Australian Government
Department of Health

Annual Report 2016-17

Welcome to the Department of Health 2016-17 Annual Report

Australia's health system is world-class, supported by universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.

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 the first head of the Department, Dr J H L Cumpston.

We have continued to evolve over the past 96 years, and have undergone a number of changes in name, function and structure, while retaining the continued commitment of improving health and wellbeing for all Australians.

The health system touches every individual from cradle to grave. It is a complex landscape with many interdependencies, and many stakeholders. As stewards of the health system, the Department continues to work with stakeholders as essential partners in driving health reform.

Our Purpose is to assist the Government to lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs, and best practice regulation.

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Department of Health Annual Report 2016-17

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Letter of Transmittal

Australian Government
Department of Health

Secretary

The Hon Greg Hunt MP
Minister for Health
Minister for Sport
Parliament House
CANBERRA ACT 2600

Dear Minister

I present you with the Department of Health Annual Report for the period 1 July 2016 to 30 June 2017.

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.

The report contains information specific to the Department required under other legislation, including the:

- *National Health Act 1953* (Appendix 1 - Processes Leading to Pharmaceutical Benefits Advisory Committee Consideration Annual Report for 2016-17);
- *Industrial Chemicals (Notification and Assessment) Act 1989* (Appendix 2 - Report from the Director of the National Industrial Chemicals Notification and Assessment Scheme);
- *Public Governance, Performance and Accountability Rule 2014* (Appendix 3 - Australian National Preventive Health Agency Financial Statements); and
- *Human Services (Medicare) Act 1973* and *Tobacco Plain Packaging Act 2011* (Part 3.4 – External Scrutiny and Compliance).

Yours sincerely

Glenys Beauchamp

13 October 2017

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Secretary's Review

We are increasingly embracing change as a means of continuous improvement – offering new models of care, structures, approaches and level of engagement with stakeholders, including consumers, to build much-needed sustainability into the health system. Over time, the result of our efforts will be a system that works better for consumers and health professionals alike, and fundamentally delivers better health outcomes for the nation.

Driving innovation in the health system

During the year, we continued to apply new thinking, research, evaluation, and different sources of data to better equip the health system to meet current and future health needs.

The first disbursements from the Medical Research Future Fund of $65.9 million were earmarked for programs to improve health system efficiency, patient care and access, health outcomes, and new technology in health. As well, the Biomedical Translation Fund was established to support commercialisation of health and medical research. The first investment of $10 million announced during the year will focus on researching new ways to treat peanut allergies in children.

The national My Health Record system moved closer to full implementation. Successful trials have demonstrated that opt-out participation is the fastest way to realise the significant health and economic benefits of this system, including through avoided hospital admissions, fewer adverse drug events, reduced duplication of tests, better coordination of care for people seeing multiple health care providers, and better informed treatment decisions. Working with the Australian Digital Health Agency, we have begun national opt-out arrangements which will give every Australian a My Health Record by December 2018, unless they choose not to have one.

Improving models of primary health care

The Department continued a large body of work reshaping the primary health care system. This work provides all Australians with access to preventive, primary and mental health care, with a particular focus on people with chronic and complex conditions, and those living in rural, regional and remote communities.

Primary Health Networks are at the forefront of primary health care in Australia, tailoring health services to local community needs, including an expanded role in mental health and suicide prevention, along with digital health, immunisation and cancer screening.

The Department developed implementation arrangements for the commencement of services under the Health Care Homes model from 1 October 2017 for up to 20 Health Care Homes; with the remaining practices to begin on 1 December 2017. Health Care Homes introduce a new way to fund and deliver health care for the increasing number of Australians with chronic and complex conditions. This gives them a home base for their conditions to be managed through a tailored care plan implemented by a team of health care providers. Phasing the rollout of services will ensure best practice implementation.

We are playing a critical role in shaping a new era of mental health care. Significant work was undertaken to implement the Government's mental health reform agenda within a stepped care model, and develop the Fifth National Mental Health and Suicide Prevention Plan through extensive consultation with States and Territories, the sector, consumers and carers.

It is imperative that Australia's health workforce is appropriately skilled and located in the right places. During the year, the Department coordinated work to improve the capacity and quality of the health workforce. This includes training more medical students in regional and rural areas through establishing 26 regional training hubs, and expanding specialist training.

Improving the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS)

Work continued to improve the sustainability of the MBS and the PBS. The Department continued to support the clinician-led review of the 5,700-odd items on the MBS. More than 2,850 MBS items are currently under active review by the independent MBS Taskforce. Aligning rebated services with contemporary, evidence-based medical practices improves patient outcomes and helps future proof the MBS. Alongside the MBS Taskforce Review, the Medical Services Advisory Committee continued to provide independent expert advice on the safety, effectiveness and cost-efficiency of new medical procedures and technologies.

The Department worked with the pharmaceutical industry to strengthen the PBS and provide certainty to the industry through a stable PBS pricing environment. This included supporting the use of generic and biosimilar medicines to give patients access to more, and cheaper medicines. In addition, the Sixth Community Pharmacy Agreement was varied to recognise and strengthen the important role of pharmacists in providing medicine, services and advice to patients. The agreement focuses on supporting the viability of community pharmacies, and the supply of medications and new services, to help patients manage their medications.

Supporting public hospitals

We are developing a long-term plan to place public hospital funding on a fiscally sustainable footing. The Council of Australian Governments approved a Heads of Agreement for public hospital funding from 1 July 2017 to 30 June 2020 ahead of consideration for the longer term. The relationships with States and Territories has been enhanced through a process of close and effective collaboration. Work will continue to support the efficient pricing, funding, delivery, performance, and reform of public hospitals services.

As of 1 July 2017, the Tasmanian Government resumed ownership of the Mersey Community Hospital, ending ownership by the Commonwealth and providing planning and certainty for consumers and providers of hospital services in north-west Tasmania.

Supporting aged care

We continue to work closely with stakeholders in reforming aged care for Australians, with the aim of giving people more choice and access to services. The successfully implemented Increasing Choice in Home Care initiative provides older people with consumer-driven, high quality and innovative aged care services required to meet individual needs and circumstances. In particular, it expands options for people to stay in their own homes for as long as possible, ensuring they receive the care they need, when and where they need it.

In addition, we engaged closely with the sector to improve the My Aged Care website and contact centre, the starting point for people looking for aged care services and easy to understand information about their options.

Promoting and learning from international best practice

Australia is well regarded in international health fora and the Department's contribution is a major factor. In 2016-17, the Department continued to participate in international engagements, such as the first ever G20 Health Ministers' Meeting in Berlin in May, maintaining partnerships and harnessing information on international best practice in health. Australia is considered to be a leader on a range of health issues including health emergency preparedness and response, antimicrobial resistance, universal health coverage, health technology assessments, and effective tobacco control.

The Department led Australia's delegations to World Health Organization (WHO) governing body meetings, the World Health Assembly, meetings of the WHO Executive Boards and the Western Pacific Regional Committee Meeting.

Streamlining regulation

The Department, through the Therapeutic Goods Administration, began implementing the response to the Review of Medicines and Medical Devices Regulation. This will enable lifesaving medicines and medical devices to come onto the Australian market faster, in some cases two years faster, through removing or streamlining unnecessary or inefficient processes.

Medicinal cannabis cultivation received the green light from Parliament. Updated laws allowed the Department to grant 15 licenses to cultivate, produce and manufacture cannabis for medicinal purposes in Australia.

Promoting sport and sport integrity

The Department continued to work closely with States and Territories, the Australian Sports Commission and the Australian Sports Anti-Doping Authority to ensure a coordinated and consistent approach to sports policy in Australia. We supported a range of initiatives to connect more Australians to local sport, to promote clean sport, and to prepare for major sporting events including the 2017 men's and women's Rugby League World Cups, and the Gold Coast 2018 Commonwealth Games.

Improving Indigenous health care

The Department has made progress in our ongoing commitment to closing the gap in health outcomes and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. This was detailed in the *Aboriginal and Torres Strait Islander Health Performance Framework* released in May 2017. Targeted activities have delivered genuine reductions in the burden of disease in Aboriginal and Torres Strait Islander peoples over the past couple of decades. These include smoking rates – down 9.7 per cent, child mortality – down 33 per cent, and blindness and vision impairment – down from six times to three times that of non-Indigenous Australians.

The new funding agreement with the National Aboriginal Community Controlled Health Organisation will assist in continuing improvements. We have also been working hard on the next iteration of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, which will address the social and cultural determinants of Indigenous health.

Farewell

This is my last Secretary's Review. After almost three years as Secretary at Health and nearly 40 years as a public servant, I have resigned to explore new opportunities. I believe I leave the Department in good shape, with a strong organisational culture and much improved capability to advance the health agenda. I thank staff and stakeholders for their rich and varied contributions and wish you all the best for the future.

Martin Bowles PSM

Secretary
2014–2017

Chief Medical Officer's Report

In my first nine months as Chief Medical Officer (CMO), I have been greatly impressed by the strong collaboration seen across the complex, federated Australian Health system, in delivering health outcomes for the community.

The partnership between the States and Territories and the Commonwealth is exemplified in the collaborative approach to public health issues that are coordinated through the Australian Health Protection Principal Committee. My predecessor, Professor Chris Baggoley AO, worked tirelessly on optimising this partnership and deserves great recognition for this and for many other outstanding achievements during his time as CMO.

Partnerships, generally, are crucial to the success of the CMO role. I have enjoyed working closely with many other bodies (such as the Learned Colleges, the Australian Medical Association (AMA), professional associations, disease specific organisations, industry, community organisations and many others). Each brings a unique perspective to the common goal of better health and wellbeing for our community. Strong and open communication is essential to progress the many system reforms and refinements that will always be required.

Building our medical workforce

On 1 January 2017, I became the Chair of the National Medical Training Advisory Network (NMTAN). The role of NMTAN is to advise governments on how to improve the coordination of medical training nationally and assist in medical workforce reform.

Medical workforce modelling indicates an oversupply of doctors nationally, but getting doctors with the right skills to the right places, particularly in regional and rural Australia, remains an issue that still needs addressing. We also must ensure that our specialist training programs are less influenced by the service needs of the health system and more focussed on producing the right numbers of specialists to meet our future workforce requirements.

The number of medical graduates has doubled over the last 15 years and the Assistant Minister for Health, the Hon Dr David Gillespie MP, asked NMTAN to consider the number and distribution of medical school places at Australian universities. NMTAN's advice will inform a review currently being undertaken by the Department of Health and the Department of Education and Training.

NMTAN is also responsible for guiding the development of the *Australia's Future Health Workforce* series of reports, which make national workforce projections by medical specialty. The Dermatology report was released in 2017, and NMTAN made significant progress on the Emergency Medicine and Ophthalmology reports.

In the year ahead, I look forward to continuing to work with NMTAN members, health departments, the Learned Colleges, and the AMA to develop a range of reform proposals for consideration.

Improving immunisation rates

Australia's high childhood immunisation rates continue to get even better, with over 93 per cent of Australian five year olds now fully vaccinated. Aboriginal and Torres Strait Islander five year olds are the first cohort to achieve the 95 per cent target set for the World Health Organization's Western Pacific Region. This was also an aspirational target set by the Department and State and Territory Chief Health Officers. To further improve childhood immunisation rates, particularly in areas of lower coverage, the Government this year announced a $5.5 million communications strategy over three years to reinforce to parents the value and safety of childhood vaccines.

In 2016-17, there was also a significant focus on adult vaccinations with the introduction of the National Shingles Vaccination Program and concerted communications efforts to improve seasonal influenza vaccine uptake amongst pregnant women.

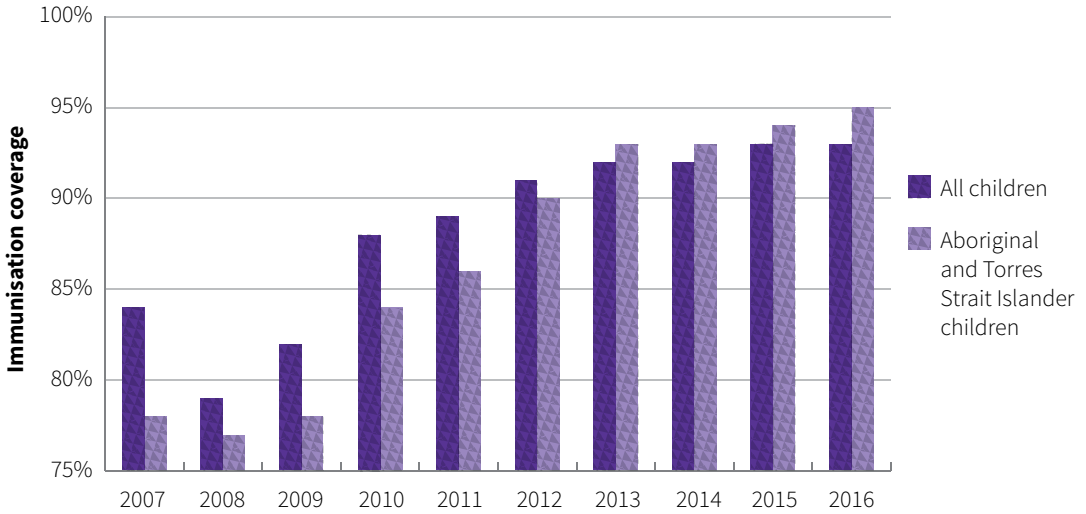
The Government has further invested in the infrastructure required to support effective policy and program design and implementation. On 30 September 2016, the Australian Childhood Immunisation Register became the whole-of-life Australian Immunisation Register. As a result, the Register is now able to record vaccination information on over 25 million individuals and has improved functionality to better support providers and parents.

In November 2016, Australia's world leading AusVaxSafety National Surveillance System was launched. AusVaxSafety is an active, enhanced surveillance system capable of monitoring, detecting and providing real-time feedback on any potential safety signals due to serious or significant adverse effects following immunisation with vaccines on the National Immunisation Program.

The Government also finalised the transition of vaccine purchasing from States to the Commonwealth, with National Immunisation Program vaccines now subject to national coordination and procurement, to drive significant efficiencies and achieve overall value for money.

In March 2017, the Council of Australian Governments Health Council requested that the Australian Health Ministers' Advisory Council (AHMAC) consider options for responding to circumstances where an accelerated response to rising cases of a vaccine preventable disease might be required. The Department undertook this work as a key priority, in consultation with States and Territories, and a proposed National Priority Response Pathway for the National Immunisation Program was approved by AHMAC.

Figure 1: Fully immunised children at five years of age in Australia



Measles outbreak in western Sydney

On 20 March 2014, the World Health Organization announced that measles elimination had been achieved in Australia. Although Australia has interrupted measles transmission locally, it is still an important issue in our region.

In March 2017, an outbreak of measles was reported in western Sydney, as a result of a traveller entering the country, following infection overseas. This incident demonstrates the importance of ensuring the Australian population is receiving the necessary vaccinations to minimise the transmission of illness and to safeguard the health of vulnerable Australians who are unable to receive vaccinations.

Invasive meningococcal disease

Australia has been fortunate that the overall incidence of invasive meningococcal disease (IMD) remains low and has decreased since the introduction in 2003 of the meningococcal C vaccine on the National Immunisation Program.

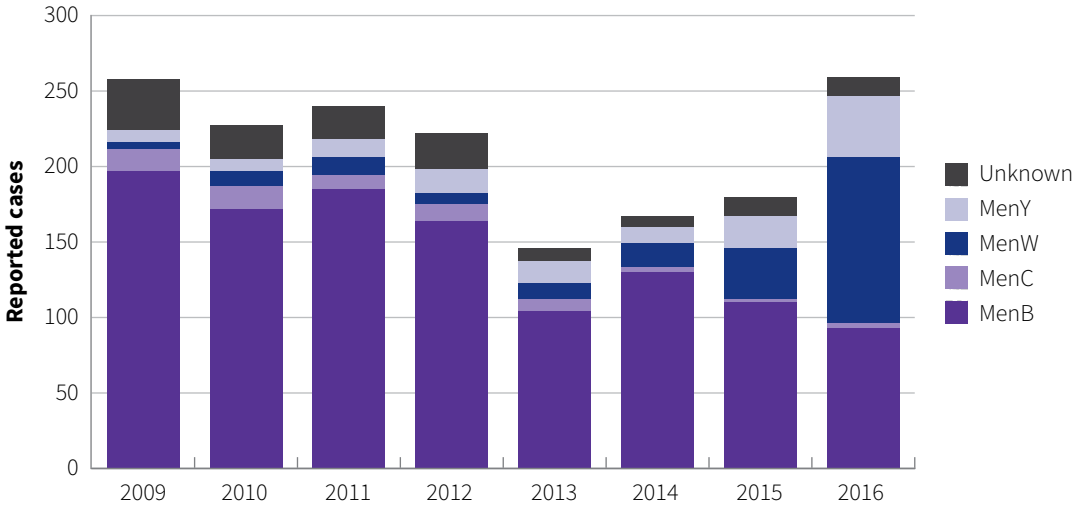
Meningococcal disease is a rare but very serious illness that usually appears as meningitis or septicaemia. This infection can develop very quickly and can be fatal in 5–10 per cent of cases. The bacteria are common and around 5–20 per cent of people carry them at the back of the nose and throat, without showing any illness or symptoms.

The four most common types of IMD in Australia are MenB, MenC, MenW, and MenY. Over the last 20 years, MenB has been the most common cause of IMD in Australia. However, IMD has recently become a national issue, as we have experienced a significant rise in MenW IMD cases between 2014 (10 per cent of all IMD or 17 cases) and 2016 (43 per cent of all IMD or 108 cases).

There is no clear reason for the rise in IMD due to MenW in Australia, but we do know that other countries in Europe, the United Kingdom and South America have experienced similar increases in the prevalence of MenW.

I have established a dedicated MenW Incident Management Team within the Department. This team is working closely with the States and Territories through the Communicable Disease Network Australia to coordinate national monitoring and assessment of the epidemiology of IMD due to MenW in Australia. This national monitoring will help to inform additional national response options and the implementation of nationally consistent messaging.

Figure 2: Reported cases of invasive meningococcal disease in Australia



Eradicating polio

Australia stands committed to the global polio eradication effort and encourages continued focus on polio elimination. In 2017, we are closer than ever to achieving this goal, with only six cases of wild type polio reported in only two countries by the end of June. The Government, through the Department of Foreign Affairs and Trade, recently announced a further $18 million to the Global Polio Eradication Initiative to help finally bring the fight against this terrible disease to an end. This will bring our total contribution to the Initiative to $104 million since 2011.

Harnessing new technologies for foodborne disease surveillance

2016 marked the first time whole genome sequencing (WGS) of microorganisms was used in Australia to investigate multi-state outbreaks of foodborne disease.

OzFoodNet, Australia's enhanced foodborne disease surveillance network, commenced a multi-jurisdictional epidemiological outbreak investigation for *Salmonella* Hvittingfoss, which was associated with the consumption of rockmelons.

Over 150 cases of salmonella were associated with the outbreak and WGS was used to definitively link 110 human cases of *Salmonella* Hvittingfoss infection to each other and to the affected rockmelons. WGS can be used to replace other costly and time-consuming typing methods, enabling accurate, timely and more cost-effective ways of identifying associations and links between cases, food and the environment. WGS also provides reassurance to consumers that outbreak cases are identified quickly and accurately.

The Department works closely with the Bi-National Food Safety Network, which includes Food Standards Australia New Zealand, the Department of Agriculture and Water Resources and the food enforcement agencies of all Australian states and territories and New Zealand, to quickly and effectively manage foodborne diseases.

Hepatitis A and frozen berries an ongoing concern

Since the 2015 outbreak of hepatitis A associated with imported frozen mixed berries, there have been several international outbreaks of hepatitis A associated with frozen berries, including in New Zealand and Canada.

In May 2017, Australia experienced a further four cases of hepatitis A, in three states, likely to be linked to frozen mixed berries. OzFoodNet commenced an investigation and testing confirmed that the hepatitis A virus detected in each of these cases had an identical genotype and genetic sequence to the 2015 outbreak. The frozen berries linked to these new cases were imported in early 2015 and had remained in the country. There is no evidence of cases of hepatitis A associated with newly imported berries, since border controls were put in place in February 2015.

As of 30 June 2017, the investigations into this outbreak were ongoing but no further cases have been identified.

Clinical guidance for medicinal cannabis

Medicinal cannabis has been a very topical issue this year. There is much passion and enthusiasm for its use in a variety of clinical conditions and governments have made significant progress in improving access for patients. It is important, however, not to let the passion and enthusiasm get ahead of the science. Like any therapeutic substance, medicinal cannabis and the derived products of cannabis need to be subjected to proper scientific evaluation of therapeutic efficacy.

A recent trial showing some benefit of cannabidiol in the rare Dravet's form of epilepsy is one of the few rigorous scientific evaluations in epilepsy, despite claims of widespread benefit in this disease. Similarly, there seems to be a role for cannabis products in chemotherapy-associated nausea and in pain management, but to what extent and in what circumstances it has superiority over existing medications remains to be determined. As Australians gain increased access to cannabis and its derivatives, it remains crucial that appropriate trials are conducted in all of the indications where benefits are claimed.

The Government has appointed an Australian Advisory Council on the Medicinal Use of Cannabis chaired by Professor Jim Angus. In conjunction with the work of the Advisory Committee, and to assist clinicians, the National Drug and Alcohol Research Centre is reviewing what evidence exists for the use of medicinal cannabis and developing clinical guidance documents.

Debilitating symptom complexes attributed to ticks

There is debate within the community about the existence of an Australian form of classical Lyme disease. Some Australians, who have not travelled overseas to endemic areas, have developed symptoms which they believe are consistent with a form of chronic Lyme disease. While classical Lyme disease exists overseas, chronic Lyme disease is a disputed diagnosis and is not generally recognised by the medical profession, even in Lyme endemic countries.

The Department remains aware of the distressing nature of this issue and acknowledges that many Australians are experiencing chronic debilitating symptoms that are causing them significant hardship and interfering substantially with their lives. Their needs have not been met, so far.

In 2015, the Department contracted the National Serology Reference Laboratory to evaluate the different tests used in Australia and overseas to diagnose Lyme disease. The final report of this evaluation and the results of the evaluation are expected to be published later in 2017.

Further, the Government is currently considering twelve recommendations from a Senate Inquiry, tabled on 30 November 2016, into the growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients.

The situation will continue to be monitored closely, with further research encouraged by the Department to identify the cause of these symptoms and also to examine whether a tick-borne aetiology can be identified.

Antimicrobial Resistance (AMR)

The challenge of this global threat continues to rise, with increased incidence, in many countries, of infections with highly resistant bacteria, sometimes untreatable. The Government is pursuing several strategies, including campaigns to reduce community prescribing of antibiotics, proposed restriction of the use of some valuable antibiotics in animals and improving antimicrobial stewardship and infection control in all health care settings. A key challenge is to get broad community awareness of the serious threat posed by the reduction in the number of available antibiotics to treat infections. Consumers as well as health and veterinary practitioners must accept the imperative to only use antibiotics in those circumstances, where the evidence clearly indicates that they are of benefit.

The Department has recently undertaken a review of our national surveillance of antimicrobial use and resistance and is looking to significantly enhance the surveillance function, by linking it to a future public health response and developing surveillance in animal health.

Professor Brendan Murphy

Chief Medical Officer
September 2017

Chief Operating Officer's Report

Continuing to mature organisational capability

At the beginning of the year we received the report of an independent Health Check to look at the extent to which the Department has improved its organisational capability since the Capability Review in 2014. Key capability areas identified for improvement included: leadership and culture; governance and delivery; and risk.

The Health Check found that the Department had made significant progress against all areas. It also emphasised that maturing capability required a sustained focus over several years.

Accordingly, building capability continued to be at the core of much of our corporate effort in 2016-17.

Leadership and culture

Survey results have demonstrated that the Department's leadership and culture have improved. The APS State of the Service Employee Census (Staff Survey) results showed our staff are more highly engaged than the APS average and their perception of senior leadership is significantly higher than the APS average.

We developed a new Leadership and Management Framework. It outlines the leadership expectations required at each level and provides an overview of options available for staff to improve their leadership performance.

Options include the Department's leadership development programs, which were revised during the year to support continued building of leadership at all levels. A particular focus was support and development for Executive Level staff, including by incorporating 360 degree feedback into relevant development programs. Feedback from staff, colleagues and supervisors is used as the basis for participants to identify professional strengths and developmental opportunities.

Governance and delivery

The Data Governance and Analytics Committee was established as an additional senior governance committee. It leads the oversight and direction for the strategic management and sharing of the Department's data holdings, analytics and compliance activities.

Additional arrangements were put in place to monitor the delivery of major initiatives. They have provided the Executive with visibility of implementation planning and progress, facilitating the identification of skill gaps and other risks and the taking of action to mitigate them. We now have a solid foundation for maturing project management and related capabilities within the Department.

Risk

A new Risk Management Framework was established to assist departmental leaders and staff to make well-informed risk-based decisions. It includes the identification of 12 Enterprise Level Risks, an Enterprise Risk Appetite Statement and an updated Risk Management Policy.

Fraud and corruption

The Department is committed to building a fraud and corruption awareness culture, which helps to protect the integrity of its information and resources. In 2016-17 our long-term strategic educational approach included:

- information sessions and other communications targeted at leadership and management groups; and
- training via various learning options, with 84 per cent of staff having completed the training.

A significant shift was reflected in the Staff Survey results, with staff reporting levels of knowledge and confidence consistent with a strong culture of fraud and corruption awareness.

Records management

The Records Management Capability Program continued throughout 2016-17 to improve the management of documents and records. It addresses compliance with legislated records management obligations and addresses audit recommendations. Benefits of the program include increased efficiency, improved accountability and reduced organisational risk.

Harnessing diversity

To build on our progress in recognising Aboriginal and Torres Strait Islander cultures, and developing a culturally capable workplace, we have launched our new *Innovate Reconciliation Action Plan* (RAP). Our RAP will help us to deepen our awareness, understanding and appreciation of Aboriginal and Torres Strait Islander cultural issues, and making a further contribution towards a reconciled Australia. A greater cultural understanding within the Department will also ensure we are delivering appropriate and effective health policies and programs for Aboriginal and Torres Strait Islander peoples.

In addition, the Department has developed the first *Accessibility Action Plan*, including establishing a working group to develop a Lesbian, Gay, Bisexual, Transgender and Intersex Action Plan.

These plans challenge us to think about how all employees are responsible for embracing equity within the workforce.

Health State Network

Since its creation on 1 July 2016, the Health State Network (HSN) Division has been implementing an operating model to: engage with the Department's stakeholders; manage aged care provider compliance and regulation; and administer grant funding.

Key features of the operating model include:

- progressing the streamlining of grants administration and moving to adopt whole-of-government grant processes where possible;
- a functional realignment that changes the way the HSN works towards greater consistency, efficiency and quality;
- revising and redesigning the end-to-end grant process that takes a risk proportioned approach to grants administration;
- implementing the Domain Management model, which enables a consistent approach to the HSN's engagement with policy areas to deliver on the policy objectives of their respective domains; and
- leading the local rollout of significant policy reforms such as Commonwealth Home Support Programme, mental health and Primary Health Networks.

Through the HSN, we have used our local presence to work with stakeholders across the health system. We have developed strong relationships with Primary Health Networks, and worked with providers of health and aged care services to support services across the community.

Overall the HSN has administered more than $5.3 billion in grant payments, with 10,000 grant activities delivered by 4,200 organisations across the country.

Efficient and effective delivery of corporate services

A corporate front door on the Health intranet was introduced in July 2016, making it faster and easier to find information and contacts for hundreds of corporate services. Using an interactive carousel display to guide, staff can identify the service they need, when they need it. User testing demonstrates the increased efficiency from this self-service tool, with employees across the Department able to successfully find information up to 55 per cent quicker.

The corporate front door spearheaded the development of other self-service systems and tools across the Department to better enable employees to do their jobs, manage their business and meet their compliance obligations.

Financial results

In 2016-17, the Department administered 28 programs on behalf of Government. Administered expenses totalled $63.4 billion and comprised primarily payments for personal benefits of $42.6 billion (67 per cent of the total), including those for medical services, pharmaceutical services and private health insurance rebates. Subsidies, predominantly for Aged Care, amounted to $12.1 billion (19 per cent of the total). Grants expenditure was $7.5 billion (12 per cent of the total), the majority ($6.8 billion) of which was paid to non-profit organisations.

At 30 June 2017, the Department's administered assets totalled $2.3 billion, including investments in health related agencies and inventories held under the National Medical Stockpile. Administered liabilities were $2.9 billion which included provisions for personal benefits, grants and subsidies.

Key administered expenditure is illustrated in Figures 3 and 4.

The Department incurred an operating loss of $55.5 million, prior to unfunded depreciation. This loss was largely a result of undertaking important additional activities within existing resources. Included in the operating loss is the Medicine and Medical Devices Review which was agreed by Government through the 2016-17 Budget process and was funded by revenue derived from industry.

Downsizing the workforce to reflect future funding levels has been a key priority for the Department. Measures, including a comprehensive voluntary redundancy program and continued recruitment controls, have been effective in reducing staffing to an affordable level.

The Department is committed to managing within resources provided by Government to deliver key programs and reforms and remains in a positive net asset position as at 30 June 2017.

Financial statements

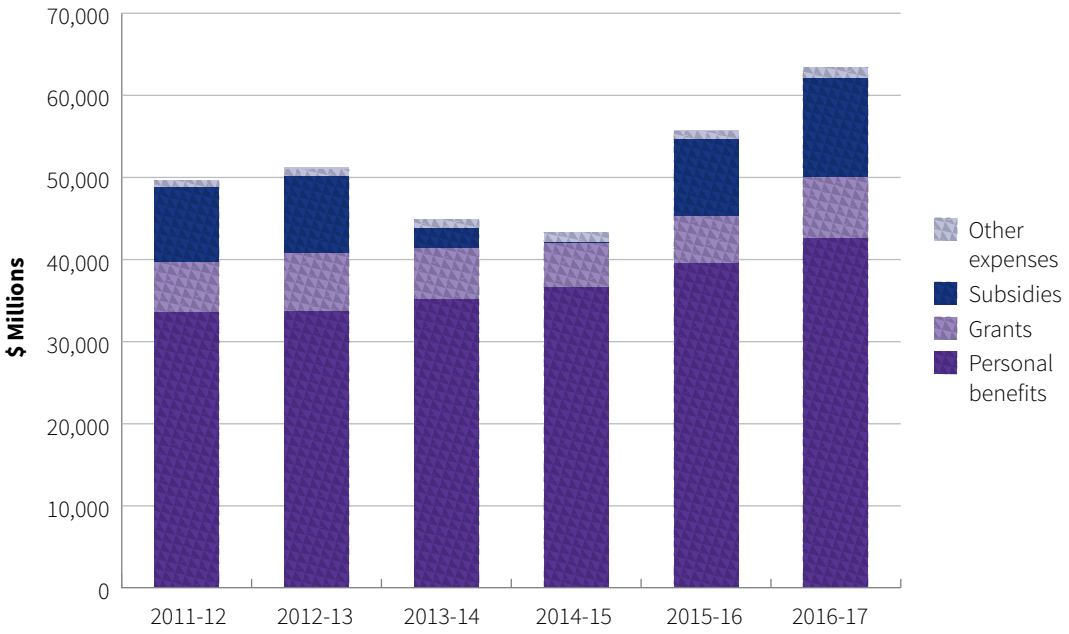
The Auditor-General has provided the Department with an unmodified audit opinion for the 2016-17 financial statements.

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

Alison Larkins

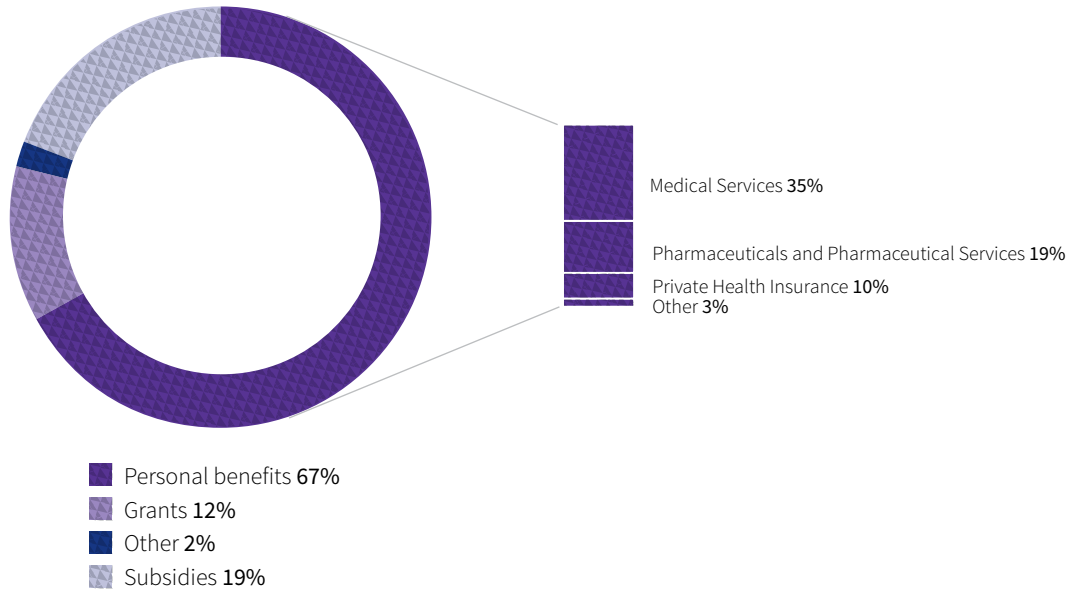
Chief Operating Officer
September 2017

Figure 3: Breakdown of administered expenditure



Note: The movement in subsidies from 2014-15 to 2015-16 relates to aged care programs following the Machinery of Government changes in 2015.

Figure 4: Administered expenditure by category




AUSTRALIA
Australian Government
Department of Health

Part 1: About the Department

Part 1.1: Department Overview

The Department of Health is a Department of State. In 2016-17 we operated under the *Public Service Act 1999* and the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

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.

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 people with cultural and diverse backgrounds 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 research, innovation and technology; and
- regulation that protects the health and safety of the community, while minimising unnecessary compliance burdens.

Better sport outcomes through:

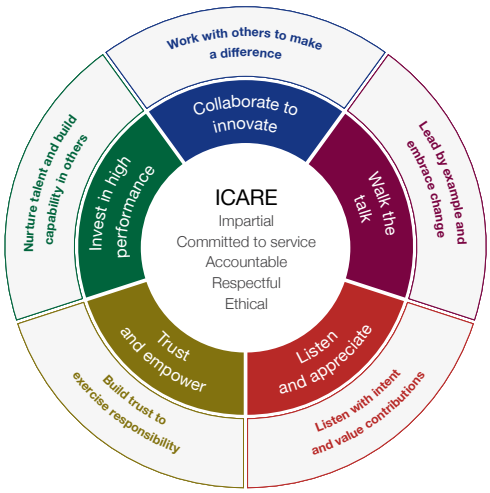
- boosting participation opportunities for all Australians;
- optimising international performance; and
- safeguarding integrity in sport.

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 2016-17, with a particular emphasis on leadership modelling these behaviours.



Portfolio structure

In 2016-17, the Health Portfolio consisted of:

- the Department of Health (refer *Part 1.3: Structure Chart* on p. 26);
- 17 portfolio entities (refer *Part 1.6: Portfolio Entity-Specific Outcomes* on p. 31); and
- 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.

Ministerial changes

On 24 January 2017, the Hon Greg Hunt MP was sworn in as the Minister for Health and Minister for Sport; the Hon Ken Wyatt AM, MP as the Minister for Aged Care and Minister for Indigenous Health; and the Hon Dr David Gillespie MP as Assistant Minister for Health (for further information refer *Part 1.4: Ministerial Responsibilities* on p. 29).

Machinery of Government changes

There were no Machinery of Government changes that impacted the Department of Health during 2016-17.

Part 1.2: Executive

as at 30 June 2017

From left to right:

Dr Lisa Studdert, Alison Larkins, Mark Cormack, Adjunct Professor John Skerritt, Martin Bowles PSM, Dr Margot McCarthy, Andrew Stuart, Professor Brendan Murphy and Paul Madden.

The Department's Executive was current at 30 June 2017. 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 Portfolio.

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.

Professor Brendan Murphy

Chief Medical Officer

Professor Brendan Murphy is the Chief Medical Officer for the Australian Government and is the principal medical adviser to the Minister and the Department of Health. He also holds direct responsibility for the Department of Health's Office of Health Protection. Professor Murphy is the Australian Member on the International Agency for Research on Cancer Governing Committee and represents Australia at the World Health Assembly.

Prior to his appointment, Professor Murphy was the Chief Executive Officer of Austin Health in Victoria.

Professor Murphy is a Professorial Associate at the University of Melbourne and an Adjunct Professor at Monash University, a Fellow of the Australian Academy of Health and Medical Sciences, a Fellow of the Royal Australian College of Physicians and Australian Institute of Company Directors.

He was formerly Chief Medical Officer and director of nephrology at St Vincent's Health, and sat on the Boards of the Florey Institute of Neuroscience and Mental Health, the Olivia Newton-John Cancer Research Institute and the Victorian Comprehensive Cancer Centre. He was also the independent chair of Health Services Innovation Tasmania, a former president of the Australian and New Zealand Society of Nephrology and former deputy chair of Health Workforce Australia.

Mark Cormack

Deputy Secretary, Strategic Policy and Innovation

Mark Cormack is responsible for strategic national health policy, including portfolio engagement and coordination, international strategies and best practice regulation. Mark is also responsible for major national programs including, primary health care, including Health Care Homes and Primary Health Networks, 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.

Alison Larkins

Chief Operating Officer

Alison Larkins joined the Department of Health in July 2016 as Chief Operating Officer. Alison is responsible for the Department's corporate and enabling areas that support the Department in meeting its purpose. Responsibilities include finance, legal, corporate services, the health state network and information technology.

Alison co-chairs the Department's Strategic Policy Committee and is deputy chair of the Finance and Resource Committee and the People, Values and Capability Committee.

Previously Alison was an acting Deputy Secretary at the Department of the Prime Minister and Cabinet with responsibility for social policy. She also led the Department's Reform of the Federation White Paper Taskforce as well as the National Ice Taskforce working across the Commonwealth and with State and Territory Governments.

Prior to this, Alison worked at the Department of Immigration and Border Protection leading their Refugee Humanitarian and International Policy Division. Alison also held the roles of Acting Ombudsman and Deputy Ombudsman at the Commonwealth Ombudsman's Office.

Alison is also a member of the IPAA ACT Council.

Paul Madden

Special Adviser, Strategic Health Systems Information Management

Paul Madden holds the position of Deputy Secretary/Special Adviser, Strategic Health Systems and Information Management. Paul provides advice and leadership on a range of technical and strategic issues in Health, including Digital Health, My Health Record and the National Cancer Screening Register program.

Paul is a member of the Departmental Executive Committee and is chair of the Cervical Screening Renewal and Register Board and also the Chair of the National Cancer Screening Register Program, State and Territory Board.

Dr Margot McCarthy

Deputy Secretary, Ageing and Aged Care

Dr Margot McCarthy joined the Department in November 2015 as Deputy Secretary of the Ageing and Aged Care Group 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.

Adjunct Professor John Skerritt

Deputy Secretary, Health Products Regulation

Adjunct Professor John Skerritt is responsible for Health Products Regulation including medicines regulation, medical devices, blood and tissue products, and quality and regulatory practice relating to Therapeutic Goods. 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 Lisa Studdert

Acting Deputy Secretary, National Program Delivery

Dr Lisa Studdert joined the Department of Health in June 2013 as a First Assistant Secretary in the Therapeutic Goods Administration. Lisa is currently the Acting Deputy Secretary for the National Program Delivery Group which incorporates the areas of health workforce, Indigenous health, population health including drugs and alcohol policy, tobacco, food, cancer, palliative care and preventive health and sport.

In 2011, Lisa worked as a Manager at the Senior Executive Service level at the Australian National Preventive Health Agency and she has a background working in population and preventive health policy and programs in Australia and internationally.

Lisa has recently completed a period working in the office of Minister Greg Hunt and before that with Minister Sussan Ley.

Lisa is a PhD graduate of Cornell University.

Andrew Stuart

Deputy Secretary, Health Benefits

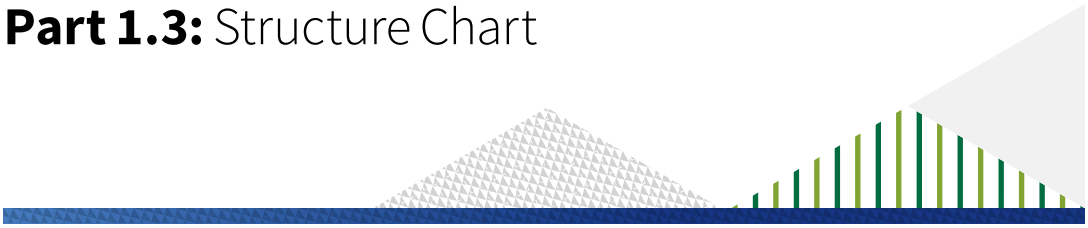
Andrew Stuart has had an extensive career in the Department of Health spanning across Ageing and Aged Care, Population Health, Primary Care, health financing and corporate affairs.

Currently, Andrew leads the Health Benefits Group. He is responsible for medical benefits, pharmaceutical benefits and health benefit compliance, 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.

During 2016-17 Andrew's responsibilities included 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.

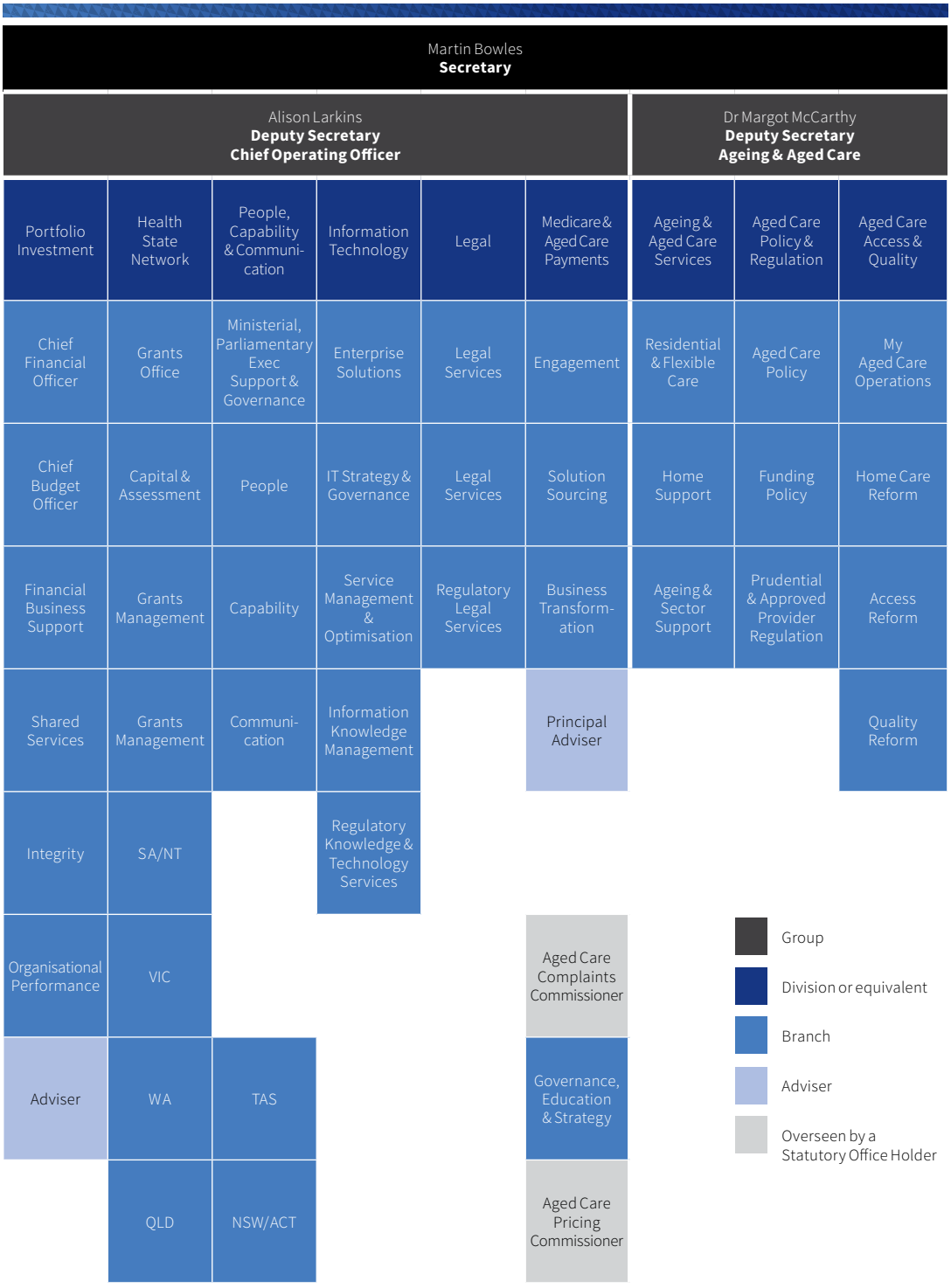
Part 1.3: Structure Chart



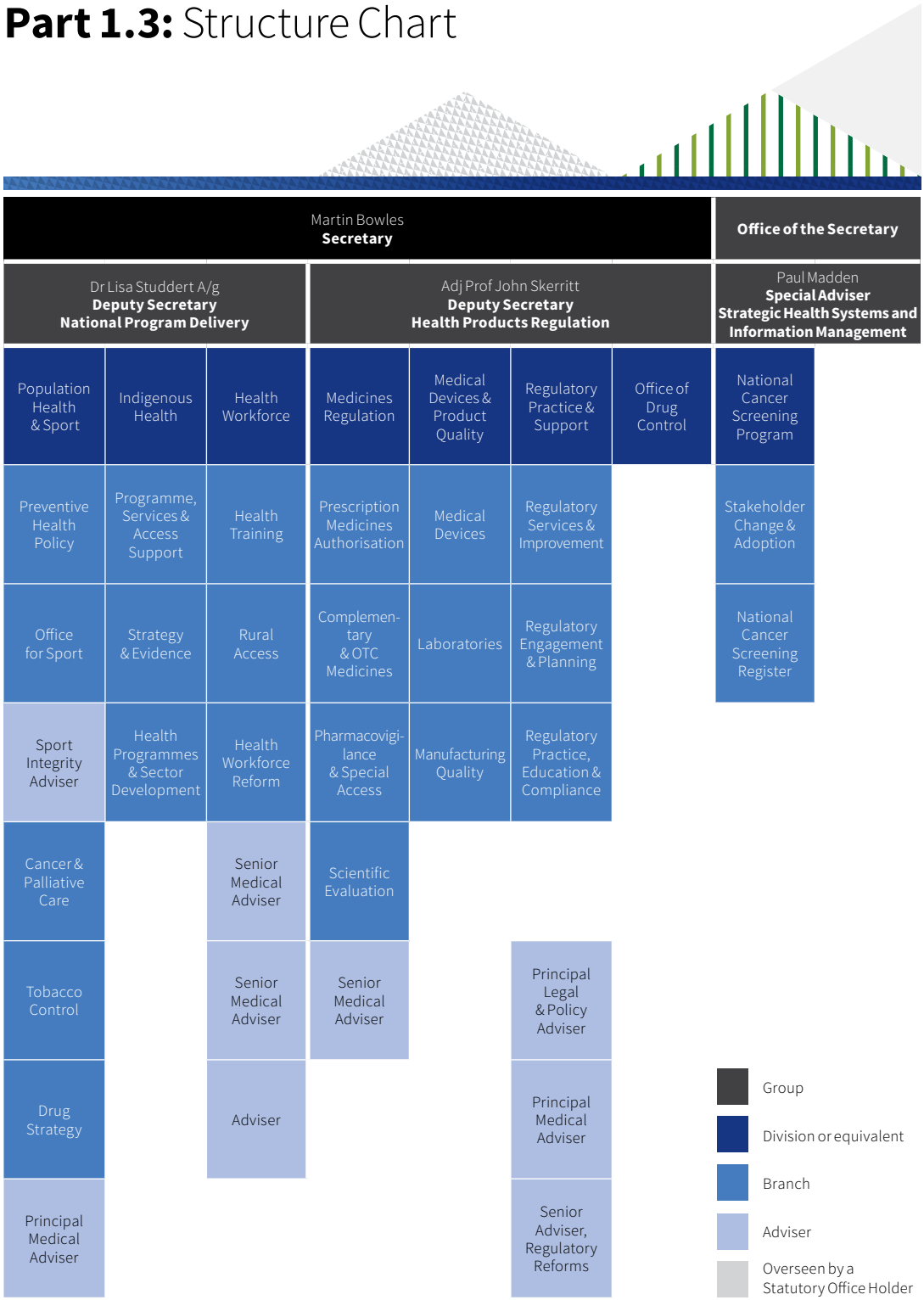
Martin Bowles
Secretary

Prof Brendan Murphy **Chief Medical Officer Health Protection**		Mark Cormack **Deputy Secretary Strategic Policy and Innovation**				Andrew Stuart **Deputy Secretary Health Benefits**		
Office of Health Protection	Deputy Chief Medical Officer	Research, Data & Evaluation	Health Services	Health Systems Policy	Chief Nurse & Midwifery Officer	Provider Benefits Integrity	Medical Benefits	Pharma-ceutical Benefits
Health Protection Policy	Principal Medical Adviser	Health & Medical Research	Primary Healthcare	Portfolio Strategies, Engagement & Coordination	Health Adviser – Geneva	Operations	Medical Specialist Services	Pharma-ceutical Policy
Health Emergency Management	Principal Medical Adviser	Health Analytics	Hospitals & Acute Services	International Strategies		Systems	Office of Hearing Services	Pharma-ceutical Evaluation
Immunisation		Health System Financing	Mental Health Early Intervention	Best Practice Regulation	Office of the Gene Technology Regulator	Analytics	Primary Care & Diagnostics	Pharma-ceutical Access
		Performance, Evaluation & Quality	Mental Health Services	Strategic Policy	Regulatory Practice & Compliance		Medicare Reviews Unit	Private Health Insurance
			Primary Health Networks	Primary Care Reform & Implementation	Evaluation	Office of Chemical Safety (incorporating NICNAS)	Internal Office of Health Technology Assessment	
			Principal Medical Adviser	Digital Health		NICNAS	Principal Medical Adviser	
				Principal Adviser			Principal Medical Adviser	

The above structure chart is as at 30 June 2017. The current structure chart is available at:
www.health.gov.au/internet/main/publishing.nsf/Content/health-struct.htm


Martin Bowles
Secretary
Alison Larkins
Deputy Secretary
Chief Operating Officer
Dr Margot McCarthy
Deputy Secretary
Ageing & Aged Care
Portfolio Investment
Health State Network
People, Capability & Communi-cation
Information Technology
Legal
Medicare & Aged Care Payments
Ageing & Aged Care Services
Aged Care Policy & Regulation
Aged Care Access & Quality
Chief Financial Officer
Grants Office
Ministerial, Parliamentary Exec Support & Governance
Enterprise Solutions
Legal Services
Engagement
Residential & Flexible Care
Aged Care Policy
My Aged Care Operations
Chief Budget Officer
Capital & Assessment
People
IT Strategy & Governance
Legal Services
Solution Sourcing
Home Support
Funding Policy
Home Care Reform
Financial Business Support
Grants Management
Capability
Service Management & Optimisation
Regulatory Legal Services
Business Transform-ation
Ageing & Sector Support
Prudential & Approved Provider Regulation
Access Reform
Shared Services
Grants Management
Communi-cation
Information Knowledge Management
Principal Adviser
Quality Reform
Integrity
SA/NT
Regulatory Knowledge & Technology Services
Organisational Performance
VIC
Aged Care Complaints Commissioner
Adviser
WA
TAS
Governance, Education & Strategy
QLD
NSW/ACT
Aged Care Pricing Commissioner
Group
Division or equivalent
Branch
Adviser
Overseen by a Statutory Office Holder

Part 1.3: Structure Chart



Part 1.4: Ministerial Responsibilities

as at 30 June 2017

The Hon Greg Hunt MP
Minister for Health
Minister for Sport

As senior Minister, Minister Hunt held overall responsibility for the Portfolio, with specific responsibility for:

- Medicare benefits
- Pharmaceutial benefits
- Public hospitals
- Mental health policy
- Primary health care
- Preventive health
- Pathology and diagnostic imaging
- Drug and alcohol policy and programs
- Health workforce
- Health protection
- Private health insurance
- Digital health
- Health and medical research
- Sport

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

Minister Wyatt, had responsibility for:

- Aged care policy and funding
- Aged care service delivery and implementation
- Aged care workforce
- Dementia
- Indigenous health services
- Hearing services
- Oversight of the following Portfolio entities:
  - Australian Aged Care Quality Agency
  - Organ and Tissue Authority (Australian Organ and Tissue Donation and Transplantation Authority)

The Hon Dr David Gillespie MP
Assistant Minister for Health

Assistant Minister Gillespie, had responsibility for:

- Rural, regional and remote health
- Rural health workforce policy and programs
- Food regulation and policy (including Chair the Australia-New Zealand Ministerial Forum on Food Regulation)
- Tobacco
- National Rural Health Commissioner
- Office of Chemical Safety
- Office of the Gene Technology Regulator
- National Industrial Chemicals Notification Scheme
- Oversight of the following Portfolio entities:
  - Australian Radiation Protection and Nuclear Safety Agency
  - Food Standards Australia New Zealand (including Per- and poly-fluoroalkyl substances (PFAS))
  - National Blood Authority

Part 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 2016-17.

Outcome 1: Health System Policy, Design and Innovation

1.1: Health Policy Research and Analysis

1.2: Health Innovation and Technology

1.3: Health Infrastructure

1.4: Health Peak and Advisory Bodies

1.5: International Policy

Outcome 2: Health Access and Support Services

2.1: Mental Health

2.2: Aboriginal and Torres Strait Islander Health

2.3: Health Workforce

2.4: Preventive Health and Chronic Disease Support

2.5: Primary Health Care Quality and Coordination

2.6: Primary Care Practice Incentives

2.7: Hospital Services

Outcome 3: Sport and Recreation

3.1: Sport and Recreation

Outcome 4: Individual Health Benefits

4.1: Medical Benefits

4.2: Hearing Services

4.3: Pharmaceutical Benefits

4.4: Private Health Insurance

4.5: Medical Indemnity

4.6: Dental Services

4.7: Health Benefit Compliance

4.8: Targeted Assistance – Aids and Appliances

Outcome 5: Regulation, Safety and Protection

5.1: Protect the Health and Safety of the Community Through Regulation

5.2: Health Protection and Emergency Response

5.3: Immunisation

Outcome 6: Ageing and Aged Care

6.1: Access and Information

6.2: Home Support and Care

6.3: Residential and Flexible Care

6.4: Aged Care Quality

Part 1.6: Portfolio Entity-Specific Outcomes

In 2016-17 the Health Portfolio consisted of the Department and 17 Portfolio entities. Each entity has its own specific outcome, with performance against their outcome reported in their respective annual report.

Australian Aged Care Quality Agency

Outcome 1: High-quality care for persons receiving Australian Government subsidised aged care through the accreditation of aged care services in residential settings, the quality review of aged care services provided in the community and the provision of quality information to consumers, as well as the provision of information, education and training to aged care providers.

Australian Commission on Safety and Quality in Health Care

Outcome 1: 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 Digital Health Agency

Outcome 1: To deliver national digital healthcare systems to enable and support improvement in health outcomes for Australians.

Australian Institute of Health and Welfare

Outcome 1: A robust evidence-base for the health, housing and community sectors, including through developing and disseminating comparable health and welfare information and statistics.

Australian Radiation Protection and Nuclear Safety Agency

Outcome 1: 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

Outcome 1: Protection of the health of athletes and the integrity of Australian sport including through engagement, deterrence, detection and enforcement to minimise the risk of doping.

Australian Sports Commission

Outcome 1: Increased participation in organised sport and continued international sporting success including through leadership and development of a cohesive and effective sports sector, provision of targeted financial support, and the operation of the Australian Institute of Sport.

Australian Sports Foundation Limited

Outcome 1: Improved Australian sporting infrastructure through assisting eligible organisations to raise funds for registered sporting projects.

Cancer Australia

Outcome 1: 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

Outcome 1: 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

Outcome 1: 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

Outcome 1: 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

Outcome 1: 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

Outcome 1: 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 Mental Health Commission

Outcome 1: Provide expert advice to the Australian Government and cross-sectoral leadership on the policy, programmes, 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.

Organ and Tissue Authority (Australian Organ and Tissue Donation and Transplantation Authority)

Outcome 1: Improved access to organ and tissue transplants, including through a nationally coordinated and consistent approach and system.

Professional Services Review

Outcome 1: 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

Part 2.1: 2016-17 Annual Performance Statements

The 2016-17 Annual Performance Statements are in accordance with s39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) for the 2016-17 financial year. The Annual Performance Statements accurately present the Department of Health's performance in accordance with s39(2) of the PGPA Act.

Glenys Beauchamp PSM

Secretary
October 2017

Introduction

As required under the PGPA Act, this report contains the Department of Health's Annual Performance Statements for 2016-17. The Annual Performance Statements detail results achieved against the planned performance criteria set out in the *2016-17 Health Portfolio Budget Statements, 2016-17 Health Portfolio Additional Estimates Statements*, and the Department's *2016-17 Corporate Plan*.

Structure of the Annual Performance Statements

The Annual Performance Statements demonstrate the direct link between the Department's activities throughout the year, and the contribution to achieving the Department's Purpose. The Annual Performance Statements are divided into chapters, with each chapter focussing on the objectives of an Outcome and addressing the associated performance criteria**.** Each chapter contains:

- an analysis of the Department's performance by Outcome and Program;
- activity highlights that occurred during 2016-17;
- key activities planned for 2017-18; and
- results and discussion against each performance criteria.

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

Results key

Met

100% of the target for 2016-17 has been achieved.

Substantially met

75–99% of the target for 2016-17 has been achieved.

Not met

Less than 75% of the target for 2016-17 has been achieved.

Data not available

Data is not available to report for the 2016-17 reporting year.

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.

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.

Our 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.

Our Outcomes

Outcome 1: Health System Policy, Design and Innovation

1.1: Health Policy Research and Analysis
1.2: Health Innovation and Technology
1.3: Health Infrastructure
1.4: Health Peak and Advisory Bodies
1.5: International Policy

Outcome 2: Health Access and Support Services

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

Outcome 3: Sport and Recreation

3.1: Sport and Recreation

Outcome 4: Individual Health Benefits

4.1: Medical Benefits
4.2: Hearing Services
4.3: Pharmaceutical Benefits
4.4: Private Health Insurance
4.5: Medical Indemnity
4.6: Dental Services
4.7: Health Benefit Compliance
4.8: Targeted Assistance – Aids and Appliances

Outcome 5: Regulation, Safety and Protection

5.1: Protect the Health and Safety of the Community Through Regulation
5.2: Health Protection and Emergency Response
5.3: Immunisation

Outcome 6: Ageing and Aged Care

6.1: Access and Information
6.2: Home Support and Care
6.3: Residential and Flexible Care
6.4: Aged Care Quality

Outcome 1:
Health System Policy, Design and Innovation

Australia's health system is better equipped to meet current and future health needs by applying research, evaluation, innovation, and use of data to develop and implement integrated, evidence-based health policies, and through support for sustainable funding for health infrastructure

Analysis of performance

In 2016-17, the Government continued to increase investment in health and medical research through the Medical Research Future Fund and Biomedical Translation Fund. In addition, the Department completed the My Health Record participation trials which demonstrated that opt-out participation is the fastest way to realise the significant health and economic benefits of My Health Record. The Department also continued to work collaboratively with other Commonwealth entities, health peak and advisory groups, international health bodies, and States and Territories to ensure a nationally consistent approach to achieving better health outcomes for all Australians.

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

Highlights

Driving innovation through the first disbursements of $65.9 million from the Medical Research Future Fund (MRFF)

Disbursements will fund eight investments to improve health system efficiency, patient care and access, health outcomes, and innovation in health.
Refer *Program 1.1*

Harnessing the *Second Australian Atlas of Healthcare Variation* (the Atlas) to improve patient outcomes

The Atlas, developed by the Australian Commission on Safety and Quality in Health Care in consultation with the Department and other relevant stakeholders, is a valuable resource for mapping and identifying variation in health care and understanding how care may be better provided to ensure quality, appropriateness and value of services.
Refer *Program 1.1*

Commencing national opt-out arrangements for My Health Record

Following successful trials, national opt-out arrangements will begin in 2018 in order to bring forward the significant benefits offered by the My Health Record system to consumers and the health care system.
Refer *Program 1.2*

Promoting and learning from international best practice

Actively participating in international engagements, such as the first ever G20 Health Minister's Meeting, ensures that Australia's global health agenda is promoted and information on international best practice is harnessed.
Refer *Program 1.5*

Looking ahead

- Administer $119.1 million of MRFF disbursements in 2017-18 to further support innovative health and medical research that can be translated and commercialised into practice to improve health outcomes for Australians.
- Develop, with States and Territories, a forward looking implementation plan for the Haemopoietic Progenitor Cell sector, to ensure that Australian patients can continue to access matched stem cells for treatment.
- Review and update the current Intergovernmental Agreement on National Digital Health between the Commonwealth, and State and Territory Governments, which outlines the governance, function, performance and accountability of the Australian Digital Health Agency.
- Work with the Australian Digital Health Agency to implement national opt-out arrangements that will provide a My Health Record for every Australian by December 2018, unless they choose not to have one.
- The Government will provide $68 million to establish Australia's first Proton Beam Therapy facility for advanced research and treatment of cancer in South Australia.

Purpose, programs and program objectives contributing to Outcome 1

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.
Program 1.1: Health Policy Research and Analysis
Providing support to Council of Australian Governments' (COAG) Health Council and the Australian Health Ministers' Advisory Council (AHMAC)
Improving research capacity
Improving safety and quality in health care
Improving Australians' access to organ and tissue transplants
Supporting access to blood and blood products
Performance criteria from the 2016-17 Corporate Plan
Program 1.2: Health Innovation and Technology
Providing national digital health leadership
Performance criteria from the 2016-17 Corporate Plan
Program 1.3: Health Infrastructure
Improving primary health care infrastructure
Investing in other major health infrastructure
Program 1.4: Health Peak and Advisory Bodies
Supporting the Australian Government with informed policy advice and facilitating engagement with the health sector
Program 1.5: International Policy
Facilitating international engagement on health issues
Performance criteria from the 2016-17 Corporate Plan

Program 1.1: Health Policy Research and Analysis

The Department met the majority of performance targets related to Program 1.1: Health Policy Research and Analysis.

In May 2017, as part of the 2016-17 Budget, the Government announced the first disbursements of $65.9 million from the Medical Research Future Fund (MRFF). Disbursements will fund eight investments with a balance of long-term research and quick win programs which will improve health system efficiency, patient care and access, health outcomes, and innovation in health.

Complementing the investment through the MRFF, a further $10 million from the Biomedical Translation Fund was committed in May 2017 to develop a promising new treatment for peanut allergies in children.

During 2016-17, the Department continued work to ensure that Australian patients requiring a stem cell transplant for therapeutic treatment were able to be matched with a donor or cord blood unit in Australia, and where a match was not available domestically, the Australian Bone Marrow Donor Registry conducted international searches for a match.

Providing support to Council of Australian Governments' (COAG) Health Council and the Australian Health Ministers' Advisory Council (AHMAC)

Work with States and Territories to facilitate a nationally consistent focus on achieving better health outcomes for all Australians.
Source: 2016-17 Health Portfolio Budget Statements, p. 45

2016-17 Target	2016-17 Result
Australian Government health priorities are progressed through the COAG Health Council.	Priorities were agreed and progressed by AHMAC and endorsed by the COAG Health Council. **Result: Met**

The COAG Health Council, supported by its advisory body AHMAC, focussed on progressing a broad range of issues in 2016-17 including: long-term reform of the health system; Health Care Homes; mental health and suicide prevention; Aboriginal and Torres Strait Islander Health; digital health; health workforce; safety and quality; advancing the clinical trial environment; and health promotion and prevention.

Improving research capacity

Investment in medical research supports sustainability for the health system and drives innovation.
Source: 2016-17 Health Portfolio Budget Statements, p. 45

2016-17 Target	2016-17 Result
Strategic investment of total available funding in 2016-17.	Strategic investment of the first disbursements from the Medical Research Future Fund (MRFF) were announced in the 2017-18 Budget context. The total package includes $60.9 million available for 2016-17 disbursement and an extra $5 million over the out years. **Result: Substantially met**

Strategic investment of the first disbursements of $65.9 million from the MRFF was announced in May 2017 as part of the 2017-18 Budget. Disbursements will fund eight investments, aligned with the *Australian Medical Research and Innovation Strategy 2016–2021* and related *Priorities 2016–2018*, prepared by the independent Australian Medical Research Advisory Board. This balance of long-term research and quick win programs will improve health system efficiency, patient care and access, health outcomes, and innovation in health. The initiatives include:

- $20 million for preventive health and research translation projects, including $10 million for Advanced Health Translation Centres and $10 million for the Australian Prevention Partnership Centre.
- $33 million for clinical trials and to build on Australia's world class strengths to ensure Australia is a preferred destination for clinical trial research.
- $12.9 million for breakthrough research investments to drive cutting edge science and accelerate research for better treatments and cures.

The disbursement of funds from the Medical Research Future Fund is guided by the Australian Medical Research and Innovation Strategy, and the Australian Medical Research and Innovation Priorities.
Source: 2016-17 Health Portfolio Budget Statements, p. 45

2016-17 Target	2016-17 Result
The *Australian Medical Research and Innovation Strategy 2016–2021*, and the *Australian Medical Research and Innovation Priorities 2016–2018* delivered to Government in 2016.	Both inaugural documents were delivered to Government and launched by the Prime Minister on 9 November 2016. **Result: Met**

The *Australian Medical Research and Innovation Strategy 2016–2021*, and related *Priorities 2016–2018* were developed following extensive consultation with the health and medical research sector, health service clinicians and managers, patients and the general public during May and August 2016. In accordance with the *Medical Research Future Fund Act 2015*, these documents were used to guide the Government decisions on the 2016-17 Medical Research Future Fund strategic investments disbursements.

The Biomedical Translation Fund is established to support commercialisation of Australian health and medical research.
Source: 2016-17 Health Portfolio Budget Statements, p. 45

2016-17 Target	2016-17 Result
Fund established in 2016.	Fund established in 2016. **Result: Met**

The Government has established a $500 million Biomedical Translation Fund (BTF), with $250 million of Commonwealth funding that has been matched by private sector investors. The BTF will be used to make for-profit venture capital investments to support the development and commercialisation of biomedical discoveries in Australia, for the health and economic wellbeing of Australians. The Government has licensed three experienced venture capital fund managers to manage the fund. The first investment under the fund of $10 million was announced on 27 May 2017, and will focus on researching new ways to treat peanut allergies in children.

Improving safety and quality in health care

Relevant evidence-based resources are available to help reduce unwarranted health care variation by changing clinical practice.

Source: 2016-17 Health Portfolio Budget Statements, p. 46

2016-17 Target	2016-17 Result
Information is available to consumers, clinicians and health services to promote adoption of clinical best practice.	Information to promote adoption of clinical best practice is available for consumers, clinicians and health services. **Result: Met**

The Department worked collaboratively with the Australian Commission on Safety and Quality in Health Care and other relevant stakeholders to develop the *Second Australian Atlas of Healthcare Variation* (The Atlas). The Atlas highlights variation by mapping the use of health care according to where people live. Mapping variation is an invaluable tool for understanding how our health care system is providing care and how to develop tools and resources to improve the quality, value and appropriateness of health care.

Potential unwarranted health care variation has been identified.

Source: 2016-17 Health Portfolio Budget Statements, p. 46

2016-17 Target	2016-17 Result
Agreement with relevant stakeholders on unwarranted health care variation for further investigation.	Relevant stakeholders agreed on unwarranted health care variation for further investigation. **Result: Met**

The Department has worked collaboratively with the Australian Commission on Safety and Quality in Health Care and other relevant stakeholders, such as jurisdictional health department officials and clinical experts, to identify 18 clinical items for examination in the development of the *Second Australian Atlas of Healthcare Variation*. The 18 items relate to potentially preventable hospitalisations for select chronic conditions, including diabetes complications, interventions related to women's health and maternity, and hospitalisations for cardiovascular conditions, cataract surgery and knee replacement.

Improving 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: 2016-17 Health Portfolio Budget Statements, p. 47

2016-17 Target	2016-17 Result
Increased diversity of tissue types of donors and cord blood units available for transplant.	The Australian Bone Marrow Donor Registry and National Cord Blood Collection Network reported an increased diversity of tissue types of donors and cord blood units available for transplant in 2016-17. **Result: Met**

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, to meet the needs of eligible Australian patients.

Source: 2016-17 Health Portfolio Budget Statements, p. 47

2016-17 Target	2016-17 Result
Funding is provided to meet the Commonwealth's agreement with the Australian Bone Marrow Donor Registry, and through that, meet the needs of patients requiring a stem cell transplant.	The Australian Bone Marrow Donor Registry has been fully funded as per the Commonwealth's agreement. All Australian patients that applied for assistance to access an international donor or cord blood unit for the purposes of stem cell transplantation, through the Bone Marrow Transplant Program, have received assistance. **Result: Met**

The Australian Bone Marrow Donor Registry has developed a strategy to further improve the ethnic diversity of the Registry, which is being reviewed. Whilst the diversity of both donors and banked cord blood units has improved, further improvements are required to better meet the population profile of Australia.

The Australian Bone Marrow Donor Registry continued to conduct searches of international registries as required, for matched donors and cord blood for Australian patients who were unable to find a match domestically.

Number of searchable Indigenous cord blood units.
Source: 2016-17 Health Portfolio Budget Statements, p. 47

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
70	82 **Result: Met**	N/A	N/A	N/A	N/A

Percentage of searchable cord blood units where one or both parents claim ancestry that is not North-West European.
Source: 2016-17 Health Portfolio Budget Statements, p. 47

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
50%	62% **Result: Met**	N/A	N/A	N/A	N/A

Number of banked[1] cord blood units
• Total
• Indigenous
Source: 2016-17 Health Portfolio Budget Statements, p. 47

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
1,600 50	1,557 68 **Result: Substantially Met**	1,700 60	1,765 119	1,957 101	523 64

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 lifesaving treatment for cancer and other serious conditions.

Sufficient numbers of cord blood units continue to be banked by the three public cord blood banks in Australia to be made available for transplantation. The trend of delayed cord clamping[2] has not adversely affected the collection of cord blood. Ethnically diverse cord blood units continue to be collected and made available for transplant in the three public cord blood banks. The result was significantly above the target due to children with one or two parents of ancestry other than North-Western European being targeted in collection areas. Indigenous cord blood units continue to be collected and made available for transplantation.

The performance result of 'substantially met' is based on meeting 98% of the target.

[1] After collection, a cord blood unit is processed and a sample sent for tissue typing. The unit is considered 'banked' when it has been recorded and placed in cryogenic storage. The unit is considered 'searchable' when the tissue typing information is recorded, all regulatory requirements met and it is available for use by patients.

[2] Delayed cord clamping is when a baby's umbilical cord is not clamped or cut until it has stopped pulsing or until the placenta has been delivered.

Supporting access to blood and blood products

Effective planning of the annual blood supply through the National Supply Plan and Budget.
Source: 2016-17 Health Portfolio Budget Statements, p. 48

2016-17 Target	2016-17 Result
Implementation of the 2016-17 National Supply Plan and Budget that was agreed by all Health Ministers in 2015-16.	National Supply Plan and Budget was implemented during 2016-17. **Result: Met**

The National Supply Plan and Budget ensured there was sufficient blood and blood products budgeted for each State and Territory. Funding was paid quarterly in advance to ensure there was an uninterrupted supply to meet clinical need.

The supply of blood and essential blood products are effectively supported in order to meet Australia's clinical need.
Source: 2016-17 Health Portfolio Budget Statements, p. 48

2016-17 Target	2016-17 Result
Funding is provided to meet the Commonwealth's contribution under the National Blood Agreement.	All Commonwealth funding was provided as per the National Blood Agreement. **Result: Met**

The supply of blood and essential blood products was 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.[3] The Commonwealth met funding of 63% of the supply of blood and a range of essential blood products as agreed under the National Blood Agreement.

Performance criteria from the 2016-17 Corporate Plan

Australian Government health priorities are progressed through the COAG Health Council.
Source 2016-17 Department of Health Corporate Plan, p. 25

Refer p. 43 for performance criterion addressing progress of health priorities through the COAG Health Council.

Australian hospitals and health services meet National Safety and Quality Health Service Standards, and adequate systems are in place to monitor and report on health products safety.
Source: 2016-17 Department of Health Corporate Plan, p. 26

As part of the legislative function of the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Commission reports on the state of safety and quality in the Australian health system.

The National Safety and Quality Health Service (NSQHS) Standards are making a difference by enhancing leadership for safety and quality; clinical engagement; and effective systems.

A full report on the key safety and quality themes can be found in the ACSQHC's publication *Vital signs 2016: the state of safety and quality in Australian health care*.

As at 30 June 2016, 98% of all hospitals and day procedure services in Australia have been assessed against the NSQHS Standards.[4]

[3] Several Territories are considered as covered under the National Blood Agreement. Further information on covered Territories is available at: www.legislation.gov.au/Details/C2016C00846

[4] Source: *Australian Commission on Safety and Quality in Health Care Annual Report 2015-16*.

Program 1.2: Health Innovation and Technology

The Department met the performance target related to Program 1.2: Health Innovation and Technology.

In 2016-17, the Department continued to support a national shared electronic health record system. The final evaluation report for the My Health Record participation trials was released in May 2017. The report provided evidence from all four trial sites to inform Government about the participation arrangements and implementation approaches that will be most effective for bringing forward the benefits of My Health Record nationally. The evaluation report found that implementation of opt-out arrangements nationally was the best way to deliver the benefits of the system.

Providing national digital health leadership

Trials of new participation arrangements are undertaken, including for an opt-out system.
Source: 2016-17 Health Portfolio Budget Statements, p. 49

2016-17 Target	2016-17 Result
Trials to be completed by 31 October 2016.	The trials of new participation arrangements for My Health Record (opt-in and opt-out) were completed by 31 October 2016. **Result: Met**

Trials of opt-in and opt-out participation arrangements were conducted at four trial sites: opt-out in Northern Queensland and the Nepean Blue Mountains of New South Wales, and opt-in in Western Australia and Ballarat. These trials delivered an evidence-base to inform Government about the most effective participation arrangements and implementation approaches to bring forward the benefits of My Health Record nationally. The trials demonstrated that opt-out participation is the fastest way to realise the significant health and economic benefits of My Health Record for all Australians. This has enabled the design of initiatives that will increase participation in and use of the My Health Record system across the nation.

Funding to implement the national rollout of the opt-out model was provided in the 2017-18 Budget, which will deliver a My Health Record for every Australian by December 2018, unless they choose not to have one.

Performance criteria from the 2016-17 Corporate Plan

Increase in the number of consumers and providers using My Health Record.
Source: 2016-17 Department of Health Corporate Plan, p. 24

During 2016-17 the Department saw an overall increase in the use of the My Health Record system. In total:

- 664,278 people accessed their own records in the My Health Record system;
- 2,217 health care providers viewed records in the My Health Record system; and
- 4,538 health care providers uploaded records to the My Health Record.

During 2016-17, health care providers uploaded a total of 218,776,890 documents.

Participation (opt-out and opt-in) trial findings inform future recommendations to Government to increase participation in, and meaningful use of, My Health Record.
Source: 2016-17 Department of Health Corporate Plan, p. 24

Refer p. 49 for performance criterion addressing participation in My Health Record.

Program 1.3: Health Infrastructure

The Department met all performance targets related to Program 1.3: Health Infrastructure.

In 2016-17, the Department supported improvements to the health system through investment in health infrastructure that provides increased opportunities for training and teaching of health practitioners.

During 2016-17, funding agreements for 52 Rural General Practice Grants were established. The program will deliver improved health services through additional infrastructure, increased levels of teaching and training for health practitioners, and more opportunities to deliver healthy living education to local communities.

The Department continued to monitor health infrastructure projects to ensure projects were compliant and meeting agreed milestones.

Improving primary health care infrastructure

Number of Rural General Practice Grants (RGPG) supporting additional infrastructure to enable increased levels of teaching and training for health practitioners.
Source: 2016-17 Health Portfolio Budget Statements, p. 50

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
30	52 **Result: Met**	N/A	N/A	N/A	N/A

The Department made 67 grant funding offers to applicants through the RGPG Program. Of the 67 offers, 52 funding agreements were in place by 30 June 2017, the remaining offers will be finalised in 2017-18.

Investing in other major health infrastructure

Effective monitoring of health infrastructure projects for compliance with agreed outputs.
Source: 2016-17 Health Portfolio Budget Statements, p. 50

2016-17 Target	2016-17 Result
Reports are received for all projects in the required timeframe and remedial action taken as required.	Reports for the relevant infrastructure projects have been received by the Department within the required timeframes and where required, remedial action has been taken. **Result: Met**

The majority of projects 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.

Program 1.4: Health Peak and Advisory Bodies

The Department met the performance target related to Program 1.4: Health Peak and Advisory Bodies.

In 2016-17, the Department actively engaged with national peak and advisory bodies on a range of issues contributing to the Government's health agenda.

In 2016-17, the Department funded organisations to provide advice on a range of issues including the National Digital Health Strategy, Medicare Benefits Schedule reviews, the Fifth National Mental Health and Suicide Prevention Plan, Health Care Homes, and the Practice Incentives Program.

The Department aims to ensure that sector and community views on health issues are represented in the development of Government policies and programs, and support the dissemination of information on Government policies and programs.

Supporting the Australian Government with informed policy advice and facilitating engagement with the health sector

Advice obtained from national peak and advisory bodies informs policy and program development.
Source: 2016-17 Health Portfolio Budget Statemeats, p. 51

2016-17 Target	2016-17 Result
Funding agreements with a range of national peak and advisory bodies commencing from 1 July 2016.	The Department had funding agreements in place with a range of national peak and advisory bodies, which commenced from 1 January 2016. **Result: Met**

The Department funds health peak and advisory organisations to consult with members on policy and program issues, to provide the Government with informed and impartial advice, and to share information on Government health policies and programs. Community consultation can be undertaken by organisations in addition to members, however this is not mandatory. Advice was provided via formal written submissions and participation in Government meetings and forums.

The Department received advice on health matters from 21 funded health peak and advisory bodies throughout 2016-17. These organisations consulted with their members on matters such as: the Medicare Benefits Schedule Review; the redesign of the Practice Incentives Program; the Fifth National Mental Health and Suicide Prevention Plan; and Primary Health Networks.

During the development of the Fifth National Mental Health and Suicide Prevention Plan, there was strong engagement with peak bodies and key stakeholders, with extensive feedback being received. Recommendations from peak bodies and key stakeholders were considered with many incorporated. The advice provided by these organisations was considered by Senior Governance Committees and plays a vital role in ensuring that programs and policies are developed to address community needs and concerns.

Program 1.5: International Policy

The Department met all performance targets related to Program 1.5: International Policy.

In 2016-17, the Department continued to participate in international engagements, maintaining partnerships and harnessing information on international best practice in health.

Australia is recognised as having a world-class health system, and is well regarded in international health fora. Australia is considered a leader on a range of health issues including: health emergency preparedness and response; antimicrobial resistance; universal health coverage; health technology assessments; and tobacco control.

In January 2017, the Department led Australia's representation at the Organisation for Economic Co-operation and Development (OECD) High-level Policy Forum and Ministerial meeting in Paris. Australia participated in discussions with OECD Ministers about their views on the future of health and health care. Health welcomed the OECD Council Recommendation on Health Data Governance and endorsed a Ministerial Statement setting out future priorities.

In May 2017, Australia participated in the first ever G20 Health Ministers' Meeting, hosted by Germany. The delegation contributed to G20 discussions on key global health issues including antimicrobial resistance, and preventing and responding to global health emergencies.

Facilitating international engagement on health issues

Reform of the World Health Organization (WHO) continues to improve global and regional capacity to prevent and respond to health emergencies.
Source: 2016-17 Health Portfolio Budget Statements, p. 52

2016-17 Target	2016-17 Result
Australia contributes to debate on WHO reform in regional and global governing bodies.	The Department continues to engage through formal and informal channels to further the WHO reform agenda across all levels of the WHO. **Result: Met**

The Department continues to engage both formally and informally in discussions to advocate for a continued and strengthened focus on the program, governance and managerial reforms of the WHO. The Department has spoken in strong support of the alignment of the WHO's work with the 2030 Sustainable Development Agenda, including the need for an assessment of how the WHO's capabilities and comparative advantage would assist in defining a more strategic positioning of the WHO.

Number of international health delegation visits facilitated by the Department.
Source: 2016-17 Health Portfolio Budget Statements, p. 52

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
15–20	22 **Result: Met**	16	20	20	25

Hosting 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. Hosting these delegations assists the Department to build networks and professional linkages between individuals and organisations, exchange ideas and experiences, and facilitate international discussions on health issues. In 2016-17, the Department hosted delegations from Bangladesh, Canada, India, Iran, Japan, the Netherlands, the Philippines, Singapore, South Korea, Sweden, Taiwan, Timor-Leste and the United States of America. Areas of discussion across these delegations varied, with many focussed on issues such as health technology assessment, medical data, pharmaceuticals, health security, health workforce, health system financing and innovation in health care.

Australia's interests secured at relevant meetings of key international health bodies and organisations.

Source: 2016-17 Health Portfolio Budget Statements, p. 52

2016-17 Target	2016-17 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 actively engaged and led Australia's participation in meetings of the WHO governing bodies, Organisation for Economic Co-operation and Development (OECD) Health Committee, Asia-Pacific Economic Cooperation (APEC) Health Working Group and other international fora. **Result: Met**

In 2016-17, the Department continued to lead Australia's delegations to WHO governing body meetings, World Health Assembly, meetings of the WHO Executive Boards and the WHO Western Pacific Regional Committee Meeting. Participation in these meetings ensures Australia's domestic, regional and global interests are promoted and protected, and all decisions or resolutions adopted during the meetings are aligned with, or not contrary to, Australia's domestic and foreign policies. Examples of active engagement are included below.

Under the APEC Health Working Group, which meets twice a year, the Department currently chairs a sub-working group to implement the Healthy Asia-Pacific 2020 Initiative – APEC's key plan for promoting health and wellbeing in the region and encouraging APEC economies to develop sustainable and high performing health systems.

Australia's delegation was highly active in the lead up to and during the 70th World Health Assembly in May 2016. The Chief Medical Officer delivered Australia's plenary statement which reinforced our commitment to universal health coverage and addressed the importance of ensuring sustainable health financing. Australia hosted a side event in partnership with the Fred Hollows Foundation on universal eye health and co-sponsored a further five official side events on health security, essential surgery, world no tobacco day, strengthening regulation and human rights. In addition, members of the delegation participated in and attended a range of other events and meetings on issues including non-communicable diseases, mental health, health security and health workforce.

In November 2016, Australia (represented by the Department) was appointed to the bureau of the OECD Health Committee, a key platform of influence in the governance of the forum. The then Secretary, Martin Bowles, delivered the keynote speech at the Commonwealth Fund International Symposium on Health Care Policy in December 2016.

At the Heads of Health meeting in April, the Department made interventions during sessions on Universal Health Coverage, non-communicable diseases and Pacific Health Security. These interventions supported continued efforts into these important regional health issues. Attendance at this meeting also helped inform Australia's position on the May elections of a new Director-General for the WHO.

Performance criteria from the 2016-17 Corporate Plan

Departmental representatives actively engage in meetings of the World Health Organization (WHO) governing bodies, Organisation for Economic Co-operation and Development (OECD) Health Committee, Asia-Pacific Economic Cooperation (APEC) Health Working Group and other international forums.

Source: 2016-17 Department of Health Corporate Plan, p. 25

Refer above on this page for performance criterion addressing engagement in meetings of the WHO, OECD, APEC and international forums.

First G20 Health Ministers' meeting

In Berlin in May 2017, Australia joined its 19 counterparts in the first ever meeting of G20 Health Ministers. The meeting brought together decision makers from G20 member nations to share information and better plan for collaboration during international health crises.

The Hon Ken Wyatt AM, MP, Minister for Aged Care and Minister for Indigenous Health represented Australia at the meeting. Minister Wyatt was joined by representatives of the other members of the G20 – Argentina, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, Republic of Korea, Mexico, Russia, Saudi Arabia, South Africa, Turkey, United Kingdom, United States, and the European Union.

Global health risks, such as infectious disease outbreaks and antimicrobial resistance, have a severe impact on the lives and wellbeing of millions of people, as well as on the global economy. These challenges cannot be addressed by any one country or sector alone, and need a coordinated and integrated response. As the premier forum for international economic cooperation, the G20 can make a real contribution to tackling global health challenges.

Health Ministers at the meeting took part in a global health emergency simulation exercise – a first for senior political leaders. The exercise helped develop Ministers' awareness of global health crisis management, and encouraged countries to improve their epidemic preparedness and response capacities.

Australia's participation at the meeting was an opportunity for us to share our national experiences in responding to health emergencies and to encourage other countries to strengthen their health systems, to make the world a healthier and safer place for all.

Following the exercise, Minister Wyatt announced that Australia will provide $2 million to support the Coalition for Epidemic Preparedness Innovations (CEPI) to develop vaccines to fight emerging infectious diseases.

> ***"It is better to be prepared, rather than react to epidemics. Australia's support for CEPI will work to fuel an end-to-end approach to vaccine development, with vaccine development platforms ready for deployment before the epidemic begins."***
>
> ***"This investment complements Australia's commitment to global health and will build global innovative partnerships and create opportunities for global research collaboration."***

Outcome 1 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 1.1: Health Policy Research and Analysis[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	55,191	50,336	(4,855)
Special Accounts			
Medical Research Future Fund	60,876	17,960	(42,916)
Special appropriations			
National Health Act 1953 – blood fractionation, products and blood related products to National Blood Authority	664,802	657,785	(7,017)
Public Governance, Performance and Accountability Act 2013 s77 – repayments	2,000	576	(1,424)
Other Services (*Appropriation Act No. 2*)	-	3,169	3,169
Departmental expenses			
Departmental appropriation[2]	63,732	61,848	(1,884)
Expenses not requiring appropriation in the budget year[3]	3,966	7,804	3,838
Total for Program 1.1	**850,567**	**799,478**	**(51,089)**
Program 1.2: Health Innovation and Technology			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	41,363	38,894	(2,469)
Departmental expenses			
Departmental appropriation[2]	11,627	10,675	(952)
Expenses not requiring appropriation in the budget year[3]	733	1,230	497
Total for Program 1.2	**53,723**	**50,799**	**(2,924)**
Program 1.3: Health Infrastructure[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	5,797	4,921	(876)
Special appropriations			
Health Insurance Act 1973 – payments relating to the former Health and Hospitals Fund	37,321	17,554	(19,767)
Departmental expenses			
Departmental appropriation[2]	2,787	2,944	157
Expenses not requiring appropriation in the budget year[3]	194	336	142
Total for Program 1.3	**46,099**	**25,755**	**(20,344)**

Outcome 1 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 1.4: Health Peak and Advisory Bodies			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	7,983	8,098	115
Departmental expenses			
Departmental appropriation[2]	1,504	1,528	24
Expenses not requiring appropriation in the budget year[3]	121	170	49
Total for Program 1.4	**9,608**	**9,796**	**188**
Program 1.5: International Policy			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	14,340	13,038	(1,302)
Departmental expenses			
Departmental appropriation[2]	7,471	7,835	364
Expenses not requiring appropriation in the budget year[3]	586	872	286
Total for Program 1.5	**22,397**	**21,745**	**(652)**
Outcome 1 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	124,674	115,287	(9,387)
Special Accounts	60,876	17,960	(42,916)
Special appropriations	704,123	675,915	(28,208)
Other Services (*Appropriation Act No. 2*)	-	3,169	3,169
Departmental expenses			
Departmental appropriation[2]	87,121	84,830	(2,291)
Expenses not requiring appropriation in the budget year[3]	5,600	10,412	4,812
Total expenses for Outcome 1	**982,394**	**907,573**	**(74,821)**
Average staffing level (number)	**505**	**510**	**5**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

[1] This program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

[2] Departmental appropriation combines 'Ordinary annual services (*Appropriation Act No. 1*)' and 'Revenue from independent sources (s74)'.

[3] Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Outcome 2:
Health Access and Support Services

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

Analysis of performance

In 2016-17, the Department continued working towards providing all Australians with access to preventive, primary and mental health care, with a particular focus on members of the community with complex health care needs and those living outside of metropolitan and urban areas. As part of this work, the Department has also continued to improve the capacity and quality of the health workforce.

The Department has made significant progress in implementing the Australian Government's mental health reforms, including expanding the role of Primary Health Networks to lead mental health and suicide prevention planning at a regional level. A number of key outcomes were also achieved in the Department's ongoing commitment to closing the gap by improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

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

Highlights

Twelve suicide prevention trial sites established to deliver tailored mental health services

Each of the 12 trial sites will be administered by a local Primary Health Network and bring together community representatives, mental health primary care service providers, representatives of the education and emergency services sector, and State and Territory representatives to identify issues and deliver tailored services at the local level.
Refer *Program 2.1*

The gap in vision is closing for Indigenous Australians

Through improved access to early screening and clinical services, blindness and vision impairment among Aboriginal and Torres Strait Islander peoples has reduced from six times that of non-Indigenous Australians in 2008 to three times that of non-Indigenous Australians in 2016.
Refer *Program 2.2*

Increased opportunities for medical students to continue training in regional and rural communities

Twenty-six regional training hubs have been established to help retain medical students in regional and rural communities. The training hubs will work collaboratively with health services, medical colleges and other medical and education training stakeholders to develop training pathways which will enable more training to be undertaken in regional and rural Australia.
Refer *Program 2.3*

Highlights continued on next page

Saving lives through early detection of bowel cancer

Additional age cohorts were invited to screen under an accelerated transition to biennial screening for people aged 50–74. It is estimated that the National Bowel Cancer Screening Program will prevent over 90,000 bowel cancer cases and 59,000 deaths from 2015 to 2040.[5] Increasing participation rates, in line with current projections, will have an even greater impact, with the potential to prevent up to 84,000 deaths by 2040.
Refer *Program 2.4*

Improving primary health care services

The 31 Primary Health Networks have commissioned new services to meet the needs of their communities. They have supported general practice and other primary care providers, particularly to increase uptake of digital health, immunisation and cancer screening.
Refer *Program 2.5*

Looking ahead

- The Head to Health website will be launched giving Australians easy access to mental health advice and resources.
- The National Cancer Screening Register will be in place to support the renewal of the National Cervical Screening Program and the expansion of the National Bowel Cancer Screening Program.
- The Department will lead key activities that focus on palliative and end-of-life care. This will include updating the National Palliative Care Strategy, in collaboration with States and Territories, and developing a national implementation plan.
- The Department will continue to support the Government to address the impact of cancer in children and young people through a range of initiatives, including support for adolescents and young adults with cancer and supporting CanTeen to continue to deliver the Government's Youth Cancer Services Program.
- Together with State and Territory Governments, the Department will continue to promote and support breastfeeding in Australia, through the production of a National Enduring Breastfeeding Strategy.

[5] Lew et al. 2017. Long-term evaluation of benefits, harms, and cost-effectiveness of the National Bowel Cancer Screening Program in Australia: a modelling study. Lancet Public Health 2017; 2: e331–4

Purpose, programs and program objectives contributing to Outcome 2

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.
Program 2.1: Mental Health
Investing in more and better coordinated services for people with mental illness
Performance criteria from the 2016-17 Corporate Plan
Program 2.2: Aboriginal and Torres Strait Islander Health
Improving access to comprehensive and culturally appropriate health care in areas of need
Reducing chronic disease
Improving child and maternal health
Performance criteria from the 2016-17 Corporate Plan
Program 2.3: Health Workforce
Increasing the capacity and effectiveness of training and education for the future health workforce
Redesigning the supply of, and support for, health professionals in rural, regional and remote Australia
Improving access to health services for rural Australians
Performance criteria from the 2016-17 Corporate Plan
Program 2.4: Preventive Health and Chronic Disease Support
Reducing the incidence of chronic disease and complications, and promoting healthier lifestyles
Supporting the development and implementation of evidence-based food regulatory policy
Improving early detection, treatment and survival outcomes for people with cancer
Improving access to high quality palliative care services for all Australians
Reducing harm to individuals and communities from misuse of alcohol, pharmaceuticals and use of illicit drugs
Reducing the harmful effects of tobacco use
Performance criteria from the 2016-17 Corporate Plan
Program 2.5: Primary Health Care Quality and Coordination
Focussing investment in frontline medical services for patients through Primary Health Networks
Improving models of primary care
Establishing the Primary Health Care Development Program
Program 2.6: Primary Care Practice Incentives
Providing general practice incentive payments
Program 2.7: Hospital Services
Supporting the States and Territories to deliver efficient public hospital services
Improving health services in Tasmania
Supporting the Mersey Community Hospital
Performance criteria from the 2016-17 Corporate Plan

Program 2.1: Mental Health

The Department met or substantially met all performance targets related to Program 2.1: Mental Health.

Significant work was undertaken to implement the Government's mental health reform agenda, with a number of key achievements being reached.

From 1 July 2016, Primary Health Networks commenced commissioning mental health and suicide prevention services, within a stepped care model, to deliver the level and type of care that meets the needs of consumers through integrated regional services.

Twelve suicide prevention trials were established in 11 Primary Health Networks to respond to the increasing number of suicides across Australia.

To allow for a greater level of consumer feedback, there was a delay in launching the Head to Health website. A first draft of the website was co-designed with key stakeholders, and testing commenced seeking feedback from a range of intended users to inform its public release.

The Fifth National Mental Health and Suicide Prevention Plan was developed through an extensive consultation process undertaken in conjunction with States and Territories and the mental health sector, including consumers and carers. It was endorsed by the Council of Australian Governments' Health Council on 4 August 2017.

In 2017-18, the Government will deliver additional funding for community mental health, mental health research, assistance to prevent suicide at hotspot locations, and telehealth access for psychological services in rural and regional Australia.

Investing in more and better coordinated services for people with mental illness

Support Primary Health Networks to effectively implement reform activities and maximise use of the flexible funding pool.
Source: 2016-17 Health Portfolio Budget Statements, p. 60

2016-17 Target	2016-17 Result
Transition of regionally delivered mental health and suicide prevention programs to the Primary Health Networks funding pool, to enable service commissioning to commence from July 2016.	All 31 Primary Health Networks have been funded, and were commissioning services for a range of regionally delivered mental health and suicide prevention services from 1 July 2016. **Result: Met**

The Government is providing $1.2 billion from 2016-17 to 2018-19 to Primary Health Networks to lead mental health and suicide prevention planning at a regional level.

Through a new flexible primary mental health care funding pool, Primary Health Networks will improve outcomes for people with or at risk of mental illness and/or suicide, in partnership with relevant services.

Support better coordination and integration of mental health and suicide prevention services at a national and regional level to improve consumer outcomes.

Source: 2016-17 Health Portfolio Budget Statements, p. 60

2016-17 Target	2016-17 Result
Development of Primary Health Networks regional mental health and suicide prevention plans commenced by 30 June 2017.	The Department has consulted with Primary Health Networks, States and Territories, peak bodies, carers and consumers on the draft regional planning guidance material. The majority of Primary Health Networks commenced their regional planning prior to 30 June 2017. **Result: Substantially met**

Primary Health Network development of the Regional Mental Health and Suicide Prevention Plan is a pivotal element of broader mental health reform. The Department has decided to extend the timeframe in which Primary Health Networks are to submit their regional mental health and suicide prevention plans. This will align with the implementation of Primary Health Network training in the use of the National Mental Health Service Planning Framework and the release of the Fifth National Mental Health and Suicide Prevention Plan which includes a strong focus on regional planning.

Establish a new digital mental health gateway that promotes access to information, advice and digital mental health treatment.

Source: 2016-17 Health Portfolio Budget Statements, p. 60

2016-17 Target	2016-17 Result
Early consultation with the digital mental health sector in the design, development and delivery of the gateway to be completed by 31 August 2016.	Substantial early consultation and development was completed by August 2016. A test version was released to stakeholders in March 2017, with the public release of the Head to Health website being delayed by Government until the last quarter of 2017. **Result: Substantially met**

Throughout 2016-17, the Department undertook substantial consultation on the design and development of Head to Health. This included:

- more than 20 site visits with service providers and academics;
- two discovery workshops with more than 40 people;
- 11 meetings of the Digital Mental Health Advisory Committee;
- 11 co-design workshops across Australia with 129 participants; and
- engagement with a Core Community Group of 20 members with lived experience of mental illness and carers as subject matter experts.

The Department is now in the process of seeking feedback on the website from a diverse range of people prior to its release to the public in the last quarter of 2017. The decision to delay the launch of Head to Health ensures a better, more fit-for-purpose product to be released, through a greater level of feedback and consumer testing.

Performance criteria from the 2016-17 Corporate Plan

Reduction in the proportion of adults with very high psychological distress.
Source: 2016-17 Department of Health Corporate Plan, p. 25

Future data will be captured as part of the Australian Health Survey and will be published by the Australian Bureau of Statistics (ABS).

Program 2.2: Aboriginal and Torres Strait Islander Health

The Department met the majority of performance targets related to Program 2.2: Aboriginal and Torres Strait Islander Health.

The Department is making significant progress improving Aboriginal and Torres Strait Islander Health outcomes, however, despite a 15 per cent reduction in mortality rates between 1998 and 2015, there have been no significant gains made against the Closing The Gap target in life expectancy by 2031.

There has also been a 33 per cent decline in Indigenous child mortality between 1998 and 2015. The target to halve the gap in child mortality by 2018 has been on track in previous years; however, the 2016 Indigenous child mortality rate was slightly outside the range required for this target to be on track this year.

The Department continues to work with Aboriginal and Torres Strait Islander peoples to accelerate our progress through the delivery of culturally appropriate primary health care and targeted programs.

The prevalence of blindness and vision impairment among Aboriginal and Torres Strait Islander peoples has reduced from six times that of non-Indigenous Australians in 2008 to three times that of non-Indigenous Australians in 2016. These results are due to: more Indigenous Australians having the recommended annual eye check; the number of outreach optometry services almost tripling; and cataract surgery rates increasing significantly. Through improved screening and treatment, trachoma prevalence has reduced from 14 per cent in 2009 to less than five per cent in 2016.

In 2016-17, the Department continued working in partnership with the Indigenous community to improve health outcomes for Aboriginal and Torres Strait Islander peoples. In September 2016, the Implementation Plan Advisory Group (IPAG) was established to provide a forum for Government to work in partnership with Aboriginal and Torres Strait Islander health leaders to review, assess and guide action under the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The role of the IPAG is to review progress, assess action and identify emerging policy and strategic issues for the Implementation Plan, as well as provide advice to the Department and the Department of the Prime Minister and Cabinet.

In August 2016, the Australian Health Ministers' Advisory Council (AHMAC) endorsed the *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* to guide the development, implementation and evaluation of maternal, child and family health services for Aboriginal and Torres Strait Islander peoples across Australia.

The Framework was developed in collaboration with community leaders and a cultural advisory group. The Department consulted widely with Aboriginal and Torres Strait Islander communities across the country, listening to what they need, so services are delivered in the way that best suits the community.

The Framework provides guidance for policy and program design, and for the development and implementation of culturally appropriate services to meet the needs of Aboriginal and Torres Strait Islander peoples.

In October 2016, the *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health* was released by AHMAC. The Framework provides a guide for a national approach to support the delivery of culturally safe and responsive health care to Aboriginal and Torres Strait Islander peoples. The objective of the Framework is to improve health outcomes for Aboriginal and Torres Strait Islander peoples in a more timely, efficient and effective way, with a reduction in experiences of racism and discrimination and improved consumer and community satisfaction.

In June 2017, a new Network Funding Agreement was signed with the National Aboriginal Community Controlled Health Organisation (NACCHO). Through this agreement, NACCHO will form a collaborative network with its State and Territory counterpart organisations to support Aboriginal Community Controlled Health Services and strengthen links between the sector and mainstream health providers. The agreement will also support Aboriginal Community Controlled Health Services to improve their service delivery and assist mainstream health services in delivering accessible, responsive and culturally safe care to Aboriginal and Torres Strait Islander peoples.

In 2017-18, the Department will continue work to develop new and innovative approaches to better address the social and cultural determinants of health, which is expected to accelerate progress in closing the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

Improving access to comprehensive and culturally appropriate health care in areas of need

Continue to implement actions in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (the plan) 2013–2023.
Source: 2016-17 Health Portfolio Budget Statements, p. 61

2016-17 Target	2016-17 Result
Monitor and review progress against the plan in consultation with the Indigenous health sector.	Progress against the deliverables and goals of the plan continue to be monitored and reviewed through the Implementation Plan Advisory Group and the *2017 Aboriginal and Torres Strait Islander Health Performance Framework*. **Result: Met**

Published in May 2017, the *2017 Aboriginal and Torres Strait Islander Health Performance Framework* reports on progress against the 20 Implementation Plan goals for the first time. Of the 20 Implementation Plan goals, ten are currently on track, five are not on track, and five were unable to be assessed.

The results show that the Government is exceeding the immunisation targets for Indigenous one and five year olds. There have also been continued increases in the rates of Indigenous mothers accessing antenatal care.

While the rates of health assessments have increased over time across all the age groups, they currently fall below the trajectories required to be assessed as on track to meet the 2023 goal.

Number of Indigenous adult and child health checks completed.
Source: 2016-17 Health Portfolio Budget Statements, p. 61

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
189,394	217,678 **Result: Met**	196,759	171,786	150,534	122,161

All Aboriginal and Torres Strait Islander peoples are eligible for an annual Indigenous-specific health check. The health check includes an assessment of the patient's physical health, as well as their psychological and social wellbeing. It also assesses what preventive health care, education and other assistance should be offered to the patient to improve their health and wellbeing. Early intervention and preventive care are crucial to delivering many long-term health and life expectancy goals.

Reducing 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.
Source: 2016-17 Health Portfolio Budget Statements, p. 62

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
60–65%	Data not available	63%	N/A	N/A	N/A

Data to support this performance criterion will be available in June 2018.

People with type 2 diabetes are more prone to high blood pressure, increasing the risk of other health conditions including stroke, heart disease and kidney disease. Regular blood pressure monitoring is important to reduce the consequences of diabetes.

Chronic disease related mortality rate per 100,000:

- **Aboriginal and Torres Strait Islander**
- **Non-Aboriginal and Torres Strait Islander**
- **Rate difference**

Source: Source: 2016-17 Health Portfolio Budget Statements, p. 62

2015 Target	2015 Estimated result[6]	2014	2013	2012	2011
614–650	774.4[7]	756.5	784	898	N/A
426–431	448.8[8]	447.4	449	451	N/A
185–222	325.6[9]	309.1	335	447	N/A
	Result: Not met				

Although there has been a statistically significant decline in Aboriginal and Torres Strait Islander rates of chronic disease mortality over the period 1998–2015, there has been no statistically significant change in the gap between the two populations. This is partly because the non-Indigenous rates in chronic disease mortality have declined faster than Indigenous rates.

Child 0-4 mortality rate per 100,000:

- **Aboriginal and Torres Strait Islander**
- **Non-Aboriginal and Torres Strait Islander**
- **Rate difference**

Source: 2016-17 Health Portfolio Budget Statements, p. 62

2015 Target	2015 Estimated result[10]	2014	2013	2012	2011
107–158	163.6[11]	159.1	185	165	N/A
78–89	75.0[12]	74.7	84	77	N/A
23–76	88.6[13]	85.7	101	87	N/A
	Result: Not met				

Indigenous child mortality rates have declined by 33% between 1998 and 2015, with the mortality gap also declining by 31% over the same period. Continued improvements in key preventive factors, such as access to antenatal care and reducing smoking during pregnancy, continue to be important contributors to declining rates. However, the most recent data put rates just outside the Closing the Gap target to halve the mortality rate of children under five by 2018, despite having been above the required trend since 2013. Less than satisfactory reductions in child mortality rates also alter the progress in reducing the gap in life expectancy.

[6] Source: AIHW National Mortality Database, calendar years 1998–2015 (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. Estimated result is based on preliminary data that will not be finalised until 2018.

[7] 2015 data, due to the time lag in ABS mortality data publication.

[8] This is contextual data and is listed to provide comparison.

[9] Ibid.

[10] Source: AIHW National Mortality Database, calendar years 1998-2015 (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. Estimated result is based on a preliminary data that will not be finalised until 2018.

[11] 2015 data, due to the time lag in ABS mortality data publication.

[12] This is contextual data and is listed to provide comparison.

[13] Ibid.

Improving child and maternal health

Number of services funded to provide *New Directions: Mothers and Babies Services*.
Source: 2016-17 Health Portfolio Budget Statements, p. 63

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
124	124 **Result: Met**	110	85	85	85

The Department continued working towards the goal of funding a total of 136 *New Directions: Mothers and Babies Services* (NDMBS) by 2018.

The NDMBS 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 breast-feeding; nutrition and parenting; monitoring of developmental milestones; immunisation status and infections; and health checks for children before starting school. The program is flexible to local needs and provides access to a broad range of child and maternal health functions as part of a broader primary health care service.

Number of organisations funded to provide Australian Nurse Family Partnership Program Services.
Source: 2016-17 Health Portfolio Budget Statements, p. 63

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
9	12 **Result: Met**	5	3	N/A	N/A

In 2016-17, an additional seven organisations were contracted to implement the Australian Nurse Family Partnership Program (ANFPP). Due to a staggered implementation approach, the Department was able to engage an additional three organisations earlier than anticipated. The goal of having 13 organisations supported will be achieved by 2018.

The ANFPP is a specialised nurse-led home visiting program that supports women pregnant with an Aboriginal and/or Torres Strait Islander child who may benefit from a more intensive level of support to improve their own health and the health of their baby. 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.

Performance criteria from the 2016-17 Corporate Plan

Halve the mortality gap for Indigenous children under five by 2018.
Source: 2016-17 Department of Health Corporate Plan, p. 24

Refer p. 67 for performance criterion addressing the mortality gap for Indigenous children under four.

Increased average number of years a person could expect to live if they experienced the age/sex specific death rates that applied at their birth throughout their lifetime.
Source: 2016-17 Department of Health Corporate Plan, p. 24

This performance criterion is supported by data from the Australian Bureau of Statistics, which is reported each year with a two year data lag. Data for 2016-17 will be available in 2019.

Life expectancy estimates continue to improve in Australia. This increase can be attributed to factors such as improved health services, safer working environments and advances in medical technology.

Reduction in presentation of Type 2 diabetes.
Source: 2016-17 Department of Health Corporate Plan, p. 24

In 2014-15, an estimated 1.2 million (5.1%) Australians had diabetes, an increase from 4.5% in 2011-12.[14] The majority of these (85%) had type 2 diabetes and 15% had type 1 diabetes.[15]

In 2014-15, non-Indigenous Australians, compared with Indigenous Australians were:

- 3.5 times as likely to have diabetes (3.3 times as likely in 2011-12);
- 4.0 times as likely to be hospitalised for diabetes; and
- 4.0 times as likely to die from diabetes.

Improved equity and access to health care.
Source: 2016-17 Department of Health Corporate Plan, p. 24

Indigenous Australians have a lower life expectancy, higher rates of chronic and preventable illnesses, and poorer self-reported health than non-Indigenous Australians. Similarly, Australians living in rural and remote areas tend to have shorter lives and higher rates of disease and injury than their major cities counterparts.[16] For more information about initiatives supporting improvement in equity and access to health care for Indigenous Australians and Australian's living in rural and remote areas, refer *Program 2.2: Aboriginal and Torres Strait Islander Health*, p. 65 and *Program 2.3: Health Workforce* p. 70.

[14] Based on self-reported data which is likely to underestimate the prevalence of diabetes as it cannot include people with undiagnosed diabetes.

[15] Source: Australian Bureau of Statistics, 2013. Australian Health Survey: biomedical results for chronic diseases, 2011–12. ABS cat. no. 4364.0.55.005. Canberra: ABS.

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

Program 2.3: Health Workforce

The Department met the majority of performance targets related to Program 2.3: Health Workforce.

In 2016-17, the Government invested in a Specialist Training Program extending vocational training for specialist registrars to provide services to the community during their training. The investment in this program is to expand training capacity helping to meet community needs for specialist medical services.

Additionally, the Commonwealth Medical Internships program has increased clinical training capacity nationally for junior doctors expanding their training into private hospital settings, including regional locations, growing the medical workforce and improving access and service delivery for patients.

The Department continues to support long-term rural medical clinical training placements which aim to increase the number of appropriately qualified doctors working in rural, regional, and remote Australia.

Three new University Departments of Rural Health (UDRH) were established in Broome, Toowoomba and Wagga Wagga, adding to the 12 existing UDRH. This expansion will provide increased rural practice opportunities for nursing, midwifery and allied health students.

The Health Workforce Data website[17] was launched in January 2017. The website provides stakeholders and the public with access to the National Health Workforce Dataset, reports and summary tables for the health workforce in Australia. The website allows users to generate tables and graphs for individual health professions by demographic, geographic and employment characteristics. Users can also analyse data across all the registered professions according to their area(s) of interest. The health workforce data tool enables users to better understand and plan the health workforce of Australia.

The Department managed the redesign of the Rural Workforce Agencies Program to deliver better health outcomes for people living in regional, rural and remote communities. Through the program the network agencies will undertake activities to meet community needs, and health workforce demands, in regional, rural and remote Australia. The agencies will focus on enabling access to essential primary health care, quality of access and future workforce planning.

In 2017-18, the Department will further implement the *2015-16 Mid-Year Economic and Fiscal Outlook* measure *Integrated Rural Training Pipeline* and increase training opportunities in rural areas with investment in a Rural Junior Doctor Training Innovation Fund. The Rural Health Multidisciplinary Training Program will continue to deliver high quality rural clinical training placements for medical, nursing, midwifery and allied health students, building on the expansion of the program.

Increasing the capacity and effectiveness of training and education for the future health workforce

Establish a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors.

Source: 2016-17 Health Portfolio Budget Statements, p. 64

2016-17 Target	2016-17 Result
Implement a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors commencing in semester one 2017.	Following a decision of Government this initiative will not be proceeding. Instead, the Government is focussing its investment on distribution of health workforce in rural and remote areas with the continued support of the Rural Health Multidisciplinary Training Program. **Result: Not met**

Through the University Departments of Rural Health, there has been a doubling of the support provided to expand clinical training capacity for nursing, midwifery and allied health students in rural and remote Australia.

[17] Available at: data.hwa.gov.au/

Number of commencing GP trainees funded through the Australian General Practice Training Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 64

Academic Year 2016 Target	Academic Year 2016 Result	2015	2014	2013	2012
1,500	1,500 **Result: Met**	1,500	1,192	1,108	1,000

In total, 1,500 new GP registrars commenced training across Australia with at least 50% of all Australian General Practice Training Program training being undertaken in rural, regional and remote locations.

Number of medical internship positions funded through the Commonwealth Medical Internships Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 64

Academic Year 2016 Target	Academic Year 2016 Result	2015	2014	2013	2012
≤100	100 **Result: Met**	100	N/A	N/A	N/A

Medical students must complete a medical internship to obtain full registration as a general medical practitioner in Australia. The Commonwealth Medical Internships Program provides medical internships for Australian-trained international full-fee paying medical students. The program was established in partnership with the private sector to increase the number of internships available in Australia.

Number of training positions funded through the Specialist Training Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 64

Academic Year 2016 Target	Academic Year 2016 Result	2015	2014	2013	2012
900	900 **Result: Met**	900	900	750	600

The Specialist Training Program seeks to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote and private facilities. The Specialist Training Program is delivered through 12 specialist medical colleges under funding agreements with the Department.

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

Implementation of the *Integrated Rural Training Pipeline for Medicine* measure.
Source: 2016-17 Health Portfolio Budget Statements, p. 65

2016-17 Target	2016-17 Result
Regional training hubs selected through a competitive process by 1 January 2017.	A competitive process was conducted in late 2016. 26 regional training hubs will be established across rural and regional Australia, with implementation to commence in mid-2017. **Result: Met**

The regional training hubs will enable students to continue rural training past university into postgraduate medical training. The hubs will work with local health services to help medical students continue their training through university into postgraduate medical training, and then working within rural Australia.

Percentage of medical students participating in the Rural Health Multidisciplinary Training Program – 1 year rural clinical placement.

Source: 2016-17 Health Portfolio Budget Statements, p. 65

Academic Year 2016 Target	Academic Year 2016 Result	2015	2014	2013	2012
>25%	34% **Result: Met**	33%	33%	33%	32%

The Government continues to support the Rural Health Multidisciplinary Training Program.

In the 2016 academic year, 992 graduating medical students spent a year or more at a rural clinical school, representing 34% of graduating medical students.

Number of weeks of rural multidisciplinary placements supported through the Rural Health Multidisciplinary Training Program.

Source: 2016-17 Health Portfolio Budget Statements, p. 65

Academic Year 2016 Target	Academic Year 2016 Result	2015	2014	2013	2012
20,384	33,000 **Result: Met**	24,290	N/A	N/A	N/A

In the 2016 academic year, 12 University Departments of Rural Health, under the Rural Health Multidisciplinary Training Program, supported over 7,000 undergraduate students to undertake rural clinical placements of two weeks or longer, comprising around 33,000 placement weeks.

This result has exceeded the Department's target. The significant increase in placement weeks was achieved following the Government's decision to double the support provided to expand clinical training capacity for nursing, midwifery and allied health students in rural and remote Australia. This is in addition to new funding for the establishment of three new University Departments of Rural Health in areas that are not serviced by the existing network. These decisions were part of the Government's Building a Health Workforce for Rural Australia initiative, announced in the *2015-16 Mid-Year Economic and Fiscal Outlook*.

Number of practices supported through the Practice Nurse Incentive Program.

Source: 2016-17 Health Portfolio Budget Statements, p. 65

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
4,100	5,487 **Result: Met**	4,594	4,338	4,236	3,978

The Practice Nurse Incentive Program (PNIP) is a demand-driven program that provides incentive payments to practices to support an enhanced role for nurses working in general practice. Uptake of the PNIP has been steadily increasing since commencement in 2012.

Urban areas account for approximately 50% of participating PNIP practices. Rural and remote incentive payments attract a rural loading of up to 50%, depending on rurality to encourage uptake in non-urban areas.

Improving access to health services for rural Australians

Strengthen the quality, capacity and training opportunities of the health workforce. Source: 2016-17 Health Portfolio Budget Statements, p. 66	
2016-17 Target	**2016-17 Result**
Implement a grants program for professional entry nursing, midwifery and allied health students to undertake clinical placements in the private and non-government sectors commencing in semester one 2017.	Following a decision of the Government this initiative will not be proceeding. Instead, the Government is focussing its investment on distribution of health workforce in rural and remote areas with the continued support of the Rural Health Multidisciplinary Training Program. **Result: Not met**

Through the University Departments of Rural Health, there has been a doubling of the support provided to expand clinical training capacity for nursing, midwifery and allied health students in rural and remote Australia. The three new University Departments of Rural Health that were established during the year will further support rural clinical training.

Establishment of the Health Workforce Program to strengthen the capacity of the health workforce. Source: 2016-17 Health Portfolio Budget Statements, p. 66	
2016-17 Target	**2016-17 Result**
Implementation of the new Health Workforce Program by 30 June 2016 with funding agreements to commence in 2016-17.	The new Health Workforce Program was set up during 2015-16 to allow for commencement on 1 July 2016. Programs formerly under the Health Workforce Capacity and Primary Health Care (Rural Health Services) programs formally transferred to the Health Workforce Program on 1 July 2016. **Result: Met**

The consolidation of the Government's access quality and health workforce distribution programs under the single Health Workforce Program allows more transparency and better consideration of those programs.

Improve access to training scholarships for health professionals.
Source: 2016-17 Health Portfolio Budget Statements, p. 66

2016-17 Target	2016-17 Result
Through the delivery of scholarships by a single agency to the health workforce for the 2017 academic year.	The new Health Workforce Scholarship Program (HWSP) combines previous scholarship schemes for the medical, nursing and allied health professions into a single program that achieves consistency in the application process, rules and obligations for all participants. Commencement of the HWSP was delayed until the second half of the 2017 academic year. At this time it is anticipated that the application process for scholarships will be commencing late in the 2017 academic year. **Result: Substantially met**

While previous scholarship programs placed significant focus on undergraduates, the HWSP targets efforts toward further training for existing health professionals in rural, regional and remote Australia through support for up-skilling, continuing professional development and broadening scope of practice through post-graduate study. This scholarship support will bring training costs more in line with urban health professionals.

The Department delayed the commencement of the HWSP to enable a comprehensive consultation process and ensure the new program meets the needs of Australia's health workforce. The design of the HWSP was finalised in early 2017 and a targeted, competitive Grant Opportunity was conducted.

A funding agreement was finalised with the new administrator, Rural Workforce Agencies (led by Health Workforce Queensland) in June 2017.

Medical specialist, GP, allied and other health services provided through the Rural Health Outreach Fund meet the needs of regional, rural and remote communities.
Source: 2016-17 Health Portfolio Budget Statements, p. 66

2016-17 Target	2016-17 Result
Organisations funded to support rural outreach will be guided by existing advisory forums and Indigenous Health Partnership forums, to identify community needs and better meet the needs of regional, rural and remote communities.	Organisations funded through the Rural Health Outreach Fund (RHOF) undertook comprehensive consultation processes to identify and address community needs. **Result: Met**

Organisations funded through the RHOF undertook needs assessment and planning for outreach 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. These consultations were guided by Advisory Forums and Indigenous Health Partnership Forums to identify community needs.

Number of communities receiving outreach services through the Rural Health Outreach Fund.
Source: 2016-17 Health Portfolio Budget Statements, p. 66

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
375	484 **Result: Met**	515	483	460	421

484 regional, rural and remote communities have received services under the Rural Health Outreach Fund. Targets have been exceeded due to jurisdictional fundholders undertaking ongoing reviews and streamlining of services to ensure they are delivered by the most efficient and effective means.

Number of patient contacts delivered through the Rural Health Outreach Fund.
Source: 2016-17 Health Portfolio Budget Statements, p. 66

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
163,000	225,865 **Result: Met**	247,455	216,787	190,460	192,985

There were over 225,865 patient contacts under the Rural Health Outreach Fund.

Number of patient consultations at Royal Flying Doctor Service primary health clinics.
Source: 2016-17 Health Portfolio Budget Statements, p. 66

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
36,000	44,325 **Result: Met**	34,352	36,365	42,608	43,142

Over 44,000 patient consultations were conducted at Royal Flying Doctor Service primary health clinics. Through the clinics, patients are able to access a range of health care services including general practitioner, women or children's health care nurse, population health and emergency care.

Performance criteria from the 2016-17 Corporate Plan

Increased ratio of nurses, GPs and specialists to population in regional and remote areas.
Source: 2016-17 Department of Health Corporate Plan, p. 25

Between 2001 and 2011 the number of General Practitioners, specialists and nurses increased an average of 3.1%, 4.8%, and 3.0% per annum.[18]

In 2014, there were 1,134 full-time equivalent nurses and midwives, 387 medical practitioners and 508 other health professionals employed for every 100,000 people.[19]

Full-time equivalent nurses and midwives and medical practitioners per 100,000 people in 2014

Locations	Nurses and midwives	Medical practitioners
Major cities	1,145	437
Inner regional areas	1,096	292
Outer regional areas	1,077	272
Remote areas	1,239	264
Very remote areas	1,233	264

[18] Source: Australian Bureau of Statistics 2001 and 2011 Census of Population and Housing.

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

Program 2.4: Preventive Health and Chronic Disease Support

The Department met the majority of the performance targets related to Program 2.4: Preventive Health and Chronic Disease Support. However data were not available to report on some of the performance targets for the program.

In 2016-17, the Department supported the Government in its ongoing efforts to increase cancer screening rates. Early detection and treatment saves lives. The National Bowel Cancer Screening Program and the National Breast Cancer Screening Program (BreastScreen Australia) both actively invited participation by eligible Australians. As well as saving lives, increased participation also has the potential to lead to savings for the health system, including from averted cancer treatment costs.

To support the renewal of the National Cervical Screening Program and the expansion of the National Bowel Cancer Screening Program, the Department is developing a National Cancer Screening Register. The national register was to be implemented by 1 May 2017. There was a delay in implementation due to the complexity of assimilating and migrating data from eight State and Territory cervical registers and the Department of Human Services data migration, into one register. The National Cancer Screening Register implementation schedule has been re-phased to incorporate cervical screening data by 1 December 2017 and bowel screening following in mid-2018.

In February 2017, all Health Ministers endorsed the *National Strategic Framework for Chronic Conditions*. The Framework was developed by the Australian Government, in partnership with States and Territories, to address the increasing prevalence and impact of chronic conditions in Australia. It forms the overarching policy for the prevention and management of chronic conditions in Australia. It moves away from a disease specific approach and provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions, improve the health and wellbeing of individuals, and deliver a more sustainable health system.

A review of the mandatory folic acid fortification of wheat flour for bread making (in Australia) and mandatory iodine fortification of bread (in both Australia and New Zealand) was completed in 2017. The joint Food Regulation Standing Committee/Australian Health Ministers' Advisory Council Mandatory Fortification Working Group, chaired by the Department, was established to oversee the review. The Department managed the contracts associated with the review.

Mandatory folic acid fortification was introduced to reduce the incidence of neural tube defects (NTDs) in Australia by improving the folate status of women of child bearing age. Mandatory iodine fortification was introduced to address the re-emergence of iodine deficiencies in the general populations of Australia and New Zealand. The review found that the policy objectives of the initiatives have been achieved. The mandatory folic acid fortification results showed that the rate of decline in NTDs was within the range predicted. A particularly significant decline was seen in the rate of NTDs among babies of teenage mothers, and of Aboriginal and Torres Strait Islander women.

For the first time, Australia has a long-term framework for reducing and preventing the harms associated with alcohol and other drugs through the agreement of a ten-year National Drug Strategy (NDS). The *National Drug Strategy 2017–2026* continues the strong partnership between health agencies, law enforcement and justice agencies and represents the agreement of all governments on the policy priorities for the next ten years to build safe, healthy and resilient Australian communities. The Department was a key contributor in finalising the new NDS both through representation on the National Drug Strategy Committee (and its predecessor the Intergovernmental Committee on Drugs) and also the provision of secretariat support to the Ministerial Drug and Alcohol Forum.

In 2017-18, the Department will continue to support the provision of high quality palliative care in Australia through a range of National Palliative Care Projects. The Department will lead work, in collaboration with States and Territories, to develop a nationally agreed reporting mechanism to complement the *National Strategic Framework for Chronic Conditions*. The Department will also continue implementation of biennial screening under the National Bowel Cancer Screening Program. Three million people will be invited to screen in 2017-18 and all eligible Australians aged 50–74 will be invited to screen every two years by 2020. This will result in more people having bowel cancer detected as early as possible when it can be most successfully treated.

BreastScreen Australia – helping to save the lives of Australian women

Launched in April 2015, the National BreastScreen Australia campaign is contributing to an increase in the number of older women undergoing free breast screenings which could save their lives.

The campaign was developed to improve the early detection of breast cancer. In 2013-14, $55.7 million was provided over four years to expand BreastScreen Australia's target age range from women 50–69 years to women 70–74 years. In 2017-18 a further $64.3 million was provided over four years until 2020-21.

The campaign lets women know that the invitation for free breast screening has been expanded to include women aged 70–74 years. It encourages women to be screened every two years and where to call to make a screening appointment.

The risk of breast cancer increases with age, and by expanding the target age range to include these older women, BreastScreen Australia will deliver up to 220,000 additional screening services over four years and detect up to 600 additional breast cancers per year.

The campaign encourages women to act when they receive their free breast screening invitation every two years:

> ***"… the letter kept staring at me so I decided to just get it over with. They found one lump close to my breast bone which fortunately hadn't spread to the lymph nodes which was good news."*** – Gladys, 77

> ***"If I hadn't have had the breast screen I wouldn't have known I had cancer, I didn't have any symptoms. If I hadn't been prompted to go, I may not have gone for a few years. It could be the difference between me sitting here today and not sitting here at all."*** – Rachel, 53

The campaign has been delivered over three phases, in April 2015, February 2016 and most recently February 2017. Advertising was online through paid search, digital display and social media as well as traditional channels including women's magazines and newspapers.

The proportion of 70–74 year old women who took part in the BreastScreen Australia Program in 2014-15 was 48.7%. The campaign is expected to further increase participation rates in this age group.

Reducing the incidence of chronic disease and complications, and promoting healthier lifestyles

Implementation Plan for the *Australian National Diabetes Strategy 2016–2020* developed in negotiation with jurisdictions.
Source: 2016-17 Health Portfolio Budget Statements, p. 68

2016-17 Target	2016-17 Result
Australian National Diabetes Strategy 2016–2020 Implementation Plan finalised by the end of 2016.	The Implementation Plan is expected to be finalised in the second half of 2017. **Result: Not met**

The finalisation of the Implementation Plan has been delayed by a number of factors including: time taken to finalise the Australian Health Ministers' Advisory Council cost-shared budget bid supporting this work; the comprehensive nature of the national stakeholder activity; and, following a consultation process, the need to comprehensively consider all stakeholder comments on the draft Implementation Plan. The development of the Implementation Plan has been informed by:

- The *Australian National Diabetes Strategy 2016–2020*;
- a national stocktake of diabetes related activities undertaken by all jurisdictions;
- the report from the National Diabetes Strategy Advisory Group to the Minister for Health; and
- the advice of all jurisdictions through the jurisdictional working group.

Australian Government nutrition policy is informed by evidence-based advice.
Source: 2016-17 Health Portfolio Budget Statements, p. 68

2016-17 Target	2016-17 Result
Ongoing promotion and implementation of *Australian Dietary Guidelines* and *Australian Guide to Healthy Eating*.	*Australian Dietary Guidelines* and *Australian Guide to Healthy Eating* were promoted and implemented in a variety of settings. **Result: Met**

Australian Dietary Guidelines and *Australian Guide to Healthy Eating* informed nutrition programs such as the Health Star Rating front-of-pack labelling system, Healthy Weight Guide and Healthy Food Partnership. These resources were also promoted through the Eat for Health website[20] and through brochures and posters.

[20] Available at: www.eatforhealth.gov.au

The Health Star Rating campaign – inspiring positive behavioural change

The Health Star Rating is a front-of-pack labelling system that assesses the nutritional profile of packaged food and assigns it a rating from ½ a star to 5 stars. It provides a quick, easy, standard way to compare similar packaged foods (such as one breakfast cereal against another). The more stars, the healthier the choice.

Australia has one of the highest rates of obesity in the world, with 63.8% of Australians overweight or obese. Food plays a key role in health and wellbeing, but many Australians are struggling to maintain a balanced diet aligned with the Australian Dietary Guidelines. The Health Star Rating system is one of the many initiatives working to address this.

The campaign educates and encourages consumers to use the Health Stars to make healthier choices through a mix of advertising, public relations and online communication. The campaign also encourages industry uptake of the system.

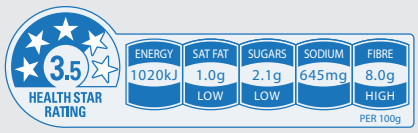
The most recent campaign phase, partnered with social media influencers, was launched in February 2017. This successfully generated positive discussion and questions from consumers around the Health Star Rating system. For example:

> ***"Oh wow! how does that work? I figure there's a team of scientists that work this stuff out. Tell me what you're thinking?"*** – Instagram user

> ***"Find them really useful especially when buying things like muesli bars. So much hidden calories in some of the brands"*** – Instagram user

The most recent campaign evaluation showed an increase in consumer awareness and understanding of the Health Star Rating system, from 59% in June 2016 to 75% in April 2017, equating to 3 in 4 Australians.

The Health Star Rating system continues to increase positive behaviour change. The most recent campaign evaluation found that 20% of all consumers aged 18 and above had bought a product with a higher Health Star Rating than their usual product. This number increased to 46% of consumers who had reported seeing the latest campaign.



A *National Strategic Framework for Chronic Conditions* is developed in partnership with jurisdictions to guide chronic conditions policy and strategies into the future.
Source: 2016-17 Health Portfolio Budget Statements, p. 68

2016-17 Target	2016-17 Result
The *National Strategic Framework for Chronic Conditions* is submitted for approval through the Australian Health Ministers' Advisory Council process by the end of 2016.	The *National Strategic Framework for Chronic Conditions* (the Framework) was submitted through the Australian Health Ministers' Advisory Council approval process for its 2 December 2016 meeting. The Framework was endorsed by all Health Ministers in February 2017 and publicly released on 22 May 2017. **Result: Met**

The Framework supersedes the *National Chronic Disease Strategy 2005* and the associated national service improvement frameworks.

The Framework moves away from a disease specific approach and will provide high level guidance to enable all levels of Government and health professionals to develop future policies, strategies, actions and services to work towards delivery of a more effective and coordinated national response to chronic conditions and their risk factors. This will improve the health and wellbeing of individuals, and deliver a more sustainable health system.

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

Develop advice and policy for the Australian Government on food regulatory issues.
Source: 2016-17 Health Portfolio Budget Statements, p. 68

2016-17 Target	2016-17 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 maternal and infant nutrition, front-of-pack labelling, low tetrahydrocannabinol hemp in food, and labelling of food including health claims, which assisted in evidence-based policy decision making.

Throughout 2016-17, the Department commissioned consumer research on the outcomes of the implementation of key food regulation policies such as front-of-pack labelling, obtained and conducted data analysis of key reports such as the *Australian Burden of Disease Study 2011* and *Australia's Health 2016* from the Australian Institute of Health and Welfare and the *National Health Survey 2014-15* from the Australian Bureau of Statistics. These key reports were used to extract data and longer term trends to provide advice to Government and as evidence in formulating advice and policy development.

Promote a nationally consistent, evidence-based approach to food policy and regulation.
Source: 2016-17 Health Portfolio Budget Statements, p. 68

2016-17 Target	2016-17 Result
Consistent regulatory approach across Australia is achieved through 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 2016-17, 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.

Improving early detection, treatment and survival outcomes for people with cancer

Continue to implement the accelerated expansion of the National Bowel Cancer Screening Program to a biennial screening interval (by 2020).

Source: 2016-17 Health Portfolio Budget Statements, p. 69

2016-17 Target	2016-17 Result
Commencement of invitations to 54, 58 and 68 year olds in 2017 and the continued delivery of communication and program enhancement activities.	Invitations to 54, 58 and 68 year olds commenced on 1 January 2017. Ongoing program enhancement activities are continuing to be delivered. **Result: Met**

Invitations to the additional age cohorts commenced as planned, through existing program implementation arrangements.

Program resources continue to support promotion of the program and encourage participation, as well as assisting with State and Territory based campaign activities to promote the program. The resources are continually reviewed to ensure effective communication with consumers and health care professionals.

Program enhancement activities are underway, including under the Primary Healthcare Engagement Strategy (for example, program-specific promotion, training and resources to support the primary care workforce to engage with the program) and development of an Alternative Pathways Pilot to support increased participation of Aboriginal and Torres Strait Islander peoples.

Support the renewal of the National Cervical Screening Program and expansion of the National Bowel Cancer Screening Program.

Source: 2016-17 Health Portfolio Budget Statements, p. 69

2016-17 Target	2016-17 Result
Implementation of the National Cancer Screening Register to commence on 1 May 2017.	In February 2017 it was announced that the implementation of the National Cancer Screening Register would be delayed and would commence on 1 December 2017. **Result: Not met**

The National Cancer Screening Register schedule has been re-phased to incorporate cervical screening data by 1 December 2017 and bowel screening following in mid-2018. The National Cancer Screening Register system and operations will meet rigorous privacy, security and clinical safety standards before the system is implemented.

Support the expansion of the BreastScreen Australia Program to extend the invitation to Australian women 70–74 years of age through the implementation of a nationally consistent communication strategy.

Source: 2016-17 Health Portfolio Budget Statements, p. 69

2016-17 Target	2016-17 Result
Continue delivery of communication activities such as print, radio and online promotion.	Phase three of communication activities to support the expansion of BreastScreen Australia was launched in February 2017. **Result: Met**

In February 2017, the Government launched the third and final phase of the campaign *An invitation that could save your life* to support the expansion of the BreastScreen Australia Program target age to include women 70–74 years of age.

Public relations activities included a film interview with Deborah Hutton as part of an Australian Women's Weekly editorial activity.

Stakeholder engagement was achieved through mail outs and provision of campaign resources, information packages, case study stories, and stakeholder engagement tools. The Department's Facebook and Twitter accounts were used to promote campaign messages and increase community engagement. Media activities were also adapted for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds.

Number of breast care nurses employed through the McGrath Foundation.

Source: 2016-17 Health Portfolio Budget Statements, p. 70

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
57	57 **Result: Met**	57	57	53	44

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.

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

Source: 2016-17 Health Portfolio Budget Statements, p. 70

2016-17 Target	2016-17 Result	Jan 2014 – Dec 2015	Jan 2013 – Dec 2014	Jan 2012 – Dec 2013
41.0%	Data not available	38.9%[21]	37.0%[22]	36.0%

Results are published over a two-year rolling period. As there is a time lag between an invitation being sent, test results and collection of data from the National Bowel Cancer Screening Program Register, final participation rates for 2016-17 will be published in the Australian Institute of Health and Welfare's *National Bowel Cancer Screening Program: Monitoring report* (1 Jan 2015 – 31 Dec 2016 participation data) in mid-2018.

[21] AIHW 2017. National Bowel Cancer Screening Program: monitoring report 2017. Cancer series no. 103. Cat. no. CAN 103. Canberra: AIHW.

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

Percentage of women 50–69 years of age participating in BreastScreen Australia.
Source: 2016-17 Health Portfolio Budget Statements, p. 70

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
55.0%	Data not available	54.7%	54.0%	53.7%	54.4%

Percentage of women 70–74 years of age participating in BreastScreen Australia.
Source: 2016-17 Health Portfolio Budget Statements, p. 70

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
54.0%	Data not available	52.4%	48.7%	40.8%	N/A

In 2016-17, the Government continued to work with the States and Territories to provide free screening to ensure more Australian women are screened. This included continuing to actively invite women 70–74 years of age to participate in BreastScreen Australia.

As there is a time lag between an invitation being sent, test results and collection of data from registries, participation rates for 2016 and 2017 are not yet available. These participation rates will be published in the Australian Institute of Health and Welfare's *BreastScreen Australia monitoring report* (1 Jan 2015 – 31 Dec 2016 participation results) in September 2018.

Percentage of women in the target age group participating in the National Cervical Screening Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 70

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
57.0%	Data not available	56.3%	56.9%	57.8%[23]	58.2%[24]

As there is a time lag between test results and collection of data from state and territory registers, participation rates for 2016-17 are not yet available. These participation rates will be published in the Australian Institute of Health and Welfare's *Cervical Screening in Australia report* in 2018.

In 2014 and 2015, 56.9% of women aged 20–69 participated in the National Cervical Screening Program (NCSP), which is more than 3.8 million women.

In April 2014, the Medical Services Advisory Committee recommended that a five yearly primary human papillomavirus 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 based on current evidence. In accordance with this advice, the renewal of the NCSP will be implemented on 1 December 2017.

[23] Figures used in the 2015-16 Department of Health Annual Report are not aligned to the data published on the AIHW website. The correct figures are provided here and are sourced using the AS rate on the AIHW website: www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/cancer/overview

[24] Figures used in the 2014-15 Department of Health Annual Report are not aligned to the data published on the AIHW website. The correct figures are provided here and are sourced using the AS rate on the AIHW website: www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/cancer/overview

Improving access to high quality palliative care services for all Australians

Implementation of the National Palliative Care Projects and other activities consistent with the National Palliative Care Strategy 2010.

Source: 2016-17 Health Portfolio Budget Statements, p. 71

2016-17 Target	2016-17 Result
Continue to implement national projects that support quality improvement in palliative care priority areas including education, training, quality standards and advance care planning. Full implementation of the National Palliative Care Projects by 30 June 2017. Following June 2017, evaluation of these projects will inform future palliative and end of life care funding and activities.	National palliative care projects continued to be implemented in 2016-17. These projects supported quality improvement in palliative care priority areas including education, training, quality standards and advance care planning. The National Palliative Care Strategy (the Strategy) was evaluated and a process to update the Strategy in collaboration with State and Territory Governments commenced. **Result: Met**

National palliative care projects include significant investment in advance care planning, workforce development, and national benchmarking and national continuous quality improvement processes. Through collaboration across projects and within the sector, this investment resulted in national training materials, assessment tools, and other resources to assist health, social service and residential aged care providers. This included a focus on the uptake of advance care plans and other mechanisms for increasing individual choice, improving care quality, and engagement in the planning for care goals. These projects have had a major influence on the palliative care sector as well as the broader health system, and have contributed significantly to achieving the objectives of the Strategy and improving access to quality palliative care.

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

Establish a new Centre for Clinical Excellence for Emerging Drugs of Concern, which will provide timely and relevant data and research that informs the development of alcohol and other drug information, early intervention, prevention, and treatment activities.

Source: 2016-17 Health Portfolio Budget Statements, p. 72

2016-17 Target	2016-17 Result
Clinical Centre for Excellence will be established during 2016-17.	The Centre for Clinical Excellence (the Centre) was established on 6 March 2017. **Result: Met**

Under the National Ice Action Strategy, funding has been allocated to the establishment of a Centre for Clinical Excellence for Emerging Drugs of Concern. This centre will support clinical research into new treatment options, training of health professionals and evaluating treatment effectiveness. The contract with the consortium managing the Centre was executed in March 2017. The Centre has identified its board of management and has appointed Associate Professor Nadine Ezard as Director. It is anticipated the Centre will be fully operational in 2017-18.

Provide funding to drug and alcohol organisations to support early intervention, prevention, information, and treatment activities.

Source: 2016-17 Health Portfolio Budget Statements, p. 72

2016-17 Target	2016-17 Result
Implementation of the new Drug and Alcohol Program commencing in 2016-17.	The new Drug and Alcohol Program was implemented in November 2016 and program guidelines were published on the Department's website.[25] **Result: Met**

The new Drug and Alcohol Program will provide funding to a range of drug and alcohol-related activities. This includes funding drug and alcohol treatment services, a range of prevention activities, as well as supporting national leadership activities to guide Australian drug and alcohol policy.

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

Availability of prevention and early intervention substance misuse resources for teachers, parents and students.

Source: 2016-17 Health Portfolio Budget Statements, p. 72

2016-17 Target	2016-17 Result
Continue dissemination of materials and delivery of the National Drugs Campaign including provision of resources for parents, teachers and students. Increasing access to new material through the National Drugs Campaign website as measured by an increase in site visits.	Up-to-date information on alcohol and other drugs continues to be disseminated via the Positive Choices web portal,[26] and the new Cracks in the Ice online Community Toolkit. The Positive Choices web-portal has over 60,000 users and there have been over 427,944 page views. Since the launch of the Cracks in the Ice Community Toolkit on 3 April 2017, there have been over 11,000 requests for hard copy resources by over 370 organisations and community groups. Development work to support future roll out of the next phase of the National Drugs Campaign was undertaken throughout 2016-17. **Result: Met**

The Positive Choices web portal enhances access to evidence-based alcohol and other drug prevention resources and programs, which can be used by schools in an Australian context, for students, parents and teachers.

Over this period, a range of promotional activities have been undertaken including: cross-promotion across other alcohol and other drug websites conferences; seminars; webinars; e-newsletters; Facebook; and Twitter.

[25] Available at: www.health.gov.au/internet/main/publishing.nsf/content/drug-and-alcohol-program

[26] Available at: www.positivechoices.org.au

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

Source: 2016-17 Health Portfolio Budget Statements, p. 73

2016-17 Target	2016-17 Result	2013	2010	2007	2004
<13.4%	15.6% **Result: Not met**	15.0%	14.7%	13.4%	15.3%

The results of the 2016 National Drug Strategy Household Survey[27] show an increase in illicit drug use for people aged 14 years and older from the previous survey conducted in 2013. The marginal increase in illicit drug use is largely driven by increases in cannabis use, and pharmaceutical misuse in older age groups. However, there has been significant overall reduction among Australians aged 14 years and older who have recently or ever used meth/amphetamine. These include a significant reduction in lifetime use of meth/amphetamines from 7% in 2013 to 6.3% in 2016 and a significant reduction in recent (in the last 12 months) use of meth/amphetamines from 2.1% in 2013 to 1.4% in 2016.

Reducing 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: 2016-17 Health Portfolio Budget Statements, p. 73

2016-17 Target	2016-17 Result
Deliver a campaign within the agreed timeframes focussing on groups with high smoking prevalence, which will raise awareness of the dangers of smoking.	The latest phase of the *Don't Make Smokes Your Story* campaign, which focussed on Aboriginal and Torres Strait Islander smokers aged 18–40 years, was launched online on 29 January 2017. **Result: Met**

The *Don't Make Smokes Your Story* campaign supports Indigenous smokers and the broader smoking population to quit smoking and remain smoke free. The campaign commenced on television, print, radio, digital and out-of-home formats on 5 March 2017 and concluded in mid-June 2017. Public relations activities were also implemented to extend the key campaign message.

The initial evaluation research was undertaken in July and August 2016, with 310 Indigenous smokers and recent quitters. Amongst those surveyed, the campaign was found to have high appeal with the primary target audience, effectively demonstrated the benefits of quitting for smokers and their families, and encouraged quit attempts. The story and character of Ted was believable, credible, relatable and appealing. Overall the audience felt the campaign was delivering important messages.

The campaign achieved considerable behaviour change, with 64% of the target audience taking some action towards quitting smoking as a result of seeing the campaign. Of the Indigenous smokers exposed to the campaign, 9% reported that they had quit as a result of the campaign and 27% stated they had reduced the amount they smoke. Substantial proportions of Indigenous smokers stated they had discussed smoking/quitting with family or friends (20%), or with a doctor (8%) or health intermediary (7%). Stated future intentions to change smoking behaviour were also very high.

The 2017 phase of media activity is currently being evaluated.

[27] Available at: www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-key-findings/contents/summary

Percentage of population 18 years of age and over who are daily smokers.[28,29,30]
Source: 2016-17 Health Portfolio Budget Statements, p. 73

2016-17 Target	2016-17 Result	2014-15	2011-12	2007-08
11.3%	Data not available	14.7%	16.3%	19.1%

The Australian Bureau of Statistics National Health Survey (NHS) is undertaken every three years. The next NHS is expected to be reported in early 2019. The latest results from the Australian Institute of Health and Welfare National Drug Strategy Household Survey shows that the smoking rate for daily smokers aged 18 years or older was 12.8% in 2016.

Performance criteria from the 2016-17 Corporate Plan

Increased participation in cancer screening programs.
Source: 2016-17 Department of Health Corporate Plan, p. 23

Refer p. 82-83 for performance criteria addressing participation in cancer screening programs.

Reduction in deaths from bowel, breast and cervical cancer through prevention and early detection.
Source: 2016-17 Department of Health Corporate Plan, p. 23

Cancer screening programs aim to reduce illness and death resulting from cancer through an organised approach to screening. For more information about participation in cancer screening programs, refer p. 76. While the data below show the number of deaths are increasing for each cancer, this is due to the overall increase in population size. A more accurate measure is the mortality rate which adjusts for the overall increase in population size. Mortality rates for these cancers have not been estimated for 2017 however historical trend data on mortality rates for these cancers up until 2014 show decreases in mortality over time.

In 2013, there were 14,962 new cases of bowel cancer diagnosed in Australia (8,214 males and 6,748 females). In 2017, it is estimated that 16,682 new cases of bowel cancer will be diagnosed in Australia (9,127 males and 7,555 females). In 2014, there were 4,071 deaths from bowel cancer in Australia (2,236 males and 1,835 females). In 2017, it is estimated that this will increase to 4,114 deaths (2,136 males and 1,978 females).[31]

In 2013, there were 16,045 new cases of breast cancer diagnosed in Australia (142 males and 15,902 females). In 2017, it is estimated that 17,730 new cases of breast cancer will be diagnosed in Australia (144 males and 17,586 females). In 2014, there were 2,844 deaths from breast cancer in Australia (30 males and 2,814 females). In 2017, it is estimated that this will increase to 3,114 deaths (28 males and 3,087 females).[32]

In 2013, there were 813 new cases of cervical cancer diagnosed in Australia. In 2017, it is estimated that 912 new cases of cervical cancer will be diagnosed in Australia. In 2014, there were 223 deaths from cervical cancer in Australia. In 2017, it is estimated that this will increase to 254 deaths.[33]

[28] In line with the monitoring of progress against the 2018 Council of Agreement Governments performance benchmark for tobacco in the general population, results reported under this target have been amended to show age-standardised data sourced from the Australian Bureau of Statistics National Health Survey (NHS). Updated information from the next NHS is expected to be available in 2018-19.

[29] Results from 2007-08 to 2014-15 as reported under this target in the Department's 2015-16 Annual Report were also sourced from the NHS. However, age-standardised rates were not reported under this target in the 2015-16 Annual Report.

[30] The Department also monitors and reports on smoking prevalence in the general population using data from the National Drug Strategy Household Survey (NDSHS). Data from the NDSHS showed that daily smoking prevalence among those aged 18 years and older in the general population declined from 13.3% in 2013 to 12.8% in 2016. This change was not statistically significant.

[31] Source: Australian Institute of Health and Welfare, 2017. Cancer in Australia 2017. Cancer series no.101. Cat. no. CAN 100. Canberra: AIHW.

[32] Ibid.

[33] Ibid.

Increased upload of Advance Care Plans in My Health Record and timely referral to palliative care services.

Source: 2016-17 Department of Health Corporate Plan, p. 25

In 2016-17 the number of Advance Care Plans uploaded to My Health Record was 1,162, this was an increase from 209 in 2015-16. Data relating to timely referral to palliative care services is not collected.

Reduced rate of risky alcohol use and reduced rate of illicit drug use.

Source: 2016-17 Department of Health Corporate Plan, p. 23

Key findings from the *2016 National Drug Strategy Household Survey* show that between 2013 and 2016, the proportion of people who drank alcohol at levels placing them at lifetime risk of harm (more than two standard drinks per day on average) fell from 18.2% to 17.1%.

Males were more than twice as likely as females to exceed the lifetime risk guidelines in 2016 (24% compared with 9.8%). However, the difference is narrowing as fewer males drank at risky levels in 2016 (significantly declined from 26% in 2013 to 24%) while female risky drinking remained unchanged (10.0% to 9.8%).[34]

In 2016, about 8.5 million (or 43%) people in Australia aged 14 or older had used an illicit drug in their lifetime (including misuse of pharmaceuticals). Around 3.1 million (or 15.6%) had illicitly used in the last 12 months and 2.5 million (12.6%) had used an illegal drug not including pharmaceuticals.

Although the proportion using any illicit drug did not significantly increase from 2013 to 2016, there has been a gradual increase in use since 2007 (from 13.4% to 15.6%) and the number of people illicitly using drugs has increased from about 2.3 million to 3.1 million.[35]

Increase in the number of Commonwealth funded alcohol and other drug treatment episodes.

Source: 2016-17 Department of Health Corporate Plan, p. 25

2015-16	2014-15	2013-14	2012-13
206,635	170,367	180,783	162,362

The above performance criterion is supported by data from the Australian Institute of Health and Welfare.[36] Data for 2016-17 will be released in 2018.

In 2015-16, there were an estimated 133,895 clients aged 10 years and over who received treatment from publicly funded alcohol and other drug (AOD) treatment agencies across Australia. The number of closed treatment episodes has increased over the last 10 years, from 147,325 in 2006-07 to 206,635 in 2015-16. In 2015-16, 14% of all clients were Aboriginal or Torres Strait Islander peoples aged 10 and over.[37]

The top four drugs that led clients to seek treatment were alcohol (32%), cannabis (23%), amphetamines (23%), and heroin (6%). The median age of clients in AOD treatment services is rising, from 31 years of age in 2006-07 to 33 years of age in 2015-16.

[34] The alcohol risk data presented here are reported against guideline 1 and guideline 2 of *The Australian guidelines to reduce health risks from drinking alcohol* released in March 2009 by the National Health and Medical Research Council.

[35] Source: National Drug Strategy Household Survey 2016 – key findings. Available at: www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-key-findings/contents/summary

[36] Source: Australian Institute of Health and Welfare, 2017. Alcohol and other drug treatment services in Australia 2015-16. Drug treatment series no. 29. Cat. no. HSE 187. Canberra: AIHW.

[37] Source: Australian Bureau of Statistics, 2016. Estimates of Aboriginal and Torres Strait Islander Australians, June 2011. ABS cat. no. 3238.0.55.001. Canberra: ABS.

Reduced rate of daily smokers.
Source: 2016-17 Department of Health Corporate Plan, p. 23

Refer p. 87 for performance criterion addressing rates of daily smokers.

Increase in the number of people accessing treatment support services for youth, prostate and breast cancers.
Source: 2016-17 Department of Health Corporate Plan, p. 23

During 2016-17, 1,534 patients were supported by Youth Cancer Services and 657 new patients were referred. This compares to 1,599 patients and 621 new referrals in 2015-16.

In 2016-17, there were 57 Commonwealth-supported breast care nurses located across Australia, with around 86% of these nurses situated in regional and remote communities. This compares to 44 breast care nurses funded in 2012-13.

In 2016-17, there were 14 Full-Time Equivalent Commonwealth-supported prostate cancer nurses. The 2017-18 Budget provided further funding of $5.9 million over three years to expand the current Prostate Cancer Nurse program to fund up to an additional 14 prostate nurses across Australia.

Halt the rising prevalence of adults who are overweight or obese.
Source: 2016-17 Department of Health Corporate Plan, p. 23

This performance criterion is supported by data from the Australian Bureau of Statistics, which is collected approximately every three years through the National Health Survey. Data for 2014-15, indicates that there was no significant increase of adults who were overweight or obese compared to 2011-12 figures.

Program 2.5: Primary Health Care Quality and Coordination

The Department met the majority of performance targets related to Program 2.5: Primary Health Care Quality and Coordination.

In 2016-17, the Department continued to support the Government to strengthen primary health care by focussing on frontline health services and improving delivery, quality and coordination of services.

Primary Health Networks were established to increase the efficiency and effectiveness of medical 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. In 2016-17, Primary Health Networks commenced commissioning activities to address the priorities identified through their baseline regional needs assessments.

The Department commenced implementation of Health Care Homes. Patient enrolments have been deferred to ensure that tools and resources are developed to a high standard. A Health Care Home is a general practice or Aboriginal Community Controlled Health Service that coordinates care for patients with chronic and complex conditions and provides patients with continuity of care using a team based approach according to each patients' needs and wishes.

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

Primary Health Networks move to a commissioning role.
Source: 2016-17 Health Portfolio Budget Statements, p. 75

2016-17 Target	2016-17 Result
All Primary Health Networks commence commissioning activities within the first six months of 2016-17.	All Primary Health Networks commenced commissioning activities within the first six months of 2016-17. **Result: Met**

All Primary Health Networks have commenced their commissioning activities within the target timeframe. Commissioning describes a broad set of linked activities, including: strategic planning through assessing regional health needs; priority setting; procurement of health services through contracts; monitoring service delivery; and reviewing and evaluating the services which have been delivered.

Percentage of Primary Health Networks with updated baseline needs assessments and strategies for responding to identified service gaps.
Source: 2016-17 Health Portfolio Budget Statements, p. 75

2016-17 Target	2016-17 Result
Completed by 100% of Primary Health Networks by 30 June 2017.	100% of Primary Health Networks have submitted updated needs assessments and strategies for responding to identified service gaps. **Result: Met**

All Primary Health Networks have reviewed their initial needs assessments and updated them after analysis of relevant new population health data, market analysis and further stakeholder consultation on service gaps, major health concerns and system capacity issues.

Strategies to address the priority needs identified through the needs assessment process are articulated in annual Primary Health Network activity work plans. These work plans outline the commissioning and integration activities which Primary Health Networks intend to undertake.

Improving models of primary care

Establishment of a governance structure to facilitate stage 1 of a new Health Care Home model.
Source: 2016-17 Health Portfolio Budget Statements, p. 75

2016-17 Target	2016-17 Result
The governance structure will be established by November 2016.	The governance structure was established in July 2016. **Result: Met**

An Implementation Advisory Group and supporting working groups have been established to provide advice to the Department on the implementation of Health Care Homes. These will continue to support the program during stage one.

Number of Primary Health Network regions which have begun patient enrolment into Health Care Homes.
Source: 2016-17 Health Portfolio Budget Statements, p. 75

2016-17 Target	2016-17 Result
Patient enrolment has commenced in up to seven Primary Health Network regions by 30 June 2017.	Patient enrolment has not yet commenced. **Result: Not met**

A deferred and staged commencement of Health Care Homes was announced in the 2017-18 Budget. The deferral will ensure that the tools and resources to support Health Care Homes are available and developed to a high standard. This has included an independent privacy impact assessment to inform implementation, including the development of a Risk Stratification Tool. Health Care Homes will commence service delivery in 20 practices from 1 October 2017 and the remaining practices from 1 December 2017. Health Care Homes will be implemented across ten Primary Health Network regions, as announced in August 2016.

Establishing the Primary Health Care Development Program

Improved delivery of health services through current and emerging interactive communication channels.
Source: 2016-17 Health Portfolio Budget Statements, p. 75

2016-17 Target	2016-17 Result
Increased use of the National Health Services Directory and first point of call services by the Australian population and health professionals.	There has been a 40% increase in the use of the National Health Services Directory and first point of call services. **Result: Met**

Total web enquiries for the period 1 July 2016 to 30 June 2017 was 3,735,318.

The National Health Services Directory continues to provide a comprehensive, reliable and accurate database of Australian health and related services. It provides a central source of information that supports both consumers and health professionals looking for information about services and service providers.

Program 2.6: Primary Care Practice Incentives

The Department met all performance targets related to Program 2.6: Primary Care Practice Incentives.

In 2016-17, the Government continued to fund the Practice Incentives Program (PIP) supporting general practice activities. PIP continued to support general practice activities by encouraging continuing improvements, increased quality of care, enhanced capacity and improved access and health outcomes for patients. With increased use of My Health Record, consumers and health care providers had better access to health information.

In 2016-17 the PIP eHealth Incentive continued to support general practices to remain up-to-date with the latest developments in eHealth technology as it became available.

In 2017-18, the Department will implement the 2017 Budget measure *Quality Improvements in General Practice – implementation of the Practice Incentive Program*. This measure will benefit Indigenous Australians with chronic disease and patients in rural and remote areas through retaining the Indigenous Health Incentive and the Procedural General Practitioner Payment.

Providing general practice incentive payments

Revise the Digital Health PIP Incentive.
Source: 2016-17 Health Portfolio Budget Statements, p. 76

2016-17 Target	2016-17 Result
Provide general practices with access to the revised Digital Health Incentive from 1 August 2016.	From 1 May 2016, general practices have access to the revised Practice Incentives Program (PIP) eHealth incentive. 88% of PIP registered general practices participated in the PIP eHealth Incentive in 2016-17. **Result: Met**

From 1 May 2016, the PIP eHealth Incentive eligibility requirements were changed to encourage the use of the My Health Record system, through the upload of shared health summaries at a rate of 0.5% per 1,000 Standardised Whole Patient Equivalent.

Percentage of general practice (GP) patient care services provided by PIP practices.
Source: 2016-17 Health Portfolio Budget Statements, p. 76

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
84.2%	91.0% **Result: Met**	86.0%	85.0%	84.7%	84.4%

The Government has continued to support improvements to primary health care delivery through the Practice Incentives Program (PIP), with 91% of general practice patient care provided by practices participating in the PIP.

There are 11 incentives under the PIP that focus on eHealth, teaching, Indigenous health, asthma, cervical screening, diabetes, quality prescribing, general practitioner aged care access, procedural services, after hours access and rural health.

Number of general practices participating in the PIP After Hours Incentive.
Source: 2016-17 Health Portfolio Budget Statements, p. 76

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
4,650	5,068 **Result: Met**	4,680	N/A	N/A	N/A

In 2016-17 a total of 5,068 practices were registered for the Practice Incentives Program (PIP) after hours incentive which provides the community with access to after hours primary care.

The PIP after hours incentive consists of five payment levels and provides practices with flexibility to select the level of after hours coverage to provide to their patients.

Program 2.7: Hospital Services

The Department met all performance targets related to Program 2.7: Hospital Services.

On 1 July 2017, the Tasmanian Government resumed ownership of the Mersey Community Hospital, following the signing of the Mersey National Partnership Agreement on 19 June 2017, allowing the facility to operate seamlessly as part of the Tasmanian public hospital system. Funding of $730.4 million has been provided to ensure the sustainability of hospital services for a further ten years.

Supporting the States and Territories to deliver efficient public hospital services

Provide accurate advice to the Minister on public hospital funding policy.
Source: 2016-17 Health Portfolio Budget Statements, p. 77

2016-17 Target	2016-17 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**

Relevant advice to the Minister for Health on public hospital funding matters was provided within agreed timeframes, consistent with Government agreed processes. Advice provided specifically supported the development of the Addendum to the National Health Reform Agreement, and collaborative efforts with State and Territory Governments meetings of the Council of Australian Governments.

Improving health services in Tasmania

Implementation of elective surgery reform activities across Tasmania.
Source: 2016-17 Health Portfolio Budget Statements, p. 77

2016-17 Target	2016-17 Result
Reform activities, including the purchase of elective surgery procedures from public and private providers, are undertaken in accordance with the National Partnership Agreement requirements.	The performance indicator for this schedule required 1,223 surgeries to be completed in the period. Tasmania has reported 1,510 surgeries completed for the period. **Result: Met**

Tasmania has exceeded the planned number of surgeries to be delivered by 287 for the period ending April 2017.

Supporting the Mersey Community Hospital

Ensure that residents of north-west Tasmania have ongoing access to hospital services.
Source: 2016-17 Health Portfolio Budget Statements, p. 78

2016-17 Target	2016-17 Result
The Australian Government will work with the Tasmanian Government to determine future arrangements for the management, administration and operation of the Mersey Community Hospital once the current Heads of Agreement expires on 30 June 2017.	On 19 June 2017, arrangements for the return of the Mersey Community Hospital to Tasmanian Government ownership from 1 July 2017 were formalised, with financial support provided by the Commonwealth to support the continued operation of the hospital. **Result: Met**

On 1 July 2017, the Tasmanian Government resumed ownership of the Mersey Community Hospital, supporting the facility to operate seamlessly as part of the Tasmanian public hospital system. A lump sum payment of $730.4 million in 2016-17 has been provided to Tasmania to ensure the sustainability of hospital services for a period of ten years.

Performance criteria from the 2016-17 Corporate Plan

Shorter waiting times for elective surgery in days.
Source: 2016-17 Department of Health Corporate Plan, p. 25

	2015-16	2014-15	2013-14	2012-13	2011-12
Days waited at 50th percentile	37	35	36	36	36
Days waited at 90th percentile	260	253	262	265	250
Percentage who waited more than 365 days	2.0	1.8	2.4	2.7	2.7

This performance criterion is supported by data from the Australian Institute of Health and Welfare. Data for 2016-17 is not yet available.

Between 2011-12 and 2015-16, the number of admissions from public hospital elective surgery waiting lists increased by an average of 2.4% each year. In 2015-16, approximately 712,000 patients were admitted from public hospital elective surgery waiting lists.

Reduced waiting times for emergency hospital care.
Source: 2016-17 Department of Health Corporate Plan, p. 25

	2015-16	2014-15	2013-14	2012-13	2011-12
Median waiting time (minutes)	19	18	18	19	21
90th percentile waiting time (minutes)	93	93	93	101	108
Proportion seen on time (%)	74	74	75	73	72

This performance criterion is supported by data from the Australian Institute of Health and Welfare. Data for 2016-17 is not yet available.

Patients receiving emergency care are assigned one of five clinically-relevant triage categories which indicate how quickly they should receive treatment. In 2015-16:

- 1 'Resuscitation' (within seconds): 100% of patients were seen on time;
- 2 'Emergency' (within 10 minutes): 77% of patients were seen on time;
- 3 'Urgent' (within 30 minutes): 67% of patients were seen on time;
- 4 'Semi-urgent' (within 60 minutes): 74% of patients were seen on time; and
- 5 'Non-urgent' (within 120 minutes): 93% of patients were seen on time.

In 2015-16, 73% of patients had their treatment completed within four hours.

Outcome 2 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 2.1: Mental Health[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	711,603	712,832	1,229
Departmental expenses			
Departmental appropriation[2]	22,933	21,088	(1,845)
Expenses not requiring appropriation in the budget year[3]	1,360	2,406	1,046
Total for Program 2.1	**735,896**	**736,326**	**430**
Program 2.2: Aboriginal and Torres Strait Islander Health[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	780,207	779,044	(1,163)
Departmental expenses			
Departmental appropriation[3]	41,497	42,052	555
Expenses not requiring appropriation in the budget year[4]	3,231	4,795	1,564
Total for Program 2.2	**824,935**	**825,891**	**956**
Program 2.3: Health Workforce			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[5]	1,292,030	1,243,345	(48,685)
Departmental expenses			
Departmental appropriation[2]	34,686	32,078	(2,608)
Expenses not requiring appropriation in the budget year[3]	1,714	3,702	1,988
Total for Program 2.3	**1,328,430**	**1,279,125**	**(49,305)**
Program 2.4: Preventive Health and Chronic Disease Support[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[6]	384,973	364,773	(20,200)
Departmental expenses			
Departmental appropriation[2]	37,102	42,462	5,360
Expenses not requiring appropriation in the budget year[3]	3,507	4,901	1,394
Total for Program 2.4	**425,582**	**412,136**	**(13,446)**
Program 2.5: Primary Health Care Quality and Coordination			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	405,076	400,498	(4,578)
Departmental expenses			
Departmental appropriation[2]	18,784	18,403	(381)
Expenses not requiring appropriation in the budget year[3]	1,178	2,098	920
Total for Program 2.5	**425,038**	**420,999**	**(4,039)**

Outcome 2 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 2.6: Primary Care Practice Incentives			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	372,977	341,845	(31,132)
Departmental expenses			
Departmental appropriation[2]	2,134	2,129	(5)
Expenses not requiring appropriation in the budget year[3]	103	246	143
Total for Program 2.6	**375,214**	**344,220**	**(30,994)**
Program 2.7: Hospital Services[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	92,534	109,019	16,485
Non cash expenses[4]	33,197	1,355	(31,842)
Departmental expenses			
Departmental appropriation[2]	27,726	26,250	(1,476)
Expenses not requiring appropriation in the budget year[3]	3,821	6,588	2,767
Total for Program 2.7	**157,278**	**143,212**	**(14,066)**
Outcome 2 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	4,039,400	3,951,356	(88,044)
Non cash expenses[4]	33,197	1,355	(31,842)
Departmental expenses			
Departmental appropriation[2]	184,862	184,462	(400)
Expenses not requiring appropriation in the budget year[3]	14,914	24,736	9,822
Total expenses for Outcome 2	**4,272,373**	**4,161,909**	**(110,464)**
Average staffing level (number)	**1,037**	**1,040**	**3**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

[1] This program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

[2] Departmental appropriation combines 'Ordinary annual services (*Appropriation Act No. 1*)' and 'Revenue from independent sources (s74)'.

[3] Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

[4] Non cash expenses relate to depreciation of buildings.

[5] Internal allocation of $4.85m from Program 2.3 to Program 2.4 approved by the Minister for Health post-Budget 2017.

[6] Re-allocation of $0.95m from Program 2.3 to Program 3.1 agreed by Department of Finance.

Outcome 3:
Sport and Recreation

Improved opportunities for community participation in sport and recreation, excellence in high-performance athletes, and protecting the integrity of sport through, investment in sport infrastructure, coordination of Commonwealth involvement in major sporting events, and research and international cooperation on sport issues

Analysis of performance

In 2016-17, the Department continued to work collaboratively with States and Territories, the Australian Sports Commission (ASC) and the Australian Sports Anti-Doping Authority (ASADA) to ensure a coordinated and consistent approach to sports policy in Australia. The Department developed, implemented and supported initiatives that: connected more Australians to local sporting activities; improved the understanding of and ability to respond to integrity threats to sport; educated athletes about ethical decision-making; and raised awareness of water and snow safety.

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

Highlights

Supporting active communities

Support continued for the ASC's *Play.Sport.Australia*. strategy and Sporting Schools program. Over 5,800 schools registered for the Sporting Schools program, offering a fun and supportive environment for school children to participate in sport.
Refer *Program 3.1*

Preparation for major sporting events

The Department continued to work closely with Commonwealth entities and key stakeholders to lead and coordinate Government support for the 2017 men's and women's Rugby League World Cups (co-hosted with New Zealand and Papua New Guinea), and the Gold Coast 2018 Commonwealth Games, to help create enjoyable, safe and successful events.
Refer *Program 3.1*

Protecting the integrity of sport in Australia and internationally

In 2017, Australia assumed the chairing role for the Governments' group for the World Anti-Doping Agency and has strongly promoted global collaboration to fight doping in sport.
Refer *Program 3.1*

Poisons Standard to be updated to include stimulants DMBA and DMHA

To further protect the health and wellbeing of consumers and limit the potential for inadvertent doping violations by athletes, the stimulants 1,3-dimethylbutylamine (DMBA) and 1,5-dimethylhexylamine (DMHA) and similar substances will be included on Schedule 10 of the Standard for the Uniform Scheduling of Medicines and Poisons. This prohibits the sale, supply and use of these substances which have been used in a number of sporting food supplements in recent years.
Refer *Program 3.1*

Looking ahead

- Work will continue to submit scheduling applications for new and untested substances prohibited from sport and potentially unsafe for consumers on the Poisons Standard.
- The Department will contribute to the staging of upcoming major international sporting events to be held in Australia, including:
  - the Gold Coast 2018 Commonwealth Games;
  - the Invictus Games 2018; and
  - the 2020 International Cricket Council World Twenty20.
- The Department is providing support to preliminary work on Football Federation Australia's possible bid for the rights to host the FIFA 2023 Women's World Cup.
- A National Sport Plan is being developed that is intended to be a system wide examination of sport in Australia to strategically position sport into the future. The National Sport Plan will incorporate four key pillars of participation, performance, prevention through physical activity, and integrity.

Purpose, programs and program objectives contributing to Outcome 3

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.
Program 3.1: Sport and Recreation
Increasing participation in sport and recreation
Supporting upcoming major sporting events
Improving water and snow safety
Protecting the integrity of sport
Performance criteria from the 2016-17 Corporate Plan

Program 3.1: Sport and Recreation

The Department met all performance targets related to Program 3.1: Sport and Recreation.

The Department continues to engage with a wide range of stakeholders and interest groups in relation to sports matters, recognising that the system, from grass roots to elite, relies on investment and cooperation from many stakeholders. This includes multiple levels of government, international sporting organisations, international bodies and domestic representative and commercial groups.

In 2016-17, the Department continued to work with State and Territory Governments and the Australian Sports Commission (ASC), to develop and implement initiatives that encourage more Australians to participate in sport. The Department supports the ASC on its implementation of the *Play.Sport.Australia.* strategy which has a strong focus on connecting adults and children with local community sporting activities. The Government also announced the development of a National Sport Plan to provide a long term strategy for the Australian sporting sector.

The Department continued to provide specific advice and support to a variety of sports stakeholders to address a range of integrity threats, including doping, match-fixing, illicit drug use in sport, and criminal association. In addition, the Department continued working directly with sports to identify specific threats and construct robust internal integrity frameworks. The Department also worked closely with the Australian Sports Anti-Doping Authority (ASADA) and the ASC on athlete education programs, and with the Therapeutic Goods Administration to improve regulation of substances prohibited from sport.

Australia continues to operate anti-doping arrangements that are considered by many anti-doping experts to be among world's best practice. Stimulants 1,3-dimethylbutylamine (DMBA) and 1,5-dimethylhexylamine (DMHA) will be listed on Schedule 10 of the Standard for the Uniform Scheduling of Medicines and Poisons to limit the potential for inadvertent doping violations by athletes. Minimising doping in sport boosts community confidence in sporting outcomes and reduces negative health impacts that can be caused through use of performance enhancing substances.

In conjunction with ASADA, the Department developed and launched an e-learning program about ethical decision-making in sport, as well as developed lesson plans on sport integrity for the National Curriculum for Health and Physical Education. Over 600 participants across 55 sports have completed the e-learning program. Almost 90 per cent of participants who completed the feedback questionnaire strongly agreed or agreed that they are now more likely to consider their values and principles when making decisions around sport integrity issues.

Early preparations have also commenced for upcoming major sporting events, assisting to ensure that these events will be enjoyable and safe for athletes and spectators.

The Department has supported the Governments contribution to safer communities through the provision of water and snow safety equipment as well as awareness initiatives and increased support to Surf Life Saving Australia to improve training for life savers.

Increasing participation in sport and recreation

Coordinate across Government to support the development and implementation of strategies and policies to increase participation in sport and physical activity from community to elite level, reduce injury risks and improve health outcomes for people involved in sport, through the provision of information to the community and sport sector, and advice to Government entities.

Source: 2016-17 Health Portfolio Budget Statements, p. 82

2016-17 Target	2016-17 Result
Strategies and policies developed during 2016-17 encompass sport and population health outcomes, deliver whole-of-government objectives, and are implemented in consultation with stakeholders in a timely manner.	The Department, in consultation with relevant stakeholders, continued to develop and implement strategies, policies and programs aimed at increasing participation in sport and physical activity. **Result: Met**

In 2016-17, the Department engaged with States and Territories through the Committee of Australian Sport and Recreation Officials to review and update the National Sport and Active Recreation Policy Framework with a new Strategic Agenda and clear roles and responsibilities. The Department also continued to work closely with the Australian Sports Commission on the *Play.Sport.Australia.* strategy, and the Sporting Schools program.

In May 2017, the Minister for Sport announced the development of a National Sport Plan (the Plan) to assist with understanding Australia's expectations of the sports sector, and provide a long term strategy for the future of sport in Australia. The Plan will consider participation, performance, prevention through physical activity, and integrity.

Supporting upcoming major sporting events

Well-coordinated preparation across Government entities to facilitate the implementation of strategies and policies, which support the hosting of major international sporting events and achieving legacy benefits in Australia.

Source: 2016-17 Health Portfolio Budget Statements, p. 82

2016-17 Target	2016-17 Result
Strategies and policies are implemented during 2016-17, in consultation with key stakeholders, which contribute to the Australian Government's delivery of a safe and secure event for participants and spectators.	The Department worked closely with key stakeholders to develop coordination strategies and progress preparations for upcoming major sporting events in Australia. **Result: Met**

In 2016-17, the Department worked with other Government entities, event organisers and State and Territory Governments on a number of upcoming major events, including: the men's and women's Rugby League World Cups 2017; Gold Coast 2018 Commonwealth Games; Invictus Games 2018; and 2020 International Cricket Council World Twenty20.

In supporting these events, the Department contributed to developing policies and strategies covering a wide array of whole-of-government activity. This included: customs, immigration and biosecurity arrangements; radio communication and spectrum management; anti-doping; legacy, trade and tourism; and security.

Improving 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: 2016-17 Health Portfolio Budget Statements, p. 83

2016-17 Target	2016-17 Result
Water and snow safety programs result in increased water and snow safety awareness – as reported by water and snow safety organisations.	The Department continued to develop water and snow safety strategies and supported key organisations to deliver programs and interventions promoting water and snow safety to Australians and international visitors, and to raise awareness of the dangers in aquatic and alpine environments. **Result: Met**

Throughout 2016-17, the Department continued to support key participation initiatives and strategies, including water and snow safety organisations and projects to support a 50% reduction in drowning deaths by 2020. These were achieved through: the National Recreation and Safety Program; the Saving Lives in the Water (Element 1 and Element 2) initiative; and the Water Safety: Reduce Drownings initiative.

According to Royal Life Saving Society - Australia's 2017 Drowning Report (the Report), in 2016-17, 291 people drowned in Australian waterways. This represents an increase of 3% from the previous year.

The Report highlighted the issue of fatal drowning rates amongst males. During the 2015-16 period, 74% of all drowning deaths were males. The Department continues to work with water safety organisations to address the issue of the high rates of males drowning.

A new element in the 2017 Report considered the rates of drowning per 100,000 population. Interim analysis shows an overall 24% reduction in fatal drowning since 2002-03, when compared to population growth per 100,000 over this period. Royal Life Saving Society Australia estimates this reduction equates to approximately 90 deaths averted per year.

As part of the *2015-16 Mid-Year Economic and Fiscal Outlook*, Surf Life Saving Australia received an additional $10 million over four years to improve volunteer training for Australia's life savers. Surf Life Saving Australia is using the additional training funding to update training technology, expand the scope of volunteer training, upskill existing trainers and assessors, and expand recruitment.

Protecting 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: 2016-17 Health Portfolio Budget Statements, p. 84

2016-17 Target	2016-17 Result
Sports integrity education platforms are developed and supported, including through regular meetings with sporting organisations, State and Territory Governments, industry stakeholders and relevant entities both nationally and internationally.	The Department continued to develop and support sports integrity platforms, and build the resilience of Australian sport to integrity threats, through regular interactions with stakeholders. **Result: Met**

In 2016-17, five sport integrity network meetings were held with participants drawn from sporting organisations, Commonwealth and State and Territory Governments, regulators, industry and law enforcement.

An e-learning program focussed on ethical decision-making in sport was developed and launched through a joint project with the Department and the Australian Sports Anti-Doping Authority (ASADA). The e-learning program provides users with a framework on ethical decision-making, and includes scenarios on doping, illicit drug use, and match-fixing. The Department and ASADA have also developed lesson plans on sports integrity for the National Curriculum for Health and Physical Education.

Over 600 participants across 55 sports have completed the e-learning program. Almost 90% of participants who completed the feedback questionnaire strongly agreed or agreed that they are now more likely to consider their values and principles when making decisions around sport integrity issues.

In August 2016, the Department updated content in the Illicit Drugs in Sport e-learning program. This program assists Australian sporting organisations to educate their members of the harms associated with illicit drug use in sport.

Increased capacity of Australian sporting organisations to address sports integrity issues.
Source: 2016-17 Health Portfolio Budget Statements, p. 84

2016-17 Target	2016-17 Result
Ongoing assessment of integrity vulnerabilities of priority national sporting organisations and delivery of support for relevant sports integrity initiatives.	In 2016-17, the Department completed three sports integrity threat assessments for national sporting organisations. **Result: Met**

Sports integrity assessments and ongoing interactions with sporting organisations reinforced the importance of addressing and responding to integrity threats. Direct funding was provided to one sporting organisation (refer case study on p. 105) with specific vulnerabilities to allow the development of a comprehensive integrity framework. The Department continued to collaborate closely with the Australian Criminal Intelligence Commission on a range of sports integrity matters.

Protecting the integrity of Australian sport

The National Integrity of Sport Unit (NISU) was formed in 2012 to provide a central coordination point for the protection of Australian sport from rising integrity threats including match-fixing, doping, criminal infiltration and other unethical conduct.

As part of its protection strategy the NISU developed the Sports Integrity Threat Assessment Methodology, drawing on criminal intelligence threat analysis methods, to systematically identify specific integrity threats to individual sports in Australia. To date, 23 sports have been examined, providing an understanding of threats to their integrity and ways to protect it.

One of the sports analysed was Australian basketball, identifying integrity threats, including significant on- and offshore betting markets on Australian basketball competitions. During 2016-17, Health and Basketball Australia joined forces, with support from the Australian Sports Commission, to completely revamp Basketball Australia's sports integrity framework. The framework addresses issues such as match-fixing, doping and illicit drug use, as well as promoting best practice in the application of sports science and sports medicine. Education and communication activities were central to ensuring the Australian basketball community was aware of the new framework and its obligations. This framework also provides a model for other sports, nationally and internationally.

Protecting the integrity of Australian sport means we can be confident our sport comprises fair and honest performances and outcomes. Positive conduct by athletes, administrators, officials, supporters and other stakeholders, on and off the sporting arena, maintains the reputation and standing of sport overall.

Delivery of internationally compliant Australian anti-doping arrangements.
Source: 2016-17 Health Portfolio Budget Statements, p. 84

2016-17 Target	2016-17 Result
Australian anti-doping arrangements are compliant with the World Anti-Doping Code, and address doping in the contemporary sports environment.	Australia's anti-doping arrangements comply with the World Anti-Doping Code, and address doping in the contemporary sports environment. **Result: Met**

In 2016-17, the Department continued to support the operation of the World Anti-Doping Agency (WADA) and the Australian Sports Anti-Doping Authority (ASADA), and the integrity of sport by combating doping in sport.

In addition, the Department supported the Minister for Sport in discharging responsibilities in relation to anti-doping, including through:

- tabling of the Government's response to the recommendations from the 2013 Senate Inquiry into the Practice of Sports Science;
- enhancing collaboration by WADA Public Authorities including hosting a meeting in Montreal on 16 May 2017;
- facilitating the Australian Government's involvement at the WADA Executive and Foundation Board meetings;
- working with the Department of Industry, Innovation and Science to sustain the operation of Australia's WADA-accredited testing laboratory; and
- managing administrative processes that support the application of Australia's anti-doping legislation (for example, appointments, amendments to legislation).

Performance criteria from the 2016-17 Corporate Plan

Major international sporting events including the Rugby League World Cup 2017 and Gold Coast 2018 Commonwealth Games are supported by Australian Government agencies in the planning and delivery phases.

Source: 2016-17 Department of Health Corporate Plan, p. 26

Refer p. 102 for performance criterion addressing major international sporting events supported by the Australian Government.

Improved water safety outcomes in Australia.

Source: 2016-17 Department of Health Corporate Plan, p. 26

Refer p. 103 for performance criterion addressing water safety outcomes.

WADA identifies Australia's anti-doping arrangements as consistent with the principles of the World Anti-Doping Code, as required by the Convention.

Source: 2016-17 Department of Health Corporate Plan, p. 26

Refer p. 105 for performance criterion addressing Australia's anti-doping arrangements.

Outcome 3 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 3.1: Sport and Recreation[1]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[2]	18,475	19,466	991
Special Accounts			
Sport and Recreation	407	298	(109)
Departmental expenses			
Departmental appropriation[3]	7,126	8,205	1,079
Expenses not requiring appropriation in the budget year[4]	715	903	188
Total for Program 3.1	**26,723**	**28,872**	**2,149**
Outcome 3 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[2]	18,475	19,466	991
Special Accounts	407	298	(109)
Departmental expenses			
Departmental appropriation[3]	7,126	8,205	1,079
Expenses not requiring appropriation in the budget year[4]	715	903	188
Total expenses for Outcome 3	**26,723**	**28,872**	**2,149**
Average staffing level (number)	**49**	**51**	**2**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

1 This program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

2 Re-allocation of $0.95m from Program 2.3 to Program 3.1 agreed by Department of Finance.

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 are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

Outcome 4:
Individual Health Benefits

Access to cost-effective medicine, medical, dental and hearing services, and improved choice in health services, including through the Pharmaceutical Benefits Scheme, Medicare, targeted assistance strategies and private health insurance

Analysis of performance

In 2016-17, the Government continued to improve access to cost-effective medical, dental and hearing services, and medicines. The Government worked to improve choice in health services and targeted assistance strategies through the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS).

The Government continued to work with health insurers to provide affordable private health insurance and to support individuals and families with the cost of private health insurance through the private health insurance rebate. During 2016-17, the Department also enhanced the integrity of health provider claiming and supported an independent taskforce to continue to methodically review all items currently on the MBS.

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

Highlights

More than 2,850 MBS items are currently under active review

Aligning rebated services with contemporary, evidence-based medical practices are improving patient outcomes.
Refer *Program 4.1*

Streamlining evaluation of genomic testing for heritable medical conditions

A Clinical Utility Card was developed for use by the Medical Services Advisory Committee to streamline the evaluation of genomic test applications for heritable medical conditions in Australia that can significantly affect clinical management and patient outcomes.
Refer *Program 4.1*

Improving pathology services

The Quality Use of Pathology Program provided funding to support a range of quality initiatives to improve requesting processes and service provision. The National Pathology Accreditation Program continues to assure that laboratories follow best practice including through quality standards for cervical screening and genomic testing.
Refer *Program 4.1*

Improving access and reducing red tape for hearing service providers

The creation of a new website and online portal improved access and reduced red tape for hearing service providers and suppliers of hearing technology, making claiming and payments for hearing services and devices faster.
Refer *Program 4.2*

Highlights continued on next page

Recognising and strengthening the role of pharmacists

Variations to the Sixth Community Pharmacy Agreement recognise and strengthen the role of pharmacists in providing medicines, services and advice to patients.
Refer *Program 4.3*

Raised $29 million in debts and recovered more than $13 million

Changes to the provider compliance program through the use of new and sophisticated data analytics capability and behavioural economics approaches have seen improvements in the integrity of health provider claiming.
Refer *Program 4.7*

More than 4,000 eligible children and young people have benefited from continuous glucose monitoring

Access to continuous glucose monitoring products were fully subsidised for eligible children and young people aged under 21 years with type 1 diabetes through the National Diabetes Services Scheme.
Refer *Program 4.8*

Looking ahead

- Implement changes to the Radiation Oncology Health Programs Grants Scheme to ensure the ongoing quality and efficacy of radiotherapy equipment and treatment in Australia for cancer patients.
- Streamline the PBS listing processes and implement strategic agreements with our industry partners.
- Examine reforms to private health insurance to simplify and deliver better value to consumers; improve transparency; simplify consumer products; and improve affordability.
- Review the schemes funded under the Indemnity Insurance Fund to examine whether the current schemes remain fit for purpose and to inform potential future reform options for the schemes.
- Strengthen compliance against prohibited practices under the *Health Insurance Act 1973* relating to pathology approved collection centres.
- Create an Office of Health Technology Assessment to build the Department's expertise as world leaders in health technology assessment, and its integral role in making available to all Australians the best health services, devices and medicines at an affordable cost.

Purpose, programs and program objectives contributing to Outcome 4

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.
Program 4.1: Medical Benefits
Supporting a Medicare System that is modern, sustainable and in line with current clinical evidence
Facilitating access to health services for Australians who travel to countries with a Reciprocal Health Care Agreement
Supporting access to clinically necessary medical services, which are not available in Australia
Providing financial assistance to eligible persons for out-of-pocket costs for ill health or injury arising from specific overseas disasters
Supporting safe and effective diagnostic imaging services
Supporting quality pathology services
Improving access to prostheses for women who have had a mastectomy as a result of breast cancer
Supporting the delivery of high quality radiation oncology services
Performance criteria from the 2016-17 Corporate Plan
Program 4.2: Hearing Services
Supporting access for eligible clients to quality hearing services
Supporting research into hearing loss prevention and management
Program 4.3: Pharmaceutical Benefits
Supporting timely access to medicines and pharmacy services
Listing cost-effective, innovative, clinically effective medicines on the PBS
Increasing the sustainability of the PBS
Providing access to new and existing medicines for patients with life threatening conditions
Undertaking post-market surveillance
Monitoring the use of diagnostics, therapeutics and pathology
Program 4.4: Private Health Insurance
Supporting the affordability of private health insurance through the private health insurance rebate
Ensuring access to safe and effective medical devices through the Prostheses List
Promoting a viable, sustainable and cost-effective private health insurance sector
Performance criteria from the 2016-17 Corporate Plan
Program 4.5: Medical Indemnity
Ensuring the insurance products are available and affordable
Ensuring the stability of the medical indemnity insurance industry
Program 4.6: Dental Services
Improving access to public dental services for children and adults
Performance criteria from the 2016-17 Corporate Plan
Program 4.7: Health Benefit Compliance
Supporting the integrity of health provider claiming
Program 4.8: Targeted Assistance – Aids and Appliances
Improving health outcomes for people with diabetes across Australia through the provision of subsidised products and self-management services
Assisting people with a stoma by providing stoma related products
Improving the quality of life for people with Epidermolysis Bullosa

Program 4.1: Medical Benefits

The Department met the majority of performance targets related to Program 4.1: Medical Benefits.

The Department continued its commitment to improving health service delivery to the Australian community by supporting the Medicare Benefits Schedule (MBS) Taskforce in their work to review all MBS items. This review aims to improve patient outcomes by aligning MBS items with evidence-based, contemporary best-clinical practice. The Taskforce, with the support of the Department, has established over 65 clinical committees and working groups with more than 440 clinicians, consumers and health system experts participating. Currently more than 50 per cent of over 5,700 MBS items are under review. While the performance target on the MBS Review has not been met, the Taskforce has made significant progress towards reviewing the large number of items currently listed on the MBS.

The Medical Services Advisory Committee (MSAC) developed a Clinical Utility Card (CUC) to assist in streamlining the evaluation of genomic test applications for heritable medical conditions in Australia. The CUC can significantly affect clinical management and improve patient outcomes. The CUC is a pathway to/through MSAC, that permits evaluation of a group of genes or gene mutations for diagnostic testing. Instead of evaluating the cost-effectiveness of testing each individual gene mutation in the group, the CUC relies on a 'star performer' gene to drive the evaluation. This is expected to provide patients with access to a wider range of genetic tests for a given disease and improve disease detection and treatment rates, with minimal increase in cost of testing.

During 2016-17, the Department continued work to ensure that pathology services are safe and effective by developing national accreditation standards for pathology laboratories. The National Pathology Accreditation Advisory Council continued to refine the accreditation framework, including producing best practice standards for cervical screening and genomic testing. Four accreditation standards were developed and published. This included two new standards and two revised standards.

Supporting a Medicare System that is modern, sustainable and in line with current clinical evidence

Continued review of MBS items to ensure they are safe, effective and cost-effective.
Source: 2016-17 Health Portfolio Budget Statements, p. 91

2016-17 Target	2016-17 Result
The majority of MBS items have been reviewed by June 2017.	13% of items have been reviewed by the Clinical Committees and finalised. More than 50% are currently under review. **Result: Not met**

The MBS Review Taskforce, clinical committees (including in diagnostic imaging and pathology), and working groups are supported in their work by the Department.
Source: 2016-17 Health Portfolio Budget Statements, p. 91

2016-17 Target	2016-17 Result
The Department supports public consultation and stakeholder engagement processes as agreed by the MBS Taskforce.	The Department has provided secretariat support for 18 Clinical Committees and over 40 working groups. The Clinical Committees have been assisted to review items and draft recommendations for public consultation. **Result: Met**

More than 50% of over 5,700 Medicare Benefits Schedule (MBS) items are currently under active review. Since the Review commenced, over 65 Clinical Committees and working groups were established. 13% of items have been reviewed by Clinical Committees with draft recommendations prepared or agreed by the Taskforce for public consultation.

The review process has previously encountered challenges associated with the planning and phasing in of new committees. The clinical committee process established by the Taskforce is resource intensive but critical to ensuring broad support for Taskforce recommendations. The Department and the Taskforce continue to look for opportunities to refine this process.

The Taskforce has finalised its advice to the Minister on 232 MBS items, with 11 reports endorsed for public consultation. The Taskforce will consider stakeholder feedback from public consultation and provide its final recommendations to the Government.

As part of the 2017-18 Budget, the Government agreed to continue the Review for a further three years.

Facilitating access to health services for Australians who travel to countries with a Reciprocal Health Care Agreement

Australians visiting the 11 Reciprocal Health Care Agreement countries receive necessary treatment, and visitors from those countries are able to access public health care in Australia.
Source: 2016-17 Health Portfolio Budget Statements, p. 91

2016-17 Target	2016-17 Result
Timely resolution of issues related to access to health services encountered by Australians visiting a country with a Reciprocal Health Care Agreement, and for visitors to Australia accessing the Australian health care system.	Visitors from Reciprocal Health Care Agreement countries received necessary treatment and no significant issues were encountered when accessing public health care. All minor issues were resolved in a timely manner. **Result: Met**

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

During 2016-17, 110,711 MBS services were provided to visitors to Australia under the Reciprocal Health Care Agreements with a total of $7.34 million paid in benefits.

Supporting access to clinically necessary medical services, which are not available in Australia

Financial assistance is provided to eligible applicants through the Medical Treatment Overseas Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 92

2016-17 Target	2016-17 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, with financial assistance provided to eligible applicants. **Result: Met**

In 2016-17, the Department received 19 applications for financial assistance. Of these, 12 individuals were eligible and received funding to undergo treatment overseas. Assessment of these applicants was supported by independent expert advice from professional medical groups.

Providing financial assistance to eligible persons for out-of-pocket costs for ill health or injury arising from specific overseas disasters

Financial assistance to eligible Australians for out-of-pocket health care costs incurred as a result of specific overseas disasters is provided.
Source: 2016-17 Health Portfolio Budget Statements, p. 92

2016-17 Target	2016-17 Result
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 2016-17, the Department of Human Services paid $409,864 for 2,224 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 2016-17, all reimbursements were provided in a timely manner.

Supporting safe and effective diagnostic imaging services

Commence a review of the Diagnostic Imaging Accreditation Scheme to strengthen the standards and streamline processes.
Source: 2016-17 Health Portfolio Budget Statements, p. 93

2016-17 Target	2016-17 Result
The Diagnostic Imaging Accreditation Scheme Advisory Committee agrees and commences their forward work plan by January 2017.	The Diagnostic Imaging Accreditation Scheme Advisory Committee has met on two occasions and agreed a forward work plan on 30 June 2017. **Result: Not met**

The Diagnostic Imaging Accreditation Scheme Advisory Committee (the Committee) considered a planning framework and priorities at their inaugural meeting in December 2016. The Committee requested further information about the operation of the Scheme before agreeing a forward work plan. A consolidated forward work plan was not agreed by January 2017. The Committee had agreed a small number of priorities and a framework for finalising the elements of an ongoing work plan.

As at 30 June 2017, the Committee had agreed the elements of an ongoing work plan, a Stakeholder Engagement Plan and convened a small number of working groups to provide advice on the interpretation of current standards. Work has commenced on designing a process for reviewing and developing future standards.

The Committee comprises individuals with expertise in diagnostic imaging policy, practice, standards development and accreditation, health administration and health consumer advocacy. The Committee's role is to provide advice on the development of standards, implementation arrangements and conformity assessment, and associated regulation impacts.

Supporting quality pathology services

Number of new and/or revised national accreditation standards produced for pathology laboratories.
Source: 2016-17 Health Portfolio Budget Statements, p. 93

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
4	4 **Result: Met**	3	4	13	0

In 2016-17, four accreditation standards were produced for pathology laboratories. Two new standards and two revised standards were listed, respectively. The standards published were:

- Requirements for Human Genome Testing Utilising Massively Parallel Sequencing;
- Requirements for Laboratories Reporting Tests for the National Cervical Screening Program;
- Requirements for Transfusion Laboratory Practice; and
- Requirements for Gynaecological (Cervical) Cytology.

Percentage of Medicare-eligible pathology laboratories meeting accreditation standards.
Source: 2016-17 Health Portfolio Budget Statements, p. 93

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

Pathology laboratories must meet specific accreditation standards in order to be accredited and thereby eligible for Medicare benefits for pathology services.

Improving 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: 2016-17 Health Portfolio Budget Statements, p. 93

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
90%	95% **Result: Met**	98%	98%	98%	98%

Of the 14,393 eligible claims made, 95% were processed within 10 business days of lodgement.

Supporting the delivery of high quality radiation oncology services

Undertake a review of the Radiation Oncology Health Program Grants (ROHPG) Scheme.
Source: 2016-17 Health Portfolio Budget Statements, p. 94

2016-17 Target	2016-17 Result
Review of the Radiation Oncology Health Program Grants Scheme to be completed by the first quarter of 2016-17. The review also provides an opportunity to respond to the 2015-16 Australian National Audit Office audit.	The review of the ROHPG Scheme was complete in August 2016. **Result: Met**

The Australian National Audit Office audit recommended that the Department should review the underlying program design of the ROHPG Scheme, including mechanisms to improve pricing transparency.

In 2016-17, the Department undertook a review of the Scheme. Reflecting the findings of the review,[38] the Government announced in the *2016-17 Mid-Year Economic and Fiscal Outlook* the measure *Radiation Oncology Health Program Grants Scheme – Efficiencies*. This measure aims to achieve efficiencies of $18.7 million over four years from 1 July 2017 through improvements in the administration of the ROHPG by: focussing funds towards high-cost linear accelerators and directing these funds to areas of need as agreed by States and Territories; and providing support of high use of radiotherapy as an affordable treatment in a way that is sustainable and consistent with broader Commonwealth policy and funding. Further, this measure has continued to provide targeted and sustainable Commonwealth support for radiotherapy as a high quality affordable treatment, while funding was provided to the Australian Radiation Protection and Nuclear Safety Agency for a new linear accelerator to ensure radiotherapy services are safe, accurate and high quality.

The number of sites delivering radiation oncology.
Source: 2016-17 Health Portfolio Budget Statements, p. 94

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
82	83 **Result: Met**	80	75	69	66

The Department continues to improve access to high quality radiation oncology services by funding approved equipment, quality programs and initiatives to support the radiation oncology workforce and the number of sites providing radiation oncology. These payments allow for equipment to be replaced at the end of its lifespan so that treatment is delivered with up-to-date technology.

Performance criteria from the 2016-17 Corporate Plan

Continued review of Medical Benefits Schedule (MBS) items to ensure they are safe, effective and cost-effective, with the majority reviewed by June 2017.
Source: 2016-17 Health Corporate Plan, p. 25

Refer p. 113 for performance criterion addressing the continued review of MBS items.

[38] Available at: www.health.gov.au/internet/main/publishing.nsf/Content/radonc-rohpg-review

Program 4.2: Hearing Services

The Department met all performance targets related to Program 4.2: Hearing Services.

The Hearing Services Program 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.

The Department engaged with the hearing sector to facilitate the development of a Service Delivery Framework. Following completion of this work it was agreed that hearing services would be included in the development of the National Safety and Quality Health Service Standards for primary care settings and governed by the Australian Commission on Safety and Quality in Health Care under its Australian Health Services Safety and Quality Accreditation Scheme.

During 2016-17, the Government continued to fund research and development activities into hearing health, prevention and rehabilitation. The creation of a new website and online portal, through the Hearing Services Online Project, has improved access and reduced red tape for hearing service providers and suppliers of hearing technology. The final portal was released on 31 December 2016.

Supporting access for eligible clients to quality hearing services

Quality service provision and client outcomes are better supported through a proposed hearing sector endorsed Service Delivery Framework.
Source: 2016-17 Health Portfolio Budget Statements, p. 95

2016-17 Target	2016-17 Result
Hearing sector endorsement of the proposed Service Delivery Framework is achieved by December 2016.	The hearing sector continued to develop the Service Delivery Framework in 2016 and collaborated through an Implementation Planning Steering Group to determine the most appropriate regulation model. The hearing sector subsequently endorsed self-regulation of key components of the Service Delivery Framework, and the inclusion of hearing services in the National Safety and Quality Health Service Standards for primary care under development by the Australian Commission on Safety and Quality in Health Care. **Result: Met**

During 2016, the hearing sector agreed that hearing services should be included in the National Safety and Quality Health Services Standards for primary care settings. The Australian Commission on Safety and Quality in Health Care is now working with the sector to develop the standards.

Policies and program improvements are developed and implemented in consultation with consumers and service providers. Source: 2016-17 Health Portfolio Budget Statements, p. 95	
2016-17 Target	**2016-17 Result**
Stakeholders have adequate opportunities to participate in consultations, including consultation on National Disability Insurance Scheme transition arrangements.	There were no consultations held on National Disability Insurance Scheme transition arrangements in 2016-17. Stakeholder views were sought on a review of service items, fees and assistive technology supply. This was followed by the release of a public discussion paper, with a two month response period. Thirty seven responses were received and are currently being analysed. **Result: Met**

Ongoing work with service providers to raise awareness of their obligations under the program continues. An independent organisation has been contracted to undertake a review of services and technology supply for the program which includes an initial information gathering exercise followed by a public discussion paper seeking comment and input.

Number of people who receive voucher services nationally. Source: 2016-17 Health Portfolio Budget Statements, p. 95					
2016-17 Target	**2016-17 Result**	**2015-16**	**2014-15**	**2013-14**	**2012-13**
723,319	713,182 **Result: Met**	692,283	669,793	647,545	636,389

The voucher component of the program is client demand-driven, and the projected target is an estimation based on population parameters. The performance result of 'met' is based on meeting all of the 2016-17 actual demand.

Supporting research into hearing loss prevention and management

Funding of hearing health research projects is in accordance with Hearing Services Program objectives. Source: 2016-17 Health Portfolio Budget Statements, p. 96	
2016-17 Target	**2016-17 Result**
Research activities are consistent with, and support, the Hearing Services Program.	Research and development activities into hearing health, prevention and rehabilitation, was undertaken by the National Acoustic Laboratories and various other research institutions, consistent with the Hearing Services Program funded through the Hearing Loss Prevention Program. **Result: Met**

Through the Hearing Services Program, funding is allocated to National Acoustic Laboratories to progress work undertaken as part of an agreed project schedule.

Program 4.3: Pharmaceutical Benefits

The Department met or substantially met the majority of performance targets related to Program 4.3: Pharmaceutical Benefits.

Access to pharmaceutical products and services is key to improving the health of all Australians. In 2016-17, the Department worked with the pharmaceutical industry to support the Government strengthening the Pharmaceutical Benefits Scheme (PBS) and provide certainty to the pharmaceutical industry through a stable PBS pricing environment. This was expressed through agreements with the key industry associations in the sector. This will also provide patients access to more medicines by supporting the use of generic and biosimilar medicines.

During 2016-17, the Government ensured that pharmaceutical wholesalers continued to be financially supported through the Community Service Obligations Funding Pool, to supply PBS medicines to pharmacies across Australia within the guaranteed supply period, regardless of their location.

The Department continued to support the Pharmaceutical Benefits Advisory Committee (PBAC) to ensure new medicines are considered and listed on the PBS in a timely manner. This ensures the Australian public has access to new and affordable innovative medicines in a timely manner. The PBAC Guidelines were revised to ensure the PBAC submission and assessment process incorporates current international best practice, and the processes are consistent and transparent.

An agreement with the Pharmacy Guild of Australia to vary the Sixth Community Pharmacy Agreement recognises and strengthens the role of pharmacists in providing medicines, services and advice to patients. The Agreement focusses on supporting the viability of our network of community pharmacies, the supply of medications and the delivery of services, to help patients manage their medications.

New hope for people with lung and renal cancer

Nivolumab, a new medicine that improves outcomes for people with late stage lung and renal cancer, was recommended in March 2017 for listing on the PBS.

In making its recommendation for listing, the Pharmaceutical Benefits Advisory Committee noted the clear community need for this significant new treatment. Nivolumab can extend life and improve quality of life for patients who meet the criteria for treatment, and is safer and more effective than current therapies.

Nivolumab is a type of immunotherapy that helps make cancer cells more vulnerable to attack by your body's own immune system.

It activates T cells (white blood cells that help your body fight disease) so that they can attack cancer cells anywhere in your body.

It is very different to conventional treatments such as chemotherapy and radiation, because it uses the body's own immune system to fight cancer.

The PBS listing means that patients will pay only a maximum of $38.80 per treatment phase for the medicines, with concessional patients paying just $6.30.

Without subsidy, the medicine would cost a patient more than $130,000 per year.

Clinicians have expressed their excitement at being able to offer this medicine, noting that it is a great advancement in the treatment of cancers that have typically had a very poor outcome.

Consumer groups also said they value nivolumab as another treatment option, due to better outcomes and tolerability in comparison with other available treatments.

This significant listing on the PBS will take effect on 1 August 2017 and will benefit more than 4,500 Australians each year.

> ***"It's a special feeling when you can recommend new effective medicines for people with diseases previously considered untreatable."*** – Professor Andrew Wilson, Chair of the Pharmaceutical Benefits Advisory Committee

Supporting 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 and business.

Source: 2016-17 Health Portfolio Budget Statements, p. 97

2016-17 Target	2016-17 Result
Periodically increase the volume and nature of data on the Department of Health website during the course of 2016-17.	During 2016-17 there were monthly updates of PBS related tables on the PBS website[39] as well as the addition of a number of tables in the publication *Expenditure and Prescriptions twelve months to 30 June 2016*. **Result: Met**

Aggregate tables on PBS prescriptions and expenditure by date-of-supply and date-of-processing are made publically available on the PBS website.[40] These tables are updated monthly to provide the community with the latest available view of PBS prescription data.

The Department has a contract in place to maintain the PharmCIS application and manages a formal change control process to modify the PharmCIS application to accommodate policy, legislative and PBS listing changes each month.

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.

Source: 2016-17 Health Portfolio Budget Statements, p. 97

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
>90%	91.96% **Result: Met**	91.8%	N/A	N/A	N/A

91.96% of communities with a population of at least 1,000 people have timely access to PBS subsidised medicines at a community pharmacy or approved supplier when needed. Approved suppliers can be a pharmacy, a medical practitioner (in rural/remote locations where there is no 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.

Source: 2016-17 Health Portfolio Budget Statements, p. 97

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
>80%	90% **Result: Met**	97%	N/A	N/A	N/A

In 2016-17, 90% of communities with a population in excess of 1,000 people had access to advice and reviews, when needed. These activities support the quality use of medicines and aim to reduce medicine related problems.

[39] Available at: www.pbs.gov.au/info/browse/statistics

[40] Ibid.

Percentage of subsidised PBS units delivered to community pharmacy within agreed requirements of the Community Service Obligation.

Source: 2016-17 Health Portfolio Budget Statements, p. 98

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
>95%	97.5% **Result: Met**	96%	N/A	N/A	N/A

The timely supply of PBS medicines is secured under the Community Service Obligations (CSO) Funding Pool. Wholesalers engaged under the CSO are contractually required to deliver PBS medicines within the guaranteed supply period of 72 hours for medicines on the high volume list, and 24 hours for all other medicines.

Average cost per subsidised script funded by the PBS.

Source: 2016-17 Health Portfolio Budget Statements, p. 98

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
$28.17	$31.08 **Result: Substantially Met**	$27.37	N/A	N/A	N/A

In 2016-17 the average cost per subsidised script funded by the PBS was $31.08. The actual result was higher than target due to the higher than expected take-up of the new and expensive hepatitis C medicines.

The performance result of 'significantly met' is based on the result being 10% higher than the target.

Average cost per script paid by consumers for subsidised medicines.

Source: 2016-17 Health Portfolio Budget Statements, p. 98

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
$10.15	$9.84 **Result: Met**	$9.27	N/A	N/A	N/A

In 2016-17, the average cost of subsidised scripts paid by consumers under the PBS was $9.84. This is across all PBS Section 85 prescriptions, including under co-payment prescriptions.

Listing 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: 2016-17 Health Portfolio Budget Statements, p. 98

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	N/A	N/A	N/A

The Pharmaceutical Benefits Advisory Committee (PBAC) met on six occasions in 2016-17, including three special meetings in August 2016, December 2016 and April 2017.[41]

All submissions were considered within the specified 17 week timeframe from lodgement. 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: 2016-17 Health Portfolio Budget Statements, p. 98

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
80%	85% **Result: Met**	92%	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 85% being listed on the PBS within six months of agreement on price, and the overall cost to Government, that is the Budget impact, meeting the performance target.

Increasing the sustainability of the PBS

Estimated savings to Government from price disclosure.
Source: 2016-17 Health Portfolio Budget Statements, p. 99

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
$3,268.3m	$2,429.2m **Result: Substantially met**	$2,258.4m	N/A	N/A	N/A

Consumers continue to receive benefit from price reductions through price disclosure. Lower than estimated savings occurred in 2016-17 which may reflect that many PBS drugs already have low prices due to price disclosure.

New price disclosure savings will continue into the future, driven in particular by the enhanced uptake drivers for biosimilars announced in the 2017-18 Budget.

[41] Refer *Appendix 1: Processes Leading to PBAC Consideration – Annual Report for 2016-17* for more information.

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

Eligible patients have timely access to the Life Saving Drugs Program (LSDP).
Source: 2016-17 Health Portfolio Budget Statements, p. 99

2016-17 Target	2016-17 Result
Patient applications are processed within 30 calendar days of receipt of the complete data package to support the application.	All new applications were processed within 30 calendar days. **Result: Met**

Number of patients assisted through the LSDP.
Source: 2016-17 Health Portfolio Budget Statements, p. 99

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
302	393 **Result: Met**	335	278	257	228

Percentage of Government-accepted recommendations from LSDP post-market reviews that are implemented.
Source: 2016-17 Health Portfolio Budget Statements, p. 99

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	N/A	N/A	N/A	N/A	N/A

Percentage of eligible patients with access to fully subsidised medicines through the LSDP.
Source: 2016-17 Health Portfolio Budget Statements, p. 99

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

The LSDP processed new applications in accordance with the LSDP guidelines. New applications with all the required documents were processed within 30 calendar days. The actual number of treated patients exceeded the target due to new medicines being included on the LSDP and the number of patients increasing.

There were no Government-accepted recommendations from the LSDP review to implement in 2016-17. The LSDP continues to operate unchanged while the review is under consideration, with all eligible patients continuing to have access to fully subsidised medicines through the LSDP.

In 2016-17 there were 12 drugs funded through the program to treat eight serious and rare medical conditions. These conditions were: 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.

Undertaking post-market surveillance

Post-market reviews deliver relevant and high quality advice to the Pharmaceutical Benefits Advisory Committee (PBAC) and Government.
Source: 2016-17 Health Portfolio Budget Statements, p. 100

2016-17 Target	2016-17 Result
Reference Groups established, and engage constructively with professional and community stakeholders in the conduct of the reviews.	Reference Groups were established and engaged constructively with key stakeholders in the conduct of post-market reviews. To ensure relevant and high quality advice was delivered, each Reference Group included members with clinical and technical expertise, industry representatives, and consumer advocates. For each review, key stakeholders were invited to provide input to the review, comment on the draft report, and attend stakeholder forums. On average, around 15 stakeholders provided a submission to each review and seven provided a submission on the draft reports. Input was received from up to 130 attendees for each stakeholder forum, either through face-to-face meetings or through surveys for stakeholders who were not well enough to attend in person. **Result: Met**

Reference Groups supported each of the post-market reviews for:

- PBAC Guidelines (one meeting held on 5 August 2016);
- PBS Authority Required Medicines (all meetings were held in 2015-16);
- Ezetimibe (three meetings were held: 23 September 2016, 30 November 2016 and 17 March 2017);
- chronic obstructive pulmonary disease medicines (three meetings were held: 10 October 2016, 13 December 2016 and 26 April 2017);
- pulmonary arterial hypertension medicines (first met in 2017-18); and
- the use of biologics in the treatment of severe chronic plaque psoriasis (one meeting held on 18 May 2017).

In conducting these reviews, the Reference Groups provided: advice on the scope and requirements for medicine utilisation and literature reviews; comment on reports on medicine utilisation, efficacy, safety and cost-effectiveness; insight into clinical practice and consumer issues; and comments on the draft and final review reports.

Percentage of post-market reviews completed within scheduled timeframes.
Source: 2016-17 Health Portfolio Budget Statements, p. 100

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
90%	100% **Result: Met**	100%	N/A	N/A	N/A

Two reviews were completed in 2016-17:

- Pharmaceutical Benefits Advisory Committee Guidelines; and
- PBS Authority Required Medicines.

Two reviews continued in 2016-17:

- Ezetimibe; and
- chronic obstructive pulmonary disease medicines.

Two reviews commenced in 2016-17:

- pulmonary arterial hypertension medicines; and
- the use of biologics in the treatment of severe chronic plaque psoriasis.

Percentage of Government-accepted recommendations from post-market reviews that have been implemented within six months.

Source: 2016-17 Health Portfolio Budget Statements, p. 100

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
80%	85% **Result: Met**	80%	N/A	N/A	N/A

All recommendations from the PBAC Guidelines Review have been implemented. The revised guidelines are published on the PBS website. Education sessions were provided to promote a common understanding and interpretation of the guidance within the guidelines.

The Review of PBS Authority Required Medicines covered a total of 853 medicine items, of which the PBAC recommended changes to approximately 560. Around 70% of the Review recommendations were implemented concurrently during the Review. The remaining recommendations will be implemented as resources become available.

Monitoring the use of diagnostics, therapeutics and pathology

Information regarding quality use of medicines is provided to health professionals and consumers to support use of therapeutics wisely, judiciously and safely to achieve better health and economic outcomes.

Source: 2016-17 Health Portfolio Budget Statements, p. 101

2016-17 Target	2016-17 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 health professionals and consumers.	The Government funded NPS MedicineWise to produce its scheduled publications, resources, and educational visits which provided evidence-based information on therapeutics, including new and revised listings of medicines on the PBS, for health professionals and consumers. **Result: Met**

Education was provided to health professionals in the form of educational visits, online modules, resources and publications. Targeted consumer information campaigns included appropriate use of antibiotics and other therapeutic topics. NPS MedicineWise published *Rational Assessment of Drugs and Research, Australian Prescriber* and an annual evaluation report of all NPS MedicineWise programs.

NPS also made significant progress through its Choosing Wisely Australia initiative. A large cross section of professional colleges, societies and associations worked with NPS to develop recommendations that address inappropriate, overused or harmful care practices.

Program 4.4: Private Health Insurance

The Department met all performance targets related to Program 4.4: Private Health Insurance.

During 2016-17, the premium round process identified opportunities for improved stakeholder consultation. This has resulted in a more streamlined application form, regular forums for feedback and discussion as well as opportunities for stakeholders to be involved in activities to improve industry compliance.

During 2016-17, the Government continued to work with insurers to provide affordable health insurance and supported individuals and families with private health insurance through the private health insurance rebate.

The Department also continued to administer the Prostheses List, with more than 11,000 items included for surgical implantation. This facilitates access to safe and clinically effective medical devices through the private health insurance system for consumers.

The Department has continued to consult with key stakeholders on reforms to improve the affordability and value for money of private health insurance. The number of people with hospital treatment policies has increased by 21,985 from March 2016 to March 2017. 11.4 million Australians have private health insurance and contribute to taking the pressure off the public health system.

Supporting 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: 2016-17 Health Portfolio Budget Statements, p. 102

2016-17 Target	2016-17 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.	Ongoing discussions were held with stakeholders, including two forums, regular meetings and weekly communications with the private health insurance sector. **Result: Met**

The Department held two stakeholder consultation forums in Sydney and Melbourne. The Department provides weekly communications to the private health insurance sector outlining current policy initiatives undertaken by the Department, information on compliance and enforcement, information on the annual premium process and information about the rebate. Regular meetings were also held with the Department of Human Services, industry peak bodies, the Australian Taxation Office, the Australian Prudential Regulation Authority and the Private Health Insurance Ombudsman.

Percentage of insurers' average premium increases publicly released in a timely manner.
Source: 2016-17 Health Portfolio Budget Statements, p. 102

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

All insurers' premium increases were published on the Department's website[42] on 10 February 2017.

The number of people covered by private health insurance hospital treatment cover.
Source: 2016-17 Health Portfolio Budget Statements, p. 102

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
10.9m	11.3m **Result: Met**	11.3m	11.2m	11.1m	10.8m

Actual figures are published by the Australian Prudential Regulation Authority.

Ensuring 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: 2016-17 Health Portfolio Budget Statements, p. 102

2016-17 Target	2016-17 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**

Percentage of applications to list devices on the Prostheses List completed within 22 weeks.
Source: 2016-17 Health Portfolio Budget Statements, p. 102

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
87%	97% **Result: Met**	89.7%	88. 9%	N/A	N/A

The Department has continued to administer and maintain the Prostheses List, which includes more than 11,000 items for surgical implantation to provide life-saving and life-enhancing therapy to patients. In 2016-17, 97% of applications submitted through the Prostheses Listing process were completed within 22 weeks.

[42] Available at: www.health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round

Promoting a viable, sustainable and cost-effective private health insurance sector

Establish and work with the Private Health Sector Committee to develop and implement private health insurance reforms.
Source: 2016-17 Health Portfolio Budget Statements, p. 103

2016-17 Target	2016-17 Result
Meet at least nine times during 2016-17 to provide technical and specialist advice on a range of reform activities.	The Private Health Ministerial Advisory Committee met nine times during 2016-17. **Result: Met**

This committee was established as the Private Health Ministerial Advisory Committee on 8 September 2016 to examine private health insurance reform and provide government with advice on reform options including developing easy-to-understand categories of health insurance and developing standard definitions for medical procedures across all insurers for greater transparency and simplified billing.

A summary of each meeting is published on the Department's website.[43]

Ensure that all health funds complete due diligence when assessing the increase in annual premiums.
Source: 2016-17 Health Portfolio Budget Statements, p. 103

2016-17 Target	2016-17 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**

Australian Prudential Regulation Authority used the premium applications to assess insurer capital adequacy, solvency and prudential viability.

Performance criteria from the 2016-17 Corporate Plan

Increase in the percentage of Australians with private health insurance.
Source: 2016-17 Department of Health Corporate Plan, p. 25

Type of cover	2016-17	2015-16	2014-15	2013-14
Hospital cover	46.1%	47.0%	47.4%	47.2%
General cover	55.0%	55.7%	55.8%	55.2%

In 2016-17 there was a slight decrease in the number of people who held Hospital and General cover compared with 2015-16. Further information can be found on the Australian Prudential Regulation Authority's website.[44]

[43] Available at: www.health.gov.au/internet/main/publishing.nsf/Content/phmac

[44] Available at: www.apra.gov.au/PHI/PHIAC-Archive/Pages/Quarterly-Statistics.aspx

Program 4.5: Medical Indemnity

The Department met all performance targets related to Program 4.5: Medical Indemnity.

The Department works with the Department of Human Services to administer a number of schemes that support the stability of the medical indemnity industry and surety for privately practicing doctors, and midwives and their patients.

The Premium Support Scheme, funded by the Government, assists eligible doctors through a subsidy that reduces their medical indemnity costs. Government-supported, affordable professional indemnity insurance is also available for qualified and experienced privately practicing midwives. Improving the availability of affordable professional indemnity insurance helps to reduce out-of-pocket costs for patients and supports patient choice.

Ensuring that insurance products are available and affordable

The continued availability of professional indemnity insurance for eligible midwives.
Source: 2016-17 Health Portfolio Budget Statements, p. 104

2016-17 Target	2016-17 Result
Maintain a contract with a medical indemnity provider to provide professional indemnity insurance to eligible midwives.	A contract has been maintained with a medical indemnity provider for the provision of professional indemnity insurance to eligible midwives. **Result: Met**

Percentage of eligible midwife applicants covered by the Midwife Professional Indemnity Scheme.
Source: 2016-17 Health Portfolio Budget Statements, p. 105

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

Eligible midwives were able to purchase Commonwealth supported professional indemnity insurance from Medical Insurance Group Australia (MIGA).

All eligible privately practising midwives who applied for Commonwealth supported professional indemnity insurance through MIGA were offered cover.

Percentage of eligible applicants receiving a premium subsidy through the Premium Support Scheme.
Source: 2016-17 Health Portfolio Budget Statements, p. 105

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

Number of doctors that receive a premium subsidy support through the Premium Support Scheme.
Source: 2016-17 Health Portfolio Budget Statements, p. 105

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
1,500	1,268 **Result: Met**	1,237	1,400	1,613	1,847

All eligible applicants received a premium subsidy through the Premium Support Scheme in 2016-17. The reduction over time in the number of doctors seeking a premium subsidy indicates that the medical indemnity measures administered by the Department are helping make indemnity insurance premiums more affordable for doctors.

Ensuring the stability of the medical indemnity insurance industry

Percentage of medical indemnity insurers who have a Premium Support Scheme contract with the Australian Government that meets the Australian Prudential Regulation Authority's Minimum Capital Requirement.
Source: 2016-17 Health Portfolio Budget Statements, p. 105

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

All medical indemnity insurers that have entered into a Premium Support Scheme contract with the Government in 2016-17 met the Australian Prudential Regulation Authority's Minimum Capital Requirement.

Program 4.6: Dental Services

The Department did not meet the performance targets related to Program 4.6: Dental Services.

Following a Government decision, the Child and Adult Public Dental Scheme did not proceed. Instead, the Child Dental Benefits Schedule continued, with funding for adult dental services continued through a National Partnership Agreement. The continuation of these arrangements ensured that the Commonwealth continued to support the delivery of dental services to a potential recipient pool of over three million eligible Australians.

Improving access to public dental services for children and adults

Improved access to public dental services for eligible patients.
Source: 2016-17 Health Portfolio Budget Statements, p. 106

2016-17 Target	2016-17 Result
Increase in the volume of public dental services adjusted for complexity.	Following a Government decision, this initiative did not proceed. **Result: Not met**

Following a Government decision the Child and Adult Public Dental Scheme did not proceed. Instead the Child Dental Benefits Schedule continued, with funding for adult dental services continued through a National Partnership Agreement.

Performance criteria from the 2016-17 Corporate Plan

Increased access to public dental services provided by State and Territory Governments.
Source: 2016-17 Department of Health Corporate Plan, p. 25

Refer above on this page for performance criterion addressing access to public dental services.

Program 4.7: Health Benefit Compliance

The Department met all performance targets related to Program 4.7: Health Benefit Compliance.

The Department continued to support the integrity of health provider claims through early intervention and identification, as well as detecting and investigating instances of fraud. The Department has undertaken activities that enhance the integrity of the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme, Child Dental Benefits Schedule and health incentive programs contributing to the sustainability of the health system. A detailed review was undertaken of the Department's provider compliance function resulting in a restructure that better supports contemporary compliance approaches and efficient business processes, including through data analytics and behavioural economic approaches.

Improvements to the provider compliance program through the use of data analytics and behavioural economics has seen improvements in the integrity of health provider claiming. This has resulted in: 29 fraud cases successfully prosecuted; 81 requests to the Director of Professional Services Review to review the appropriateness of services of health practitioners; more than $29 million of debt raised following compliance activities; and more than $13 million of debt recovered. The Department completed 500 audits and reviews of health providers focussed on high risk/complex compliance issues however, these did not generate the target value of $50,000 per debt raised.

Supporting the integrity of health provider claiming

Implement a contemporary compliance program that utilises advanced analytics, effectual tools and behavioural economics to support the integrity of health provider claiming.
Source: 2016-17 Health Portfolio Budget Statements, p. 108

2016-17 Target	2016-17 Result
Enhanced activities are delivered by 30 June 2017 that contribute to an agreed contemporary compliance program that results in a change in provider claiming practices.	The Department has undertaken a number of activities to better support contemporary compliance approaches and efficient business processes, including through enhanced data analytics capability and behavioural economics approaches. **Result: Met**

Key activities undertaken focussed on improving compliance outcomes through enhancement of data analytics, behavioural economics and contemporary compliance approaches. In addition, the Department invested in data analytics training and secure data infrastructure to support these approaches. The Department raised $29 million in debts against providers and recovered more than $13 million in 2016-17, both significant increases since 2015-16. Investments in improved capabilities in 2016-17 are expected to deliver further increases in debts raised and recovered, as well as in behaviour change from providers, in 2017-18.

Complete audits and reviews of health providers including general audits, practitioner reviews and criminal investigations.

Source: 2016-17 Health Portfolio Budget Statements, p. 108

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
2,500	3,035 **Result: Met**	N/A	N/A	N/A	N/A

3,035 audits and reviews were completed which includes general audits, practitioner reviews and criminal investigations.

Complete audits and reviews of health providers focussed on high risk/complex compliance issues.

Source: 2016-17 Health Portfolio Budget Statements, p. 108

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
500	500 **Result: Met**	N/A	N/A	N/A	N/A

An additional 500 audits and reviews were completed which focussed on higher risk/complex compliance issues. However, these did not generate the target value of $50,000 per debt raised.

Program 4.8: Targeted Assistance – Aids and Appliances

The Department met the majority of performance targets related to Program 4.8: Targeted Assistance – Aids and Appliances.

The National Diabetes Services Scheme ensures that people with diabetes have timely, reliable and affordable access to products and services to assist people to effectively self-manage their condition. This includes fully subsidised continuous glucose monitoring (CGM) products for more than 4,000 eligible children and young people aged under 21 years with type 1 diabetes, with most accessing CGM technology for the first time.

In 2016-17, the Government continued to assist over 40,000 people with a stoma by ensuring they have access to stoma related appliances through the Stoma Appliance Scheme. There are currently over 400 products available through the scheme.

The Department also continued to ensure access to clinically necessary dressings and products for people with Epidermolysis Bullosa.

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

Number of people under 18 years of age, with type 1 diabetes receiving subsidised insulin pumps and associated consumables (under the Insulin Pump Program).
Source: 2016-17 Health Portfolio Budget Statements, p. 109

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
68	66 **Result: Substantially met**	66	65	204	76

Target of 68 subsidies was based on an average subsidy of $6,000 per recipient. However, 97% of recipients required a full subsidy of $6,400, resulting in total funding supporting slightly fewer people.

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

The National Diabetes Services Scheme (NDSS) meets the needs of stakeholders.
Source: 2016-17 Health Portfolio Budget Statements, p. 109

2016-17 Target	2016-17 Result
Annual survey of registrants demonstrates that the needs of stakeholders are being met.	Over 90% of surveyed registrants indicated that the NDSS improved their knowledge and understanding of diabetes and helped them manage their condition more effectively. **Result: Met**

Number of people with diabetes receiving benefit from the NDSS.
Source: 2016-17 Health Portfolio Budget Statements, p. 109

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
1,397,803	1,395,031 **Result: Met**	1,320,328	1,259,203	1,133,412	1,086,860

The NDSS is a demand-driven program. In 2016-17, the number of people with type 1, type 2 and gestational diabetes receiving benefit from the NDSS was 1,256,070. There were also a further 138,961 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.

Assisting people with a stoma by providing stoma related products

Number of people receiving stoma related products.
Source: 2016-17 Health Portfolio Budget Statements, p. 110

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
44,000	44,424 **Result: Met**	43,767	42,678	42,228	N/A

Average cost per aid and appliance delivered to eligible persons.
Source: 2016-17 Health Portfolio Budget Statements, p. 110

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
Increase at a rate less than Consumer Price Index (CPI).	$2.56 **Result: Met**	$2.52	N/A	N/A	N/A

In 2016-17, 52 new products were listed on the Stoma Appliance Scheme, providing people with a stoma with greater choice of new improved products which could lead to improved health outcomes.

In 2016-17, the average cost per aid and appliance for the Stoma Appliance Scheme was $2.56. The cost per aid and appliance increased less than the CPI rate for the June quarter.

Improving the quality of life for people with Epidermolysis Bullosa

Number of people with Epidermolysis Bullosa (EB) receiving subsidised dressings.
Source: 2016-17 Health Portfolio Budget Statements, p. 110

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
180	173 **Result: Substantially met**	185	179	136	99

Average time from receipt of an approved claim to delivery of aids and appliances.
Source: 2016-17 Health Portfolio Budget Statements, p. 110

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
No increase on prior year.	Increase of 0.2 of a day. **Result: Not met**	Average one business day – no increase.	N/A	N/A	N/A

The Scheme is demand-driven and less people required access to dressings in 2016-17 than originally anticipated. The performance result of 'substantially met' for the number of people with EB receiving subsidised dressings is based on meeting 96% of the target.

There was a slight increase (0.2 of a day) in the average delivery time of aids and appliances from the previous year. External factors, such as delivery location, have impacted on the delivery of this measure.

Outcome 4 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 4.1: Medical Benefits			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	104,881	106,250	1,369
Special appropriations			
Health Insurance Act 1973 – medical benefits	22,092,457	22,098,281	5,824
Departmental expenses			
Departmental appropriation[1]	27,814	30,829	3,015
Expenses not requiring appropriation in the budget year[2]	2,914	4,888	1,974
Total for Program 4.1	**22,228,066**	**22,240,248**	**12,182**
Program 4.2: Hearing Services			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	516,141	498,327	(17,814)
Departmental expenses			
Departmental appropriation[1]	7,273	7,558	285
Expenses not requiring appropriation in the budget year[2]	1,840	845	(995)
Total for Program 4.2	**525,254**	**506,730**	**(18,524)**
Program 4.3: Pharmaceutical Benefits			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	697,149	686,315	(10,834)
Special appropriations			
National Health Act 1953 – pharmaceutical benefits	11,297,940	12,057,625	759,685
Departmental expenses			
Departmental appropriation[1]	54,212	58,969	4,757
Expenses not requiring appropriation in the budget year[2]	7,710	5,820	(1,890)
Total for Program 4.3	**12,057,011**	**12,808,729**	**751,718**
Program 4.4: Private Health Insurance			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	3,768	5,169	1,401
Special appropriations			
Private Health Insurance Act 2007 - incentive payments and rebate	6,054,635	5,994,087	(60,548)
Departmental expenses			
Departmental appropriation[1]	10,392	11,712	1,320
Expenses not requiring appropriation in the budget year[2]	1,074	967	(107)
Total for Program 4.4	**6,069,869**	**6,011,935**	**(57,934)**

Outcome 4 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 4.5: Medical Indemnity			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	150	222	72
Special appropriations			
Medical Indemnity Act 2002	91,800	91,302	(498)
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	6,870	-	(6,870)
Departmental expenses			
Departmental appropriation[1]	998	1,571	573
Expenses not requiring appropriation in the budget year[2]	108	168	60
Total for Program 4.5	**99,926**	**93,263**	**(6,663)**
Program 4.6: Dental Services[3]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	-	-	-
Special appropriations			
Dental Benefits Act 2008	331,860	319,384	(12,476)
Departmental expenses			
Departmental appropriation[1]	2,511	2,202	(309)
Expenses not requiring appropriation in the budget year[2]	170	249	79
Total for Program 4.6	**334,541**	**321,835**	**(12,706)**
Program 4.7: Health Benefit Compliance			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	12,000	6,211	(5,789)
Departmental expenses			
Departmental appropriation[1]	64,748	57,341	(7,407)
Expenses not requiring appropriation in the budget year[2]	2,050	6,582	4,532
Total for Program 4.7	**78,798**	**70,134**	**(8,664)**
Program 4.8: Targeted Assistance - Aids and Appliances			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	4,442	3,506	(936)
Special appropriations			
National Health Act 1953 – aids and appliances	354,493	338,991	(15,502)
Departmental expenses			
Departmental appropriation[1]	4,245	4,120	(125)
Expenses not requiring appropriation in the budget year[2]	499	404	(95)
Total for Program 4.8	**363,679**	**347,021**	**(16,658)**

Outcome 4 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Outcome 4 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	1,338,531	1,306,000	(32,531)
Special appropriations	40,230,055	40,899,670	669,615
Departmental expenses			
Departmental appropriation[1]	172,193	174,302	2,109
Expenses not requiring appropriation in the budget year[2]	16,365	19,923	3,558
Total expenses for Outcome 4	**41,757,144**	**42,399,895**	**642,751**
Average staffing level (number)	**999**	**971**	**(28)**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

[1] Departmental appropriation combines 'Ordinary annual services (*Appropriation Act No.1*)' and 'Revenue from independent sources (s74)'.

[2] Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

[3] This program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

Outcome 5:
Regulation, Safety and Protection

Protection of the health and safety of the Australian community and preparedness to respond to national health emergencies and risks, including through immunisation, initiatives, and regulation of therapeutic goods, chemicals, gene technology, and blood and organ products

Analysis of performance

In 2016-17, the Department continued to deliver world-class regulation of therapeutic goods, contributing to better health outcomes for Australians. Work continued to aid in the protection of the Australian people and the environment by disseminating high quality assessments about risks from the use of new and existing industrial chemicals. Legislative changes have allowed for the legal cultivation, production and manufacturing of medicinal cannabis products in Australia. The expansion to the whole-of-life Australian Immunisation Register has enabled increased reporting for immunisation coverage data for additional population groups and a range of private vaccines.

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

Highlights

Medicinal cannabis cultivation gets the green light

New laws allowed the Department to grant 15 licences to cultivate, produce and manufacture cannabis for medicinal purposes in Australia.
Refer *Program 5.1*

Renewed funding for OzFoodNet

Through OzFoodNet, the Department will continue to work with State and Territory health authorities on enhanced foodborne disease surveillance to help rapid identification and response to outbreaks of foodborne illnesses.
Refer *Program 5.2*

Support for world leading AusVaxSafety initiative

Investment in the world-leading AusVaxSafety, a new national collaborative active vaccine safety initiative, has ensured continued safety and public confidence in immunisation.
Refer *Program 5.3*

Looking ahead

- The Department, through the Therapeutic Goods Administration, will reduce regulatory burden on business through the roll out of a manufacturer compliance framework, an electronic Conformity Assessment application form, and a new notifications process for low risk changes to registered medicines.
- The Government will provide early access to certain new medicines that address unmet clinical needs for serious conditions, supported by a strengthened post-market monitoring and vigilance system.
- The next iteration of the National Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategies (2018–22) will be developed to set the direction for a coordinated national response to HIV, hepatitis B, hepatitis C, STI, and with a dedicated strategy to specifically address BBV and STI in the Aboriginal and Torres Strait Islander population.
- 10–19 year olds and newly arrived refugees and humanitarian entrants will now have access to essential vaccines under the expansion of the National Immunisation Program.
- Australia's first national immunisation campaign in 20 years will be implemented, aiming to improve vaccination coverage rates, timely completion of schedule points and confidence in the program.
- Reforms to the National Industrial Chemicals Notification and Assessment Scheme will reduce regulatory burden on Australian importers and manufacturers of industrial chemicals, and remove unnecessary barriers to the introduction of safer chemicals, whilst continuing to protect the public and environment.

Purpose, programs and program objectives contributing to Outcome 5

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.
Program 5.1: Protect the Health and Safety of the Community Through Regulation
Therapeutic Goods
Regulating therapeutic goods for safety, effectiveness/performance and quality
Participating in international regulatory convergence and work sharing activities
Promoting best practice regulation of therapeutic goods
Drug Regulation
Regulating the import, export, and manufacture of controlled drugs
Regulating the cultivation and manufacture of medicinal cannabis
Chemical Safety
Aiding 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
Protecting the health and safety of people and the environment by regulating work with genetically modified organisms (GMOs)
Performance criteria from the 2016-17 Corporate Plan
Program 5.2: Health Protection and Emergency Response
Reducing the incidence of blood borne viruses and sexually transmissible infections
Providing a comprehensive and effective response to national health emergencies
Improving biosecurity and minimising the risks posed by communicable diseases
Supporting the development of policies and implementation activities relating to health protection issues of national significance
Program 5.3: Immunisation
Increasing national immunisation coverage rates and improving the effectiveness of the National Immunisation Program
Performance criteria from the 2016-17 Corporate Plan

Program 5.1: Protect the Health and Safety of the Community Through Regulation

The Department met the majority of performance targets related to Program 5.1: Protect the Health and Safety of the Community Through Regulation.

In 2016-17, the Department continued to participate in international fora that aim to promote enhanced information sharing and cooperation, and regulatory convergence in relation to therapeutic goods. Collaborating with international regulators continues to enable the Department to make more informed and consistent regulatory decisions about the safety, quality and effectiveness of therapeutic goods in Australia.

In 2016-17, the Department, through the Therapeutic Goods Administration (TGA), began implementing the response to the Review of Medicines and Medical Devices Regulation, announced in the 2016-17 Budget. The first legislative changes to implement the reforms were enacted in June 2017. A key challenge faced by the TGA was commencing the implementation of regulatory reform, while maintaining core activities associated with providing high quality regulation of therapeutic goods in Australia. This challenge is expected to continue in 2017-18 as implementation of regulatory reform continues.

The Office of Drug Control (ODC) is facilitating access to medicinal cannabis products for patients that have medical conditions where there is evidence to support its use. To fully achieve this, a number of legislative and regulatory changes were required. On 30 October 2016, ODC implemented amendments to the *Narcotic Drugs Act 1967* that have allowed for the cultivation, production and manufacturing of cannabis to commence, as well as enabled access to medicinal cannabis under prescription for suitable patients. In November 2016, initial applications were received by ODC with a total of 15 licences being granted by 30 June 2017.

ODC faced a number of challenges in 2016-17, mostly around unknown factors in relation to the size of the medicinal cannabis industry, the anticipated numbers of licence applications, and the implementation of regulations designed in the absence of a functioning industry. In addition, ODC was increasingly involved in detailed stakeholder discussions and consultation in response to substantial political and public interest in the medicinal cannabis industry. These challenges affected other core business around licensing for prohibited substance imports and manufacture oversight for other narcotic drugs, and resulted in reduced ability to meet priority targets and delayed processing times.

In 2016-17, through its administration of the National Industrial Chemicals Notification and Assessment Scheme (NICNAS), the Department continued to provide high quality assessment reports that inform the public, workers, the Government and industry of risks from the introduction and use of industrial chemicals, thereby promoting their safe use. The Department also continued the implementation of significant reforms to NICNAS that were announced in the 2015-16 Budget. The details of the implementation were developed through extensive stakeholder consultation, within the policy framework agreed by Government. The proposed changes have caused some challenges to staff administering NICNAS. This is due to the need to develop and consult on the technical details of the reforms while continuing to operate under the current scheme.

The launch of the NICNAS Business Services web portal increased the efficiency of annual registration processes for both industrial chemical introducers and the regulator by moving from paper-based to online processes.

The Department through the Office of the Gene Technology Regulator (OGTR) continued to ensure that the community can have confidence that Genetically Modified Organisms approved in Australia have followed a robust risk assessment process and any identified risks have been managed effectively. In 2016-17, the OGTR continued to progress the technical review of the Gene Technology Regulations 2001 with significant community and stakeholder consultation. The proposed amendments would provide greater regulatory clarity to stakeholders, reduce burden and promote innovation.

Therapeutic Goods

Regulating therapeutic goods for safety, effectiveness/performance and quality

Continue to regulate therapeutic goods for safety, effectiveness/performance and quality.
Source: 2016-17 Health Portfolio Budget Statements, p. 117

2016-17 Target	2016-17 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 Therapeutic Goods Administration (TGA) continued to undertake effective pre-market evaluation and post-market monitoring and assessment of therapeutic goods, as required under the *Therapeutic Goods Act 1989* and associated regulations. **Result: Substantially met**

The Department, through the TGA, demonstrates its regulatory performance via its reporting framework. The framework consists of various reports that focus on the TGA's performance and engagement with stakeholders, as well as more detailed information about regulatory and corporate activities.

Detailed information regarding pre and post-market statistics and information about the TGA's performance against the Regulator Performance Framework is available on the TGA website.[45] The outcomes of laboratory testing and compliance and enforcement actions by the TGA are published on the TGA website.[46]

A performance result of 'substantially met' is based on meeting 99.8% 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).
Source: 2016-17 Health Portfolio Budget Statements, p. 117

2016-17 Target	2016-17 Result
SUSMP is amended as soon as practicable after the Secretary's delegate's final decision under the Therapeutic Goods Regulations 1990.	There were five updates to the SUSMP during 2016-17. Each update was made as soon as practicable after a final decision was made. **Result: Met**

All required SUSMP legislative instruments were amended as soon as practicable after the Secretary's delegate's final decision during 2016-17. All amendments were made available on the Federal Register of Legislation website[47] for July 2016, October 2016, November 2016, February 2017 and June 2017.

[45] Available at: www.tga.gov.au/publication/performance-reports

[46] Available at: www.tga.gov.au/ws-labs-index

[47] Available at: www.legislation.gov.au/Details/F2017L00605

Percentage of evaluations/assessments completed within legislated timeframes:
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
c) Conformity assessments for medical devices processed within 255 working days.
Source: 2016-17 Health Portfolio Budget Statements, p. 118

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	a) 100% b) 99.8% c) 100% **Result:** **a) Met** **b) Substantially met** **c) Met**	a) 100% b) 99.1% c) 100%	a) 99.7% b) 98% c) 100%	a) 99.8% b) 100% c) N/A	a) 99.7% b) 100% c) N/A

Category 1 applications are for new medicines, presentations and indications. All Category 1 applications (332) were processed within the legislated timeframe.

Category 3 applications are initiated by sponsors for manufacturing and quality changes, and are usually to an existing registered medicine. Majority of Category 3 applications (1,372 of 1,375) were processed within the legislated timeframe. Internal processing delays associated with provision of data contributed to failing to meet the timeframes for three applications.

All conformity assessments for medical devices (204) were processed in under 200 working days.

Performance result relating to b) of 'substantially met' is based on meeting 99.8% of the target.

Percentage of alleged breaches of the *Therapeutic Goods Act 1989* received that are assessed within 10 working days and an appropriate response initiated.
Source: 2016-17 Health Portfolio Budget Statements, p. 118

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

During 2016-17, 3,702 alleged breaches and/or referrals were assessed against the Therapeutic Goods Administration regulatory scheme and triaged using a risk-based regulatory compliance framework. Responses to alleged breaches may include investigation and prosecution, or referral for investigation to another State, Territory or Commonwealth agency.

Percentage of licensing and surveillance inspections closed out within target timeframes.
Source: 2016-17 Health Portfolio Budget Statements, p. 118

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
85%	87% **Result: Met**	87%	N/A	N/A	N/A

The Department has maintained an improved process for conducting post-inspection activities introduced in the previous reporting period, which has enabled more efficient resolution of deficiencies and close-out of inspections, and alignment with international practice.

Participating in international regulatory convergence and work sharing activities

Implement international harmonisation and work sharing activities with comparable international regulators.
Source: 2016-17 Health Portfolio Budget Statements, p. 118

2016-17 Target	2016-17 Result
Enhanced cooperation and work sharing, including increased reliance on medicines evaluation and facilities inspection information from international regulators, as outlined in the Therapeutic Goods Administration's *International Engagement Strategy 2016–2018*.	The Department contributed to public health and safety through active engagement in international regulatory initiatives alongside comparable international regulators, as outlined in the TGA's *International Engagement Strategy 2016–2020* (released December 2016). **Result: Met**

In 2016-17, the Department continued to participate in international fora that aim to promote enhanced information sharing, cooperation and regulatory convergence in relation to therapeutic goods. This includes international initiatives such as the vice-chairmanship of the International Coalition of Medicines Regulatory Authorities; the International Medical Devices Regulators' Forum (including the Medical Devices Single Audit Program); the Australia, Canada, Singapore and Switzerland consortium; as well as bilateral collaboration with like-minded regulators.

Percentage of good manufacturing practice clearances of overseas manufacturers that take into account approvals by equivalent international regulators.
Source: 2016-17 Health Portfolio Budget Statements, p. 119

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
85%	92% **Result: Met**	95%	N/A	N/A	N/A

The Therapeutic Goods Administration maintained its ability to issue Good Manufacturing Practice clearances in a shorter timeframe.

Promoting best practice regulation of therapeutic goods

Implement reforms that enhance the Therapeutic Goods Administration's current regulatory processes and are consistent with the Government's regulatory reform agenda.

Source: 2016-17 Health Portfolio Budget Statements, p. 119

2016-17 Target	2016-17 Result
Begin implementation of the Government's response to the Review of Medicines and Medical Devices Regulation.	Implementation of the Government's response to the Review of Medicines and Medical Devices Regulation (the Review) began in a staged approach to allow continuity of routine regulatory business. **Result: Met**

The Government's response to the Review was released in September 2016, initiating a significant program of work, including stakeholder consultation, legislative changes and business improvement projects. Consultation was undertaken to inform implementation of the recommendations, which included 13 public consultations.

The first tranche of legislative changes to implement the reforms, the *Therapeutic Goods Amendment (2016 Measures No. 1) Act 2017*, was enacted in June 2017. The supporting regulations, the Therapeutic Goods Legislation Amendment (2017 Measures No. 1) Regulations 2017, were endorsed by the Governor-General in June 2017.

To support the reforms, a number of IT projects have been initiated such as an online catalogue of approved ingredients for use in complementary medicines, an e-form for variation of prescription medicines, and enhanced adverse event reporting analytics and database capability. A new priority review pathway that will enable faster access to important new medicines for Australian patients, as well as enhanced post-market monitoring and vigilance, will also be supported by new e-forms. A new workflow system for the approval of applications for access to unapproved goods and reduction in requirements for authorised prescribers under the Special Access Scheme, were also implemented.

The Small and Medium Enterprise Assist service, designed to help small and medium enterprises and research institutions to better understand and navigate Australia's therapeutic goods regulation and legislation, was launched in June 2017.

Streamlining regulation for listed complementary medicines

In September 2016, the Government released its response to the Review of Medicines and Medical Devices Regulation (the Review), accepting the majority of the Review recommendations that will significantly benefit consumers, the therapeutic goods industry and health professionals.

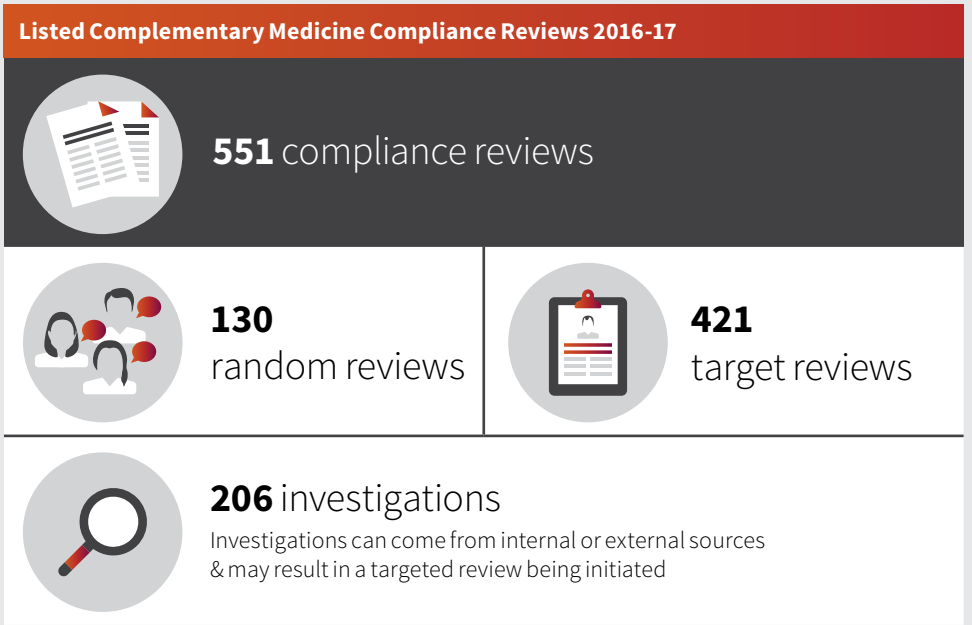
The Review identified ways we can streamline our existing regulatory framework, further enhance our post-market compliance framework and improve consumers' access to new therapeutic goods, while still ensuring their safety and effectiveness.

In Australia, therapeutic goods include medicines which contain ingredients such as herbs, vitamins, minerals, nutritional supplements, homoeopathic and certain aromatherapy preparations. These are referred to as 'complementary medicines'. Complementary medicines are either listed (low-risk) or registered (higher-risk) on the Australia Register of Therapeutic Goods. Most complementary medicines are listed on the Register based on their low-risk ingredients and low-level indications.

Currently there are more than 11,000 listed products on the Register.

Each year, consumers benefit from extensive post-market compliance and monitoring processes, where a proportion of listed medicines undergo random or targeted review. In 2016-17 the TGA completed 551 reviews, more than double the amount completed in 2014-15.

To support the reform proposals, changes such as – only allowing sponsors to select therapeutic claims from a prescribed list – will strike a balance between supporting consumer choice, providing flexibility for industry and ensuring the safe and effective use of therapeutic products. In addition, TGA have adopted a 'co-design' approach to strengthen relationships with key stakeholders and to encourage greater rates of compliance with the regulatory requirements.



Drug Regulation

Regulating the import, export, and manufacture of controlled drugs

Provide timely and quality advice to meet Australia's reporting obligations under the International Narcotic Drugs Conventions.
Source: 2016-17 Health Portfolio Budget Statements, p. 119

2016-17 Target	2016-17 Result
Timely response to requests for data and completion of quarterly and annual reports.	16 of the 49 reports were completed within the deadlines. However, as of 28 September 2017, all reports have been completed. **Result: Not met**

Australia is required to provide reports and estimates of drugs imported, exported, manufactured, consumed and stock levels under the *Single Convention on Narcotic Drugs of 1961* and the *Convention on Psychotropic Substances of 1971*. The controlling body, the International Narcotic Control Board, sets deadlines for all parties on reporting.

Increasing resource pressures have affected international drug reporting, as during this period resources have been prioritised to maintain client service levels and implement the Government's reforms on medicinal cannabis.

An updated drug reporting system has been procured from the United Nations Office on Drugs and Crime. Implementation of this system is anticipated in 2017-18. This system aims to improve client self-reporting and process efficiencies.

Percentage of applications for the import, export, and manufacture of controlled substances that are assessed and processed within agreed timeframes.
Source: 2016-17 Health Portfolio Budget Statements, p. 119

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
95%	98% **Result: Met**	99%	N/A	N/A	N/A

During 2016-17, 98% of applications were completed within the required timeframe, 3% above the target. The Department issued a total of 7,549 licences and permits authorising the import, export and manufacture of controlled drugs, which represents a 7% increase compared to 2015-16. The Department also provided 158 basic checks and statements to law enforcement.

Regulating the cultivation and manufacture of medicinal cannabis

Implement amendments to the *Narcotic Drugs Act 1967* to regulate and provide access to medicinal cannabis, in accordance with the International Narcotic Drugs Conventions.
Source: 2016-17 Health Portfolio Budget Statements, p. 120

2016-17 Target	2016-17 Result
Development of supporting regulations, a cost recovery model, licensing and permit procedures, a compliance and enforcement plan and a communications strategy by November 2016.	All documentation listed was completed and published online by November 2016. **Result: Met**

The necessary regulations, cost recovery model and procedures were developed and content published online to support the 30 October 2016 amendments to the *Narcotic Drugs Act 1967*. Following amendments, individuals and businesses were able to apply for cannabis licences and permits.

Percentage of applications for the production of medicinal cannabis processed within agreed timeframes.
Source: 2016-17 Health Portfolio Budget Statements, p. 120

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
90%	85% **Result: Substantially met**	N/A	N/A	N/A	N/A

A total of 111 licence applications for the production of medicinal cannabis were received. Licence applications began to arrive in the second quarter of 2016-17, with the rate of applications increasing in 2017, leading to some delays in processing and assessing applications.

The performance result of 'substantially met' is based on meeting 94% of the target.

Chemical Safety

Aiding 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: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result
Peer review and stakeholder feedback support assessment outcomes.	Peer review and stakeholder feedback supported assessment outcomes. **Result: Met**

In 2016-17, under the *Industrial Chemicals (Notification and Assessment) Act 1989*, the Department published assessment reports for 163 new chemicals, 4,367 existing chemicals, and one secondary notification assessment of a previously assessed chemical. All reports were peer reviewed, and stakeholder feedback was sought and considered prior to finalising the reports. No applications for review of regulatory outcomes were made to the Administrative Appeals Tribunal.

Contribution to the international harmonisation of regulatory approaches and methodologies for assessing industrial chemicals by reviewing Australian processes.
Source: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result
Regulatory approaches and methodologies developed by the Organisation for Economic Co-operation and Development (OECD) Chemicals Committee and its key sub-committees are reviewed for their application to NICNAS assessments of industrial chemicals.	The Department's technical experts reviewed and contributed to the development of OECD methodologies and guidance materials to promote international harmonisation of the regulation of industrial chemicals. **Result: Met**

Through active participation in the OECD Chemicals Committee and its key sub-committees, the Department worked to ensure that risk assessment approaches and methodologies developed by these international bodies would satisfy Australia's national interest and facilitate international harmonisation, where appropriate. The Department's technical experts reviewed and contributed to documents prepared by these bodies in relation to nanomaterials, hazard and exposure assessment.

The Department also contributed to the work of the Global Perfluorinated Chemicals (PFC) Group, established jointly by the OECD and the United Nations Environment Program.

All introducers of industrial chemicals are aware of their legal obligations.
Source: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result
Identified introducers are registered and provided with regular information updates.	98% of identified introducers were registered and provided with regular updates including upcoming information sessions, registration renewal information, opportunities for consultation on the NICNAS reforms and advice on the development of the new Industrial Chemicals Bill. Over 300 registrants attended NICNAS information sessions conducted in major capital cities, which were designed to inform introducers of their obligations under the *Industrial Chemicals (Notification and Assessment) Act 1989*. **Result: Substantially met**

A total of 6,676 introducers of relevant industrial chemicals were registered with NICNAS in 2016-17, representing the highest number of registrants in the history of the scheme. During 2016-17, as a direct result of compliance monitoring activities, over 500 introducers registered with NICNAS for the first time.

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: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result
Reforms to NICNAS more efficiently and effectively achieve the objects of the *Industrial Chemicals (Notification and Assessment) Act 1989*.	The Department published two consultation papers in 2016-17 to obtain stakeholder feedback on the proposed approach to the implementation of the NICNAS reforms, and a paper on the proposed Cost Recovery Model for the reformed scheme. The reforms aim to deliver a more efficient and effective regulatory scheme by making regulatory effort more proportionate to risk, removing unnecessary barriers to the introduction of safer industrial chemicals and using international assessment materials where possible and appropriate. Enhanced monitoring and compliance powers will maintain the integrity of the scheme in protecting human health and the environment. **Result: Met**

Stakeholder input to the NICNAS reforms process through workshops and written submissions has informed the development of new primary legislation. This included the establishment of an ad-hoc working group to obtain expert input on technical aspects of the reforms. Consultation on delegated legislation and guidance materials is ongoing.

New legislation was introduced into Parliament on 1 June 2017.

Effective use of international information.
Source: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result
Criteria approved by the Health Minister for accepting international standards and risk assessment materials will be applied by NICNAS.	The Department has applied the criteria approved by the Health Minister for accepting international standards and risk assessment materials to the development of reform proposals and to the administration of NICNAS. **Result: Met**

In 2016-17, 12 comparable international agency assessments were used to undertake new chemical assessments. Use of comparable international agency assessments delivers efficiencies in the assessment process by reducing regulatory duplication and creating cost savings for industry. All NICNAS existing chemical assessments considered international standards and risk assessment material in accordance with criteria approved by the Health Minister.

The new legislation introduced into Parliament on 1 June 2017 allows chemicals that would otherwise require assessment under the new scheme (but have already been subject to an assessment by a comparable regulator that meets the criteria approved by the Health Minister), to be introduced without further assessment in Australia.

Percentage of new industrial chemical assessments completed within legislated timeframes.
Source: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
96%	99.6% **Result: Met**	99%	98%	98%[48]	95%

Under NICNAS, the Department completed 257 pre-market assessments of new chemicals with 256 of these completed within legislated timeframes. Timely completion of assessments provides certainty for industry and promotes the availability of new industrial chemicals to the community.

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: 2016-17 Health Portfolio Budget Statements, p. 121

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
45%	50% **Result: Met**	45%	40%	35%	30%

The Department, through NICNAS, monitored the introduction of industrial chemicals and identified 10 introducers who were non-compliant with obligations associated with new industrial chemicals in 2016-17. These introducers are being case-managed to ensure adequate resolution of issues involving reporting and notification of new chemicals.

An additional 39 companies were found to be at risk of non-compliance due to inadequate record keeping. These introducers were provided guidance and the opportunity to meet with Department staff to discuss their obligations under the Act.

[48] This figure was published incorrectly in the Department of Health Annual Report 2015-16 and has now been updated to reflect the correct result.

Gene Technology Regulation

Protecting the health and safety of people and the environment by regulating work with genetically modified organisms (GMOs)

Progress technical review of the Gene Technology Regulations 2001.
Source: 2016-17 Health Portfolio Budget Statements, p. 122

2016-17 Target	2016-17 Result
Draft amendment regulations, informed by stakeholder submissions, will be prepared in 2016. Consultation on proposed amendments will be undertaken in 2016-17.	Stakeholder consultation on proposed amendments will commence in 2017-18. **Result: Not met**

The Department, through the Office of the Gene Technology Regulator (OGTR), consulted with a wide range of stakeholders on regulatory options to address new technologies, outlined in a discussion paper. The OGTR received 741 submissions in response to the two month public submission period. Due to the complexity of the topic and significant community and stakeholder interest, the OGTR held follow-up discussions with a broad range of submitters.

Provide open, effective and transparent regulation of GMOs.
Source: 2016-17 Health Portfolio Budget Statements, p. 122

2016-17 Target	2016-17 Result
Risk assessments and risk management plans prepared for 100% of applications for licensed dealings. Stakeholders, including the public, consulted on all assessments for proposed release of GMOs into the environment.	Risk assessments and risk management plans were prepared for 100% of applications for release of GMOs into the environment. Stakeholders, including the public, were consulted on the assessments of these applications. **Result: Met**

In 2016-17, stakeholders, including the public, were consulted on 11 risk assessment and risk management plans in response to licence applications for field trials of GM banana, cotton, Indian mustard, potato, wheat, barley, sorghum, and a vaccine for chickens, and commercial releases of two types of GM cotton and a dengue vaccine.

Protect people and environment through identification and management of risks from GMOs.
Source: 2016-17 Health Portfolio Budget Statements, p. 122

2016-17 Target	2016-17 Result
Scientifically robust risk assessment and effective 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.	Scientifically robust risk assessments were prepared and all the risks identified for GMOs were effectively managed. The regulated entities reported high levels of compliance with the gene technology legislation and no adverse effects on Australian people or the environment from the approved GMOs. **Result: Met**

In 2016-17, there were no adverse effects on human health or the environment from authorised GMOs. High level of compliance with the gene technology legislation continued with no enforcement action required. Risk assessment and risk management plans for the release of GMOs are available online.[49]

[49] Available at: www.ogtr.gov.au/internet/ogtr/publishing.nsf/Content/ir-1

Facilitate cooperation and provision of advice between relevant regulatory agencies with responsibilities for GMOs and/or genetically modified products.

Source: 2016-17 Health Portfolio Budget Statements, p. 122

2016-17 Target	2016-17 Result
High degree of cooperation with relevant regulatory agencies and timely provision of advice, including supporting engagement in international fora.	A high degree of cooperation was maintained with relevant regulatory agencies with timely advice provided, as required. **Result: Met**

The Department, through the OGTR engaged with international fora relevant to GMO regulation including the Organisation for Economic Co-operation and Development 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 in meetings supporting the United Nations Convention on Biological Diversity and Cartagena Protocol on Biosafety.

Percentage of field trial sites and higher level containment facilities inspected.

Source: 2016-17 Health Portfolio Budget Statements, p. 123

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
≥20%	43% of field trial sites 26% of higher level containment facilities **Result: Met**	46% 21%	44% 26%	40% 25%	42% 25%

In 2016-17, the Department, through the OGTR inspectors, exceeded operational targets by inspecting 43% of field trial sites to monitor compliance with licence conditions. Sites were inspected in New South Wales, Queensland, Victoria and Western Australia. Crops inspected included GM canola, wheat, barley, cotton, sugarcane, white clover and safflower.

The Department, through the OGTR also inspected 26% of higher level containment facilities to ensure compliance with certification conditions. These inspections focused on the integrity of the physical structure of the facility and on the general laboratory practices followed.

Percentage of licence decisions made within statutory timeframes.

Source: 2016-17 Health Portfolio Budget Statements, p. 123

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	95%	100%	100%

In 2016-17, 100% of the licence decisions were made within the statutory timeframes. From these:

- six licences were issued for field trials of GM banana, cotton, Indian mustard, potato, wheat and a clinical trial of influenza vaccine;
- three commercial release licences were issued for two types of GM cotton, and a dengue vaccine; and
- ten licences were issued for work with GMOs in high level contained laboratory facilities.

Performance criteria from the 2016-17 Corporate Plan

Effective pre-market evaluation and post-market monitoring and assessment of therapeutic goods, as legislated.

Source: 2016-17 Department of Health Corporate Plan, p. 26

Refer p. 146 for performance criterion addressing pre-market evaluation, post-market monitoring and assessment of therapeutic goods.

Program 5.2: Health Protection and Emergency Response

The Department met the majority of performance targets related to Program 5.2: Health Protection and Emergency Response.

In 2016-17, specific priority populations most affected by blood borne viruses (BBV) and sexually transmissible infections (STI) as identified in the National BBV and STI Strategies 2014–2017, were supported through priority actions designed to increase prevention, testing and treatment related to BBV and STI. Priority actions undertaken included improving health professionals and affected populations' knowledge of the new hepatitis C treatments; supporting the capacity of community organisations to provide prevention education on HIV, and continuing to support activities to increase uptake of hepatitis B vaccinations in children.

The *Emergency Response Plan for Communicable Disease Incidents of National Significance* was completed and endorsed in May 2017. The plan provides a framework for escalating arrangements to ensure effective response to communicable disease, protecting the health of Australians. Greater effectiveness in managing the response will support minimising the impact on the community should an emergency occur.

Rapid responses to outbreaks of foodborne illnesses continue to be supported by the Commonwealth and State and Territory Governments through the signing of the Schedule for the OzFoodNet Program, which sits under the National Partnership Agreement (NPA) on Specified Projects. The NPA supports the delivery of OzFoodNet, a national system of enhanced foodborne disease surveillance that provides comprehensive information on foodborne disease and the capacity to rapidly identify and respond to outbreaks of foodborne disease.

In 2016-17, the Department continued to effectively respond to national health emergencies such as the ongoing Zika virus outbreak, limiting the morbidity and mortality from such events, which is essential in protecting the health of Australians.

The Government funds the Northern Territory Government through a bilateral Project Agreement to maintain the national Australian Medical Assistance Team (AUSMAT) capability.

The AUSMAT capability was deployed in February 2016 to Fiji for approximately three weeks to provide assistance after tropical cyclone Winston. The initial AUSMAT team of six personnel were deployed to Rakiraki, one of the most severely affected areas, and worked alongside local Fijian health personnel in mobile teams that were equipped to visit and assist people in remote communities. During the deployment, AUSMAT personnel provided medical assistance to more than 1,700 people across Fiji and supported the Fijian health authorities to establish enhanced surveillance and emergency management systems.

As Australia's National Focal Point under the International Health Regulations (2005), the Department's National Incident Room (NIR) responds to approximately 12 incidents a month. On a larger scale, the NIR provides the capability to coordinate a national response to health emergencies and health aspects of other emergencies. In 2016-17, responses were carried out for the international Zika virus outbreak and for the rise in invasive meningococcal disease cases due to serogroup W. In April 2017, the NIR facilitated communications from other areas of the health sector to Queensland Health during the response to Tropical Cyclone Debbie.

In order to reduce the risk of transmissible disease, in 2016-17 the Department continued to fund a mosquito control program that manages and successfully controls exotic mosquito populations with particular focus on the strategic transport hubs of Horn Island and Thursday Island.

The Department progressed a range of activities to support minimising the development and spread of antimicrobial resistance (AMR). Limiting the development and spread of AMR continues to protect the health of the Australian community by helping to ensure that antimicrobial treatments remain a viable and effective method of treating common infections.

As of November 2016, the new Health Protection Program came into effect, consolidating a number of activities that were previously funded separately. These activities are an important part of the Department's public health protection framework that supports an innovative and efficient health sector that contributes to improved health and safety outcomes for the Australian public.

Reducing the incidence of blood borne viruses and sexually transmissible infections

Support programs which are effective in reducing the spread of communicable disease and work towards the targets contained in the National BBV and STI Strategies 2014–2017.

Source: 2016-17 Health Portfolio Budget Statements, p. 124

2016-17 Target	2016-17 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 on progress of programs that support the National BBV and STI Strategies 2014–2017 was undertaken according to the evaluation framework. **Result: Met**

The reporting, presented to the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee, identified that all priority action areas contained in the National BBV and STI Strategies 2014–2017 were supported through programs and policy work undertaken by the Commonwealth, State and Territory Governments and community partners.

Providing a comprehensive and effective response to national health emergencies

Develop, exercise and refine national health emergency policy under the National Health Emergency Response Arrangements.

Source: 2016-17 Health Portfolio Budget Statements, p. 124

2016-17 Target	2016-17 Result
National Health Emergency Response Arrangements will be exercised and revised and an emergency response plan for communicable disease incidents of national significance will be developed.	The National Health Emergency Response Arrangements were exercised and revised through specific plans, and the Emergency Response Plan for Communicable Disease Incidents of National Significance (CDPlan) was completed and endorsed by the Australian Health Protection Principal Committee on 11 August 2016, with national arrangements endorsed in May 2017. **Result: Met**

The CDPlan provides a framework for identifying, monitoring and responding to emerging and nationally significant communicable diseases. The processes documented in the CDPlan have been tested during the recent response to invasive meningococcal disease due to serogroup W. Lessons learnt from this response will inform the review of the CDPlan.

The Domestic Health Response Plan for Chemical, Radiological, Biological and Nuclear Incidents of National Significance, a sub-plan to the National Health Emergency Response Arrangements, has been revised and is currently circulating with stakeholders for consultation. To refine the processes undertaken to implement the National Health Emergency Response Arrangements, the Department's staff undertook 34 training exercises.

Containment of national health emergencies through the timely engagement of national health coordination mechanisms and response plans.
Source: 2016-17 Health Portfolio Budget Statements, p. 124

2016-17 Target	2016-17 Result
National responses to health emergencies are successfully managed.	Effective responses were carried out for the international Zika virus outbreak, the rise in meningococcal W cases in Australia, Tropical Cyclone Winston in Fiji, and Tropical Cyclone Debbie in Queensland. **Result: Met**

An Australian National Audit Office audit report tabled on 22 June 2017 assessed the effectiveness of the Department's strategies for managing a communicable disease emergency (refer page 227 for audit recommendations). The report found that the Department responded effectively to the three communicable disease incidents examined, has developed strategies to manage its coordination role for communicable disease emergencies, and collects sufficient information to identify communicable disease incidents.

Improving biosecurity and minimising 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: 2016-17 Health Portfolio Budget Statements, p. 125

2016-17 Target	2016-17 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*.	Data was provided electronically, daily to the National Notifiable Diseases Surveillance System from States and Territories, and was available on request. **Result: Met**

Throughout 2016-17, data was made available to stakeholders upon request and published in the *Communicable Diseases Intelligence* journal.[50] Data sets for invasive pneumococcal disease, influenza, salmonella and invasive meningococcal disease are now publicly available.[51]

[50] Available at: www.health.gov.au/internet/main/publishing.nsf/content/cda-pubs-cdi-cdiintro.htm

[51] Available at: www9.health.gov.au/cda/source/cda-index.cfm

Manage and control exotic mosquito populations to reduce the risk of disease transmission in the Torres Strait and mainland Australia.

Source: 2016-17 Health Portfolio Budget Statements, p. 125

2016-17 Target	2016-17 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.	Surveillance reports continue to confirm the suppression of exotic mosquito populations in the Torres Strait. There have been no detections of the targeted exotic mosquito on mainland Australia. **Result: Met**

The program to protect Australia by preventing expansion of areas infested with the exotic mosquito, *Aedes albopictus*, has remained successful during 2016-17. Focus has been maintained on suppression of the exotic mosquito on the strategic transport hubs of Horn Island and Thursday Island. The intensive control and monitoring activities on these islands in recent years have resulted in near elimination, such that the species has been undetectable in most of the surveys conducted.

Mosquito suppression strategies have effectively prevented growth or expansion of the residual population of exotic mosquitoes and consequently there have been no detections of the exotic mosquito in surveys conducted on the mainland of Australia.

The development and spread of antimicrobial resistance (AMR) is minimised as a result of the *National Antimicrobial Resistance (AMR) Strategy 2015–19*.

Source: 2016-17 Health Portfolio Budget Statements, p. 125

2016-17 Target	2016-17 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.	In 2016-17, progress reports indicated that a range of activities were undertaken to contribute to minimise the development and spread of AMR in accordance with the National AMR Implementation Plan. **Result: Met**

The National AMR Implementation Plan incorporates an extensive stocktake of AMR-related activities being undertaken in Australia. In 2016-17, substantial progress has been made to support the AMR Strategy and Implementation Plan. Activities included:

- development of the national AMR and antimicrobial usage surveillance report;
- continuing to review and enhance the national AMR surveillance system;
- development of a 'One Health' AMR website to better coordinate AMR-related activities, information and education resources both in Australia and internationally;
- commitment of funds for AMR research funding through the Medical Research Future Fund;
- a mail-out campaign for general practice to enhance awareness of AMR prescribing issues; and
- commencement of a pilot project to implement the National Antimicrobial Prescribing Survey in General Practice.

Additionally, the Australian Strategic and Technical Advisory Group on antimicrobial resistance met in December 2016 to conduct a gap analysis workshop for AMR, and work has commenced on the development of a progress report on the National Antimicrobial Resistance Strategy. The Commonwealth (including the Department) has also actively participated in international fora including the United Nations, World Health Organization, Organisation for Economic Co-operation and Development, G20 and various other alliances and interest groups, to progress AMR issues.

Percentage of designated points of entry into Australia capable of responding to public health events, as defined in the International Health Regulations (2005).

Source: 2016-17 Health Portfolio Budget Statements, p. 125

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

With the speed of air travel, an outbreak of an infectious disease may occur on the other side of the world and an infected traveller may bring that disease into Australia within hours.

Under the *Biosecurity Act 2015*, all aircraft and vessels must enter Australian territory at designated Points of Entry (PoE) that meet a minimum number of standards as set by the Director of Biosecurity and Director of Human Biosecurity. There are 94 PoE in Australia, of which 14 are also designated as PoE under the International Health Regulations (IHR). To be a PoE under the IHR there are a number of capacities that must be maintained at all times including: access to medical services, good health and hygiene standards at airport and seaport terminals, vector control[52] programs, emergency plans which incorporate strategies to respond to health emergencies, and ready access to ambulance services.

An internal audit conducted in 2016 by the Department found that all 14 PoE were assessed as meeting the capacities under the IHR, and specifically that 100% of Australian PoE are capable of responding to public health events as defined in the IHR.

Supporting the development of policies and implementation activities relating to health protection issues of national significance

Establishment of the Health Protection Program to support the development of policies and activities relating to health issues of national significance comprising:

- **prevention;**
- **preparedness; and**
- **response.**

Source: 2016-17 Health Portfolio Budget Statements, p. 126

2016-17 Target	2016-17 Result
Implementation of the new Health Protection Program from 1 July 2016.	The Health Protection Program (HPP) commenced November 2016. **Result: Not met**

The HPP consolidates a number of activities that were previously funded under the Health Protection Fund, the Health Surveillance Fund and the Communicable Disease Prevention and Service Improvement Grants Fund.

The HPP was covered by the three existing guidelines until they were consolidated under the new HPP guidelines that were approved by the Minister for Finance on 1 February 2017. Due to the delays from the extensive approval processes required for legislative authority, the program was unable to commence from 1 July 2016.

The HPP will fund a small number of grants to organisations that due to their national role, World Health Organization accreditation or expertise may be required to provide ongoing surveillance and assistance in health protection.

[52] Vector control is any method to limit or eradicate the mammals, birds, insects or other arthropods which transmit disease pathogens.

Program 5.3: Immunisation

The Department either met or substantially met the majority of performance targets related to Program 5.3: Immunisation.

In 2016-17, advice was received which made the Department reconsider the need for a specific and expanded Australian Schools Vaccination Register, expanding on the existing National Human Papillomavirus Vaccination Register. As requested by Government, the Department is now looking at alternatives to the Australian Schools Vaccination Register that include options that may involve the whole-of-life Australian Immunisation Register.

As at September 2016, the whole-of-life Australian Immunisation Register came into full effect, expanding on the previous Australian Childhood Immunisation Register. This expansion has enabled increased reporting for additional population groups such as older Australians, enabling the capture of data for most privately purchased vaccines, in addition to these data provided through the National Immunisation Program (NIP).

Through the delivery of the NIP, childhood immunisation rates continue to be high, indicating a high level of protection in the Australian community. This high level of protection has continued to result in strengthening the protection for those medically unable to immunise.

Even though there has been an increase in immunisation coverage rates for Aboriginal and Torres Strait Islander children at 12–15 months of age, a significant gap still remains due to persistent adverse social and environmental barriers. Increased coverage rates ensure better protection against vaccine preventable diseases circulating within the community.

In order to provide assurance that all Australians are receiving safe vaccines, the Government invested in the AusVaxSafety National Surveillance System. This has provided access to a world-leading surveillance system, providing real-time feedback on NIP vaccines, enhancing the overall quality of vaccine safety in Australia.

In 2016-17, the Department completed a transition to a centralised procurement process for the supply of vaccines under the NIP. Centralised purchasing arrangements allow for the secure, ongoing supply of quality, safe and efficacious vaccines for the Australian population.

Increasing national immunisation coverage rates and improving the effectiveness of the National Immunisation Program

Key actions of the National Immunisation Strategy 2013-2018 (NIS) are implemented.
Source: 2016-17 Health Portfolio Budget Statements, p. 127

2016-17 Target	2016-17 Result
NIS actions to improve vaccination coverage rates are undertaken in accordance with the NIS Implementation Plan.	Actions to improve vaccination coverage rates were undertaken in accordance with the NIS Implementation Plan. **Result: Substantially met**

In 2016-17, three key actions were progressed.

- Improving immunisation data in order to increase vaccination coverage rates, especially in adolescents and adults.
- The expansion of the Australian Childhood Immunisation Register to become the whole-of-life Australian Immunisation Register, effective as of September 2016. This expansion will, over time enable reporting of whole-of-life immunisation coverage data for population groups such as older Australians.
- Implementing a new vaccination program from 1 November 2016 under the National Immunisation Program to provide a vaccine to protect 70 year olds against shingles, with a five year catch up program for people aged 71–79 years old.

New National Partnership Agreement on Essential Vaccines (NPEV) for 2017 onwards in place by 30 June 2017.

Source: 2016-17 Health Portfolio Budget Statements, p. 127

2016-17 Target	2016-17 Result
New NPEV agreed by First Ministers by 30 June 2017.	On 23 June 2017, the Prime Minister offered the new NPEV to all States and Territories. The new NPEV came into effect in July 2017. **Result: Not met**

The new NPEV strengthens governance of the National Immunisation Program and encourages continuous improvements in immunisation coverage rates, including amongst at risk cohorts, and sustainability by addressing wastage and leakage of vaccines.

Number of completed tenders under the NPEV (Essential Vaccines Procurement Strategy).

Source: 2016-17 Health Portfolio Budget Statements, p. 128

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
3	4 **Result: Met**	4	1	0	3

In 2009-10, the Department commenced the transition to centralised purchasing arrangements for essential vaccines funded under the National Immunisation Program (NIP). This transition was completed in 2016-17 with the procurement of five final vaccines for the NIP which supported the efficient and effective delivery of the program and ensured States and Territories were able to continue improving immunisation coverage rates. These vaccines were:

- Rotavirus vaccine for infants aged 2 and 4 months;
- hepatitis B (hepB) vaccine supplies for infants at birth;
- HepB-DTPa-Hib-IPV (hepatitis B, diphtheria, tetanus, acellular pertussis (whooping cough), Haemophilus influenzae type b, inactivated poliomyelitis (polio)) for infants aged 2, 4 and 6 months;
- DTPa-IPV (diphtheria, tetanus, acellular pertussis (whooping cough) and inactivated poliomyelitis (polio)) vaccine supplies for children aged 4 years; and
- adolescent booster dTpa (diphtheria, tetanus and acellular pertussis (whooping cough)) vaccine supplies for adolescents aged 10–15 years.

The Department also finalised procurement for the supply of the Herpes Zoster (Shingles) vaccines for older Australians.

Increase the immunisation coverage rates among children 12–15 months of age.

Source: 2016-17 Health Portfolio Budget Statements, p. 128

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
92.0%	93.8% **Result: Met**	93.0%	91.3%	90.4%	91.3%

Increase the immunisation coverage rates among children 24–27 months of age.

Source: 2016-17 Health Portfolio Budget Statements, p. 128

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
92.0%	90.9% **Result: Substantially met**	90.7%	89.2%	92.4%	92.4%

Increase the immunisation coverage rates among children 60–63 months of age.

Source: 2016-17 Health Portfolio Budget Statements, p. 128

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
92.5%	93.6% **Result: Met**	92.9%	92.3%	92.0%	91.5%

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

Source: 2016-17 Health Portfolio Budget Statements, p. 128

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
88.5%	92.2% **Result: Met**	89.8%	N/A	N/A	N/A

Immunisation coverage rates have continued to increase in 2016-17. This trend is expected to continue towards the World Health Organization Western Pacific Region, Chief Medical Officer's and Chief Health Officers' aspirational target coverage rate of 95%. The Department will continue to work with States and Territories to achieve this target.

In 2016-17, there has been an impact on coverage rates amongst children 24–27 months of age due to the changes in the definition of 'fully immunised'. Additional antigens have been included in the 'fully immunised' calculations which have resulted in lower coverage rates. These changes usually resolve over time as the additional vaccines become routine. The performance result of 'substantially met' for the 24–27 months of age cohort is based on meeting 98.8% of the target.

Immunisation coverage rates among 12–15 months of age Aboriginal and Torres Strait Islander children continues to improve with the gap between non-Indigenous children in the same cohort decreasing from 3.2% in 2015-16 to 1.6% in 2016-17.

Performance criteria from the 2016-17 Corporate Plan

Reduction in the number of notified cases preventable via immunisation.
Source: 2016-17 Department of Health Corporate Plan, p. 23

This performance criterion is supported by data from the Australian Institute of Health and Welfare and the National Notifiable Diseases Surveillance System, which is reported each year but has a two year data lag. Data for 2016-17 will be available in 2019 in *Australia's Health 2018*.

Data for 2014 indicates that 37% of all disease notifications in 2014 were for vaccine preventable diseases. This was a 70% increase on vaccine preventable disease cases notified in 2013. This increase can be attributed to a rise in influenza notifications, which peaked higher in 2014 than in previous seasons.

Outcome 5 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 5.1: Protect the Health and Safety of the Community through Regulation			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	-	-	-
Departmental expenses			
Departmental appropriation[1]	16,081	15,587	(494)
to Special Accounts	(10,522)	(10,522)	-
Expenses not requiring appropriation in the budget year[2]	88	473	385
Special Accounts			
OGTR Special Account[3]	7,773	7,453	(320)
NICNAS Special Account[4]	19,676	18,192	(1,484)
TGA Special Account[5]	153,535	149,656	(3,879)
Expense adjustment[6]	(8,566)	(5,636)	2,930
Expenses not requiring appropriation in the budget year[2]	-	119	119
Total for Program 5.1	**178,065**	**175,322**	**(2,743)**
Program 5.2: Health Protection and Emergency Response[7]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	88,699	79,724	(8,975)
Non cash expenses[8]	21,515	21,539	24
Special Accounts			
Human Pituitary Hormones Special Account (s78 PGPA Act)	160	199	39
Departmental expenses			
Departmental appropriation[1]	15,799	15,694	(105)
Expenses not requiring appropriation in the budget year[2]	1,221	1,923	702
Total for Program 5.2	**127,394**	**119,079**	**(8,315)**
Program 5.3: Immunisation[7]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	36,352	34,023	(2,329)
to Australian Childhood Immunisation Special Account	(5,913)	(6,971)	(1,058)
Special Accounts			
Australian Childhood Immunisation Register Special Account (s78 PGPA Act)	9,650	9,955	305
Special appropriations			
National Health Act 1953 – essential vaccines	302,619	294,505	(8,114)
Departmental expenses			
Departmental appropriation[1]	7,923	7,816	(107)
Expenses not requiring appropriation in the budget year[2]	555	909	354
Total for Program 5.3	**351,186**	**340,237**	**(10,949)**

Outcome 5 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Outcome 5 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	125,051	113,747	(11,304)
to Special Accounts	(5,913)	(6,971)	(1,058)
Non cash expenses[8]	21,515	21,539	24
Special Accounts	9,810	10,154	344
Special appropriations	302,619	294,505	(8,114)
Departmental expenses			
Departmental appropriation[1]	39,803	39,097	(706)
to Special Accounts	(10,522)	(10,522)	-
Expenses not requiring appropriation in the budget year[2]	1,864	3,305	1,441
Special Accounts	172,418	169,784	(2,634)
Total expenses for Outcome 5	**656,645**	**634,638**	**(22,007)**
Average staffing level (number)	**895**	**887**	**(8)**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

[1] Departmental appropriation combines 'Ordinary annual services (*Appropriation Act No. 1*)' and 'Revenue from independent sources (s74)'.

[2] Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

[3] Office of the Gene Technology Regulator Special Account.

[4] National Industrial Chemicals Notification and Assessment Scheme Special Account.

[5] Therapeutic Goods Administration Special Account.

[6] Special accounts are reported on a cash basis. The adjustment reflects the difference between expense and cash, and eliminates inter-entity transactions between the core Department and TGA.

[7] This program excludes National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

[8] Non cash expenses relate to the write down of drug stockpile inventory due to expiration, consumption and distribution.

Outcome 6:
Ageing and Aged Care

Improved wellbeing for older Australians through targeted support, access to quality care and related information services

Analysis of performance

In 2016-17, the Department continued to improve access to aged care services for older Australians. This included implementation of reforms enabling older Australians greater choice in their care, supported by the provision of good quality aged care information available through My Aged Care and the Australian Aged Care Quality Agency. Additionally, the Department continued to deliver Government programs that provided support for older people with dementia and people from diverse backgrounds to ensure that all older Australians have access to aged care services.

These activities have contributed to the Department's achievement of objectives under Outcome 6 and our Purpose.

Highlights

Improved My Aged Care processes and communications

Intensive sector engagement has resulted in progressive improvements to My Aged Care policy, processes, systems, and communication. More information from the Australian Aged Care Quality Agency is now available to enable consumers to choose services that best fit their needs.
Refer *Program 6.1*

Providing consumer-driven services through Increasing Choice in Home Care

The successfully implemented Increasing Choice in Home Care reforms provides older people with consumer-driven, high quality and innovative aged care services required to meet individual needs and circumstances.
Refer *Program 6.2*

Commencing the Short-Term Restorative Care and Continuity of Support programs

Options are now available to assist with reversing and/or slowing functional decline in older people and improving their wellbeing. Older people who are currently receiving State and Territory managed specialist disability services, but are ineligible for the National Disability Insurance Scheme, are also now supported.
Refer *Programs 6.2 & 6.3*

Provided $34 million in funding to support 42 aged care and dementia care projects

The aged care, research and education sectors have been awarded $34 million in grants across three financial years to support innovation in dementia care and other aged care services. This will strengthen the capacity of the aged care sector to better respond to existing and emerging challenges in the provision of care for older Australians.
Refer *Program 6.4*

Looking ahead

- The Department will negotiate new two year funding agreements with existing Commonwealth Home Support Programme (CHSP) and eligible Western Australian Home and Community Care (HACC) providers to 30 June 2020, to provide a greater focus on activities that support independence and wellness, and more choice for consumers.
- From 1 July 2018, Western Australian HACC services for people aged 65 years and over (and 50 years and over for Aboriginal and Torres Strait Islander peoples) will transition to the CHSP.
- Continue development of a Single Aged Care Quality Framework across all aged care services to introduce a single set of contemporary standards and improved quality assessment arrangements.
- Develop an Aged Care Diversity Framework to enhance the sector's capacity to better meet the diverse characteristics and life experiences of older people.
- Establish a taskforce to develop an aged care workforce strategy to identify options to boost supply, address demand and improve productivity for the aged care workforce.
- The Department will provide advice to Government in response to a number of aged care reviews, including the Review of National Aged Care Quality Regulatory Processes, the Legislated Review of Aged Care 2017, and the Senate Inquiry into the Effectiveness of the Aged Care Quality Assessment.

Purpose, programs and program objectives contributing to Outcome 6

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.
Program 6.1: Access and Information
Providing equitable and timely access to aged care assessments and making it easier for older people to find aged care services and information
Performance criteria from the 2016-17 Corporate Plan
Program 6.2: Home Support and Care
Providing entry level, support and care services through the Commonwealth Home Support Programme (CHSP) and providing coordinated Home Care Packages tailored to meet individuals' specific care needs
Program 6.3: Residential and Flexible Care
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
Administering the Accommodation Payment Guarantee Scheme
Performance criteria from the 2016-17 Corporate Plan
Program 6.4: Aged Care Quality
Promoting quality
Caring for and supporting people with dementia
Supporting the needs of people with dementia through the Dementia and Aged Care Services Fund
Supporting a diverse community
Performance criteria from the 2016-17 Corporate Plan

Program 6.1: Access and Information

The Department met the majority of performance targets related to Program 6.1: Access and Information.

In 2016-17, the Department continued to improve the quality of My Aged Care as the single entry point to the aged care system in Australia. The Department worked closely with key stakeholders to further improve My Aged Care services and increase awareness of My Aged Care through a range of communication activities.

The Department has also ensured that the Aged Care Assessment Program and Regional Assessment Service workforce completed mandatory training, to help ensure nationally consistent assessment of eligibility of clients for their aged care services.

Following a review of Commonwealth advocacy services in 2015, the Department has worked to redesign the National Advocacy Program, which included combining advocacy services delivered through the Commonwealth Home Support Programme. Advocacy services perform an important role in supporting older people to access and interact with the aged care system. Through advocacy services older people are supported and empowered to make informed decisions about the aged care services they receive and have their aged care rights protected.

My Aged Care – the starting point to access aged care

My Aged Care is the starting point to find information about, and access to, aged care support and services for older people, their families and carers.

My Aged Care includes a website and contact centre. The website provides information on the different types of aged care services available such as help at home, short-term support services and residential care as well as information about costs and service providers.

The My Aged Care contact centre can arrange for a trained worker to visit and assess people's care needs and eligibility for services, and work with older people to develop a support plan tailored to individual needs, goals and preferences.

"All the information is in one place – very clear to understand and relay to my 86-year-old grandmother." – Family member

"Very easy to follow path to information I required. Only my initial visit as I am now 82 and my husband 86 it is time to think about our future needs. Reassuring to find a website you can follow which pre-empts the questions one has at this time of life. Good size print and simple sentences." – Care recipient

"It was a positive conversation and it was certainly helpful, she outlined the sorts of things that potentially could happen so it sounded good." – Care recipient

"When you rang [My Aged Care], someone answered right away and helped you…I was absolutely stunned with the efficiency…they immediately got the person that would help me." – Care recipient

Providing equitable and timely access to aged care assessments and making it easier for older people to find aged care services and information

Aged Care Assessment Program (ACAP) and Regional Assessment Service organisations' training resources reflect current program operation and enable consistent decision-making.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result
All ACAP training reflects the current operation model, with six monthly reviews of all training resources to ensure currency is maintained.	ACAP training material was reviewed in July 2016 and January 2017 to maintain currency. **Result: Met**

The My Aged Care Statements of Attainment were reviewed by the Department and the Registered Training Organisation for accuracy twice in 2016-17.

Additional guidance and training materials were reviewed and provided to the ACAP and Regional Assessment Service organisations. Examples of these include:

- the My Aged Care National Screening and Assessment Form and Systems training material;
- a short course to support the changes to the Home Care Packages Program and the introduction of Short-Term Restorative Care for existing Aged Care Assessment Team staff; and
- quick reference guides and user guides.

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: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result
100% of the My Aged Care assessment workforce completes the mandatory training for their screening, assessment or delegate roles.	100% of the My Aged Care assessment workforce completed training as mandated in the Department's agreements with all assessment workforce organisations. **Result: Met**

My Aged Care assessment organisations were compliant with the My Aged Care program requirements that all assessment workforce staff complete mandatory training.

Training ensures the assessment workforce is equipped to undertake nationally consistent quality assessments of aged care needs with individual clients.

Continuing uptake of new models of Community Visitors Scheme.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result
Increase uptake of new models of Community Visitors Scheme.	Uptake of new models of the Community Visitors Scheme, including one-on-one home care visits and group visits in residential care, was increased. **Result: Met**

The Community Visitors Scheme uses volunteers to make regular visits to people who are socially isolated, or are at risk of being socially isolated or lonely.

In 2016-17, the Department continued delivery of the Community Visitors Scheme, providing one-on-one visits in aged care homes, for people receiving home care packages and group visits in residential aged care settings. This included targeting special needs groups, including people from culturally and linguistically diverse backgrounds and lesbian, gay, bisexual, transgender and intersex people.

Older Australians have access to advocacy services to promote their rights in the aged care sector.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result
Government funded advocacy services delivered include access for rural and remote communities and special needs groups.	Advocacy services through the National Aged Care Advocacy Program (NACAP) continued to be delivered nationally during 2016-17, with a particular focus on special needs groups as defined under the *Aged Care Act 1997*, which includes people living in rural and remote communities. **Result: Met**

During 2016-17, the Department provided funding to one organisation in each State and Territory (two in the Northern Territory) to deliver individual advocacy support through the NACAP. This ensured that advocacy services were accessible to older people in rural and remote communities. Advocacy providers are also required to ensure they deliver culturally appropriate support to special needs groups.

Following a review of Commonwealth advocacy services in 2015, during 2016-17, the Department redesigned the NACAP to create a single aged care advocacy program. This included combining advocacy services delivered through the Commonwealth Home Support Programme. In 2016-17, the NACAP handled more than 5,800 advocacy cases, 3,300 general enquiries, and provided over 1,700 face-to-face education sessions.

Average number of unique visitors per month to the My Aged Care website.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
131,000	238,650 **Result: Met**	203,045	116,366	56,000	N/A

Visits to the My Aged Care website have increased as a result of the Department's communication activities. The Department regularly promotes the My Aged Care website through emails to more than 14,000 stakeholders, and through print materials for consumers. An advertising campaign promoting My Aged Care, in print, radio, digital and social media in June 2017 significantly increased traffic to the website for that month.

Percentage of calls made to the My Aged Care Contact Centre answered within 20 seconds.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
80%	81% **Result: Met**	N/A	N/A	N/A	N/A

Percentage of surveyed consumers that are satisfied with the service provided by My Aged Care Contact Centre.
Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
>90%	95% **Result: Met**	97%	N/A	N/A	N/A

The Department has worked closely with Healthdirect Australia and Stellar to build and maintain quality performance of both the My Aged Care website and contact centre. A number of initiatives to improve quality and performance have been implemented during 2016-17.

Percentage of referrals issued via My Aged Care systems that assist clients to access appropriate assessment and services, and are accepted by assessors and providers.

Source: 2016-17 Health Portfolio Budget Statements, p. 135

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
75%	72% **Result: Substantially met**	N/A	N/A	N/A	N/A

The target for referrals accepted in 2016-17 was not met, however over the course of the year there has been a steady improvement in the percentage of referrals issued which are accepted. Assessors and service providers receive referrals with the expectation they will accept them. In the event a referral is rejected, for example, a client's circumstances have changed, a reason for rejection is recorded.

The performance result of 'substantially met' is based on meeting 96% of the target.

Percentage of high priority Aged Care Assessment Team (ACAT) assessments completed within 48 hours of referral.

Source: 2016-17 Health Portfolio Budget Statements, p. 136

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
90%	71% **Result: Substantially met**	96.9%	94.8%	89.0%	88.0%

The Department substantially met the target for the number of high priority assessments completed in 2016-17. The Department has agreements with State and Territory Governments to manage the Aged Care Assessment Program, and is actively working with the State and Territory Governments to improve performance in 2017-18.

The performance result of 'substantially met' is based on meeting 79% of the target.

Number of new client registrations.

Source: 2016-17 Health Portfolio Budget Statements, p. 136

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
202,200	338,346 **Result: Met**	288,649	N/A	N/A	N/A

The 2016-17 result reflects the number of new client registration events that have occurred on My Aged Care systems. Client registration events are demand-driven and have exceeded the 2016-17 target. The increase in the number of registrations on My Aged Care systems is a result of the Department's increased My Aged Care promotion and communication activities.

Number of assessments completed on My Aged Care.
Source: 2016-17 Health Portfolio Budget Statements, p. 136

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
505,300	374,679 **Result: Not met**	183,887	N/A	N/A	N/A

Aged Care Assessment Team (ACAT) workforces commenced assessing clients on My Aged Care in late 2015-16. The results for 2016-17 represent the first full year of client assessments completed by both the ACAT and Regional Assessment Service workforces on My Aged Care. Assessment numbers are demand driven and the target estimate for 2016-17 was not met. This is due to better triaging and information provision from the My Aged Care Contact Centre, avoiding the need for some clients to be reassessed.

Performance criteria from the 2016-17 Corporate Plan

Increased access to aged care services and information through My Aged Care.
Source: 2016-17 Department of Health Corporate Plan, p. 23

Refer p. 175 for performance criterion addressing access to aged care services and information through My Aged Care.

Program 6.2: Home Support and Care

The Department met or substantially met all performance targets related to Program 6.2: Home Support and Care.

In 2016-17, older people had access to 1,523 Commonwealth Home Support Programme (CHSP) providers. These providers delivered a range of entry-level support services to help frail older people to continue living in their own homes for as long as they can and wish to do so. CHSP support is underpinned by a wellness approach, which is about building on older people's strengths, capacity and goals to help them remain independent and to live safely at home.

In February 2017, the Government introduced the Increasing Choice in Home Care reforms, announced in the 2015-16 Budget. The reforms have allowed consumers and their families to make informed choices about home care and select a provider that best meets their needs. Providers have also been given better opportunities to expand their service offering and market themselves through the My Aged Care website.

In accordance with the Council of Australian Governments' commitment, the Commonwealth Continuity of Support Programme commenced to ensure that older people with disability, who are currently receiving State and Territory administered specialist disability services, but who are ineligible for the National Disability Insurance Scheme, will be provided with continuity of support.

Providing entry level, support and care services through the Commonwealth Home Support Programme (CHSP) and providing coordinated Home Care Packages tailored to meet individuals' specific care needs

Continuity of services delivering the Commonwealth Home Support Programme (CHSP) including Home and Community Care (HACC) services transitioned from Victoria.
Source: 2016-17 Health Portfolio Budget Statements, p. 137

2016-17 Target	2016-17 Result
Services continue to be provided during 2016-17 through the CHSP.	Services continued to be delivered through the CHSP. **Result: Met**

Number of older people receiving a service through the Commonwealth Home Support Programme.
Source: 2016-17 Health Portfolio Budget Statements, p. 138

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
896,979	722,838[53] **Result: Substantially met**	N/A	N/A	N/A	N/A

Number of Commonwealth Home Support Programme (CHSP) providers.
Source: 2016-17 Health Portfolio Budget Statements, p. 138

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
1,480	1,523 **Result: Met**	N/A	N/A	N/A	N/A

During 2016-17, the Government funded a total of 1,523 executed agreements with CHSP providers to deliver services in all States and Territories except for HACC type services in Western Australia (WA).

On 1 July 2016, the Department successfully transitioned 372 Victorian HACC providers to the CHSP. The transition of Western Australian HACC services for older people will occur from 1 July 2018.

[53] There has been a change to the counting methodology used for 2016-17 due to comprehensive CHSP data now available through the Data Exchange (DEX).

Establishment of the Commonwealth Continuity of Support (CoS) Programme.
Source: 2016-17 Health Portfolio Budget Statements, p. 137

2016-17 Target	2016-17 Result
CoS Programme established, and implemented from 1 July 2016 in line with National Disability Insurance Scheme (NDIS) roll out.	The CoS Programme guidelines were established by 1 July 2016. The Programme was implemented from 1 December 2016 in regions of New South Wales, Queensland and Tasmania in line with the roll out of the NDIS. **Result: Substantially met**

Commencement of the programme was held up due to a delay in agreeing administrative arrangements with State and Territory Governments. While the delay resulted in the initial transition dates moving to 1 December 2016, it has not affected the forward schedule, with full implementation still expected by 30 June 2020.

Individual transition dates within the implementation schedule are not in line with specific NDIS transition dates for all jurisdictions. In such cases, the changes were agreed bilaterally to achieve administrative simplicity for the transition and to manage the initial commencement delays. Expected full implementation of the CoS Programme is still in line with the NDIS full scheme implementation for each jurisdiction.

On 31 January 2017, the Department entered into a bilateral agreement with the Western Australia Government to transition aged care and disability services in Western Australia to the CoS Programme from 1 July 2019.

Number of older people receiving support through Commonwealth Continuity of Support (CoS) Programme.
Source: 2016-17 Health Portfolio Budget Statements, p. 138

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
1,875	968 **Result: Not met**	N/A	N/A	N/A	N/A

The number of older people receiving CoS support is lower than the target due to revised implementation arrangements being agreed with some State and Territory Governments.

Stage 1 of Increasing Choice in Home Care will be implemented from February 2017.
Source: 2016-17 Health Portfolio Budget Statements, p. 137

2016-17 Target	2016-17 Result
Systems changes will be made that accommodate the implementation of Stage 1 of the Increasing Choice in Home Care service.	Systems changes were released to accommodate the implementation of Stage 1 of the Increasing Choice in Home Care service. **Result: Met**

The Increasing Choice in Home Care reforms were introduced on 27 February 2017, including the successful release of My Aged Care system changes. Consumers have adjusted to their new level of choice and control. Providers are also adapting well to a new system that is market-based and consumer-driven.

Number of allocated Home Care Packages at end of financial year.
Source: 2016-17 Health Portfolio Budget Statements, p. 138

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
90,763	91,980 **Result: Met**	N/A	N/A	N/A	N/A

Home Care Packages are now assigned to eligible consumers through the national prioritisation system managed by My Aged Care. The new process allows a fairer allocation of packages to consumers, based on their individual needs and circumstances, and the time they have been waiting for care, regardless of where they live.

Program 6.3: Residential and Flexible Care

The Department met or substantially met the majority of performance targets related to Program 6.3: Residential and Flexible Care.

Residential aged care provides accommodation and care for older people who are unable to continue living independently in their own homes, on both a permanent and short-term basis. In 2016-17, the number of operational residential aged care places increased to 204,366, representing an increase in capacity and ensuring that more older Australians are able to access appropriate care.

Through the 2016-17 Aged Care Approvals Round, the Department allocated 475 Short-Term Restorative Care (STRC) places; 400 of these commenced in February 2017, with the remaining places commencing on 1 July 2017. The STRC Programme was announced by the Government in 2015 and increases the care options available to older people, through time-limited, goal-oriented, multi-disciplinary and coordinated packages of services.

The Department continued to increase availability of flexible aged care services, through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and the Multi-Purpose Service Program. There was a delay in conducting a funding round for the NATSIFACP, which meant the Department was unable to achieve its target for the number of places available under the program. However, a new flexible aged care service is being established in Nhulunbuy, Northern Territory, which will include up to 25 places.

In 2016-17, the Department adjusted its strategy in reviewing Aged Care Funding Instrument claims. This change meant that the Department conducted fewer reviews and focussed resources on undertaking more comprehensive reviews of high risk services. While these reviews took longer than previous routine reviews, they addressed risks to Commonwealth expenditure more effectively.

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

Establish the Short-Term Restorative Care (STRC) Programme and undertake a competitive Aged Care Approvals Round (ACAR) (which would include STRC).
Source: 2016-17 Health Portfolio Budget Statements, p. 140

2016-17 Target	2016-17 Result
Competitive ACAR undertaken, including new Short-Term Restorative Care places with outcomes to be announced in late 2016.	The STRC Programme was established through legislative changes in 2016 and the allocation of places in 2017. The 2016-17 ACAR was undertaken, with applications closing on 28 October 2016. ACAR outcomes were announced in two stages: STRC places on 23 February 2017; residential aged care places and capital funding on 26 May 2017. **Result: Substantially met**

The STRC Programme was established through legislative changes made in May 2016.

In the 2016-17 ACAR, 10,386 new aged care places were allocated, consisting of 475 STRC places and 9,911 residential aged care places.

In addition, $64 million in capital grants was allocated to build new and upgrade existing residential aged care services.

The ACAR process was completed in 2016-17. The target timeframe for the announcement of STRC results was not met due to the high numbers and competitiveness of applications. The timeframes were in line with expectations for an open, competitive process.

Over 3,000 people a year may be able to access care through the 475 STRC places allocated in the 2016-17 ACAR. The allocation of residential aged care places and capital grant funding will continue to provide older Australians with greater choice and flexibility should their care needs increase.

Expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and the Multi-Purpose Services Program.
Source: 2016-17 Health Portfolio Budget Statements, p. 140

2016-17 Target	2016-17 Result
Conduct a funding round to expand existing services funded under the NATSIFACP, with places allocated in 2016; and conduct a Multi-Purpose Service approvals round with places allocated in 2016.	The funding round to expand the NATSIFACP is due to be finalised in September 2017. The Multi-Purpose Services Program funding round was finalised in December 2016, and places were allocated in January 2017. **Result: Not met**

The Department did not meet its target to conduct a funding round to expand the NATSIFACP in 2016. The funding round required significant consideration by Government to ensure the expansion targeted areas of greatest need. The funding round opened on 1 June 2017 and closed on 27 July 2017.

A total of 55 new places were approved through the Multi-Purpose Services Program funding round and 156 places were amended from low to high levels of care, which reflects increased care needs of care recipients.

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: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
850	820 **Result: Substantially met**	820	802	739	679

Additional places will be allocated following the expansion of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, due to be finalised in September 2017. In addition, a new flexible aged care service is being established in Nhulunbuy, Northern Territory. Up to 25 places will be made available to establish this service.

The performance result of 'substantially met' is based on meeting 96% of the target.

Number of operational Residential Aged Care places available by 30 June each year.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
206,700	204,335 **Result: Substantially met**	199,449	195,953	192,834	189,761

The number of operational residential aged care places has increased since 2015-16. The Department continues to monitor the impact of the red tape reduction measures introduced in early 2016 that encourage providers to operationalise their provisionally allocated places.

The number of operational residential care places at a given point in time depends on the activities of approved providers. Places may be taken out of operation for many reasons, including for refurbishment, or to allow for extensions to be built.

While the target was 'substantially met', the result represents an increase in the number of operational aged care places.

The performance result of 'substantially met' is based on meeting 99% of the target.

Number of operational transition care places available by 30 June each year.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
4,000	4,019 **Result: Met**	4,000	4,000	4,000	4,000

Between 2012 and 2017 there were 4,000 transition care places available nationally. In 2017, 60 additional time-limited transition care places were allocated to Western Australia aimed at addressing short-term concerns flowing from the demand for residential care in that state. Of these 60 places, 19 were made operational in 2016-17.

Number of operational Short-Term Restorative Care places available by 30 June each year.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
400	400 **Result: Met**	N/A	N/A	N/A	N/A

On 23 February 2017, 400 Short-Term Restorative Care (STRC) places commenced with immediate effect. Approved providers of STRC have been able to deliver care through these places and claim subsidy with respect to them from the point of allocation.

Number of operational Multi-Purpose Services places available by 30 June each year.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
3,845	3,636 **Result: Substantially met**	3,592	3,545	3,525	3,483

There were fewer applications for new flexible care places than expected in the 2016-17 allocations round. A total of 55 new places were approved, 31 of which were provisional allocations that are not yet operational. There was a higher demand to change the level of care for existing places (156) from low to high, which is reflective of more complex care needs of care recipients.

There are 58 provisional allocations in total, which will become operational when capital works are complete.

The performance result of 'substantially met' is based on meeting 95% of the target.

Number of Innovative Pool places available by 30 June each year.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
84	62 **Result: Met**	75	84	92	100

The Innovative Pool Program is designed to test new approaches to providing flexible models of aged care service delivery, and is not intended to provide ongoing services. In 2016-17, there were 62 places in the Innovative Pool Program. Only the existing cohort of clients are able to receive care through this program. As such, the number of individuals in the program, and thus the number of allocated places, decreases as they exit the program. The decrease in the number of innovative pool places is a positive result as it reflects that people have been able to access appropriate care through other aged care and disability programs.

Number of annual reviews of Aged Care Funding Instrument funding claims to ensure residents are correctly funded.
Source: 2016-17 Health Portfolio Budget Statements, p. 141

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
20,000	10,318 **Result: Not met**	15,763	20,587	20,349	21,426

The number of reviews undertaken did not meet the 2016-17 target as the Department adjusted its strategy to focus resources on undertaking more comprehensive reviews of high risk services. These reviews took approximately twice the time of routine reviews but were far more effective in addressing risks to Commonwealth expenditure, through better targeting and identification of incorrect Aged Care Funding Instrument claiming, and correction of these claims.

Administering the Accommodation Payment Guarantee Scheme

All lump sums are refunded once a refund declaration has been issued.
Source: 2016-17 Health Portfolio Budget Statements, p. 142

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	N/A	N/A

All refunds are made within 14 days following the Secretary's refund declaration.
Source: 2016-17 Health Portfolio Budget Statements, p. 142

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	N/A	N/A

During 2016-17, the Secretary made one refund declaration under the Accommodation Payment Guarantee Scheme. The Department made the refund within a week of the declaration.

Performance criteria from the 2016-17 Corporate Plan

Improved outcomes for people who are financially disadvantaged and in need of residential-based care.
Source: 2016-17 Department of Health Corporate Plan, p. 25

In 2016-17, 45.6% of residents in care were classified as concessional, assisted, supported or low means. This is an increase from 37.7% in 2015-16.

Fewer hospital patient days (compared to 2014–15 financial year) used by people who would be eligible for residential aged care.
Source: 2016-17 Department of Health Corporate Plan, p. 25

This performance criterion is supported by data from the Australian Institute of Health and Welfare. Data for 2016-17 will be released in July 2018.

The data over the last three previous financial years shows an increase in the number of hospital days used by people eligible for residential aged care. The highest rates were for patients living in remote or very remote areas and for those living in the two lowest socioeconomic status groups.

Program 6.4: Aged Care Quality

The Department met all performance targets related to Program 6.4: Aged Care Quality.

In 2016-17, the Department continued to strengthen the capacity of the aged care sector to support delivery of care and services to people with dementia, their carers and families, and people from diverse backgrounds. The Department provided $34 million for 42 projects to be implemented between 2016 and 2019. These projects include a trial of innovative virtual support for carers of people with dementia in rural communities, and models of care aimed at improving care for people with dementia in rural and remote environments.

The Department also provided support for activities focussing on older Aboriginal and Torres Strait Islander peoples and services. Projects funded included the use of remote community art centres to link older Aboriginal peoples to community aged care services, and the creation of culturally appropriate care workforce models for aged care workers. These projects aim to ensure people from Aboriginal and Torres Strait Islander backgrounds receive the same quality of aged care as other older Australians.

Activities which address the *National Ageing & Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* and the *National Ageing and Aged Care Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Strategy* help embed in aged care the principles of access and equity, inclusion, empowerment, quality, and capacity building for older CALD and LGBTI people. The aged care sector has seen improvements in these principles since the development and implementation of these strategies in 2012. Reports on the implementation of each strategy are due to be published in late 2017.

The Department also promoted the provision of quality aged care services, through increasing the availability of Australian Aged Care Quality Agency information on the My Aged Care website, enabling clients to make informed decisions. The Department continued to monitor compliance with the *Aged Care Act 1997*, taking appropriate action to bring providers back to compliance as quickly as possible to protect the health, safety and wellbeing of care recipients.

Promoting quality

More information about the quality of aged care services is available to consumers on My Aged Care.

Source: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 Result
Links from My Aged Care to the Australian Aged Care Quality website are established in 2017 to enable consumers to access information about the performance of aged care services against quality standards.	Links from My Aged Care to the Australian Aged Care Quality Agency (Quality Agency) website were established in 2017. **Result: Met**

The Quality Agency undertakes accreditation and review audits to assess and monitor the performance of residential aged care homes. The Quality Agency must publish Residential Aged Care Accreditation Decisions and the site audit report upon which these decisions rely. These contain findings about whether the home meets the required standards and expected outcomes, which help current and prospective residents make informed decisions about their care.

The Department has strengthened the existing web links to the Quality Agency's Accreditation Decisions and site audit reports by making these more prominent on the My Aged Care service finder pages and the page that explains the accreditation process.

A new non-compliance service finder was added to My Aged Care to allow consumers to more easily search for compliance action taken against individual homes. This includes current and archived notices of non-compliance and sanctions.

Extent to which the Department has taken appropriate action to identify and respond to provider financial risk where those risks have been assessed as being at the highest level.

Source: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 Result
Action taken by the Department is proportionate to the level of risk and in accordance with the *Aged Care Act 1997*.	Identification of and response action taken by the Department continues to be proportionate to the level of risk and in accordance with the Act. **Result: Met**

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: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 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 serious non-compliance in accordance with the Act. **Result: Met**

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: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

The Department applies a risk-based approach in responding to identified instances of non-compliance.

Following assessment, all instances of financial non-compliance identified were responded to appropriately and proportionately in accordance with the *Aged Care Act 1997*. In the reporting period, no sanctions were imposed on approved providers for financial non-compliance.

The Department imposed 11 sanctions on 11 approved providers. Nine sanctions were imposed following identification of an immediate and severe risk to the safety, health or welfare of care recipients, and two sanctions were imposed following approved providers not addressing and remedying non-compliance by the agreed date. The imposed sanctions, based on assessment, were in accordance with the *Aged Care Act 1997*.

Percentage of General Purpose Financial Reports submitted by approved providers reviewed to assess financial risk.

Source: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

Risk profiling was applied across all approved providers 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: 2016-17 Health Portfolio Budget Statements, p. 144

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
100%	100% **Result: Met**	100%	100%	100%	100%

Detailed risk assessments were undertaken on all approved providers assessed at the highest financial risk level. Compliance approaches were identified to bring those providers back to compliance if required.

Caring for and supporting people with dementia

Number of service episodes delivered by Dementia Behaviour Management Advisory Services (DBMAS) 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: 2016-17 Health Portfolio Budget Statements, p. 145

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
7,100	7,308 **Result: Met**	7,941	7,323	N/A	N/A

The DBMAS became a national service on 1 October 2016, replacing eight separately managed services. During 2016-17, 88% of surveyed users[54] of the new national service reported that the intervention from DBMAS increased their confidence when caring for someone experiencing behavioural and psychological symptoms of dementia.

Number of service episodes delivered by Severe Behaviour Response Teams (SBRT).
Source: 2016-17 Health Portfolio Budget Statements, p. 145

2016-17 Target	2016-17 Result	2015-16	2014-15	2013-14	2012-13
610	531 **Result: Met**	319	N/A	N/A	N/A

This is a demand-driven program with referrals from Dementia Behaviour Management Advisory Services. The SBRT provides intensive support for people living with very severe behavioural and psychological symptoms. During 2016-17, 90% of surveyed service users[55] were satisfied with the SBRT service.

Service episodes are client demand-driven. The performance result of 'met' is based on meeting all of the 2016-17 actual demand.

[54] People surveyed include providers of care for, and the families of, people living with dementia.
[55] Ibid.

Supporting the needs of people with dementia through the Dementia and Aged Care Services Fund

Funding will be available under the Dementia and Aged Care Services (DACS) Fund.
Source: 2016-17 Health Portfolio Budget Statements, p. 146

2016-17 Target	2016-17 Result
An open grant funding round is advertised in 2016.	An open grant funding round was held in 2016. **Result: Met**

The Department held an open competitive grant funding round which closed on 20 December 2016, with applications sought across six grant categories. $34 million in funding has been granted to 42 projects which will be implemented between 2016 and 2019. They include a trial of innovative virtual support for carers of people with dementia in rural communities; a multi-lingual virtual house for the delivery of practical information to enable older people to age safely at home; models of care aimed at improving care for people with dementia in rural and remote environments; a telehealth-facilitated model of care; and a trial of a virtual reality driving simulator to support older people in testing their driving skills.

Activities and projects that improve the lives of people with dementia are delivered, including as part of Severe Behaviour Response Teams (SBRT).
Source: 2016-17 Health Portfolio Budget Statements, p. 146

2016-17 Target	2016-17 Result
Continued Government funding of a number of programs which provide additional support for people with dementia.	Funding was provided for the suite of existing dementia programs. **Result: Met**

During 2016-17, the Department moved to a national service provision model for Dementia Behaviour Management Advisory Services and the Dementia Training Program. Other core programs that continued to receive funding are the National Dementia Support Program and the SBRT.

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: 2016-17 Health Portfolio Budget Statements, p. 146

2016-17 Target	2016-17 Result
The 2016 grant funding round is advertised in 2016 and will include a focus on Aboriginal and Torres Strait Islander peoples and services.	An open funding round was advertised and held in 2016. **Result: Met**

A priority of the 2016-17 Dementia and Aged Care Services Fund Innovation and Research round was support for activities focussing on older Aboriginal and Torres Strait Islander peoples and services. Ten projects were funded, including the use of remote community art centres to link older Aboriginal and Torres Strait Islander peoples to community aged care services, the creation of culturally appropriate care workforce models, a telehealth-facilitated model of care, and supporting Aboriginal community members to undertake professional 'within community' model of caring for people with dementia. In addition, five minor capital projects were funded.

Supporting a diverse community

Continued implementation of the National Ageing & Aged Care Strategy (for people from CALD backgrounds) and the National Ageing and Ageing Care LGBTI Strategy.

Source: 2016-17 Health Portfolio Budget Statements, p. 146

2016-17 Target	2016-17 Result
Continued Government funding of Partners In Culturally Appropriate Care (PICAC) to support and promote an understanding of cultural issues impacting upon CALD people accessing aged care services including issues and accessibility of services through My Aged Care. Continued Government funding of LGBTI and CALD projects under Dementia and Aged Care Services (DACS). Continued support for the CALD and LGBTI Ageing and Aged Care Working Groups.	The PICAC Program continued to be funded to equip aged care providers to deliver culturally appropriate care to older people from CALD backgrounds. The Government continued to fund LGBTI and CALD projects under DACS, with new projects funded through the 2016 DACS funding round. Support for the CALD and LGBTI Ageing and Aged Care Strategy Working Groups was ongoing. **Result: Met**

Under the PICAC program, an organisation is funded in each State and the Northern Territory (Australian Capital Territory services are delivered by the New South Wales provider) to support aged care providers to deliver culturally appropriate care to older people from CALD communities, and to help older CALD people and their families make informed decisions about their aged care needs. In 2016-17, a particular focus of PICAC was the accessibility of services through My Aged Care.

In addition to the standard PICAC funding, the NSW/ACT PICAC provider continued to undertake the My Aged Care CALD Accessibility Project, funded through DACS, which aims to identify barriers to accessing My Aged Care for older CALD people, and propose solutions. A conference was held on 20-21 September 2016, which brought together departmental staff, aged care providers, CALD community groups, and Government Ministers to discuss these issues and solutions.

CALD and LGBTI Ageing and Aged Care Strategy Working Groups continued in 2016-17, with seven face-to-face meetings held in total (up from four in 2015-16), supplemented by a number of teleconferences. With assistance from the CALD and LGBTI Working Groups, the Government reviewed the implementation of both Strategies.

Performance criteria from the 2016-17 Corporate Plan

Aged care providers meet the required quality and prudential standards.

Source: 2016-17 Department of Health Corporate Plan, p. 23 & 26

The Government, through the Australian Aged Care Quality Agency (AACQA), promotes high quality care by monitoring the performance of aged care providers against the Accreditation Standards, using assessment contact and review audits. Latest figures from 2015-16 show that 94.4% of homes achieved compliance by the end of the 'timetable for improvement' period. Further information can be found in the AACQA 2015-16 Annual Report.

Improved equity of access to care for special needs populations.
Source: 2016-17 Department of Health Corporate Plan, p. 25

The *Aged Care Act 1997* specifies that special needs groups include: people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; veterans; people who live in rural or remote areas; people who are financially or socially disadvantaged; people who are homeless or at risk of becoming homeless; care-leavers; parents separated from their children by forced adoption or removal; lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

For the latest information about equity of access to care for special needs populations refer to Chapter 8 of the *2015-16 Report on the Operation of the Aged Care Act 1997*.[56]

[56] Available at: agedcare.health.gov.au/publications-and-articles/reports/report-on-the-operation-of-the-aged-care-act-1997

Outcome 6 – Budgeted expenses and resources

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 6.1: Access and Information			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	195,875	193,806	(2,069)
Departmental expenses			
Departmental appropriation[1]	43,457	43,098	(359)
Expenses not requiring appropriation in the budget year[2]	2,582	4,970	2,388
Total for Program 6.1	**241,914**	**241,874**	**(40)**
Program 6.2: Home Support and Care[3]			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	2,269,276	2,228,706	(40,570)
Special appropriations			
Aged Care Act 1997 – Home Care Packages	1,726,419	1,586,164	(140,255)
National Health Act 1953 – continence aids payments	85,291	84,614	(677)
Departmental expenses			
Departmental appropriation[1]	43,151	41,812	(1,339)
Expenses not requiring appropriation in the budget year[2]	2,858	4,774	1,916
Total for Program 6.2	**4,126,995**	**3,946,070**	**(180,925)**
Program 6.3: Residential and Flexible Care			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[4]	107,546	106,934	(612)
Zero Real Interest Loans			
– appropriation	67,040	39,180	(27,860)
– expense adjustment[5]	(47,451)	(14,990)	32,461
Special appropriations			
Aged Care Act 1997 – residential care	10,885,981	10,806,366	(79,615)
Aged Care Act 1997 – flexible care	431,390	419,208	(12,182)
Aged Care (Accommodation Payment Security) Act 2006	801	128	(673)
Departmental expenses			
Departmental appropriation[1]	48,661	48,326	(335)
Expenses not requiring appropriation in the budget year[2]	2,983	5,353	2,370
Total for Program 6.3	**11,496,951**	**11,410,505**	**(86,446)**

Outcome 6 – Budgeted expenses and resources (continued)

	Budget estimate 2016-17 $'000 (A)	Actual 2016-17 $'000 (B)	Variation $'000 (B) - (A)
Program 6.4: Aged Care Quality			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)	131,432	121,975	(9,457)
Departmental expenses			
Departmental appropriation[1]	52,011	48,699	(3,312)
Expenses not requiring appropriation in the budget year[2]	2,684	5,040	2,356
Total for Program 6.4	**186,127**	**175,714**	**(10,413)**
Outcome 6 totals by appropriation type			
Administered expenses			
Ordinary annual services (*Appropriation Act No. 1*)[4]	2,771,169	2,690,601	(80,568)
– expense adjustment[5]	(47,451)	(14,990)	32,461
Special appropriations	13,129,882	12,896,480	(233,402)
Departmental expenses			
Departmental appropriation[1]	187,280	181,935	(5,345)
Expenses not requiring appropriation in the budget year[2]	11,107	20,137	9,030
Total expenses for Outcome 6	**16,051,987**	**15,774,163**	**(277,824)**
Average staffing level (number)	**1,157**	**1,149**	**(8)**

Note: Budget estimate represents estimated actual from 2017-18 Health Portfolio Budget Statements.

[1] Departmental appropriation combines 'Ordinary annual services (*Appropriation Act No. 1*)' and 'Revenue from independent sources (s74)'.

[2] Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and audit fees.

[3] This program excludes Home and Community Care National Partnership payments to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

[4] 'Ordinary annual services (*Appropriation Act No. 1*)' against program 6.3 excludes amounts appropriated in Bill 1 for Zero Real Interest Loans as this funding is not accounted for as an expense.

[5] Payments under the Zero Real Interest Loans program are a loan to aged care providers and not accounted for as an expense. The concessional loan discount is the expense and represents the difference between an estimate of the market rate of interest, and that recovered under the loan agreement, over the life of the loan. This adjustment recognises the difference between the appropriation and the concessional loan discount expense.

Part 2.2: Entity Resource Statement

		Actual available appropriation 2016-17 $'000 (A)	Payments made 2016-17 $'000 (B)	Balance remaining 2016-17 $'000 (A) - (B)
Ordinary annual services[1]				
Departmental appropriation				
Prior year departmental appropriation		105,209	105,209	-
Departmental appropriation [2]		655,204	619,788	35,416
Departmental capital budget [3]		9,828	9,828	-
Receipts retained under PGPA Act - section 74		114,459	114,459	-
Total		**884,700**	**849,284**	**35,416**
Administered expenses[4]				
Outcome 1		124,674	122,866	
Outcome 2		4,037,502	3,962,757	
Outcome 3		18,475	18,798	
Outcome 4		1,338,531	1,316,086	
Outcome 5		125,051	135,414	
Outcome 6		2,771,169	2,742,323	
Receipts retained under PGPA Act - section 74		43,413	-	
Payments to corporate Commonwealth entities		405,074	405,074	
Total		**8,863,889**	**8,703,319**	
Total ordinary annual services	**A**	**9,748,589**	**9,552,603**	
Other services[5]				
Departmental non-operating				
Prior year departmental appropriation		1,425	-	1,425
Equity injections		6,571	5,321	1,250
Total		**7,996**	**5,321**	**2,675**
Administered non-operating				
Prior year administered appropriation		142,087	11,758	
Administered assets and liabilities		150,537	23,486	
Payments to corporate Commonwealth entities		10,589	10,589	
Total		**303,213**	**45,833**	
Total other services	**B**	**311,208**	**51,154**	
Total available annual appropriations and payments		**10,059,798**	**9,603,757**	

		Actual available appropriation 2016-17 $'000 (A)	Payments made 2016-17 $'000 (B)	Balance remaining 2016-17 $'000 (A) - (B)
Special appropriations				
Special appropriations limited by criteria/entitlement				
Aged Care (Accommodation Payments Security) Act 2006			720	
Aged Care Act 1997			12,948,343	
Health Insurance Act 1973			22,039,801	
National Health Act 1953			13,754,186	
Medical Indemnity Act 2002			61,952	
Dental Benefits Act 2008			319,304	
Private Health Insurance Act 2007			5,992,179	
Public Governance, Performance and Accountability Act 2013 – s77			576	
Total special appropriations	**C**		**55,117,061**	
Special accounts[6]				
Opening balance		95,762		
Appropriation receipts[7]		20,948		
on-appropriation receipts to special accounts		165,545		
Payments made		-	185,753	
Total special accounts	**D**	**282,255**	**185,753**	**96,502**
Total resourcing and payments[8]	**A+B+ C+D**	**10,342,053**	**64,906,571**	
Less appropriations drawn from annual or special appropriations above				
and credit to special accounts		20,948		
and credit to corporate entities		415,663	415,663	
Total net resourcing and payments for the Department of Health		**9,905,442**	**64,490,908**	

Note: Actual available appropriation represents estimated actual from the 2017-18 Health Portfolio Budget Statements.

1 *Appropriation Act (No. 1) 2016-17*, *Appropriation Act (No. 3) 2016-17*, *Supply Act (No.1) 2016-17*. This also includes prior year departmental appropriation and section 74 retained revenue receipts.

2 This includes an amount of $577,000 appropriated in 2017-18 Budget relating to 2016-17.

3 For accounting purposes this amount has been designated as 'contributions by owners'.

4 In 2017 administered ordinary annual services appropriations, $135,447,039.00 of the *Appropriation Act (No.1) 2016-17* and $25,561,444.40 of the *Supply Act (No.1) 2016-17*, were permanently quarantined under section 51 of the PGPA Act.

5 *Appropriation Act (No.2) 2016-17*, *Supply Act (No.2) 2016-17*.

6 Does not include 'Relevant Public Money' held in Services for Other Entities and Trust Moneys special account (SOETM).

7 Appropriation receipts from the Department of Health and special appropriations for 2016-17 included above.

8 Total resourcing excludes the actual available appropriation for all Special Appropriations.

Part 3: Management and Accountability

Part 3.1: Corporate Governance

Senior governance committees

The senior governance committees provide advice and recommendations to the Executive to support organisational performance. In August 2016, the Department established the new Data Governance and Analytics Committee to provide oversight and direction for the strategic management and sharing of the Department's data holdings, analytics and compliance activities. Figure 3.1.1 below shows the Department's senior governance committee structure.

Figure 3.1.1: Senior governance committee structure

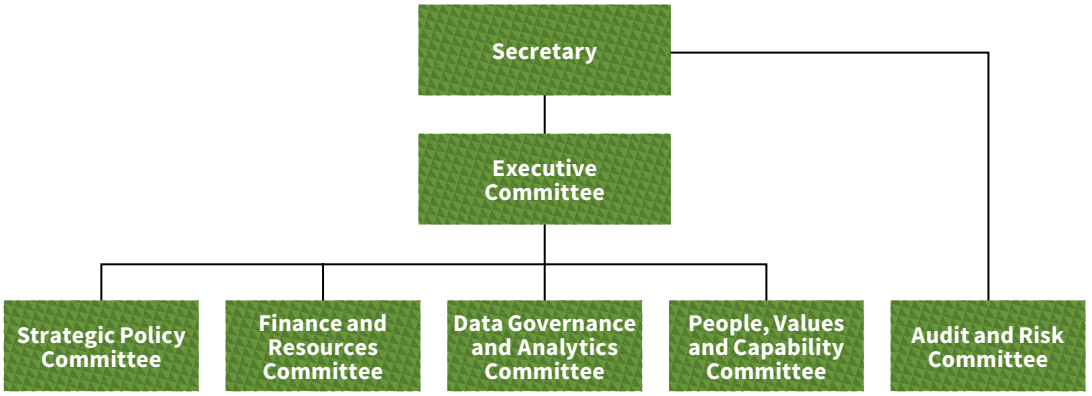


Table 3.1.1: Senior governance committees

Committee	Role
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 Committee met 10 times in 2016-17. Biographies for the Executive members of the Committee are located within *Part 1.1: Executive*.
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 2016–20*. The Committee met 11 times in 2016-17.
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 2016-17.
Data Governance and Analytics Committee	The Data Governance and Analytics Committee is chaired by a Deputy Secretary with members chosen from the SES. It makes recommendations to the Secretary and the Executive Committee on the whole-of-portfolio approach to data capture, use, access, release and analytics that drive data sharing and connection, and better informed health policy. It leads and has oversight of the direction for the strategic management and sharing of the Department's data holdings, analytics and compliance activities. The Committee met seven times in 2016-17.
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. It makes recommendations to the Secretary and the Executive Committee on strategies to embed the Department's values, ensures the Department has the people and capability it needs, that the Department's workforce is sustainable to maintain and increase productivity and efficiency, and support staff health and wellbeing, consistent with the *People Strategy 2016–20*. The Committee met 11 times in 2016-17.
Audit and Risk Committee	The Audit and Risk Committee membership comprises of an independent external chair, two independent external members and two members chosen from the SES. 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 non-financial performance reporting. The Committee met six times in 2016-17.

Audit and Risk Committee membership

As at 30 June 2017, membership of the Audit and Risk Committee comprised:

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 35 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 members 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 1.2: Executive* for Adjunct Professor Skerritt's full profile.

Organisational planning

Organisational planning is fundamental to defining our approach to managing our priorities, resources and funding. Our planning considers the challenges that may prevent success, ensuring strategies are defined to actively manage our work. The plans detailed below support a cascade of key objectives and provide clarity about the Department's strategic direction and performance expectations.

Planning and performance reporting

- **Portfolio Budget Statements** – Government priorities and performance measures.
- **Strategic Intent** – Defines our Vision, our Purpose, our Strategic Priorities and captures our culture and values.
- **Corporate Plan** – Is a four year plan, outlining how we will achieve our Purpose, Strategic Priorities, build organisational capability, manage risk and performance.
- **Business Planning** – Defines our priorities, key initiatives and activities, measures of success, and identified risks, cascading key objectives from group to section.
- **Performance Development Scheme** – Defines performance expectations and development opportunities for individuals.
- **Individual Development Plans** – Identifies immediate development needs against the capabilities of an individual's role.
- **Annual Report** – Informs the performance of entities in relation to activities undertaken.
- **Annual Performance Statements** – Reports against non-financial performance criteria included in Portfolio Budget Statements and Corporate Plans.

Strategic Intent

The Strategic Intent was established in 2015-16. It defines our Vision, Purpose and Strategic Priorities against our six Outcomes. It spans a four year period and is reviewed annually to ensure the Department continues to be aligned with Government priorities.

The Strategic Intent encompasses a 'whole-of-health system' view and sets the direction for our annual Corporate Plan and organisational planning processes.

Corporate Plan

The Corporate Plan is the primary planning document of the Department. It describes the Department's current position, informed by our Strategic Intent, setting our Purpose and the strategies we will pursue to achieve our Vision of better health and wellbeing for all Australians, now and for future generations.

The four year horizon for the Corporate Plan outlines the Department's medium-term direction to deliver on the Government's health, aged care and sport agenda, including detail about significant activities, capability and risks. The Corporate Plan supports the Government's long-term national health plan that:

- guarantees Medicare and the Pharmaceutical Benefits Scheme;
- supports our hospitals;
- prioritises mental and preventive health; and
- invests in medical research.

The Corporate Plan spans four reporting periods and is updated annually.

The Corporate Plan is a central part of the Department's business and risk planning and performance framework, and will support planning activities across the organisation.

The Corporate Plan has been prepared to meet requirements defined in the *Public Governance, Performance and Accountability Rule 2014*.

Risk management

The Department encourages staff to positively engage with risk and to make decisions using a risk-based approach.

During 2016-17, the Department identified 12 Enterprise Level Risks, finalised the Enterprise Risk Appetite Statement, and updated and endorsed a new Risk Management Policy to support our changing environment.

The Risk Management Framework will assist the Department to make well-informed risk-based decisions on all aspects of business, including budget and resource allocation. A key focus in 2017-18 will be to embed the Enterprise Risk Appetite Statement and increase our risk maturity. This will clearly link the key risks associated with our strategic objectives.

In 2017, the Department maintained its 'Integrated' level of maturity against the Comcover Risk Management Benchmarking Survey. The Department has continued to work to increase risk awareness of staff, through both internal and external training, presentations and workshops.

Audit and fraud control

The Department undertook audit and fraud control assurance activities that promoted and supported effective corporate governance. In 2016-17, the monitoring of fraud risk and controls has been strengthened through a specific program of ongoing business engagements. The Department has continued to build a strong fraud and corruption awareness culture, through a long-term strategic educational approach. In addition, a Professional Integrity and Security Framework was developed to support governance controls.

The internal audits that were completed during 2016-17 covered and supported: compliance with the Department's control frameworks for information management and data utilisation; the payment of accounts; personnel management processes; property and lease management; IT system remediation and project delivery; business continuity planning; and the implementation of Commonwealth health programs.

During 2016-17, the Department:

- finalised nine audits from the 2016-17 Internal Audit Work Program. A further seven audits, including one management requested audit, from the 2016-17 Internal Audit Work Program were underway or pending finalisation as at 30 June 2017; and
- received 127 fraud allegations. The Department investigated three of these allegations, while a further 51 were referred to law enforcement or other agencies for review or action. The increase of fraud allegations during 2016-17 were attributable to the Department's *Building a Fraud Awareness Culture Strategy*, newly adopted internal and external facing reporting mechanisms and additional regulatory responsibilities.

Compliance reporting

There have been no significant breaches of finance law by the Department during 2016-17. 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. Any fraud investigations with financial aspects are addressed through the Department's fraud minimisation and control processes.

Certification of departmental fraud control arrangements

I, Glenys Beauchamp, certify that the Department has:

- prepared fraud risk assessments and fraud control plans;
- in place appropriate fraud prevention, detection, investigation, and reporting mechanisms that meet the specific needs of the Department; and
- taken all reasonable measures to appropriately deal with fraud relating to the Department.

Glenys Beauchamp PSM
Secretary
October 2017

Part 3.2: People

People Strategy

The Department's *People Strategy 2016–20* outlines our approach to continuing to build a contemporary, capable, well led, talented, adaptive and flexible workforce. It has four key areas of action; as shown in Figure 3.2.1.

The People Strategy drives our continued improvement of the way we manage our workforce to ensure we are well positioned to deliver our Purpose. This includes ensuring we build the right capability to meet the challenges ahead.

Figure 3.2.1: *People Strategy 2016–20* key areas of action

Organisational performance

The Australian Public Service (APS) State of the Service Employee Census (Staff Survey) continues to provide valuable insight into staff views. The survey was conducted between 8 May and 9 June 2017, with 74 per cent of staff participating.

The Staff Survey shows the Department's leadership and culture have improved over the past twelve months, placing the Department in a good position to meet its objectives and future challenges. Results show the Department's staff are more highly engaged than the APS average (6.8 compared to 6.6 out of 10). Staff perception of senior leadership in the Department was significantly above the APS average in all categories. Refer *Figure 3.2.2* and *Figure 3.2.3*.

The Department also conducts a Pulse Survey twice a year, which complements the annual Staff Survey. The Pulse Survey is an internal tool to further measure employee outcomes, organisational performance, leadership and culture. The Pulse Survey links to and supports the Strategic Intent, *Our Behaviours in Action* and the People Strategy.

The collection of people data is critical in helping the Department continue to drive improvements in performance and culture.

Figure 3.2.2: APS employee engagement

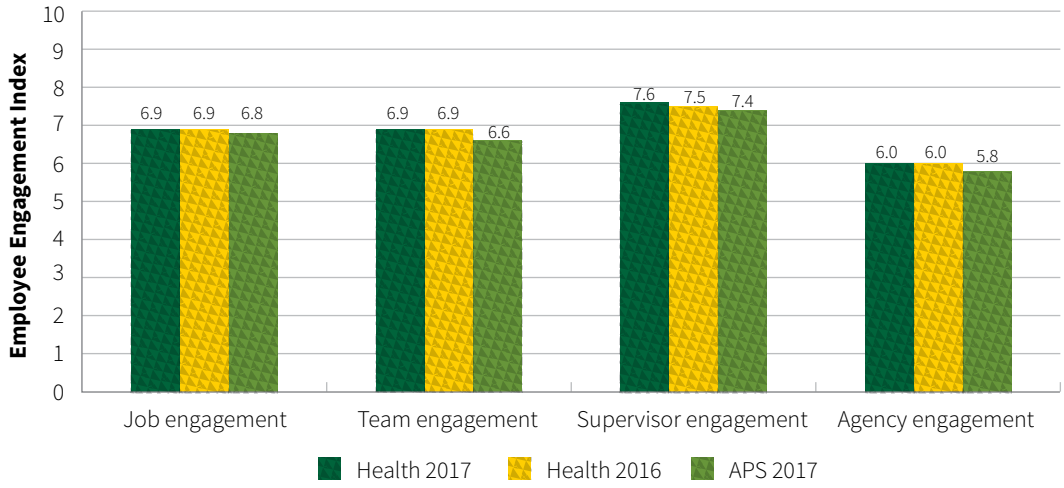
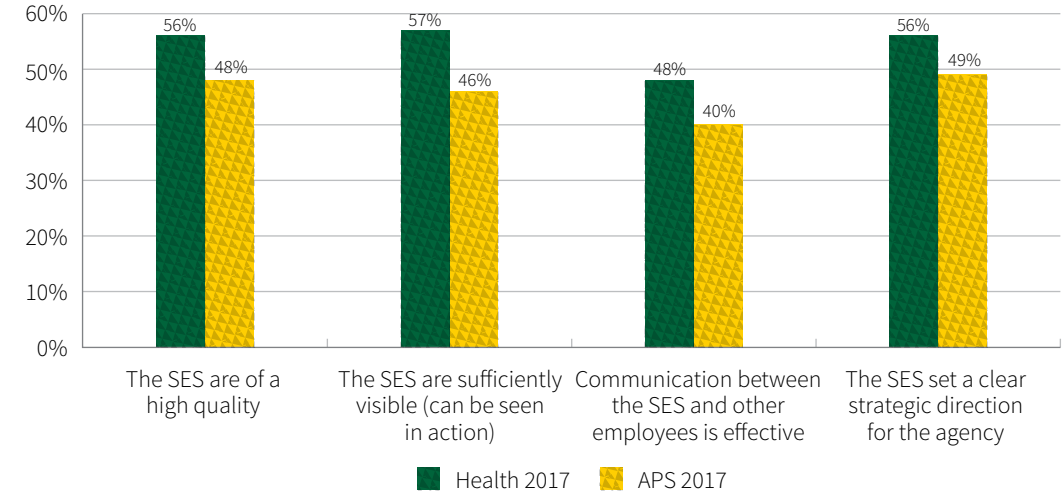


Figure 3.2.3: APS senior leadership perception



Workforce composition

As at 30 June 2017, the Department has a workforce of 4,720 APS staff (including staff on leave and secondment). This is a decrease from 5,037 as at 30 June 2016, which is largely attributed to tighter recruitment controls and a Voluntary Redundancy Program. The workforce profile at 30 June 2017 was as follows:

- 96.1 per cent of staff were ongoing and 3.9 per cent were non-ongoing;
- 21.6 per cent of staff were employed on a part-time basis;
- 68.6 per cent of staff were female; and
- 2.6 per cent of staff identified as Aboriginal and/or Torres Strait Islander.

Figure 3.2.4: Comparison of gender profile at 30 June 2017 [57,58]

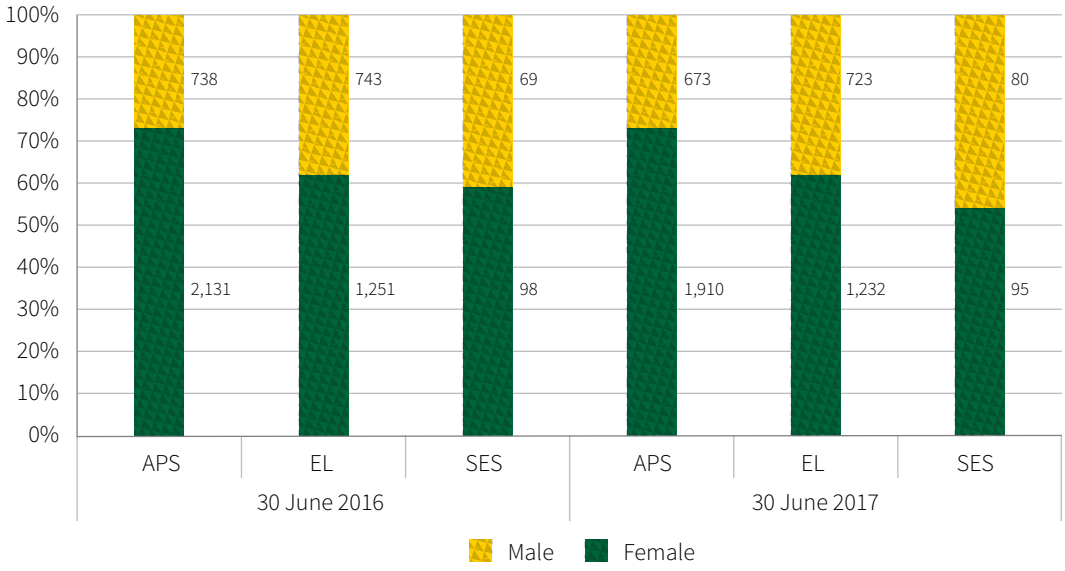


Table 3.2.1: Comparison of Indigenous staff by employment status between 30 June 2016 and 30 June 2017

	Indigenous staff	
Employment status	**30 June 2017**	**30 June 2016**
Ongoing	121	102
Non-ongoing	1	6
Total Indigenous staff	**122**	**108**
Percentage of Indigenous staff in the Department	**2.6%**	**2.1%**

[57] Excluding 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.

[58] The Department has implemented the Australian Government Guidelines on the Recognition of Sex and Gender and made changes to the Human Resource Management System to enable collection of non-binary gender. At 30 June 2017, no staff has self-identified as non-binary.

Staffing retention and turnover

A 2016-17 Voluntary Redundancy Program was implemented to support the Department's efforts to adjust the size of its workforce. The strategy was, in part, developed in response to a reduction in our staff turnover rate.

The ongoing staff turnover rate in 2016-17, excluding voluntary redundancies, was 7.7 per cent, a decrease from 12 per cent in 2015-16. Including the Voluntary Redundancy Program, the ongoing staff turnover rate was 13.4 per cent.

The strategy has enabled the Department to enter the 2017-18 financial year with a more sustainable workforce profile.

Analysing workforce composition

The Department completed its first full segmentation of the workforce by job family to better understand key factors of different occupational groups, such as attraction, retention and engagement. A job family is a high level grouping of similar jobs that have related skills, tasks and knowledge. This represents a significant step forward in the development of the Department's workforce planning. Through this information, the Department has increased capacity to identify critical capabilities and roles, develop career pathways for staff and share professional expertise across functional areas as well as the wider APS.

Table 3.2.2: Staff numbers by classification at 30 June 2017

	Female		Male		2016-17 Total	2015-16 Total
Classification	Full-time	Part-time	Full-time	Part-time		
Secretary	-	-	1	-	1	1
Holder of Public Office	3	-	2	-	5	5
Senior Executive Band 3	4	-	4	-	8	7
Senior Executive Band 2	16	-	13	-	29	30
Senior Executive Band 1	61	2	50	-	113	107
Executive Level 2	270	58	210	10	548	565
Executive Level 1	548	283	424	35	1,290	1,327
APS 6	697	296	335	24	1,352	1,429
APS 5	362	127	146	14	649	726
APS 4	239	73	73	6	391	460
APS 3	34	15	14	8	71	117
APS 2	5	12	8	12	37	57
APS 1	1	2	4	4	11	13
Health Entry-Level Broadband	46	-	24	-	70	52
Legal 2	12	4	7	1	24	24
Legal 1	11	5	7	-	23	20
Chief Medical Officer	-	-	1	-	1	1
Medical Officer 6	1	2	3	1	7	7
Medical Officer 5	8	1	7	2	18	16
Medical Officer 4	5	4	12	2	23	19
Medical Officer 3	10	6	7	2	25	29
Medical Officer 2	4	6	3	1	14	12
Public Affairs 3	4	2	1	-	7	7

Table 3.2.2: Staff numbers by classification at 30 June 2017 (continued)

	Female		Male		2016-17 Total	2015-16 Total
Classification	Full-time	Part-time	Full-time	Part-time		
Public Affairs 2	1	-	1	-	2	2
Professional 1	-	-	-	-	-	1
Senior Principal Research Scientist	-	-	1	-	1	2
Principal Research Scientist	-	-	-	-	-	1
Department total	**2,342**	**898**	**1,358**	**122**	**4,720**[59]	**5,037**

This table includes:

- headcount figures of departmental staff as at 30 June 2017;
- staff on leave and secondment; and
- staff acting at a higher level, for any period as at 30 June 2017 (that is, these staff are listed against their higher classification).

Table 3.2.3: Distribution of staff by State and Territory at 30 June 2017[60]

State	Total
Australian Capital Territory	3,745
New South Wales	362
Victoria	249
Queensland	142
Western Australia	66
Northern Territory	24
South Australia	86
Tasmania	46
Department total	**4,720**

[59] The majority of the 2016-17 decrease in staffing numbers from 2015-16 can be attributed to the Voluntary Redundancy Program.

[60] This table includes the head count figures of all staff by State and Territory as at 30 June 2017, including staff on leave, secondment and outposted staff.

Employment arrangements

The Department's practices for making employment arrangements with it's staff are consistent with the requirements of the *Workplace Bargaining Policy 2015* and the *Fair Work Act 2009*. Information on employment arrangements is outlined below.

Enterprise Agreement

The *Department of Health Enterprise Agreement 2016–2019* (EA) provides the terms and conditions of employment for non-SES staff. The EA commenced operation on 3 February 2016 and will nominally expire on 26 January 2019.

The EA contains a flexibility provision, which enables the Department to make an Individual Flexibility Arrangement with a non-SES staff member. An Individual Flexibility Arrangement varies specified terms and conditions provided under the EA for that individual where necessary and appropriate. For further information on the number of staff with these arrangements refer *Table 3.2.4*.

Table 3.2.4: Non-SES staff covered by Individual Flexibility Arrangements and the EA at 30 June 2017

Number of staff covered by the:		Total
EA	EA and an approved Individual Flexibility Arrangement	
4,233	329	4,562

All salary increases awarded to staff by the EA are funded through savings generated by a range of productivity improvements. These savings have been achieved through corporate initiatives or productivity improvements, such as property and ICT efficiencies, through streamlining processes, and removal of restrictive and/or inefficient work practices.

The Department does not have any Australian Workplace Agreements in place and generally does not use common law contracts. However, common law contracts may be used where necessary to establish and/or supplement conditions and entitlements.

Performance pay

The Department no longer offers performance pay to new or ongoing staff. As a result, no departmental staff received performance payments in 2016-17.

Remuneration for senior officials

The Department maintained a remuneration position consistent with equivalent public sector entities during 2016-17. 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.

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*.

Table 3.2.5: Average annual reportable remuneration paid to substantive executives during the reporting period

Total remuneration $	Executives no.	Average reportable salary[61] $	Average contributed superannuation $	Average allowances $	Average bonus paid $	Average total remuneration $
200,000 and less	34	95,825	15,875	10	-	111,710
200,001 to 225,000	34	189,867	29,196	91	-	219,154
225,001 to 250,000	40	203,554	33,210	33	-	236,774
250,001 to 275,000	24	225,718	36,821	47	-	262,585
275,001 to 300,000	18	246,183	38,889	51	-	285,124
300,001 to 325,000	8	268,207	43,913	116	-	312,236
325,001 to 350,000	5	293,387	43,749	52	-	337,187
350,001 to 375,000	3	323,400	47,523	-	-	370,923
375,001 to 400,000	3	338,450	54,571	-	-	393,021
400,001 to 450,000	4	365,708	61,368	174	-	427,251
450,001 to 500,000	3	401,586	66,674	-	-	468,260
500,001 to 750,000	-	-	-	-	-	-
750,001 to 775,000	1	736,848	31,409	-	-	768,258
Total number of executives[62]	**177**	**-**	**-**	**-**	**-**	**-**

[61] Excludes payments made on termination, including employee entitlements and separations.

[62] Any employee who held a substantive SES or equivalent position during 2016-17 is represented as one (1).

Table 3.2.6: Remuneration paid to highly paid staff during the reporting period

Total remuneration $	Executives no.	Average reportable salary[63] $	Average contributed superannuation $	Average allowances $	Average bonus paid $	Average total remuneration $
200,001 to 225,000	10	179,639	30,962	123	-	210,724
225,001 to 250,000	2	197,846	34,224	-	-	232,070
250,001 to 275,000	1	220,574	33,938	-	-	254,512
275,001 to 300,000	1	244,170	35,420	-	-	279,590
300,001 to 325,000	2	263,149	42,624	1,560	-	307,333
Total number of highly paid staff[64]	**16**	**-**	**-**	**-**	**-**	**-**

Table 3.2.7: SES staff and equivalent staff with Individual Agreements at 30 June 2017

Nominal classification	Number of staff with Individual Agreements		Total
	Female	Male	
Senior Executive Band 3	3	4	7
Senior Executive Band 2	14	11	25
Senior Executive Band 1	53	41	94
Chief Medical Officer	-	1	1
Medical Officer 6	3	4	7
Medical Officer 5	9	9	18

[63] Excludes payments made on termination, including employee entitlements and separations.

[64] Also includes employees who have been provided with higher duties in 2016-17.

Table 3.2.8: Non-salary benefits

Non-SES staff
Access to engage in private medical practice for Medical Officers
Access to Individual Flexibility Arrangements
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
Australian Defence Force Reserve, full-time service or cadet leave
Annual close down and early stand down at Easter and Christmas Eve
Annual leave
Annual free onsite influenza vaccinations for staff
Bereavement and compassionate leave
Breastfeeding facilities and family care rooms
Community service leave
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
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
SES staff
All the above benefits except flextime and access to Individual Flexibility Arrangements
Airport lounge membership
Car parking
Cash-out of annual leave
Executive Vehicle Allowance
Individual determinations made under section 24(1) of the *Public Service Act 1999*
IT Reimbursement Scheme

Salary ranges

Table 3.2.9: EL and APS levels salary structure

Classification	Salary ranges at 30 June 2017 $
Executive Level 2	139,182
	132,500
	128,219
	117,557
Executive Level 1	112,377
	107,929
	102,820
	98,531
APS 6	90,455
	88,475
	84,070
	80,181
APS 5	77,459
	73,573
	71,624
APS 4	70,607
	68,662
	66,824
APS 3	65,376
	62,410
	60,651
	58,981
APS 2	55,696
	54,148
	52,569
	51,038
APS 1	49,044
	46,763
	45,214
	43,670
Staff at 20 years of age	39,740
Staff at 19 years of age	35,374
Staff at 18 years of age	30,569
Staff under 18 years of age	26,202

Table 3.2.10: Health Entry-Level Broadband

Local title	APS classification	Salary ranges at 30 June 2017 $
Health Entry-Level (T, I, A, or G)	APS 4	70,607
		68,662
		66,824
	APS 3	65,376
		62,410
		60,651
		58,981
	APS 2	55,696
		54,148
		52,569
		51,038
	APS 1	49,044
		46,763
		45,214
		43,670
	Staff at 20 years of age	39,740
	Staff at 19 years of age	35,374
	Staff at 18 years of age	30,569
	Staff under 18 years of age	26,202

Notes:

(T) = Trainees

(I) = Indigenous Australian Government Development Program participants

(A) = Indigenous Apprenticeship Programme

(G) = Graduates

Table 3.2.11: Professional 1 salary structure

Local title	APS classification	Salary ranges at 30 June 2017 $
Professional 1	APS 5	77,459
	APS 5	73,573
	APS 4	68,662
	APS 4*	66,824
	APS 3**	62,411
	APS 3	60,651

Notes:

* Salary on commencement for a professional with a four year degree (or higher).

** Salary on commencement for a professional with a three year degree.

Table 3.2.12: Medical Officer salary structure

Local title	Salary ranges at 30 June 2017 $
Medical Officer Class 4	167,183
	157,804
	151,887
Medical Officer Class 3	145,827
	139,279
Medical Officer Class 2	131,246
	124,563
Medical Officer Class 1	113,830
	103,119
	95,814
	88,446

Table 3.2.13: Legal salary structure

Local title	APS classification	Salary ranges at 30 June 2017 $
Legal 2	Executive Level 2	144,054
		137,801
		133,347
Legal 1	Executive Level 1	121,930
		112,247
		102,820
	APS 6	88,475
		84,069
		80,180
	APS 5	74,213
	APS 4	69,573

Table 3.2.14: Public Affairs salary structure

Local title	APS classification	Salary ranges at 30 June 2017 $
Senior Public Affairs 2	Executive Level 2	144,750
		139,124
Senior Public Affairs 1	Executive Level 2	132,500
Public Affairs 3	Executive Level 1	120,805
		114,945
		107,959
Public Affairs 2	APS 6	90,549
		84,069
		80,180
	APS 5	77,459
		73,573
	APS 4	70,606
	APS 4*	66,824

Note:

* This level is generally reserved for staff with less than two years' experience.

Table 3.2.15: Research Scientist salary structure

Local title	APS classification	Salary ranges at 30 June 2017 $
Senior Principal Research Scientist	Executive Level 2	176,761
		159,003
Principal Research Scientist	Executive Level 2	155,884
		151,052
		144,887
		141,067
		135,835
Senior Research Scientist	Executive Level 2	141,548
		132,500
		128,219
		117,557
Research Scientist	Executive Level 1	105,879
		98,531
	APS 6	84,224
		79,826
		77,656

Capability

Building the right capability

The Department's *Learning and Development Strategy 2016–2019* (L&D Strategy) supports the People Strategy and aims to create a diverse learning environment that builds a capable workforce to achieve departmental outcomes. The L&D 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 2016-17, the Department delivered a number of new learning and development initiatives including:

- 21st Century Services pilot program to develop strategic policy – an instructor-led program delivered to 90 staff to provide participants with a foundation for applying design and systems thinking in the workplace;
- Cultural Appreciation Program – an internally facilitated program delivered to 176 staff, growing from the pilot program delivered in August 2015 reaching 106 staff, to build the knowledge and appreciation of Aboriginal and Torres Strait Islander perspectives, history, diversity and culture for all staff; and
- Early Intervention pilot – delivered to 145 staff to equip managers and staff to confidently recognise and respond when an employee is showing signs of injury and/or illness, in order to reduce the risk of long term injury and illness.

The Department continued to deliver training incorporating elements from the Australian Public Service Commission fundamental programs. To build the capability of the Department's staff through face-to-face learning, 7,981 instructor-led training places were filled across subject areas including:

- information technology;
- writing and communication;
- stakeholder engagement;
- fraud and corruption awareness;
- project management; and
- leadership and management.

The Department also offers e-learning programs to staff, encompassing subjects such as APS Values, cultural awareness, work health and safety, financial management and knowledge management. In 2016-17, the Department focussed training on fraud awareness and record keeping. E-learning programs were accessed 8,811 times during 2016-17.

Training participation rates in 2016-17 have significantly increased on last year, largely due to the Department's increased focus on fraud and corruption awareness, and an upgrade to records management software that has required additional training of staff.

Continuing to improve our leadership

The Department continues to deliver leadership development programs, building the leadership and management capability within the Department. During 2016-17, leadership programs were redesigned to address the need to build leadership capabilities at all levels and strengthen key capabilities outlined in the *Strategic Intent 2016–20*.

During 2016-17, the Department's leadership development programs were redesigned to address the need to build leadership at all levels and strengthen key capabilities outlined in the Department's *Strategic Intent 2017–21*, *People Strategy 2016–20*, and *Our Behaviours in Action*. The leadership programs include:

- Ignite – to equip participants to better deal with emotions and behaviours in the workplace;
- Foundational – to strengthen capabilities critical to supervisor success;
- Expansion – to strengthen and deepen capabilities that enable more influential and collaborative work practices to address complex leadership issues and challenges in a dynamic work environment; and
- Section Leaders – to support and strengthen leadership capabilities that support organisational and enterprise leadership.

Specific support and capability development for Executive Level (EL) staff has been a focus in 2017-18. The Department's 360 degree feedback survey was incorporated into the revised Expansion and Section Leaders leadership development programs. The survey enables EL staff to identify professional strengths and developmental opportunities through feedback received from their staff, colleagues and supervisors.

The Department has been working to provide additional support and guidance for its leaders beyond instructor-led programs, with the development of the Leadership and Management Framework. The Framework outlines the leadership expectations required at each level and provides an overview of core leadership and management options available for staff. The Framework supports the People Strategy, and embeds *Our Behaviours in Action* through the development of leadership at all levels.

The Department also continued to develop the leadership capability of SES staff, by providing 'SES Snapshot' sessions which focus on an individual topic of interest each month, as well as facilitating 'learning circles' that allow our SES staff to share and discuss matters in an open and supportive forum. These initiatives provide for continual learning and development through practical and social learning.

Culture

Workforce inclusivity and diversity

The Department is committed to reflecting the diversity of the Australian community in its workforce by building an inclusive culture that respects and celebrates differences. Diversity in our experiences, backgrounds, skills, talents and views enriches our working environment and capacity to deliver health outcomes for all Australians.

In 2016-17, the Department appointed nine new Diversity Champions from its Senior Executive cohort. These officers raise awareness and understanding by educating colleagues and advocating for diversity across the Department more broadly.

The Department supports three formal staff networks – the National Aboriginal and Torres Strait Islander Staff Network, Health Pride Network, and Disability and Carers Network – that also aim to raise awareness of the benefits of an inclusive culture. In 2016-17, the Department participated in a number of whole-of-Government fora, roundtables and meetings with stakeholders and corporate partners including the Australian Network on Disability, and Pride in Diversity.

In 2016-17, the Department developed the first *Accessibility Action Plan* and the fourth *Reconciliation Action Plan*, as well as establishing a working group to develop a Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Action Plan. The new *Innovate Reconciliation Action Plan 2017–19* was developed in consultation with Reconciliation Australia, Health's Aboriginal and Torres Strait Islander Champions, the National Aboriginal and Torres Strait Islander Staff Network, as well as other employees across the Department. These plans collectively outline clear pathways for the Department to achieve a more inclusive workplace. For further information on the *Accessibility Action Plan*, refer *Part 3.4: External Scrutiny and Compliance*.

NATIONAL ABORIGINAL & TORRES STRAIT ISLANDER STAFF NETWORK
Supporting our Mob in Health

HEALTH PRIDE NETWORK

STAFF WITH DISABILITY NETWORK

Recognising staff

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 2017, four individual and four team awards were presented across the Department in the categories of innovation, service, relationships and leadership.

Career and Succession

Performance development

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. All staff engage in a formal Performance Development Scheme 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 2016-17 include:

- development of a performance management framework to strengthen and simplify understanding of the Department's performance processes and tools;
- reviewing and updating the Department's performance, underperformance and reward and recognition policies and guidelines;
- ongoing development of tools and training to support quality performance conversations;
- updates and simplifications to the IT systems used to support the formal performance assessment process.

Investing in high performance is central to *Our Behaviours in Action*, with nurturing talent and building capability fundamental to this investment.

During 2016-17, 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 under the APS Code of Conduct.

All alleged breaches of the APS Code of Conduct are treated seriously and managed in accordance with best practice. The majority of complaints received were handled through local management action or preliminary investigation. The Department finalised 12 APS Code of Conduct investigations during 2016-17, resulting in nine breaches of the APS Code of Conduct being determined.

Entry-level programs

During 2016-17, improvements have been made to learning and development for the Department's entry-level programs, including Graduates and Indigenous Entry Level Program participants (Trainees).

The revised Graduate training approach incorporated learning in the following key areas:

- understanding Government;
- understanding the health system; and
- understanding self.

The Trainees undertake core learning and development through their respective trainee programs – the Indigenous Apprenticeship Programme and the Indigenous Australian Government Development Program.

Once Trainees successfully complete all components of the program, they receive a nationally recognised accredited qualification, the Diploma of Government.

These areas for development are underpinned by the APS core skills programs and consist of a number of blended learning methods including face-to-face, online, on-the-job and self-directed learning which align to the 70:20:10 principle.

Grads lead the charge on innovation

All levels of staff are encouraged to embrace innovation and members of our 2016 IT graduate program readily took up the challenge.

In partnership with the Therapeutic Goods Administration (TGA), the graduate group developed the MedSearch app – taking the product information search capability available on the TGA website and recreating it for iOS and Android mobiles.

The app allows health professionals and consumers to quickly search for and retrieve product information, including scientific information about medicines and how to use them safely and effectively. The MedSearch App also includes extra features, including the ability to add results to a favourites list for easy access.

The app has already received accolades, winning project of the year at the Australian Government ICT Entry-level Programs graduation ceremony, beating teams from across the public service to take out the top honour.

> ***"Everyone involved in MedSearch blossomed to meet the challenges of the project. You hope that what you did is going to make a real difference for people in the community."***
> – Grant Millsteed, Health 2016 ICT graduate

Career development and mobility

The Department is committed to career development, and supports secondment and mobility opportunities both with the APS and private sector. Health is one of seven agencies participating in Operation Free Range, an Australian Public Service Commission-led study on APS mobility. The study seeks to understand the barriers to, and good practice for inter-agency mobility. Ongoing staff are encouraged to apply, and hiring managers are encouraged to consider mobility into the agency.

Part 3.3: Financial Management

Financial accountability responsibilities

The Department's financial accountability responsibilities are set out in the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and subordinate legislation, collectively known as finance law.

In support of the finance law, the Department's Accountable Authority Instructions are issued in accordance with section 20A of the PGPA Act. The Department has also issued Finance Business Rules that clearly set out the rules and processes required for the administration of the Department.

The finance law, supporting instructions and rules, provide a framework to ensure the efficient, effective, economical and ethical use of public resources. The Department's Finance and Resources Committee provides advice and makes recommendations to the Executive Committee on financial matters including operation and capital expenditures. Further, the Department's Audit and Risk Committee provides independent advice and assurance to the Accountable Authority (the Secretary). Further detail on the Department's governance committees is provided in *Part 3.1: Corporate Governance*.

The finance law also mandates the production of audited financial statements prepared in accordance with the Australian Accounting Standards. The complete set of financial statements for the Department is provided in *Part 4: Financial Statements*. The *Chief Operating Officer's Report* provides an overview of the Department's financial results for 2016-17.

Managing our assets

The Department holds financial and non-financial assets. Financial assets include cash and receivables, which are subject to internal controls and reconciliations.

Non-financial assets are held for operational purposes and include computing software and hardware, building fit-out, furniture and fittings. Decisions about whole-of-life asset management are undertaken in the context of the broader Department's strategic planning to ensure that investment in assets supports cost effective achievement of the Department's objectives.

Effective management of the Department's limited capital budgets is achieved by:

- including whole-of-life consideration in proposals for capital expenditures;
- whole-of-Department prioritisation of capital projects and major purchases by the Department's Finance and Resources Committee;
- undertaking regular stocktakes of physical assets; and
- annually reviewing assets for indications of impairment and changes in expected useful lives.

Procurement

Purchasing

The Department's approach to procurement activity is driven by the core principles of the Commonwealth's financial management framework. The framework encourages competition, value for money, transparency, and accountability as well as the efficient, effective, ethical and economical use of Commonwealth resources.

During 2016-17, the Department increased its focus on procurement communication, education and quality assurance processes to improve compliance.

The Department is currently undertaking a Procurement Transformation Project to further strengthen governance and quality assurance for legislative compliance, data integrity and reporting accuracy of procurement activities.

Initiatives to support small business

Small and Medium Enterprises (SME) make up the majority of all Australian businesses, contribute billions of dollars to the economy and provide employment for millions of Australians. The Department supports small business participation in the Commonwealth Government procurement market. SME participation statistics are available on the Department of Finance's website at: www.finance.gov.au/procurement/statistics-on-commonwealth-purchasing-contracts/

63% of the Department's contracts are with SMEs, representing **22%** of total value

65% of the Therapeutic Goods Administration's contracts are with SMEs, representing **70%** of total value[65]

The Department's measures to support SMEs include:

- implementation of the Indigenous Procurement Policy (IPP), of which detailed information is included below;
- 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) to minimise the burden on businesses contracting with the Commonwealth Government; and
- internal guidance and advice to support 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 most recent Survey of Australian Government Payments to Small Business,[66] released in April 2017, showed that the Department paid 81.4 per cent of invoices on time. This result was significantly poorer than the Commonwealth average of 97.8 per cent. Significant structural changes adversely affected payment times and, in response, the Department introduced a new electronic Vendor Invoice Management system in November 2016 to enhance efficiencies in the payment of supplier invoices.

[65] Data was published in December 2016 and represents performance in the 2015-16 financial year.

[66] Available at: www.treasury.gov.au/publication/australian-government-pay-on-time-survey-performance-report/

Indigenous Procurement Policy

Indigenous businesses are vital to creating jobs and employing more Indigenous Australians. The Indigenous Procurement Policy aims to enable these Indigenous businesses to grow and create opportunities for Indigenous Australians.

The Department's target of 73 contracts with Indigenous businesses in 2016-17 was significantly exceeded with a total of 346 engagements worth a combined total value of $11.5 million. A focus on communications, updated procurement processes and improved reporting mechanisms delivered this achievement. The Indigenous Procurement Policy Strategy was introduced in January 2017 and the updated *Innovate Reconciliation Action Plan*, which incorporates Indigenous business development targets, was launched in early July 2017.

The Department continues to promote awareness of opportunities to procure goods and services from Indigenous businesses and is a member of Supply Nation, which supports and empowers Indigenous enterprises to achieve success and build business.

Consultants

The Department engages consultants when specialist expertise or independent research, review or assessment are required 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.

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 2016-17, 560 new consultant contracts were awarded, with a total expenditure of $99.3 million. This represents a 33 per cent increase in the number of contracts from 2015-16 where 421 contracts were awarded. The value of contracts in 2016-17 increased by more than 70 per cent from 2015-16 where $22.6 million was expended.

The increase in consultancy expenditure during 2016-17 can be attributed to work carried out for the Aged Care Digital Payments Program and evaluation of submissions to the Pharmaceutical Benefits Advisory Committee.

In addition, 179 ongoing consultancy contracts where active during 2016-17, involving total actual expenditure of $32.9 million.

Further information on the value of contracts and consultancies valued over $10,000 is available on the AusTender website at: www.tenders.gov.au

Exempt contracts and Australian National Audit Office access

Exempt contracts

In 2016-17, 116 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*. This represents a reduction from 2015-16 where 171 contracts were exempt from reporting.

Australian National Audit Office access clauses

In 2016-17, there were nil departmental contracts exempt from the standard contract clauses which grant the Auditor-General access to contractor premises.

Grants

The Department supports a range of Government policy decisions through provision of grant funding across 21 Programs and six Outcomes. The Department's grants administration practices are based on the mandatory requirements and principles of grants administration in the Commonwealth Grant Rules and Guidelines. The Commonwealth Grant Rules and Guidelines establish the overarching Commonwealth grants policy framework and articulate expectations of non-corporate Commonwealth entities in relation to grants administration.

Much of the Department's grants administration is delivered by the Department's Health State Network Division. For further information on key activities in 2016-17, refer *Chief Operating Officer's Report*.

The Department's grants administration is also undertaken in partnership with the Community Grants Hub within the Department of Social Services.

In line with the requirements of the Commonwealth Grants Rules and Guidelines, the Department has adopted a risk-based approach to grants administration. Key to the Department's risk-based approach is risk assessment and management at the design, select and manage stages of the grants administration lifecycle. This approach helps the Department achieve value for money, meet outcomes, reduce red tape for funded organisations and apply the principle of proportionality.

Information on grants awarded by the Department during the period 1 July 2016 to 30 June 2017 is available at: www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting

Part 3.4: External Scrutiny and Compliance

External Scrutiny

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 2016-17, the ANAO tabled seven audits that involved the Department, detailed below. The Department agreed to all audit recommendations (some with qualification), with relevant implementation activities either underway or completed.

Audits specific to the Department

Audit	**Machinery of Government Changes**[67] Audit Report No.3 of 2016-2017, tabled 31 August 2016
Objective	The audit assessed the effectiveness of the management of Machinery of Government (MoG) changes, including a detailed examination of those changes that affected the Department in 2013.
Recommendations	No recommendations were made in relation to the Department.

Audit	**Community Pharmacy Agreement: Follow-on Audit**[68] Audit Report No.9 of 2016-2017, tabled 31 August 2016
Objective	The audit assessed the adequacy and effectiveness of the Department's implementation of the recommendations made in the ANAO Report No.25 2014-15: Administration of the Fifth Community Pharmacy Agreement.
Recommendations	No additional recommendations were made.

Audit	**Confidentiality in Government Contracts: Senate Order for Entity Contracts (Calendar Year 2015 Compliance)**[69] Audit Report No.18 of 2016-2017, tabled 27 September 2016
Objective	The audit assessed the appropriateness of the use and reporting of confidentiality provisions in a sample of Australian Government contracts, including contracts administered by the Department.
Recommendations	No recommendations were made in relation to the Department.

[67] Available at: www.anao.gov.au/work/performance-audit/management-machinery-government-changes

[68] Available at: www.anao.gov.au/work/performance-audit/community-pharmacy-agreement-follow-on-audit

[69] Available at: www.anao.gov.au/work/performance-audit/confidentiality-government-contracts-senate-order-2015

Audit	**The Management, Administration and Monitoring of the Indemnity Insurance Fund**[70] Audit Report No.20 of 2016-2017, tabled 19 October 2016
Objective	The audit assessed the Departments of Health and Human Services' administration, including oversight and monitoring arrangements, for the Indemnity Insurance Fund.
Recommendations	The ANAO made four recommendations: • conduct a 'first principles review' of the Indemnity Insurance Fund and related schemes; • develop and implement a fit-for-purpose monitoring and reporting arrangement; • establish suitable governance and stakeholder engagement arrangements; and • review Indemnity Insurance Fund administrative arrangements.

Audit	**Indigenous Aged Care**[71] Audit Report No.53 of 2016-2017, tabled 31 May 2017
Objective	The audit assessed the effectiveness of Australian Government funded aged care services delivered to Aboriginal and Torres Strait Islander peoples.
Recommendations	The ANAO made four recommendations: • provide access to available funding and apply a consistent assessment process; • implement a coordinated approach to risk management for providers who receive multiple sources of program funding; • monitor the number of Aboriginal and Torres Strait Islander peoples accessing Commonwealth funded aged care services and service providers that deliver aged care services; and • ensure that the funding provided through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is appropriately targeted.

Audit	**Department of Health's Coordination of Communicable Disease Emergencies**[72] Audit Report No.57 of 2016-2017, tabled 22 June 2017
Objective	The audit assessed the effectiveness of the Department's strategies for managing a communicable disease emergency.
Recommendations	The ANAO made three recommendations: • mandate the use of an effective incident management system to manage communicable disease incidents and notifications; • ensure public communication regarding communicable disease incidents is consistent, accurate and timely; and • develop a process to record, prioritise and implement lessons and agreed recommendations from tests, exercises, communicable disease emergency responses and relevant reviews.

[70] Available at: www.anao.gov.au/work/performance-audit/management-administration-and-monitoring-indemnity-insurance-fund

[71] Available at: www.anao.gov.au/work/performance-audit/indigenous-aged-care#4-1-recommendations

[72] Available at: www.anao.gov.au/work/performance-audit/department-health-coordination-communicable-disease-emergencies

Audit	**Procurement of the National Cancer Screening Register**[73] Audit Report No.61 of 2016-2017, tabled 29 June 2017
Objective	The audit assessed whether the Department effectively procured services to operate a National Cancer Screening Register.
Recommendations	The ANAO made one recommendation: • ensure that actual, potential and perceived conflicts of interest records are maintained, up-to-date and appropriately addressed, and that Senior Executive Service employees declare in writing, at least annually, their own and their immediate family's financial and other interests.

Parliamentary scrutiny

The Department appears before a number of parliamentary committees to answer questions about our administration of the health and aged care systems.

During 2016-17, the Department received a total of 56 Parliamentary Questions on Notice from the House of Representatives and the Senate, and 1,422 Senate Estimates Questions on Notice.

Joint Committee of Public Accounts and Audit reviews

During 2016-17, the Joint Committee of Public Accounts and Audit tabled no reviews that involved the Department.

Senate Estimates hearings

The Department appeared before the Community Affairs Legislation Committee on three occasions during 2016-17:

- Supplementary Budget Estimates – 19 October 2016;
- Additional Estimates – 1 March 2017; and
- Budget Estimates – 29 and 30 May 2017.

The Department also appeared before the Finance and Public Administration Legislation Committee for the Cross Portfolio Indigenous hearings:

- Supplementary Budget Estimates – 21 October 2016;
- Additional Estimates – 3 March 2016; and
- Budget Estimates – 26 May 2017.

[73] Available at: www.anao.gov.au/work/performance-audit/procurement-national-cancer-screening-register

Parliamentary Committee inquiries

The Department provided evidence and/or submissions to Parliamentary Committee inquiries on the following occasions.

Committee	Evidence/submission provided
Senate Standing Committee on Community Affairs – *Legislation Committee*	• Industrial Chemicals Bill 2017 and related Bills • Therapeutic Goods Amendment (2016 Measures No. 1) Bill 2016 [Provisions] • National Cancer Screening Register Bill 2016 [Provisions] • National Cancer Screening Register (Consequential and Transitional Provisions) Bill 2016 [Provisions]
Senate Standing Committee on Community Affairs – *References Committee*	• Number of women in Australia who have had transvaginal mesh implants and related matters • Future of Australia's aged care sector workforce • Price regulation associated with the Prostheses List Framework • Complaints mechanism administered under the Health Practitioner Regulation National Law • Growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients • Medical complaints process in Australia • Indefinite detention of people with cognitive and psychiatric impairment in Australia
Senate Standing Committee on Foreign Affairs, Defence and Trade – *References Committee*	• Suicide by veterans and ex-service personnel
Senate Select Committee into Funding for Research into Cancers with Low Survival Rates	• Impact of health research funding models on the availability of funding for research into cancers with low survival rates
Senate Standing Committee on Legal and Constitutional Affairs – *References Committee*	• Inquiry into serious allegations of abuse, self-harm and neglect of asylum seekers in relation to the Nauru Regional Processing Centre, and any like allegations in relation to the Manus Regional Processing Centre
Senate Select Committee on Red Tape	• The effect of red tape on tobacco retail
House of Representatives Standing Committee on Health	• Inquiry into the hearing health and wellbeing of Australia
Joint Committee on Law Enforcement	• Inquiry into crystal methamphetamine (ice) • Inquiry into illicit tobacco
Joint Standing Committee on the National Disability Insurance Scheme	• Services for people with psychological disabilities related to a mental health condition • The Provision of Hearing Services under the National Disability Insurance Scheme

Judicial decisions and decisions of administrative tribunals

During 2016-17, the Department was involved in:

- Zero matters in the High Court;
- One matter in the Full Federal Court;
- 10 matters in the Federal Court;
- 29 matters in the Administrative Appeals Tribunal; and
- Four decisions were made by the Australian Information Commissioner.

Reports 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 2016-17, the Commonwealth Ombudsman investigated ten complaints against the Department's administrative practices. Four of the ten complaint investigations have been finalised by the Ombudsman as at 30 June 2017. None of the finalised complaints investigations resulted in a finding of administration deficiency.

Capability reviews

There were no capability reviews of the Department released during 2016-17.

Freedom of Information

In 2016-17, the Department received 337 Freedom of Information (FOI) requests.

Entities subject to the *Freedom of Information Act 1982* are required to publish information to the public as part of the Information Publication Scheme (IPS). Each agency must display on its website a plan showing what information it publishes in accordance with the IPS requirements. Documents that the Department has released in response to FOI requests during 2016-17 can be found on the Freedom of Information Disclosure Log at: www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2016-17.

Work Health and Safety

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.

The majority of the Department's staff work in an office, exposing them to well-documented ergonomic risks. The Department is responsible for providing well-designed and innovative work spaces and work health and safety (WHS) programs.

Some of the Department's staff work in the Therapeutic Goods Administration (TGA) laboratories with the potential risk for staff being exposed to potentially hazardous substances, including acids, flammable solvents and mercury.

More unusually, as the TGA is in a rural setting, venomous snakes have been known to enter high traffic areas including courtyards, walkways, the car park and bike cages.

The Department has policies and procedures in place to appropriately protect the workforce from, and respond to, all potential hazards, including wildlife.

Improving WHS in the workplace

Initiatives undertaken in 2016-17 to improve WHS in the Department included:

- collaborating with the Australian Taxation Office and other Commonwealth entities to undertake a cooperative procurement for rehabilitation providers and medical services, making access to credible rehabilitation services faster and easier. The program is new and outcomes haven't yet been realised;
- reviewing and refinement of the triage system introduced with the Department's Call Centre to manage enquiries to improve front-end response to injuries and incidents. There have been improvements in responding to accident/incident reports, the call-back time for injured/ill workers has reduced from less than three days, down to less than two days;
- implementing Injury Connect, a rehabilitation case management database system, to enable accurate reporting and evaluation. Reporting capability has improved the overall monitoring of injury management caseloads; and
- refining the ergonomic assessment program, through qualified occupational therapists undertaking individual and group assessments. In 2016-17 a total of 963 assessments were undertaken, of which seven per cent were related to new injury symptoms, four per cent were for pre-existing injuries and 89 per cent preventive. Since the inception of the in-house program in October 2015, the number of body-stressing claims has decreased significantly from nine in 2014-15 to one in 2016-17.

The Health and Wellbeing Program

In July 2016, the Health and Wellbeing Program and Framework was launched.

Under the Program, the Department delivered:

- an annual vaccination program to 2,423 employees across the country, representing 49.8 per cent of employees;
- an Employee Assistance Program, with 761 new referrals in 2016-17;
- the Early Intervention initiative (refer case study below) to 128 participants; and
- the 10,000 steps walking challenge, aimed to increase employees' physical activity during the day. Over 450 employees registered for the challenge.

Early Intervention Initiative

The Department's Early Intervention Initiative seeks to raise awareness of early warning signs of illness and injury and how to take quick, effective action to support staff, either to stay at work or to support a faster return to work following an illness or injury.

The program promotes a range of initiatives, such as workstation assessments, access to flexible working arrangements, and the development and rollout of manager training to identify and respond to early warning signs of illness or injury.

This initiative will support the prevention of long-term absence from the workplace and development of chronic illness, as well as increasing the probability of staff returning to work. Further, the initiative will contain the costs of incapacity while empowering managers to assist their employees to manage their injury or illness.

Evaluation of the Department's WHS performance

In June 2016, Comcare undertook an audit of the Department's WHS management system, resulting in a number of differences. A corrective actions management plan was developed, and actions are being progressively implemented.

The Department provides ongoing support to employees and managers to assist both workers' compensation claims and non-work related injury and illness. Since 2013-14, the number of compensation claims accepted for the Department has been consistently declining. The number of accepted claims have been trending down from 58 in 2014-15 to 15 in 2016-17. The annual audit for the Rehabilitation Management System will be undertaken in August 2017.

Notifiable incidents

The Department received 376 accident and incident reports in 2016-17. There were two notifiable incidents sent to Comcare. The incidents have been investigated and where action has been required action plans have been developed.

Addressing disability and recognising carers

Supporting staff

The Department is committed to being an employer of choice for people with disability and those with caring responsibilities. The Department's goal is to minimise barriers to employment for people with disability, fostering an environment that enables people with disability, and carers, to maximise their productivity and potential. By embracing diversity within the workforce, we will strengthen our ability to provide better health and wellbeing for all Australians.

The Department's *2016–2019 Accessibility Action Plan* (AAP) aims to ensure that we meet our legislative obligations in relation to anti-discrimination and equal employment for our employees. The AAP describes how we will build and strengthen our culture to ensure that disability on its own does not limit participation in the workforce. Over the next two years, we will implement the AAP and embed a culture of inclusivity.

Our AAP uses a human rights approach to disability and focuses on five key areas:

- Leadership – to increase the representation of employees with disability in senior and network roles;
- Inclusivity – to foster inclusive cultures in the workplace;
- Opportunities – to expand the range of employment opportunities for people with disability;
- Investing in capability – to invest in developing the capability of employees with disability; and
- Training needs – by offering training to improve disability awareness, and integrate disability awareness principles into existing management development and orientation programs.

The AAP was developed cooperatively with the Department's Disability and Carers Network (DCN) to represent the interests of staff. In December 2016, the DCN celebrated International Day of People with Disability by hosting a story sharing event to raise awareness of personal experiences.

The DCN was formerly the Disability Network, however in 2016-17 it embraced the sentiments of the Statement for Australian Carers by recognising carers into the network's title and work mandate. During Carers Week in October 2016, the DCN hosted a Carers Week morning tea with guest speakers from Carers Australia, who discussed the intersection between disability and Aboriginal and Torres Strait Islander culture.

Carers are an integral part of the Department's current AAP. A range of employment provisions and entitlements also support staff with disability or caring responsibilities, including:

- counselling for staff and family members for work or personal issues;
- paid and unpaid carers leave;
- purchased leave of up to six weeks per calendar year; and
- family care rooms and facilities for breastfeeding mothers in the workplace.

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 Australian Public Service Commission's State of the Service reports 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 (the Strategy) has been overtaken by the *National Disability Strategy 2010–2020*. The Strategy 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 the Department of Social Services' website at: www.dss.gov.au

The 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. The Department ensures the needs of people with disability are considered through the policy work for our identified outcomes and priorities, through specific stakeholder workshops, discussion papers and other engagement mechanisms.

Working with carer organisations

The Department consults with carer organisations to develop support mechanisms and implements reforms to ensure that programs and services continue to meet the requirements of the *Carer Recognition Act 2010* and consider the needs of carers, people with disability and vulnerable populations.

Mental health services

The Department is developing a more effective mental health system to improve outcomes for consumers. 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. These reforms are being progressed in partnership with consumers, carers, mental health stakeholders, and State and Territory Governments.

We provided funding of $500,000 to Mental Health Australia to sponsor the National Mental Health Consumer and Carer Forum; to provide administrative support to the National Register of Mental Health Consumer and Carer Representatives; and to merge links to pool expertise and networks to progress mental health policy topics of national interest.

We have also entered into a Memorandum of Understanding with the National Mental Health Commission to build the capacity, skills and experience of carers and consumers or those with lived experience to support implementation of the mental health reform agenda.

Aged care services

In 2016-17, the Department reviewed the *National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse Backgrounds (CALD)* and the *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*. Carers and carer organisations were consulted through the Ageing and Aged Care CALD Working Group, the Ageing and Aged Care LGBTI Working Group, the Aged Care Sector Committee, the National Aged Care Alliance, and formal survey and submission processes undertaken through the Department's Consultation Hub.

Additionally, in consultation with peak bodies representing Australia's carers, the Department established the Short-Term Restorative Care (STRC) Programme in 2016-17. STRC aims to reverse and/or slow functional decline in older people and improve their wellbeing. STRC places were allocated through a competitive process, in which applicants were required to demonstrate how they would effectively engage with both prospective care recipients and their carers in the development of care plans.

The Department held a Ministerial Dementia Forum in December 2016 to hear directly from people living with dementia and carers about what they require in a dementia consumer supports program.

In response to a review of Commonwealth funded aged care advocacy services, the Department will develop a National Aged Care Advocacy Framework, which will recognise carers, family members, family of choice and other representatives of aged care consumers as partners in care as well as partners in advocacy. Carers will be able to access advocacy services on behalf of consumers receiving, or seeking to receive, Australian Government funded aged care services.

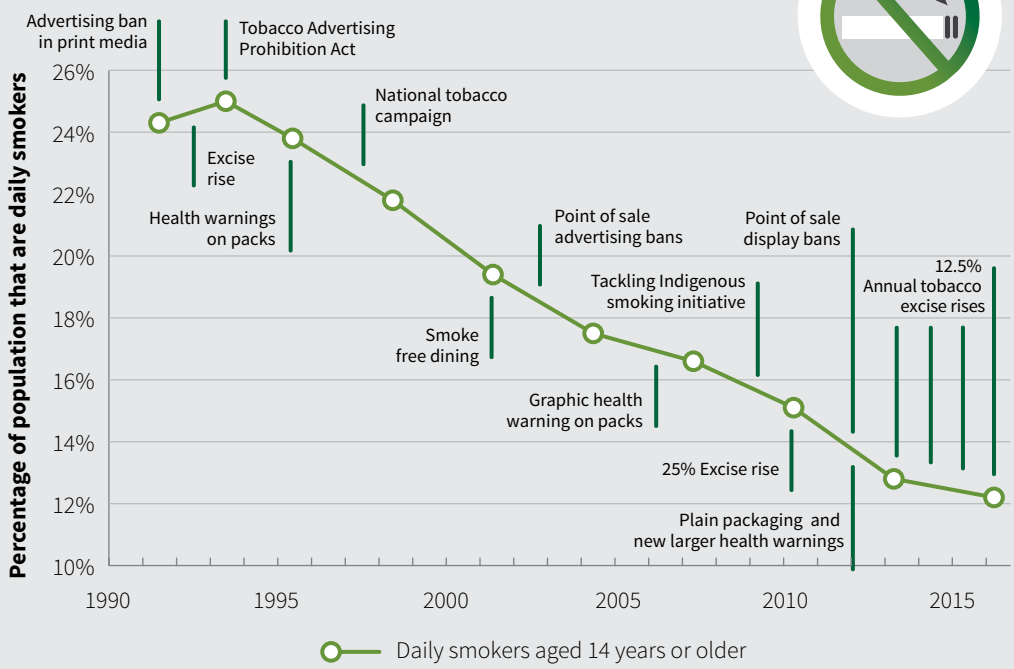
Tobacco Plain Packaging

The Department pursuant to section 108 of the *Tobacco Plain Packaging Act 2011* (the Act) reports that 402 potential contraventions of the Act were investigated in 2016-17. The majority of these matters were continuing investigations from the previous year. In 2016-17, 101 warning letters were issued.

A copy of this report has been provided to the Minister for Health.

Working towards a tobacco-free future

Figure 3.4.1: Daily smokers aged 14 years or older from 1991 to 2016



Smoking is the leading cause of preventable death and disease in Australia. It causes many types of cancer, heart disease and stroke, and chest and lung illnesses, and claims the lives of almost 19,000 Australians every year.

Over the past two decades, the Australian Government has committed to a comprehensive range of tobacco control measures, including excise increases on tobacco, plain packaging of tobacco products, graphic health warnings, prohibition of tobacco advertising, social marketing campaigns and other education programs, and support for smokers to quit. Collectively, these have played a significant role in reducing Australia's smoking rates, which are now among the lowest in the world. Since 1991, the national daily smoking rate for people aged 14 years or older in Australia has almost halved – from 24.3 per cent in 1991 to 12.2 per cent in 2016.[74]

As well as reduced smoking rates, recent surveys have shown that fewer teenagers are taking up smoking, young people are delaying the take-up of smoking, and people who do smoke are smoking fewer cigarettes.

[74] Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2016 key findings.

The *Human Services (Medicare) Act 1973*

The *Human Services (Medicare) Act 1973* provides for the Chief Executive Medicare to authorise the exercise of powers requiring a person to give information or to produce a document that is in the person's custody, or under the person's control, and the power to obtain a statutory report under section 42 of the Act.

Section 42(1) paragraphs (a) to (h)		Occurrences
(a)	the number of signed instruments made under section 8M	7
(b)	the number of notices in writing given under section 8P	76
(c)	the number of notices in writing given to individual patients under section 8P	0
(d)	the number of premises entered under section 8U	0
(e)	the number of occasions when powers were used under section 8V	0
(f)	the number of search warrants issued under section 8Y	2
(g)	the number of search warrants issued by telephone or other electronic means under section 8Z	0
(h)	the number of patients advised in writing under section 8ZN	0

Ecologically sustainable development

Ecologically sustainable development principles

The principles of ecologically sustainable development (ESD) outlined in section 3A of the *Environment Protection and Biodiversity Conservation Act 1999* are that:

- decision-making processes should effectively integrate both long-term and short-term economic, environmental, social and equity considerations;
- if there are threats of serious or irreversible environmental damage, lack of full scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation;
- the present generation should ensure that the health, diversity and productivity of the environment is maintained or enhanced for the benefit of future generations;
- the conservation of biological diversity and ecological integrity should be a fundamental consideration in decision-making; and
- improved valuation, pricing and incentive mechanisms should be promoted.

Our contribution

In 2016-17, the Department continued its commitment to ESD through 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. The Department also administers legislation that is relevant to, and meets the principles of, ESD, including the:

- *Gene Technology Act 2000*

  Through the Gene Technology Regulator, the Department protects the health and safety of people and the environment by identifying risks posed by gene technology and manages those risks through regulating activities with genetically modified organisms (GMOs). These activities range from contained work in certified laboratories to release of GMOs into the environment. The Regulator imposes licence conditions to protect the environment, and uses extensive powers to monitor and enforce those conditions.

- *Industrial Chemicals (Notification and Assessment) Act 1989*

  The National Industrial Chemicals Notification and Assessment Scheme (NICNAS) aids in the protection of the Australian people and the environment by assessing the risks of industrial chemicals and promoting their safe use. NICNAS operates within an agreed framework for chemical management that is consistent with the National Strategy for ESD and is aligned with the United Nations Conference on Environment and Development Agenda 21 (Rio Declaration) chapter on the environmentally sound management of toxic chemicals.

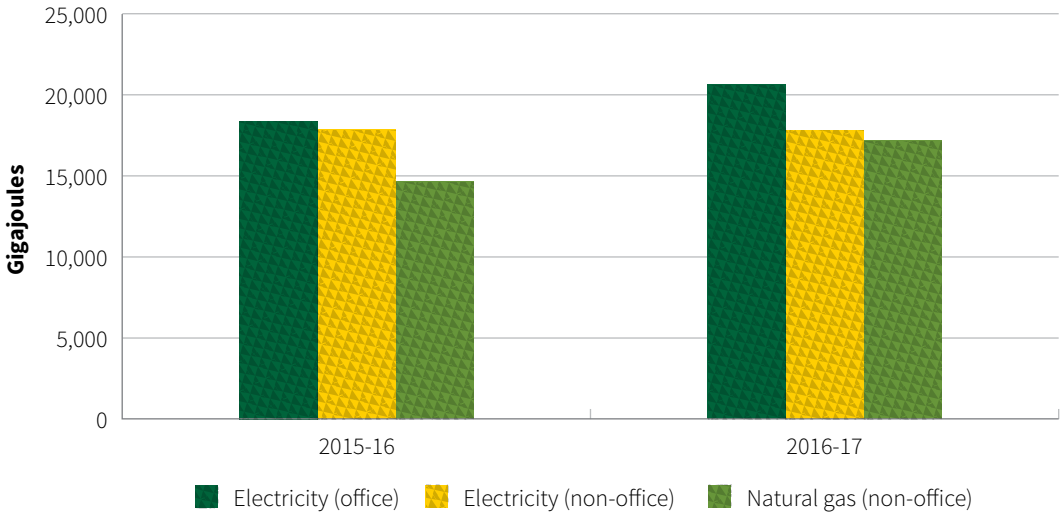
Environmental impact of our operations

The Energy Efficient 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) 'A' grade standard of the Building Owners and Managers Association International guidelines and meet a minimum National Australian Built Environment Rating System rating of 4.5 stars.

Energy consumption

Figure 3.4.2: The Department's electricity and natural gas consumption



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 2016-17, the Department met the target, using only 4,480 MJ per person, per annum.

This achievement reflects the Department's efforts in its leased property portfolio to reduce energy consumption through technology such as:

- T5 fluorescent and movement activated sensor lighting;
- double glazed windows;
- energy efficient heating;
- ventilation; and
- air-conditioning systems.

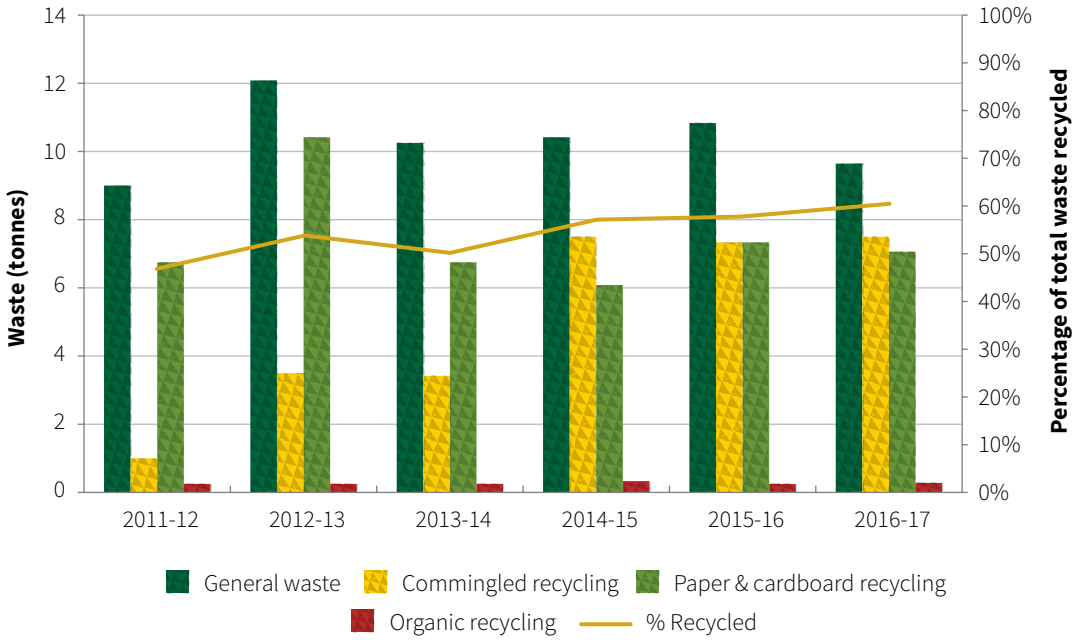
There is no target for energy consumption for non-office space, which includes sites used for laboratories, workshop and storage facilities. This includes the Symonston facility, which also accounts for the Department's use of natural gas.

The Department monitors the energy consumption in these facilities as part of its commitment to reducing the impact on the environment from its activities.

The Department also participated in Earth Hour 2017 by switching off building lights, terminals, monitors and office equipment at all its properties around Australia.

Waste management

Figure 3.4.3: Average monthly waste produced by the Department



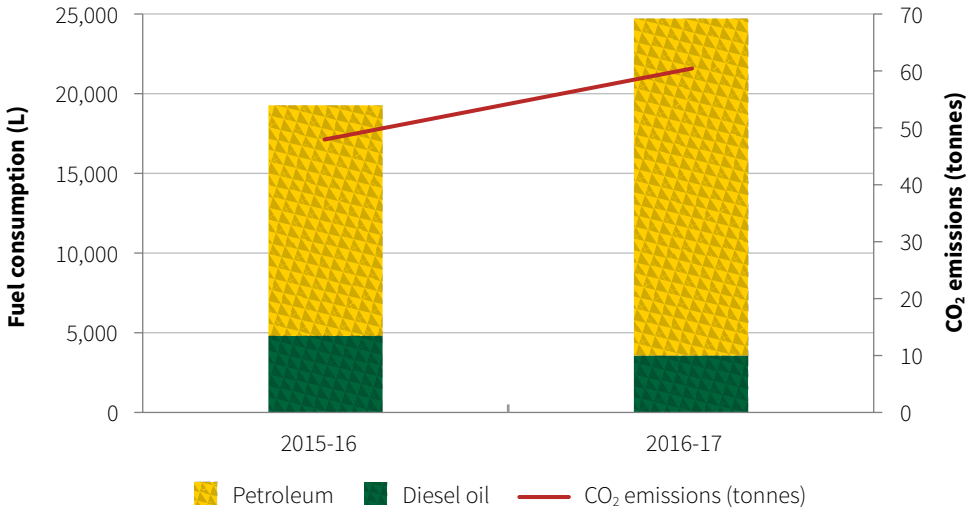
The Department is committed to protecting the environment through the implementation of efficient and effective waste management programs.

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.

The Department aims to increase the amount of waste recycled as a share of the total waste. In 2016-17, the Department recycled over half of its total waste produced, with 105.22 tonnes of the total 192.03 tonnes of waste being recycled.

Vehicle fleet management

Figure 3.4.4: Fleet fuel consumption and CO_2 emissions



In 2016-17, the Department operated 45 vehicles, up from 30 in 2015-16, which together travelled a total of 324,125 km and expended 860,858 MJ. This resulted in an energy consumption of approximately 2.66 MJ/km.

The Department works to ensure its fleet provide value for money and is environmentally friendly. Additionally, the Department works towards a target of 28 per cent of leased/pool vehicles meeting the Green Vehicle Guide scored of at least 10.5 out of 20.

Other sustainable initiatives

In support of the ICT Sustainability plan, the IT Division is committed to the protection of the environment and the continuous improvement of its performance in the reduction of environment impacts across its business activities.

In December 2016, the Department completed 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 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.

Advertising and market research

In 2016-17, the Department is required to report on all payments over $13,000 (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 2016-17.

Advertising campaigns

During 2016-17, the Department conducted the following advertising campaigns:

- Aged Care campaign;
- BreastScreen Australia campaign;
- *Girls Make Your Move* campaign;
- Health Star Rating system campaign; and
- National Tobacco Campaign (*Don't Make Smokes Your Story* 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/

Table 3.4.1: Advertising, market research, direct mail and media advertising payments for 2016-17

Organisation	Service provided	Paid (GST Incl)
Advertising agencies (creative advertising agencies which have developed advertising campaigns)		
AJF	*Girls Make Your Move* – creative development and supply	$27,221
Carbon Creative	National Tobacco Campaign – creative development and supply	$160,301
303MullenLowe	Aged Care Changes Campaign – creative development and supply	$144,485
Total		**$332,007**
Market research		
Bastion Latitude	Concept testing for Palliative Care communication	$132,000
Bastion Latitude	Exploratory communication research on physical activity and sport participation among young males	$436,590
Bastion Latitude	Exploratory communication research for Palliative Care	$109,951
GfK Australia	Evaluation research for the *Girls Make Your Move* campaign	$110,550
Hall and Partners | Open Mind	Exploratory communication market research to support the Review of Pharmacy Remuneration and Regulation	$152,229
National Heart Foundation	Consumer use and understanding of the Health Star Rating System survey	$86,900
ORC International	Evaluation research for the National Tobacco Campaign (*Don't Make Smokes Your Story* campaign)	$165,871
ORC International	Exploratory communication research on community knowledge and understanding of Biosimilar medicines for Biosimilar Awareness Initiative	$384,332
Pollinate	Evaluation research for the Health Star Rating System campaign	$48,400
Snapcracker Research and Strategy	Concept testing for the National Childhood Immunisation Education Program	$132,000
Snapcracker Research and Strategy	Exploratory communication research for Immunisation	$125,000
Snapcracker Research and strategy	Exploratory communication research for alcohol and other drugs	$203,514

Organisation	Service provided	Paid (GST Incl)
Snapcracker Research and Strategy	Concept testing for the National Drugs Campaign	$209,220
Taylor Nelson Sofres Australia T/a Kantar	Exploratory communication research for healthy weight and dietary guidelines	$660,000
Taylor Nelson Sofres Australia T/a Kantar	Concept testing and evaluation research services for the Aged Care communication campaign	$275,688
Taylor Nelson Sofres Australia T/a Kantar	Concept testing and research Services for the *Girls Make Your Move* campaign	$80,300
WhereTo Research	Exploratory communication research for private health insurance	$199,100
WhereTo Research	Evaluation research for the Cancer Screening campaigns	$79,200
WhereTo Research	Exploratory communication research into Best Practice Palliative Care in General Practice	$100,000
Woolcott Research	Material testing and concept testing for the National Cervical Screening Program	$185,645
Total		**$3,876,490**
Direct mail organisations[75] (includes organisations which handle the sorting and mailing out of information material to the public)		
National Mailing and Marketing Pty Ltd	Shingles Information Resources mail out	$16,096
National Mailing and Marketing Pty Ltd	2017 Seasonal Influenza(Part 1 and Part 2) mail out	$55,092
National Mailing and Marketing Pty Ltd	Introduction of the Rotavirus Vaccine letter and advice mail out	$13,973
National Mailing and Marketing Pty Ltd	Health Care Reform mail out	$106,039
Total		**$191,200**
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 BreastScreen Australia campaign	$999,943
Dentsu Mitchell	Media Buying for the *Girls Make Your Move* campaign	$7,034,041
Dentsu Mitchell	Media buying for the National Tobacco campaign	$7,685,243
Dentsu Mitchell	Media buying for the Aged Care Changes campaign	$3,048,762
Dentsu Mitchell	Media buying for the Health Star Rating campaign	$2,186,658
Total		**$20,954,647**
Grand total		**$25,354,344**

[75] 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.


13,780,263
607,058
1,797,862
362,173
382,422
9,652
2,606
cy-related transactions:
ward exchange trades
oss currency swaps
urchased foreign currency options
Written foreign currency options
traded products:
ncy futures
currency options

Part 4: Financial Statements

Part 4.1: 2016-17 Financial Statements Process

The Department is required to prepare annual financial statements to comply with the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). The statements must comply with the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015* and Australian Accounting Standards. Additional guidance is provided by the Department of Finance through Resource Management Guide No. 125.

In preparing the 2016-17 financial statements, the Department applied professional judgement to ensure that the financial statements fairly present the financial position, financial performance and cash flows.

From 2016-17, the Department has reduced disclosure of certain technical information to shorten the statements and enhance their readability. The Department has also reformatted its financial statements to increase the proximity of like disclosures and incorporate accounting policy detail with the items they describe. Items that do not add material value in separate disclosure have been disclosed in aggregate form only.

The Department has continued its practice of additional disclosures where, in the opinion of the Chief Financial Officer, these disclosures add value for the reader. In 2016-17, this includes a note specific to the Therapeutic Goods Administration special account and detailed descriptions supporting the note disclosures.

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.

Readers of the financial statements will be assisted by the colour coding incorporated in the statements, notes and narrative. Expenses administered by the Department on behalf of the Government are shaded grey, unshaded items are operational in nature (departmental expenses), and accounting policy has a mauve background.

For further information, refer *Chief Operating Officer's Report* on p. 12, which contains a summary of the Department's 2016-17 financial results.

Part 4.2: 2016-17 Financial Statements

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Department of Health

Independent Auditor's Report

Auditor-General for Australia

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Department of Health for the year ended 30 June 2017:

(a) comply with Australian Accounting Standards – Reduced Disclosure Requirements 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 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Department of Health, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

- Statement by the Secretary and Chief Financial Officer;
- Overview;
- Departmental Statement of Comprehensive Income;
- Departmental Statement of Financial Position;
- Departmental Statement of Changes in Equity;
- Departmental Cash Flow Statement;
- Administered Schedule of Comprehensive Income;
- 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.

Basis for Opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Department of Health in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* to the extent that they are not in conflict with the *Auditor-General Act 1997* (the Code). I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Key Audit Matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial statements of the current period. These matters were addressed in the context of my audit of the financial statements as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

Key audit matter	How the audit addressed the matter
Accuracy of payments of personal benefits and subsidies *Refer to Note 18B. 'Personal benefits' and Note 18C 'Subsidies – aged care'* I focused on expenses related to health and aged care	To address this key audit matter, I have: • gained an understanding of the key business processes, controls and information technology (IT) systems related to the calculation and processing of payments;

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Department of Health

Independent Auditor's Report

programs including Medicare, Pharmaceutical Benefits Scheme and Private Health Insurance Rebate because these payments are: • calculated by multiple, complex information technology systems which have been designed to meet legislative requirements; • based on the information provided by the payment recipients and may be significantly impacted by delays in recipients providing correct or updated information and/or provision of misleading information in order to obtain financial gain; and • significant to the financial statements; The Department of Health is reliant on the Department of Human Services (Human Services) for making these payments. During 2016–17 financial year, Health recognised personal benefits expenses of $42,555,967,000 and $12,002,391 of aged care subsidies expenses.	• assessed and tested the design and operation of the IT environment including controls related to the security, access management and unauthorised changes to the IT systems; • assessed the internal controls related to the accreditation and registration of medical providers, pharmacies and aged care providers; • assessed the compliance risk management processes including risk identification, risk assessment and risk prioritisation processes for a selection of payments for further evaluation; and • tested a sample of payments to check eligibility of recipients and accuracy of payments.
Key audit matter **Valuation of personal benefits provisions and subsidies provisions** *Refer to Note 18B 'Personal benefits provisions' and Note 18C 'Subsidies provisions'* I considered this area a key audit matter due to the significant judgments involved in estimating the personal benefits and subsidies provisions. The judgements relate to the amount and timing of future cash flows, estimating the period over which these provisions are expected to be settled by the Department of Health and use of appropriate discount rate. These judgements rely on the quality of the underlying data used in the estimation process. As at 30 June 2017, the personal benefits provisions were $1,057,773,000 and subsidies provisions were $450,000,000.	**How the audit addressed the matter** To address this key audit matter, I have: • evaluated the Department of Health's review and approval process to assess the reasonableness of actuarial assumptions used in the estimation of provisions; • assessed the appropriateness of significant assumptions and judgements made during the estimation process including the timing of future cash flows and appropriateness of the discount rate used; and • assessed the sources of data used in the estimation process for accuracy, completeness and relevance.
Key audit matter **Completeness and accuracy of Pharmaceutical Benefits Scheme recoveries** *Refer to Note 21A 'Recoveries – PBS drug recoveries' and 'Accrued recoveries revenue – Pharmaceutical benefits'* I considered this area a key audit matter due to the: • complexities involved in calculating Pharmaceutical Benefits Scheme (PBS) recovery revenue using data sourced from the Department of Human Services; • complex risk sharing arrangements between the Department of Health and pharmaceutical companies for recovery of PBS expenditure; and • weaknesses identified during the 2015–16	**How the audit addressed the matter** To address this key audit matter, I have: • tested a sample of invoices to assess whether invoices were raised in accordance with the recovery arrangements with pharmaceutical companies; • assessed the sources of data used in the estimation process for accuracy, completeness and relevance. • tested the mathematical accuracy of the model. This involved recalculating the recoveries revenue, on a sample basis, in accordance with the agreements with pharmaceutical companies; and • on a sample basis, assessed whether invoices

Department of Health

Independent Auditor's Report

financial statements audit in the policies and procedures related to capturing and reporting the recoveries. These weaknesses were reported as a moderate risk issue in the ANAO Report No. 33 *Audits of the Financial Statements of Australian Government Entities for the Period Ended 30 June 2016*.	raised subsequent to year-end were recorded in the correct accounting period.
In 2016–17, $3,267,515,000 of PBS drug recoveries revenue, including $856,998,000 of accrued PBS recoveries revenue was recognised.	

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Department of Health the Secretary 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 – Reduced Disclosure Requirements 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.

In preparing the financial statements, the Secretary is responsible for assessing the Department of Health's ability to continue as a going concern, taking into account whether the entity's operations will cease as a result of an administrative restructure or for any other reason. The Secretary is also responsible for disclosing matters related to going concern as applicable and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

Auditor's Responsibilities for the Audit of the Financial Statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit 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;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

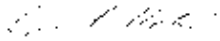
I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Department of Health

Independent Auditor's Report

From the matters communicated with those charged with governance, I determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. I describe these matters in our auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Australian National Audit Office



Grant Hehir
Auditor-General

Canberra
31 August 2017

Department of Health

Statement by the Secretary and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2017 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 2017

Signed.....

Craig Boyd
Chief Financial Officer
Department of Health

31 August 2017

Department of Health

Overview

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 is to lead and shape Australia's health system and sporting outcomes through evidence based policy, well targeted programs and best practice regulation.

Effective 1 July 2016, the Department's Outcome and Program structure were revised and the number of Outcomes were reduced from 11 to 6. Details of the revised Outcome and Program structure are included in the 2016-17 Health Portfolio Budget Statements. The Outcomes effective for 2016-17 were:

Outcome 1	Health System Policy, Design and Innovation;
Outcome 2	Health Access and Support Services;
Outcome 3	Sport and Recreation;
Outcome 4	Individual Health Benefits;
Outcome 5	Regulation, Safety and Protection; and
Outcome 6	Ageing and Aged Care.

The continued existence of the Department in its present form and with its present programs is dependent on Government policy and on continued 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.

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 for reporting periods ending on or after 1 July 2015; and
- Australian Accounting Standards and Interpretations – Reduced Disclosure Requirements 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 held 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.

Department of Health

Overview

Like items together with disclosure of the relevant accounting policy are grouped together in the notes to the financial statements. The accounting policy disclosures have been shaded mauve to distinguish them from other commentary.

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).

All transactions between the Department and the three departmental 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.

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 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 AASB 124 *Related Party Transactions* which is reported in detail at Note 5: Key management personnel remuneration and Note 6: Related party transactions.

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 Secretary and Chief Financial Officer, for which the Department is still assessing the potential impact on the financial statements:

- AASB 9 *Financial Instruments;*
- AASB 15 *Revenue from Contracts with Customers;*
- AASB 16 *Leases;* and
- AASB 1058 *Income of Not-for-Profit Entities.*

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.

4. Significant Accounting Judgements and Estimates

Except where specifically identified and disclosed, 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.

5. 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.

The Australian Digital Health Agency (Digital Health) commenced from 1 July 2016. Details of the asset transfer between the Department and Digital Health are included at Note 26: Restructuring.

Department of Health

Overview

6. 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.

7. Correction of prior period error and changes in classification

During 2016-17 the Department determined that its administered recoveries revenue and accrued recoveries relating to Pharmaceutical Benefit Scheme listed drugs were understated in its 2015-16 financial statements. This error was corrected by restating each of the affected financial statement line items for the prior period. There was also an amount reported as recoveries receivable in 2015-16 which should have been classified as loans and receivables. The following table summarises the impact of the restatement of the Department's 2015-16 financial statements.

Administered Schedule of Comprehensive Income
for the period ended 30 June 2016

	Previous amount $'000	Adjustments $'000	Restated amount $'000
Income			
Recoveries	2,556,834	130,793	2,687,627
Other revenue	274,778	-	274,778
Total income	**2,831,612**	**130,793**	**2,962,405**
Net cost of services	**52,927,833**	**(130,793)**	**52,797,040**

Administered Schedule of Assets and Liabilities
as at 30 June 2016

	Previous amount $'000	Adjustments $'000	Restated amount $'000
ASSETS			
Financial assets			
Cash and cash equivalents	171,579	-	171,579
Accrued recoveries[1]	837,220	88,865	926,085
Loans and receivables	536,297	41,928	578,225
Other investments	380,117	-	380,117
Total financial assets	**1,925,213**	**130,793**	**2,056,006**
Total assets administered on behalf of Government	**2,118,498**	**130,793**	**2,249,291**
Net liabilities	**1,136,461**	**(130,793)**	**1,005,668**

8. Events after the reporting period

TGA special account annual charges 2016-17

Sponsors of certain products on the Australian Register of Therapeutic Goods during the 2016-17 year have until 15 September 2017 to apply for exemption from the annual charges for the year. An estimate of the value of the exemptions has been incorporated in 2016-17 revenues.

Administered Inventory

$0.8m of administered inventory held in the National Medical Stockpile will pass its expiry date during the period July to October 2017 (2016: $10.117m). Another $3.3m worth of inventory is due to pass its expiry date at the end of July 2017, however an extension of useful life is possible for these items.

[1] In 2016 accrued recoveries were described as recoveries receivable.

Department of Health

Departmental statement of comprehensive income
for the period ended 30 June 2017

		ACTUAL		BUDGET ESTIMATE	
				Original	Variance
	Notes	**2017**	2016	2017	2017
		$'000	$'000	$'000	$'000
NET COST OF SERVICES					
EXPENSES					
Employee benefits	4A	**557,695**	464,527	583,308	(25,613)
Suppliers	7A	**324,285**	304,416	204,951	119,334
Depreciation and amortisation	11	**26,548**	23,984	28,817	(2,269)
Other expenses	7B	**2,978**	3,850	11,900	(8,922)
Total expenses		**911,507**	796,777	828,976	82,531
OWN-SOURCE INCOME					
Revenue	8A	**172,247**	176,624	175,581	(3,334)
Gains	8B	**1,975**	448	-	1,975
Total own-source income		**174,222**	177,072	175,581	(1,359)
Net cost of services		**737,284**	619,705	653,395	83,889
Revenue from Government	9A	**655,162**	594,997	625,680	29,482
Deficit attributable to the Australian Government		**(82,122)**	(24,708)	(27,715)	(54,407)
OTHER COMPREHENSIVE INCOME					
Items not subject to subsequent reclassification to net cost of services					
Changes in asset revaluation surplus		**4,770**	-	-	4,770
Total other comprehensive income		**4,770**	-	-	4,770
Total comprehensive loss attributable to the Australian Government		**(77,353)**	(24,708)	(27,715)	(49,638)

The above statement should be read in conjunction with the accompanying notes.

Department of Health

Departmental statement of financial position
as at 30 June 2017

		ACTUAL		BUDGET ESTIMATE	
				Original	Variance
	Notes	**2017**	2016	2017	2017
		$'000	$'000	$'000	$'000
ASSETS					
Financial assets					
Cash and cash equivalents	10A	**95,722**	90,672	69,374	26,348
Appropriations receivable	9B	**31,286**	115,572	136,777	(105,491)
Trade and other receivables	8C	**18,209**	21,548	12,143	6,066
Accrued revenue		**2,160**	8,649	5,257	(3,097)
Total financial assets		**147,378**	236,441	223,551	(76,173)
Non-financial assets					
Land and buildings	11	**54,923**	53,278	52,628	2,295
Property, plant and equipment	11	**5,378**	6,316	10,062	(4,684)
Intangibles	11	**119,147**	106,146	151,860	(32,713)
Prepayments		**13,149**	7,834	4,788	8,361
Lease incentives		**13,823**	3,895	-	13,823
Total non-financial assets		**206,420**	177,469	219,338	(12,918)
Total assets		**353,798**	413,910	442,889	(89,091)
LIABILITIES					
Payables					
Supplier payables		**59,416**	61,620	85,930	(26,514)
Employee payables	4B	**4,593**	3,187	19,937	(15,344)
Other payables	7D	**51,503**	42,009	25,163	26,340
Total payables		**115,511**	106,816	131,030	(15,519)
Provisions					
Employee provisions	4C	**153,207**	152,143	162,835	(9,628)
Other provisions	7E	**30,398**	28,560	27,349	3,049
Total provisions		**183,605**	180,703	190,184	(6,579)
Total liabilities		**299,116**	287,519	321,214	(22,098)
Net assets		**54,682**	126,391	121,675	(66,993)
EQUITY					
Contributed equity		**252,569**	246,925	288,583	(36,014)
Asset revaluation reserve		**35,206**	30,436	30,507	4,699
Accumulated deficit		**(233,092)**	(150,970)	(197,415)	(35,677)
Total equity		**54,682**	126,391	121,675	(66,993)

The above statement should be read in conjunction with the accompanying notes.

Department of Health

Departmental statement of changes in equity
for the period ended 30 June 2017

		ACTUAL		BUDGET ESTIMATE	
				Original	Variance
	Notes	**2017**	2016	2017	2017
		$'000	$'000	$'000	$'000
ACCUMULATED DEFICIT					
Opening balance					
Balance carried forward from previous period		**(150,970)**	(128,775)	(169,700)	18,730
Comprehensive loss for the period		**(82,122)**	(24,708)	(27,715)	(54,407)
Transfers between equity components		**-**	2,513	-	-
Closing balance as at 30 June		**(233,092)**	(150,970)	(197,415)	(35,677)
ASSET REVALUATION RESERVE					
Opening balance					
Balance carried forward from previous period		**30,436**	30,507	30,507	(71)
Other comprehensive income		**4,770**	-	-	4,770
Transfers between equity components		**-**	(71)	-	-
Closing balance as at 30 June		**35,206**	30,436	30,507	4,699
CONTRIBUTED EQUITY					
Balance carried forward from previous period		**246,925**	217,325	263,746	(16,821)
Transfers between equity components		**-**	(2,442)	-	-
Transactions with Owners					
Equity injection - appropriations		**6,571**	20,034	18,349	(11,778)
Return of Capital					
- reduction in equity appropriations[1]		**(10,755)**	-	-	(10,755)
Equity injection - restructuring		**-**	12,256	-	-
Departmental capital budget		**9,828**	6,656	6,488	3,340
Departmental capital budget - restructuring		**-**	965	-	-
Restructuring		**-**	(7,869)	-	-
Total transactions with owners		**5,644**	32,042	24,837	(19,193)
Closing balance as at 30 June		**252,569**	246,925	288,583	(36,014)
TOTAL EQUITY					
Opening balance					
Balance carried forward from previous period		**126,391**	119,057	124,553	1,838
Comprehensive loss for the period		**(77,353)**	(24,708)	(27,715)	(49,638)
Transactions with owners		**5,644**	32,042	24,837	(19,193)
Closing balance as at 30 June		**54,682**	126,391	121,675	(66,993)

[1] The detail for the reduction in equity appropriation can be found in the 2016-17 Portfolio Additional Estimates Statements.

The above statement should be read in conjunction with the accompanying notes.

Department of Health

Departmental cash flow statement
for the period ended 30 June 2017

	Notes	ACTUAL 2017 $'000	ACTUAL 2016 $'000	BUDGET ESTIMATE Original 2017 $'000	BUDGET ESTIMATE Variance 2017 $'000
OPERATING ACTIVITIES					
Cash received					
Appropriations		**844,086**	678,390	627,735	216,351
Sale of goods and rendering of services		**181,537**	161,373	217,839	(36,302)
Net GST received		**28,858**	25,816	24,810	4,048
Other		**-**	2,063	1,782	(1,782)
Total cash received		**1,054,481**	867,642	872,166	182,315
Cash used					
Employees		**(553,374)**	(471,954)	(467,646)	(85,728)
Suppliers		**(360,130)**	(339,331)	(311,040)	(49,090)
Net GST paid		**-**	-	(4,347)	4,347
Section 74 receipts transferred to the Official Public Account		**(114,459)**	(58,550)	(65,147)	(49,312)
Other		**(526)**	(1,105)	(7,932)	7,406
Total cash used		**(1,028,489)**	(870,940)	(856,112)	(172,377)
Net cash from/(used by) operating activities	3	**25,993**	(3,298)	16,054	9,939
INVESTING ACTIVITIES					
Cash received					
Proceeds from sales of property, plant and equipment		**81**	9,210	-	81
Total cash received		**81**	9,210	-	81
Cash used					
Purchase of property, plant, equipment and intangibles		**(36,488)**	(35,438)	(54,506)	18,018
Total cash used		**(36,488)**	(35,438)	(54,506)	18,018
Net cash used by investing activities		**(36,407)**	(26,228)	(54,506)	18,099
FINANCING ACTIVITIES					
Cash received					
Appropriations - Equity injection		**5,321**	27,341	18,349	(13,028)
Appropriations - Departmental capital budget		**10,143**	13,226	6,488	3,655
Total cash received		**15,465**	40,567	24,837	(9,372)
Net cash received from financing activities		**15,465**	40,567	24,837	(9,372)
Net increase/(decrease) in cash held		**5,050**	11,041	(13,615)	18,665
Cash and cash equivalents at the					
- beginning of the reporting period		**90,672**	79,631	82,989	7,683
- end of the reporting period	10A	**95,722**	90,672	69,374	26,348

The above statement should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Note 1: Departmental operating result reconciliation

The Government funds the Department on a net cash appropriation basis, where appropriation revenue is not provided for depreciation and amortisation expenses. Depreciation and amortisation is included in the Department's cost recovered operations.

The Department's accountability for its operating result is directed at the result net of unfunded depreciation and amortisation.

	2017	2016
	$'000	$'000
Total comprehensive loss	**(77,353)**	(24,708)
Unfunded depreciation and amortisation		
Total depreciation	**26,548**	23,984
Less cost recovered depreciation		
NICNAS	**(433)**	(228)
TGA	**(4,286)**	(4,579)
Net unfunded depreciation	**21,829**	19,177
Comprehensive loss net of unfunded depreciation and amortisation	**(55,524)**	(5,531)

Included in the total comprehensive loss – as per the Statement of Comprehensive Income – are the following:

- The application of prevailing bond rates to the Department's employee provisions reduced expenses by $3.190m for the year.
- The Department recognised a gain of $1.801m related to the software for the National Complaints and Compliance Information Management System (NCCIMS). NCCIMS was transferred from the Department of Social Services during the financial year.

Department of Health

Notes to and forming part of the financial statements

Note 2: Departmental explanation of budget variances

General Commentary
AASB 1055: *Budgetary Reporting* requires explanations of major variances between the original budget as presented in the 2016-17 Portfolio Budget Statements (PBS) and the final 2017 outcome. The information presented below should be read in the context of the following:

- The original budget was prepared before the 2016 final outcome could be known. As a consequence, the opening balance of the statement of financial position was estimated and in some cases variances between the 2016 final outcome and budget estimates can in part be 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;
- The Department considers that major variances are those greater than 10% of the 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 budget was prepared under the Commonwealth budgeting framework where revenue is not appropriated for depreciation and amortisation expenses, except as funded through cost recovered activity. For the 2016-17 financial year the Department also budgeted for an additional operating loss of $7.6m to undertake development work in response to the review of regulation of medicines and medical devices which was to be funded through prior year surpluses held in the Therapeutic Goods Administration special account; and
- The Budget is not audited.

Net cost of services
The total variation in departmental expenses was more than $82.5m higher than the 2016-17 PBS. The principal reason for the significantly higher levels of expenditure is due to the Department undertaking additional activities, only partly funded through the Mid-Year Economic and Fiscal Outlook (MYEFO). In addition, there was an overall increase in supplier expenses partly offset by a decrease in employee benefits.

The increase in supplier expenses is partly a result of the difference in the composition of budgeted and actual figures. This includes amounts relating to the payment of contractors which are budgeted as a component of employee benefits but which are reported as supplier expenses for the actual amounts incurred. The Department also recorded in suppliers expenses a payment of $7.9m to the Australian Sports Commission (Sporting Grants Efficiency Dividend) which had been budgeted in other expenses.

After taking account of this difference there has been an overall increase in employee benefits of approximately $16.8m, the majority of which relate to separation and redundancy. The Department has introduced a number of initiatives to manage staff numbers to an affordable level through control of recruitment which has seen non-ongoing engagements limited to essential positions.

Department of Health

Notes to and forming part of the financial statements

The increase in supplier expenses, again after taking into account the difference in the composition of the budget and actual expenses, is primarily due to the Department undertaking additional activities within existing resources. During the year the Department:

- integrated three state networks following the significant machinery of Government changes in the previous financial year;
- underwent organisational restructures to more effectively support its core functions while reducing its cost base;
- undertook additional activities to assist the Digital Payments Taskforce and the Major Sporting Events Support Taskforce;
- implemented the Medicare Benefits Schedule review; and
- incurred increased costs for undertaking evaluations to support the Pharmaceutical Benefits Advisory Committee.

The increase in the activities undertaken was in part offset funded through additional Revenue from Government which was up $29.482m from the level in the 2016-17 PBS. The additional Revenue from Government was partly funded through a reduction in equity injections.

The increase in expenses being partly offset by the additional Revenue from Government resulted in the Department's comprehensive loss being $54.407m higher than the anticipated loss in the 2016-17 PBS.

Financial assets
Total financial assets are $76.173m lower than the budgeted amount. The principal element of this reduction is the decrease in appropriations receivable which was about $105.491m lower as the Department drew upon the available balance to fund its activities. This reduction was in part offset by increase in both cash and cash equivalents up by $26.348m and trade and other receivables up by $6.066m.

Non-financial assets
Total non-financial assets are below budget by $12.918m largely through the reductions in intangibles and property, plant and equipment offset by an increase in other non-financial assets, this being principally related to prepaid expenses and assets associated with the recognition of lease incentives.

Payables
Total payables is under budget by about $15.519m as a result of lower supplier ($26.514m) and employee ($15.344m) payables. The significant increase in other payables results from unforeseen additional lease incentives as the Department has entered into new lease arrangements to meet accommodation requirements. Employee and supplier payable variances are driven by the timing of payments made by the Department at year end.

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 additional activities undertaken by the Department and which resulted in additional cash transactions for the year.

The cash flows from investing activities essentially relate to outflows associated with the purchase of non-financial assets being property, plant and equipment and intangibles. The level of these purchases was lower than anticipated at the time of the preparation of the budget.

The cash flows from financing activities are essentially driven by equity injections and amounts for the Departmental Capital Budget. Overall the amounts received in cash for these items was approximately $9.372m lower than anticipated at the time of the preparation of the budget.

Department of Health

Notes to and forming part of the financial statements

Note 3: Departmental cash flow reconciliation

	2017	2016
	$'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	**95,722**	90,672
Statement of Financial Position	**95,722**	90,672
Discrepancy	**-**	-
Reconciliation of net cost of services to net cash from operating activities		
Net cost of services	**(737,284)**	(619,705)
Add revenue from Government	**655,162**	594,997
Adjustment for non-cash items		
Gain on sale of assets and other gains	**(1,975)**	(448)
Depreciation/amortisation	**26,548**	23,984
Net write-down of non-financial assets	**1,445**	28
Decrease in net assets from restructure	**-**	(13,541)
Movements in assets and liabilities		
Assets		
Decrease/(increase) in net receivables	**77,857**	(19,218)
Decrease/(increase) in other financial assets	**6,489**	(3,144)
Decrease/(increase) in other non-financial assets	**(15,243)**	(7,925)
Liabilities		
Increase in employee provisions/payables	**4,321**	30,972
Increase/(decrease) in supplier payables	**(2,431)**	152
Increase in other payables	**9,267**	4,007
Increase in other provisions	**1,838**	6,543
Net cash from/(used by) operating activities	**25,993**	(3,298)

Department of Health

Notes to and forming part of the financial statements

Note 4: Employees

	2017 $'000	2016 $'000
Note 4A: Employee benefits		
Wages and salaries	**376,187**	321,540
Superannuation:		
Defined contribution plans	**35,183**	27,876
Defined benefit plans	**45,106**	39,785
Leave and other entitlements	**78,491**	71,506
Separation and redundancies	**22,728**	3,820
Total employee benefits	**557,695**	464,527
Note 4B: Employee payables		
Wages and salaries	**3,977**	2,926
Superannuation	**302**	187
Separations and redundancies	**314**	-
Other employee payables	**-**	74
Total employee payables	**4,593**	3,187
Note 4C: Employee provisions		
Leave	**149,382**	151,721
Separations and redundancies	**3,825**	422
Total employee provisions	**153,207**	152,143

All employee payables are expected to be settled within 12 months of the balance date.

Accounting policy

Liabilities for 'short-term employee benefits' (as defined in AASB 119 Employee Benefits) and termination benefits due within 12 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.

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.

Department of Health

Notes to and forming part of the financial statements

The Department recognises a payable for separation and redundancy where an employee has accepted an offer of a redundancy benefit and agreed a termination date. A provision for separation and redundancy is recorded when the Department has a detailed formal plan for the payment of redundancy benefits. The provision is based on the discounted anticipated costs for identified employees engaged in the redundancy program.

Under the *Superannuation Legislation Amendment (Choice of Funds) Act 2004*, employees 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 superannuation 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.

Department of Health

Notes to and forming part of the financial statements

Note 5: Key management personnel remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly. The Department has determined the key management personnel to be the Secretary, the Chief Medical Officer (CMO) and seven Deputy Secretaries. Key management personnel also include officers who have acted as the CMO or a Deputy Secretary and have exercised significant authority in planning, directing and controlling the activities of the Department.

Key management personnel remuneration is reported in the table below:

	2017	2016
	$'000	$'000
Key management personnel remuneration		
Short-term employee benefits	**3,713**	3,684
Post-employment benefits	**551**	499
Other long-term employee benefits	**348**	375
Termination benefits	**-**	152
Total key management personnel remuneration expenses [1]	**4,612**	4,710

The total number of key management personnel that are included in the above table is 14 (2016: 14).

Remuneration information for executives and other highly paid officials, published in accordance with the Executive Remuneration Reporting Guidelines issued by the Department of Prime Minister and Cabinet, is available on the Department's website[2].

[1] The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Minister. The Portfolio Minister's remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the entity.
[2] Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/executive-remuneration.

Department of Health

Notes to and forming part of the financial statements

Note 6: Related party transactions

AASB124 *Related Party Transactions* was amended to include not-for-profit entities, including Commonwealth non-corporate entities, in the reporting requirements from 1 July 2016.

Related party relationships:
The entity is an Australian Government controlled entity. Related parties to this entity are key management personnel including the Portfolio Minister and Executive Government, and other Australian Government entities.

Transactions with related parties:
Given the breadth of Government activities, related parties may transact with the government sector in the same capacity as ordinary citizens. Such transactions include receipt of a Medicare rebate, Medicare bulk billing provider payments, pharmaceutical benefits or a zero real interest loan for aged care providers. These transactions have not been separately disclosed in this note.

Significant transactions with related parties can include:

- the payments of grants or loans;
- purchases of goods and services;
- asset purchases, sales transfers or leases;
- debts forgiven; and
- guarantees.

Giving consideration to relationships with related entities and transactions entered into during the reporting period by the entity, it has been determined that there are no related party transactions to be separately disclosed.

Department of Health

Notes to and forming part of the financial statements

Note 7: Departmental suppliers, other expenses and payables

	2017 $'000	2016 $'000
Note 7A: Suppliers		
Goods and services supplied or rendered		
Contractors and consultants	**73,264**	84,532
Information technology costs	**84,671**	79,888
Contracted services	**33,853**	25,478
Property	**16,963**	11,195
Travel	**11,067**	9,577
Training and other staff related expenses	**5,095**	6,646
Legal	**2,308**	5,920
Committees	**3,632**	3,967
Other	**32,691**	17,788
Total goods and services supplied or rendered	**263,544**	244,991
Other suppliers		
Operating lease rentals	**55,056**	52,403
Workers compensation premiums	**5,686**	7,022
Total other suppliers	**60,741**	59,425
Total suppliers	**324,285**	304,416
Note 7B: Other expenses		
Write-down and impairment of assets		
Impairment of financial instruments	**1,007**	366
Impairment of land and buildings	**69**	-
Impairment of property, plant and equipment	**87**	28
Impairment on intangibles	**1,289**	2,351
Payments made on behalf of Portfolio agencies [1]	**525**	1,077
Act of Grace payments	**1**	28
Total write-down and impairment of assets	**2,978**	3,850

[1] Payments made on behalf of Portfolio agencies are recovered, refer Note 8A.

Department of Health

Notes to and forming part of the financial statements

	2017 $'000	2016 $'000
Note 7C: Commitments		
Lease commitments		
Operating leases[1]	**424,041**	345,780
Total commitments	**424,041**	345,780
Minimum lease payments expected to be settled		
Within 1 year	**56,366**	53,296
Between 1-5 years	**227,894**	188,734
More than 5 years	**139,781**	103,750
Total leases	**424,041**	345,780

[1] The operating lease commitments relate to property lease payments.

Note: Commitments are not reported in the Statement of Financial Position.

Accounting policy

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.

	2017 $'000	2016 $'000
Note 7D: Other payables		
Lease incentive	**29,900**	23,656
Unearned income	**21,375**	18,353
Other	**227**	-
Total other payables	**51,503**	42,009
Note 7E: Other provisions		
Provision for surplus lease space	**47**	-
Provision for restoration	**3,002**	3,079
Provision for lease straightlining	**27,349**	25,481
Total other provisions	**30,398**	28,560

Accounting policy

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.

Department of Health

Notes to and forming part of the financial statements

	Provision for surplus lease space $'000	Provision for restoration[1] $'000	Provision for lease straightlining[2] $'000	Total $'000
As at 1 July 2016	**-**	**3,079**	**25,481**	**28,560**
Additional provisions made	**47**	**17**	**2,409**	**2,473**
Amounts used	**-**	**(94)**	**(466)**	**(560)**
Amounts reversed	**-**	**-**	**(75)**	**(75)**
Total as at 30 June 2017	**47**	**3,002**	**27,349**	**30,398**

[1] The Department currently has six (2016: seven) 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.

[2] The Department holds a provision for lease straight-lining on the existing ten leases.

Department of Health

Notes to and forming part of the financial statements

Note 8: Departmental income and receivables

	2017 $'000	2016 $'000
Note 8A: Revenue		
Sale of goods and rendering of services		
Sale of goods	**591**	1,449
Rendering of services	**170,126**	173,112
Recoveries received from Portfolio entities	**525**	1,077
Resources received free of charge		
Financial statement audit services	**850**	975
Other revenue	**155**	11
Total own-source revenue	**172,247**	176,624

Financial statement audit services were provided free of charge to the Department by the Australian National Audit Office (ANAO) and are recorded at the fair value of resources received. No other services were provided by the auditors of the financial statements.

Note 8B: Gains		
Gains from sale of assets		
Infrastructure, Plant and Equipment		
Proceeds from sale	**10**	9,209
Less: Carrying value of assets sold	**(8)**	(9,131)
Resources received free of charge	**1,801**	-
Other gains	**172**	370
Total gains	**1,975**	448

Accounting policy

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.

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 or other terms in accordance with the Therapeutic Goods Regulations 1990, are recognised at the nominal amounts due less any impairment allowance account. Collectability of the 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 the TGA introduced the annual charges exemption scheme to provide relief from annual charges until a product on the Australian Register of Therapeutic Goods commences generating turnover. Under this scheme, which is detailed in the regulations covering therapeutic goods, some of the charges in respect of 2016-17 may not be known until the end of the declaration period on 22 July 2017. While there is some uncertainty in the revenue calculation for the financial year, the uncertainty is reducing as the scheme progresses and annual data is accumulated.

Department of Health

Notes to and forming part of the financial statements

Gains

Gains from disposal of non-current assets are recognised when control of the asset has passed to the buyer.

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.

	2017	2016
	$'000	$'000
Note 8C: Receivables		
Trade and other receivables		
Goods and services receivable	**16,155**	16,242
GST receivable from the Australian Taxation Office	**3,013**	5,974
Total trade and other receivables (gross)	**19,168**	22,216
Less impairment allowance [1]	**(958)**	(668)
Total trade and other receivables (net)	**18,209**	21,548

[1] The impairment allowance relates to receivables for goods and services.

Credit terms for goods and services were within: the Department 30 days (2016: 30 days), TGA 28 days (2016: 28 days).

Reconciliation of the impairment allowance

	2017	2016
	$'000	$'000
Opening balance	**(668)**	(1,505)
Amounts written off	**137**	584
Amounts recovered and reversed	**367**	803
Increase recognised in net surplus	**(794)**	(550)
Closing balance	**(958)**	(668)

Department of Health

Notes to and forming part of the financial statements

Note 9: Departmental appropriation income and receivable

	2017 $'000	2016 $'000
Note 9A: Revenue from Government		
Appropriations		
Departmental appropriations	**655,162**	594,997
Total revenue from Government	**655,162**	594,997
Note 9B: Appropriations receivable		
Existing programs	**28,611**	103,076
Undrawn equity injection	**2,675**	12,180
Departmental capital budget	**-**	316
Total appropriations receivable	**31,286**	115,572

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.

Accounting policy

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.

Department of Health

Notes to and forming part of the financial statements

Note 10: Departmental cash and other financial instruments

	2017 $'000	2016 $'000
Note 10A: Cash and cash equivalents		
Cash and cash equivalents		
Cash in special accounts	**82,297**	83,239
Cash on hand or on deposit	**13,425**	7,433
Total cash and cash equivalents	**95,722**	90,672
Note 10B: Financial instruments (assets)		
Goods and services receivable	**15,349**	16,242
Less: Impairment allowance	**(958)**	(668)
Total financial instruments (assets)	**14,391**	15,574
Net gains or losses on financial assets		
Loans and receivables		
Impairment	**1,007**	366
Net gains or losses on financial assets	**1,007**	366

Note 10C: Financial instruments (liabilities)

All trade creditors are measured at their amortised cost and represent the total financial instruments (liabilities).

Accounting policy

Cash and equivalents

Cash and cash equivalents include:

- cash in special accounts includes amounts that are banked in the Australian Government's Official Public Account; and
- cash on hand or on deposit includes the amounts held in the departmental bank accounts which includes special account balances.

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'. Financial assets are initially measured at their fair value plus transaction costs where appropriate. 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.

Loans and receivables - 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 10D: Risks arising from financial instruments

Credit risk
The Department is not exposed to a high level of credit risk as the majority of financial assets are in the nature of cash and receivables. These financial assets are carried at amounts not best representing maximum exposure to credit risk.

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 $0.958m in 2017 (2016: $0.668m) to an impairment allowance account.

The Department held no collateral to mitigate against credit risk.

Liquidity risk
As 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 Department’s supplier payables are a non-derivative financial liability; the Department has no derivative financial liabilities in either the current or prior years.

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 11: Departmental property, plant and equipment and intangibles

Reconciliation of the opening and closing balances for 2017

	Land and buildings	**Property, plant and equipment**	Computer software - internally developed	Computer software - purchased	**Total intangibles**	**Total Non-financial assets**
	$'000	**$'000**	$'000	$'000	**$'000**	**$'000**
As at 1 July 2016						
Gross book value	**60,676**	**8,564**	221,220	4,652	**225,872**	**295,112**
Accumulated depreciation/amortisation and impairment	**(7,398)**	**(2,248)**	(115,350)	(4,376)	**(119,726)**	**(129,372)**
Total as at 1 July 2016	**53,278**	**6,316**	105,870	276	**106,146**	**165,740**
Additions						
Purchase or internally developed	**3,939**	**1,242**	31,562	199	**31,761**	**36,942**
Revaluations recognised in other comprehensive income	**4,770**	**-**	-	-	**-**	**4,770**
Depreciation and amortisation	**(7,107)**	**(1,971)**	(17,114)	(357)	**(17,471)**	**(26,548)**
Reclassification	**112**	**(112)**	(1,066)	1,066	**-**	**-**
Disposals	**(69)**	**(97)**	-	-	**-**	**(166)**
Impairment	**-**	**-**	(1,261)	(28)	**(1,289)**	**(1,289)**
Total as at 30 June 2017	**54,923**	**5,378**	117,991	1,156	**119,147**	**179,449**
Total as at 30 June 2017 represented by						
Work in progress	**747**	**-**	35,833	-	**35,833**	**36,579**
Gross book value	**54,176**	**9,221**	195,314	5,412	**200,726**	**264,123**
Accumulated depreciation/amortisation and impairment	**-**	**(3,843)**	(113,155)	(4,256)	**(117,411)**	**(121,254)**
Total as at 30 June 2017	**54,923**	**5,378**	117,991	1,156	**119,147**	**179,448**

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Reconciliation of the opening and closing balances for 2016

	Land and buildings	Property, plant and equipment	Computer software - internally	Computer software - purchased	Total intangibles	Total Non-financial assets
	$'000	$'000	$'000	$'000	$'000	$'000
As at 1 July 2015						
Gross book value	53,196	7,065	194,072	5,867	199,939	260,200
Accumulated depreciation/amortisation and impairment	(169)	-	(103,268)	(5,266)	(108,534)	(108,703)
Total as at 1 July 2015	53,027	7,065	90,804	601	91,405	151,497
Additions						
Purchase or internally developed	2,143	1,001	31,790	-	31,790	34,934
Acquisitions of entities or operations (including restructuring)	6,240	50	-	-	-	6,290
Depreciation and amortisation	(7,269)	(2,259)	(14,216)	(240)	(14,456)	(23,984)
Reclassification	(245)	487	(157)	(85)	(242)	-
Assets held for sale	-	9,131	-	-	-	9,131
Disposals	-	-	-	-	-	-
From disposal of entities or other operations (including restructuring)	(618)	-	-	-	-	(618)
Other	-	(9,131)	-	-	-	(9,131)
Impairment	-	(28)	(2,351)	-	(2,351)	(2,379)
Total as at 30 June 2016	53,278	6,316	105,870	276	106,146	165,740
Total at 30 June 2016 represented by						
Work in progress	1,170	-	49,695	-	49,695	50,865
Gross book value	59,506	8,564	171,525	4,652	176,177	244,247
Accumulated depreciation/amortisation and impairment	(7,398)	(2,248)	(115,350)	(4,376)	(119,726)	(129,372)
Total as at 30 June 2016	53,278	6,316	105,870	276	106,146	165,740

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Accounting policy

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.

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.

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 (AVS) on 30 June 2015. A desktop review of assets was undertaken as at 31 March 2017 and updated for any changes to assumptions by 30 June 2017. The review indicated that the carrying value of the property, plant and equipment (leasehold improvements) as at 30 June 2017 required adjustment to align the carrying value with the fair value. No other class of departmental asset had a material difference 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.

Department of Health

Notes to and forming part of the financial statements

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:
- Buildings on freehold land: 20 to 25 years;
- Leasehold improvements*:* The lower of the lease term or the estimated useful life; and
- Plant and equipment: 3 to 20 years.

Impairment
All assets were assessed for impairment as at 30 June 2017. 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.

De-recognition
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.

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:
- Internally developed software two to ten years; and
- Purchased software two to seven years.

All software assets were assessed for indications of impairment as at 30 June 2017.

Department of Health

Notes to and forming part of the financial statements

Note 12: Fair value measurement

Accounting policy

The Department's assets are held for operational purposes, not for the purposes of deriving a profit. As allowed for by AASB 13 *Fair Value Measurement*, quantitative information on significant unobservable inputs used in determining fair value is not disclosed.

Assets held at fair value include leasehold improvements and property, plant and equipment but exclude assets under construction. Assets not held at fair value include intangibles and assets under construction.

The Department reviews its valuation model each year via a desktop exercise with a formal revaluation undertaken every three years: the last revaluation was undertaken in 2015. If the valuation indicators of a particular asset class change materially, that class is subject to specific valuation in the reporting period. The valuation modelling was undertaken by AVS.

The categories of fair value measurement are:

Level 1: Quoted prices (unadjusted) in active markets for identical assets 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, either directly or indirectly.

Level 3: Unobservable inputs.

Departmental assets are held at fair value and are measured at category levels 2 or 3 with no fair values measured at category level 1.

Leasehold improvements are predominately measured at category level 3 and the valuation methodology used is Depreciated Replacement Cost (DRC). Under DRC the estimated cost to replace the asset is calculated, with reference to new replacement price per square metre, and then adjusted to take into account its consumed economic benefit (accumulated depreciation). The consumed economic benefit has been determined based on the professional judgement of AVS with regard to physical, economic and external obsolescence factors. For all leasehold improvement assets, the consumed economic benefit is determined based on the term of the associated lease.

Property, plant and equipment (PPE) is measured at either category level 2 or 3. The valuation methodology is either market approach or DRC, based on replacement cost for a new equivalent asset. The significant unobservable inputs used in the fair value measurement of PPE assets are the market demand and AVS professional judgement.

Department of Health

Notes to and forming part of the financial statements

Note 13: Departmental contingent assets and liabilities

	Guarantees		Claims for damages or costs		Total	
	2017	2016	**2017**	2016	**2017**	2016
	$'000	$'000	**$'000**	$'000	**$'000**	$'000
Contingent assets						
Balance from previous period	**-**	-	**19**	238	**19**	238
New contingent assets recognised	**-**	-	**142**	9	**142**	9
Re-measurement	**-**	-	**-**	(178)	**-**	(178)
Rights expired	**-**	-	**(11)**	(50)	**(11)**	(50)
Total contingent assets	**-**	-	**150**	19	**150**	19
Contingent liabilities						
Balance from previous period	**5,000**	5,000	**5,010**	4,630	**10,010**	9,630
New	**-**	-	**195**	-	**195**	-
Re-measurement	**-**	-	**(4,000)**	550	**(4,000)**	550
Obligations expired	**-**	-	**(560)**	(170)	**(560)**	(170)
Total contingent liabilities	**5,000**	5,000	**645**	5,010	**5,645**	10,010
Net contingent liabilities	**(5,000)**	(5,000)	**(495)**	(4,991)	**(5,495)**	(9,991)

Accounting Policy

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.

The Department applies Accounting Standard AASB 137 *Provisions, Contingent Liabilities and Contingent Assets* in determining disclosure of contingent assets and liabilities.

Department of Health

Notes to and forming part of the financial statements

Quantifiable contingencies

Quantifiable contingent assets

The Department has quantifiable contingent assets as at 30 June 2017 of $0.150m (2016: $0.019m).

Quantifiable contingent liabilities

Claims for damages and costs
The schedule of contingencies shows contingent liabilities in respect of claims for damages/costs of $0.645m (2016: $5.010m). 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 shows a contingent liability in respect of claims for payments for Price Disclosure services of $5.000m (2016: $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 and liabilities

At 30 June 2017 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 and the information is not disclosed on the grounds that it might seriously prejudice the outcomes of these cases.

The Department has provided indemnities 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 14: Departmental appropriations

Table A: Annual and Unspent Appropriation ("Recoverable GST exclusive")

	2017 $'000	2016 $'000
DEPARTMENTAL		
Ordinary Annual Services		
Annual appropriation[1,2]	**654,627**	458,366
Capital budget[3]	**9,828**	11,209
Receipts retained under PGPA Act - Section 74	**114,459**	56,407
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	**778,914**	658,983
Appropriation applied (current and prior years)	**(849,284)**	(655,122)
Variance[4]	**(70,370)**	3,861
Unspent appropriations		
Own unspent appropriation balance	**34,838**	70,464
Prior year section 75 transfers	**-**	34,787
Closing unspent appropriation balance[5]	**34,838**	105,251
Balance comprises appropriations as follows:		
Appropriation Act (No. 1) 2014-2015[6]	**-**	33,134
Appropriation Act (No. 3) 2014-2015	**-**	6,646
Appropriation Act (No. 1) 2015-2016	**-**	38,672
Appropriation Act (No. 1) 2015-2016 - Cash at bank	**-**	1,859
Appropriation Act (No. 1) 2015-2016 - Departmental Capital Budget	**-**	316
Appropriation Act (No. 3) 2015-2016	**-**	24,624
Supply Act (No. 1) 2016-2017	**1**	-
Appropriation Act (No. 1) 2016-2017	**-**	-
Appropriation Act (No. 1) 2016-2017 - Cash at bank[7]	**6,804**	-
Appropriation Act (No. 1) 2016-2017 - Departmental Capital Budget	**-**	-
Appropriation Act (No. 3) 2016-2017	**28,033**	-
Appropriation Act (No. 3) 2016-2017 - Departmental Capital Budget	**-**	-
Total unspent appropriation - ordinary annual services	**34,838**	105,251

[1] There were no amounts temporarily quarantined from 2017 or 2016 departmental ordinary annual services appropriations.
[2] There were no amounts withheld under section 51 of the PGPA Act from 2017 or 2016 departmental ordinary annual services appropriations.
[3] Departmental capital budgets are appropriated through Appropriation Acts (No. 1,3) and Supply Acts (No. 1,3). They form part of ordinary annual services and are not separately identified in the Appropriation Acts.
[4] The variance of $70,370,000 for departmental ordinary annual services primarily represents the timing difference of payments to suppliers or employees.
[5] This balance is net of $436,000 which is permanently quarantined under section 51 of the PGPA Act. This amount is detailed in footnote to the respective Act. The total unspent appropriations gross of quarantined amounts under section 51 of the PGPA Act is $35,274,000.
[6] An amount of $436,000 has been withheld against this appropriation item under section 51 of the PGPA Act which represents a loss of control. Therefore, this amount has not been disclosed as available in the table above.
[7] Cash at bank mainly relates to deposits made on 30 June, subject to Section 74 of the PGPA Act (annotated Appropriation Act No. 1.)

Department of Health

Notes to and forming part of the financial statements

	2017	2016
	$'000	$'000
Other Services - Equity		
Annual appropriation[1,2]	**18,349**	20,034
Transfers of appropriations under PGPA Act - Section 75	**-**	12,256
Total appropriation	**18,349**	32,290
Appropriation applied (current and prior years)	**(5,321)**	(27,341)
Variance[3]	**13,028**	4,949
Unspent appropriations		
Own unspent appropriation balance	**2,675**	12,180
Closing unspent appropriation balance[4]	**2,675**	12,180
Balance comprises appropriations as follows:		
Appropriation Act (No. 2) 2015-2016[2]	**-**	556
Appropriation Act (No. 4) 2015-2016[2]	**1,425**	11,624
Appropriation Act (No. 2) 2016-2017[2]	**1,250**	-
Total unspent appropriation - other services - equity	**2,675**	12,180

[1] There were no amounts temporarily quarantined from 2017 or 2016 departmental other services - equity appropriations.
[2] In 2017 departmental other services – equity appropriations $6,871,000 of the Appropriation Act (No. 2) 2016-2017 and $4,907,000 of the Supply Act (No. 2) 2016-2017 were permanently quarantined under section 51 of the PGPA Act. In 2016 departmental other services – equity appropriations $556,000 of the Appropriation Act (No. 2) 2015-2016 and $10,199,000 of the Appropriation Act (No. 4) 2015-2016 were 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 above.
[3] The variance of $13,028,000 for departmental equity primarily relates to the quarantined appropriations noted above.
[4] This balance is net of $22,533,000.00 which is permanently quarantined under section 51 of the PGPA Act. These amounts are detailed in footnotes to the respective Act. The total unspent appropriations gross of quarantined amounts under section 51 of the PGPA Act is $25,208,000.00.

Department of Health

Notes to and forming part of the financial statements

Note 15: Therapeutic Goods Administration

Note 15A: Therapeutic Goods Administration overview

The Therapeutic Goods Administration (TGA) contributes to Outcome 5 - Regulation, Safety and Protection. The TGA recovers the cost of all activities undertaken within the scope of the *Therapeutic Goods Act 1989* from industry through fees and charges.

Included below is financial information for the TGA, which operates via a special account. The balance of the special account represents a standing appropriation from which payments are made for the purposes of the special account. The TGA special account is reported in Note 27: Special accounts.

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.

	2017	2016
	$'000	$'000
Note 15B: TGA Comprehensive income		
Expenses		
Employee benefits	**78,781**	66,158
Consultants and contractors	**17,670**	15,353
Property expenses (including lease payments)	**-**	509
Corporate Services[1]	**36,488**	35,690
Other	**7,528**	6,297
Depreciation and amortisation	**4,286**	4,672
Write-down and impairment of assets	**1,961**	105
Total expenses	**146,715**	128,784
Revenues		
Sale of goods and rendering of services	**139,037**	141,539
Other revenue and gains	**12**	148
Total own-source revenue	**139,049**	141,687
Revenue from Government	**2,574**	3,177
(Loss)/surplus on continuing operations	**(5,092)**	16,080

[1] While corporate services have been provided centrally by the Department since 1 July 2015 a different accounting treatment for corporate costs in 2017 has required the 2016 balances to be restated for comparative purposes. Previously corporate amounts were disaggregated across employee and supplier costs.

Department of Health

Notes to and forming part of the financial statements

	2017 $'000	2016 $'000
Note 15C: TGA Financial Position		
Assets		
Financial assets[1]	**71,725**	78,142
Non-financial assets	**34,850**	25,022
Total assets	**106,575**	103,164
Liabilities		
Payables	**32,522**	24,457
Provisions	**20,468**	23,781
Total liabilities	**52,990**	48,238
Equity		
Contributed equity	**2,029**	2,029
Asset revaluation reserve	**7,968**	4,217
Retained surplus	**43,589**	48,680
Total Equity	**53,585**	54,926

[1] Includes cash balance of $62.605m which is disclosed in Note 27: Special accounts.

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 2016-17 includes an estimate for annual charges.

Department of Health

Administered schedule of comprehensive income
for the period ended 30 June 2017

		ACTUAL		BUDGET ESTIMATE	
				Original	Variance
	Notes	**2017**	2016	2017	2017
		$'000	$'000	$'000	$'000
NET COST OF SERVICES					
Expenses					
Grants	18A	**7,468,532**	5,818,319	8,155,592	(687,060)
Personal benefits	18B	**42,555,967**	39,507,641	39,790,370	2,765,597
Subsidies	18C	**12,102,130**	9,290,201	13,042,844	(940,714)
Suppliers	19A	**807,335**	676,768	539,636	267,699
Payments to corporate Commonwealth entities	20A	**405,074**	328,658	405,074	-
Depreciation and amortisation	23A	**1,355**	20,383	963	392
Other expenses	19B	**60,222**	117,475	30,890	29,332
Total expenses		**63,400,615**	55,759,445	61,965,369	1,435,246
Income					
Recoveries	21A	**3,725,543**	2,687,627	2,112,811	1,612,732
Other revenue	21B	**255,203**	274,778	113,695	141,508
Total income		**3,980,746**	2,962,405	2,226,506	1,754,240
Net cost of services		**59,419,869**	52,797,040	59,738,863	(318,994)
Deficit		**(59,419,869)**	(52,797,040)	(59,738,863)	318,994
OTHER COMPREHENSIVE INCOME					
Items not subject to subsequent reclassification to net cost of services					
Changes in asset revaluation reserves		**(13,958)**	9,692	-	(13,958)
Changes in administered investment reserves		**57,697**	(9,906)	-	57,697
Total other comprehensive income		**43,739**	(214)	-	43,739
Total comprehensive loss		**(59,376,130)**	(52,797,254)	(59,738,863)	362,733

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Administered schedule of assets and liabilities
as at 30 June 2017

		ACTUAL		BUDGET ESTIMATE	
				Original	Variance
	Notes	**2017**	2016	2017	2017
		$'000	$'000	$'000	$'000
ASSETS					
Financial assets					
Cash and cash equivalents	22A	**146,809**	171,579	336,648	(189,839)
Accrued recoveries revenue	21A	**928,986**	926,085	217,425	711,561
Loans and other receivables	21B	**671,594**	578,225	948,329	(276,735)
Investments	20B	**454,972**	380,117	596,242	(141,270)
Total financial assets		**2,202,361**	2,056,006	2,098,644	103,717
Non-financial assets					
Land and buildings	23A	**-**	33,197	22,542	(22,542)
Computer software	23A	**-**	48,823	-	-
Inventories held for distribution	23B	**115,262**	111,265	119,510	(4,248)
Total non-financial assets		**115,262**	193,285	142,052	(26,790)
Total assets administered on behalf of Government		**2,317,623**	2,249,291	2,240,696	76,927
LIABILITIES					
Payables					
Suppliers	19A	**22,841**	9,881	7,110	15,731
Subsidies	18C	**51,296**	263,538	153,048	(101,752)
Personal benefits	18B	**975,974**	898,425	984,261	(8,287)
Grants	18A	**317,461**	378,070	409,473	(92,012)
Total payables		**1,367,572**	1,549,914	1,553,892	(186,320)
Provisions					
Subsidies	18C	**450,000**	425,000	430,718	19,282
Personal benefits	18B	**1,057,773**	1,280,045	1,011,494	46,279
Total provisions		**1,507,773**	1,705,045	1,442,212	65,561
Total liabilities administered on behalf of Government		**2,875,345**	3,254,959	2,996,104	(120,759)
Net liabilities		**557,722**	1,005,668	755,408	(197,686)

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Administered reconciliation schedule

	2017	2016
	$'000	$'000
Opening assets less liabilities as at 1 July	**(1,005,668)**	(1,406,441)
Adjusted opening assets less liabilities	**(1,005,668)**	(1,406,441)
Net cost of services		
Income	**3,980,746**	2,962,405
Expenses		
Payments to entities other than corporate Commonwealth entities	**(62,995,541)**	(55,430,787)
Payments to corporate Commonwealth entities	**(405,074)**	(328,658)
Other comprehensive income		
Revaluations transferred to/(from) reserves	**43,739**	(214)
Transfers (to)/from Australian Government		
Appropriation transfers from OPA		
Administered assets and liabilities appropriations		
Payments to entities other than corporate Commonwealth entities	**35,244**	33,202
Payments to corporate Commonwealth entities	**10,589**	-
Annual appropriations		
Payments to entities other than corporate Commonwealth entities	**8,253,833**	6,619,347
Payments to corporate Commonwealth entities	**405,074**	328,658
Special appropriations (unlimited)		
Payments to entities other than corporate Commonwealth entities	**55,037,751**	48,149,354
Special appropriations (limited)		
Refund of receipts (section 77 of the PGPA Act)	**576**	7,926
Net GST appropriations	**(12,748)**	25,875
Appropriation transfers to OPA		
Transfers to OPA	**(3,857,420)**	(2,135,107)
Restructuring	**(48,823)**	168,773
Closing assets less liabilities as at 30 June	**(557,722)**	(1,005,668)

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Administered cash flow statement
for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000
OPERATING ACTIVITIES			
Cash received			
Recoveries		**3,766,815**	2,301,933
Net GST received		**562,908**	359,467
Health and hospital fund receipts		**-**	54,984
Special accounts receipts		**64,870**	-
Other		**62,503**	138,616
Total cash received		**4,457,096**	2,855,000
Cash used			
Grants		**(8,045,959)**	(6,204,054)
Subsidies		**(12,234,931)**	(9,180,995)
Personal benefits		**(42,820,809)**	(39,613,098)
Suppliers		**(819,757)**	(684,997)
Payments to corporate Commonwealth entities		**(405,074)**	(328,658)
Total cash used		**(64,326,530)**	(56,011,802)
Net cash used by operating activities	17	**(59,869,434)**	(53,156,802)
INVESTING ACTIVITIES			
Cash received			
Repayments of advances and loans		**28,102**	16,402
Total cash received		**28,102**	16,402
Cash used			
Advances and loans made		**(39,180)**	(22,298)
Purchase of intangible assets		**-**	(31,626)
Equity injections to corporate Commonwealth entities		**(10,589)**	-
Purchase of investments		**(6,568)**	-
Total cash used		**(56,337)**	(53,924)
Net cash used by investing activities		**(28,235)**	(37,522)
Net decrease in cash held		**(59,897,669)**	(53,194,324)
Cash and cash equivalents at the beginning of the reporting period		**171,579**	336,648
Cash from Official Public Account			
Appropriations		**63,697,234**	55,105,285
Special Accounts		**8,613**	10,093
Capital appropriations		**45,833**	33,202
Administered GST appropriations		**544,762**	380,296
Total cash from Official Public Account		**64,296,442**	55,528,876
Cash to Official Public Account			
Special Accounts		**(8,613)**	(10,093)
Return of GST appropriations to the Official Public Account		**(557,510)**	(354,421)
Other		**(3,857,420)**	(2,135,107)
Total cash to Official Public Account		**(4,423,543)**	(2,499,621)
Cash and cash equivalents at the end of the reporting period	22A	**146,809**	171,579

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Administered cash flow statement
for the period ended 30 June 2017

Accounting policy
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 reconciliation schedule.

Department of Health

Notes to and forming part of the financial statements

Note 16: Administered explanation of budget variances

Administered expenses

Total administered expenses for 2016-17 were approximately $1,435m (2.3%) higher than the original budget. This variance was largely driven by a significant overspend in personal benefits ($2,766m), further contributed to by the overspend against suppliers ($268m). This was partially offset by underspends against grants ($687m) and subsidies ($941m).

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, Private Health Insurance Rebate, Dental Services and Home Support and Care. The most significant elements of the 2016-17 overspend were:

- Pharmaceuticals and Pharmaceutical Services: overspending by $1,908m;
- Home Support and Care: overspending by $800m;
- Dental Services: overspending by $319m; and
- Medical Benefits: overspending by $237m.

Conversely, the following program groups reported underspends against the original budget:

- Private Health Insurance: underspending by $255m; and
- Targeted Assistance – Aids and Appliances: underspending by $149m.

The core reason for the overall overspend in personal benefits was the high demand for new Hepatitis C drugs since their introduction in late 2015-16. The overspend against Home Support and Care was due to the fact that the classification of this program was amended from subsidies to personal benefits from 1 February 2017 because of changes in the underlying program delivery – this overspend is therefore matched with a corresponding underspend against subsidies. The Dental Services variance was driven by another classification difference, with the budget reflecting these expenses as grants and not personal benefits – this overspend is therefore matched with a corresponding underspend against grants. The Targeted Assistance variance was also a result of a classification difference, with the budget reporting all program expenses as personal benefits, but a portion of the actuals is deemed to be grants – this underspend is matched with a corresponding overspend against grants. The variances in Medical Benefits and Private Health Insurance are the result of normal fluctuations in these large special appropriations and represent a small fraction of the total program expenditure.

The overspend in suppliers was largely attributable to the aged care programs ($153m), which were not included in the original budget. The key driver of these expenses was the Regional Assessment Service.

The above overspends were reduced by an underspend against subsidies, due to the Home Support and Care program being reclassified to personal benefits (substantially the entire underspend), and a range of underspends in grants ($687m in aggregate). The biggest contributors to the grants underspends included:

- Dental Services: underspending by $416m due to the actual expenses being classified as personal benefits – this was corrected at MYEFO;
- Home Support and Care: underspending by $209m; and
- Health Policy Research and Analysis: underspending by $97m.

Conversely, Targeted Assistance – Aids and Appliances reported a large overspend against grants ($197m) due to the budget being reported against personal benefits.

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.

Department of Health

Notes to and forming part of the financial statements

Overall, when the effects of classification differences between various expense categories are eliminated, the $1,435m overspend against the original budget is driven by the $1,943m overspend in Pharmaceutical Benefits and $261m overspend in Medical Benefits (both mostly relating to personal benefits). These were partially offset by the $255m underspend in Private Health Insurance (personal benefits), the $237m underspend in Home Support and Care and a range of smaller underspends against a number of grants-based program groups.

Administered revenues
Total administered revenue for 2016-17 was $1,754m (78.8%) above the original budget. The two key contributors to this result were recoveries ($1,613m over budget) and other revenue ($142m over budget).

The main driver behind the increase in recoveries was the value of PBS drug recoveries ($1,633m over budget), 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 2016-17 was the high demand for Hepatitis C drugs following their introduction in late 2015-16.

The variance in other revenue was driven by miscellaneous receipts, generally relating to the acquittal and collection of unspent grant funding. In aggregate, total other revenue is consistent with prior year.

Administered assets
Total assets administered on behalf of the Commonwealth at 30 June 2017 were $77m (3%) greater than the original budget estimate.

The highest contributors to this variance was accrued recoveries revenue ($712m above the budget), relating to the PBS drug recoveries. Due to the nature of these recoveries, the value of accrued revenue can fluctuate with no predictable pattern from one year to another. A significant contributor to the increase at the end of 2015-16, which was sustained into 2016-17, was the high demand for the new Hepatitis C drugs following their introduction in late 2015-16. This was not reflected in the original budget.

This variance was partially offset by cash and cash equivalents, loans and other receivables, and investments at 30 June 2017, all being significantly lower than the original budget.

Cash and cash equivalents ($190m below the budget) and loans and other receivables ($277m below the budget) were budgeted based on the preliminary estimates of the prior year's final outcome, and as such are subject to significant uncertainty. Concerning in particular cash and cash equivalents, while a balance of approximately $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. In relation to investments ($141m below the budget), the original budget included $250m worth of investments in the Biomedical Translation Fund (BTF), and did not incorporate the value of portfolio agency investment in the Australian Digital Health Agency (Digital Health), established effective as of 1 July 2016. The BTF commenced operation in the last quarter of 2016-17, therefore only $7m was capitalised as at 30 June 2017. The value of investment in Digital Health was estimated at $92m, based on the agency's net assets as at 30 June 2017.

Administered liabilities
Total liabilities administered on behalf of the Commonwealth at 30 June 2017 were $121m (4%) lower than the original budget estimate. Once the changes in classification between subsidies and personal benefits are taken into account, this variance is largely driven by the overall decrease in grants payable ($92m). Grant liabilities are budgeted on the basis of estimated milestone and delivery completion and the standard payment cycles, however the actual value of grant liabilities at a point in time can fluctuate widely from month to month.

Department of Health

Notes to and forming part of the financial statements

Note 17: Administered cash flow reconciliation

	2017 $'000	2016 $'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	**146,809**	171,579
Administered Schedule of Assets and Liabilities	**146,809**	171,579
Discrepancy	**-**	-
Reconciliation of net cost of services to net cash used by operating activities		
Net cost of services	**(59,419,869)**	(52,797,040)
Adjustment for non-cash items		
Depreciation and amortisation	**1,355**	20,383
Net write-down of assets	**33,572**	107,326
Net loss on sale of assets	**17,884**	-
Inventory adjustments	**16**	5
Foreign exchange losses (net)	**-**	1
Concessional loans discount and unwinding	**16,112**	2,552
Movements in assets and liabilities		
Assets		
Decrease/(increase) in net receivables	**(113,401)**	(849,421)
Decrease/(increase) in inventories	**(25,487)**	(6,642)
Liabilities		
Increase/(decrease) in suppliers payable	**12,958**	(634)
Increase/(decrease) in subsidies payable	**(212,242)**	111,316
Increase/(decrease) in personal benefits payable	**77,549**	(16,666)
Increase/(decrease) in grants payable	**(60,609)**	(8,533)
Increase/(decrease) in subsidies provision	**25,000**	12,000
Increase/(decrease) in personal benefits provision	**(222,272)**	268,551
Net cash used by operating activities	**(59,869,434)**	(53,156,802)

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Note 18: Administered transfer payments

	2017	2016
	$'000	$'000
Note 18A: Grants		
Grants paid		
Public sector		
Australian Government entities (related entities)	**684,991**	730,250
Health and hospital fund	**-**	44,391
Private sector		
Profit and non-profit organisations	**6,771,706**	5,025,630
Health and hospital fund	**-**	8,201
Overseas	**11,835**	9,847
Total grants paid	**7,468,532**	5,818,319
Grants payable		
Public sector		
Australian Government entities (related entities)	**8,609**	32,244
Private sector		
Profit and non-profit organisations	**308,852**	345,826
Total grants payable	**317,461**	378,070

Accounting policy

The Department administers a number of grant schemes on behalf of the Government. Grant 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. Settlement is made according to the terms and conditions of each grant. This is usually within 30 days of performance or eligibility. All grants liabilities are expected to be settled within 12 months of the balance date.

Department of Health

Notes to and forming part of the financial statements

	2017 $'000	2016 $'000
Note 18B: Personal Benefits		
Personal benefits paid		
Indirect		
Medical services	**22,481,669**	21,428,064
Pharmaceuticals and pharmaceutical services	**12,162,451**	10,832,702
Private health insurance	**5,994,087**	5,887,067
Primary care practice incentives	**341,699**	340,120
Hearing services	**497,825**	475,905
Targeted assistance	**143,886**	405,287
Home support and care	**886,627**	-
Other	**47,723**	138,496
Total personal benefits paid	**42,555,967**	39,507,641
Personal benefits payable		
Medical services	**295,793**	321,172
Pharmaceuticals and pharmaceutical services	**6,171**	23,252
Private health insurance	**478,309**	476,400
Home support and care	**85,189**	-
Other	**110,512**	77,601
Total personal benefits payable	**975,974**	898,425
Personal benefits provisions		
Outstanding claims		
Medical services	**740,223**	678,452
Pharmaceuticals and pharmaceutical services	**317,550**	601,593
Total personal benefits provisions	**1,057,773**	1,280,045

Accounting policy

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 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);
- Hearing Services (reduce the incidence and consequences of avoidable hearing loss in the community by providing access to high quality hearing services and devices); and
- Home Support and Care (providing coordinate home support and care packages tailored to meet individuals' specific care needs).

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Personal benefits are assessed, determined and paid by the Department of Human Services (DHS) in accordance with provisions of the relevant legislation under delegation from the Department. 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.

Significant accounting judgements and estimates
Medicare payments processed by DHS on behalf of the Department are either reimbursements 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 weights recent payment experience more heavily and is therefore self-adjusting for emerging trends.

	2017	2016
	$'000	$'000
Note 18C: Subsidies		
Subsidies paid		
Subsidies in connection with		
Aged care	**12,002,391**	9,161,229
Medical indemnity	**91,301**	81,517
Other	**8,438**	47,455
Total subsidies paid	**12,102,130**	9,290,201
Subsidies payable		
Subsidies in connection with		
Aged care	**51,296**	258,433
Mental health	**-**	4,167
Other	**-**	938
Total subsidies payable	**51,296**	263,538

Accounting policy
The Department administers a number of subsidy schemes on behalf of the Government. Subsidies liabilities are recognised to the extent that (i) the services required to be performed by the recipient have been performed or (ii) the eligibility criteria have been satisfied, but payments due have not been made. All subsidies liabilities are expected to be settled within 12 months of the balance date.

Department of Health

Notes to and forming part of the financial statements

Subsidies provisions

	Balance as at 30 June 2016	Claims paid	Administered Schedule of Comprehensive Income Impact	Balance as at 30 June 2017
	$'000	$'000	$'000	$'000
Medical Indemnity Liabilities				
Incurred But Not Reported	**28,000**	**(1,078)**	**(922)**	**26,000**
High Cost Claims Scheme	**316,000**	**(47,718)**	**65,718**	**334,000**
Run-Off Cover Scheme	**81,000**	**(4,271)**	**13,271**	**90,000**
Total	**425,000**	**(53,067)**	**78,067**	**450,000**

	2017 $'000	2016 $'000
Subsidies expected to be settled		
No more than 12 months	**60,750**	61,438
More than 12 months	**389,250**	363,562
Total subsidies provisions	**450,000**	425,000

Accounting policy

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).

The payments for medical indemnity are managed by the 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, 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 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.

Department of Health

Notes to and forming part of the financial statements

The methods used by the AGA to estimate the liability under the different schemes are as follows:

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.

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:
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.

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 2017, 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 been made, the AGA noted a relatively high level of uncertainty in the estimate.

HCCS:
Under HCCS, the Government pays 50% of the cost of claims made to all 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.

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.

Significant accounting judgements and estimates

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.

Department of Health

Notes to and forming part of the financial statements

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 2.2% 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 five years for the medical indemnity payments. This discount rate is deemed to be more appropriate than the ten year bond yield at 30 June 2017, which was 2.6%. A discount rate of 1.7% 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 3% would result in a discounted liability estimate which is about 3.3% ($15m) less than the base estimate. On the other hand, decreasing the discount rate to 2% would result in a discounted liability estimate which is about 0.9% ($4m) higher than base estimate.

	2016-17			2015-16
	discounted 2% $m	discounted 2.2%[1] $m	discounted 3% $m	discounted 1.7% $m
Incurred But Not Reported	27	26	26	28
High Cost Claims Scheme	336	334	324	316
Run-Off Cover Scheme	91	90	85	81
Total	454	450	435	425

[1] 2.2% was used as the basis of estimation in 2016-17.

Department of Health

Notes to and forming part of the financial statements

Note 19: Administered suppliers and other expenses and payables

	2017	2016
	$'000	$'000
Note 19A: Suppliers		
Services rendered		
Consultants	**20,415**	16,034
Contract for services	**725,253**	606,068
Travel	**772**	653
Communications and publications	**25,945**	26,831
Committee related expenses	**3,890**	2,366
Other	**31,060**	24,816
Total services rendered	**807,335**	676,768
Suppliers payable		
Trade creditors and accruals	**22,841**	9,881
Total suppliers payable	**22,841**	9,881
Note 19B: Other Expenses		
Other expenses		
Write-down and impairment of assets		
Impairment on financial instruments	**12,098**	1,950
Write-off of inventories	**21,474**	105,376
Net loss on sale of land and buildings	**17,884**	-
Payments to Special Accounts	**8,613**	10,093
Other	**153**	56
Total other expenses	**60,222**	117,475

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Note 20: Administered Corporate Commonwealth Entities

		2017 $'000	2016 $'000
Note 20A: Appropriations			
Appropriations transferred to corporate entities			
Australian Institute of Health and Welfare		**26,918**	15,625
Food Standards Australia New Zealand		**17,184**	17,257
Australian Sports Commission		**250,669**	253,646
Independent Hospital Pricing Authority		**-**	25,877
National Health Performance Authority		**-**	16,253
Australian Digital Health Agency		**110,303**	-
Total appropriations transferred corporate entities		**405,074**	328,658
Note 20B: Investments			
Investments in portfolio agencies			
Equity interest - Australian Institute of Health and Welfare	(i)	**30,930**	6,723
Equity interest - Food Standards Australia New Zealand	(ii)	**7,808**	7,745
Equity interest - Australian Commission on Safety and Quality in Health Care	(iii)	**2,715**	2,136
Equity interest - Australian Sports Commission	(iv)	**302,209**	310,208
Equity interest - Australian Sports Foundation Ltd	(v)	**3,847**	4,375
Equity interest - Independent Hospital Pricing Authority	(vi)	**8,577**	24,125
Equity interest - National Health Performance Authority		**-**	24,805
Equity interest - Australian Digital Health Agency	(vii)	**92,318**	-
Total investments in portfolio agencies		**448,404**	380,117
Other investments			
Biomedical Translation Fund - BioScience Managers		**6,568**	-
Total other investments		**6,568**	-
Total investments		**454,972**	380,117

Accounting policy

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 25A.

Department of Health

Notes to and forming part of the financial statements

(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 Australian Digital Health Agency was established on 1 July 2016 to improve health outcomes for Australians through the delivery of digital healthcare systems and the national digital health strategy for Australia.

Transferred entities

The National Health Performance Authority has been 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.

Other investments

The Biomedical Translation Fund (BTF) is an equity co-investment venture capital program announced in the National Innovation and Science Agenda to support the development of biomedical ventures in Australia. The BTF Program will help translate biomedical discoveries into high growth potential companies that are improving long term health benefits and national economic outcomes. It is delivered by AusIndustry on behalf of the Department through licensed private sector venture capital fund managers.

Due to the early operational phase of the program, at 30 June 2017 these investments were measured at the value of capital funding provided to the fund managers for investment purposes.

Accounting policy

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 2017. 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.

None of the investments are expected to be recovered within 12 months.

Department of Health

Notes to and forming part of the financial statements

Note 21: Administered income, debtors and loans

	2017 $'000	2016 $'000
Note 21A: Recoveries		
Recoveries received		
Medical and pharmaceutical benefits and health rebate schemes	**61,278**	72,904
PBS drug recoveries	**3,267,515**	1,707,023
Aged care recoveries, cross-billings and budget neutrality adjustments	**396,182**	907,700
Other recoveries	**568**	-
Total recoveries received	**3,725,543**	2,687,627
Accrued recoveries revenue		
Personal benefits		
Pharmaceutical benefits	**856,998**	843,589
Home support and care	**9,746**	-
Medicare benefits	**28,142**	34,828
Other personal benefits	**474**	497
Subsidies		
Medical indemnity	**6,494**	10,933
Aged care	**27,083**	36,189
Other	**49**	49
Total accrued recoveries revenue	**928,986**	926,085

Accounting policy

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 PBS drug recoveries; and
- recoveries from the DHS Recovery of Compensation for Health Care and Other Services Special Account.

All accrued recoveries revenue is expected to be recovered within 12 months.

Department of Health

Notes to and forming part of the financial statements

	2017	2016
	$'000	$'000
Note 21B: Other Revenue, Receivables and Loans		
Other revenue		
Health and hospital fund	**-**	54,984
Special accounts revenue	**64,870**	-
Levies and taxes	**18,932**	17,799
Interest from loans	**12,343**	4,757
Other	**159,058**	197,238
Total other revenue received	**255,203**	274,778
Other receivables		
Trade and other miscellaneous receivables	**373,903**	252,510
GST receivable from the Australian Taxation Office	**43,854**	62,000
Total other receivables	**417,757**	314,510
Advances and loans		
Aged care facilities		
Nominal value	**317,774**	306,696
Less: Unexpired discount	**(51,456)**	(35,344)
Total advances and loans	**266,318**	271,352

Accounting policy

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.

Total loans and other receivables (gross)	**684,075**	585,862
Aged as follows		
Not overdue	**588,431**	516,314
Overdue by:		
0 to 30 days	**4,148**	5,797
31 to 60 days	**6,624**	8,596
61 to 90 days	**8,794**	2,774
More than 90 days	**76,078**	52,381
Total overdue	**95,644**	69,548
Total loans and other receivables (gross)	**684,075**	585,862
Less impairment allowance	**(12,481)**	(7,637)
Total loans and other receivables (net)	**671,594**	578,225
Loans and other receivables - past due but not impaired	**83,163**	61,911

Accounting Policy

Credit terms for goods and services were 30 days (2016: 30 days).

Department of Health

Notes to and forming part of the financial statements

	2017	2016
	$'000	$'000
Loans and other receivables (net) expected to be recovered		
No more than 12 months	**433,747**	299,995
More than 12 months	**237,847**	278,230
Total loans and other receivables (net) expected to be recovered	**671,594**	578,225

Reconciliation of the Impairment Allowance

	2017	2016
	$'000	$'000
Opening balance	**(7,637)**	(7,675)
Amounts written off	**4,348**	1,760
Amounts recovered and reversed	**2,127**	362
Increase recognised in net cost of services	**(11,319)**	(2,084)
Closing balance	**(12,481)**	(7,637)

Accounting Policy

The entire impairment allowance relates to debts aged more than 90 days.

Department of Health

Notes to and forming part of the financial statements

Note 22: Administered cash and other financial instruments

	2017	2016
	$'000	$'000
Note 22A: Financial Assets		
Loans and receivables		
Cash and cash equivalents		
Cash on hand or on deposit	**91,310**	164,509
Cash in special accounts	**55,499**	7,070
Total cash and cash equivalents	**146,809**	171,579
Accrued recoveries revenue	**855,485**	872,047
Other receivables	**361,422**	244,873
Advances and loans	**266,318**	271,352
Total loans and receivables	**1,630,034**	1,559,851
Available-for-sale financial assets		
Investments in portfolio agencies	**448,404**	380,117
Other investments	**6,568**	-
Total available-for-sale financial assets	**454,972**	380,117
Total financial assets	**2,085,006**	1,939,968
Net gains or losses on financial assets		
Loans and receivables		
Interest revenue	**12,343**	4,757
Impairment	**(12,098)**	(1,950)
Net gains or losses on loans and receivables	**245**	2,807
Net gains or losses on financial assets	**245**	2,807
Note 22B: Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors	**22,841**	9,881
Grants payable	**317,461**	378,070
Total financial liabilities measured at amortised cost	**340,302**	387,951
Total financial liabilities	**340,302**	387,951
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)

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Note 22C: Risks arising from financial instruments

Credit risk

The Administered activities of the Department are not exposed to a high level of credit risk as the majority of financial assets are recoveries receivable, concessional loans and other receivables, as well as investments in Government controlled and funded entities. These financial assets are carried at amounts not best representing maximum exposure to credit risk.

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 $12.481m in 2017 (2016: $7.637m) to an impairment allowance account.

The Department held no collateral to mitigate credit risk.

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.

Market risk

The Department holds financial instruments that are of a nature that do not expose the Department to certain market risks, such as currency risk or other price risk.

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.

Department of Health

Notes to and forming part of the financial statements

Note 23: Administered non-financial assets

Note 23A: Property, Plant and Equipment and Intangibles

Reconciliation of the opening and closing balances for 2017

	Land	Buildings	Total land and buildings	Computer Software	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2016					
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 1 July 2016	**1,895**	**31,302**	**33,197**	**48,823**	**82,020**
Restructure	**-**	**-**	**-**	**(48,823)**	**(48,823)**
Other movements					
Expected loss on sale recognised in other comprehensive income	**(895)**	**(13,063)**	**(13,958)**	**-**	**(13,958)**
Expected loss on sale recognised in net cost of services	**(1,000)**	**(16,884)**	**(17,884)**	**-**	**(17,884)**
Assets held for sale	**-**	**-**	**-**	**-**	**-**
Depreciation and amortisation	**-**	**(1,355)**	**(1,355)**	**-**	**(1,355)**
Total as at 30 June 2017	**-**	**-**	**-**	**-**	**-**

Accounting policy

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.

Land and buildings were transferred to the Tasmanian Government for a total consideration of $1, effective 1 July 2017. The expected loss on sale was recognised as at 30 June 2017, and land and buildings were designated as assets held for sale. The total value of assets held for sale was $1 as at 30 June 2017, therefore no additional disclosures associated with assets held for sale could be made.

Computer software, comprising *My Health Record*, was transferred to the Australian Digital Health Agency at cost, effective 1 July 2016. This is disclosed in Note 26: Restructuring.

Department of Health

Notes to and forming part of the financial statements

Reconciliation of the opening and closing balances for 2016

	Land	Buildings	Total land and	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

	2017	2016
	$'000	$'000
Note 23B: Inventory		
National Medical Stockpile		
Opening balance	**111,265**	210,005
Add purchases	**25,536**	6,579
Less deployment	**(16)**	(5)
Less impairment	**(21,474)**	(105,376)
Add stocktake adjustments	**(49)**	63
Less sale of inventory to the States and Territories	**-**	(1)
Closing balance	**115,262**	111,265

Accounting policy

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.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Note 24: Administered contingent assets and liabilities

	Indemnities		Claims for costs		Aged Care Accommodation Bond Guarantee Scheme		Total	
	2017	2016	**2017**	2016	**2017**	2016	**2017**	2016
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Contingent assets								
Balance from previous period	**-**	-	**-**	-	**-**	-	-	-
New contingent assets recognised	**-**	-	**20,000**	-	**-**	-	**20,000**	-
Total contingent assets	**-**	-	**20,000**	-	**-**	-	**20,000**	-
Contingent liabilities								
Balance from previous period	**60,000**	52,000	**90**	81	**208**	-	**60,298**	52,081
New contingent liabilities recognised	**-**	-	**20,245**	22	**-**	208	**20,245**	230
Re-measurement	**13,000**	8,000	**-**	(13)	**-**	-	**13,000**	7,987
Liabilities recognised	**-**	-	**(8)**	-	**(136)**	-	**(144)**	-
Obligations expired	**-**	-	**(82)**	-	**(72)**	-	**(154)**	-
Restructure	**-**	-	**-**	-	**-**	-	**-**	-
Total contingent liabilities	**73,000**	60,000	**20,245**	90	**-**	208	**93,245**	60,298
Net contingent liabilities	**(73,000)**	(60,000)	**(245)**	(90)	**-**	(208)	**(73,245)**	(60,298)

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Department of Health

Notes to and forming part of the financial statements

Quantifiable Contingent Assets

Claims for costs

The Schedule of contingencies reports contingent assets in respect of claims for costs of $20m (2016: nil).

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 $73m (2016: $60m).

Claims for Costs

The table also reports a contingent liability in respect of claims for costs of up to $20.245m (2016: $0.090m).

Aged Care Accommodation Bond Guarantee Scheme

The Department is not currently aware of the potential for the accommodation bond scheme to be activated (2016: $0.208m).

Unquantifiable Contingent Assets

Compensation from Sanofi

The Department has initiated legal action against Sanofi to recover significant lost savings it claims were denied to it because interim injunctions granted to Sanofi in unsuccessful patent litigation delayed a generic version of clopidogrel being listed on the Pharmaceutical Benefits Scheme and thereby delayed statutory price reductions for brands of clopidogrel.

Compensation from Wyeth

The Department has initiated legal action against Wyeth to recover significant lost savings it claims were denied to it because interim injunctions granted to Wyeth in unsuccessful patent litigation delayed a generic version of venlafaxine being listed on the Pharmaceutical Benefits Scheme and thereby delayed statutory price reductions for brands of venlafaxine.

Compensation from AstraZeneca

The Department has initiated legal action against AstraZeneca to recover significant lost savings it claims were denied to it because interim injunctions granted to AstraZeneca in unsuccessful patent litigation delayed a generic version of rosuvastatin being listed on the Pharmaceutical Benefits Scheme and thereby delayed statutory price reductions for brands of rosuvastatin.

Unquantifiable Contingent Liabilities

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.

Department of Health

Notes to and forming part of the financial statements

From the latest available information, the maximum contingent liability, in the unlikely event that all providers defaulted, is $21.7 billion. Since the scheme was introduced it has been activated ten times requiring payment of $42.95m. It is difficult to predict if the past patterns of payments are indicative of future payments. The scheme was not activated during the period ended 30 June 2017, but minor residual payments were made in relation to a refund owed from the previous year.

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 2017 no claims have been made (2016: Nil).

Medical Indemnity

The Department of Human Services (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 2017, 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 2017 no claims have been made or notified (2016: 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 2017 no claims have been made (2016: 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 2017 no claims have been made (2016: 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. For the period ended 30 June 2017 no claims have been made (2016: Nil).

Department of Health

Notes to and forming part of the financial statements

Blood and Blood Products Liability Cover

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 2017 no claims have been made (2016: 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 contracts under which contingent liability is recognised will expire in February 2018, October 2020 and June 2025 respectively. 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 2017 no claims have been made (2016: 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 gonadotropin manufactured before 31 December 1985. For the period ended 30 June 2017 no claims have been made (2016: 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 2017 no claims have been made (2016: Nil).

2018 Commonwealth Games

The Australian Government has provided guarantees in support of the Gold Coast bid to host the 2018 Commonwealth Games.

Significant Remote Contingencies

The Department did not have any significant remote contingencies this year or prior year.

Department of Health

Notes to and forming part of the financial statements

Note 25A: Administered appropriations

Table A: Annual and Unspent Appropriations ('Recoverable GST exclusive')

	2017 $'000	2016 $'000
ADMINISTERED		
Ordinary Annual Services - Administered items		
Annual appropriation[1,2]	**8,576,410**	5,804,936
Receipts retained under PGPA Act - Section 74	**43,413**	107,701
Transfers of appropriations under PGPA Act - Section 75	**-**	1,507,863
Total appropriation	**8,619,823**	7,420,500
Appropriation applied (current and prior years)[4]	**(8,298,244)**	(6,727,047)
Variance[3]	**321,579**	693,453
Unspent appropriations		
Own unspent appropriation balance	**493,857**	448,062
Prior year section 75 transfers	**215,882**	215,882
Closing unspent appropriation balance[5]	**709,739**	663,944
Balance comprises appropriations as follows:		
Appropriation Act (No. 1) 2012-2013[6]	**3,323**	3,323
Appropriation Act (No. 1) 2013-2014[6]	**26,391**	26,391
Appropriation Act (No. 1) 2014-2015[7,8]	**213,993**	213,993
Appropriation Act (No. 5) 2014-2015[8]	**46,689**	46,689
Appropriation Act (No. 1) 2015-2016[1,2]	**67,448**	366,133
Appropriation Act (No. 3) 2015-2016	**-**	7,415
Supply Act (No. 1) 2016-2017[2]	**39,359**	-
Appropriation Act (No. 1) 2016-2017[2]	**235,776**	-
Appropriation Act (No. 3) 2016-2017	**76,760**	-
Total unspent appropriation - ordinary annual services - administered items	**709,739**	663,944

[1] There were no amounts temporarily quarantined from 2017 administered ordinary annual services appropriations. In 2016 administered ordinary annual services appropriations $25,253,000.00 of the *Appropriation Act (No. 1) 2015-2016* was temporarily quarantined. This does not represent a loss of control of the appropriations and this amount is still reported as available above.

[2] In 2017 administered ordinary annual services appropriations $135,447,039.00 of the *Appropriation Act (No. 1) 2016-2017* and $25,561,444.40 of the *Supply Act (No. 1) 2016-2017* were permanently quarantined under section 51 of the PGPA Act. In 2016 administered ordinary annual services appropriations $542,555,073.63 of the *Appropriation Act (No. 1) 2015-2016* and $2,391,581.98 of the *Appropriation Act (No. 3) 2015-2016* were 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 above.

[3] The administered ordinary annual services items variance of $321,579,000.00 relates to the utilisation of retained funding from 2016 during 2017 (the former section 11 of the Appropriation Acts).

[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.

Department of Health

Notes to and forming part of the financial statements

[5] This balance is net of $1,330,118,322.84 which is permanently quarantined under section 51 of the PGPA Act. These amounts are detailed in footnotes to the respective Act. The total unspent appropriations gross of quarantined amounts under section 51 of the PGPA Act is $2,039,857,322.18.
[6] 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 above.
[7] This balance includes temporarily quarantined amounts to the total of $47,800,000.00. This does not represent a loss of control of the appropriations and therefore these amounts were reported as available above. Another $618,915,913.02 was permanently quarantined against this appropriation item under section 51 of the PGPA Act. This represents a loss of control of the appropriations and therefore this amount was not reported as available above.
[8] These balances will lapse on 1 July 2017 when the underlying Appropriation Acts are repealed.

	2017	2016
	$'000	$'000
Ordinary Annual Services - Payments to corporate Commonwealth entities		
Annual appropriation	**405,074**	346,502
Total appropriation	**405,074**	346,502
Appropriation applied (current and prior years)	**(405,074)**	(328,658)
Variance	**-**	17,844
Other services - Administered assets and liabilities		
Annual appropriation	**150,537**	156,741
Total appropriation	**150,537**	156,741
Appropriation applied (current and prior years)	**(35,244)**	(33,202)
Variance[1]	**115,293**	123,539
Unspent appropriations		
Own unspent appropriation balance	**257,381**	142,087
Closing unspent appropriation balance	**257,381**	142,087
Balance comprises appropriations as follows:		
Appropriation Act (No. 2) 2013-2014[2]	**14,226**	14,226
Appropriation Act (No. 2) 2014-2015[3]	**840**	840
Appropriation Act (No. 2) 2015-2016	**-**	2,021
Appropriation Act (No. 4) 2015-2016	**115,263**	125,000
Supply Act (No. 2) 2016-2017	**53,907**	-
Appropriation Act (No. 2) 2016-2017	**73,145**	-
Total unspent appropriation - other services - administered assets and liabilities	**257,381**	142,087

[1] The administered other services assets and liabilities variance of $115,293,000 relates largely to funding for the investment in the Biomedical Translation Fund.
[2] This balance has been temporarily quarantined. This does not represent a loss of control of the appropriation and therefore this amount was reported as available above.
[3] This balance will lapse on 1 July 2017 when the underlying Appropriation Act is repealed.

Department of Health

Notes to and forming part of the financial statements

Other Services - Payments to corporate Commonwealth entities		
Annual appropriation	**10,589**	-
Total appropriation	**10,589**	-
Appropriation applied (current and prior years)	**(10,589)**	-
Variance	**-**	-

Table B: Special Appropriations Applied ('Recoverable GST exclusive')

	Appropriation applied	
	2017	2016
Authority	**$'000**	$'000
Aged Care (Accommodation Payment Security) Act 2006	**720**	-
Aged Care Act 1997	**12,948,343**	9,831,715
Health Insurance Act 1973	**22,039,801**	21,167,610
National Health Act 1953	**13,754,186**	11,798,076
Medical Indemnity Act 2002	**61,952**	69,264
Private Health Insurance Act 2007	**5,992,179**	5,896,162
Dental Benefits Act 2008	**319,304**	312,724
Health and Other Services (Compensation) Act 1995	**-**	-
Medical Indemnity Agreement (Financial Assistance - Binding Commonwealth Obligations) Act 2002	**-**	-
Midwife Professional Indemnity (Commonwealth Contribution)	**-**	-
Public Governance, Performance and Accountability Act 2013 s.77	**576**	7,926
Total special appropriations applied	**55,117,061**	49,083,477

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 C: Disclosure by Agent in Relation to Annual and Special Appropriations ('Recoverable GST exclusive')

	2017	2016
	$'000	$'000
Department of Social Services		
Total receipts	**31,507**	6,127
Total payments	**(31,507)**	(6,127)

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 2017 and 2016.

Department of Health

Notes to and forming part of the financial statements

Note 25B: Compliance with statutory requirement 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 $55 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 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. If an overpayment occurs a breach of section 83 could result despite future payments being adjusted to recover the overpayment. In addition, simple administrative errors can 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. During 2016-17, the Department:

- considered processes to minimise the risk of section 83 breaches as part of any review of legislation or administrative processes;
- 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 Appropriations

The Department administers 11 pieces of legislation, as disclosed in Note 25A Table B, with Special Appropriations for statutory payments. Some payments under the following legislation have been identified as having either actual or potential breaches of section 83:

Health Insurance Act 1973

In 2016-17, there were three cases of non-compliance under the Chronic Disease Dental Scheme totalling $390,981.

These breaches have been confirmed by the Australian Government Solicitor and the related debts have been partially waived on the basis that it would be inequitable to recover the debts owed by the providers of the 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 been correctly implemented.

DHS have advised that during 2016-17, 168 instances under the Medicare Easyclaim Program have been identified with a total value of $30,464 where the payment made was not authorised by section 125(1) of the *Health Insurance Act 1973*.

DHS have also advised that during 2016-17 there have been potential breaches with regards to the Stoma Appliance: Paraplegic and Quadriplegic Program. DHS have put in place remedial actions with reviews of the program's conformance assessment and risk plans.

Department of Health

Notes to and forming part of the financial statements

Special Accounts
Currently the Department has nine Special Accounts, detailed in 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.

Continued Focus
The Department will continue to review legislation, new policy proposals, business rules and payment processes to assess the risk of breaches of section 83. In addition, it will continue ongoing reviews of special accounts by the Department's Integrity Branch as part of its rolling compliance program.

Note 26: Restructuring

The Australian Digital Health Agency (Digital Health) commenced from 1 July 2016 to manage the governance, operation and ongoing delivery of digital health including redevelopment of the *My Health Record* software. The value of the software asset as at 1 July 2016 was $48.823m.

Staff members transferring to the Digital Health did so through transfer under section 26 of the *Public Service Act 1999*, and are not considered to have moved under a restructure arrangement.

Department of Health

Notes to and forming part of the financial statements

Note 27: Special accounts

	Services for Other Entities and Trust Moneys Account [1]		Australian Immunisation Register Account [2]		Human Pituitary Hormones Account [3]		Sport and Recreation Account [4]	
	2017	2016	**2017**	2016	**2017**	2016	**2017**	2016
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**18,773**	13,849	**3,876**	2,258	**2,570**	2,675	**624**	714
Timing adjustments related to prior years	**(270)**	-	**-**	-	**-**	-	**-**	-
Increases								
Appropriation credited to special account	**10,226**	11,870	**6,971**	7,270	**-**	-	**-**	-
Other increases	**8,470**	12,609	**3,724**	4,060	**-**	-	**270**	331
Total increases	**18,696**	24,479	**10,695**	11,330	**-**	-	**270**	331
Available for payments	**37,199**	38,328	**14,571**	13,588	**2,570**	2,675	**894**	1,045
Decreases								
Administered	**-**	-	**9,955**	9,712	**199**	105	**298**	421
Total administered decreases	**-**	-	**9,955**	9,712	**199**	105	**298**	421
Relevant Money	**18,064**	19,555	**-**	-	**-**	-	**-**	-
Total relevant money decreases	**18,064**	19,555	**-**	-	**-**	-	**-**	-
Total decreases	**18,064**	19,555	**9,955**	9,712	**199**	105	**298**	421
Total balance carried to the next period	**19,135**	18,773	**4,616**	3,876	**2,371**	2,570	**596**	624

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

[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; 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.

[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 ceased on 1 October 2016 under Part 6 (sunsetting) of *the Legislative Instruments Act 2003.* A new special account was established to replace it. The new special account is the Australian Immunisation Register 2016.

[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.

[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 ceased on 1 October 2016 under Part 6 (sunsetting) of the *Legislative Instruments Act 2003.* A new special account was established to replace it.

Department of Health

Notes to and forming part of the financial statements

	Therapeutic Goods Administration Account [5]		Gene Technology Account [6]		Industrial Chemicals Account [7]		HHF Health Portfolio Account [8]		Medical Research Future Fund Account [9]	
	2017	2016	**2017**	2016	**2017**	2016	**2017**	2016	**2017**	2016
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**66,039**	61,059	**7,872**	7,585	**14,806**	10,503	**-**	-	**-**	-
Timing adjustments related to prior years	**-**	-	**60**	-	**(85)**	-	**-**	-	**-**	-
Increases										
Appropriation credited to special account	**2,574**	4,177	**7,641**	7,734	**3,762**	3,874	**-**	-	**60,876**	-
Other increases	**143,647**	134,552	**139**	152	**17,764**	16,302	**-**	54,984	**-**	-
Total increases	**146,221**	138,729	**7,780**	7,886	**21,526**	20,176	**-**	54,984	**60,876**	-
Available for payments	**212,260**	199,788	**15,712**	15,471	**36,247**	30,679	**-**	54,984	**60,876**	-
Decreases										
Departmental	**149,656**	133,749	**7,453**	7,599	**18,192**	15,873	**-**	-	**-**	-
Total departmental decreases	**149,656**	133,749	**7,453**	7,599	**18,192**	15,873	**-**	-	**-**	-
Administered								54,984	**12,960**	-
Total administered decreases	**-**	-	**-**	-	**-**	-	**-**	54,984	**12,960**	-
Total decreases	**149,656**	133,749	**7,453**	7,599	**18,192**	15,873	**-**	54,984	**12,960**	-
Total balance carried to the next period	**62,605**	66,039	**8,259**	7,872	**18,055**	14,806	**-**	**-**	**47,916**	**-**

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

[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 was 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. The account balance was nil at the time of abolition.

[9] Establishing Instrument: *Medical Research and Future Fund Act 2015*
Appropriation: *Public Governance, Performance and Accountability Act 2013*; section 80
Purpose: to provide grants of financial assistance to support medical research and medical innovation.
The Medical Research Future Fund Special Account was established on 26 August 2015.

[10] Medicare Guarantee Fund (Health) Special Account
Establishing Instrument: Medicare Guarantee Act 2017
Appropriation: *Public Governance, Performance and Accountability Act 2013*; section 80
Purpose: to secure the ongoing funding of the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.
The Medicare Guarantee Fund (Health) Special Account was established on 26 June 2017. No financial activity occurred in the 2017 financial year.

Department of Health

Notes to and forming part of the financial statements

Note 28: Regulatory charging summary

	2017 $'000	2016 $'000
Amounts applied		
Departmental		
Annual appropriations	**31,471**	20,262
Own source revenue	**164,973**	147,761
Administered		
Annual appropriations	**3,860**	2,243
Total amounts applied	**200,304**	170,266
Expenses		
Departmental	**195,788**	164,874
Administered	**3,889**	2,250
Total expenses	**199,677**	167,124
Revenue		
Departmental	**162,032**	164,367
Administered	**14,157**	14,906
Total external revenue	**176,189**	179,273
Amounts written off		
Departmental	**200**	565
Administered	**-**	58
Total amounts written-off	**200**	623

Where appropriate, amounts applied in the prior year comparatives have been restated.

Regulatory charging activities:
The **Therapeutic Goods Administration** (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.

National Industrial Chemicals Notification and Assessment Scheme (NICNAS) charges are levied for registration or assessment of chemicals across Australia.

The **Prostheses Listing** arrangements refer to the activities involved in listing prostheses and their benefits for the purposes of private health insurance reimbursement.

The **National Joint Replacement Registry** facilitates the collection of data that provides a prospective case series on all joint replacement surgery undertaken in Australia.

Administered revenue only is recorded for the **Private Health Insurance Ombudsman Levy.**

Listing of medicines on the **Pharmaceutical Benefits Scheme** and designated vaccines on the **National Immunisation Program** are subject to regulatory charges.

Medicinal cannabis: Licence and permit applications for the cultivation and manufacture of Australian produced medicinal cannabis products.

Documentation for the above activities is available at:
http://www.tga.gov.au/cost-recovery-implementation-statements
https://www.nicnas.gov.au/about-nicnas/cost-recovery/cost-recovery-impact-statement
http://www.health.gov.au/internet/main/publishing.nsf/Content/69F6A026037D6093CA257BF0001B5EDA/$File/PL-CRIS-update-2016.pdf
http://www.health.gov.au/internet/main/publishing.nsf/Content/phib-njrr
http://www.pbs.gov.au/industry/listing/elements/fees-and-charges/cost-recovery-implementation-statement-2016-2017.pdf
https://www.odc.gov.au/publications/cost-recovery-implementation-statement-regulation-medicinal-cannabis

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Appendices

Appendix 1: Processes Leading to PBAC Consideration – Annual Report for 2016-17

Introduction

This is the eighth 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 2016-17 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 in each year, prepare and give to the Minister a report on processes leading up to the Pharmaceutical Benefits Advisory Committee consideration, including:*
>
> *a) the extent and timeliness with which responsible persons are provided copies of documents relevant to their submission 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;*
>
> *c) the number of responsible persons seeking a review of the Pharmaceutical Benefits Advisory Committee recommendation.*

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 and health economists, as well as industry and consumer nominees. Its primary role is to consider medicines for listing on the PBS and vaccines for inclusion 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 considering 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 three 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;
- **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; and
- **The Nutritional Products Working Party (NPWP)** which advises the PBAC on matters relating to the effectiveness and use of therapeutic foods and nutritional products.

Roles of the PBAC

- 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

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-subcommittee 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 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

During 2016-17, the PBAC held three ordinary meetings (as is usual practice) and considered a total of 97 major submissions. For the:

- **July 2016 PBAC meeting**, 20 responsible persons lodged major submissions. 20 sponsors responded to their commentaries.
- **November 2016 PBAC meeting**, 31 responsible persons lodged major submissions. 31 sponsors responded to their commentaries.
- **March 2017 PBAC meeting**, 21 responsible persons lodged major submissions. 21 sponsors responded to their commentaries and one sponsor withdrew its submission before responding to its commentary.

Consequently, of the 72 major submissions considered by PBAC in 2016-17, 72 responsible persons exercised their right to respond to their commentaries.

c) Number of responsible persons seeking a review of PBAC recommendations

During the 2016-17 financial year, there were no requests to the PBAC for an Independent Review.

Number and category of applications for each PBAC meeting in 2016-17[76]

July 2016 PBAC Meeting

Category	Number
Major	20
Minor	28

November 2016 PBAC Meeting

Category	Number
Major	31
Minor	37

March 2017 PBAC Meeting

Category	Number
Major	21
Minor	23

Number and category of withdrawn applications for each PBAC meeting in 2016-17

July 2016 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	3	Decision by applicants – no reason provided
Minor	0	–

November 2016 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	3	Decision by applicants – no reason provided
Minor	3	Decision by applicants – no reason provided

March 2017 PBAC Meeting

Category	Number	Reasons for withdrawal
Major	2	Decision by applicants – no reason provided
Minor	2	Decision by applicants – no reason provided

[76] Figures do not take into account extended meetings where two or more drugs are discussed within one meeting date.

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 2016-17 responded to their commentary.

July 2016 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
20	20	5

November 2016 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
31	31	13

March 2017 PBAC Meeting

Number of major submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC
21	21	6

Number of pre-submission meetings held in 2016-17[77]

Pre-submission meetings per month	Meetings held
2016	
July	0
August	9
September	5
October	2
November	0
December	6
2017	
January	4
February	2
March	1
April	7
May	7
June	1
Total	**44**

[77] Figures do not take into account extended meetings where two or more drugs are discussed within one meeting date.

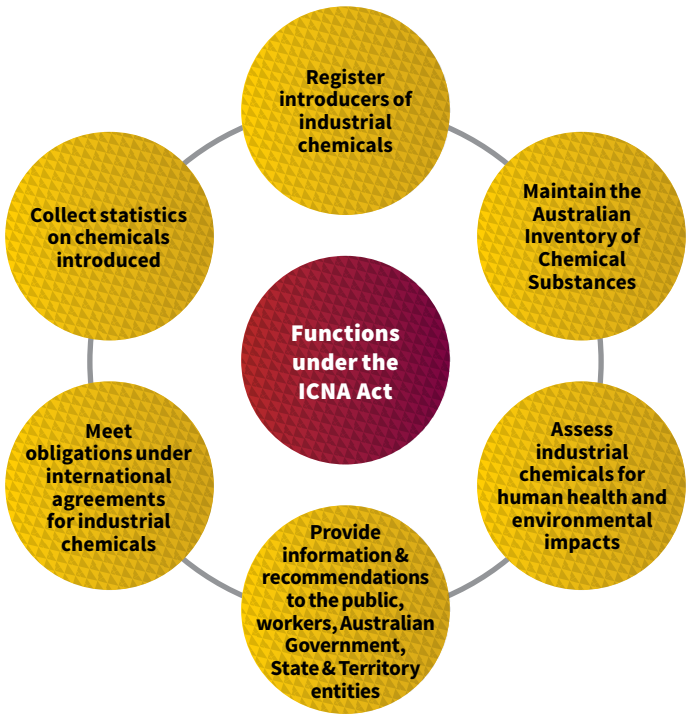
Appendix 2: Report from the Director of the National Industrial Chemicals Notification and Assessment Scheme on the operation of the *Industrial Chemicals (Notification and Assessment) Act 1989*

About NICNAS

The National Industrial Chemicals Notification and Assessment Scheme (NICNAS) is a statutory scheme established under the *Industrial Chemicals (Notification and Assessment) Act 1989* (ICNA Act).

Under NICNAS, the risks to human health and the environment arising from the introduction (by import or manufacture) of industrial chemicals in Australia are assessed. NICNAS risk assessment reports inform State, Territory and Australian Government entities, whose combined role is to regulate the safe transport, storage, use and disposal of chemicals in Australia through a range of other legislation. Other activities conducted to support the scheme, such as registration of chemical introducers, maintenance of the Australian Inventory of Chemical Substances, and education and compliance functions, also promote the safer use of industrial chemicals. The range of NICNAS functions is illustrated in Figure 1.

Figure 1: Functions under the ICNA Act



The Director of NICNAS (the Director) is a statutory office holder appointed under the ICNA Act to independently exercise powers and functions to achieve the objects of the Act.

The Director is supported by staff in the Office of Chemical Safety (OCS) within the Department of Health, with assistance from staff in the Department of the Environment and Energy. The Director is also the Executive Director of the OCS.

In 2016-17, NICNAS:

- met all qualitative and quantitative performance criteria published in the 2016-17 Health Portfolio Budget Statements (refer *Outcome 5: Regulation, Safety and Quality*, p. 152–154 of this Annual Report);
- conducted post-market reviews of the risks of industrial chemicals already in use in Australia;
- published a report on industrial chemicals used in tattoo inks;
- launched the new NICNAS website;
- launched the new online registration portal for businesses; and
- supported the implementation of significant reforms to the scheme.

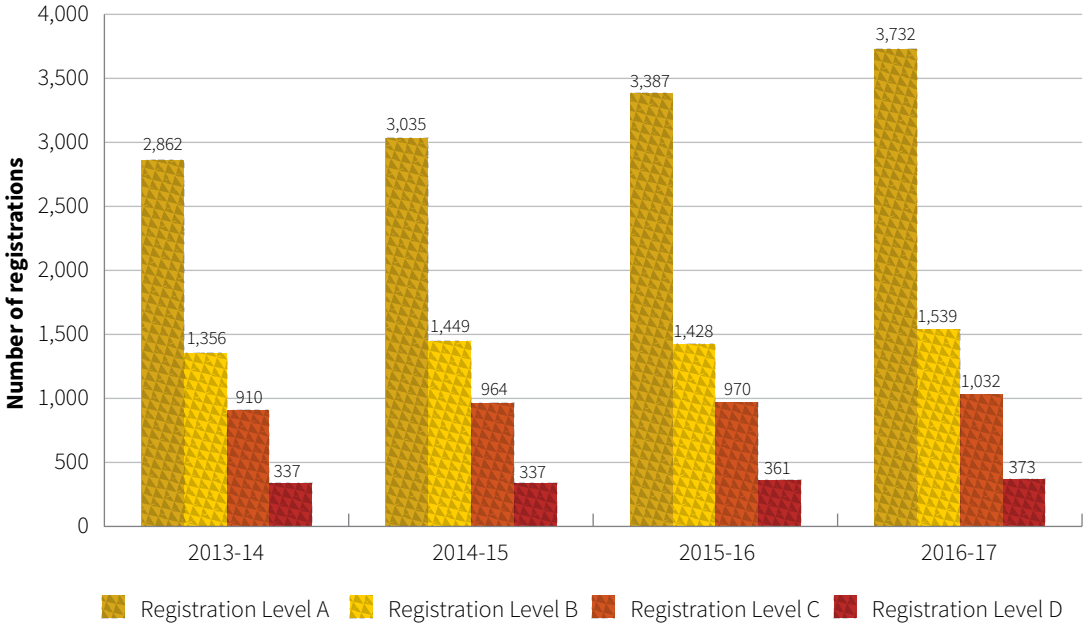
Registration of importers and/or manufacturers of industrial chemicals

Every manufacturer and/or importer ('introducer') of industrial chemicals must be registered with NICNAS. Once registered, the introducer's details are added to the Register of Industrial Chemical Introducers that is available on the NICNAS website.[78]

Registration of introducers helps NICNAS inform industry about their legal obligations, promotes the safer use of industrial chemicals through the provision of information about chemicals, and maintains public confidence in Australia's chemical industry.

The revenue from registration charges allows NICNAS to assess the risks of existing chemicals, as well as undertake compliance, communication and business support activities. Trends in registration are shown in Figure 2.

Figure 2: Four-year trend data for NICNAS registrations



Source: Annual Reports and internal data

[78] Available at: www.nicnas.gov.au

Key registration statistics during 2016-17

- Over 70 per cent of introducers self-registered online after the implementation of the NICNAS business portal.
- 6,676 businesses registered with NICNAS, representing the highest number of registrants in the history of the scheme.
- Decrease in manual processing of registration renewal payments from 100 per cent to less than 10 per cent as a direct result of the move to online registration.

Compliance monitoring

NICNAS's compliance monitoring activities have a strong focus on education and awareness-raising to assist introducers in understanding their obligations under the ICNA Act. These activities are supported by targeted auditing to determine an introducer's compliance with their obligations.

Key compliance statistics during 2016-17

- Over 400 registrant representatives attended awareness-raising information sessions Australia-wide.
- Over 500 new introducers registered with NICNAS as a direct result of compliance monitoring activities.
- The registration level of over 650 introducers was varied as a direct result of compliance monitoring activities.
- Over 100 new industrial chemicals requiring notification or reporting to NICNAS were identified through compliance monitoring of registered introducers.

Australian Inventory of Chemical Substances

Chemicals listed on the Australian Inventory of Chemical Substances (AICS) ('existing industrial chemicals') can be introduced into Australia for any industrial purpose (in accordance with any conditions of use specified on AICS) without notification to NICNAS.

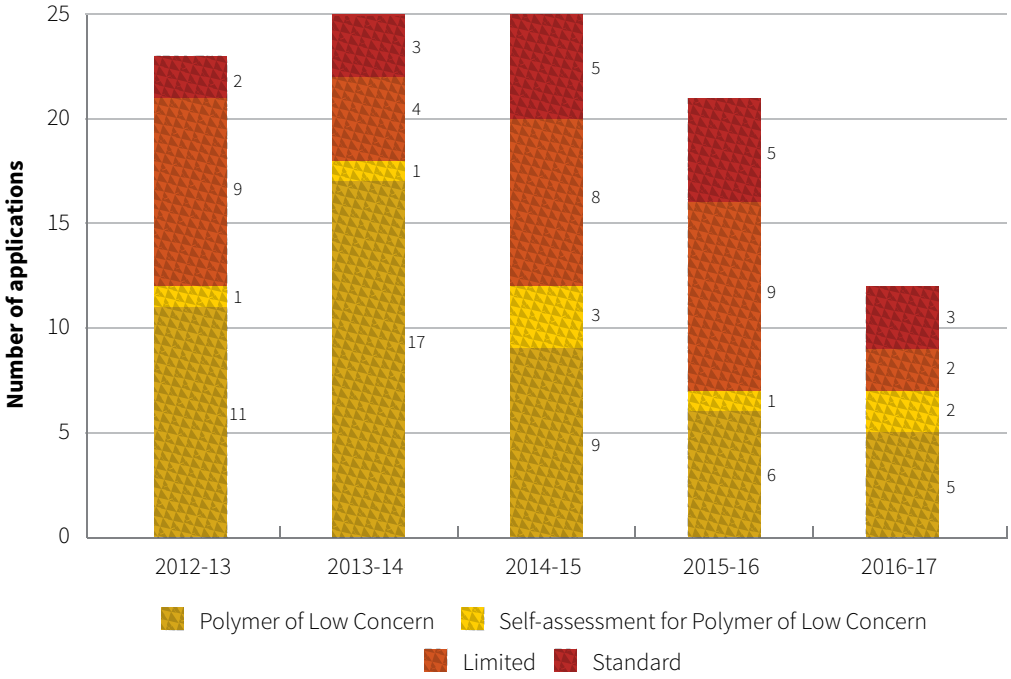
The AICS is a legal record that distinguishes 'existing' from 'new' industrial chemicals and consists of non-confidential (public) and confidential sections.

New industrial chemicals require assessment under NICNAS for risks to the environment and human health before they can be imported or manufactured, unless they are eligible for exemption from assessment under the ICNA Act. Once an assessment certificate has been issued, chemicals are listed on the AICS either five years after assessment or, upon application, can be listed on the AICS immediately.

An application for listing on the confidential section of the AICS can be made to protect the commercial interests of an introducer. Such applications are subject to a statutory test that weighs the public interest in the availability of information about the chemical against the commercial prejudice to the introducer that would result from the publication of this information. Successful applications are reviewed after five years, with re-application of the statutory public interest test.

Figure 3 shows trends in confidential listing applications over recent years.

Figure 3: The original assessment categories for confidential listing applications from 2012-13 to 2016-17



Source: NICNAS internal data

In 2016-17, industry was requested to provide NICNAS with information on the chemical identity (Chemical Abstracts Index name, Chemical Abstracts Service number and molecular formula) of all industrial chemicals making up products listed in the Trade Name Annex (TNA) of the AICS. Provisions under the ICNA Act allow for the removal of products from the TNA and the addition of their constituents to the AICS without assessment. Information was requested on 7 March 2017, to be submitted to NICNAS within one year.

Key AICS statistics for the year ending 30 June 2017

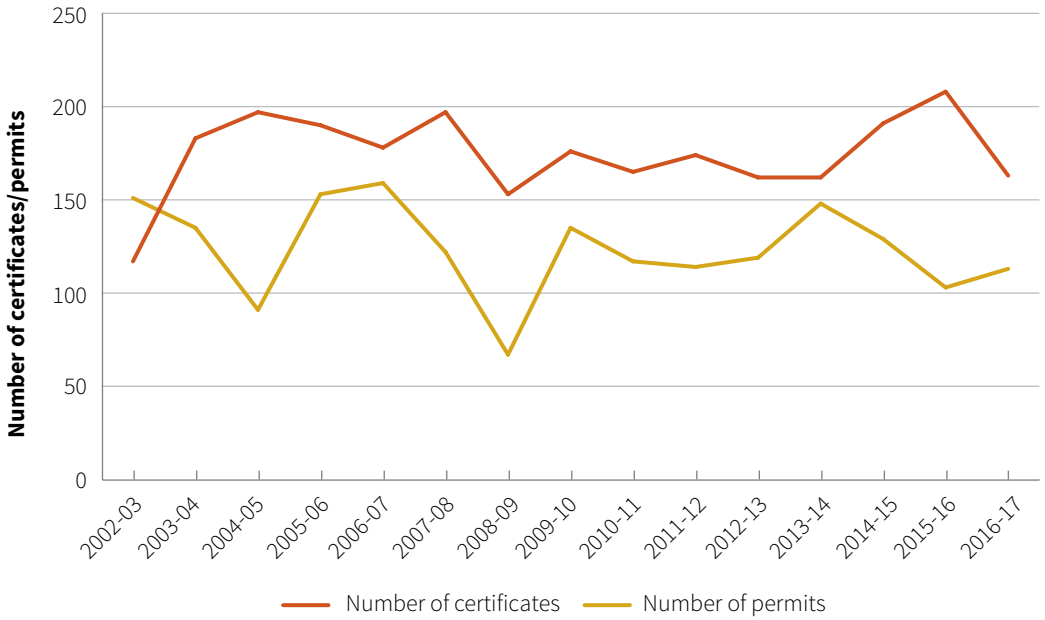
- 40,286 chemicals were on the public AICS, with 98 chemicals on the confidential AICS.
- 127 chemicals for which an assessment certificate had been issued five years previously were due to transfer to the public AICS.
- The number of applications for listing on the confidential AICS had declined over the previous three years (Figure 3). Of the 12 applications for confidential listing received and approved, seven applications were for Polymers of Low Concern (PLCs) (two self-assessed as PLCs and five PLCs assessed under NICNAS).
- 243 requests were received from bona fide introducers for a search of the confidential section of the AICS.
- 124 inquiries were received in response to the call for information on products in the TNA section of the AICS, and information on 18 products (containing 44 chemicals) was submitted.

New imported and/or manufactured industrial chemicals

Any chemical that is not listed on the AICS, or is listed on the AICS but proposed for a use outside the conditions prescribed on the AICS, or is ineligible for exemption under the ICNA Act, must be notified for assessment under NICNAS. Permits and certificates are issued after risks to human health and the environment from a chemical are assessed and are required prior to manufacture or importation of the chemical into Australia.

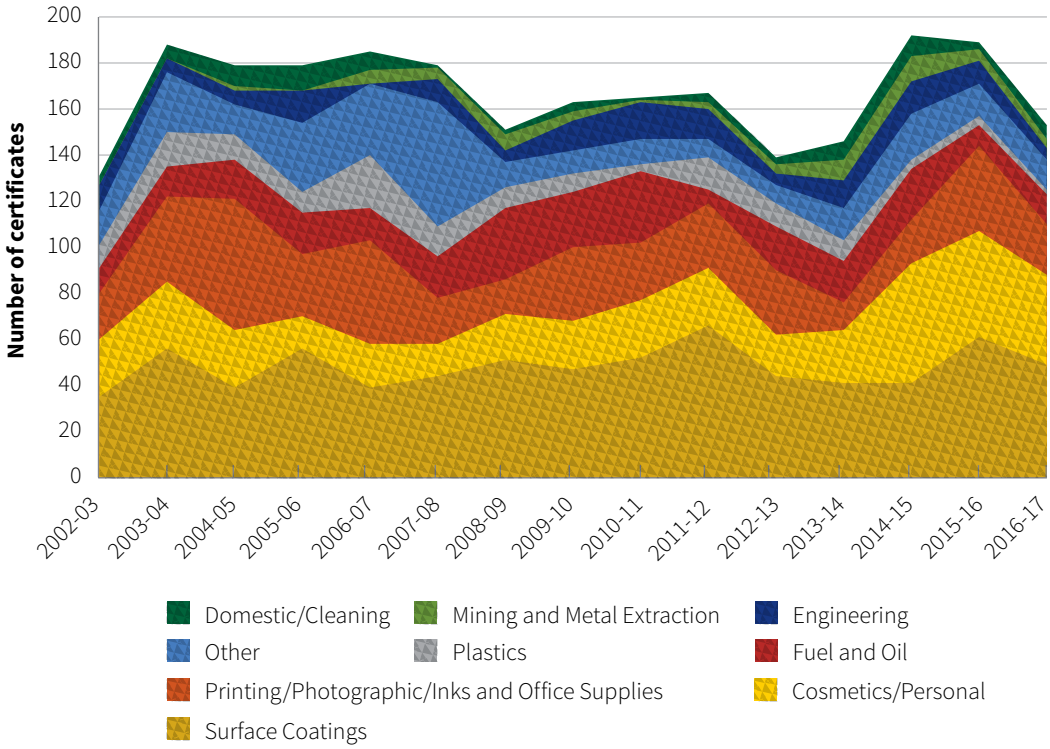
Figures 4, 5 and 6 describe trends in the assessment of new chemicals notified by industry.

Figure 4: Certificates and permits issued 2002-03 to 2016-17



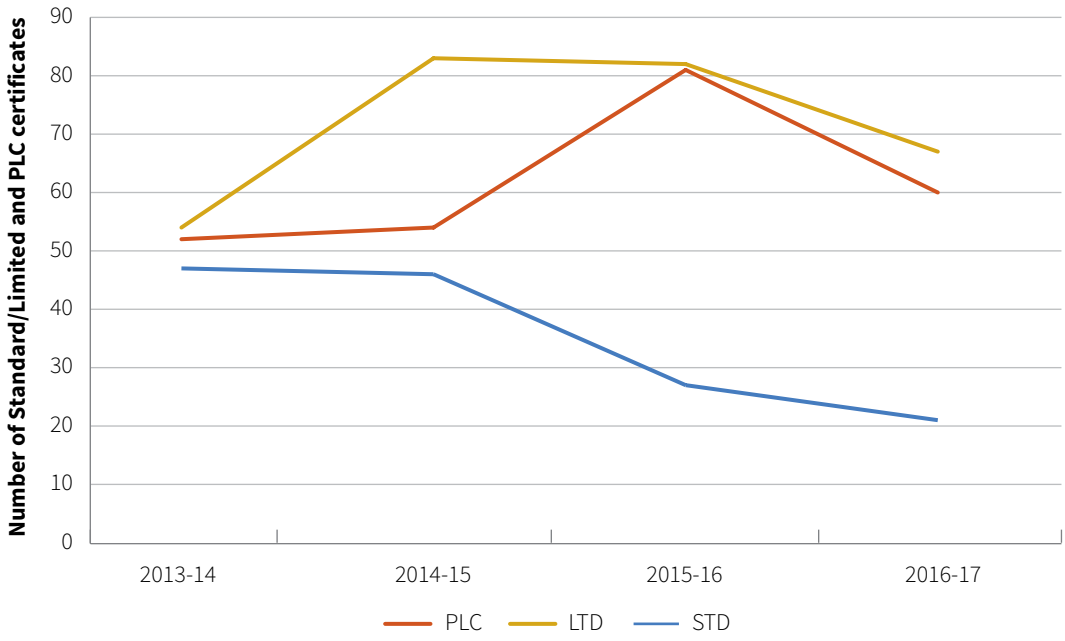
Source: NICNAS internal data

Figure 5: Standard, Limited and Polymer of Low Concern Certificates issued by use category from 2002-03 to 2016-17



Note: The area displays trends over time and are stacked so that each series adjoins but does not overlap the preceeding series.
Source: Annual Reports and internal data

Figure 6: Standard, Limited and Polymer of Low Concern Certificates issued from 2013-14 to 2016-17



Source: Annual Reports and internal data

Key statistics for new industrial chemicals for the year ending 30 June 2017

- 276 certificates and permits for new industrial chemicals were issued during the year.
- 10,150 industrial chemicals were reported as being introduced under exemption categories by 217 introducers.

Assessment of existing industrial chemicals

Inventory Multi-Tiered Assessment and Prioritisation (IMAP) framework

The IMAP framework consists of three tiers of chemical assessment, with the assessment effort increasing with each tier. The aim is to provide more timely information about the hazards and risks associated with the use of industrial chemicals by identifying chemicals which:

- pose no unreasonable risk to human health or the environment (Tier I);
- require human health or environmental risk management measures to be instituted for safe use (Tier II); and
- require more in-depth assessment to fully determine its impact on human health and/or the environment (Tier III).

Implementation of Stage Two of the IMAP framework began 1 July 2016. Based on the findings of a review of IMAP Stage One (2012–2016), the framework has been refined, including by identifying and de-prioritising chemicals of low regulatory concern, adjusting mechanisms for prioritising chemicals of concern, establishing alternative information-gathering mechanisms for 'data-poor' chemicals, and implementing new architecture (databases/networks) for conducting assessments electronically. These refinements enabled NICNAS to significantly increase the number of assessments conducted using the IMAP framework.

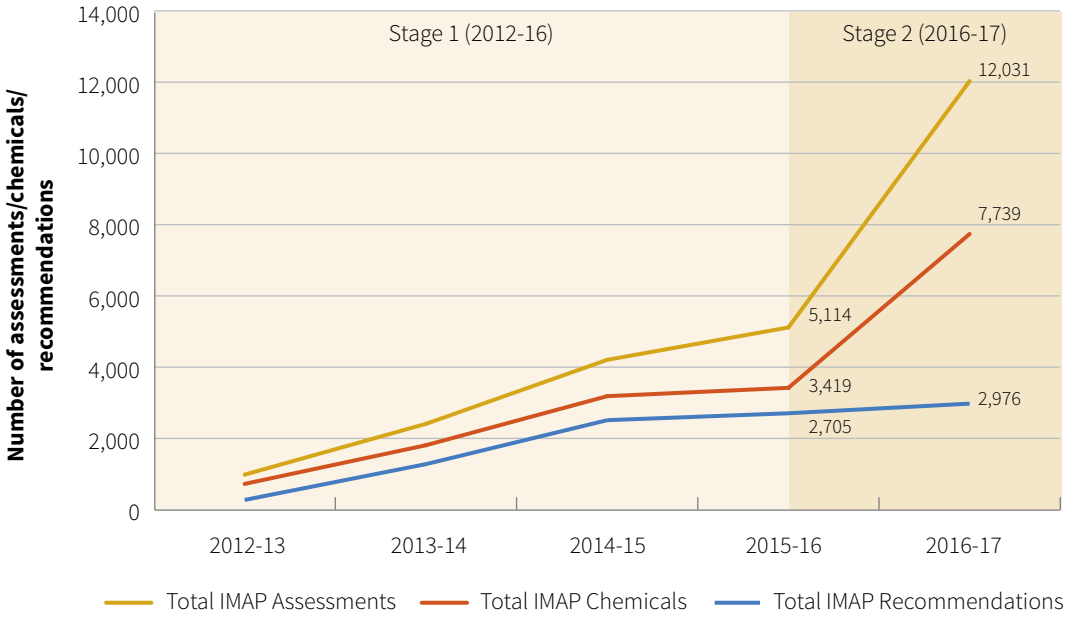
Information on the potential risks associated with the use of chemicals assessed using the IMAP framework is provided to international regulatory authorities and local risk management agencies. Collaboration with a range of international and local counterparts, industry bodies and community groups ensured that evidence to support the recommendations was available.

IMAP Stage Two includes consideration of a large number of chemicals that posed a low risk to human health or the environment (Tier I assessments). This assessment approach balances the assessment pace with the impact on stakeholders. Tools and approaches developed during Stage Two enabled NICNAS to gain efficiencies in the screening of chemicals on the AICS. The large increase in chemicals published at Tier I was focused on chemicals with excluded non-industrial uses, low concern polymers, substances derived from natural products, plant extracts used in low volumes and chemicals identified as low concern to human health by the application of expert validation rules. The identification of low risk chemicals in Stage Two is consistent with international best practice, provides valuable information to stakeholders and contributes to preparatory (pre-prioritisation) work to identify criteria for the identification of higher risk chemicals requiring assessment.

Improvements in assessment methods and processes developed for IMAP Stage Two will contribute to the ongoing assessment of chemicals already in commerce that is planned as part of reforms to NICNAS.

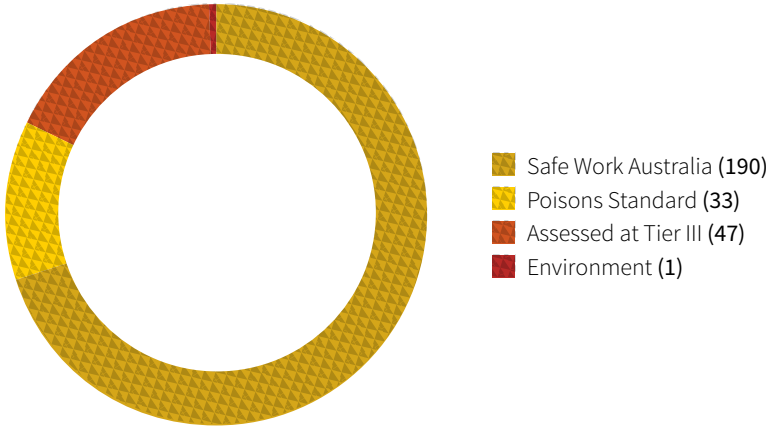
The outcomes of IMAP Stages One and Two are illustrated in Figures 7 and 8 and Table 1.

Figure 7: Outcomes of IMAP Stages One and Two, years 1–5



Source: Annual Reports and internal data

Figure 8: Total recommendations from IMAP Stage Two



Source: Annual Reports and internal data

Table 1: Cumulative (Tier I, II, III) assessments in Stage One and Stage Two

	Stage One (2012–16) (Tranches 1–18)	**Stage Two (2016–17)** (Tranches 19–21)
Tier III	11	5
Tier II	2,731	302
Tier I	2,372	6,610
Total assessments	**5,114**	**6,917**

Source: Annual Reports and internal data

Key existing chemical assessment statistics during 2016-17

- 6,917 human health and environment assessments for 4,367 unique industrial chemicals (compared to the previous year's (2015-16) total of 909 assessments).
- A total of 6,610 Tier I assessments.
- 271 recommendations to manage newly identified risks associated with the industrial use of 223 unique chemicals.

Secondary notification assessments

When new information or other changed circumstances warrant re-assessment of a chemical previously assessed by NICNAS, introducers of the chemical must provide further information to NICNAS, in a process known as secondary notification.

Key secondary notification assessment statistics during 2016-17

- One Secondary Notification assessment report was published.
- One draft report of a Secondary Notification was provided to applicants.
- Two Secondary Notifications were declared (one for a new chemical and one for an existing chemical).

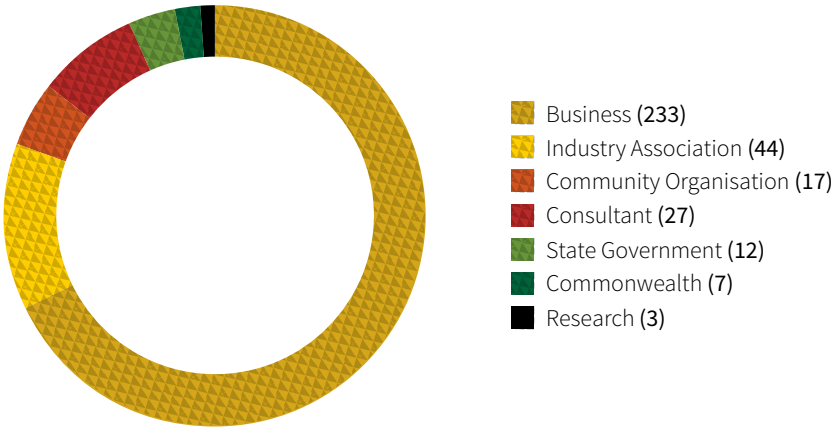
NICNAS reforms

As announced in the 2015-16 Budget, significant reforms to the scheme are expected to commence from 1 July 2018.

Details supporting the implementation of these reforms have been developed through a series of government reviews and extensive consultation with industry, community, Australian Government and State and Territory Government stakeholders.

Figure 9 describes aspects of the stakeholder consultation for the NICNAS Reforms.

Figure 9: Groups registered to receive information on the NICNAS Reforms



Source: NICNAS internal data

Key NICNAS reform statistics for 2016-17

- The last of four consultation papers on matters to be included in the primary legislation and one technical consultation paper on matters to be included in delegated legislation were published. Public workshops were held during the consultation period in each case, attended by over 170 stakeholders.
- Over 300 individual stakeholders from community, industry and Government entities specifically requested further information on the NICNAS Reforms.
- An ad-hoc working group of technical experts provided additional advice on the implementation of the reforms.
- A discussion paper on the Cost Recovery Model to support the reformed scheme was published.

Stakeholder consultation

The NICNAS Strategic Consultative Committee (SCC), with representatives from peak industry and community groups, met on two occasions (October 2016 and March 2017) to provide strategic advice to the Director on efficiently achieving the objectives of the ICNA Act and development of the NICNAS reforms. As the external validation body for NICNAS under the Regulator Performance Framework (RPF), the SCC validated NICNAS's self-assessment report under this framework.

The SCC was consulted in advance of the publication of the two consultation papers on the NICNAS reforms. A summary of outcomes of SCC meetings is published on the NICNAS website.[79]

[79] Available at: www.nicnas.gov.au/about-us/advisory-groups/strategic-consultative-committee

The SCC also discussed:

- NICNAS regulatory and financial performance.
- Options for managing confidential information supplied by a third party when secondary notification of a chemical is required.
- Transition approaches for the NICNAS Existing Chemicals Program to the reformed scheme.
- The AICS Trade Names Annex.
- Establishment of a technical working group to provide scientific advice on matters relating to categorisation and assessment prior to further public consultation on delegated legislation.

Digital services

The redeveloped and upgraded NICNAS website was launched in 2016-17 with improved navigation, usability, search performance and design. All new site content meets the Web Content Accessibility Guidelines (WCAG) 2.0 accessibility guidelines and the Australian Digital Service Standard, which includes a shift towards plain English content.

International engagement

NICNAS staff administering actively collaborated with international counterparts through a variety of fora. The Organisation for Economic Co-operation and Development Chemicals Committee and its key subsidiary committees are the principal mechanisms through which NICNAS staff engage multilaterally. Formal bilateral memoranda of understanding are in place with counterparts in Europe, United States, Canada and New Zealand. NICNAS staff also actively contribute to the work of the Asia-Pacific Economic Cooperation Chemical Dialogue. International collaboration facilitates access to scientific expertise, assessment tools and methodologies, benefiting NICNAS and promoting international harmonisation of regulatory requirements. International engagement has been particularly valuable in developing the implementation detail of the reforms.

Staff development

The OCS Learning Centre, a cloud based system with an online Toxicology Course, was launched in 2017 to maintain the high level of scientific rigour in the risk assessment of industrial chemicals.

Financial performance

Compared with 2015-16, total revenue and expenses have increased by $0.887 million and $0.9 million, respectively.

Revenue recovered from the regulated industry was $17.4 million, which is $1.1 million higher than the previous year due to a 9 per cent increase in the number of registrants.

Net revenue from other sources was $0.3 million, which is $0.2 million lower than the previous year, due a reduction in externally-funded projects.

Total expenses were $15.5 million, which is $0.9 million higher than the previous year. This result is due to operational costs associated with the increase in reform-related activities in 2016-17.

As shown in Table 2, the NICNAS final net result for 2016-17 was a surplus of $2.2 million which will be maintained in the NICNAS Special Account. Funds in the Special Account will provide for business continuity requirements, future capital projects and to fund the resources required to finalise the delegated legislation, cost recovery arrangements, technical guidance materials and tools, in preparation for implementation of the new scheme on 1 July 2018.

Table 2: Five year comparison of NICNAS revenue and expenses

	2012-13 $'000	2013-14 $'000	2014-15 $'000	2015-16 $'000	2016-17 $'000
Industry cost recovered revenue	11,089	12,819	13,045	16,324	17,383
Other revenue	2,809	2,094	1,023	493	321
Total revenue	13,898	14,913	14,068	16,817	17,704
Total expenses	13,074	13,906	13,764	14,602	15,502
Operating surplus/(deficit)	824	1,007	304	2,215	2,202

Acknowledgements

I would like to acknowledge the hard work and dedication of staff in both the Department of Health and the Department of the Environment and Energy, who have contributed not only to the efficient operation of the current scheme during 2016-17, but also to the development of the new scheme to replace NICNAS from July 2018.

I have appreciated the strategic advice that I have received from members of the NICNAS Strategic Consultative Committee and the technical input from members of the ad hoc working party supporting the NICNAS reforms.

In addition, I would like to thank a range of other industry and community stakeholders, as well as staff from other Australian Government, State and Territory entities who have also made important contributions to the effective regulation of industrial chemicals in Australia.

Dr Brian Richards

Director of NICNAS

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Freecall: 1800 638 528

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Appendix 3: 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.

The Secretary of the Department of Health, pursuant to subsection 17A(3) of the Public Governance, Performance and Accountability Rule 2014, is responsible for producing the financial statements for ANPHA, as would have been required by the accountable authority under the *Public Governance, Performance and Accountability Act 2013*.

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INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian National Preventitive Health Agency for the year ended 30 June 2017:

(a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian National Preventative Health Agency as at 30 June 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian National Preventative Health Agency, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

- 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;
- Overview comprising significant accounting policies; and
- Notes to and forming part of the financial statements and other explanatory information.

Basis for Opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Australian National Preventative Health Agency in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* to the extent that they are not in conflict with the *Auditor-General Act 1997* (the Code). I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Australian National Preventative Health Agency the Secretary 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 – Reduced Disclosure Requirements 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.

In preparing the financial statements, the Secretary is responsible for assessing the Australian National Preventative Health Agency's ability to continue as a going concern, taking into account whether the Australian National Preventative Health Agency's operations will cease as a result of an administrative restructure or for any other reason. The Secretary is also responsible for disclosing matters related to going

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Australian National Preventive Health Agency

Independent Auditor's Report

concern as applicable and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

Auditor's Responsibilities for the Audit of the Financial Statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit 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;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office

Muhammad Qureshi
Acting Executive Director

Delegate of the Auditor-General

Canberra
31 August 2017

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* (PGPA Act) 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 2017.

In our opinion the attached financial statements for the period 1 July 2016 to 30 June 2017:
a) comply with subsection 42(2) of the PGPA Act;
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 17

Signed.....

Craig Boyd
Chief Financial Officer
Department of Health

31 August 17

Australian National Preventive Health Agency

Statement of comprehensive income
for the period ended 30 June 2017

	Notes	2017	2016
		$	$
NET COST OF SERVICES			
EXPENSES			
Employee benefits		-	-
Supplier		**15,652**	20,105
Impairment of other Commonwealth entity travel debts		-	18,007
Total expenses		**15,652**	38,112
OWN-SOURCE INCOME			
Gains			
Other Gains - FBT refund		-	14,714
Total own-source revenue		-	14,714
Other revenue			
Resources received free of charge		**14,954**	19,132
Total other revenue		**14,954**	19,132
Total own-source income		**14,954**	33,846
Net (cost of) services		**(698)**	(4,266)
Surplus (Deficit)		**(698)**	(4,266)
Surplus (Deficit) attributable to the Australian Government	1.3	**(698)**	(4,266)

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 2017

	Notes	2017	2016
		$	$
ASSETS			
Financial assets			
Cash and cash equivalents	1.3	-	17,626
Departmental appropriation receivable		**1,364,169**	1,347,241
Total financial assets		**1,364,169**	1,364,867
Total assets		**1,364,169**	1,364,867
LIABILITIES			
Total liabilities		**-**	-
Net assets		**1,364,169**	1,364,867
EQUITY			
Accumlated surplus		**1,364,169**	1,364,867
Total equity		**1,364,169**	1,364,867

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 2017

	Retained earnings		Total equity	
	2017	2016	**2017**	2016
	$	$	**$**	$
Opening balance				
Balance carried forward from previous period	**1,364,867**	1,369,133	**1,364,867**	1,369,133
Opening balance	**1,364,867**	1,369,133	**1,364,867**	1,369,133
Comprehensive income				
Deficit for the period	**(698)**	(4,266)	**(698)**	(4,266)
Total comprehensive income	**1,364,169**	1,364,867	**1,364,169**	1,364,867
Closing balance as at 30 June	**1,364,169**	1,364,867	**1,364,169**	1,364,867

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 2017

	Notes	2017 $	2016 $
OPERATING ACTIVITIES			
Cash received			
Net GST received		-	1,656
FBT Refund		-	14,714
Total cash received		-	16,370
Cash used			
Suppliers		**(698)**	(973)
Total cash used		**(698)**	(973)
Net cash from operating activities	1.3	**(698)**	15,397
FINANCING ACTIVITIES			
Cash used			
Cash returned to the Official Public Account		**(16,928)**	-
Total cash used		**(16,928)**	-
Net cash from financing activities		**(16,928)**	-
Net (decrease) in cash held		**(17,626)**	15,397
Cash and cash equivalents at the beginning of the reporting period		**17,626**	2,229
Cash and cash equivalents at the end of the reporting period	1.3	**-**	17,626

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 2017

	2017	2016
	$	$
ASSETS		
Financial assets		
Trade and other receivables	**12,382,827**	12,382,827
Total financial assets	**12,382,827**	12,382,827
Total assets administered on behalf of Government	**12,382,827**	12,382,827
Net assets	**12,382,827**	12,382,827

Australian National Preventive Health Agency

Administered reconciliation schedule
as at 30 June 2017

	2017	2016
	$	$
Opening administered assets less administered liabilities as at 1 July	**12,382,827**	12,382,827
Surplus (deficit) items:		
Transfers to OPA	**-**	-
Closing administered assets less administered liabilities as at 30 June	**12,382,827**	12,382,827

The above 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 15 May 2014 by the Australian Government. The bill was referred to the Senate Community Affairs Committee on 15 May and on 14 July 2014, the Committee recommended that the Bill be passed. The House of Representatives passed the bill on 3 June 2014 and the bill was introduced to the Senate on 16 June 2014 and was negatived by the Senate on the second reading on 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, 2016-17 or 2017-18, Appropriation Acts. At 30 June 2017 ANPHA has no debts. ANPHA has no employees. The Chief Executive Officer 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 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 Act 2013* (PGPA Act), 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. 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:
• Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 for reporting periods ending on or after 1 July 2015; and
• Australian Accounting Standards and Interpretations – Reduced Disclosure Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

Australian National Preventive Health Agency

Overview

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 dollar 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 2016 or 30 June 2017.

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.

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.

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.

Financial statement audit services were provided free of charge by the Australian National Audit Office (ANAO) and are recorded at the fair value of resources received 2016-17: $8,000 (2015-16:$9,500). No other services were provided by the auditors of the financial statements.

Australian National Preventive Health Agency

Overview

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 2017.

Cash

Cash is recognised at its nominal amount. Cash and cash equivalents include:

a) cash on hand; and
b) cash in special accounts.

ANPHA no longer holds any cash independently, ANPHA closed all bank accounts prior to 30 June 2017, balances in these accounts were formally returned to the Official Public Account.

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.

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 2016-17 or in the comparative year 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')

	2017	2016
Authority	**$**	**$**
DEPARTMENTAL		
Appropriation Act (No.1) 2013-2014	**1,364,169**	1,364,867
Total departmental	**1,364,169**	1,364,867

Note 1.2: Special Accounts

Special Accounts (Recoverable GST exclusive)

	The Australian National Preventive Health Agency Special Account (Administered)[1,2,3]	
	2017	2016
	$	$
Balance brought forward from previous period	**12,382,827**	12,382,827
Available for payments	**12,382,827**	12,382,827
Total balance carried to the next period	**12,382,827**	12,382,827

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.

Australian National Preventive Health Agency

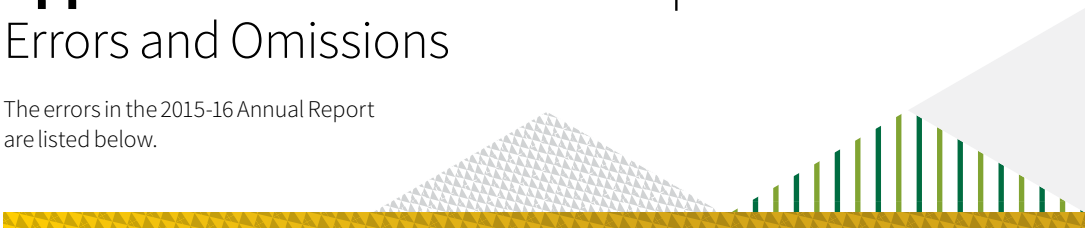
Notes to and forming part of the financial statements

Note 1.3: Cash Flow Reconciliation

	2017	2016
	$	$
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	**-**	17,626
Statement of financial position	**-**	17,626
Difference	**-**	-
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	**(698)**	(4,266)
Movement in assets / liabilities		
Assets		
(Increase) / decrease in net receivables	**-**	19,663
Liabilities		
Net cash from operating activities	**(698)**	15,397

Appendix 4: 2015-16 Annual Report – Errors and Omissions

The errors in the 2015-16 Annual Report are listed below.



Page 274 – Part 3.6 Work Health and Safety

The section under the heading *Health and Safety Outcomes (including the impact on injury rates of workers) achieved as a result of initiatives* incorrectly read:

> In 2013-14 there were 58 claims, … and there have been 23 accepted claims for 2015-16.

This data incorrectly reported all 2015-16 delegated decisions which included initial liability claims, secondary claims and accepted impairment matters.

The sentence should read:

> In 2015-16 a total of 8 claims were awarded a decision to accept initial liability.

Page 275 – Part 3.6 Work Health and Safety

The section under the heading *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* incorrectly read:

> 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.

This data incorrectly included one incident that was deemed not notifiable.

The sentence should read:

> During 2015-16 there were two dangerous incidents notified to Comcare with respect to the Departments statutory obligation under section 35 of the WHS Act. One was a laboratory fire and the second was the discovery of asbestos material.

Page 434 – Australian Digital Health Agency

The section under the heading *Financial Statement* in the 2016-17 Annual Report incorrectly read:

Statement of Comprehensive Income *for the period ended 30 June 2016*	Notes	2016 $'000

Statement of Financial Position *as at 30 June 2016*	Notes	2016 $'000

These table headings incorrectly included $'000.

The table headings under the Financial Statements section should read:

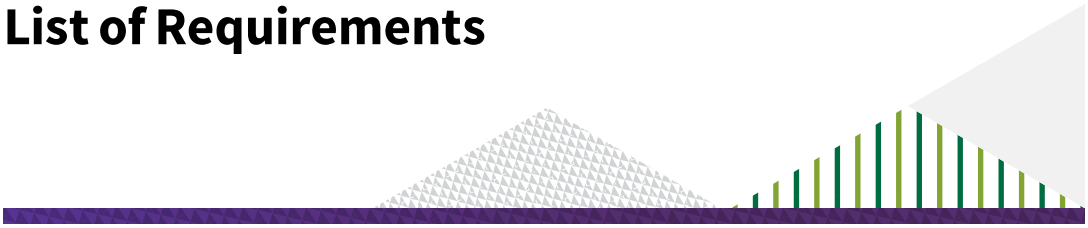
Statement of Comprehensive Income *for the period ended 30 June 2016*	Notes	2016 $

Statement of Financial Position *as at 30 June 2016*	Notes	2016 $


340
320
300
N
W

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 accountable authority on date final text approved, with statement that the report has been prepared in accordance with section 46 of the 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
17AJ(b)		Alphabetical index.	Mandatory	Page 372
17AJ(c)		Glossary of abbreviations and acronyms.	Mandatory	Page 365
17AJ(d)		List of requirements.	Mandatory	Page 360
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	Page 18
17AE(1)(a)(ii)		A description of the organisational structure of the entity.	Mandatory	Page 26
17AE(1)(a)(iii)		A description of the outcomes and programs administered by the entity.	Mandatory	Page 30
17AE(1)(a)(iv)		A description of the purposes of the entity as included in corporate plan.	Mandatory	Page 18
17AE(1)(b)		An outline of the structure of the portfolio of the entity.	Portfolio departments – mandatory	Page 19
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	Not applicable

PGPA Rule Reference	Part of Report	Description	Requirement	Location
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	Page 36
17AD(c)(ii)	***Report on Financial Performance***			Part 1
17AF(1)(a)		A discussion and analysis of the entity's financial performance.	Mandatory	Page 14 & Page 244
17AF(1)(b)		A table summarising the total resources and total payments of the entity.	Mandatory	Page 193
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 14
17AD(d)	**Management and Accountability**			
	Corporate Governance			Part 3.1
17AG(2)(a)		Information on compliance with section 10 (fraud systems)	Mandatory	Page 203
17AG(2)(b)(i)		A certification by accountable authority that fraud risk assessments and fraud control plans have been prepared.	Mandatory	Page 203
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 203
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 203
17AG(2)(c)		An outline of structures and processes in place for the entity to implement principles and objectives of corporate governance.	Mandatory	Page 198
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 3.4
17AG(3)		Information on the most significant developments in external scrutiny and the entity's response to the scrutiny.	Mandatory	Page 226
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	Page 230

PGPA Rule Reference	Part of Report	Description	Requirement	Location
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 3.4
17AG(3)(c)		Information on any capability reviews on the entity that were released during the period.	If applicable, Mandatory	Not applicable
	Management of Human Resources			Part 3.2
17AG(4)(a)		An assessment of the entity's effectiveness in managing and developing employees to achieve entity objectives.	Mandatory	Page 204
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	Page 206
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	Page 209
17AG(4)(c)(i)		Information on the number of SES and non-SES employees covered by agreements etc. identified in paragraph 17AD(4)(c).	Mandatory	Page 209
17AG(4)(c)(ii)		The salary ranges available for APS employees by classification level.	Mandatory	Page 213
17AG(4)(c)(iii)		A description of non-salary benefits provided to employees.	Mandatory	Page 212
17AG(4)(d)(i)		Information on the number of employees at each classification level who received performance pay.	If applicable, Mandatory	Page 209
17AG(4)(d)(ii)		Information on aggregate amounts of performance pay at each classification level.	If applicable, Mandatory	Page 209
17AG(4)(d)(iii)		Information on the average amount of performance payment, and range of such payments, at each classification level.	If applicable, Mandatory	Page 209
17AG(4)(d)(iv)		Information on aggregate amount of performance payments.	If applicable, Mandatory	Page 209
	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	Page 222
	Purchasing			Part 3.3
17AG(6)		An assessment of entity performance against the Commonwealth Procurement Rules.	Mandatory	Page 223

PGPA Rule Reference	Part of Report	Description	Requirement	Location
	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	Page 224
17AG(7)(b)		A statement that "*During 2016-17, 560 new consultancy contracts were entered into involving total actual expenditure of $99.3 million. In addition, 179 ongoing consultancy contracts were active during 2016-17 involving total actual expenditure of $32.9 million.*"	Mandatory	Page 224
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	Page 224
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	Page 224
	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	Page 225
	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	Page 225
	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	Page 223

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(10)(b)		An outline of the ways in which the procurement practices of the entity support small and medium enterprises.	Mandatory	Page 223
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 of Health 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	Page 223
	Financial Statements			Part 4
17AD(e)		Inclusion of the annual financial statements in accordance with subsection 43(4) of the Act.	Mandatory	Page 245
17AD(f)	**Other Mandatory Information**			
17AH(1)(a)(i)		If the entity conducted advertising campaigns, a statement that; '*During 2016-17, the Department of Health conducted the following advertising campaigns:* • Aged Care • BreastScreen Australia • *Girls Make Your Move* • Health Star Rating system • National Tobacco campaign *(Don't Make Smokes Your Story 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. Those reports are available on the Department of Finance's website www.finance.gov.au/advertising/*'	If applicable, Mandatory	Page 240
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 of Health during the period 1 July 2016 to 30 June 2017 is available at www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting*'	If applicable, Mandatory	Page 225
17AH(1)(c)		Outline of mechanisms of disability reporting, including reference to website for further information.	Mandatory	Page 233
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 230
17AH(1)(e)		Correction of material errors in previous annual report.	If applicable, Mandatory	Page 356
17AH(2)		Information required by other legislation.	Mandatory	Part 3.4, Appendices

Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAR	Aged Care Allocation Round
ACAT	Aged Care Assessment Team
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AMR	Antimicrobial Resistance
AMA	Australian Medical Association
ANFPP	Australian Nurse Family Partnership Program
ANPHA	Australian National Preventive Health Agency
APEC	Asia-Pacific Economic Cooperation
ASADA	Australian Sports Anti-Doping Authority
ASC	Australian Sports Commission
AUSMAT	Australian Medical Assistance Team
BBV	Blood Borne Virus(es)
BTF	Biomedical Translation Fund
CALD	Culturally and Linguistically Diverse
CGM	Continuous glucose monitoring
CMO	Chief Medical Officer
COAG	Council of Australian Governments
CSO	Community Service Obligations
DACS	Dementia and Aged Care Services
DBMAS	Dementia Behaviour Management Advisory Service
ESD	Ecologically Sustainable Development
GM	Genetically Modified
GMO(s)	Genetically Modified Organism(s)
GP(s)	General Practitioner(s)
HIV	Human Immunodeficiency Virus
IMAP	Inventory Multi-tiered Assessment and Prioritisation
IMD	Invasive meningococcal disease
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LSDP	Life Saving Drugs Program

MBS	Medicare Benefits Schedule
MIGA	Medical Insurance Group Australia
MRFF	Medical Research Future Fund
MSAC	Medical Services Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NCSP	National Cervical Screening Program
NDSHS	National Drug Strategy Household Survey
NDSS	National Diabetes Services Scheme
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NICNAS	National Industrial Chemicals Notification and Assessment Scheme
NIP	National Immunisation Program
NIS	National Immunisation Strategy
NMTAN	National Medical Training Advisory Network
NPA	National Partnership Agreement
NPEV	National Partnership Agreement on Essential Vaccines
NPS	National Prescribing Service
ODC	Office of Drug Control
OECD	Organisation for Economic Co-operation and Development
OGTR	Office of Gene Technology Regulator
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PHN(s)	Primary Health Network(s)
PIP	Practice Incentives Program
PNIP	Practice Nurse Incentive Program
RHOF	Rural Health Outreach Fund
ROHPG	Radiation Oncology Health Program Grants
RPGP	Rural General Practice Grants
SBRT	Severe Behaviour Response Team
SES	Senior Executive Service
STI	Sexually Transmissible Infection(s)
STRC	Short-Term Restorative Care
SUSMP	Standard for the Uniform Scheduling of Medicines and Poisons
TGA	Therapeutic Goods Administration
WADA	World Anti-Doping Authority
WHO	World Health Organization

Glossary

Aedes albopictus	Exotic mosquitoes that are carriers (vectors) of dengue, yellow fever, Zika and chikungunya.
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 (eg. 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.
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	A mosquito-borne viral infection.
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.
Digital Health	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. The Department provides access to clinically appropriate dressings through the National Epidermolysis Bullosa Dressing Scheme.
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 and their families 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 • 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.
Jurisdictions	In the Commonwealth of Australia, these include the six States, the Commonwealth Government 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).
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 (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.
Obesity	Marked degree of overweight, defined for population studies as a body mass index of 30 or over.
Oncology	The study, knowledge and treatment of cancer and tumours.
Organisation for Economic Co-operation and Development (OECD)	An organisation of 35 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 page 30.

Out-of-pocket costs	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, 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 2016-17, the Department had 28 specific programs (see page 30).

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 legs, 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.
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 (QUM)	QUM means: • selecting management options wisely • choosing suitable medicines if a medicine is considered necessary, • using medicines safely and effectively. The definition of QUM 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.
Vaccination	The process of administering a vaccine to a person to produce immunity against infection. See **immunisation**.
World Health Organization (WHO)	The World Health Organization is a specialised agency of the United Nations (UN). 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