agency

Australian Digital Health Agency ABN 84 425 496 912

Background

In November 2013, the Australian Government commissioned a review of the Personally Controlled eHealth Record (PCEHR) to assess the status of the PCEHR implementation and to work with health professionals and industry to prioritise further implementation. The Review was released on 19 May 2014.

The 2015-16 Federal Budget measure *My Health Record – A New Direction for Electronic Health Records in Australia* provided funding to strengthen eHealth governance arrangements consistent with the Review recommendations.

This included the transition of relevant activities and resources from the National E-Health Transition Authority (NEHTA), and also from the national My Health Record system operation activities managed by the Department of Health, to a new entity called the Australian Digital Health Agency (the Agency).

Purpose, enabling legislation and functions

The Agency is a Corporate Commonwealth entity under the *Public Governance, Performance and Accountability (PGPA) Act 2013*, and was established under the *PGPA (Establishing the Australian Digital Health Agency) Rule 2016*.

The Agency reports to the Minister for Health, The Honourable Sussan Ley MP, and to State and Territory Health Ministers through the Council of Australian Governments (COAG) Health Council.

The Agency commenced operations on 1 July 2016. NEHTA and Department of Health functions and resources transferred to the Agency on this date.

There are offices in Brisbane, Canberra, Melbourne and Sydney.

About the Australian Digital Health Agency

The Agency is the national body responsible for the strategic management and governance of the national digital health strategy and the design, delivery and operations of the national digital health care system. The Agency will provide the leadership, coordination and delivery of a collaborative and innovative approach to utilising technology to support and enhance a clinically safe and connected national health system to improve health service delivery and health outcomes for the Australian community.

There are three main objectives:

1. building foundations for better health outcomes through improved governance, and management and delivery of national digital health services;
2. promoting and facilitating user communication, engagement and collaboration through open innovation; and
3. operating an effective and secure digital health care system.

To achieve these, the following functions will be performed:

- coordinate and provide input into the ongoing development of the National Digital Health Strategy;
- implement those aspects of the National Digital Health Strategy that are agreed or directed by the COAG Health Council;
- develop, implement, manage, operate, continuously innovate and iteratively improve specifications, standards, systems and services in relation to digital health, consistent with the National Digital Health Work Program;
- develop, implement and operate comprehensive and effective clinical governance, using a whole-of-system approach, to ensure clinical safety in the delivery of the National Digital Health Work Program;
- develop, monitor and manage specifications and standards to maximise effective operation between public and private sector digital health care systems;
- develop and implement compliance approaches in relation to the adoption of agreed specifications and standards relating to digital health; and
- liaise and cooperate with overseas and international bodies on matters relating to digital health.

The Board

Mr Jim Birch AM, Chair is also Chair of the Australian Red Cross Blood Service, Deputy Chair of the Independent Hospital Pricing Authority, Chair of Mary MacKillop Care SA and a board member of the Australian Red Cross Society, the Little Company of Mary Health Care and Cancer SA. He was formally a Partner in Ernst and Young having been the Global Health Leader. He has also been the Government and Public Sector Leader from 2012 until the end of 2014. Formerly, Mr Birch was also the Lead Partner in Health and Human Services for Asia Pacific. He has over 35 years experience in planning, leading and implementing change in complex organisations transcending such areas as health care, justice and human services. Mr Birch has been a Chief Executive of the Human Services and Health Department (South Australia), Deputy Chief Executive of Justice and Chief Executive of major health service delivery organisations, including teaching hospitals. Mr Birch has previously been Chair of the Australian Health Ministers' Advisory Council, a member of the Australian Commission on Safety and Quality in Health Care, and was a Board Member of the National E-Health Transition Authority and Chair of Rural Health Workforce Australia. He has a Bachelor of Health Administration from the University of New South Wales.

Mr Robert Bransby has been Managing Director of HBF Health Limited since January 2008 having been appointed Chief Executive Officer in 2007 and Group General Manager in 2005. He was formerly a Director of HealthGuard Health Benefits Pty Ltd and was Director of HBF Insurance Pty Ltd before the sale of HBF's general insurance business in 2011. During his term HBF has consolidated its position as Western Australia's leading health fund, reaffirming its focus on member health and embarking on an ambitious strategy to become a valued health partner to HBF members. Mr Bransby has long held a leadership position within the health insurance sector and is President of the industry association, Private Healthcare Australia. He is well known for championing the interests of health fund members, and as an advocate for not-for-profit health insurers. Prior to working at HBF, Mr Bransby enjoyed a successful career in banking, holding positions including Corporate Finance Manager, Corporate Banking Western Australia and Head of Business Financial Services in New South Wales during 25 years at the National Australia Bank Ltd. He is President of Private Healthcare Australia (PHA), Pioneer Credit Ltd, Synergy, Commonwealth Financial Planning Limited, BW Financial Advice Limited, Count Financial Limited and Financial Wisdom Limited. He is also a Commissioner of the Insurance Commission of WA.

Dr Eleanor Chew is a specialist general practitioner and medical educator, with extensive experience representing the role of primary care in the health services profession. A graduate of the University of Queensland, Dr Chew has worked as a GP in Brisbane, Darwin, Perth and Canberra in a variety of practice settings including solo, small practices, and corporate practice. Dr Chew is a past Vice President and Chair of

the Royal Australian College of General Practitioners RACGP, and is an experienced leader with strategic vision and a solid understanding of governance responsibilities. Through her roles with the RACGP, Dr Chew has interacted extensively with other Colleges, the AMA, Medical Board, Medical Defence Organisations, and State and Commonwealth departments, advocating for general practitioners and gaining valuable insights into the many challenges facing the health care system. Dr Chew serves on a range of committees and working groups focussed on the advancement of quality primary care, in both the private and government sectors.

Dr Elizabeth Deveny is the Chief Executive Officer of the South Eastern Melbourne Primary Health Network. She was previously the Chief Executive Bayside Medicare Local and Acting Chief Executive Officer Northern Melbourne Medicare Local. She has worked as a Research Fellow in both the Department of Ophthalmology and the Department of Paediatrics at the University of Melbourne. Dr Deveny has a Doctor of Philosophy, a Master's Degree in Health Education, and a Bachelor of Training and Development from the University of Melbourne.

Mr Paul Madden is the Strategic Health Systems and Information Management Special Adviser with the Commonwealth Department of Health. His role includes supporting the Government in leading the national rollout of digital health initiatives including foundation technologies and related services across Australia, the continued and improved operation of the My Health Record system, and the trials of opt-out participation arrangements. He is a member of the Department of Health Executive Committee. He is responsible for the setting and operation of governance policies and processes for data and information management. Prior to joining the Department, Mr Madden was Program Director of the Standard Business Reporting Program led from the Australian Treasury from 2007-2010.

Ms Lyn McGrath is the Executive General Manager, Retail Sales at the Commonwealth Bank of Australia (CBA), leading the largest distribution business within CBA; a team of over 10,000 people across Australia, the UK and China. She has been in her current position since 2010, promoted from her previous role of Regional General Manager, Sydney Region. Prior to this, Ms McGrath held roles with St George in the Retail Bank as Head of Customer Experience and as Regional Manager, Northern Sydney. She has extensive senior management experience in strategic and operational roles within the utilities and media industries and over 20 years experience in Financial Services. Ms McGrath is highly regarded for her transformational leadership and customer experience strategy. She holds an MBA and BA from Macquarie University as well as a Dip PR (Hons). She is a Graduate of the Australian Institute of Company Directors and currently holds Board positions at Commonwealth Financial Planning and the Evidence for Learning Board, a joint initiative with Social Ventures Australia and the Commonwealth Bank. Ms McGrath is a Senior Fellow with FINSIA and a Fellow with the Australian Institute of Management. In 2012, she was named as one of the 100 Most Influential Women in Australia by the Australian Financial Review.

Mr Stephen Moo is the Chief Information Officer for the Northern Territory Department of Health. He has been employed in the health sector for over 34 years, with the last 16 years having direct responsibility for the design, development, implementation and on-going systems management for major corporate client and clinical information systems, and information communications and infrastructure. He has overseen the Northern Territory's eHealth program for the past 11 years and is the principal architect and sponsor for the development and implementation of a comprehensive eHealth program that is widely regarded as one of the most advanced of its kind in Australia. As Chair of the National Health Chief Information Officer Forum for the past eight years, Mr Moo has played a key role in the development of the National eHealth Strategy and national eHealth foundation services and standards with the previous National E-Health Transition Authority. Mr Moo was appointed by the Australian Health Ministers' Advisory Council as the Jurisdictional ICT representative on the eHealth Implementation Taskforce Steering Committee, which assisted to establish the Australian Digital Health Agency. Mr Moo is a strong advocate for ensuring clinical information systems and eHealth solutions development have appropriate expert clinical sponsorship and actively involves clinical business analysts, clinical educators and clinical champions with the necessary expert knowledge and skills in information management to deliver clinically appropriate information technology solutions. Mr Moo has recently overseen the development of NT Health's Strategic Information Plan and the original Core Clinical System Renewal Programme (CCSRP) Business Case that will support the replacement of NT Health's Core Clinical Information Systems over five years. With many years of experience as the Chief Information Officer of NT Health, he will be a major contributor to the CCSRP over the next five years. This will see the development and implementation of a state-of-the-art electronic clinical Health Record to be used across all areas of NT Health service delivery.

Ms Stephanie Newell is a facilitator, educator and health care consumer advocate who is highly regarded across multiple industry sectors for her collaborative and innovative approach. Ms Newell works in partnership across all levels of health care so that health services and health systems are safe, consumer focussed and are informed by, and designed with, health care consumers for health care consumers. Ms Newell is currently the Consumer and Community Engagement Coordinator with the Health Consumers' Council of Western Australia, the state's peak body for health consumers. Her previous work as a consultant educator and facilitator includes six years developing and facilitating the 'Partnering with Consumers to Achieve Quality Outcomes in Healthcare' & 'Patient-centred Care' workshops across Australia for The Australian Council on HealthCare Standards. Ms Newell is a foundational member and a designated 'Patients for Patient Safety Champion' of the World Health Organization's Patients for Patient Safety program and a member of the Global Patient and Family Advisory Group of the Beryl Institute for Patient Experience. She also contributes to a number of Australian and international health care policy and research groups and initiatives in areas which include consumer engagement, patient experience, patient safety, quality improvement, accreditation and standards development. Ms Newell holds post graduate qualifications in Entrepreneurship, Commercialisation and Innovation from the University of Adelaide and is currently undertaking a Master of Clinical Science by Research.

Dr Bennie Ng is the General Manager, Partnerships and Strategy at Healthscope, a leading healthcare provider in Australia. He commenced his career as a General Practitioner, and has most recently been the Head of Social Policy at the Office of the Prime Minister. In addition to a health advisory role to the Australian Government, he has held other senior positions in strategy, services planning and general management including the Head of Clinical Services Planning at the Hong Kong Hospital Authority, the General Manager Cancer Medicine and Director of Medical Services at the Peter MacCallum Cancer Centre in Melbourne. Dr Ng has a Bachelor's Degree in Medicine and Surgery from the University of Western Australia and a Masters of Business Administration from Curtin University. He is a Fellow of the Royal Australasian College of Medical Administrators and the Royal Australian College of General Practitioners.

Professor Johanna Westbrook is Professor of Health Informatics and Director, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, at Macquarie University. She is internationally recognised for her research evaluating the effects of information and communication technology (ICT) in health care and has published over 300 papers. This research has led to significant advances in our understanding of how clinical information systems deliver (or fail to deliver) expected benefits and supported translation of this evidence into policy, practice, and IT system changes. In 2014 Professor Westbrook was awarded Australian ICT Professional of the Year by the Australian Information Industry Association. She has a PhD in Epidemiology from the University of Sydney, a Masters in Health Administration from the University of New South Wales, and a Bachelor of Applied Science (with Distinction) from the University of Sydney. She is a Fellow of the American College of Medical Informatics and the Australasian College of Health Informatics.

Mr Michael Walsh is the Director-General Queensland Health where he leads a public health and hospital system for a population of 4.7 million people. Prior to this role, he was the inaugural Chief Executive / CIO of eHealth NSW, providing eHealth and ICT services to the NSW Health System. Mr Walsh has also worked as Chief Executive of HealthShare NSW, the NSW Health shared service provider. He has extensive experience at the Government Senior Executive level in both NSW and Queensland and has worked in the private sector including for a leading consulting firm. Mr Walsh has led large organisational strategy and change programs including major departmental integrations; significant ICT programs; and, large hospital infrastructure programs such as the $10 billion Queensland Hospital rebuilding program including the Gold Coast University Hospital, Sunshine Coast University Hospital and Queensland Children's Hospital. Mr Walsh has a strong background in public sector governance and leadership. He also has strong experience in portfolio, program and project management, business case development and implementation of major government initiatives.

Organisational structure

The organisation is structured into five divisions:

- **Innovation and Development Division** – coordinates strategic, innovation and technical aspects of the digital health program. It focuses on the strategic leadership coordination and management of the digital health strategy and associated work program, open innovation, design authority and design integration, specifications and standards, product development, benefits evaluation programs of work and provision of Program Management Office services.
- **Core Services Systems Operations Division** – operates and ensures that all of the national digital health operational systems meet the agreed performance standards; and provides leadership for cyber security, privacy, fraud, compliance and risk management, eHealth reference platform, clinical informatics, terminology and tooling.
- **Clinical and Consumer Engagement and Clinical Governance Division** – leads the active and consistent engagement of the health care provider community, health care provision researchers and members of the public. It also manages the clinical and clinical informatics input to the design of the digital health system as well as the development, implementation, operation and monitoring of a clinical governance framework, clinical functional assurance, clinical incident management and safety review programs.
- **Government and Industry Collaboration and Adoption Division** – is responsible for leading and driving, collaboration and education, and the non-clinical input to the strategy, design, implementation of the national digital health systems and non-clinical adoption approaches. The division takes a key role in the management of strategic relationships with consumers, State and Territory, Federal Government, Health Sector Business Non-Government Organisations (NGO), software vendors and professional association stakeholders. Additionally, it oversees the development and provision of public information strategies and campaigns and closely links communication strategies and priorities with the Minister's, the Department of Health's and the Agency's objectives.
- **Organisational Capability and Change Management Division** – is responsible for the provision of quality strategic and operational delivery of a significant program of organisational capability and change management, and communications and media, as well as financial services, people and capability management, knowledge management and information and communications technology support, Agency performance reporting (including reporting to COAG) and Board and Committee Secretariat and Legal Services. It also leads and collaborates with internal and external stakeholders to manage the day-to-day operations of the Agency.

Performance

While the Agency was established as a Corporate Commonwealth entity on 30 January 2016 (following registration of the *PGPA (Establishing the Australian Digital Health Agency) Rule 2016 on* 29 January 2016), it was not due to commence operations until 1 July 2016.

The only significant activity by the Agency between 30 January and 1 July 2016 was to establish the Board of the Agency in April 2016. All Board members are non-executive members.

The Board convened on four occasions during this period to position the Agency to become operational on 1 July 2016.

All members of the board attended those four meetings, with the exception of Michael Walsh (who attended one of the meetings), Stephen Moo and Stephanie Newell (who attended two meetings), and Lyn McGrath (who attended three meetings).

Board members and the CEO are paid in accordance with Remuneration Tribunal determinations as provided by the PGPA Act 2013.

No Board member or CEO has received or become entitled to receive a benefit by reason of a contract made by the Agency with the Board member or CEO or with a related entity of the Board member or CEO.

Financial management

Overview

During 2015-16, Agency activity was delivered by the Department of Health. These services included the financial management of the Agency.

The Agency did not have a budget for 2015-16. All expenditure relating to the Agency for this period was met by the Department of Health. The charges have been included in the financial statements as resources free of charge.

The Agency's financial statements reflect the six months from January 2016 to June 2016.

In November 2013, the Australian Government commissioned a review of the Personally Controlled eHealth Record (PCEHR) to assess the status of the PCEHR implementation and to work with health professionals and industry to prioritise further implementation. The Review was released on 19 May 2014.

The 2015-16 Federal Budget announcement *My Health Record – A New Direction for Electronic Health Records in Australia* provided funding to strengthen eHealth governance arrangements consistent with the Review recommendations.

This included the transition of relevant activities and resources from NEHTA, and also from the national My Health Record system operation activities managed by the Department of Health to the new Agency.

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Aged Care

I have audited the accompanying annual financial statements of the Australian Digital Health Agency for the period ended 30 June 2016, which comprise:

- Statement by the Chair of the Board, Chief Executive Officer and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position; and
- Notes to and forming part of the financial statements comprising a summary of significant accounting policies and other explanatory information.

Opinion

In my opinion, the financial statements of the Australian Digital Health Agency:

(a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian Digital Health Agency as at 30 June 2016 and its financial performance and cash flows for the period then ended.

Board Members' Responsibility for the Financial Statements

The Members of the Australian Digital Health Agency's Board are responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards and the rules made under that Act and are also responsible for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the

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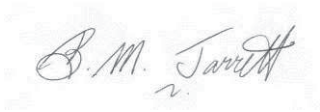
entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Australian National Audit Office



Brandon Jarrett

Executive Director

Delegate of the Auditor-General

Canberra

13 September 2016

Australian Government
Australian Digital Health Agency

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Sydney NSW 2000
Telephone: (02) 8298 2600
Facsimile: (02) 8298 2666
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STATEMENT BY THE CHAIR, CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2016 comply with subsection 42(2) of the *PGPA Act 2013*, and are based on properly maintained financial records as per subsection 41(2) of the that Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the corporate Commonwealth entity will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the directors.

Signed.....	Signed.....	Signed.....
Jim Birch AM Chair	Tim Kelsey Chief Executive Officer	Frances Wade Chief Financial Officer
13 September 2016	13 September 2016	13 September 2016

Financial Statement

Statement of Comprehensive Income
for the period ended 30 June 2016

	Notes	2016 $'000
NET COST OF SERVICES		
Expenses		
Employee Benefits	4, 5	**198,741**
Suppliers		**22,698**
Total expenses		**221,439**
Gains		
Resources Free of Charge		**203,471**
Total gains		**203,471**
Surplus/(Deficit)		**(17,968)**

Statement of Financial Position
as at 30 June 2016

	Notes	2016 $'000
Liabilities		**7,968**
Employee Benefits Payable	4	**10,000**
Suppliers		**17,968**
Total Liabilities		
Equity		
Accumulated Results		**(17,968)**
Total Equity		**(17,968)**

Australian Digital Health Agency

Notes to and forming part of the financial statements

Note 1
Objective of the Agency

In November 2013, the Australian Government commissioned a review of the PCEHR to assess the status of the PCEHR implementation and to work with health professionals and industry to prioritise further implementation. The Review was released on 19 May 2014.

The 2015-16 Federal Budget announcement *My Health Record - A New Direction for Electronic Health Records* in Australia provided funding to strengthen eHealth governance arrangements consistent with the Review recommendations.

This included the transition of relevant activities and resources to the Agency from NEHTA, and the national My Health Record system operation activities managed by the Department of Health to the Agency.

The Agency was established as a Corporate Commonwealth entity on 30 January 2016 following registration of the *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* on 29 January 2016, and commenced operations on 1 July 2016.

All assets and liabilities of NEHTA and My Health Record system operation activities managed by the Department of Health transferred to the Agency on that date. Prior to 1 July 2016, the Department of Health was primarily responsible for the establishment of the Agency, and as a result there was no funding allocated to, or expenditure by, the Agency for 2015-16.

The Agency had no cash flows during 2015-16 and the Agency held no assets during 2015-16.

The Basis of Preparation

The financial statements are general purpose financial statements and are required by Section 42 of the PGPA Act 2013, and have been prepared in accordance with the:

- *PGPA (Financial Reporting) Rule 2015* (FRR) for reporting periods ending on or after 1 July 2015; and
- Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian Dollars.

New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

The Agency adopted all new, revised and amending standards and interpretations that were issued by the AASB prior to the sign-off date and are applicable to the current reporting period. The adoption of these standards and interpretations did not have a material effect, and are not expected to have a future material effect on the Agency's financial statements.

During the period, the Agency adopted early AASB 2015-7 *Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-for-Profit Public Sector Entities.* The result of this early adoption of the standard has had an immaterial effect on the fair value disclosures included in the financial statements.

Future accounting standard requirements

The following new, revised and amending standards and interpretations were issued by the AASB prior to the signing of the statement by the Agency Chair, Chief Executive Officer and Chief Financial Officer, and the Agency is still assessing the potential impact on the financial statements:

- AASB 15 *Revenue from Contracts with Customers*
- AASB 16 *Leases*
- AASB 124 *Related Party Disclosures*

All other new, revised, and amending standards or interpretations that have been issued by the AASB prior to sign off date that are applicable to the future reporting period(s) are not expected to have a future material financial impact on the Agency's financial statements.

Taxation

The entity is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Resources Free of Charge

All resources received have been at no loss or gain to the Agency. The Department of Health has been funded in 2015-16 to establish the Agency. Resources received free of charge relate to the remuneration and travel costs paid by the Department of Health for the Chief Executive Officer and Board members of the Agency. These are disclosed in Notes 4 and 5.

Leave

The liability for employee benefits includes provisions for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the Agency is estimated to be less than the annual entitlement for sick leave.

Events after the Reporting Period

The *Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016* transferred all of NEHTA's functions, resources, assets and liabilities to the new Agency on 1 July 2016. As a new Commonwealth entity, the Agency will be undertaking compliance activities to establish a market value for those assets and liabilities for taxation and financial reporting purposes. That valuation process will be conducted during 2016-17, and any determinations reported in the annual financial statement of the Agency in its Annual Report for 2016-17. In addition, the Agency is awaiting advice from the Australian Taxation Office (ATO) with regard to the progress of the application of a Private Ruling in respect of whether a Capital Gains Tax event occurred on the transfer date of 1 July 2016.

A reliable estimate will be made on the financial effect of the transfer of capitalised assets from NEHTA to the Agency after receipt of the ATO determination on the private ruling. Other assets and liabilities which transferred include: cash and equivalents of $55.3 million, trade and other receivables and other current assets of $2.3 million and liabilities of $5.3 million.

For 2016-17, the Agency has access to a total of $207.3 m in funding. This is comprised of $110.3 million Commonwealth funding, $32.3 million from State and Territory Governments under the Intergovernmental Agreement approved by the Australian Health Ministers' Advisory Council (AHMAC), and $52.4 million of cash reserves transferred from NEHTA. For 2017-18, there is an approved allocation of $82 million for the continued operation and improvement of the My Health Record system.

Leasing Commitments

Operating Lease Commitments

On 1 July 2016, commercial property leases were transferred from NEHTA to the Agency, to provide offices for its activities in various cities.

These property leases are non-cancellable. There are three leases that extend beyond 30 June and two of the leases allow for sub leasing. Rent is payable monthly in advance for all leases and agreements. Contingent rental provisions within the leases require lease payments to be increased by 3.5% to 4.00% per annum, depending on the lease. Lease with expiry dates greater than 30 June 2016 were transferred to the Agency.

Future minimum rentals payable under non-cancellable operating leases contracted for but not capitalised in the financial statements as at 30 June 2016 are as follows:

	$
Not later than twelve months	1,787,301
Between one and five years	1,330,052
	3,117,353

Key Management Personnel

The key management personnel of the Agency is the Chief Executive Officer.

	$
Key Management Personnel Salaries	79,055
Key Management Personnel Superannuation	3,034
Key Management Personnel Accrued Leave	7,968
Total Key Management Personnel Remuneration	**90,057**

Remuneration of Board Members

The Board members of the Agency comprise the Chair and seven Board members.

	$
Salary	99,254
Superannuation	9,334
Total Remuneration	**108,684**

Audit of the Financial Statements

Amounts received or due for audit of the financial statements is $10,000.

Navigation Aids

List of Requirements

The list below outlines compliance with key annual performance reporting information, as required in section 17AJ(d) of the *Public Governance, Performance and Accountability Rule 2014.*

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AD(g)	**Letter of Transmittal**			
17AI		A copy of the letter of transmittal signed and dated by the accountable authority on date final text approved, with statement that the report has been prepared in accordance with section 46 of the PGAA Act and any enabling legislation that specifies additional requirements in relation to the annual report.	Mandatory	Page 1
17AD(h)	**Aids to Access**			
17AJ(a)		Table of contents.	Mandatory	Page 2-3
17AJ(b)		Alphabetical index.	Mandatory	Page 458
17AJ(c)		Glossary of abbreviations and acronyms.	Mandatory	Page 448
17AJ(d)		List of requirements.	Mandatory	Page 440
17AJ(e)		Details of contact officer.	Mandatory	Page ii
17AJ(f)		Entity's website address.	Mandatory	Page ii
17AJ(g)		Electronic address of report.	Mandatory	Page ii
17AD(a)	**Review by Accountable Authority**			
17AD(a)		A review by the accountable authority of the entity.	Mandatory	Page 4
17AD(b)	**Overview of the Entity**			
17AE(1)(a)(i)		A description of the role and functions of the entity.	Mandatory	Part 1
17AE(1)(a)(ii)		A description of the organisational structure of the entity.	Mandatory	Page 29

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AE(1)(a)(iii)		A description of the outcomes and programs administered by the entity.	Mandatory	Page 34
17AE(1)(a)(iv)		A description of the purposes of the entity as included in corporate plan.	Mandatory	Page 26
17AE(1)(b)		An outline of the structure of the portfolio of the entity.	Portfolio departments - mandatory	Page 28
17AE(2)		Where the outcomes and programs administered by the entity differ from any Portfolio Budget Statements, Portfolio Additional Estimates Statements or other portfolio estimates statements that was prepared for the entity for the period, include details of variation and reasons for change.	If applicable, Mandatory	Page 28
17AD(c)	**Report on the Performance of the Entity**			
	Annual Performance Statements			**Part 2**
17AD(c)(i); 16F		Annual Performance Statement in accordance with paragraph 39(1)(b) of the Act and section 16F of the Rule.	Mandatory	Part 2
17AD(c)(ii)	***Report on Financial Performance***			**Part 1**
17AF(1)(a)		A discussion and analysis of the entity's financial performance.	Mandatory	Pages 16-17 & Part 4
17AF(1)(b)		A table summarising the total resources and total payments of the entity.	Mandatory	Page 222
17AF(2)		If there may be significant changes in the financial results during or after the previous or current reporting period, information on those changes, including: the cause of any operating loss of the entity; how the entity has responded to the loss and the actions that have been taken in relation to the loss; and any matter or circumstances that it can reasonably be anticipated will have a significant impact on the entity's future operation or financial results.	If applicable, Mandatory.	Page 17 & Part 4

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AD(d)	**Management and Accountability**			
	Corporate Governance			**Part 3.1**
17AG(2)(a)		Information on compliance with section 10 (fraud systems).	Mandatory	Part 3.1
17AG(2)(b)(i)		A certification by accountable authority that fraud risk assessments and fraud control plans have been prepared.	Mandatory	Page 233
17AG(2)(b)(ii)		A certification by accountable authority that appropriate mechanisms for preventing, detecting incidents of, investigating or otherwise dealing with, and recording or reporting fraud that meet the specific needs of the entity are in place.	Mandatory	Page 233
17AG(2)(b)(iii)		A certification by accountable authority that all reasonable measures have been taken to deal appropriately with fraud relating to the entity.	Mandatory	Page 233
17AG(2)(c)		An outline of structures and processes in place for the entity to implement principles and objectives of corporate governance.	Mandatory	Part 3.1
17AG(2)(d) – (e)		A statement of significant issues reported to Minister under paragraph 19(1)(e) of the Act that relates to non-compliance with Finance law and action taken to remedy non-compliance.	If applicable, Mandatory	Not applicable
	External Scrutiny			**Part 3.2**
17AG(3)		Information on the most significant developments in external scrutiny and the entity's response to the scrutiny.	Mandatory	Part 3.2
17AG(3)(a)		Information on judicial decisions and decisions of administrative tribunals and by the Australian Information Commissioner that may have a significant effect on the operations of the entity.	If applicable, Mandatory	Part 3.2
17AG(3)(b)		Information on any reports on operations of the entity by the Auditor-General (other than report under section 43 of the Act), a Parliamentary Committee, or the Commonwealth Ombudsman.	If applicable, Mandatory	Part 3.2
17AG(3)(c)		Information on any capability reviews on the entity that were released during the period.	If applicable, Mandatory	Not applicable

PGPA Rule Reference	Part of Report	Description	Requirement	Location
	Management of Human Resources			**Part 3.4 & Part 3.5**
17AG(4)(a)		An assessment of the entity's effectiveness in managing and developing employees to achieve entity objectives.	Mandatory	Part 3.4
17AG(4)(b)		Statistics on the entity's APS employees on an ongoing and non-ongoing basis; including the following: • Statistics on staffing classification level; • Statistics on full-time employees; • Statistics on part-time employees; • Statistics on gender; • Statistics on staff location; • Statistics on employees who identify as Indigenous.	Mandatory	Part 3.5
17AG(4)(c)		Information on any enterprise agreements, individual flexibility arrangements, Australian workplace agreements, common law contracts and determinations under subsection 24(1) of the *Public Service Act 1999*.	Mandatory	Part 3.4
17AG(4)(c)(i)		Information on the number of SES and non-SES employees covered by agreements etc. identified in paragraph 17AG(4)(c).	Mandatory	Part 3.4 & Part 3.5
17AG(4)(c)(ii)		The salary ranges available for APS employees by classification level.	Mandatory	Part 3.5
17AG(4)(c)(iii)		A description of non-salary benefits provided to employees.	Mandatory	Part 3.5
17AG(4)(d)(i)		Information on the number of employees at each classification level who received performance pay.	If applicable, Mandatory	Part 3.5
17AG(4)(d)(ii)		Information on aggregate amounts of performance pay at each classification level.	If applicable, Mandatory	Part 3.5
17AG(4)(d)(iii)		Information on the average amount of performance payment, and range of such payments, at each classification level.	If applicable, Mandatory	Part 3.5

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(4)(d)(iv)		Information on aggregate amount of performance payments.	If applicable, Mandatory	Part 3.5
	Assets Management			**Part 3.3**
17AG(5)		An assessment of effectiveness of assets management where asset management is a significant part of the entity's activities.	If applicable, mandatory	Part 3.3
	Purchasing			**Part 3.3**
17AG(6)		An assessment of entity performance against the *Commonwealth Procurement Rules*.	Mandatory	Part 3.3
	Consultants			**Part 3.3**
17AG(7)(a)		A summary statement detailing the number of new contracts engaging consultants entered into during the period; the total actual expenditure on all new consultancy contracts entered into during the period (inclusive of GST); the number of ongoing consultancy contracts that were entered into during a previous reporting period; and the total actual expenditure in the reporting year on the ongoing consultancy contracts (inclusive of GST).	Mandatory	Part 3.3
17AG(7)(b)		A statement that *"During 2015-16, 421 new consultancy contracts were entered into involving total actual expenditure of $22.6 million. In addition, 327 ongoing consultancy contracts were active during 2015-16 involving total actual expenditure of $23.8 million."*	Mandatory	Part 3.3
17AG(7)(c)		A summary of the policies and procedures for selecting and engaging consultants and the main categories of purposes for which consultants were selected and engaged.	Mandatory	Part 3.3
17AG(7)(d)		A statement that *"Annual reports contain information about actual expenditure on contracts for consultancies. Information on the value of contracts and consultancies is available on the AusTender website."*	Mandatory	Part 3.3

PGPA Rule Reference	Part of Report	Description	Requirement	Location
	Australian National Audit Office Access Clauses			**Part 3.3**
17AG(8)		If an entity entered into a contract with a value of more than $100,000 (inclusive of GST) and the contract did not provide the Auditor-General with access to the contractor's premises, the report must include the name of the contractor, purpose and value of the contract, and the reason why a clause allowing access was not included in the contract.	If applicable, Mandatory	Not applicable
	Exempt Contracts			**Part 3.3**
17AG(9)		If an entity entered into a contract or there is a standing offer with a value greater than $10 000 (inclusive of GST) which has been exempted from being published in AusTender because it would disclose exempt matters under the FOI Act, the annual report must include a statement that the contract or standing offer has been exempted, and the value of the contract or standing offer, to the extent that doing so does not disclose the exempt matters.	If applicable, Mandatory	Part 3.3
	Small Business			**Part 3.3**
17AG(10)(a)		A statement that *"the Department of Health supports small business participation in the Commonwealth Government procurement market. Small and Medium Enterprises (SME) and Small Enterprise participation statistics are available on the Department of Finance's website."*	Mandatory	Part 3.3
17AG(10)(b)		An outline of the ways in which the procurement practices of the entity support small and medium enterprises.	Mandatory	Part 3.3
17AG(10)(c)		If the entity is considered by the Department administered by the Finance Minister as material in nature — *a statement that "the Department recognises the importance of ensuring that small businesses are paid on time. The results of the Survey of Australian Government Payments to Small Business are available on the Treasury's website: www.treasury.gov.au"*	If applicable, Mandatory	Part 3.3

PGPA Rule Reference	Part of Report	Description	Requirement	Location
	Financial Statements			**Part 4**
17AD(e)		Inclusion of the annual financial statements in accordance with subsection 43(4) of the Act.	Mandatory	Part 4
17AD(f)	**Other Mandatory Information**			
17AH(1)(a)(i)		If the entity conducted advertising campaigns, a statement that "*During 2015-16, the Department conducted the following advertising campaigns:* • *BreastScreen Australia system campaign* • *Girls Make Your Move campaign* • *Health Star Rating system campaign* • *National Bowel Cancer Screening Program campaign* • *National Drugs campaign* • *National Tobacco campaign* *Further information on those advertising campaigns is available at www.health.gov.au, and in the reports on Australian Government advertising prepared by the Department of Finance and published at www.finance.gov.au/advertising/*"	If applicable, Mandatory	Part 3.9
17AH(1)(a)(ii)		If the entity did not conduct advertising campaigns, a statement to that effect.	If applicable, Mandatory	Not applicable
17AH(1)(b)		A statement that "*Information on grants awarded by the Department during the period 1 July 2015 to 30 June 2016 is available at: www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting*"	If applicable, Mandatory	Part 3.3
17AH(1)(c)		Outline of mechanisms of disability reporting, including reference to website for further information.	Mandatory	Part 3.7

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AH(1)(d)		Website reference to where the entity's Information Publication Scheme statement pursuant to Part II of FOI Act can be found.	Mandatory	Page 240
17AH(1)(e)		Correction of material errors in previous annual report.	If applicable, Mandatory	Not applicable
17AH(2)		Information required by other legislation.	Mandatory	Part 3.2 & Appendices

Acronyms and **Abbreviations**

A

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
AGPT	Australian General Practice Training Ltd.
AHMAC	Australian Health Ministers' Advisory Council
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
AMR	Antimicrobial Resistance
ANAO	Australian National Audit Office
ANFPP	Australian Nurse Family Partnership Program
ANPHA	Australian National Preventive Health Agency
APEC	Asia-Pacific Economic Cooperation
APRA	Australian Prudential Regulation Authority
APS	Australian Public Service
APSC	Australian Public Service Commission
APVMA	Australian Pesticides and Veterinary Medicines Authority
ASADA	Australian Sports Anti-Doping Authority
AURA	Antimicrobial Use and Resistance in Australia

B

BBV	Blood Borne Virus(es)
BTF	Biomedical Translation Fund

C

CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CTF	Clinical Training Funding
CSO	Community Services Obligations

D

DBMAS	Dementia Behaviour Management Advisory Service
DHS	Department of Human Services
DIAS	Diagnostic Imaging Accreditation Scheme
DSS	Department of Social Services

E

EL	Executive Level
ESD	Ecologically Sustainable Development

F

FOI	Freedom of Information
FTE	Full-time Equivalent

G

GM	Genetically Modified
GMO(s)	Genetically Modified Organism(s)
GP(s)	General Practitioner(s)
GPRIP	General Practice Rural Incentives Program

H

HIV	Human Immunodeficiency Virus
HPC	Haemopoietic Progenitor Cell
HPV	Human Papillomavirus

I

IAHP	Indigenous Australians Health Programme
IMAP	Inventory Multi-tiered Assessment and Prioritisation
INF	International Netball Federation
IPP	Indigenous Procurement Policy
ICT	Information and Communication Technology
IT	Information Technology

L

LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LSDP	Life Saving Drugs Program

M

MBS	Medicare Benefits Schedule
MHDAPC	Mental Health Drug and Alcohol Principle Committee
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MIGA	Medical Insurance Group Australia
MMR	Measles, Mumps, Rubella Vaccine
MRFF	Medical Research Future Fund
MSAC	Medical Services Advisory Committee

N

NABERS	National Australian Built Environment Rating Scheme
NAIDOC	National Aborigines and Islanders Day Observance Committee
NCERG	National Cancer Expert Reference Group
NCSP	National Cervical Screening Program
NDSHS	National Drug Strategy Household Survey
NDSS	National Diabetes Services Scheme
NHMRC	National Health and Medical Research Council
NICNAS	National Industrial Chemicals Notification and Assessment Scheme
NIP	National Immunisation Program
NIS	National Immunisation Strategy
NPAAC	National Pathology Accreditation Advisory Council
NPEV	National Partnership Agreement on Essential Vaccines
NPS	National Prescribing Service

O

OCP(s)	Optimal Care Pathway(s)
OECD	Organisation for Economic Co-operation and Development
OGTR	Office of the Gene Technology Regulator

P

PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PCC	Pathology Clinical Committee
PGPA	Public Governance, Performance and Accountability
PHN(s)	Primary Health Network(s)

PIP	Practice Incentives Program
PSAC	Pathology Services Advisory Committee

R

RCTS	Rural Clinical Training and Support
RFDS	Royal Flying Doctor Service
RLIF	Rugby League International Federation
RRTIG	Rural and Regional Teaching Infrastructure Grants

S

SBRT	Severe Behaviour Response Team
SES	Senior Executive Service
SME	Small and Medium Enterprises
STI	Sexually Transmissible Infection(s)
SUSMP	Standard for the Uniform Scheduling of Medicines and Poisons

T

TGA	Therapeutic Goods Administration

U

UNESCO	United Nations Educational, Scientific and Cultural Organization

W

WHO	World Health Organization
WHS	Work Health and Safety

Glossary

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.
Aedes aegypti* and *Aedes albopictus	Mosquito species that may be carriers (vectors) of dengue, yellow fever, Zika and chikungunya. In Australia, *Aedes aegypti* is only found in parts of northern, central and southwest Queensland and *Aedes albopictus* is only found in the Torres Strait.
Allied health practitioners/ providers	For the purpose of this report, allied health practitioners/providers are those registered under the National Registration Accreditation Scheme. These professions include: Psychologists, Pharmacists, Physiotherapists, Optometrists, Chiropractors, Podiatrists, Osteopaths, Medical radiation practitioners, Dental professionals, Occupational therapists, Chinese medicine practitioners, and Aboriginal and Torres Strait Islander health practitioners.
Antimicrobial resistance (AMR)	The ability of a microorganism (like bacteria, viruses and parasites) to stop an antimicrobial (such as antibiotics, antivirals and antimalarials) from working against it.
Blood Borne Viruses (BBV)	Viruses that are transmitted through contact between infected blood and uninfected blood (e.g. hepatitis B, hepatitis C and HIV).
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.
Chikungunya virus	An alphavirus which is transmitted between people through the bite of an infected *Aedes albopictus* or *Aedes aegypti* mosquito.
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.
Communicable disease	An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means. Communicable (infectious) diseases include sexually transmitted diseases; vector-borne diseases; vaccine preventable diseases and antimicrobial resistant bacteria.
Dengue virus	A flavivirus, which is transmitted between people through the bite of an infected *Aedes aegypti* or *Aedes albopictus* mosquito.

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 over the age of 45 years, but increasingly occurring in younger age groups, and is usually able to be regulated through dietary control.
Ebola Virus Disease	Ebola virus disease, formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. The average Ebola case fatality rate is around 50 per cent.
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.
Elective surgery	Elective care in which the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.
Epidemic	An outbreak of a disease or its occurrence at a level that is clearly higher than usual, especially if it affects a large proportion of the population.
Epidermolysis Bullosa	A rare inherited skin disorder which causes blistering.
Financial year	The 12 month period from 1 July to 30 June.
Front-of-pack labelling	Single, interpretive five star rating front-of-pack labelling system for use on packaged foods sold in Australia indicating nutritional content and kilojoules.
General Practitioner (GP)	A medical practitioner who provides primary care to patients within the community.
Gene technology	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.
Haemopoietic progenitor cell (HPC)	Blood cells found in bone marrow, peripheral blood and umbilical cord blood that are capable of self-renewal into all blood cell types.
Health care	Services provided to individuals or communities to promote, maintain, monitor or restore health. Health care is not limited to medical care and includes self-care.
Health outcome	A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention. See **Outcomes**.
Hepatitis A (infectious hepatitis)	An acute but benign form of viral hepatitis transmitted by ingesting food or drink that is contaminated with faecal matter.
Hepatitis B (serum hepatitis)	An acute (sometimes fatal) form of viral hepatitis transmitted by sexual contact, by transfusion or by ingestion of contaminated blood or other bodily fluids.

Hepatitis C	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).
Human papillomavirus (HPV)	The virus that causes genital warts and which is linked in some cases to the development of more serious cervical cell abnormalities.
Illicit drugs	The term 'illicit drug' can encompass a number of broad concepts including: • illegal drugs – a drug that is prohibited from manufacture, sale or possession in Australia – for example, cannabis, cocaine, heroin and ecstasy; • misuse or extra-medical use of pharmaceuticals – drugs that are available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse – for example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids; and • other psychoactive substances – legal or illegal, potentially used in a harmful way – for example, kava, or inhalants such as petrol, paint or glue.
Immunisation	Inducing immunity against infection by the use of an antigen to stimulate the body to produce its own antibodies. See **vaccination**.
Incidence	The number of new cases (of an illness or event, and so on) occurring during a given period. Compare with **prevalence**.
Influenza (flu)	An acute contagious viral respiratory infection marked by fevers, muscle aches, headache, cough and sore throat.
Intern	A doctor in their first postgraduate year and who holds provisional registration with the Medical Board of Australia.
Jurisdictions	In the Commonwealth of Australia, these include the Commonwealth Government, the six States, and the two Territories.
Measles	A highly contagious infection, usually of children, that causes flu-like symptoms, fever, a typical rash and sometimes serious secondary problems such as brain damage. Preventable by vaccine.
Medical indemnity insurance	A 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.
Medicare	A national, Government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme (Medicare).
Memorandum of Understanding	A written but non-contractual agreement between two or more entities or other parties to take a certain course of action.
Meningococcal disease	The inflammation of meninges of the brain and the spinal cord caused by *meningococcal bacteria* which invade the body through the 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).

Middle East Respiratory Syndrome Coronavirus (MERS-CoV)	MERS coronavirus is a disease caused by a new virus that can cause a rapid onset of severe respiratory disease in people. Most severe cases have occurred in people with underlying conditions that may make them more likely to get respiratory infections. All cases have lived in or travelled to the Middle East, or have had close contact with people who acquired the infection in the Middle East. There have been no cases in Australia.
Morbidity	Refers to ill health in an individual and to levels of ill health in a population or group.
Mortality	Death.
Mumps	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.
Non-communicable diseases	Non-communicable diseases, also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. The 4 main types of non-communicable diseases are cardiovascular diseases (for example heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.
Oncology	The study, knowledge and treatment of cancer and tumours.
Organisation for Economic Co-operation and Development (OECD)	An organisation of 34 countries including Australia, mostly developed and some emerging (such as Mexico, Chile and Turkey). The organisation's aim is to promote policies that will improve the economic and social wellbeing of people around the world.
Outcomes	Outcomes are the Government's intended results, benefits or consequences for the Australian community. The Government requires entities, 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. The Department's current Outcomes are listed on pages 34-35.
Out-of-pocket expenses	The total costs incurred by individuals for health care services over and above any refunds from Medicare and private health insurance funds.
Palliative care	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.
Pathology	The study and diagnosis of disease through the examination of organs, tissues, cells and bodily fluids.
Pertussis (whooping cough)	An extremely contagious respiratory infection caused by the bacterium *Bordatella pertussis*. The disease causes uncontrolled coughing and vomiting, which can last for several months and can be particularly dangerous for babies under the age of 12 months.
Pharmaceutical Benefits Scheme (PBS)	A national, Government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs for all Australians to help them afford standard medications. The Pharmaceutical Benefits Schedule lists all the medicinal products available under the PBS and explains the uses for which they can be subsidised.

Plain packaging	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.
Population health	Typically described as the organised response by society to protect and promote health, and to prevent illness, injury and disability. Population health activities generally focus on: prevention, promotion and protection rather than on treatment; populations rather than on individuals; and the factors and behaviours that cause illness. In this sense, often used synonymously with **public health**. Can also refer to the health of particular subpopulations, and comparisons of the health of different populations.
Portfolio Additional Estimates Statements	Statements prepared by portfolios to explain the Additional Estimates Budget appropriations in terms of outcomes and programs.
Portfolio Budget Statements	Statements prepared by portfolios to explain the Budget appropriations in terms of outcomes and programs.
Prevalence	The number or proportion (of cases, instances, and so forth) in a population at a given time. In relation to cancer, this refers to the number of people alive who had been diagnosed with cancer in a prescribed period (usually 1-, 5-, 10- or 26-years). Compare with **incidence**.
Primary care	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.
Program/Programme	A specific strategy, initiative or grouping of activities directed toward the achievement of Government policy or a common strategic objective. In 2015-16, the Department had 31 specific programs (see pages 34-35).
Prostheses List	Under the *Private Health Insurance Act 2007*, private health insurers are required to pay benefits for a range of prostheses that are provided as part of an episode of hospital treatment or hospital substitute treatment for which a patient has cover and for which a Medicare benefit is payable for the associated professional service. The types of products on the Prostheses List include cardiac pacemakers and defibrillators, cardiac stents, joint replacements and intraocular lenses, as well as human tissues such as human heart valves. The list does not include external limbs, external breast prostheses, wigs and other such devices. The Prostheses List contains prostheses and human tissue prostheses and the benefit to be paid by the private health insurers. The Prostheses List is published bi-annually.
Prosthesis	An artificial device that replaces a missing body part lost through trauma, disease, or congenital conditions.
Public health	Activities aimed at benefiting a population, with an emphasis on prevention, protection and health promotion as distinct from treatment tailored to individuals with symptoms. Examples include conduct of anti-smoking education campaigns, and screening for diseases such as cancer of the breast or cervix. See also **Population health**.

Quality use of medicines	Quality use of medicines means: • selecting management options wisely; • choosing suitable medicines if a medicine is considered necessary; and • using medicines safely and effectively. This definition applies equally to decisions about medicine use by individuals and decisions that affect the health of the population.
Radiation oncology (radiotherapy)	The study and discipline of treating malignant disease with radiation. The treatment is referred to as radiotherapy or radiation therapy.
Registrar	Any person undertaking medical vocational training in a recognised medical specialty training program accredited by the Australian Medical Council.
Sexually transmissible infection (STI)	An infectious disease that can be passed to another person by sexual contact. Notable examples include chlamydia and gonorrhoea.
Stoma	Artificial body opening in the abdominal region, for the purpose of waste removal.
Tuberculosis	Tuberculosis is an infectious disease that damages people's lungs or other parts of the body and can cause serious illness and death. It is caused by the bacterium *Mycobacterium tuberculosis.* Tuberculosis is spread through the air when a person with the active disease coughs, sneezes or speaks, and other people nearby breathe in the bacteria.
Vaccination	The process of administering a vaccine to a person to produce immunity against infection. See **immunisation**.
Varicella (Chicken pox)	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.
World Health Organization (WHO)	The World Health Organization is a specialised agency of the United Nations. Its primary role is to direct and coordinate international health within the United Nations' system. The WHO has 194 member states including Australia.
Zika virus	A flavivirus, closely related to dengue. It is transmitted to humans primarily through the bite of certain infected *Aedes* species mosquitoes.

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Better health and wellbeing for all Australians, now and for future generations