Audit report of the 2024–25 annual performance statements

Department of Health, Disability and Ageing

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT on the 2024-25 Annual Performance Statements of the Department of Health, Disability and Ageing

To the Minister for Finance

Qualified Conclusion

In my opinion, except for the possible effects of the matters described in the Bases for Qualified Conclusion section of my report, the 2024-25 Annual Performance Statements of the Department of Health, Disability and Ageing (DHDA):

- present fairly DHDA's performance in achieving its purpose for the year ended 30 June 2025; and
- are prepared, in all material respects, in accordance with the requirements of Division 3 of Part 2-3 of the *Public Governance, Performance and Accountability Act 2013* (the PGPA Act).

Audit criteria

To assess whether DHDA's annual performance statements complied with Division 3 of Part 2-3 of the PGPA Act, I applied the following criteria as to whether the:

- entity's key activities, performance measures and specified targets are appropriate to measure and assess the entity's performance in achieving its purposes.
- performance statements are prepared based upon appropriate records that properly record and explain the entity's performance; and
- annual performance statements present fairly the entity's performance in achieving the entity's purposes in the reporting period.

Bases for Qualified Conclusion

Limitation of Scope - Outcome 3 'Ageing and Aged Care'

The purpose of Outcome 3, 'Ageing and Aged Care' is 'Improved wellbeing for older Australians through targeted support, access to appropriate, high-quality care, and related information services.' Outcome 3 comprises three programs as follows:

- Program 3.1 – Access and Information
- Program 3.2 – Aged Care Services
- Program 3.3 – Aged Care Quality

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The data supporting the performance measures listed below is provided by external parties. DHDA was unable to demonstrate how it gains assurance over the reliability and verifiability of the data used to report results for the measures listed below. As a result, I have been unable to perform procedures to obtain sufficient appropriate audit evidence to determine whether the results for the following performance measures and targets are accurately reported:

- Performance measure 3.1A (a) and (b)
- Performance measure 3.1B (a), (b) and (c)
- Performance measure 3.2B (b) and (c)
- Performance measure 3.2C (a) and (b)
- Performance measure 3.2D (b)
- Performance measure 3.3A (c)

As the number of measures affected by the limitations and their scope encompass a significant proportion of the reported results for Outcome 3, I have been unable to conclude whether the performance statements present fairly DHDA's performance in achieving its purposes in relation to Outcome 3 'Ageing and Aged Care'.

Limitation of Scope - Performance measure 1.2A: 'Increasing access to Primary Health Network (PHN)-commissioned mental health services', and Performance measure 1.2C: 'Enhancing the national network of headspace youth services'.

Performance Measures 1.2A and 1.2C rely on reporting from external parties. DHDA was unable to demonstrate how it gains assurance over the reliability and verifiability of the data used to report results. As a result, I have been unable to perform procedures to obtain sufficient appropriate audit evidence to conclude whether the reported results present fairly DHDA's performance for these two measures.

Emphasis of Matter – Key Changes for 2024-25

I draw attention to DHDA's disclosure of changes to its performance measures and targets from those that were originally set out in DHDA's 2024–25 Corporate Plan and 2024–25 Portfolio Budget Statements and the Department of Social Services' 2024-25 Corporate Plan under the heading *key changes for 2024-25*.

My conclusion is not modified in respect of this matter.

Accountable Authority's responsibilities

As the Accountable Authority of DHDA, the Secretary is responsible under the PGPA Act for:

- the preparation of annual performance statements that accurately present DHDA's performance in the reporting period and comply with the requirements of the PGPA Act and any requirements prescribed by the *Public Governance, Performance and Accountability Rule 2014* (the Rule).
- keeping records about DHDA's performance as required by the PGPA Act, and
- establishing internal controls that the Accountable Authority determines are appropriate to enable the preparation of annual performance statements.

Auditor's responsibilities for the audit of the performance statements

My responsibility is to conduct a reasonable assurance engagement to express an independent opinion on DHDA's annual performance statements.

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which include the relevant Standard on Assurance Engagements (ASAE) 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Auditing and Assurance Standards Board.

Procedures were planned and performed to obtain reasonable assurance about whether the annual performance statements of the entity present fairly the entity's performance in achieving its purposes and comply, in all material respects, with the PGPA Act and Rule.

The nature, timing and extent of audit procedures depend on my judgment, including the assessment of the risks of material misstatement, whether due to fraud or error, in the annual performance statements. In making these risk assessments, I obtain an understanding of internal controls relevant to the preparation of the annual performance statements to design procedures that are appropriate in the circumstances.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my qualified conclusion.

Independence and quality control

I have complied with the independence and other relevant ethical requirements relating to assurance engagements and applied Auditing Standard ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements* in undertaking this assurance engagement.

Inherent limitations

Because of the inherent limitations of an assurance engagement, it is possible that fraud, error or non-compliance may occur and not be detected. An assurance engagement is not designed to detect all instances of non-compliance of the annual performance statements with the PGPA Act and the Rule as it is not performed continuously throughout the period and the assurance procedures performed are undertaken on a test basis. The reasonable assurance conclusion expressed in this report has been formed on the above basis.

Australian National Audit Office

Rona Mellor PSM
Deputy Auditor-General
Delegate of the Auditor-General

Canberra
15 October 2025

Appendix A – Referencing for Measures in the Outcome 3 Ageing and Aged Care

In preparing the Bases for Qualified Conclusion, I have referred to the following performance measures.

Key Activities	Performance Measure	Target
Outcome description: Improved wellbeing for older Australians through targeted support, access to appropriate, high-quality care, and related information services.		
Program 3.1: Access and Information Program Objective My Aged Care provides older people and their support networks with reliable and trusted information about aged care services. It provides timely and appropriate assessments aligned to needs and goals, appropriate referrals and equitable access to aged care services. Navigation services support vulnerable people who are not able to access aged care without this help.		
Facilitate access to aged care services	3.1A Older people and their support networks have access to reliable and trusted information through My Aged Care.	a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care website ≤65%
		b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre >95%
	3.1B Older people are assessed for service need.	a. Home Support assessments completed within the allocated priority timeframes (≥90%) i. high priority: 10 calendar days ii. medium priority: 14 calendar days iii. low priority: 21 calendar days
		b. Comprehensive Community-based assessments completed within the allocated priority timeframes (≥90%) i. high priority: 10 calendar days ii. medium priority: 20 calendar days iii. low priority: 40 calendar days

Key Activities	Performance Measure	Target
		c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥90%) i. high priority: 5 calendar days ii. medium priority: 10 calendar days iii. low priority: 15 calendar days
Program 3.2: Aged Care Services Program Objective Provide a range of flexible aged care programs for older people who require assistance including support at home, residential care and respite care for those who need it. Provide individualised aged care services that are aligned to needs and goals and help older people live meaningful lives and sustain connections with community.		
Support older people to live active, self-determined and meaningful lives.	3.2B Older people receive residential care services that contribute to their quality of life.	b. Maintain a sector-wide average of 200 minutes of care per resident per day, including 40 minutes of direct care by a registered nurse (RN) per day.
		c. All non-exempt residential aged care facilities of approved providers have at least one RN on-site and on duty 24 hours a day, 7 days a week.
	3.2C Older people with diverse backgrounds and life experiences or who live in rural and remote areas can receive culturally safe and equitable aged care services where they live.	a. Older people who are (self-identified as) First Nations peoples are receiving aged care services at rates comparable with their representation in Australian population estimates: Target 3.5%
		b. Older people in rural and remote areas are receiving aged care services at rates comparable with their representation in Australian population estimates: Target 11.2%
	3.2D Older people receive care and support at home that contributes to quality of life.	b. Number of clients that accessed Commonwealth Home Support Program

Key Activities	Performance Measure	Target
		Services. Target: 840,000
Program 3.3: Aged Care Quality Program Objective Older people receive safe and high-quality services which are free from discrimination, mistreatment and neglect through regulatory activities, collaboration with the aged care sector. Provide support to the aged care sector through targeted awareness and capacity building activities to ensure standards of care are upheld.		
Enable safe and high-quality aged care	3.3A Aged care workforce is available and appropriately skilled to deliver safe and high-quality care to older people.	c. Establish baseline for worker satisfaction through the biennial Aged Carae Worker Survey.

Part 2: Annual Performance Statements

Part 2.1: 2024–25 Annual Performance Statements

Statement of preparation

I, Blair Comley, as the accountable authority of the Department of Health, Disability and Ageing (the department), present the 2024–25 Annual Performance Statements for the department, as required under paragraphs 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and section 16F of the Public Governance, Performance and Accountability Rule 2014. In my opinion, these Annual Performance Statements are based on properly maintained records, accurately present the entity's performance in the reporting period and comply with subsection 39(2) of the PGPA Act.

The Australian National Audit Office (ANAO) is currently undertaking an audit of the department's 2024–25 Annual Performance Statements. I am aware the ANAO has formed the view that the Annual Performance Statements for components of certain measures do not fully meet the requirements of the PGPA Act. The department remains committed to ongoing improvement and will continue to enhance its performance reporting to the public and the Parliament.

Blair Comley PSM

Secretary

25 September 2025

Introduction

As required under the PGPA Act, this report contains the Department of Health, Disability and Ageing's Annual Performance Statements for 2024–25. The Annual Performance Statements detail results achieved against planned performance criteria set out in the 2024–25 Health and Aged Care Portfolio and 2024–25 Social Services Portfolio Budget Statements, and the Department of Health and Aged Care and Department of Social Services 2024–25 Corporate Plans.

Structure of the Annual Performance Statements

The Annual Performance Statements demonstrate the 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 focusing on the objectives of an outcome and addressing the associated performance criteria. Each chapter contains:

- narrative on program work
- an analysis of the department's performance by program
- results and discussion against each performance criteria.

Materiality, as a core principle, guides and justifies how/why the department's key activities have corresponding performance measures to assess each program and the process for selecting them. The department's performance reporting materiality policy is based on the following criteria for determining material key activities:

- funding levels
- public and stakeholder interest
- impact on health, disability and ageing.

The measurement and assessment of the key activities and performance measures as outlined in our 2024–25 Corporate Plan are aligned to our 2024–25 Annual Performance Statements. To enable a comparative analysis, the department has included prior year results back to the 2022–23 financial year where the performance information is consistent across the years.

Results Key

● **Achieved**
The result achieved the planned performance for 2024–25.

◗ **Substantially achieved**
Substantially achieved results are applied to measures which comprise of a number of sub-targets, these are aggregated, and each sub-target is weighted equally in determining the overall result.

○ **Not achieved**
The result did not achieve the planned performance for 2024–25. Where planned performance comprises of a number of sub-targets, these are aggregated, and each sub-target is weighted equally in determining the overall result.

— **Data not available**
Data is not yet available to report for the 2024–25 financial year.

2024–25 departmental results overview

	Summary of results against performance criteria			
Outcome	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**
Outcome 1: Health Policy, Access and Support	12	2	7	1
Outcome 2: Individual Health Benefits	5	-	2	-
Outcome 3: Ageing and Aged Care	2	2	3	-
Outcome 4: Disability and Carers	5	1	1	1
Total	**24**	**5**	**13**	**2**

In 2024–25, out of the total of 44 planned performance targets 24 were achieved, 5 were substantially achieved, 13 were not achieved and 2 did not have data available. Further information on the contributing factors to the results is discussed under each performance measure throughout **Part 2: Annual Performance Statements** in this Annual Report.

Where a Program has confirmed caveats and/or limitations around data utilised to report the result, a disclosure has been included in the Statements respectively. Out of the 44 planned performance targets, a total of 26 have disclosures.

Key changes for 2024–25

A summary of key changes to performance information following the publication of the 2024–25 Health and Aged Care Portfolio Budget Statements and 2024–25 Corporate Plan, and the Department of Social Services 2024–25 Corporate Plan is provided below:[4]

Measure number/ Program	Summary
1.2A – Mental Health	The data source **Numerator** and **Denominator** were updated to reflect the date the data was extracted. The methodology was updated to include: 1. **Numerator**: Reporting financial year service data, rather than a lagged reference period of 1 April to 31 March. 2. **Denominator**: Using the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December 2024 (the mid-point of the financial year), instead of the lagged 30 June 2024 ERP.
1.2B – Mental Health	The Performance Measure was updated to reflect *Patients using* Medicare-subsidised mental health services per 100,000 population. This update better reflects the proportion of the population who are receiving mental health support through the Medicare Benefits Schedule (MBS). The data source **Numerator** and **Denominator** were updated to reflect the date the data was extracted. The methodology was updated to include: 1. **Numerator**: Reporting the number of patients who received Medicare-subsidised mental health care services, rather than the number of services used. 2. **Denominator**: Using the ABS ERP as at 31 December 2024 (the mid-point of the financial year), instead of the lagged 30 June 2024 ERP.
1.2C – Mental Health	The data source was updated to reflect headspace Application Platform Interface (hAPI) data for the **Numerator**. The data source **Denominator** was updated to reflect the date the data was extracted. The methodology was updated to include: 1. **Numerator**: Reporting financial year service data, rather than a lagged reference period of 1 April to 31 March. The financial year data is directly sourced from headspace National and the Primary Mental Health Care Minimum Data Set is no longer used. 2. **Denominator**: Using the ABS ERP as at 31 December 2024 (the mid-point of the financial year), instead of lagged 30 June 2024 ERP.
1.2E – Mental Health	The 2024–25 planned performance target was updated to confirm the design phase relates to the National Suicide Prevention Outcomes Framework.

[4] The Department of Finance Resource Management Guide 134 – Annual Performance Statements for Commonwealth entities confirms if performance information, such as performance measures, targets, data sources and methodologies, differ between their Portfolio Budget Statements and from those set out in the Corporate Plan, entities should explain these changes in the Annual Performance Statements.

Measure number/ Program	Summary
1.3A & B – First Nations Health	The Program Objective for Program 1.3 has been updated to incorporate the inclusion of a new performance measure – 1.3B. The Key Activity for 1.3A has been revised in alignment with the updated Program Objective. The data source and methodology has been updated for 1.3A to further enhance detail around the methodology.
1.4A – Health Workforce	The data source has been revised for measure e. to confirm the sources that inform this measure.
1.5A – Preventive Health and Chronic Disease Support	The data source for measure a. has been revised in 2024–25 to the Household, Income and Labour Dynamics in Australia (HILDA) survey (Daily smoking prevalence reported through HILDA among adults aged ≥18 years) to support annual data availability.
1.5B – Preventive Health and Chronic Disease Support	The data source and methodology were updated to refine the National Bowel Cancer Screening Program and the National Cervical Screening Program screening results process.
1.5C – Preventive Health and Chronic Disease Support	The data source and methodology were updated for planned performance a., b. and c. to note the updates to physical measurements resuming since the COVID-19 pandemic.
1.6B – Primary Health Care Quality and Coordination	The 2024–25 Corporate Plan included an error in the planned performance target reported for 1.6B (1,393,795). The correct planned performance target for 1.6B in 2024–25 is 1,107,913.
1.8A – Health Protection, Emergency Response and Regulation	The planned performance target for 2024–25 was updated from 98% to 100%. The methodology was updated to include a reference to the *Therapeutic Goods Act 1989*.
2.5A – Dental Services	The methodology was updated to confirm the measure reports the total number of eligible notified children.
3.2D – Aged Care Services	The 2024–25 planned performance for target 'a' was updated from 299,700 to 305,897, following funding allocated during the 2024–25 Mid-Year Economic and Fiscal Outlook to release additional Home Care Packages in 2024–25.
4.2A – National Disability Insurance Scheme	The methodology was updated to reflect full scheme agreements in place with all states and territories.
4.2D - National Disability Insurance Scheme	The data source was updated for the 'Legislative amendments developed for government' measure that inform the measure.

Outcome 1: Health Policy, Access and Support

Better equip Australia to meet current and future health needs of all Australians through the delivery of evidence-based health policies; improved access to comprehensive and coordinated health care; ensuring sustainable funding for health services, research and technologies; and protecting the health and safety of the Australian community.

Programs contributing to Outcome 1

	Summary of results against performance criteria			
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**
Program 1.1: Health Research, Coordination and Access	1	-	-	-
Program 1.2: Mental Health	4	-	1	-
Program 1.3: First Nations Health	2	-	-	-
Program 1.4: Health Workforce	-	1	-	-
Program 1.5: Preventive Health and Chronic Disease Support	-	1	2	-
Program 1.6: Primary Health Care Quality and Coordination	2	-	1	-
Program 1.7: Primary Care Practice Incentives and Medical Indemnity	-	-	1	1
Program 1.8: Health Protection, Emergency Response and Regulation	3	-	1	-
Program 1.9: Immunisation	-	-	1	-
Total	**12**	**2**	**7**	**1**

Program 1.1: Health Research, Coordination and Access

Program Objective

Collaborate with state and territory governments, the broader health care sector and engage internationally to improve access to high-quality, comprehensive and coordinated health care to support better health outcomes for all Australians through nationally consistent approaches, sustainable public hospital funding, digital health, supporting health infrastructure, international standards and best practice, and improve the health and wellbeing of Australians through health and medical research.

The Medical Research Future Fund (MRFF) was established in 2015 by the Australian Government through the *Medical Research Future Fund Act 2015 (Cth)* (MRFF Act). The MRFF aims to transform health and medical research and innovation to improve lives, build the economy and contribute to health system sustainability. The MRFF is now a $24 billion[5] long-term investment supporting Australian health and medical research and innovation. Under the MRFF 3rd 10-year Investment Plan[6], the Australian Government is committing $650 million per year for up to 22 health and medical research initiatives.

Measuring the impact of the MRFF is essential in understanding whether the MRFF is meeting its stated objective. Translation of research findings into health policy and practice is a key measure of success for the MRFF, and it is important to understand factors, methods and models that promote the uptake of new evidence from research. In September 2024, the department conducted a series of roundtable discussions to seek expert views on how the MRFF can better conduct prospective evaluation among researchers and better support implementation of research into health policy, practice and systems. Experts gave broad support to:

(a) large-scale collaborative partnerships that can achieve systems change; and (b) smaller-scale projects for translating evidence into practice at the hospital/single local health district level.[7] The department will consider these findings to facilitate more effective translation and impact of MRFF funded research.

Publicly available reports on other work undertaken in 2024–25 include:

- Review of the Medical Research Future Fund Cardiovascular Health Mission.[8]
- Medical Research Future Fund Report on gender data for grant opportunities.[9]
- Medical Research Future Fund Report on Chief Investigator data.[10]

[5] As at 31 March 2025, under the MRFF 3rd 10-year Investment Plan.
[6] Available at: **www.health.gov.au/resources/publications/mrff-3rd-10-year-investment-plan-2024-25-to-2033-34**
[7] Consultation report available at: **www.health.gov.au/resources/publications/mrff-supporting-evaluation-and-implementation-research-through-the-medical-research-future-fund-consultation-report**
[8] Available at: **www.health.gov.au/resources/publications/review-of-the-medical-research-future-fund-cardiovascular-health-mission**.
[9] Available at: **www.health.gov.au/resources/publications/medical-research-future-fund-report-on-gender-data-for-grant- opportunities-december-2024**
[10] Available at: **www.health.gov.au/resources/publications/medical-research-future-fund-report-on-chief-investigator-data**

The MRFF Act stipulates requirements that ensure the financial assistance provided by the Australian Government is enhancing health and medical research funding. In 2024–25 the department supported the Australian Medical Research Advisory Board[11] to update the *Australian Medical Research and Innovation Priorities* (the Priorities). The Priorities are required to be updated every 2 years to guide MRFF funding decisions. A summary of the consultation findings and the A*ustralian Medical Research and Innovation Priorities for 2024 to 2026* are published on the department's website.[12]

The department has continued to lead collaboration with states and territories on long-term health reform. The department leads administration of the Addendum to the National Health Reform Agreement 2020–25[13] (NHRA) to improve health and wellbeing for all Australians.

During 2024–25, the department also provided advice and engaged with states and territories, portfolio agencies and other stakeholders to support government consideration of the NHRA beyond 2024–25. On 5 February 2025, the Australian Government announced it would deliver an additional $1.8 billion to states and territories to fund public hospital and health services in 2025–26. The Australian Government's total funding contribution to states and territories for public health and hospital services is estimated to be $33.91 billion in 2025–26. This is an increase of 12% from 2024–25 and includes the extra one-off funding boost.

The National Efficient Price Determination determines the contribution the Australian Government makes for public hospital services under the NHRA. It includes a mechanism for pricing on safety and quality, which provides a financial incentive for public hospitals to reduce the number of avoidable readmissions that were caused by substandard patient care. There are similar financial incentives for public hospitals to reduce the number of hospital-acquired complications.

Both the rates of hospital-acquired complications and avoidable readmissions have shown general decreases, year-on-year, from when they were introduced into pricing. Where rates of hospital-acquired complications and avoidable readmissions increase, a financial penalty is applied to deter future increases of substandard patient care. For 2023–24, both hospital-acquired complications and avoidable readmissions incurred penalties. Nationally, hospital-acquired complications resulted in a $11.96 million downwards adjustment and avoidable readmissions resulted in a $13.27 million downwards adjustment.

A range of performance information for hospitals is reported at the local, state and national level by the Australian Institute of Health and Welfare.[14]

The Australian Government is committed to a safe, secure, adequate and affordable supply of blood and blood products for all Australians. The National Blood Authority (NBA), a statutory agency within the portfolio, manages arrangements for the national supply of blood products and services in accordance with the *National Blood Authority Act 2003*. The department provides funding to the NBA to deliver an uninterrupted national supply of blood and blood products that meet clinical demand. This is measured by identified metrics in the NBA Annual Reports. The funding provided by the department is complemented by funding from states and territory governments.

[11] Available at: **www.health.gov.au/committees-and-groups/mrff-australian-medical-research-advisory-board-amrab**
[12] Available at: **www.health.gov.au/resources/publications/australian-medical-research-and-innovation-priorities-2024-2026**
[13] Available at: **www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra**
[14] Available at: **www.aihw.gov.au/hospitals**

Key Activity 1.1A:

Fund health and medical research through the Medical Research Future Fund (MRFF) that addresses the health priorities of all Australians.

Source: *Health and Aged Care Corporate Plan 2024–25, p.28*

Performance Measure 1.1A:

MRFF funds are disbursed towards grants of financial assistance to support research that addresses the Australian Medical Research and Innovation Priorities.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.58 and Health and Aged Care Corporate Plan 2024–25, p.28*

2024–25 Planned Performance	2024–25 Result
a. Disburse at least 99% of MRFF funds available in 2024–25 towards grants of financial assistance. b. 100% of grants awarded in 2024–25 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.	a. As at 30 June 2025, the program has disbursed 100% of MRFF funds available in 2024–25 towards grants of financial assistance. b. As at 30 June 2025, 100% of grants awarded in 2024–25 address one or more of the Australian Medical Research and Innovation Priorities in force.[15]
	Result: Achieved ●

Data Source and Methodology:

For both targets, the source data are held by the grant hubs for the MRFF (National Health and Medical Research Council (NHMRC) and Business Grants Hub (BGH)) within their online grants management systems and provided directly to the department.

For target a, the data used for reporting are the sum of expenses for the MRFF under Priority 4 (MRFF Health Special Account) in the relevant financial year and the available budget for the MRFF under Priority 4 in the relevant financial year.

For target b, the data used for reporting are the applications for funding submitted to NHMRC and BGH by researchers. These applications describe the health priorities that will be addressed by the research should they be successful in obtaining funding.

[15] The 2024–26 Priorities were effective on 6 November 2024, midway through the 2024–25 reporting period. MRFF grant opportunities concluding before publication of the 2024–25 Priorities were indexed against the 2022–24 Priorities, previously in force.

The legislated purpose of the MRFF is to provide grants of financial assistance to support research that contributes to improving the health and wellbeing of all Australians. To achieve this, the *Medical Research Future Fund Act 2015* (MRFF Act) requires that funding decisions take into account the *Australian Medical Research and Innovation Priorities* (the Priorities).[16] The Priorities are informed by national consultation and are publicly available. This performance measure demonstrates the extent to which the department has met its legislated requirements under the MRFF Act. Under the MRFF 3rd 10-year Investment Plan[17] (which commenced from 2024–25), the Australian Government allocated up to $650 million annually to health and medical research and medical innovation funding.

The results demonstrate that the MRFF is meeting its intended purpose of supporting health and medical research and innovation. MRFF funding is primarily disbursed through open competitive grant opportunities to ensure the integrity of the research design, quality and safety for patients, and best return on government investment. Grant opportunities are designed and developed in consultation with a range of stakeholders, including consumers to ensure that they address the Priorities. In 2024–25 the department delivered 24 Grant Opportunities[18] covering each theme under the MRFF 3rd 10-year Investment Plan. Grant opportunity guidelines and the forecast calendar[19] are published on GrantConnect[20] and on the department's website[21], to provide potential applicants with advance notice of opportunities.

Grant opportunities can lead to:

- a single research project being funded (results in a single grant agreement)
- a program of activities (2 or more projects) being funded within a topic area (results in multiple grant agreements).

The NHMRC[22] and the BGH[23] provide services for the conduct and administration of MRFF grant opportunities. This includes management of grants, as agreed and discussed jointly with the department. In 2024–25, the department continued to work collaboratively with the grant hubs to successfully deliver all grant opportunities as planned.

The department will continue to work with stakeholders to improve alignment and co-ordination with the NHMRC's Medical Research Endowment Account[24] through the joint NHMRC-MRFF committees.[25] A National Health and Medical Research Strategy is under development and will provide national direction to build on Australia's strengths in the health and medical research sector.

Consistent with the 2023–24 result, the department has succeeded in meeting the planned performance targets. The department fully disbursed funding allocation for the patient, research missions, researchers and research translation themes under the government's 10-year Investment plan. Grants awarded will continue to support lifesaving research, create jobs, strengthen the local industry base for commercialising research and innovation, and further grow Australia's reputation as a world leader in medical research. Results of the first MRFF performance indicator survey provide additional evidence of MRFF impact over the last 10 years.[26]

[16] Available at **www.health.gov.au/our-work/mrff/about/strategy-and-priorities**
[17] Available at: **www.health.gov.au/our-work/mrff/about/10-year-investment-plan**
[18] Available at: **www.health.gov.au/our-work/mrff/grant-opportunities-calendar**
[19] Ibid.
[20] Available at: **www.grants.gov.au**
[21] Available at: **www.health.gov.au/our-work/mrff/grant-opportunities-calendar**
[22] Available at: **www.nhmrc.gov.au**
[23] Available at: **www.industry.gov.au/government-government/business-grants-hub**
[24] Further information is available at: **www.transparency.gov.au/publications/health/national-health-and-medical-research-council-nhmrc/annual-report-2022-23/part-1%3A-overview/research-funding-and-expenditure**
[25] Available at: **www.nhmrc.gov.au/about-us/leadership-and-governance/committees**
[26] Available at **www.health.gov.au/resources/publications/results-of-the-medical-research-future-fund-performance-indicator-survey-december-2024**

Program 1.2: Mental Health

Program Objective

Improve the mental health and wellbeing of all Australians, including a focus on suicide prevention.

The department has continued to deliver on the program's key performance targets and implementation of national mental health reforms. During 2024–25, the department progressed the development of critical system infrastructure and services including:

- implementing the National Mental Health and Suicide Prevention Agreement (National Agreement)[27] and associated bilateral schedules.[28] Key priorities include:
  - establishing Joint Health and Mental Health Ministers meetings to drive national mental health and suicide prevention reforms. The June 2025 meeting also included representations from the sector and lived experience peak bodies
  - prioritising joint actions on child and youth mental health, cross-border information sharing, and growing the clinical and peer workforces.
- delivering the National Suicide Prevention Strategy 2025–2035 in February 2025.[29]
- continuing to grow the national network of Medicare Mental Health Centres and Kids Hubs, and headspace services with states and territories. The 2025 Federal Election commitment for mental health will see this be an ongoing implementation priority for the foreseeable future.
- progressing mental health and suicide prevention reforms announced as part of the 2024–25 Federal Budget including:
  - $588.5 million over 8 years and $113.4 million ongoing for the introduction of a new National Early Intervention Service providing free, safe and high-quality therapy and resources
  - $29.9 million over 4 years for an enhanced national network of 61 Medicare Mental Health Centres which will offer free walk-in access to psychologists and psychiatrists
  - $29.7 million over 3 years to extend the headspace Early Career Program and co-designing new fit for purpose models of care for young Australians
  - $71.7 million over 4 years funding Primary Health Networks (PHNs) to work with general practices to offer multidisciplinary services in primary care settings for people with severe and complex needs.

The National Mental Health Commission (NMHC) and the National Suicide Prevention Office (NSPO), together referred to as 'the Commission', was transferred into the Department of Health, Disability and Ageing as a non-statutory office on 1 October 2024. As a result of this transfer, the department's 2024–25 Portfolio Additional Estimates Statements confirmed the Commission's performance measures for 2024–25 (as stated in their Corporate Plan) will be reported on as departmental performance measures under Program 1.2: Mental Health, in the department's 2024–25 Annual Performance Statements.

The NMHC, incorporating the NSPO, continues to seek to increase accountability and transparency in mental health and wellbeing, and suicide prevention, through monitoring and reporting on investment in mental health and suicide prevention, and the provision of policy advice to the Australian Government. The NMHC's key monitoring and reporting mechanisms include the annual National Report Card which assesses the performance of Australia's mental health system, and annual national reports assessing progress against the National Agreement. The NSPO is a specialist office established within the Commission to lead the adoption of a national whole-of-governments approach to suicide prevention. In 2024–25 the NSPO finalised and launched the National Suicide Prevention Strategy 2025–2035 and is continuing to develop a national outcomes framework for suicide prevention.

[27] Available at: **www.federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement**
[28] Ibid.
[29] Available at: **www.mentalhealthcommission.gov.au/national-suicide-prevention-strategy**

Key Activity 1.2A:

Increasing access to Primary Health Network (PHN)-commissioned mental health services.[30]

Source: *Health and Aged Care Corporate Plan 2024–25, p.30*

Performance Measure 1.2A:

PHN-commissioned mental health services used per 100,000 population.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.60 and Health and Aged Care Corporate Plan 2024–25, p.30*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
Annual increase from 2023–24.	6,660 PHN-commissioned mental health services used per 100,000 population.	6,531 PHN-commissioned mental health services used per 100,000 population.[31]	6,503 PHN-commissioned mental health services used per 100,000 population.[32]
	Result: Achieved ●		

Disclosures:

Data caveats (all results)

The department does not obtain assurance over reporting for this measure. Results for this measure should be interpreted with caution as there are limitations within the underlying data. Performance is dependent on the demand and availability of services. Mental health service utilisation is predominantly demand-driven and shaped by a range of external factors, including population needs and broader social determinants. These include the prevalence of mental ill health in the community and environmental and economic factors, emergencies, and the prevalence of domestic and international tragedies. Service access may also be impacted by workforce availability and capability. Service use is measured by the number of service contacts.

2024–25 Result:

The methodology for this measure has been updated from that used in the 2023–24 Annual Report, the 2024–25 Portfolio Budget Statements, and the 2024–25 Corporate Plan.

For the 2024–25 Annual Report, 2 key changes have been made:

1. **Numerator**: Now reporting financial year service data, rather than a lagged reference period of 1 April to 31 March.
2. **Denominator**: Now using the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December 2024 (the mid-point of the financial year), instead of the lagged 30 June 2024 ERP.

These changes were made to align the data reference period with the financial year report scope and use the most up-to-date ERP related to the reporting period.

As a result, the 2024–25 Annual Report reflects improved data quality and methodology compared to previous reports. To ensure consistency across the 3-year time series, the 2023–24 and 2022–23 results presented in this report have been revised from those published in the 2023–24 Annual Report. Without these revisions, there would be a break in the time series, making the results non-comparable across years. It is important to note that the 2023–24 and 2022–23 data published in the 2023–24 Annual Report are not comparable to the data in this report.

[30] The 1.2A and 1.2C key activities seek an increase in the rate of services used as a measure of access. This reflects the policy position to facilitate the provision of services. As a result, the population rate measure reported is for services used. The data reported for 1.2A and 1.2C is consistent with the respective key activity that is being measured. In contrast, the key activity for 1.2B seeks an increase in the number of people accessing services. As a result, the population measure reported is for people using the service type (i.e. Medicare-subsidised mental health services), not the number of services. As detailed in the Disclosures, the use of patient data to report the 1.2B key activity measure is an improvement in the 2024–25 Annual Report to align the data reported with the key activity planned performance. No change was required to the data reported for 1.2A and 1.2C because the data reporting of services used is already aligned with the key activity based on services.

[31] The 2023–24 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2023–24 result was 6,436 PHN-commissioned mental health services used per 100,000 population.

[32] The 2022–23 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2022–23 result was 6,487 PHN-commissioned mental health services used per 100,000 population.

All results for the 3-year time series were calculated on 31 July 2025, based on PHN-commissioned mental health services data extracted from the department's Primary Mental Health Care Minimum Data Set (PMHC MDS) on that date. The extraction date is significant, as the PMHC MDS is updated daily as service contacts are entered or amended by PHNs or Service Providers.

These ongoing updates are expected and do not indicate a data quality issue. Rather, they reflect the nature of administrative datasets, where data quality improves over time as earlier data entry issues are corrected. The most recent snapshot of the data set therefore represents the highest quality data available.

2023–24 Result:

The 2023–24 result was revised for the 2024–25 Annual Report so it is consistent across the 3-year time series reported. If the 2023–24 data was not revised, there would be a break in time series and the data would not be comparable over time. The 2023–24 data reported in the 2023–24 Annual Report is not comparable to this report and could not be used to assess whether performance for this measure was met in 2024–25. The 2024–25 Annual Report change to this measure is reporting 2023–24 financial year service data (for the numerator), rather than a lagged reference period of 1 April to 31 March, and 31 December 2023 ABS ERP, rather than lagged 30 June 2023 ERP.

Revised numerator data to calculate the revised 2023–24 result was extracted from the PMHC MDS on 31 July 2025. The PMHC MDS is an administrative data set that changes daily.

Revised denominator data to calculate the revised 2023–24 result was extracted from the ABS' 19 June 2025 publication of the Australian ERP for 31 December 2023. The revisions to the PMHC MDS numerator and ABS ERP denominator used to calculate the 2023–24 result (and therefore whether the measure is met in 2024–25) ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

2022–23 Result:

The 2022–23 result was revised for the 2024–25 Annual Report so it is consistent across the 3-year time series reported. If the 2022–23 data was not revised, there would be a break in time series and the data would not be comparable over time. The 2024–25 Annual Report change to this measure is reporting 2022–23 financial year service data (for the numerator), rather than a lagged reference period of 1 April to 31 March, and 31 December 2022 ABS ERP, rather than lagged 30 June 2022 ERP.

Revised numerator data to calculate the revised 2022–23 result was extracted from the PMHC MDS on 31 July 2025. The PMHC MDS is an administrative data set that changes daily.

Revised denominator data to calculate the revised 2022–23 result was extracted from the ABS' 19 June 2025 publication of the Australian ERP for 31 December 2022. The revisions to the PMHC MDS numerator and ABS ERP denominator used to calculate the 2022–23 result ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

Data Source and Methodology

Data sources:

- **Numerator**: Administrative data. The PMHC MDS provides the basis for PHNs and the department to monitor and report on service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government. The PMHC MDS data item used to calculate the 2024–25 result was extracted on 31 July 2025.
- **Denominator**: The ERP is calculated by the ABS.

ERP is the official measure of the population of states and territories of Australia according to a usual residence population concept. The ABS ERP used to calculate the 2024–25 result is 31 December 2024 ERP as published by the ABS on 19 June 2025.[33]

Methodology:

100,000 x (Numerator ÷ Denominator)

- **Numerator**: Total number of service contacts within the financial year for all PHN-commissioned mental health services.
- **Denominator**: National total ABS ERP as at 31 December.

[33] Available at: **www.abs.gov.au/statistics/people/population/national-state-and-territory-population/dec-2024**

The Australian Government funds PHNs to conduct regional planning and commissioning of mental health and suicide prevention services. This includes services across the stepped care continuum for people with, or at risk of, mental ill health and suicidality. To ensure these services are appropriate for their communities, commissioning decisions are informed by comprehensive regional needs assessments. The needs assessment process provides PHNs with the opportunity to engage with local communities and consumers, Local Hospital Networks (or equivalents) and other key planning and funding agencies to ensure alignment of effort and investment. This approach encourages tailored solutions that meet local needs and address community priorities.

The performance measure provides a high-level indication of PHN-commissioned mental health services accessed across Australia. The 2024–25 performance result indicates an increase in access to PHN-commissioned mental health services, compared to 2023–24.

As part of the ongoing improvement in service commissioning PHNs performance is monitored through the PHN Program Performance and Quality Framework.[34] As data is received from PHNs the department identifies potential areas for improvement and works with the PHN to support activities to realise these improvements. This includes ensuring PHN activities are guided by key priorities set by the Australian Government, which can be found at: **www.health.gov.au/our-work/phn/how-we-support-PHNs#key-priorities**

Additional information on PHNs Program Performance for 2021–22 delivered under the PHN Program Performance and Quality Framework can be found at: **www.health.gov.au/resources/publications/primary-health-network-program-annual-performance-report-2021-22**. This is the latest annual performance report available.

A collection of audits providing independent advice on the PHNs compliance with its financial and performance obligations can be found at: **www.health.gov.au/resources/collections/performance-and-financial- management-review-of-the-primary-health-network**

Annual reports and other documentation including needs assessments for individual PHNs can be found on each PHN's website. A list of all PHNs can be found at: **www.health.gov.au/our-work/phn/your-local-PHN**

[34] Available at: **www.health.gov.au/resources/publications/primary-health-networks-phn-performance-and-quality-framework**

Key Activity 1.2B:

Increasing the number of people accessing Medicare-subsidised mental health services.[35]

Source: *Health and Aged Care Corporate Plan 2024–25, p.31*

Performance Measure 1.2B:

Patients using Medicare-subsidised mental health services per 100,000 population.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.61 and Health and Aged Care Corporate Plan 2024–25, p.31*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
Annual increase from 2023–24.	10,259 patients used Medicare-subsidised mental health services per 100,000 population.	10,175 patients used Medicare-subsidised mental health services per 100,000 population.[36]	10,414 patients used Medicare-subsidised mental health services per 100,000 population.[37]
	Result: Achieved ●		

Disclosures:

Data caveats (all results)

Results for this measure should be interpreted with caution. Variations in patient levels could be due to variations in access but could also be a result of differences in the prevalence of mental ill health. It also does not provide information on whether the services are appropriate for the needs of the people receiving them or correctly targeted to those most in need. This measure is also affected by availability of the workforce to deliver services and service provider gap payments. Patient counts include patients who have had at least one Medicare Benefits Schedule (MBS) mental-health service claim during the financial year. This data relates only to services claimed under specified mental health care MBS item numbers. Therefore, the reported number of patients used in the measure is unlikely to represent all patients who receive mental health care as it is unclear how many people receive GP mental health-related care that is billed as a consultation against, for example, a general MBS item number for a short consultation.

2024–25 Result:

Changes to measure wording and methodology

The wording and methodology for this measure have been updated from those used in the 2023–24 Annual Report, the 2024–25 Portfolio Budget Statements, and the 2024–25 Corporate Plan.

For the 2024–25 Annual Report, 2 key changes have been made:

1. **Numerator**: Now reporting the number of patients who received Medicare-subsidised mental health care services, rather than the number of services used. As per the 2023–24 Annual Report, numerator data is financial year.
2. **Denominator**: Now using the ABS ERP as at 31 December 2024 (the mid-point of the financial year), instead of the lagged 30 June 2024 ERP.

These changes were implemented to more directly report the key activity and use the most up-to-date ERP related to the reporting period. As a result, the 2024–25 Annual Report reflects improved data quality and methodology compared to previous reports. To ensure consistency across the 3-year time series, the 2023–24 and 2022–23 results in this report have been revised from those published in the 2023–24 Annual Report. Without these revisions, there would be a break in the time series and the data would not be comparable over time. It is important to note that the 2023–24 and 2022–23 data published in the 2023–24 Annual Report is not comparable to the data in this report.

[35] The 1.2A and 1.2C key activities seek an increase in the rate of services used as a measure of access. This reflects the policy position to facilitate the provision of services. As a result, the population rate measure reported is for services used. The data reported for 1.2A and 1.2C is consistent with the respective key activity that is being measured. In contrast, the key activity for 1.2B seeks an increase in the number of people accessing services. As a result, the population measure reported is for people using the service type (i.e. Medicare-subsidised mental health services), not the number of services. As detailed in the Disclosures, the use of patient data to report the 1.2B key activity measure is an improvement in the 2024–25 Annual Report to align the data reported with the key activity planned performance. No change was required to the data reported for 1.2A and 1.2C because the data reporting of services used is already aligned with the key activity based on services.

[36] The 2023–24 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2023–24 result was 47,357 Medicare-subsidised mental health services used per 100,000 population.

[37] The 2022–23 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2022–23 result was 50,341 Medicare-subsidised mental health services used per 100,000 population.

2023–24 Result:

The 2023–24 result was revised for the 2024–25 Annual Report, so it is consistent across the 3-year time series reported. If the 2023–24 data was not revised, there would be a break in time series and the data would not be comparable over time. The 2023–24 data reported in the 2023–24 Annual Report is not comparable to this report and could not be used to assess whether performance for this measure was met in 2024–25.

The 2024–25 Annual Report change to this measure is reporting 2023–24 data on patients for the numerator (rather than services used), and 31 December 2023 ABS ERP, rather than lagged 30 June 2022 ERP.

Revised numerator data to calculate the revised 2023–24 result was extracted from the MBS Enterprise Data Warehouse (EDW) on 17 July 2025.

Revised denominator data to calculate the revised 2023–24 result was extracted from the ABS' 19 June 2025 publication of the Australian ERP for 31 December 2023.

The revisions to the MBS EDW numerator and ABS ERP denominator used to calculate the 2023–24 result ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

2022–23 Result:

The 2022–23 result was revised for the 2024–25 Annual Report so it is consistent across the 3-year time series reported. If the 2022–23 data was not revised, there would be a break in time series and the data would not be comparable over time. The 2024–25 Annual Report change to this measure is reporting 2022–23 data on patients for the numerator (rather than services used), and 31 December 2022 ABS ERP, rather than lagged 30 June 2022 ERP.

Revised numerator data to calculate the revised 2022–23 result was extracted from the MBS EDW on 17 July 2025.

Revised denominator data to calculate the revised 2022–23 result was extracted from the ABS' 19 June 2025 publication of the Australian ERP for 31 December 2022.

The revisions to the numerator and ABS ERP denominator used to calculate the 2022–23 result ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

Data Source and Methodology:

Data sources:

- **Numerator**: Administrative data. Patient numbers are extracted from Medicare claims data held in the department's EDW. The MBS data used to calculate the 2024–25 result in this report was extracted on 17 July 2025.
- **Denominator**: The ERP is calculated by the ABS.

ERP is the official measure of the population of states and territories of Australia according to a usual residence population concept. The ABS ERP used to calculate the 2024–25 results in this report is 31 December 2024 ERP as published by the ABS on 19 June 2025.[38]

Methodology:

100,000 x (Numerator ÷ Denominator)

- **Numerator**: Number of patients accessing MBS-subsidised mental health services each financial year.
- **Denominator**: National total ABS ERP as at 31 December.

[38] Available at: **www.abs.gov.au/statistics/people/population/national-state-and-territory-population/dec-2024**

Medicare-subsidised mental health services accessed through the MBS are provided on a demand-driven basis. Demand for mental health services is influenced by the prevalence of mental ill health in the community as well as environmental and economic factors, emergencies and the prevalence of domestic and international tragedies. Service access may also be impacted by workforce availability and capability. Performance is dependent on the demand and availability of services.

Patients utilising Medicare mental health services in 2024–25 has increased slightly from 2023–24, with data indicating that activity levels are stabilising from their peak during the COVID-19 pandemic. This is consistent with broader trends in Medicare service use.

The COVID-19 pandemic and associated public health measures had a significant impact on the mental health of the community, with demand for services substantially increasing for Medicare and other community mental health services. While patient levels appear to be stabilising, they remain above pre-COVID-19 levels.

The Australian Government's commitment to strengthening Medicare will continue to have benefits across the mental health and suicide prevention system by increasing access and equity to care for all Australians. The government is continuing to expand the range and reach of free mental health supports, including through the establishment of the National Early Intervention Service, a nationwide network of Medicare Mental Health Centres, headspace and PHN supports. Continued investment in the mental health workforce, such as addressing acute bottlenecks in the psychology training pipeline and upskilling the broader health workforce on mental health will also improve access to care. It is anticipated that the broader trend for increased GP service volumes in 2024–25 compared to 2023–24 (1.9% increase)[39] may have led to improved performance against the measure in 2024–25. Measuring an increase in patients using services is a proxy measure for increased access as service use can change for various reasons; therefore, it is not possible to draw hard conclusions about year-on-year trends.

[39] Calculated using Total GP Non-Referred Attendances data in the Medicare Annual Statistics – State and territory (2009–10 to 2024–25) dataset: **www.health.gov.au/resources/collections/medicare-statistics-collection**

Key Activity 1.2C:

Enhancing the national network of headspace youth services.[40]

Source: *Health and Aged Care Corporate Plan 2024–25, p.32*

Performance Measure 1.2C:

Number of headspace services delivered per 100,000 population of 12 to 25 year olds.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.61 and Health and Aged Care Corporate Plan 2024–25, p.32*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
Annual increase from 2023–24.	12,538 headspace services were delivered per 100,000 population of 12 to 25 year olds.	10,744 headspace services were delivered per 100,000 population of 12 to 25 year olds.[41]	9,450 headspace services were delivered per 100,000 population of 12 to 25 year olds.[42]
	Result: Achieved ●		

Disclosures:

Data caveats (all results)

The department does not obtain assurance over reporting for this measure. Results should be interpreted with caution as performance is dependent on the demand and availability of services. Mental health service utilisation is predominantly demand-driven and shaped by a range of external factors, including population needs and broader social determinants. These include the prevalence of mental ill health in the community and environmental and economic factors, emergencies, and the prevalence of domestic and international tragedies. Service access may also be impacted by workforce availability and capability.

headspace data includes service use of headspace centres and the headspace Work and Study in Centres program. Service use is measured by the number of occasions of service. New categories of service activity data capture were introduced from October 2023 (Indirect and Engagement Occasions of Service) impacting the headspace service data.

[40] The 1.2A and 1.2C key activities seek an increase in the rate of services used as a measure of access. This reflects the policy position to facilitate the provision of services. As a result, the population rate measure reported is for services used. The data reported for 1.2A and 1.2C is consistent with the respective key activity that is being measured. In contrast, the key activity for 1.2B seeks an increase in the number of people accessing services. As a result, the population measure reported is for people using the service type (i.e. Medicare-subsidised mental health services), not the number of services. As detailed in the Disclosures, the use of patient data to report the 1.2B key activity measure is an improvement in the 2024–25 Annual Report to align the data reported with the key activity planned performance. No change was required to the data reported for 1.2A and 1.2C because the data reporting of services used is already aligned with the key activity based on services.

[41] The 2023–24 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2023–24 result was 8,285 headspace services delivered per 100,000 population of 12 to 25 year olds.

[42] The 2022–23 result has been revised for the 2024–25 Annual Report. See the Disclosures for more details. In the 2023–24 Annual Report, the 2022–23 result was 7,600 headspace services delivered per 100,000 population of 12 to 25 year olds.

2024–25 Result:

Changes to Methodology

The methodology for this measure has been updated from that used in the 2023–24 Annual Report, the 2024–25 Portfolio Budget Statements, and the 2024–25 Corporate Plan.

For the 2024–25 Annual Report, 2 key changes have been made:

1. **Numerator**: Now reporting financial year service data, rather than a lagged reference period of 1 April to 31 March. The financial year data is directly sourced from headspace National and the PMHC MDS is no longer used. 2024–25 data was provided to the department on 29 July 2025.
2. **Denominator**: Now using the ABS ERP as at 31 December 2024 (the mid-point of the financial year), instead of lagged 30 June 2024 ERP.

These changes were made to align the data reference period with the financial year report scope and use the most up-to-date ERP related to the reporting period.

As a result, the 2024–25 Annual Report reflects improved data quality and methodology compared to previous reports. To ensure consistency across the 3-year time series, the 2023–24 and 2022–23 results presented in this report have been revised from those published in the 2023–24 Annual Report. Without these revisions, there would be a break in the time series and the data would not be comparable over time.

It is important to note that the 2023–24 and 2022–23 data published in the 2023–24 Annual Report is not comparable to the data in this report.

headspace data used as the numerator for this performance measure aligns with data reported by headspace National in its annual reports.

2023–24 Result:

The 2023–24 result was revised for the 2024–25 Annual Report so it is consistent across the 3-year time series reported. Without revising the 2023–24 data, there would be a break in time series, and the data would not be comparable over time. The 2023–24 data reported in the 2023–24 Annual Report is not comparable to this report and could not be used to assess whether performance for this measure was met in 2024–25.

The 2024–25 Annual Report change to this measure is reporting 2023–24 financial year service data (for the numerator), rather than a lagged reference period of 1 April to 31 March, and 31 December 2023 ABS ERP, rather than lagged 30 June 2022 ERP.

Revised numerator data to calculate the revised 2023–24 result was provided to the department from headspace National on 9 July 2025. The 2023–24 numerator data used in this report is consistent with the 2023–24 data published by headspace National in its annual reports.

Revised denominator data to calculate the revised 2023–24 result was extracted from the ABS' Data Explorer on 9 July 2025 for 12 to 25-year-old ERP for 31 December 2023.

The revisions to the headspace numerator and ABS ERP denominator used to calculate the 2023–24 result ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

2022–23 Result:

The 2022–23 result was revised for the 2024–25 Annual Report so it is consistent across the 3-year time series reported. If the 2022–23 data was not revised, there would be a break in time series and the data would not be comparable over time.

The 2024–25 Annual Report change to this measure is reporting 2022–23 financial year service data (for the numerator), rather than a lagged reference period of 1 April to 31 March, and 31 December 2022 ABS ERP, rather than lagged 30 June 2022 ERP.

Revised numerator data to calculate the revised 2022–23 result was provided to the department from headspace National on 9 July 2025. The 2023–24 numerator data used in this report is consistent with the 2023–24 data published by headspace National in its annual reports.

Revised denominator data to calculate the revised 2022–23 result was extracted from the ABS' Data Explorer on 9 July 2025 for 12 to 25-year-old ERP for 31 December 2022.

The revisions to the headspace numerator and ABS ERP denominator used to calculate the 2022–23 result ensures that the most accurate data is used in the 2024–25 Annual Report and the data can be compared over the 3-year time series reported.

Data Source and Methodology:

Data sources:

- **Numerator**: Aggregated administrative data. The headspace Application Platform Interface (hAPI) is a data collection system used by headspace to collect data from their clinicians and young people. hAPI is used daily by patients and service staff to track the young person's progress and outcomes. headspace National provides hAPI data to the Department of Health, Disability and Ageing to monitor and report on service delivery, and to inform future improvements in the planning and funding of headspace services funded by the Australian Government. 2024–25 data was provided to the department on 29 July 2025.
- **Denominator**: The ERP is calculated by the ABS.

ERP is the official measure of the population of states and territories of Australia according to a usual residence population concept. The 2024–25 result is calculated using 31 December 2024 ERP for 12 to 25 year olds as published by the ABS.[43]

Methodology:

100,000 × (Numerator ÷ Denominator)

- **Numerator**: Number of headspace occasions of service for 12 to 25 year olds (inclusive) within the financial year.
- **Denominator**: National 12 to 25 year old (inclusive) ABS ERP as at 31 December.

[43] Available at: **Stat Data Explorer (BETA) • Quarterly Population Estimates (ERP), by State/Territory, Sex and Age)**

The planned performance result indicates that in 2024–25 more headspace services were delivered compared to 2023–24, with a steady increase occurring over time.

headspace[44] is the primary national platform for provision of services to young people aged 12 to 25 years who are experiencing, or at risk of, mild to moderate mental ill health. The Australian Government established 10 new headspace services during 2024–25. As at 30 June 2025, there were 172 headspace services operating nationally, including 94 headspace services located across regional Australia (RA2-RA5).[45] headspace centres and satellites have variable opening hours across the network to ensure they meet demand.

The government also funds eheadspace,[46] a national online and phone-based mental health support service for young people aged 12 to 25 years, and for families seeking support on how to help a young person in their life. In 2024–25, these services were available from 9:00am – 1:00am Australian Eastern Standard Time, 7 days a week.

The government has provided additional funding since 2022–23 to enhance the headspace network, in recognition of pressure points across the network, to increase capacity and/or access to headspace services.

An increase in the number of services used per 100,000 people indicates that service capacity and access is improving. headspace is a service young Australians know and trust. In 2023–24, 86% of young people reported being satisfied with headspace and 90% of young people would recommend headspace.[47]

Key Activity 1.2D:

Increase transparency and accountability by:

- monitoring the impact of all government's policies and investments in the mental health and suicide prevention system;
- impartially reporting on performance of the mental health and suicide prevention system, and the progress of reforms, to improve mental health, wellbeing and suicide prevention outcomes; and
- providing evidence-based mental health and suicide prevention advice to the Government to develop and promote national approaches to system improvement and investment.

Source: *National Mental Health Commission Corporate Plan 2024–25, p.6*

Performance Measure 1.2D:

The Annual National Report Card is published annually by the end of June.

Source: *National Mental Health Commission Corporate Plan 2024–25, p.6 and Health and Aged Care Portfolio Additional Estimates Statements 2024–25, p.46*

2024–25 Planned Performance	2024–25 Result
National Report Card published by 30 June 2025.	The National Report Card 2024 was published on the National Mental Health Commission's (NMHC) website on 24 July 2025.
	Result: Not achieved ○

Data Source and Methodology:

Date of release.

[44] Further information is available at: **www.headspace.org.au/**

[45] The ASGS-RA divides Australia into 5 classes of remoteness: **www.health.gov.au/topics/rural-health-workforce/classifications/asgs-ra**

[46] Further information on eheadspace can be found at: **www.health.gov.au/contacts/eheadspace**

[47] Available at: **headspace.org.au/assets/headspace-Annual-Infographic_2024.pdf**, accessed on 16 September 2025.

The National Report Card 2024 was approved by the Chief Executive Officer of the NMHC on 27 June 2025 and published on the Commission's website on 24 July 2025.[48]

An Annual National Report Card on the performance of the mental health system has been a core function of the NMHC since its establishment in 2012. From 2023 the National Report Card has focused on key data related to mental health and has included a consistent set of core indicators of system performance.[49]

The National Report Card 2024 builds on the foundations and knowledge of the National Report Card 2023 and reflects the 2024 calendar year. The National Report Card 2024 details how the core indicators are tracking and provides updates on these core indicators where new data is available. New data was not available for a significant proportion of core indicators from the primary source identified in Report Card 2023 due to the frequency in which data is collected. To provide a contemporary and holistic national view, in addition to including data updates against the primary data sources, the National Report Card 2024:

- draws together new data from supplementary data sources that assess the same or similar dimensions of the core indicators
- presents a more detailed view for particular community groups, including those living in regional or remote areas and First Nations people.

The National Report Card has been developed in close collaboration with data custodians, including the Australian Bureau of Statistics and the AIHW.

The National Report Card outlines the NMHC's intention to continue to build an understanding of the data landscape and opportunities to expand the framework. The NMHC will engage with government, lived experience representatives and the sector to identify the elements of system performance that are most critical for monitoring and reporting at a national level.

<table>
<tr><td colspan="2">Key Activity 1.2E:
Deliver the National Suicide Prevention Strategy to the Government and develop a National Suicide Prevention Outcomes Framework.
Source: National Mental Health Commission Corporate Plan 2024–25, p.6</td></tr>
<tr><td colspan="2">Performance Measure 1.2E:
Development of the National Suicide Prevention Outcomes Framework.
Source: National Mental Health Commission Corporate Plan 2024–25, p.6 and Health and Aged Care Portfolio Additional Estimates Statements 2024–25, p.47</td></tr>
<tr><td>2024–25 Planned Performance</td><td>2024–25 Result</td></tr>
<tr><td rowspan="2">Design phase of the National Suicide Prevention Outcomes Framework to be completed 30 June 2025.[50]</td><td>The National Suicide Prevention Strategy was endorsed and released by government on 20 February 2025.
A development paper defining the planned approach to the National Suicide Prevention Outcomes Framework was published on 26 September 2024, which concluded the design phase of the Framework.
Consultation to develop components of the National Suicide Prevention Outcomes Framework commenced on 16 July 2024 and remains ongoing as at 30 June 2025.</td></tr>
<tr><td>Result: Achieved ●</td></tr>
<tr><td colspan="2">Data Source and Methodology:
Date of release.</td></tr>
</table>

[48] Available at: **www.mentalhealthcommission.gov.au/publications/national-report-card-2024**

[49] National Report Card 2023 is available at: **www.mentalhealthcommission.gov.au/publications/national-report-card-2023**

[50] The 2024–25 National Mental Health Commission Corporate Plan planned performance target was 'design phase to be completed 30 June 2025'. The target has been updated to confirm the design phase relates to the National Suicide Prevention Outcomes Framework.

The NSPO delivered the National Suicide Prevention Strategy (the Strategy)[51] to the Australian Government during 2024–25. The Strategy was endorsed for release by all states and territories, and all relevant Commonwealth Government portfolios, before being formally launched on 20 February 2025. The NSPO engaged in extensive consultation across governments, the sector and people with lived and living experience of suicide throughout the Strategy's development, which contributed to endorsement by governments, as well as strong levels of support upon its release.

The design phase for the National Suicide Prevention Outcomes Framework (Outcomes Framework) was achieved with the publication of a development paper defining the planned approach on 26 September 2024,[52] prior to the NSPO being moved into the Department of Health, Disability and Ageing as part of the NMHC division. Since this point, the NSPO has focused on the development of the Outcomes Framework through procurement of technical expertise and consultation activities.

The prevalence of suicide in Australia continues to be a priority public health issue. Increasing public and political understanding of the links between social determinants and suicide contributed to significant support for the delivery of a comprehensive National Suicide Prevention Strategy containing recommended actions for different levels and parts of government.

The release of the National Suicide Prevention Strategy and the release of the Final Report of the Royal Commission into Defence and Veterans Suicide[53] has contributed to increased interest in the work of the NSPO and the direction of suicide prevention reform efforts more broadly. This has translated into a high-level of engagement in the development of the Outcomes Framework, which has positively contributed to engagement on its development.

[51] Available at: **www.mentalhealthcommission.gov.au/sites/default/files/2025-02/the-national-suicide-prevention-strategy.pdf**

[52] Available at: **www.mentalhealthcommission.gov.au/development-national-suicide-prevention-outcomes-framework#development-of-the-national-suicide-prevention-outcomes-framework**

[53] Available at: **defenceveteransuicide.royalcommission.gov.au/publications/final-report**, accessed on 16 September 2025.

Program 1.3: First Nations Health

Program Objective

Drive improved health outcomes for First Nations peoples through access to First Nations-led, culturally appropriate health care.

First Nations peoples continue to experience disproportionate negative health outcomes and barriers to accessing culturally appropriate health care. The Indigenous Australians' Health Programme[54] seeks to address this inequity through targeted investment in First Nations-led, culturally appropriate health care. This is done by prioritising and investing in the community-controlled health sector for the delivery of healthcare programs and services.

In alignment with Priority Reform 2 of the National Agreement on Closing the Gap (National Agreement),[55] the majority of Program 1.3 funding is directed to Aboriginal Community-Controlled Health Organisations (ACCHOs).[56] This recognises that ACCHOs are controlled by the community that they operate in and deliver a holistic model of care. ACCHOs facilitate the delivery of culturally appropriate, self-determined health care that is specifically tailored to the needs of individual communities. All Australian governments have committed to building a strong community-controlled sector through the National Agreement.

Increasing access to comprehensive, holistic health care through targeted initiatives that support early intervention, prevention and chronic disease management. Targeted health initiatives supplement investment in the broader health system in areas where a dedicated approach is required to address significant health inequities between First Nations and non-Indigenous peoples. This is central to delivering on the objectives of the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Health Plan).[57] This work also contributes to Targets 1 (life expectancy) and 2 (healthy birthweight) of the National Agreement.

The Program's objective is based on the 4 National Agreement Priority Reforms[58] and the goals of the Health Plan. These were developed in partnership with and agreed to by the First Nations sector, federal and state and territory governments. They outline how to drive change and improve health outcomes for First Nations peoples and identify access to culturally appropriate health care as critical to improving health outcomes for First Nations peoples.

[54] Available at: **www.health.gov.au/our-work/indigenous-australians-health-programme**
[55] Available at: **www.closingthegap.gov.au/national-agreement**
[56] Available at: **www.naccho.org.au/aboriginal-community-controlled-health/**
[57] Available at: **www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031**
[58] Available at: **www.closingthegap.gov.au/national-agreement/priority-reforms**

Key Activity 1.3A:

First Nations Community Controlled Health Care.

Support *Aboriginal Community-Controlled Health Organisations (ACCHOs) to deliver primary health care services and community driven health initiatives.*

Performance Measure 1.3A:

Increase the percentage of annual Indigenous Australians' Health Programme (IAHP) funding directed to ACCHOs.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.63 and Health and Aged Care Corporate Plan 2024–25, p.33*

2024–25 Planned Performance	2024–25 Result	2023–24
72%	76%	73%
	Result: Achieved ●	

Disclosures:

For the 2024–25 reporting period, the department's quality assurance process identified 3 funded health services previously classified as non-ACCHO in 2023–24 financial year that were classified as ACCHOs in 2024–25. The reasons for reclassification include an ACCHO newly self-reported or joined NACCHO during the reporting period. Inclusion of these 3 services represents less than a 1% increase in funding to ACCHOs as part of the 2024–25 result.

Data Source and Methodology:

Financial data is drawn from the department's Administered Reporting Information by Program (ARIP) financial reporting system. Actual expenditure is reported – calculated after the end of the financial year once actual expenditure is finalised within the department's financial systems. Raw data is not publicly available.

The department refers to the National Agreement on Closing the Gap definition of an ACCHO.[59]

In line with this definition, the department follows a quality assurance process each year to ascertain funding directed to ACCHOs.

Planned performance was forecasted in line with the ongoing commitment to transition, where appropriate, services delivered through non-indigenous organisations to ACCHOs. This includes work being undertaken as part of the department's First Nations Health Funding Transition Program.[60]

During 2024–25, under the Northern Territory Pathways to Community Control Program, one primary health care clinic managed by NT Health was successfully transitioned to community control.

In June 2024, the Australian Government announced 4-year rolling funding agreements for ACCHOs primary health care increasing funding to ACCHOs and providing greater funding certainty for the sector from 1 July 2024.[61]

The 2024–25 performance result could be attributed to the increase in ACCHOs primary health care funding through the 4-year rolling funding agreements and successful transitions to community controlled. This resulted in an increase of IAHP funding redirected to ACCHOs.

[59] Available at: **www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap/6-priority-reform-areas/two**

[60] Available at: **www.health.gov.au/our-work/first-nations-health-funding-transition-program-fnhftp**

[61] Further information can be found at: **www.health.gov.au/ministers/the-hon-mark-butler-mp/media/certainty-in-first-nations-community-healthcare-to-help-close-the-gap**

Key Activity 1.3B:

Targeted health initiatives.

Support access to comprehensive, holistic health care that targets:

- Chronic disease management.
- Health promotion, early intervention and prevention.
- Child and maternal health.

Performance Measure 1.3B:

Increase the percentage of First Nations people attending Indigenous Australians' Health Programme (IAHP) funded services who undertake a 715 health check.[62]

2024–25 Planned Performance	2024–25 Result
47%	47.9%
	Result: Achieved ●

Disclosures:

The result utilises 94% Clinical Information System reported data, with the remaining 6% of data reported manually into the Health Data Portal. Manually reported 715 health assessment data is proving to be of comparable quality to automated data once it has passed Health Data Portal validation and AIHW review.

Data Source and Methodology:

Data Source:

Health Data Portal – data for First Nations people. Source data is provided by health services through clinical information systems.

Methodology:

The result is calculated using:

Numerator: Number of regular clients that have received a 715 health check.

Denominator: Number of regular clients attending IAHP services. Data will be reported on by calendar year.

[62] Aboriginal and Torres Strait Islander peoples of all ages can get a free 715 health check annually at Aboriginal Medical Services and bulk-billing clinics. The 715 health check helps to identify whether someone is at risk of illnesses or chronic conditions. Further information can be found at: **www.health.gov.au/news/715-health-check**

Performance measure 1.3B contributes to Closing the Gap Targets 1 and 2. Target 1 (Close the Gap in life expectancy within a generation, by 2031) is showing improvement but is not on track to be met.[63] Target 2 (By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%) is showing improvement but is not on track to be met.[64]

An annual 715 health check can make a real difference in keeping people healthy and strong, through assisting with both preventative and treatment services. The health check helps identify whether someone is at risk of illnesses or chronic conditions.[65]

In September 2024, the Australian Government announced the expansion of the Deadly Choices[66] program delivered by the Institute of Urban Indigenous Health (IUIH) in Queensland, Australia. The Deadly Choices program promotes uptake of 715 health checks, aiming to increase the number of First Nations peoples undertaking a comprehensive health assessment at least once a year. Promotion of the Deadly Choices program may have contributed to a positive impact on the number of 715 health checks undertaken in 2024. The program encourages First Nations peoples to access local health services.

Prior to the expansion of the Deadly Choices program there had been a drop in the proportion of First Nations people attending IAHP funded services undertaking a 715 health check over the past 5 years. This is likely due to the impacts of COVID-19. However, since 2022 rates have shown a consistent upwards trend and in 2024 surpassed pre-COVID-19 levels by 1.1%:

- 2020 - 46.8%
- 2021 - 45.2%
- 2022 - 40.7%
- 2023 - 43.4%
- 2024 - 47.9%.

[63] Further information can be found at: **www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area1**
[64] Further information can be found at: **www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area2**
[65] Further information on chronic conditions can be found at: **www.health.gov.au/topics/chronic-conditions**
[66] Further information can be found at: **www.health.gov.au/ministers/the-hon-mark-butler-mp/media/government-backs-deadly-choices-preventative-health-program**

Program 1.4: Health Workforce

Program Objective

Ensure Australia has the workforce necessary to improve the health and wellbeing of all Australians. Improve the quality, distribution and planning of the Australian health workforce to better meet the needs of the community and deliver a sustainable, well distributed health workforce.

In 2024–25, the department continued to strengthen Australia's health workforce, delivering $1.846 billion[67] in program funding through Program 1.4: Health Workforce. This investment supported a broad range of initiatives designed to ensure health professionals are well-equipped, well-distributed, and responsive to the needs of communities across Australia.

Central to this work was a commitment to building a health workforce that better supports the health needs of the community. The department continued to support medical training, from university education through to specialist qualification, with a strong emphasis on primary care and rural placements. These efforts are helping to ensure that Australians have access to high-quality care that assists with the prevention and management of chronic illness. Increasing capacity for people to receive care in the community can minimise the development of serious health issues that require hospital treatment. This supports the health system to operate more efficiently.

During 2024–25, the department improved and expanded programs to encourage health professionals to work in rural and regional areas. This responds to the persistent challenges of health workforce maldistribution across Australia. A range of incentives, scholarships and innovative models of care were implemented to attract and retain health practitioners in rural and regional communities. These included the Australian General Practice Training (AGPT) Program, the Rural Generalist Training Scheme (RGTS), the Remote Vocational Training Scheme (RVTS), and the Bonded Medical Program, which support the training and placement of doctors in underserved areas.

The department also promoted the development of multidisciplinary primary care teams, reflecting a shift towards more integrated and collaborative models of care. Programs such as the Nursing in Primary Health Care Program and the National Nurse Clinical Placement Program contributed to this shift by supporting team-based care and expanding clinical training opportunities in primary care teams. Additional initiatives, including the Primary Care Nursing and Midwifery Scholarship Program, the Training and Professional Support for the Remote Health Workforce Program, and the Workforce Incentive Program (WIP) – Practice Stream, provided financial and professional support to enhance workforce sustainability.

These initiatives were guided by national workforce strategies and supply and demand modelling. To inform future policy, the department released the final reports of 4 major reviews in October and November 2024.[68] These reviews, which focused on general practice incentives, after-hours care, distribution levers, and scope of practice offered detailed recommendations to strengthen primary care and better utilise the full capabilities of the health workforce. In response to these reviews, the department established a dedicated taskforce to engage with stakeholders and develop advice for government on an integrated reform agenda. The taskforce will also take account of the findings of the Independent Review of Complexity of the National Registration and Accreditation Scheme,[69] undertaken during 2024–25 to address community concerns about the effectiveness of the health regulatory system.

Through these coordinated efforts, the department is laying the foundation for a more resilient, responsive and equitable health workforce; one that is prepared to meet the needs of Australians now and into the future.

[67] Figure as at 7 August 2025.

[68] Further information on the 4 primary care and workforce reviews can be found at: **www.health.gov.au/committees-and-groups/primary-care-and-workforce-reviews-taskforce#reports**

[69] Further information on the Independent Review of Complexity of the National Registration and Accreditation Scheme can be found at: **www.health.gov.au/our-work/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme**

Key Activities 1.4A:

- Implementing workforce programs to improve the health and wellbeing of all Australians.
- Supporting the health workforce across Australia, including in primary care, aged care and regional, rural and remote areas, through training programs, scholarships, incentive programs, and trials of innovative models of care and employment approaches.
- Improving distribution of the health workforce through improved incentives for primary care doctors, nurses and allied health professionals including through reforms to the Workforce Incentive Program.

Source: *Health and Aged Care Corporate Plan 2024–25, p.34*

Performance Measure 1.4A:

Effective investment in workforce programs will improve health workforce distribution in Australia.

a. Full time equivalent (FTE) Primary Care General Practitioners (GPs) per 100,000 population.[70]
b. FTE non-general practice medical specialists per 100,000 population.[71]
c. FTE primary and community nurses per 100,000 population.[72]
d. FTE primary and community allied health practitioners per 100,000 population.[73]
e. Proportion of GP training undertaken in areas outside major cities.[74]

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.65 and Health and Aged Care Corporate Plan 2024–25, p.35*

2024–25 Planned Performance		**2024–25 Result**		**2023–24**		**2022–23**	
MM1[75]	**MM2-7**	**MM1**	**MM2-7**	**MM1**	**MM2-7**	**MM1**	**MM2-7**
a. 115.6	a. 110.6	a. 112.2	a. 105.7	a. 116.6	a. 104.9	a. 125.0	a. 125.0
b. 196.6	b. 100.6	b. 198.6	b. 91.4	b. 198.4	b. 87.9	b. 193.2	b. 88.6
c. 191.5	c. 232.8	c. 230.4	c. 263.6	c. 233.0	c. 267.5	c. 220.3	c. 252.6
d. 445.9	d. 421.5	d. 483.0	d. 410.7	d. 480.6	d. 403.6	d. 456.1	d. 388.8
e. N/A[76]	e. >50%	e. N/A	e. 55.3%	e. N/A	e. 53.6%	e. N/A	e. 50.8%
		Result: Substantially achieved ◗					

[70] Medicare Benefits Scheme claims data (based on date of service).
[71] National Health Workforce Datasets (NHWDS), Medical Practitioners.
[72] NHWDS, Nurses and Midwives.
[73] NHWDS, Allied Health.
[74] Australian General Practice Training Program data and Rural Vocational Training Scheme data.
[75] Geography: Cities (MM1) and rural (MM2–7) based on Modified Monash Model 2019. Further information is available at: **www.health.gov.au/topics/rural-health-workforce/classifications/mmm**
[76] Planned performance is not applicable for MM1 e. as the geography for MM1 is Cities, and the measure is for training undertaken in areas outside of major cities.

Disclosures:

2024–25 Result:

Due to data availability timing, there is a one-year lag for the results reported in this measure.

a. data for the 2024–25 result reports 2023–24 data, as data is not available until approximately 5 months after the end of the financial year.

b., c. and d. the 2024–25 result reports 2023 data, as data is captured by calendar year and is not available until 4 to 12 months after the end of the calendar year.

e. data for the 2024–25 result reports 2024 data, as financial year data is not available until 4 months after the end of the financial year. 2024 data for the AGPT Program and RGTS were submitted in October 2024 and included planned training units until the end of 2024. Previous system of data capture for AGPT (Registrar Information Data Exchange, or RIDE) has been decommissioned from 2023. The GP Training Minimum Dataset is used to capture GP training. Training on the RGTS is included as the program requirements are similar to the AGPT Program, with an intention to increase training in rural areas. Due to the lack of data capture on hours in training by participants on the RVTS, it is estimated that 1 RVTS participant = 1 FTE for the purpose of this measure.

2023–24 Result:

a. data for the 2023–24 result reports 2022–23 data, as data is not available until approximately 5 months after the end of the financial year. Data used for this measure has been provided by a third party.

b., c., d. and e. the 2023–24 result reports 2022 data, as data is captured by calendar year and is not available until 4 to 12 months after the end of the calendar year.

2022–23 Result:

The 2022–23 results have been revised to align with the data availability for the reporting period.

a. data for the 2022–23 result reports 2021–22 data, as data is not available until approximately 5 months after the end of the financial year.

b., c., d. and e. the 2022–23 result reports 2021 data, as data is captured by calendar year and is not available until 4 to 12 months after the end of the calendar year.

Data Source and Methodology:

Data sources:

Measure a. The Medicare Benefits Scheme (MBS) claims data are administrative data, which is owned by the department, in partnership with Services Australia.

Measures b., c. and d. The data for these measures comes from an annual registration process, together with data from a workforce survey that is voluntarily completed at the time of registration, forms the National Health Workforce Dataset (NHWDS).

Measure e. The data for this measure comes from AGPT Program data, RGTS data (from 2024–25 result onwards), and RVTS. AGPT Program data and RGTS data is provided 6-monthly to the department through the GP Training Minimum Dataset by the GP Colleges. RVTS data is provided 6-monthly to the department through progress reports by RVTS Ltd and is administered and owned by the department. RVTS reports as 1 headcount = 1 FTE.

Methodology:

The daily feed of the MBS claims data from Services Australia into the department's Enterprise Data Warehouse (EDW) is managed by the IT Division. Automated data preparation processes have been developed to extract and transform the subset of MBS claims data related to Primary Care GPs. This process includes the estimation of GP Full Time Equivalent (FTE).

a. The department's achievements for this requirement are supported by the strong uptake of general practice training by junior doctors across Australia. In 2024–25, the department supported GP training through 3 key programs: the AGPT Program, the RGTS, and the RVTS. These programs were oversubscribed in the first half of 2025, with more than 5,000 registrars actively participating in training. The Bonded Medical Program[77] continued during 2024–25 to help address the shortage of medical professionals in regional, rural and remote areas of Australia. During this period, there was an increase in Bonded Return of Service Obligations being fulfilled. This program is bolstered by certain exemptions granted under section 19AB of the *Health Insurance Act 1973*, which helps to address medical workforce distribution by encouraging overseas-trained doctors and foreign graduates to work in areas of health workforce need. Exemptions under this provision enables practitioners to contribute to service delivery in underserved regions, supporting more equitable access to primary care across Australia. While the number of GPs providing services in both MM1 and MM2-7 increased in 2024–25, external factors such as a downward trend in the number of hours worked and an ageing workforce have contributed to a decline in services and GP FTE. The specialist medical and allied health workforces also observed a decrease in total number of working hours.

b. The introduction of the Expedited Specialist pathway in October 2024 has enabled highly qualified and experienced overseas-trained medical specialists from eligible jurisdictions to gain faster and safer entry into the Australian workforce.[78] As of 29 May 2025, 322 internationally qualified specialists have applied for the program, with 150 registered; including 146 GPs, 3 psychiatrists, and 1 anaesthetist. Additionally, the program has approved 123 supervised practice arrangements across all jurisdictions except Tasmania, enabling these specialists to provide needed care to Australians more quickly. The department also delivered non-GP medical specialist training through the Specialist Training Program (STP), which supported more than 1,000 full-time training posts for non-GP medical specialists in 2024. In recent years, including 2024–25, the STP has had a higher success rate in filling training posts in metropolitan areas in comparison to regional or rural areas. An independent evaluation of the STP was undertaken in 2024 and recommended that the program undergo reform to better deliver on its objectives and align with the National Medical Workforce Strategy. The Bonded Medical Program and 19AB exemptions also contributed to better distribution of non-GP specialists (as per a. above).

c. The department has exceeded the FTE for this requirement through delivering a range of programs and initiatives that strengthen the capacity, role and utilisation of Australia's primary health care nursing workforce. This was achieved by improving recruitment, retention and employment opportunities, and by supporting nurse-led, team-based models of care. Programs delivered included the Nursing in Primary Health Care Program, the National Nurse and Clinical Placement Program, the Primary Care Nursing and Midwifery Scholarship Program and the Training and Professional Support for the Remote Health Workforce Program. In addition, 2 new expedited pathways for overseas-trained registered nurses were introduced in April 2025. These streamlined registration pathways for internationally qualified registered nurses have attracted strong interest from prospective applicants.

d. The achievements against this requirement, and c. above, are supported through the WIP-Practice Stream, which provides financial incentives to encourage multidisciplinary, team-based primary care. In 2024–25, the WIP-Practice Stream supported 5,986 primary care practices to engage a range of non-medical health professionals including nurses and allied health practitioners.

e. The AGPT Program mandates that at least 50% of GP training places be delivered in regional and rural areas. In 2024, 55.3% of GP training across the 3 programs occurred in regional, rural, or remote locations—exceeding this requirement and demonstrating a strong commitment to addressing workforce distribution. This requirement was further supported by the Pre-Fellowship Program (PFP).[79] The PFP supports international medical graduates to work in primary care and remain in rural and remote communities while they gain valuable experience prior to joining a GP training pathway.

[77] Further information can be found at: **www.health.gov.au/our-work/bonded-medical-program**

[78] Further information on the Fast track pathway to specialist registration can be found at: **www.medicalboard.gov.au/News/2024-10-14-Fast-track-pathway.aspx**

[79] Further information on PFP can be found at: **www.health.gov.au/our-work/pre-fellowship-program**

Program 1.5: Preventive Health and Chronic Disease Support

Program Objective

Support the people of Australia to live longer in full health and wellbeing through reducing the rates of harmful alcohol consumption, illicit drug use, and tobacco and e-cigarettes use, and increasing healthy eating patterns, levels of physical activity and cancer screening participation.

The National Drug Strategy 2017–2026[80] (the Strategy) is the overarching framework which identifies national priorities relating to alcohol, tobacco and other drugs. The Strategy guides action by Australian and state and territory governments in partnership with service providers and the community across the pillars of demand reduction, supply reduction and harm reduction.

The Strategy includes a number of sub-strategies, including the National Tobacco Strategy 2023–2030.[81] The National Tobacco Strategy drives national action on tobacco and e-cigarette control and includes targets for adult daily smoking prevalence. The National Preventive Health Strategy 2021–2030[82] provides an overarching, long-term approach to prevention that seeks to address the wider determinants of health, reduce health inequities and decrease the overall burden of disease in Australia over the next 10 years.

The department's approach to tobacco and e-cigarette control comprises a comprehensive and sustained suite of evidence-based initiatives to reduce the prevalence of smoking and e-cigarette use and their harms.[83] Promoting behavioural change—through encouraging cessation and discouraging uptake—is complex and requires a multi-faceted approach. This includes both supply- and demand-focused measures to meet the needs of different individuals and drive incremental change over time. The department directly funds research and data collection and draws on this and a range of other evidence to inform activities. Activities include developing and implementing tobacco and vaping legislative reforms, compliance and enforcement activities, and a variety of prevention, education and cessation support measures. As part of an iterative monitoring and evaluation approach, the department continues to invest in research to track and report the outcomes of the reforms and drive action in future years. Through the Drug and Alcohol Program, the department provides funding for prevention projects, withdrawal management and rehabilitation services, treatment services, activities which seek to prevent and address Fetal Alcohol Spectrum Disorder, and research and data projects.

The department coordinates a number of activities designed to encourage and enable healthy lifestyles, physical activity, and good nutrition. This action is linked with the National Preventive Health Strategy 2021–2030 and National Obesity Strategy 2022–2032.[84] These programs seek to improve the food supply and make healthier food choices easier, ensure core guidelines regarding physical activity and healthy eating are up to date and manage core data collection and surveillance programs.

The department continued to promote the importance of undertaking screening for bowel, breast, and cervical cancers during 2024–25, with early detection a key factor in reducing morbidity and mortality rates. The department has modernised the bowel and cervical screening program, sending SMS reminders, in place of paper, commencing in late 2024. The department has also raised awareness of cancer screening, including through national and targeted campaign activity, community engagement activities and GP and healthcare provider education and training.

[80] Available at: **www.health.gov.au/resources/publications/national-drug-strategy-2017-2026**
[81] Available at: **www.health.gov.au/resources/publications/national-tobacco-strategy-2023-2030**
[82] Available at: **www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030**
[83] Further information on what we're doing about smoking and tobacco can be found at: **www.health.gov.au/topics/smoking-vaping-and-tobacco/about-smoking/what-were-doing**
[84] Available at: **www.health.gov.au/resources/publications/national-obesity-strategy-2022-2032**

As of 1 July 2024, the department lowered the eligible age for the National Bowel Cancer Screening Program (NBCSP) from 50 to 45 years, based on evidence. This change allows individuals aged 45 to 49 years to opt in and request their first free bowel cancer screening kit. People aged 50 to 74 years will continue to receive kits automatically every 2 years. Healthcare providers can also bulk order kits to issue to eligible patients during an appointment.

The BreastScreen Australia Program, managed through state and territory governments, continued to deliver essential screening and assessment services throughout 2024–25. The effectiveness of this program continues to be demonstrated through the decrease in breast cancer mortality rates per 100,000 women (from 74 in 1991 to 37 in 2022). The department continued to lead a comprehensive review of the BreastScreen Australia Program throughout 2024–25, with all Australian governments expected to consider the outcomes of the review in 2025–26. In 2024–25, the department also finalised and released an update of the BreastScreen Position Statement on breast (mammographic) density and screening,[85] which now recommends mandatory notification of breast density through BreastScreen Australia. Jurisdictions are currently in the process of implementing this change.

Australian research has predicted that if vaccination and cervical screening coverage levels are maintained, Australia will be on track to eliminate cervical cancer as a public health problem by 2035, in line with the National Strategy for the Elimination of Cervical Cancer in Australia targets.[86] Australia has reached the World Health Organization and domestic elimination target for screening of 70%.[87] A focus on optimising self-collection in 2024–25, and in the future, will be a key enabler for achieving equitable elimination of cervical cancer by increasing the access to more culturally safe and inclusive cervical screening services for all eligible people. The department has provided $21.8 million over 3 years from 2024–25 to states and territories to expand access to culturally safe and inclusive cervical screening services for all eligible populations, especially those living in rural and remote areas. The department has also delivered $14.9 million in grant funding over 2 years from 2024–25 to the Australian Centre for the Prevention of Cervical Cancer and the National Aboriginal Community Controlled Organisation to expand access to screening services in Aboriginal and Torres Strait Islander Communities nationwide.

In 2024–25, the department also undertook extensive work to prepare for the launch of a new National Lung Cancer Screening Program[88] from 1 July 2025.

[85] Available at: **www.health.gov.au/resources/publications/breastscreen-australia-position-statement-on-breast-density-and-screening**

[86] Available at: **www.health.gov.au/resources/publications/national-strategy-for-the-elimination-of-cervical-cancer-in-australia**

[87] The cervical screening coverage rate is 73.1% of the targeted population (which is women and people with a cervix aged 25 to 74 years of age) meeting the World Health Organization and Australia screening coverage elimination target of 70%.

[88] Further information is available at: **www.ncsr.gov.au/lung-program.html**

Key Activities 1.5A:

Working with Commonwealth entities, states, territories and other relevant agencies to support a collaborative approach to policy frameworks, as well as prevention and reduction of harm to individuals, families, and communities from alcohol, tobacco, e-cigarettes and other drugs through:

- implementing activities that align with the objectives of the National Drug Strategy 2017–2026 and its sub-strategies, including the National Alcohol Strategy 2019–2028 and the National Tobacco Strategy 2023–2030. This includes delivering health promotion and education activities to support smoking and nicotine cessation and prevention, to raise awareness of the Australian guidelines to reduce health risks from drinking alcohol, and the risks of drinking alcohol while pregnant and breastfeeding.
- investing in quality alcohol and drug treatment services consistent with the National Quality and Treatment Frameworks.
- supporting expansion of tobacco and e-cigarette control program activities through investment in tobacco and e-cigarette control research and evaluation.

Source: *Health and Aged Care Corporate Plan 2024–25, p.37*

Performance Measure 1.5A:

Improve overall health and wellbeing of Australians by achieving preventive health targets.

a. Percentage of adults who are daily smokers.

b. Percentage of population who drink alcohol in ways that put them at risk of alcohol related disease or injury.

c. Percentage of population who have used an illicit drug in the last 12 months.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.67 and Health and Aged Care Corporate Plan 2024–25, p.37*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. Progressive decrease of daily smoking prevalence towards <10%. b. Progressive decrease of harmful alcohol consumption towards <28.8%. c. Progressive decrease of recent illicit drug use towards <13.94%.	a. 10.7% b. 30.7% c. 17.9%	a. 10.6% b. 30.7% c. 17.9%	a. 10.1% b. N/A[89] c. 17.9%
	Result: Not achieved ○		

Disclosures:

2024–25 Result:

a. The 2024–25 result utilises latest available data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey.[90] Previous reporting in 2023–24 utilised data from the National Health Survey (NHS). The NHS and HILDA Survey are not directly comparable and do not form a time series, due in part to differences in methodology. However, the HILDA Survey result does provide a point in time assessment of progress. The 2024–25 result utilises data from Wave 23 (2023) of the HILDA Survey, collected between 25 July 2023 to 2 February 2024.

b. Updated data is not available for this period. The result utilises 2022–23 data from the National Drug Strategy Household Survey (NDSHS).[91] The NDSHS is conducted every 3 years with the next results due to become available in 2027.

c. As above, the reported result utilises the latest available data from the AIHW NDSHS, 2022–23, with updated data not available until 2027.

[89] This performance measure was revised in 2023–24, therefore previous results are not comparable.

[90] Further information is available at: **melbourneinstitute.unimelb.edu.au/hilda**

[91] Further information is available at: **www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey**

2023–24 Result:

b. The result utilises 2022–23 data from the NDSHS. The 2023–24 result establishes a baseline which will enable the department to measure a progressive decrease for forward years' results. The survey is conducted every 2 to 3 years.

c. The result reported is utilising the latest available data from the AIHW NDSHS, 2022–23. The survey is conducted every 2 to 3 years.

2022–23 Result:

a. Australian Bureau of Statistic (ABS) Smoker Status, 2021–22. This dataset combines current smoker status information from the NHS, Survey of Income and Housing, National Study of Mental Health and Wellbeing, and Survey of Disability, Ageing and Carers. These surveys collected a standard set of information which were pooled to produce the Smoker Status dataset. While similar in content, each pooled dataset has different data sources and collection methodologies for the financial year and comparisons over time should be made with caution. Further information is available at: **www.abs.gov.au/articles/insights-australian-smokers-2021-22**

c. The result was updated in the 2023–24 Annual Report to reflect the final result. The result published in the 2022–23 Annual Report was data not available.

Data Source and Methodology:

The previous **data source** for **measure a** was the ABS NHS. The dataset refers to smoking prevalence among the adult population aged 18 years and over and is conducted every 3 to 4 years. In some years in between NHS releases, the ABS has released interim smoking datasets, which pool prevalence data from a range of household surveys. Whilst these interim sets should not be compared against the full NHS dataset, they provide good point-in-time insight into smoking prevalence.

The data source for measure **a.** has been revised in 2024–25 to the Household, Income and Labour Dynamics in Australia (HILDA) survey (Daily smoking prevalence reported through HILDA among adults aged ≥18 years) to support annual data availability.

The **data source** for **measure b** and **measure c** is the NDSHS. This survey collects information on alcohol and illicit drug use among the general population in Australia and is conducted every 2 to 3 years. The NDSHS collects data on people aged 14 years and over who are at risk of alcohol-related disease or injury, and alcohol consumption, and recent illicit use of drugs by people aged 14 years and over.

a. Based on the most recent HILDA Survey findings released in December 2024, data shows that in 2023, approximately one in 10 (10.7%) adults aged 18 years and over were current daily smokers. Across the data sources listed above, which despite methodology differences demonstrate consistent trends, daily smoking prevalence has remained stable over the last 3 reporting periods. This shows a decrease when compared to the baseline of 13.8% in 2017–18. This is consistent with a steady decline observed over the last 20 years from 22.4% in 2001.

In 2024–25, the department progressed a number of commitments in line with the priorities of the National Tobacco Strategy 2023–2030 (the Strategy), and in support of the Strategy's target of daily adult smoking prevalence of <10% by 2025. There is strong evidence of links between vaping and increased likelihood of smoking. The increasing rates of e-cigarette use in previous years has the potential to disrupt the significant achievements Australia has made in tobacco control to date. Reducing the use of e-cigarettes will therefore support tobacco control objectives more broadly. The activities included in the tobacco control legislative reforms—the *Public Health (Tobacco and Other Products) Act 2023*[92]—commenced on 1 April 2024. The legislation streamlines and modernises existing laws and introduces new measures to discourage smoking and tobacco use and restrict the promotion of e-cigarettes in Australia. The legislation includes a requirement for on-product health messages to be printed on individual cigarettes for the first time in Australia. The 2024–25 reporting period represented a transition period for the legislation through providing manufacturers, importers and retailers the opportunity to move to the new arrangements. The department completed a range of activities to support implementation of the legislation, which came into full effect on 1 July 2025. The full impact of this reform is expected to be reflected in future reporting periods.

[92] Available at: **www.legislation.gov.au/C2023A00118/latest/text**

During 2024–25, the following initiatives were undertaken to support the decrease of daily smoking prevalence:

Reforms to manage access to therapeutic vapes—the *Therapeutic Goods and Other Legislation Amendment (Vaping Reforms) Act 2024*[93]—commenced on 1 July 2024 and prohibits the importation, domestic manufacture, supply, commercial possession and advertisement of disposable single use and non-therapeutic vapes. Retailers such as tobacconists, vape shops and convenience stores are now prohibited from selling any type of vape in Australia. A strengthened advertising framework for vapes was introduced, banning the advertising of vapes, except where specifically authorised by the Therapeutic Goods Administration (TGA). From 1 October 2024, new laws allowed consumers aged 18 years and over to purchase vapes with a nicotine concentration of 20mg/mL or less directly from a pharmacy, without a prescription, subject to state and territory laws. The department is supporting health professionals, including pharmacists, with updated information and education on the requirements for dispensing and supplying vapes following the rollout of Australia's vaping reforms. The department is also using a range of national and jurisdictional data sources to monitor the impacts of the vaping reforms.

Delivery of public health communication campaigns – the Youth Vaping Education Campaign and National Tobacco and E-Cigarette Campaign aim to reduce smoking and vaping rates, particularly among priority and at-risk groups including young Australians. The 'Give Up For Good' public health campaigns ran from June to December 2024, with public relations activities and community engagement continuing to June 2025. Education resources, public relations and community engagement activities extended the reach of campaign advertising amongst the general population, First Nations peoples and multicultural audiences.

Expansion of cessation supports – to meet anticipated increases in demand for quit support, the department continued to expand a range of national evidence-based cessation initiatives to help people— and the health professionals supporting them—to quit smoking and/or vaping. This includes:

- the launch of the redeveloped My QuitBuddy app featuring updated cessation content reflecting the latest evidence, more options to support diverse quit journeys, a new challenge and reward system where users can earn badges for reaching milestones, and a fresh visual redesign
- continued funding to states and territories to expand their Quitline and other quit services
- further development of the National Cessation Platform[94]
- funding the Quit Centre to deliver best-practice training, tools and resources to upskill frontline health professionals to support their patients to quit smoking and vaping as part of routine care.

These activities undertaken in 2024–25 support the sustained commitment required for further reductions in smoking prevalence, towards the goals of the National Tobacco Strategy 2023–2030.

Tobacco control is a shared responsibility between the Commonwealth and state and territory governments, with support from experts and health professionals. Strengthening our partnerships with external stakeholders and working in collaboration is a guiding principle of the National Tobacco Strategy 2023–2030.

[93] Available at: **www.legislation.gov.au/C2024A00050/asmade/text**
[94] Available at: **www.quit.org.au**

In 2024–25, the below external factors had an influence on performance:

E-cigarettes and novel nicotine products – a rapid increase in e-cigarette marketing and use has occurred in more recent years, particularly among young people. This increase, combined with increased availability of novel nicotine products such as pouches, poses a risk to population health and Australia's success in tobacco control.

State and territory government vaping legislation – on 1 July 2024, 3 jurisdictions (Tasmania, South Australia, and Western Australia) announced their intention to introduce additional legislative changes to the regulation of tobacco and/or vaping products. Other states and territories are considering and/or implementing changes to their jurisdictional retailer licensing schemes. There is significant variation in the arrangements across Australia. These changes have flow-on effects to tobacco and e-cigarette availability and use.

Impact of illicit trade in tobacco – the availability of illicit tobacco products (products on which taxes have been avoided) undermines the effectiveness of taxation in reducing affordability to prevent uptake and promote quitting, particularly among lower income groups. There is concern that people who use illicit tobacco are not exposed to the evidence-based public health measures which discourage tobacco use and encourage quit attempts. This, alongside broad accessibility of illicit tobacco, may impact smoking prevalence.

Due to availability of national datasets, the last 3 Annual Reports have used data from different sources. Caution should be exercised when directly comparing different data streams utilised in annual reporting, as they have been collected in different populations and locations, with different methodology, questions, and timing. Each data source also has its own limitations. The data samples do, however, provide useful and broadly comparable estimates of point in time change.

Noting that the 2024–25 result reports on the latest available HILDA Survey data, which was collected between 25 July 2023 to 2 February 2024, it does not reflect the impact of the activities undertaken in 2024–25. This is due to the time lag between the collection of data, analysis, and the release of results.

In the 2023–24 Annual Report, the result of 10.6% adult daily smoking prevalence was obtained from the 2022 ABS NHS findings (released 15 December 2023). The results of this survey were collected between January 2022 to April 2023.

In the 2022–23 Annual Report, the result of 10.1% adult daily smoking prevalence was obtained from the 2022 ABS release 'Insights into Australian smokers, 2021–22' (a dataset used between NHS releases). This is an experimental dataset which presented pooled data about smoker status from a range of household surveys, collected during the COVID-19 pandemic. It is not part of the NHS time-series. While similar in content to the NHS, this pooled dataset has different data sources and collection methodologies. This data can be used for a point in time analysis, however comparisons with other datasets over time are not recommended due to changes in data collection methodology following the COVID-19 pandemic.

b and c. Reporting from the NDSHS 2022–23 indicates that while targets for reducing harmful alcohol consumption have not yet been met, risky alcohol consumption is declining. In 2007, 38.1% of participants reported risky alcohol use, compared to 30.7% in 2022–23. In contrast, illicit drug use has shown a slow upward trend since 2007, rising from 13.4% in 2007 to 17.9% in 2022–23.

Through the Drug and Alcohol Program, the department provides funding for prevention projects (both locally and nationally focused), withdrawal management and rehabilitation services, treatment services, activities which seek to prevent and address Fetal Alcohol Spectrum Disorder, and research and data projects (which seek to gather the evidence about what works to inform policy development and program design). Each of these streams seek to address the 3 pillars that underpin the National Drug Strategy 2017–2026 of harm, demand and supply reduction. Activities funded by the department designed to prevent or reduce the consumption of risky alcohol and drug use in communities include:

The Positive Choices web portal – delivers alcohol and other drug prevention activities targeting school students across Australia. It helps school communities access accurate, up-to-date drug education resources and prevention programs.

SMART Recovery – aims to ensure all Australians are supported to manage problematic behaviours related to addiction, including anxiety and other mental health issues. It aims to reduce the impact of drugs and alcohol across Australia by allowing those without access to face-to-face services be able to access evidence-based peer support treatment services online.

Local Drug Action Teams and Planet Youth trial – support communities to work together to prevent and minimise the harm caused by alcohol and other drugs.

Good Sports – provides alcohol and other drug primary prevention activities in community sports clubs across Australia. The Good Sports program encourages cultural change in behaviours and attitudes to alcohol and other drug use in sporting clubs at the grass roots level. The Good Sports program includes processes and policies targeting junior players to reduce the risk of exposure to alcohol and drug use in club settings.

Cracks in the Ice program – is an e-health initiative which aims to develop and disseminate evidence-based resources about crystal methamphetamine. It aims to improve knowledge, reduce stigma and increase access to care for people who use crystal methamphetamine, as well as their families, health workers and communities.

Addressing the harms associated with alcohol and other drugs is a shared responsibility between the Commonwealth and state and territory governments, with significant contributions made by experts and health professionals. Under the National Drug Strategy 2017–2026 (the Strategy), coordination and collaboration are identified as an underlying strategic principle. The Strategy further recognises the importance to work collaboratively in coordinated multi-agency approaches to develop and deliver jurisdictional responses that seek to prevent and minimise the harms from alcohol, tobacco and other drugs.

Other external factors which may be influencing performance include:

Increased awareness of alcohol-related harms – in the 2022–23 NDSHS, 39% of participants identified alcohol as the drug responsible for the most deaths, up from 29% in 2007. Concern about excessive drinking also rose, from 26% in 2019 to 31% in 2022–23.

Rising alcohol costs – between February 2020 and February 2025, the alcohol excise on spirits increased by approximately 20%, from $86.90 per litre to $104.31 per litre. Combined with the rising cost-of-living, this increase may be influencing consumption patterns and putting downward pressure on alcohol use. International data from the 2008 economic crisis showed a reduced consumption of alcohol.

Socioeconomic disadvantage – while there is an overall reduction in risky alcohol consumption, certain groups may be more vulnerable to alcohol harms. Wastewater-based data suggests that declines in consumption are not consistent between socioeconomic groups, with the most socioeconomically disadvantaged quartile decreasing at a slower rate as well as those living in inner regional locations. As with alcohol, harms from illicit drug use are not uniform across the Australian population. Amphetamines, which were the second most reported principal drug of concern in treatment episodes in 2023–24 (behind alcohol) and among the most common illicit drugs involved in hospitalisations, were much more likely to have been used by people living in lower socioeconomic areas than higher socioeconomic areas in 2022–23.

Demographic differences – young adults aged 18 to 24 years continue to be the most likely age group to consume alcohol at risky levels, with 42% doing so in 2022–23. Notably, risky drinking among young women increased from 35% in 2019 to 40% in 2022–23. Individuals from priority population groups were more likely to use illicit drugs in 2022–23. Gay, lesbian and bisexual people were 2.4 times as likely as heterosexual people and First Nations people 1.4 times as likely as non-Indigenous people to have used any illicit drug. Gay, lesbian and bisexual people were 6.6 times as likely as heterosexual people to have used methamphetamine, and First Nations people were 2.3 times as likely as non-Indigenous people to have used methamphetamine in 2022–23.

Societal attitudes – while stigma continues to be a factor impacting uptake, approval of illicit drug use has been gradually increasing since 2007. Attitudes towards cannabis have become increasingly positive, with approval of regular use increasing from 6.6% in 2007 to 23% in 2022–23. In 2019, more NDSHS participants supported cannabis legalisation than those who opposed.

In relation to reduction in harmful alcohol, the results are less than the previous reporting period (32.0%, 2019). In relation to reduction in illicit drug use, the result is a statistically significant increase compared to the previous reporting period (16.4%, 2019).

Caution should be exercised when comparing different data streams, as they have been collected in different populations and locations, with different methodology, questions, and timing. Each data source also has its own limitations. The data samples do, however, provide useful estimates of change over the periods.

Key Activity 1.5B:

Improving early detection, treatment, and survival outcomes for people with cancer by increasing participation across the 3 cancer screening programs over the next 5 years under the National Preventive Health Strategy 2021–2030 and the National Strategy for the Elimination of Cervical Cancer in Australia.

Source: *Health and Aged Care Corporate Plan 2024–25, p.39*

Performance Measure 1.5B:

Increase the level of cancer screening participation:

a. National Bowel Cancer Screening Program.

b. National Cervical Screening Program.

c. BreastScreen Australia Program.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.68 and Health and Aged Care Corporate Plan 2024–25, p.39*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. Progressive increase towards 53.0%.	a. 42.0%[95]	a. 41.7%	a. 40.0%
b. Progressive increase towards 70.0%.	b. 61.3%[96]	b. 63.5%	b. 68.4%
c. Progressive increase towards 65.0%.	c. 52.3%	c. 51.7%	c. 50.1%
	Result: Substantially achieved ◗		

[95] The NBCSP allowed people aged 45 to 49 years to participate in the program on request from 1 July 2024. However, this age cohort is excluded from the participation rate calculation as they are not automatically invited to participate as is the case for people aged 50 to 74 years. The participation rate is for those aged 50 to 74 years who were invited to participate in the program.

[96] The preliminary cervical screening coverage rate is 71.9% of the targeted population (which is women and people with a cervix aged 25 to 74 years of age) meeting the World Health Organization and Australia screening coverage elimination target of 70%.

Disclosures:

2024–25 Result:

a. The result reported is utilising preliminary data for the National Bowel Cancer Screening Program (NBCSP) from the AIHW. Due to the time between an invitation being sent, test results and collection of data from the National Cancer Screening Register (NCSR), the participation rate presented is for 1 January 2023 to 31 December 2024. The participation rate presented is the crude rate.[97]

b. The result reported is utilising preliminary data for the National Cervical Screening Program (NCSP) from the AIHW. The result is for the 5-year period of 2020–24. The participation rate presented is the crude rate.

c. The result reported is utilising preliminary screening data from the AIHW. The result reported is for the 2 years from January 2023 to December 2024. The participation rate presented is the crude rate.

2023–24 Result:

The 2023–24 results have been revised since the 2023–24 Annual Report. A 'data not available' result for performance measures a., b. and c. was published in the 2023–24 Annual Report.

a. The result reported is utilising the latest available screening data from the AIHW. Due to the time between an invitation being sent, test results and collection of data from the NCSR, participation rates for 1 January 2022 to 31 December 2023 were reported by AIHW in June 2025. The NBCSP requires the 2-year screening cycle to be complete and is calculated on a calendar year basis. The AIHW undertakes data processes prior to publishing the participation rate. The participation rate presented is the crude rate.

b. The result reported is utilising the latest available data for the NCSP from the AIHW. The result is for the 5-year period of 2019–23. The NCSP requires the 5-year screening cycle to be complete and is calculated on a calendar year basis. The AIHW undertakes data quality processes prior to publishing the participation rate which creates an additional time lag after the completion of a screening cycle for data to be suitable for reporting. The NCSP was renewed on 1 December 2017, when it changed from 2 yearly pap testing to a 5 yearly human papillomavirus (HPV) cervical screening test. The participation rate presented is the crude rate.

c. The result reported is utilising the latest available preliminary screening data from the AIHW. The result reported is for the 2 years from January 2022 to December 2023.

   The BreastScreen Australia national participation rate relies on third party data from state and territory government BreastScreen registers being provided to the AIHW for national collation and reporting. As a result, there are delays in reporting the most recent data in a timely manner. The participation rate presented is the crude rate.

2022–23 Result:

The 2022–23 results have been revised since the 2023–24 Annual Report. A 'data not available' result for performance measures a., b. and c. was published in the 2023–24 Annual Report.

a. The result reported is utilising the screening data from the AIHW. Due to the time between an invitation being sent, test results and collection of data from the NCSR, participation rates for 1 January 2021 to 31 December 2022 were reported by AIHW in June 2024. The participation rate presented is the crude rate.

b. The result reported is utilising the screening data for the NCSP from the AIHW. The result is for the 5-year period of 2018–22, as reported by AIHW in December 2023. The participation rate presented is the crude rate.

c. The result reported is utilising the latest available preliminary screening data from the AIHW. The result reported is for the 2 years from January 2021 to December 2022. The age-standardised participation rates for January 2021 to December 2022 were reported by AIHW in October 2024. The participation rate presented is the crude rate.

[97] A crude rate is defined as the number of events over a specified period (for example, a year) divided by the total population at risk of the event.

Data Source and Methodology:

The AIHW reports on performance of the Programs on behalf of the department under a Memorandum of Understanding. Data and performance measures relating to the Programs can be found on the AIHW website.[98]

Administrative data is used to report against performance measure. The performance measure is calculated based on the activity in the programs which is usually the number of invitations to participate sent and the number of screenings undertaken.

For the NBCSP and the NCSP, eligible participant data is sourced from Medicare, Services Australia, and screening test results are provided by pathology labs and pathology providers. The NCSR maintains the database and provides data to the AIHW to produce annual program monitoring reports, available on the AIHW website. The NCSR provides this data to AIHW through an automated monthly Raw Data Extract, which is used by the AIHW to report on the performance of these Programs.

For the BreastScreen Australia Program data is recorded by each BreastScreen Service and State Coordination Unit and reported to the AIHW. The AIHW publishes, in its annual BreastScreen Australia monitoring report, both the number of screening participants, and the participation rate.

a. During 2024–25 the following activities were undertaken to increase the number of Australians completing bowel cancer screening:

- following the review of the clinical evidence and data, from 1 July 2024, the age eligibility for the program was lowered from 50 to 45 years, with 1.6 million eligible people in this age cohort able to request a kit and join the program
- around 200,000 kits were requested by the newly eligible 45 to 49 year old cohort, including a one-off promotional SMS sent over a 6-week period from April 2025. This resulted in a significant increase in kit requests each week
- SMS reminders, in place of paper, were sent for the first time starting in late 2024 (approximately 2.97 million texts)
- the Get2it national campaign, delivered in partnership with Cancer Council Australia, is on track to deliver similar results as past campaigns, with an additional 150,000 kits being returned
- the Get behind it! Community Roadshow, in partnership with Penrith Panthers for the under-screened western Sydney area, was undertaken to help reach more than 350,000 people in under-screened communities across Australia
- GPs and other healthcare providers continued to be able to directly issue bowel screening kits to patients; resulting in more than 6,500 people returning a kit since September 2022.

The department is exploring a range of solutions to improve participation, including randomised control trials targeted at identifying opportunities to increase participation and considering opportunities for program design changes.

Participation in bowel cancer screening rates remains lower than other screening programs due to a range of factors, including the large eligible population, concerns related to handling and storing stool samples, and reduced understanding with regards to the risk of developing this cancer. Delivery of activities designed to address these barriers, such as communication campaigns, increased screening rates in 2022–23 compared to periods impacted by the COVID-19 pandemic.

[98] AIHW Cancer Screening Monitoring reports are available at: **www.aihw.gov.au/reports-data/health-welfare-services/cancer-screening/reports**

b. During 2024–25 the following activities were undertaken to increase the number of Australians completing their cervical screening:

- SMS screening reminders, in place of paper, were sent for the first time starting in late 2024
- the "Own It" campaign raised awareness of the self-collect option when doing your Cervical Screening Test. The campaign promoted self-collection to healthcare providers and under-screened groups including First Nations, CALD, LGBTQ+ communities, and people with disabilities
- community engagement activities included more than 100 events nationwide. These resulted in over 200 participants using the self-collection method at pop-up screening services—many of whom had never screened before or were significantly overdue
- the "Screen Me" campaign encourages people with disability to participate in regular cervical screening.

The department has seen an increased uptake of the introduction of the self-collect option (as opposed to clinician-collected tests) which is approaching 50% of screening. The department is continuing to explore opportunities to increase participation to ensure equity of access across priority population groups.[99]

The NCSP has a 5-year screening cycle, with program participation results continuing to be impacted by the lower screening rates seen during the COVID-19 pandemic. Anecdotal evidence suggests cost-of-living pressures may be contributing to the lower screening rates, as the NCSP is the only screening program that requires a GP visit to screen.

c. During 2024–25, the following communication and engagement activities were undertaken to increase the number of women completing breast screening:

- The first new resources in more than a decade were created to raise awareness among First Nations women about the importance of breast screening. These resources were created in collaboration with state and territory BreastScreen services, the National Aboriginal Community Controlled Health Organisation (NACCHO), and First Nations women across Australia.

In 2024–25, the department supported the delivery of the BreastScreen National Policy and Funding Review, in collaboration with state and territory governments, to identify improvements to BreastScreen Australia including approaches to increasing participation.

Participation in BreastScreen Australia among the target population of woman aged 50 to 74 years is measured over 2 calendar years to align with the recommended screening interval of every 2 years. Preliminary results for 2023 to 2024 show a crude participation rate of 52.3%, with over 1.9 million women screening. Based on the most recent monitoring report from the AIHW on participation rates in the BreastScreen Australia Program, over the 2 year period of 2022 and 2023, approximately 1.9 million women participated, equivalent to 51% (age standardised rate) of eligible women aged between 50 and 74 years.[100] This is an increase from 50% seen in the previous reporting period (2021 and 2022). Of note, participation is further improved on 2020 to 2021 results (47% age standardised rate) when participation was heavily impacted by COVID-19 public health measures that resulted in service closures and reduced capacity to screen. The BreastScreen Review undertaken during 2024–25 will develop evidence-based recommendations to improve the BreastScreen Australia Program, including program participation and patient experience.

[99] Priority populations are outlined within the National Strategy for the Elimination of Cervical Cancer: **www.health.gov.au/resources/publications/national-strategy-for-the-elimination-of-cervical-cancer-in-australia**

[100] Further information is available at: **www.aihw.gov.au/reports/cancer-screening/breastscreen-australia-monitoring-report-2024/summary**

Key Activities 1.5C:

Encouraging and enabling healthy lifestyles, physical activity, and good nutrition through implementation of initiatives aligned with the National Preventive Health Strategy 2021–2030 (NPHS) and National Obesity Strategy 2022–2032, (NOS) including (but not limited to) through:

- Improving the food supply and making healthier food choices easier while monitoring Australian's eating habits. This includes through ongoing support for the Health Star Rating System, Healthy Food Partnership, Australian Dietary Guidelines, several breastfeeding initiatives, and actions to restrict inappropriate marketing of infant formulas and explore regulations to limit unhealthy food marketing to children.
- Developing a National Nutrition Policy Framework, to guide nutrition policy in future years and ensure sustained Government commitment to secure a nutritious and accessible food supply.
- Updating nutrition and food data collections to inform policy actions.
- Encouraging and enabling physical activity through updates to the Physical Activity Guidelines for adults (18 to 64 years) and older Australians (65+ years).

Source: *Health and Aged Care Corporate Plan 2024–25, p.41*

Performance Measure 1.5C:

Improve overall health and wellbeing of Australians by achieving healthy eating and physical activity targets.

a. Prevalence of insufficient physical activity amongst children, adolescents, and adults.

b. Prevalence of obesity in adults (18+).

c. Prevalence of overweight and obesity in children and adolescents aged 2 to 17 years.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.68 and Health and Aged Care Corporate Plan 2024–25, p.41*

2024–25 Planned Performance	2024–25 Result
a. Progressive decrease of prevalence towards 15%. b. Progressive decrease of prevalence. c. Progressive decrease towards a reduction of prevalence by at least 5%.	a. In 2022, there was a relative reduction of approximately 3.3% in the prevalence of insufficient physical activity for the 15 to 17 years age group (from 96.4% to 93.2%) and a relative reduction of approximately 6.5% for the 18 to 64 years age group (from 83.0% to 77.6%) in comparison to 2017–18. There is no recent data available for children. b. In 2022, there was a 0.4% increase (from 31.3% to 31.7%) in the prevalence of obesity in adults in comparison to 2017–18. c. In 2022, there was a 1.5% increase (from 24.9% to 26.4%) in the prevalence of overweight and obesity in those aged 2 to 17 years in comparison to 2017–18.
	Result: Not achieved ○

Disclosures:

2024–25 Result:

- For performance measures a. (adults), b. and c: The result reported is for the period 2022, as the National Health Survey (NHS) occurs approximately every 3 years. The next iteration of the NHS is planned to be 'continuous collect', with the first year of collection currently planned for 2027. National only level data is anticipated in the first half of 2028. The data resulting from the full survey sample would be made available after the third year of collection (2029) and published in the first half of the following year (2030).
- For performance measure a. (children): There is no result reported for children in this period, as there is no recently available data. The next release of the National Nutrition and Physical Activity Survey is anticipated to be available in Quarter 3 of 2025.

Data Source and Methodology:

a. Measured using the Australian Bureau of Statistics (ABS) NHS, approximately every 3 years. The prevalence of insufficient physical activity data is based on nationally representative self-reported data collected face-to-face by trained ABS interviewers.
b. Measured using the ABS NHS, approximately every 3 years. Estimates of Body Mass Index (BMI) are based on nationally representative measured height and weight data from the ABS 2022 NHS. For adults, obesity was classified as a BMI of 30.00 kg/m^2 or more.
c. Measured using the ABS NHS, approximately every 3 years. Estimates of BMI are based on nationally representative measured height and weight data from the ABS 2022 NHS. For children and adolescents, age and sex-specific half-year BMI cut-off points were used to classify overweight and obesity.

Encouraging and enabling healthy lifestyles, physical activity, and good nutrition is critical to achieving positive health outcomes. The 2024–25 performance result for this measure indicates that less Australians are being physically inactive, however overweight and obesity continue to be an issue. According to the AIHW, obesity is now the leading cause of disease burden in Australia.

Based on the latest available data from 2022 and comparing to 2017–18:

a. In 2022, there was a relative reduction of approximately 3.3% in the prevalence of insufficient physical activity for the 15 to 17 years age group (from 96.4% to 93.2%) and a relative reduction of approximately 6.5% for the 18 to 64 years age group (from 83.0% to 77.6%) in comparison to 2017–18. This demonstrates a positive trajectory towards achieving the planned performance. There is no recent data available for children.

b. In 2022, there was a 0.4% increase (from 31.3% to 31.7%) in the prevalence of obesity in adults in comparison to 2017–18. This demonstrates a lack of meaningful progress or a negative trend.

c. In 2022, there was a 1.5% increase (from 24.9% to 26.4%) in the prevalence of overweight and obesity in those aged 2 to 17 years in comparison to 2017–18. This demonstrates a lack of meaningful progress or a negative trend.

It is acknowledged that the performance measures and outcomes relevant to 1.5C may be influenced by multiple factors, including outside of the health sector. During 2024–25, the department continued to support a variety of initiatives to encourage and enable healthy weight and healthy living for all Australians. These include:

- initiatives to make processed food and drinks healthier, through the Food Regulation System and the Healthy Food Partnership, including the Partnership Reformulation Program
- initiatives to improve nutrition information to help consumers make healthier choices at the time of purchase, including the front-of-pack labelling Health Star Rating system
- grants for physical activity including community sport and walking activities
- reviewing and updating of relevant guidelines and frameworks for clinical practice, nutrition and physical activity
- undertaking feasibility studies on options to limit unhealthy food marketing to children and on social prescribing in the Australian context
- support for Australians to access healthcare and medicines through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme
- continued engagement with states and territory governments and Australian Government departments and agencies regarding opportunities to improve national nutrition data collection and monitoring.

In addition to the initiatives outlined above, the department continues to collaborate with state and territory governments on identified collective priority areas of the National Obesity Strategy 2022–2032. These include:

Strategy 1.4 – Make processed food and drinks healthier.

Strategy 1.5 – Improve nutrition information to help consumers make healthier choices at the time of purchase.

Strategy 1.6 – Reduce exposure to unhealthy food and drink marketing, promotion and sponsorship, especially for children.

Strategy 3.2 – Improve uptake of integrated models of care and referral pathways that focus on the individual.

Performance towards achieving the physical activity and overweight and obesity targets requires a collective and comprehensive effort across portfolios and multiple sectors. Performance may have been influenced by initiatives undertaken by other entities, including but not limited to:

- other Commonwealth entities
- state and territory governments
- healthcare providers including general practitioners, specialists and broader multidisciplinary teams
- individuals, families and communities
- not-for-profit groups, peak bodies and clinical advisory groups
- relevant industry associations and businesses
- the academic and research community
- service providers delivering program services through outsourced arrangements.

Program 1.6: Primary Health Care Quality and Coordination

Program Objective

Strengthen primary health care by delivering funding to frontline primary health care services and improving the access, delivery, quality and coordination of those services. This will help improve health outcomes for patients, particularly people with chronic and/or mental health conditions, and assist in reducing unnecessary hospital visits and admissions.

The department continued to work in partnership with Primary Health Networks (PHNs) in 2024–25, improving the efficiency, effectiveness and coordination of primary health services at the local level. The department funds PHNs to commission health services to address identified needs of people in their regions as well as priority areas set by the Australian Government. PHNs work collaboratively with health professionals in their regions to build health workforce capacity and ensure the delivery of high-quality care. They also work with Local Hospital Networks to improve service integration.

The Medicare Urgent Care Clinic (UCC) program was established in June 2023 and is commissioned by PHNs and state and territory governments. The government committed to investing $1.4 billion over 7 years from 2022–23 to establish and operate 137 Medicare Urgent Care Clinics (UCCs) across Australia. Medicare UCCs aim to ease the pressure on our hospitals and provide families with more options to see a health care professional when they have an urgent, but not life-threatening, need for care. Medicare UCC services do not require appointments and are bulk billed, resulting in no out-of-pocket costs to patients.

As at 30 June 2025, there has been over 1.6 million presentations across 87 Medicare UCCs since the first clinics were implemented in June 2023. The Medicare Urgent Care Clinics Program Evaluation: First Interim Report estimates cost of $246.50 per Medicare UCC presentation compared to the estimated $616 per Emergency Department presentation. Medicare UCCs are funded under a model that provides block funding for a one-off grant to purchase equipment required to operate as a Medicare UCC, an annual operating grant and for most Medicare UCCs, access to the Medicare Benefits Schedule (MBS).

The independent evaluation was undertaken based on the information available from the establishment of the first clinics on 30 June 2023 through to 30 September 2024. The evaluator found *"Commissioning organisations (PHNs and state territory governments) are playing a beneficial role in building relationships with local GPs and health services and navigating workforce challenges."*[101] Stakeholders consulted as part of the evaluation also noted that a key benefit of the Medicare UCC program was improved access to urgent care in the community, as an alternative to hospital emergency departments and when patients are unable to get an appointment with their regular primary care provider.

Healthdirect Australia (HDA) is a government-owned, not-for-profit organisation that provides free health information, advice and service referrals to people living in Australia. Funded by the Commonwealth and state and territory governments, HDA delivers a suite of telehealth and digital services, including:

- a 24/7 nurse triage Health Information and Advice Service (HIAS)
- after-hours GP helpline
- pregnancy, birth and baby helpline
- a secure video call platform for virtual consultations.

HDA also offers digital tools such as the Symptom Checker and Risk Checker. The HDA website and app offer clinically reviewed information on a wide range of health conditions, symptoms and treatments. The National Health Services Directory (NHSD) is also provided by HDA to help users identify nearby health services.[102]

[101] The report *Evaluation of the Medicare Urgent Care Clinics: Interim Evaluation Report 1* is available at: **www.health.gov.au/resources/publications/medicare-urgent-care-clinics-program-evaluation-first-interim-report**

[102] Further information can be found at **www.healthdirect.gov.au**

HDA services improve access to timely, urgent advice through telehealth. This supports priority groups, including people with chronic and/or mental health conditions, those requiring after-hours care, and individuals in rural and remote communities. Through clear referral pathways, HDA helps consumers navigate the health system and connect with appropriate care. This includes local primary care providers, allied health services and Medicare UCCs. In doing so, HDA services contributes to improved patient health outcomes and helps reduce unnecessary presentations to emergency departments.

Key Activity 1.6A:

Supporting Primary Health Networks (PHNs) to increase the efficiency, effectiveness, accessibility, and quality of primary health care services, particularly for people at risk of poorer health outcomes, and to improve multidisciplinary care, care coordination and integration.

Source: *Health and Aged Care Corporate Plan 2024–25, p.43*

Performance Measure 1.6A:

The number of Primary Health Network regions in which the rate of potentially preventable hospitalisations is declining, based on the latest available Australian Institute of Health and Welfare longitudinal data.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.70 and Health and Aged Care Corporate Plan 2024–25, p.43*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
28	2	24	30
	Result: Not achieved ○		

Disclosures:

Due to the delay in receiving and validating hospital data from states and territories, there is a 2-year time lag in the reported results for this performance measure. The result for 2024–25 reports data for the 2022–23 financial year. The 2-year lag has been ongoing since this measure was introduced. To mitigate the impact of the time lag on data interpretation, the department considers PPH data from 2017–18 onwards and takes into account trends over time when preparing the analysis of results.

Data Source and Methodology:

Data for this measure is sourced from the Potentially Preventable Hospitalisations (PPH) data within the National Hospital Morbidity Database (NHMD), managed by the Australian Institute of Health and Welfare (AIHW).

When calculating the PPH measure, the AIHW adopts the Australian Commission on Safety and Quality in Health Care's (ACSQHC's), 'A guide to the potentially preventable hospitalisations indicator in Australia'. This guide is published on the ACSQHC's and AIHW's website. The Meteor standard is the Admitted Patient Care National Minimum Data Set.[103]

Based on the latest available longitudinal data from the AIHW, reductions in potentially preventable hospitalisations (PPH) declined in just 2 PHN areas. The result is substantially below the planned performance target of 28 PHN areas.

The result should be interpreted in light of a national increase in PPH, with PPH increasing in every state and territory, across all remoteness areas from metropolitan to very remote, across all socio-economic categories, and in all 3 sub-categories of PPH (chronic, acute and vaccine-preventable). The overall number of hospitalisations also increased from 11.6 million in 2021–22 to 12.1 million in 2022–23.[104]

The observed increase in PPH may be attributable to a notable decline in complex care management in the general practice sector in the previous period.[105] This decline, likely attributable to the impacts of the COVID-19 pandemic, potentially contributed to the increased hospital activity in the subsequent period. A further analysis of PPH shows large increases for specific ailments, particular dental conditions, cellulitis and urinary tract infections (including pyelonephritis). As in the previous reporting period, there was also a notable increase in hospitalisations for pneumonia and vaccine-preventable influenza.

[103] Available at: **meteor.aihw.gov.au/content/740851**

[104] Figures are for the 2 most recent years for which PPH data is available.

[105] Data available at **www.health.gov.au/resources/collections/medicare-statistics-collection**.

Key Activity 1.6B:	
Support access to health care information and advice through Healthdirect Australia. Source: *Health and Aged Care Corporate Plan 2024–25, p.44*	
Performance Measure 1.6B: The number of calls handled on the Health Information and Advice phone line. Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.70 and Health and Aged Care Corporate Plan 2024–25, p.44*	
2024–25 Planned Performance	**2024–25 Result**
1,107,913[106]	1,122,181
	Result: Achieved ●
Data Source and Methodology: Data for this performance measure is sourced from de-identified unit record data from Healthdirect's Client Relationship Management (CRM) software. Performance Measure Result = **A** – **B**, where: **A** = The total number of calls handled by the Health Information and Advice phone line. **B** = Ineligible calls by the Health Information and Advice phone line (e.g. wrong number).	

The department continued to work with all state and territory governments to support Healthdirect Australia (HDA) in providing accessible, person-centred and clinically reviewed health information and advice to all people living in Australia. The department supported HDA by collaborating with state and local health policy makers and service commissioners to ensure digital solutions were tailored to community needs.

Throughout 2024–25, the department funded HDA to provide healthcare and information to the public including:

1. Telehealth services helplines:

Health Information and Advice Service (HIAS): also known as the healthdirect helpline or Nurse-on-Call in Victoria—provides 24/7 access to registered nurses who provide health advice and triage support. Based on the urgency of the situation, callers are advised on how to manage their health issue themselves or what clinical care to seek. This may include referral to the after-hours GP helpline, an urgent care clinic or a hospital emergency department for example.

After-Hours GP helpline: offers access to general practitioners in the after-hours period (6pm to 8am Monday to Friday and from 12pm Saturday to 8am Monday).

Pregnancy, Birth and Baby Helpline: provides support and information for expecting parents and parents of children, from birth to 5 years of age (available 7am to midnight (AET), 7 days a week).

Video call platform: enables virtual consultations between patients and healthcare providers.

2. Digital health tools:

Symptom checker: an online self-assessment tool that helps users assess symptoms and decide on appropriate next steps.

Healthdirect website and app: provides free, evidence-based health information and access to service directories.

Risk checker: assesses risk for chronic conditions such as heart disease, diabetes and kidney disease.

National Health Services Directory (NHSD): a searchable database of health services across Australia, including GPs, hospitals, dentists and other providers.

[106] The 2024–25 Corporate Plan included an error in the planned performance target for 1.6B as 1,393,795. The correct planned performance target for 2024–25 is 1,107,913.

HIAS facilitates access to timely and appropriate healthcare advice and aims to reduce pressure on emergency departments by guiding people to the right care at the right time. This may include referral to the after-hours GP helpline, local GPs, Medicare Urgent Care Clinics, hospital emergency departments or self-care options. HIAS receives the majority of calls handled by HDA in the provision of virtual primary care.

In 2024–25, 1,122,181 people in Australia called HIAS seeking nurse triage or health advice. The 2024–25 performance exceeded the department's target by ~1%. This is due to HDA handling more calls in total and fewer ineligible calls.[107]

Consumer surveys in the first 3 quarters of 2024–25 demonstrated approximately 90% consumer satisfaction with the HIAS.[108] Consumer and desktop research confirm that HIAS supports individuals who originally intended to attend an emergency department to safely access less costly services appropriate to their needs. This has led to 61% of Healthdirect callers being safely recommended a lower urgency care option if they thought they needed to attend an emergency department, decreasing unnecessary hospital visits.[109] Many of the consumers whose care needs were met through HIAS would not have otherwise been able to access any care.

Improving access to Healthdirect services

In 2024–25, the department collaborated with other funders of HDA services to improve service efficiency, effectiveness and appropriateness for all consumers. The department conducted consumer research with culturally and linguistically diverse, regional, rural and remote users, and people with disability to understand their usage patterns, preferences and unmet needs. This research will support new service design. The department has also initiated a strategic review of HDA to support the organisation to best meet outcomes in the Intergovernmental Agreement on National Digital Health, National Digital Health Strategy and National Healthcare Interoperability Plan.

Triage algorithms and consumer journeys on the HIAS and the online Symptom Checker tool have been progressively refined to support consumers to confidently navigate the health system. These refinements have been underpinned by enhancements to the NHSD's data quality and comprehensiveness, along with the integration of booking functionality.

In 2024–25, the department supported the transition of the after-hours GP helpline service to a new operating platform. This has enabled more detailed and secure referrals and patient summaries, including native integration with consumers' My Health Records. This transition has improved the customer experience and builds the foundation for a simple, accessible urgent care system, using HDA as a trusted front door.

Throughout 2024–25, HDA has continued to provide clinically reliable health information and advice services integrated with established care models to regions impacted by natural disasters and service closures. As part of the department's response to Cyclone Alfred, eligible consumers in Queensland were able to access the HIAS and GP helpline 24/7. In addition, the Service Finder was updated daily with GP practice closures, pharmacy and urgent care clinics including changes to opening hours. The HDA website displayed a banner across its website pages and relevant patient search engines (Service Finder) to advise consumers about changes to service operation. This helped affected Australians to access care effectively and efficiently. Similar responses were initiated by HDA during the Hunter and Mid North Coast floods and severe weather in 2024–25.

[107] A call is deemed ineligible if the caller's intent was not to access health information and advice through the helpline.
[108] Data available at **about.healthdirect.gov.au/corporate-reports**
[109] Data available at **about.healthdirect.gov.au/corporate-reports**

Key Activity 1.6C: Support access to health care information and advice through Healthdirect Australia. Source: *Health and Aged Care Corporate Plan 2024–25, p.44*	
Performance Measure 1.6C: The proportion of calls received on the Health Information and Advice phone line that are handled. Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.70 and Health and Aged Care Corporate Plan 2024–25, p.45*	
2024–25 Planned Performance	**2024–25 Result**
Benchmarking	0.801
	Result: Achieved (benchmark established) ●
D**ata Source and Methodology**: Performance Measure Result = **(A – B) / A** **A** = Total calls* received by the Health Information and Advice phone line. **B** = Ineligible calls by the Health Information and Advice phone line (e.g. wrong number, prank calls, etc.). *Total calls received refers to number of calls that complete the welcome message and are queued to talk to a triage nurse (within QLIK this is referred as 'Calls offered').	

This measure complements performance measure 1.6B by assessing the proportion of services demanded that were handled by HDA.

In 2024–25, the proportion of consumers who either waited to use or used HDA to access care information, advice and onwards referral compared to total calls received on the HIAS phone line was 0.801 (80.1%).

This is a new performance measure in 2024–25, therefore results are not available for previous years. The 2024–25 result has established a benchmark and is an indicator of how well the service is being understood as a health seeking tool by the public.

Program 1.7: Primary Care Practice Incentives and Medical Indemnity

Program Objective

Provide incentive payments to eligible general practices and general practitioners through the Practice Incentives Program to support continuing improvements, increase quality of care, enhance capacity and improve access and health outcomes for patients. Promote the ongoing stability, affordability and availability of medical indemnity insurance to enable stable fees for patients and allow the health workforce to focus on delivering high-quality services.

General practice accreditation is designed to safeguard patient safety, improve clinical outcomes and support continuous quality improvement across general practice settings. Accreditation provides assurances to the community that a general practice meets expected standards of safety and quality when delivering care to patients.

General practice accreditation remains a mandatory requirement for participation in the Practice Incentives Program (PIP). To access the PIP, general practices are required to be accredited or be registered for accreditation under the National General Practice Accreditation (NGPA) Scheme. Accreditation against the Royal Australian College of General practitioners *Standards for general practitioners* (5th edition) (the RACGP Standards) is valid for 3 years.[110]

The NGPA Scheme is managed by the Australian Commission on Safety and Quality in Health Care[111] (ACSQHC) on behalf of the department. Assessments under the NGPA Scheme are conducted by an accrediting agency approved by the ACSQHC.

To assist general practices in gaining accreditation under the NGPA Scheme, the department is providing $4.1 million in grant funding to Primary Health Networks (PHNs) from June 2024 to June 2027. PHNs are expected to proactively engage with unaccredited general practices within their regions and offer targeted support and mentoring to help these practices meet the RACGP Standards. To further support this effort, a series of fact sheets have been developed in collaboration with the ACSQHC and the RACGP. These resources are being distributed to PHNs to aid in their engagement and support activities.

The PIP Quality Improvement (QI) Incentive supports general practices in Australia to improve patient outcomes through data-driven care. The Australian Institute of Health and Welfare (AIHW) is the National Data Custodian for the PIP QI Incentive. Participating practices submit de-identified data across 10 key quality improvement measures, focusing on chronic disease management and preventive care. These measures help inform regional and national health strategies but are not used to assess individual performance. The data is aggregated and anonymised, ensuring privacy while enabling system-wide quality improvement. The initiative highlights the central role of general practices in delivering accessible, high-quality primary health care. Data from PIP QI measures reveal trends in chronic disease management, preventive screening and immunisation uptake across general practices. These insights support targeted health interventions and resource allocation at regional and national levels. The AIHW publishes annual reports on PIP QI Measures.[112]

In addition, reporting on the percentage of accredited general practices submitting PIP QI Incentive data to their PHN illustrates that general practices are working to meet overall program objectives through participation in continuous improvement activities which increase the quality of care and improve patient outcomes.

[110] Further information is available at: **www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition**
[111] Further information is available at: **www.safetyandquality.gov.au/our-work/accreditation/national-general-practice-accreditation-scheme**
[112] Available at: **www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/reports**

The department continued to support the stability, affordability and availability of medical indemnity insurance. It did this by subsidising some premiums, contributing to the cost of eligible claims, and facilitating run-off coverage after practitioners retire or cease practising. Medical indemnity insurance benefits patients by ensuring there is an appropriate mechanism in place to compensate for harm that occurs as a result of the actions of a clinician.

Medical indemnity insurance providers are expected to provide insurance cover to any practitioner who seeks it. Under the *Medical Indemnity Act 2002*, insurance providers must report on the number of practitioners who have been refused cover or charged a risk premium. The total number of refusals and surcharges should represent no more than 5% of the total insured population.

Key Activity 1.7A:

Providing Practice Incentive Program (PIP) payments to eligible general practices for participation in the Quality Improvement Incentive.

Source: *Health and Aged Care Corporate Plan 2024–25, p.46*

Performance Measure 1.7A:

Maintain Australia's access to quality general practitioner care through the percentage of accredited general practices submitting PIP Quality Improvement Incentive data to their Primary Health Network.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.72 and Health and Aged Care Corporate Plan 2024–25, p.46*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
≥95%	93.2%	92.7%	92.7%
	Result: Not achieved ○		

Disclosures:

The reported participation rate of 93.2% is based on data submitted by Primary Health Networks (PHNs) as of 30 June 2025. While every effort has been made to ensure data accuracy, some practices may have been excluded due to late submissions or data entry errors. Additionally, variations in PHN reporting methods may result in minor discrepancies. These have been reviewed and deemed not material to the overall result.

Data Source and Methodology:

Data is received from the PHNs and from Services Australia to inform the department regarding the percentage of PIP practices participating in PIP Quality Improvement (QI).

Numerator: Data on general practices participating in PIP QI is acquired from the PHNs.

Denominator: Data on general practices registered for PIP is received from Services Australia.

The number of general practices that receive a PIP QI payment (**Numerator**) divided by the number of general practices registered for PIP (**Denominator**).

The department continued to provide policy and operational support for the PIP QI Incentive throughout 2024–25.

To be eligible to participate in PIP QI, general practices must be registered for accreditation or accredited under the NGPA Scheme. In 2024–25, 78 additional eligible practices participated in the PIP QI Incentive compared to 2023–24. All practices were required to either be registered for accreditation or accredited under the NGPA Scheme.

The department has an annual agreement with the ACSQHC in relation to the NGPA Scheme which facilitates general practice accreditation and enables practices to meet eligibility requirements to participate in PIP QI. In 2024–25, the department also directly engaged with 31 PHNs to ensure quarterly aggregated data from PIP QI eligible practices was provided to the AIHW. This enabled PIP QI eligible practices to meet the requirements to receive the incentive payment.

The AIHW is the national data custodian for the PIP QI Incentive, and through an annual agreement with the department provides data and analytics services for the PIP QI Incentive. This ensures that only data of sufficient quality is included in each annual report. See forthcoming report – Practice Incentives Program Quality Improvement Measures: annual data update 2024–25.[113]

The PIP is a demand-driven program which provides a challenge in predicting future outcomes.

A linear model was used to forecast the percentage of accredited general practices submitting PIP QI Incentive data to PHNs. While there was an increase in participation following the COVID-19 pandemic, participation in the PIP QI Incentive has plateaued.

The PIP QI Incentive had a slight increase in practice participation in 2024–25. In 2023–24 there were 6,189 eligible practices participating in the PIP QI Incentive. In 2024–25 there were 6,276 eligible practices participating in the PIP QI Incentive. This represents an overall increase in practice participation of 1.4%.

In 2023–24, the percentage of accredited general practices submitting PIP QI Incentive data to PHNs was 92.7%. The 2024–25 result of 93.2% shows an increase of 0.5% in performance when compared to last year.

[113] Available at: **www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/overview**

Key Activity 1.7B:

Requiring medical indemnity to only refuse to provide cover or apply a risk surcharge on insurance premiums under limited circumstances as set out under section 52A of the *Medical Indemnity Act 2002*.

Source: *Health and Aged Care Corporate Plan 2024–25, p.47*

Performance Measure 1.7B:

Percentage of medical professionals who can access medical indemnity insurance without the application of a risk surcharge or a refusal of medical indemnity insurance cover.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.72 and Health and Aged Care Corporate Plan 2024–25, p.47*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
95.0%	Data not available	99.7%	99.60%
	Result: Data not available —		

Disclosures:

2024–25 Result:

Insurers have up to 2 months to provide data after 30 June 2025, with the final result available from November 2025.

The data used for this measure is based on self-reporting by insurers and presents a limitation in that it may not capture the full extent of refusals or risk surcharges applied. The department works closely with insurers to ensure the accuracy and completeness of the information.

2023–24 Result:

The result has now been finalised and updated accordingly.

Data Source and Methodology:

The data is sourced from annual reports submitted by medical indemnity insurers, as mandated by the *Medical Indemnity Act 2002*, and from the Run-Off Cover Scheme (ROCS) Contribution Report provided by Services Australia.

The percentage is calculated by dividing the number of medical professionals refused cover or subject to risk surcharges by the total number of medical professionals eligible for insurance. The data is collected annually, collated, de-identified, and published on the Department of Health, Disability and Ageing website.[114]

The 95% target acknowledges that a small percentage of practitioners might not meet insurer requirements due to specific risk factors, aligning with legislative provisions for refusal of cover or the application of a risk surcharge under limited circumstances. This target can be adjusted in future years as more data becomes available, and trends are established.

The key risk is that insurers may exceed their discretion in refusing insurance cover or apply a risk surcharge. This is mitigated by the limited grounds for such actions under the *Medical Indemnity Act 2002* and the availability of the Australian Financial Complaints Authority to determine practitioner complaints.

The department's performance regarding the accessibility of medical indemnity insurance in 2024–25 cannot be definitively assessed until the final data is available from medical indemnity insurers in November 2025.

The department's ongoing monitoring and engagement with insurers contribute to maintaining a high level of access to affordable medical indemnity insurance for practitioners in Australia. Past performance against this measure indicates insurers have a strong understanding of universal cover obligations under the *Medical Indemnity Act 2002*.

[114] Available at: **www.health.gov.au/resources/collections/medical-indemnity-universal-cover-annual-reports**

Program 1.8: Health Protection, Emergency Response and Regulation

Program Objective

Protect the health of the Australian community through national leadership and capacity building to detect, prevent and respond to threats to public health and safety, including those arising from communicable diseases, natural disasters, acts of terrorism and other incidents that may lead to mass casualties. Protect human health and the environment through regulatory oversight of therapeutic goods, controlled drugs, genetically modified organisms, and industrial chemicals.

The Therapeutic Goods Administration (TGA) protects and improves the health of Australians by regulating therapeutic goods to ensure their safety, efficacy, performance and quality. Where appropriate, the TGA regulates prescription medicines, non-prescription medicines, vaccines, medical devices, blood and blood products, cellular therapies, biologicals, and software used as a medical device, including artificial intelligence. In addition to the key activity reporting under Performance Measure 1.8A, the TGA publishes a comprehensive annual performance report on the TGA website.[115] This provides detailed quantitative and qualitative information on TGA activities. These include compliance and enforcement activities, education and capacity building, regulatory harmonisation efforts and other activities.

The Office of Drug Control (ODC) ensures Australia's compliance with international obligations under the 3 major International Drug Control Conventions.[116] It achieves this by regulating the legal import, export, cultivation, production and manufacture of controlled substances in Australia. The ODC works closely with global partners such as the United Nations Office on Drugs and Crime and the International Narcotics Control Board. It also works with industry members to regulate medicinal cannabis, opiate-based drugs, narcotics, psychotropics, precursor chemicals, vaping products, and kava for commercial food use. Additional details about the functions of the ODC can be found on the ODC website.[117]

Throughout 2024–25, the Gene Technology Regulatory Scheme (the Scheme) continued to ensure medical, agricultural and other research involving genetically modified organisms (GMOs) was conducted in accordance with best practice, and in a manner that protects human health and safety and the environment. The Scheme facilitates and regulates the safe conduct of medical research, regulates field trials of GMO crops, and completes high-level scientific risk assessments. The Scheme also provides the community with ongoing access to safe GMOs and products derived from GMOs.

Licensed approvals are categorised according to whether dealings (activities) with a GMO involve intentional release into the environment (DIR) or are contained and are primarily for research and do not involve release into the environment (DNIR). In 2024–25 the Regulator made a decision on 46 licences (33 DNIRs and 13 for DIRs). This is a rise of almost 44% when compared with 2023–24 when 32 licence decisions were made (26 DNIRs and 6 DIRs). This rise was mainly driven by an increase in medical therapies involving GMOs used in clinical trials or released for commercial use.

Detailed information on OGTR's performance can be found in the Gene Technology Regulator's Annual Report[118] which is published on the OGTR website[119] in late October each year.

The *Industrial Chemicals Act 2019* establishes the Australian Industrial Chemicals Introduction Scheme (AICIS) as the regulatory scheme for the introduction of industrial chemicals in Australia, whether through importation and manufacture. AICIS continues to focus on prevention and early intervention to protect human health and the environment, through effective regulatory oversight of industrial chemicals introduction.

[115] Available at: **www.tga.gov.au/resources/publication/publications/performance-reports**
[116] Further information is available at: **www.odc.gov.au/about-us/who-we-are/international-conventions**
[117] Available at: **www.odc.gov.au**
[118] Available at: **www.ogtr.gov.au/resources/collections/annual-reports-operations-gene-technology-regulator**
[119] Available at: **www.ogtr.gov.au**

Further information on AICIS can be found in Appendix 4 of this Annual Report, which describes the operation of AICIS and its additional functions in maintaining a public inventory of chemicals, undertaking compliance activities, making risk management recommendations, and meeting Australia's obligations under international agreements relating to industrial chemicals.

Key Activity 1.8A:

Regulating therapeutic goods to ensure safety, efficacy, performance and quality.

Source: *Health and Aged Care Corporate Plan 2024–25, p.48*

Performance Measure 1.8A:

Percentage of therapeutic goods evaluations that meet statutory timeframes.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.74 and Health and Aged Care Corporate Plan 2024–25, p.48*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
100%[120]	99.35%	99.93%	99.45%
	Result: Not achieved ○		

Data Source and Methodology:

Records of medicines, medical devices, and biologicals applications. Data is analysed and maintained internally by the department. Evaluation activities are measured against statutory timeframes, which are contained within the *Therapeutic Goods Act 1989* and Therapeutic Goods Regulations 1990.

In 2024–25, the Therapeutic Goods Administration (TGA) maintained high standards in evaluating therapeutic goods, achieving near-total compliance with statutory timeframes across the 6 business areas that manage evaluations for different therapeutic goods. These areas cover Prescription Medicines, Substances Used in Listed Medicines, Registered Complementary Medicines, Assessed Listed Medicines, Medical Devices Preliminary Assessment, and Medicine Devices Conformity Assessments. All 6 areas are subject to a statutory evaluation timeframe that is specific to each class of therapeutic good.

With respect to individual classes of therapeutics goods:

- The TGA completed 99.2.% of Prescription Medicines evaluations within statutory timeframes for the reporting period. The TGA completed over 500 Category 1 and 2 applications, which are more complex, higher risk, and involve clinical and/or bioequivalence evaluations. A team of case managers provided ongoing support for the registration of Category 1 and 2 applications. The TGA also completed over 2,500 Category 3 and Minor variation applications, with 25 applications exceeding their legislated due date in the reporting period. While these applications for variations have lower data requirements, they also have a shorter legislated timeframe of 45 days. Prescription Medicines saw a slight 0.3% decrease in the proportion of on-time submissions compared to the 2023–24 reporting period. Ongoing improvements to business systems and reporting will continue to reduce the number of applications that exceed legislated timeframes, progressively improving performance against this measure. Further information on the Prescription Medicine categories and evaluations is presented in the TGA Performance Report, available from the TGA website.[121]
- The TGA completed 100% of the Substances Used in Listed Medicines, Assessed Listed Medicines and Registered Complementary Medicines evaluations within statutory timeframes for the reporting period. This outcome was achieved through the improvements in processes, trained and experienced evaluators, and the quality of the applications as supported by close communications between the TGA evaluators and applicants.

[120] The 2024–25 Corporate Plan planned performance target for 1.8A was 98%. The target has been updated to 100% for the 2024–25 reporting period to reflect that this measure captures legislated timeframes.

[121] Available at: **www.tga.gov.au/resources/publication/publications/performance-reports**

- The TGA completed 100% of Medical Devices Conformity Assessments within statutory timeframes for the reporting period. This outcome was achieved through rigorous pre-market and post-market regulatory activities. Evaluation of manufacturers' submissions for TGA conformity assessment application, including technical files, risk assessments and clinical data, ensured devices are compliant with the Essential Principles and relevant standards. During 2024–25, the TGA improved processes for conformity assessment applications, particularly for recertification, to reduce assessment timeframes while ensuring compliance with safety standards. Greater collaboration with stakeholders has resulted in improvement in the quality of conformity assessment submissions. A case management model, introduced through the conformity assessment transformation project, has strengthened communication and transparency for medical device manufacturers, improving predictability.
- The TGA completed 96.9% of Medical Devices Preliminary Assessments within statutory timeframes for the reporting period. Of the 177 inclusion applications exceeding the 20-day statutory timeframe, 85 were completed on the 21st day. During 2024–25, the TGA received 1,030 more inclusion applications than the previous financial year, representing a 22% increase. Following a review of the data reporting processes in 2024–25, changes to the preliminary assessment processes have been implemented. These changes will address the applications that are completed on the 21st day, enhance data collection and cleansing, and improve guidance to the industry to support improved ongoing monitoring of compliance rates.

To improve efficiency and reduce regulatory burden, the TGA informs its decisions by collaborating and leveraging reliance with trusted international regulators. External factors such as policy changes, market dynamics, demographics, emergencies, technological advancements and international collaboration significantly impact the performance of the regulatory framework.

The TGA implemented reforms that expand the types of overseas regulator evidence recognised in the comparable overseas regulator reliance framework. The TGA continued to receive an increased number of medical device applications due to the regulatory transition in Europe; the largest source of overseas approvals utilised by applications received by the TGA.

By adapting to these evolving influences, the TGA ensures effective oversight while promoting patient safety and access to innovative medical solutions. In particular, the integrity of the system generating data was an external factor that underpinned the results for Substances Used in Listed Medicines, Assessed Listed Medicines and Registered Complementary Medicines.

The TGA also takes a risk-based approach to device regulation. The TGA maintains robust post-market surveillance, including adverse event monitoring, targeted inspections and desktop reviews, to support ongoing assurance of device safety and performance. Onsite inspections were conducted and desktop reviews undertaken to assess quality management systems and process validation. Stakeholder engagement and consultation contributed to a robust regulatory framework that safeguards patient health, while facilitating timely access to innovative medical technologies.

The digital transformation program is ongoing. While the transformation is undertaken, the TGA continues to rely on existing and legacy systems. The transformation's implementation will support the delivery of performance measures by streamlining regulatory processes, improving decision-making speed and reducing the burden on industry and staff through intuitive, user-friendly digital systems.

Key Activity 1.8B:

Regulating through compliance and monitoring and providing advice on the import, export, cultivation, production, and manufacture of controlled drugs, including medicinal cannabis, to support Australia's obligations under the International Drug Conventions.

Source: *Health and Aged Care Corporate Plan 2024–25, p.49*

Performance Measure 1.8B:

Number of completed inspections of licence holders under the *Narcotic Drugs Act 1967*.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.74 and Health and Aged Care Corporate Plan 2024–25, p.49*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
30	33	31	30
	Result: Achieved ●		

Data Source and Methodology:

The Office of Drug Control (ODC) Monitoring and Compliance Section maintains a spreadsheet database of the compliance and enforcement inspections it undertakes. This dataset is expected to be migrated into a Case Management System for the ODC. Source documents include inspection reports, the inspection spreadsheet, Quarterly Inspection Schedules and Operational Management Committee Minutes.

In 2024–25, the ODC exceeded its planned performance target, completing 33 inspections against a target of 30. This reflects the effectiveness of internal planning and operational improvements, including enhanced scheduling systems, streamlined inspections and increased staff training. The ODC also met 94% of its 2-month timeliness standard, which requires inspections to be completed and reported within 60 calendar days of initiation. This high compliance rate reflects strong coordination and responsiveness in inspection delivery, ensuring timely feedback and accountability.

When compared to 2023–24, where 31 inspections were completed against a target of 27, the ODC has maintained a positive trajectory in inspection delivery. The increase in both planned and completed inspections over time reflects growing regulatory demand and the ODC's capacity to scale operations accordingly. The improvement in meeting and exceeding targets demonstrates a trend of strengthening performance and operational maturity.

Inspection volumes and timeliness in 2024–25 were shaped primarily by the ODC's strategic approach, including its continued refinement of a risk-based inspection model. This approach ensured resources were targeted effectively and inspections were delivered efficiently. While performance was strong in 2024–25, ongoing monitoring remains essential to ensure sustainable outcomes, particularly as regulatory environments evolve. The ODC will continue to refine its risk-based inspection approach to ensure resources are targeted effectively.

Key Activity 1.8C:

Administering the National Gene Technology Scheme by assessing applications and issuing approvals, and by conducting monitoring and compliance activities for genetically modified organism (GMO) approvals.

Source: *Health and Aged Care Corporate Plan 2024–25, p.50*

Performance Measure 1.8C:

a. Percentage of statutory timeframes met for decisions on applications.

b. Percentage of reported non-compliance with the conditions of GMO approvals assessed.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.74 and Health and Aged Care Corporate Plan 2024–25, p.50*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. ≥98%	a. 100%	a. Not applicable[122]	a. Not applicable[123]
b. ≥98%	b. 100%	b. 99.1%	b. 100%
	Result: Achieved ●		

Data Source and Methodology:

Records of applications and incidents are stored in departmental databases and records management systems. Data is analysed and maintained internally by the department. Application decisions are measured against statutory timeframes within the Gene Technology Regulations 2001. All reports or allegations (incidents) received are assessed in accordance with the Monitoring and Compliance Managing Incidents Reports Standard Operating Procedures.

a. In 2024–25, the Office of the Gene Technology Regulator (OGTR) completed 100% of statutory decisions within timeframes, achieving the planned performance target of ≥98%. The scope of the performance measure was substantially updated in 2024–25, increasing the breadth of performance evaluated by the measure. Business process mapping activities conducted during the reporting period helped to identify areas where effort could be reduced without compromising quality. Sufficient staff were available to ensure that statutory timeframes were met by OGTR during 2024–25.

Applications can be received at any time, affecting starting decision timeframes and defining decision due dates. OGTR is unable to predict the number, or the timing of applications received. Timeframes begin at time of receipt of complete applications, with decisions due as determined by the legislated timeframe for the application type. An unexpected volume of licence applications was received at the end of the 2024 calendar year. Licence applications require greater time, effort and expertise from OGTR staff compared to other statutory applications. Without implementing changes identified during internal continuous improvement activities, the statutory decision timeframes were unlikely to have been achieved in 2024–25. The total number of statutory decisions made was higher than previous years, with 192 statutory decisions made in 2024–25 compared to 168 in 2023–24.

[122] The performance measure for the 2023–24 and 2022–23 reporting period was *'Percentage of GMO licence decisions made within statutory timeframes'* therefore, the 2024–25 result is not a direct comparative analysis.

[123] Ibid.

b. In 2024–25, the OGTR assessed 100% of reported non-compliance with the conditions of GMO approvals, achieving the planned performance target of ≥98%. During 2024–25, the processes for recording receipt and assessment of reports of non-compliance with GMO authorisations was improved. This was through reviewing and updating the procedures for managing incident reports and allegations, and by enabling a new function to allow the input of the date of assessment for incidents. These improvements to the management of incidents, including reports of non-compliance with GMO authorisations, increased process consistency and made reporting of incident assessment more straightforward.

The achieved performance for 2024–25 is an improvement of the result from 2023–24, where 99.1% of reports were assessed. In 2024–25, 98 reports of non-compliance with GMO authorisations were received compared to 108 reports during 2023–24. Holders of GMO authorisations are required to report any incidences of non-compliance with their authorisation instruments. Reports are submitted by GMO authorisation holders as incidences of possible non-compliance occur, and the OGTR is unable to predict the number, or timing, of reports of non-compliance with GMO authorisations. Members of the public may also report to OGTR if they become aware of any non-compliance with GMO authorisations.

Key Activity 1.8D:

Completing industrial chemical risk assessments within statutory timeframes under the Australian Industrial Chemicals Introduction Scheme, to provide timely information and recommendations about the safe use of industrial chemicals.

Source: *Health and Aged Care Corporate Plan 2024–25, p.51*

Performance Measure 1.8D:

Proportion of Industrial chemical risk assessments completed within statutory timeframes.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.75 and Health and Aged Care Corporate Plan 2024–25, p.51*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
≥95%	100%	100%	100%
	Result: Achieved ●		

Data Source and Methodology:

Data source:

Data are sourced from risk assessment records stored within the AICIS Information Technology (IT) System (Microsoft Dynamics 365 Online Customers Relationship Management (CRM)) application containing administrative data, and the International Uniform Chemical Information Database (IUCLID) application containing scientific information.

Methodology:

Chemical risk assessments go through a workflow in CRM, with start and end dates tracked automatically. 'Stop clocks' are included in the CRM workflow to generate total working days. The data are extracted from the AICIS CRM and a simple tally performed. The number of AICIS risks assessments completed on time is compared to the total number completed, to arrive at the percentage completed on time. The data are simple to extract and do not require extensive transformation or manipulation.

Risk assessment of industrial chemicals identifies risks to human health and the environment and provides information to mitigate those risks. Timely completion of chemical risk assessments facilitates the safe use of industrial chemicals by providing information and recommendations for managing risks. Timely completion of pre-market assessment applications provides regulatory certainty for industry placing industrial chemicals on the Australian market.

To protect human health and the environment, AICIS undertakes both pre-market and post-market risk assessments of industrial chemicals. Pre-market risk assessments of certificate and commercial evaluation authorisation (CEA) applications identify potential risks before introduction and recommend risk management to ensure industrial chemicals are used safely while supporting innovation and regulatory compliance. Post-market risk assessments (or evaluations) of industrial chemicals ensure safe chemical introduction under changing conditions of use, newly available data or emerging concerns through published Evaluation statements and recommend risk management.

During 2024–25, AICIS completed:

- 22 pre-market risk assessments covering 22 unique industrial chemicals, including 19 assessed introductions and 3 commercial evaluation authorisations
- 26 post-market risk assessments (evaluations), covering 1,308 unique industrial chemicals.

All risk assessments were completed within statutory timeframes, as occurred in the prior 2 years. Risk assessment quality was assured through using internal peer review processes, seeking feedback from applicants on draft assessment statements, and undertaking public consultation on draft evaluation statements.

Program 1.9: Immunisation

Program Objective

Reduce the incidence of vaccine preventable diseases to protect individuals and increase national immunisation coverage rates to protect the Australian community.

The program's objective is to reduce the incidence of vaccine-preventable diseases by increasing national immunisation rates to protect the Australian community. The National Immunisation Program (NIP) supports access to safe and effective vaccines across the life course, with targeted initiatives to improve uptake among children, adolescents, older Australians, First Nations peoples and other priority populations.

Performance is assessed using 3 key indicators:

- immunisation coverage for children at 5 years of age
- immunisation coverage for First Nations children aged 12 to 15 months
- immunisation coverage for adolescents aged 15 years old.

These measures are selected because they are identified as high-priority cohorts within national frameworks, including the National Immunisation Strategy 2025–2030, Closing the Gap, the Essential Vaccines Schedule (EVS) to the Federal Financial Agreement and the National Strategy for the Elimination of Cervical Cancer in Australia. These measures also correspond to the key milestones in the NIP vaccine schedule.

The program's impact is realised through increased coverage, which in turn reduces the incidence and burden of vaccine-preventable diseases. This relationship is well established: as coverage improves, rates of disease, hospitalisation and death decline. According to the AIHW 2019 report *'The burden of vaccine preventable diseases in Australia'*, studies showed the rate of vaccine-preventable burden decreased by 31% between 2005 and 2015.[124] This reduction occurred where vaccines were added to, or eligibility was extended under the NIP such as human papillomavirus (HPV), pneumococcal disease and rotavirus. This reinforces the program's critical role in protecting individual and community health.

Immunisation coverage for other groups, including adults, older Australians and additional priority populations, is monitored and publicly reported through resources such as the National Centre for Immunisation Research and Surveillance (NCIRS) Annual Immunisation Coverage Reports.[125,126]

In 2024–25, the department undertook a range of initiatives to strengthen immunisation uptake and confidence. This included national campaigns such as *One more way you keep them safe* and the First Nations *Super Kids* campaign. The EVS provided performance-based funding to states and territories to support improvements in childhood and adolescent coverage, including HPV.

The First Nations Vaccination Uptake Support Grant commenced in 2024–25 to support Aboriginal Community Controlled Health Services in driving improved coverage in their communities. A key development in 2024–25 was the introduction of coordinated protection against respiratory syncytial virus (RSV). From February 2025, the maternal RSV vaccine was funded under the NIP, with states and territories funding access to a long-acting monoclonal antibody for infants.

The department has commissioned a pilot project to improve maternal vaccination uptake in response to the increasing complexity of the pregnancy vaccine schedule. The project focuses on co-designed resources and delivery approaches.

[124] The AIHW report is available at: **www.aihw.gov.au/reports/immunisation/the-burden-of-vaccine-preventable-diseases/summary**

[125] NCIRS Annual Immunisation Coverage Report 2023 (summary report) is available at: **www.ncirs.org.au/annual-immunisation-coverage-report-2023**

[126] NCIRS – Immunisation Coverage Data and Reports (includes the 2024 interim release) is available at: **ncirs.org.au/health-professionals/immunisation-coverage-data-and-reports**

The release of the National Immunisation Strategy 2025–2030 in June 2025 further strengthened national coordination by providing a framework focused on 6 priority areas:

- improving access and equity
- building trust in immunisation
- better use of data
- strengthening the workforce
- harnessing new technologies
- delivering sustainable program reform.

Through implementation of the Strategy, national targets and a monitoring framework will be developed to improve performance and accountability. The department remains focused on improving vaccination uptake across all age groups, including older Australians and vulnerable adults. This work is supported by ongoing monitoring and data-driven program adjustments.

Key Activity 1.9A:

Developing, implementing and evaluating strategies to improve immunisation coverage of vaccines covered by the National Immunisation Program (NIP), including through ensuring sufficient supply and efficient use of vaccines on the NIP.

Source: *Health and Aged Care Corporate Plan 2024–25, p.52*

Performance Measure 1.9A:

Immunisation coverage rates:

a. For children at 5 years of age are increased and maintained at the protective rate of 95%.

b. For First Nations children 12 to 15 months of age are increased to close the gap between First Nations children and non-First Nations children and then be maintained.

c. For 15-year-olds, HPV vaccinations are increased with a target of 90% coverage by 2030.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.76 and Health and Aged Care Corporate Plan 2024–25, p.52*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. ≥95%	a. 93.27%	a. 93.85%	a. 94.14%
b. ≥95%	b. 89.61%	b. 90.29%	b. 90.83%
c. ≥90%	c. 81.50% (females) 78.44% (males)	c. 84.75% (females) 82.03% (males)	c. N/A[127]
	Result: Not achieved ○		

Disclosures

2024–25, 2023–24 and 2022–23 Results:

There are known data quality issues which may affect the reported performance results. This includes non-reporting of vaccinations by immunisation providers, variations in vaccine acceptance within different cohorts and communities and data entry errors.

There is also a known administrative lag in the Australian Immunisation Register (AIR) data. AIR data may fluctuate over time based on the timing of providers uploading vaccine administration information into AIR. Previous year's results have indicated that this lag does not materially impact reported results.

Data Source and Methodology:

The AIR is the data source for these measures and is administered by Services Australia on behalf of the department.

Measure a. and b. The target has been set at 95% for children aged 5 years as this level provides sufficient herd immunity to prevent transmission of vaccine preventable diseases in the community.

Measure c. The target has been set at 90% as a measure to align with the national strategy for elimination of cervical cancer.

[127] This was a new performance measure in 2023–24, therefore results are not available for previous years.

The planned performance is set at 95% for children at 5 years of age and First Nations children aged 12 to 15 months, supporting herd immunity and contributing to efforts to close the gap in immunisation coverage between First Nations and non-First Nations children. The National Immunisation Strategy for Australia 2025–2030[128] reaffirms the national target of 95% coverage for childhood immunisation. This target is considered the protective threshold required to prevent outbreaks of highly infectious vaccine-preventable diseases, such as measles, in the community.

In 2024–25, immunisation coverage for children at 5 years of age and First Nations children aged 12 to 15 months did not meet the planned performance targets of ≥95%, with rates recorded at 93.27% and 89.61% respectively. While still relatively high, these figures reflect a national downward trend in early childhood vaccination since 2020.

The 2024–25 HPV vaccination rates for 15 year old adolescents were 81.50% for females and 78.44% for males, indicating additional effort is required to meet the ≥90% coverage target by 2030.

Departmental-funded research and analysis indicate that this decline is driven by a range of complex and interrelated factors.[129] These include behavioural and social influences, such as vaccine fatigue, reduced confidence in childhood immunisation, misinformation, as well as access related challenges, including practical barriers and competing priorities for parents and carers.

The department works primarily at the national level, supporting the immunisation system through public awareness activities, partnerships, policy development, and tools that enable access. In 2024–25, this included national campaigns such as *One more way you keep them safe* and the First Nations *Super Kids* campaign.

To support access and delivery, the Commonwealth funds 31 vaccines protecting against 18 diseases through the NIP.[130] The Commonwealth also subsidises immunisation services through the Medicare Benefits Schedule, enabling vaccine delivery via general practices, Aboriginal Community Controlled Health Services and other primary care settings. The National Immunisation Program Vaccinations in Pharmacy Program further supports access by funding pharmacists to deliver vaccines.

Catch-up vaccination[131] is funded under the NIP for individuals under 20 years of age (up to 26 years for HPV) and for refugees and humanitarian entrants of any age.

In addition, performance-based funding is provided to states and territories through the EVS to support improvements in childhood and adolescent coverage (including HPV).

The department also established the First Nations Vaccination Uptake Support Grant to enable Aboriginal Community Controlled Health Organisations to deliver culturally safe, community-led vaccination activities focused on improving coverage among First Nations children and families.

The National Immunisation Strategy 2025–2030 provides a renewed national framework to support coordinated action across all governments and sectors. It will guide future efforts to improve vaccination coverage, address inequities and strengthen public confidence in immunisation.

[128] Available at: **www.health.gov.au/resources/publications/national-immunisation-strategy-for-australia-2025-2030**

[129] Further information is available at: **ncirs.org.au/our-work/national-vaccination-insights-project**

[130] Available at: **www.health.gov.au/topics/immunisation/when-to-get-vaccinated/national-immunisation-program-schedule**

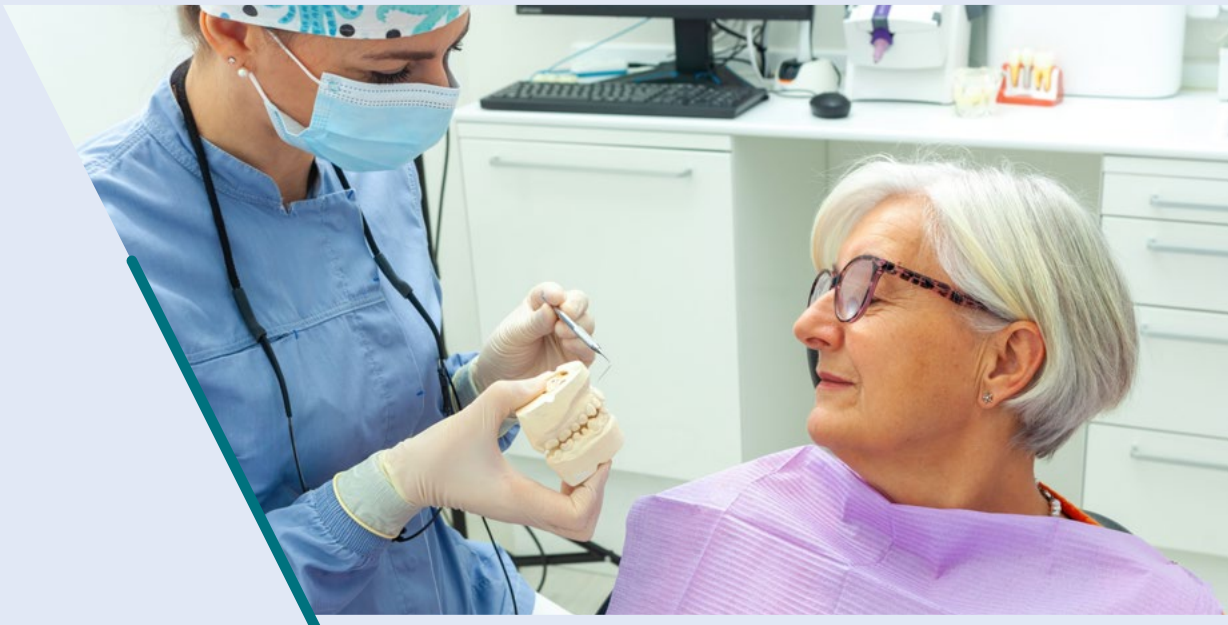
[131] Catch-up vaccination aims to provide optimal protection against disease as quickly as possible by completing a person's recommended vaccination schedule in the shortest but most effective time frame. Further information can be found here: **immunisationhandbook.health.gov.au/contents/catch-up-vaccination**

Outcome 2: Individual Health Benefits

Ensuring improved access for all Australians to cost-effective and affordable medicines, medical, dental and hearing services; improved choice in health care services, through guaranteeing Medicare and the Pharmaceutical Benefits Scheme; supporting targeted assistance strategies and private health insurance.

Programs contributing to Outcome 2

	Summary of results against performance criteria			
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**
Program 2.1: Medical Benefits	-	-	1	-
Program 2.2: Hearing Services	-	-	1	-
Program 2.3: Pharmaceutical Benefits	1	-	-	-
Program 2.4: Private Health Insurance	1	-	-	-
Program 2.5: Dental Services	1	-	-	-
Program 2.6: Health Benefit Compliance	1	-	-	-
Program 2.7: Assistance through Aids and Appliances	1	-	-	-
Total	**5**	**-**	**2**	**-**



Program 2.1: Medical Benefits

Program Objective

Deliver a modern, sustainable Medicare Benefits Schedule that supports all eligible Australians to access high-quality and cost-effective professional services. Work with consumers, health professionals, private health insurers and states and territories to continue strengthening Medicare. Provide and improve access to health services for all Australians through a contemporary Medicare Benefits Schedule (MBS) that is based on clinical evidence and which supports the provision of high quality services.

Medicare supports all Australians, and some overseas visitors,[132] to access a wide range of health and hospital services at low or no cost. The MBS is the primary mechanism through which the majority of Australians access healthcare. Through the MBS, the Australian Government provides patients with a subsidy to assist with the cost of a broad range of health services.

The MBS is a demand-driven program, with service utilisation influenced by the behaviour of both consumers and health practitioners. Consultations (often referred to as *attendances*) with general practitioners (GPs) are typically the first point of contact for patients using MBS services. As a result, the number of people accessing MBS services is closely correlated to the volume of GP attendances. In 2024–25, the MBS subsidised 475.2 million healthcare services across Australia, including 167.7 million GP attendances. The MBS paid $32.4 billion in benefits for all services claimed during this period, covering 73.9% of the total fees charged for those services.

The introduction of increased GP bulk billing incentives on 1 November 2023 influenced the GP bulk billing rate. Bulk billed services are provided at no out-of-pocket cost to the patient, with the full fee covered by the MBS. The GP bulk billing rate declined during the 2022–23 financial year and up to October 2023.

The Australian Government invested $3.5 billion in the 2023–24 Budget to triple the bulk billing incentive for GPs who bulk bill children under 16 years of age and concessional cardholders for the most common GP services.[133] This initiative aimed to strengthen access to primary care for those most in need. Following the introduction of the increased GP bulk billing incentives, the GP bulk billing rate stabilised and began to rise. The GP bulk billing rate was 77.3% in 2023–24, increasing to 77.9% in 2024–25.

The Jurisdictional Strengthening Medicare and Primary Care Forum (the Jurisdictional Forum) was established in September 2023 as a non-statutory committee. It is a mechanism for Commonwealth, state and territory relations regarding implementation of key Strengthening Medicare reforms, in response to the Strengthening Medicare Taskforce Report and against the Primary Health Care 10 Year Plan. The Jurisdictional Forum is chaired by the Department of Health, Disability and Ageing and includes senior officials from states and territories. Since its establishment and up to 30 June 2025, the Jurisdictional Forum has met 7 times to discuss the implementation of key Strengthening Medicare reform measures and other primary care initiatives that impact the delivery of health care under state and territory responsibility.

Strengthening Medicare and ensuring all Australians have access to affordable primary care services is a priority of the Australian Government. Medicare Urgent Care Clinics (UCCs) aim to ease the pressure on our hospitals and give families more options to see a healthcare professional when they have an urgent but not life-threatening need for care. The government collaborates and works closely with state and territory governments and Primary Health Networks (PHNs) in establishing and implementing Medicare UCCs. Regular engagement occurs via bilateral meetings as well as discussion at shared forums, including the Jurisdictional Forum.

[132] Some overseas visitors may also be eligible if they are visiting from a Reciprocal Health Care Agreement country. Further information is available at: **www.servicesaustralia.gov.au/reciprocal-health-care-agreements**

[133] Further information can be found at: **www.health.gov.au/sites/default/files/2025-03/the-impact-of-bulk-billing-investments-on-gp-earnings-and-billings.pd**f, accessed on 11 September 2025.

A range of Medicare statistics are regularly published by the Department of Health, Disability and Ageing as part of ongoing monitoring and reporting activities.[134] Additional Medicare data is also made available by Services Australia[135] and the Australian Institute of Health and Welfare.[136]

Key Activity 2.1A:

Supporting access to a contemporary and sustainable Medicare Benefits Schedule (MBS).

Source: *Health and Aged Care Corporate Plan 2024–25, p.55*

Performance Measure 2.1A:

Percentage of Australians accessing Medicare Benefits Schedule services.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.80 and Health and Aged Care Corporate Plan 2024–25, p.55*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
>90%	88.0%	88.6%	90.3%
	Result: Not achieved ○		

Data Source and Methodology:

Each Medicare patient has a unique identification number. The count of patients divided by the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) is equal to the proportion of patients who accessed Medicare Benefits Schedule subsidised services.

This measure has 2 components: Patient Count and ERP. Patients who have had at least one MBS claim during the relevant time period is divided by the ERP. Patient counts are extracted from Medicare claims data held in the department's Enterprise Data Warehouse (EDW). ERP figures are sourced from published ABS figures. ERP data as at the 30 June immediately prior to the Financial Year reported is used, consistent with public reporting of the measure and derivation of the threshold amount. For the 2024–25 measure this will be the ERP as at June 2024. The latest release of ERP available when the measure is reported is used.

The MBS is a demand-driven program and service utilisation depends on the behaviour of consumers and health practitioners. The decline in bulk billing rates and rise in out-of-pocket costs, coupled with increasing cost-of-living pressures, has resulted in a barrier for some patients when trying to access the care they need.

The denominator used for performance measure 2.1A is the ERP as at 30 June 2024. The 30 June ERP is used for consistency with historical statistical reporting and was the basis on which the threshold was set. Use of the 31 December ERP is preferable, as it falls midway through the financial year. If the performance measure had been calculated using the 31 December ERP, the result would be 87.4%. This does not have a material impact on the 2024–25 result.

The percentage of Australians accessing MBS services was 88.6% in 2023–24 and 88.0% in 2024–25. GP bulk billing rates had declined through 2022–23 and early 2023–24. From November 2023 GP bulk billing rates began to stabilise and increase. Performance against the target is anticipated to improve as GP bulk billing rates increase.

From 2023–24 to 2024–25, the total Medicare bulk billing rate increased by 0.4 percentage points to 75.4% and the GP Non-referred Attendance (GP NRA) bulk billing rate increased by 0.6 percentage points to 77.9%. GP NRA service utilisation increased by 1.9% in 2024–25, returning to a growth pattern similar to population growth, after a fall of -1.4% in 2023–24. Overall MBS services grew by 3.4% compared to 1.1% in 2023–24.

[134] Available at: **www.health.gov.au/resources/collections/medicare-statistics-collection**
[135] Available at: **www.servicesaustralia.gov.au/medicare-statistics**
[136] Available at: **www.aihw.gov.au/reports-data/health-welfare-services/medicare/overview**

The Australian Government has invested $7.9 billion in the 2025–26 Budget to expand eligibility for bulk billing incentives to cover all Australians from 1 November 2025 and will introduce a GP practice incentive program for practices that bulk bill all patients. These measures are designed to support GPs to continue to offer bulk billing to Medicare-eligible people who have been most impacted by rising cost-of-living pressures.

Reductions in demand for services may also result from patients accessing care through other health professionals (e.g. obtaining clinical certificates for work absences from pharmacists or accessing clinical services through pharmacy-led trials in some states). Additionally, services not funded under the MBS may be accessed through privately funded providers (e.g. online clinics), or through other government programs (e.g. Department of Veterans' Affairs). Reductions in demand for Medicare services due to these factors would be anticipated to increase in the future, as the government is undertaking work to support scope of practice reform. The department will consider whether the performance measure needs to be adjusted to reflect the expected reduction in demand due to these reforms.

Program 2.2: Hearing Services

Program Objective

Provide high-quality hearing services, including devices, to eligible people to help manage their hearing loss and improve engagement with the community.

The Hearing Services Program has 2 service delivery components, the Voucher scheme and Community Service Obligations (CSO).

Voucher scheme services are delivered by a network of over 370 hearing providers across more than 3,500 locations Australia-wide. People are eligible for the Voucher scheme services if they are an Australian citizen or permanent resident or live on Norfolk Island, are aged 21 years or older, and are:

- a pensioner concession card holder
- a member of the Australian Defence Force personnel
- a Veteran Gold Card holder or Veteran White Card holder (hearing specific conditions), or their spouse
- referred by a Disability Employment Service.[137]

CSO is delivered by Hearing Australia and supports Australians aged under 26 years, eligible Aboriginal and Torres Strait Islander peoples and eligible people who require specialist hearing services or that live in a remote area.[138]

The Hearing Services Program also supports hearing health research conducted by the National Acoustic Laboratories.[139]

The department publishes information about the program to raise awareness about hearing support available, including eligibility requirements, service offerings and how to locate a program provider. The department's administrative role also includes:

- accrediting new providers
- managing provider contracts and deeds of standing offer with device suppliers
- providing resources and education materials to support providers in meeting their obligations under the program's governing legislation and contractual requirements
- responding to provider and client enquiries
- conducting compliance activities
- managing a Memorandum of Understanding with Hearing Australia.

Further information can be found at Hearing Australia.[140]

[137] Further information can be found at: **www.health.gov.au/our-work/hearing-services-program/accessing/eligibility**
[138] Ibid.
[139] Further information can be found at: **www.health.gov.au/resources/publications/research-strategy-hearing-health**
[140] Available at: **www.hearing.com.au/**

Key Activity 2.2A:

Provide access to high-quality hearing services through the delivery of the Voucher scheme and Community Service Obligations (CSO) component of the Hearing Services Program (HSP).

Source: *Health and Aged Care Corporate Plan 2024–25, p.56*

Performance Measure 2.2A:

a. Number of active vouchered clients[141] who receive hearing services.

b. Number of active Community Service Obligations clients who receive hearing services.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.81 and Health and Aged Care Corporate Plan 2024–25, p.56*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. 899,000	a. 833,595	a. 806,756	a. 801,008
b. 81,700	b. 67,575	b. 62,041	b. 69,959
	Result: Not achieved ○		

Disclosures:

2024–25 Result:

The number of Voucher scheme clients that received a program service in the reporting period was 833,595. The data to inform this result was extracted on 15 July 2025. Providers have up to 12 months to claim for services, which may impact the final result. Any variance to the final result will be published in the 2025–26 Annual Report.

The number of CSO clients that received a program service in the reporting period was 67,575.

2023–24 Result:

The 2023–24 result for performance measure a. has been revised to reflect the final result following the conclusion of the 12 month provider claiming period for 2023–24. The result as of 30 June 2024 and published in the 2023–24 Annual Report was 800,733. The revised data result for 2023–24 was extracted on 15 July 2025.

2022–23 Result:

The result for a. was amended in the 2023–24 Annual Report to reflect the final result following conclusion of the 12 month provider claiming period for 2022–23. The result as of 30 June 2023 and published in the 2022–23 Annual Report was 802,902. The decrease is a result of an update in methodology to change from calculating by the date of payment to calculating by the date of service, as well as invalid items which were subsequently recovered for the period.

Data Source and Methodology:

Measure 2.2A(a):

Client, services and claiming data is submitted through the Hearing Services Online Portal by contracted providers. Client eligibility status is validated with Services Australia via the online Centrelink Confirmation eServices (CCES), and by contacting other relevant agencies e.g. Department of Veterans' Affairs (DVA). Claiming data is subject to a range of data integrity checks undertaken by the program's compliance team. The measure is defined by the number of vouchered clients who received at least one claimed program funded service during the (financial year) reporting period as at the reporting date.

Voucher scheme eligibility includes Pension Concession Card holders, DVA Gold Card and DVA White Card holders, Defence personnel and people referred by the Disability Employment Services Program, as defined by the *Australian Hearing Services Administration Act 1997*. A Voucher service is defined by items listed in the program's Schedule of Service Items and Fees.[142]

[141] Active clients refer to the number of current voucher holders that have accessed one or more program services during the year.

[142] Available at: **www.legislation.gov.au/Details/F2023N00172**

Measure 2.2A(b):

CSO data is sourced from Hearing Australia, the provider of CSO services and a statutory authority as established by the *Australian Hearing Services Act 1991*.

Each client's reason for CSO eligibility is recorded in the client management system following a 'first in list' principle, which ensures they are categorised correctly and only once. Hearing Australia extracts client data from the client management system into a data warehouse.

Relevant data is then extracted from the data warehouse to meet CSO reporting requirements. Each CSO client is only counted once in any financial year and will appear in the quarterly report when they receive their first service that financial year. Hearing Australia's Quarter 4 CSO Report (Annual Report) provides the total number of CSO clients supported in the reporting period.

The planned performance is an estimate based on historical program data trends, the growth of the Hearing Services Program eligible population, and in consideration of any policy changes.

Actual performance is dependent on the number of eligible people who choose to access hearing support services through a program provider during the reporting period. The delivery of services can also be affected by unexpected local emergencies or natural events, such as flooding, bushfires or workforce shortages.

Program providers have up to 12 months from the date of service to submit a claim for Voucher scheme services provided in the reporting period, which means the number of clients supported in the reporting period could increase from the result. Any variance to the performance result for 2024–25 will be published in the department's 2025–26 Annual Report.

In 2024–25, the number of vouchered clients who received hearing services was lower than forecasted. A contributing factor to this outcome was a change in voucher length to extend vouchers from 3 years to 5 years, implemented in 2020–21. This year marks the final reporting period during which the policy extending voucher validity is expected to have a measurable impact on the reported client numbers.

The number of Voucher scheme clients increased by 3.3% compared to 2023–24. This represents a growth on the previous year's result, where the number of Vouchered clients receiving program support in the reporting period was relatively low (0.7%) compared with 2022–23. This growth is consistent with an increased number of clients eligible for a new voucher being issued in the reporting period, following the expiry of previously issued vouchers that were extended to 5 years in 2020–21.

The number of CSO clients that received support in 2024–25 increased by 9% compared with the previous year.

The model used to generate future client projections is being reviewed by the department to improve the accuracy of future projections.

Program 2.3: Pharmaceutical Benefits

Program Objective

Provide all eligible Australians with reliable, timely, and affordable access to high-quality, cost-effective medicines, and pharmaceutical services, by subsidising the cost of medicines through the Pharmaceutical Benefits Scheme (PBS).

The Australian Government's investment in the PBS ensures Australians have access to affordable medicines, helping to ease personal financial pressures. For individuals managing medical conditions or co-morbidities, subsidised prescription medicines can significantly reduce out-of-pocket costs associated with treatment and ongoing care.

On 1 January 2025, the government introduced a one-year freeze on indexation of the maximum patient cost for PBS medicines. This means co-payments remain at 2024 levels: $31.60 for general patients and $7.70 for concessional patients. For pensioners and Commonwealth concession card holders, the freeze will remain in place for 5 years, until 1 January 2030.

In addition to the freeze, nearly 300 medicines are now available under 60-day prescriptions. This initiative allows patients to receive double the quantity per script, reducing the frequency of pharmacy visits and further lowering costs. Eligibility for 60-day prescriptions remains unchanged and together with the co-payment freeze, these measures help assist Australians to save both time and money.

To strengthen supply chains, the government entered into the First Pharmaceutical Wholesaler Agreement (1PWA)[143] with the National Pharmaceutical Services Association in 2024. Under this agreement, wholesalers must meet the Community Service Obligation by holding and supplying all PBS medicines to community pharmacies—typically within 24 hours—regardless of location.

[143] Available at **www.health.gov.au/resources/publications/first-pharmaceutical-wholesaler-agreement-1pwa**

Key Activity 2.3A:

Provide all eligible Australians with reliable, timely, and affordable access to high-quality, clinically effective, cost-effective medicines recommended by the Pharmaceutical Benefits Advisory Committee, by listing new medicines on the Pharmaceutical Benefits Scheme (PBS).

Source: *Health and Aged Care Corporate Plan 2024–25, p.58*

Performance Measure 2.3A:

Percentage of new medicines recommended by the Pharmaceutical Benefits Advisory Committee (PBAC) that are listed on the Pharmaceutical Benefits Scheme within 6 months of in principle agreement to listing arrangements.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.82 and Health and Aged Care Corporate Plan 2024–25, p.58*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
≥80%	100%	100%	100%
	Result: Achieved ●		

Data Source and Methodology:

Data is analysed for each new medicine listed on the PBS within a financial year. Data is maintained internally by the department. The date of listing is based on the first appearance of that new medicine in the National Health (Listing of Pharmaceutical Benefits) Instrument 2024 (PB 26 of 2024). The date when the in-principle pricing outcome letter is sent to the sponsor is used as the date of in-principle agreement to listing arrangements and is publicly available on the Medicine Status website[144] as the date government processes commence. More information on the PBAC is available on the department's website.[145]

During 2024–25, the department continued negotiations with medicine sponsors and listing activities for new medicines on the PBS, resulting in 100% of new medicines listed on the PBS within 6 months of in-principle agreement to listing arrangements. The average listing time was 4.3 months for applicants who followed the process and lodged a pricing offer at the earliest opportunity following a positive PBAC recommendation in 2023–24.

Ongoing improvements to PBS business processes has resulted in the department achieving its planned performance each year. For example, during 2017–18, the department collaborated with the medicines industry to develop a revised PBS application and assessment framework. The time to list has reduced by an average of 2.4 months (average reduction over 2019–20 to 2023–24).

Discussions about the finalisation of price and budget impact following PBAC recommendation are often complex and may, in limited circumstances, require further PBAC consideration. A 6-month timeframe is considered sufficient to provide adequate time to negotiate complex pricing and budget impact issues, seek agreement to listing arrangements, seek government approval, and finalise and distribute the amended PBS schedule. Ongoing improvements to PBS business processes has resulted in the department achieving the set performance levels.

To enhance operational efficiencies and effectiveness, the Program continues to refine business processes and invest in information technology systems, such as the Health Products Portal.[146]

[144] Available at: **www.pbs.gov.au/medicinestatus/home.html**
[145] Available at: **www.pbs.gov.au/info/industry/listing/elements/pbac-meetings**
[146] Further information on the Health Products Portal can be found at: **hpp.health.gov.au**

Program 2.4: Private Health Insurance

Program Objective

Promote affordable, cost-effective, quality private health insurance (PHI) and choice for consumers.

PHI plays an important role in supporting the Australian health system by helping patients access health services when they need them. PHI offers various benefits to consumers, including choice of doctor, coverage for some services not covered under Medicare arrangements, and shorter waiting times for some services.[147]

The program oversees strategic policy and projects relating to Australia's private health care system and its interaction with the public health care system. The focus of the program is to improve the value and affordability of PHI for consumers, promote consumer access and choice of private hospital and general treatment care. The program aims to optimise the contribution the private health sector makes to Australia's hybrid public–private health systems. The program directly supports people who hold PHI through the income-tested and age-based PHI Rebate,[148] which is paid to eligible policyholders as a percentage of the premium charged.

The department, in consultation with the Australian Prudential Regulation Authority (APRA), assesses PHI premium change applications to the Minister for Health and Ageing. This is to ensure the requested changes are not contrary to the public interest, to support the Minister's consideration under section 66-10 of the *Private Health Insurance Act 2007*. The assessment considers whether the requested increases are necessary to ensure that health insurers can continue to provide consumers with access to high-quality medical care by covering the increasing costs of health care services. This supports the value and affordability of PHI and optimises the contribution that the private health sector makes to Australia's hybrid public–private health system.

[147] Further information can be found at: **www.health.gov.au/topics/private-health-insurance/about-private-health-insurance**

[148] Further information on the PHI Rebate is available at: **www.ato.gov.au/individuals-and-families/medicare-and-private-health- insurance/private-health-insurance-rebate/income-thresholds-and-rates-for-the-private-health-insurance-rebate**

Key Activity 2.4A:

Assessment of private health insurer premium change applications.

Source: *Health and Aged Care Corporate Plan 2024–25, p.59*

Performance Measure 2.4A:

Percentage of applications to the Minister from private health insurers to change premiums charged under a complying health insurance product that are assessed within approved timeframes.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.83 and Health and Aged Care Corporate Plan 2024–25, p.59*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
100%	100%	100%	100%
	Result: Achieved ●		

Data Source and Methodology:

The method to calculate this measure is:

The number of applications assessed within approved timeframes/the number of applications received from private health insurers. Data on the number of applications received from private health insurers through a secure online system in the approved form is tracked internally by the department.

The department uses the following definitions when calculating the number of applications assessed within approved timeframes:

- 'assessed' means that advice has been provided to the Minister to decide on an insurer's proposed premium changes.
- 'approved timeframe' is 60 days prior to the price change on 1 April, plus 2 weeks for the Minister to consider the submission.

Timely assessment of insurer premium change applications enables essential information to be communicated to existing policyholders, as well as those considering purchasing PHI, to assist in informing their purchasing decisions. This includes providing an opportunity to compare offers available across a range of private health insurers.

A number of internal activities contributed to meeting this performance measure in 2024–25, including:

- early planning of the premium application process
- identification of necessary resources, capabilities and risks for management
- close consultation with private health insurers, APRA, and the Minister for Health and Ageing.

In the 2025 premium round, the department received premium change applications from 29 private health insurers. All applications were processed within the approved timeframes, leading to 100% performance in line with the performance measure for Program 2.4. The 2024–25 result is consistent with previous years' performance, demonstrating that application processes are robust and enable assessment within approved timeframes.

Key external factors impacting the assessment in 2024–25 included:

- the uncertainty of the industry impact of the New South Wales Government public hospital room rate and ambulance levy, which required additional guidance to be provided to insurers
- the continued residual impact of the COVID-19 pandemic on long-term trends in private health service levels
- monitoring insurers' progress against their commitments not to profit from the pandemic's impact
- changes to APRA industry reporting standards impacting data used for the premium round
- flow-on effects from government initiatives (such as Prescribed List reforms), which increased the complexity of assessing applications within the approved timeframe.

These factors were addressed by the internal activities identified above.

Program 2.5: Dental Services

Program Objective

Support eligible children to access essential dental health services through the Child Dental Benefits Schedule (CDBS).

The CDBS is jointly administered by the Department of Health, Disability and Ageing and Services Australia in accordance with the *Dental Benefits Act 2008* and the Dental Benefits Rules 2014.

The CDBS is a demand-driven program that aims to improve access to dental services for eligible children[149] by covering part or all the cost of basic dental services.[150] Eligible children are notified by Services Australia via an eligibility letter sent by post or through myGov, and the department provides a CDBS information brochure to all eligible children.

Oral health care is an important aspect of personal health. Poor oral health care can affect a person's ability to communicate and participate in a range of settings, including education, employment, social and community engagement. Preventative dental care is critical for young people and guaranteeing their health into the future. Poor oral health early in life is the strongest predictor of further oral disease in adult life. Providing dental services under the CDBS enables eligible children to access dental care they may have otherwise been unable to afford.

[149] Children are eligible for the CDBS when they meet the following criteria: eligible for Medicare, between 0 and 17 years old for at least one day that calendar year and they or their parent/caregiver receive an eligible payment at least once that calendar year. Further information on eligible payments can be found at: **www.servicesaustralia.gov.au/eligible-payments-for-child-dental-benefits-schedule**

[150] Further information can be found at: **www.servicesaustralia.gov.au/whats-covered-child-dental-benefits-schedule**

Key Activity 2.5A:

Working with Services Australia to increase awareness of the CDBS program to support eligible children to access essential dental health services.

Source: *Health and Aged Care Corporate Plan 2024–25, p.60*

Performance Measure 2.5A:

The percentage of eligible children accessing essential dental health services through the Child Dental Benefits Schedule.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.84 and Health and Aged Care Corporate Plan 2024–25, p.60*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
38.5%	40.7%	39.2%	38.8%[151]
	Result: Achieved ●		

Disclosures:

2024–25 Result:

The result reports uptake data for the 2024 calendar year, and eligible notified children for the 2024–25 financial year. Children who make multiple claims in the period are counted once.

Data Source and Methodology:

The National CDBS Uptake Data is collected by Services Australia, who jointly administers the program. Services Australia and the department agree to use the National CDBS Uptake Data due to the accuracy. The methodology involves 2 parameters which are: CDBS eligible children accessing CDBS funded services divided by the number of eligible notified children; this provides the utilisation rate which is displayed as a percentage.

There are a number of reasons an eligible child is not notified of eligibility for the CDBS, including withholding of address due to family violence and Services Australia not notifying newly eligible children during November and December of each year.

This is to minimise customer confusion in receiving a letter late in the year and then receiving another letter in January with a different benefit cap amount. Customers are able to check eligibility to the CDBS at any time via the myGov app.

In the 2024–25 financial year, 2,341,799 children were notified of eligibility for the program, with 954,792 eligible children accessing dental services under the CDBS in the 2024 calendar year.

Performance of the program relies on eligible children attending a dental provider and claiming under the program. Previous analysis indicates that demand for dental services under the CDBS can vary based on external circumstances, including poor oral health care, confusion around eligibility, possible out-of-pocket costs for patients, and cost-of-living pressures.

To address some of the recommendations of the Report on the Fifth Review of the *Dental Benefits Act 2008*[152] the department is working with Services Australia to raise awareness and increase uptake of the CDBS. Recent activities include:

- updating the bulk-billing patient consent form, which advises parents, carers and guardians that there will be no out-of-pocket costs for basic dental services provided within a public dental clinic
- advertising the CDBS via social media and through the department's Stronger Medicare campaign
- simplifying the eligibility notification letters for eligible children.

The department is also working with its state and territory counterparts to boost awareness and usage of the CDBS through the public dental system. The planned performance for 2024–25 was re-baselined to reflect the recovery of the program following the COVID-19 pandemic more accurately. Previous planned performance targets were based on the 2017 utilisation rates, which included a projected growth rate of 2.1%. The revised targets reflect the post- pandemic recovery in the uptake of the program and retain a 2.1% growth rate.

[151] Eligibility is based on the number of notified children data provided by Services Australia.

[152] Available at: **www.health.gov.au/resources/publications/report-on-the-fifth-review-of-the-dental-benefits-act-2008**

Program 2.6: Health Benefit Compliance

Program Objective

Support the integrity of health benefit claims through prevention, early identification and treatment of incorrect claiming, inappropriate practice and fraud.[153]

The cost of managing the compliance program in 2024–25 was $62.786 million. During 2024–25, compliance actions resulted in $54.1 million of invoices being issued and $52 million collections received during the same period. Additional compliance benefits include behavioural savings of $345.82 million. The department uses an agreed methodology to calculate behaviour saves and reductions in health payment expenditure following a compliance treatment.

There are 2 primary pathways for identifying non-compliance: human intelligence through tip-offs and technology-derived signals. The department utilises sophisticated data analytics, data matching and intelligence tools to detect and analyse suspected fraud and non-compliance. Claiming data and the industry are actively monitored to ensure our compliance priorities evolve and remain responsive to emerging risks.

Tip-offs from the public and other practitioners remain highly valuable sources of intelligence and are crucial for developing non-compliance signals for possible treatment. During 2024–25, an updated webform was developed to improve usability and accessibility, encouraging more public reporting.[154]

In 2023–24, the Medicare Integrity Taskforce was established to support the Australian Government's initial response to the Independent Review of Medicare Integrity and Compliance (Philip Review).[155] Continued support to extend and expand the government's response to the Philip Review was provided in the 2024–25 Budget, funding the taskforce for a further 2 years. Key integrity reforms delivered to date include:

- changing legislation in line with Philip Review recommendations
- increasing fraud reduction measures to strengthen Medicare integrity
- introducing system checks that help stop payment of certain claims when they are incorrect
- building new data models to find fraud and non-compliance faster.

The taskforce has also worked closely with health and medical peak body stakeholders to develop tailored education and information resources that help Medicare users understand the rules.

[153] The department measures effectiveness by identifying potentially incorrect claiming and then treating that through audits, practitioner reviews and/or investigations. These treatment activities may result in recovery of incorrectly paid benefits, or the referral of cases to the Professional Services Review or Commonwealth Director of Public Prosecutions.

[154] Available at: **www.health.gov.au/about-us/corporate-reporting/report-suspected-fraud/online-form**

[155] Available at: **www.health.gov.au/resources/publications/independent-review-of-medicare-integrity-and-compliance-final-report**

In 2024–25, the department improved its fraud identification capability, primarily using advanced analytical modelling and machine-based learning, to enhance proactive identification of serious non-compliance and fraud. This represents a significant step forward in data-driven fraud identification capability when compared to the capabilities described in the Philip Review.

Education, behaviour changes and upfront preventative system controls are vital to avoid non-compliance. These efforts are significant and growing.

The department published the 'Understanding Medicare: Provider Handbook',[156] a clear, public-facing guide that helps providers and medical administrative staff to navigate Medicare rules and requirements. This resource supports consistent compliance and helps users build a solid foundation in Medicare principles, reducing the risks of unintentional errors. The Handbook is now embedded in the provider number application process through Services Australia, linked directly to the declaration section of the application form. This establishes it as a vital reference for all Medicare billing stakeholders.

The department engaged with a broader range of peak bodies to extend the reach of compliance education and strengthen sector-wide understanding of compliance requirements. During the 2024–25 financial year, the department delivered 7 face-to-face educational events and coordinated a further 12 events scheduled to take place by the end of 2025. This represents a significant increase in support compared to the previous year and demonstrates a strong focus on proactive engagement with healthcare providers and medical administrative staff, contributing to improved performance outcomes.

The AskMBS service provides advice on the application and interpretation of the MBS and associated legislation and aims to assist health professionals to understand and comply with MBS requirements.[157] Working closely with the department's policy areas and Services Australia, AskMBS provided individualised, tailored responses to 7,070 enquiries. This gives providers up-to-date and authoritative advice to reduce non-compliance before it occurs. The public-facing AskMBS advisories provide a summary of frequently asked questions about areas of interest. Professional bodies have signalled that these are a valuable resource for providers, who use the information to support billing practices.

The department works closely with Services Australia to protect the integrity of the Medicare system:

- Services Australia processes all payments and has carriage of fraud and non-compliance by members of the public
- the department manages fraud and non-compliance by health practitioners, their staff and corporate entities
- we exchange data, intelligence and other information to work toward the common goal of protecting the integrity of the system.

The department has improved the way we work with Services Australia to protect the integrity of Medicare, including establishing the Medicare Integrity Reform Program Board.

The department has undertaken a review of key components of its compliance operating model, including its strategy, organisation and structure, and performance reporting. In 2025–26, the department will implement a new operating model with a greater focus on integrity by design, enhanced prevention efforts and automating and focusing post-payment responses. As part of this, the department will modernise the Compliance Work Management System (used for the performance measure) to ensure it is current and fit for purpose.

[156] Available at: **www.health.gov.au/resources/publications/understanding-medicare-provider-handbook**
[157] Available at: **www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/MBS-interpretation**

Key Activity 2.6A:

Ensuring that audits and reviews are targeted effectively at providers whose claiming is potentially non-compliant.

Source: *Health and Aged Care Corporate Plan 2024–25, p.61*

Performance Measure 2.6A:

Percentage of completed audits, practitioner reviews and investigations that find non-compliance.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.85 and Health and Aged Care Corporate Plan 2024–25, p.61*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
>80%	97%	>95%	>90%
	Result: Achieved ●		

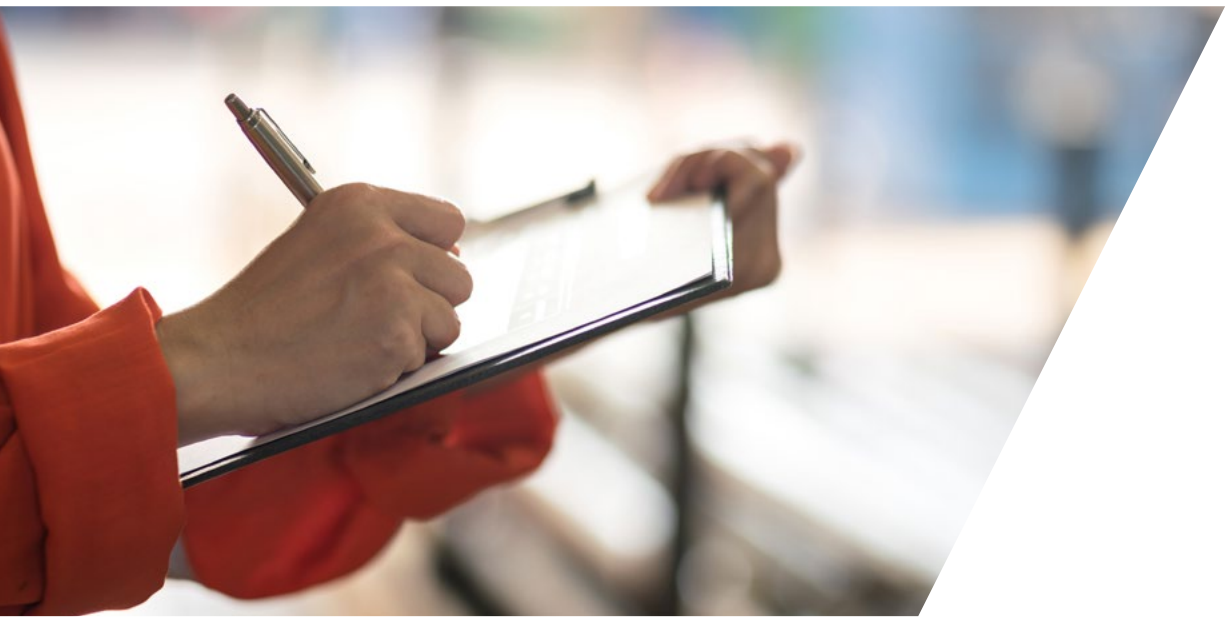
Data Source and Methodology:

Data Source:

Administrative data is used to report against this performance measure in the form of completed case records maintained in the department's Compliance Work Management System (CWMS). The specific case types that are used to report against this measure are Audit, Practitioner Review and Investigation cases. The data inputs for analysis of claims and payment information are from Services Australia which administrates health claims and payments.

Methodology:

Key Performance Indicator reporting is automatically generated from the CWMS based on documented business rules. The number of completed and non-compliant cases reported are validated by reviewing outputs against a separate, unique operational report on completed cases. The rate of non-compliance is determined by the number of non-compliant outcomes divided by the total outcomes (compliant + non-compliant).



The department uses a risk-based and proportionate approach to compliance with action taken based on the seriousness and scale of the identified behaviour. Following assessment, the department can pursue a range of responses/treatments. In 2024–25, the department pursued a range of interventions and treatments through:

- **Early intervention** activities are undertaken where it is suspected there may be inadvertent incorrect claiming. Promoting correct claiming of health benefits and encouraging practitioners to review their claiming and business processes can lead to:
  - practitioners repaying incorrectly received benefits
  - positive behaviour change
  - preventing escalation in responses or treatment to more costly and time-consuming treatments.

  In 2024–25, the department undertook a letter campaign in response to concerns about multiple magnetic resonance imaging (MRI) item claims for single body regions on the same day. Targeted letters were issued to 85 identified providers. Of those, 89% responded, with 82% submitting a Voluntary Acknowledgements of Incorrect Claims form, resulting in $1.07 million in debts. Responses came from corporate imaging practices, citing administrative errors or a separate and distinct scan had not been requested. The project significantly exceeded expectations, with debts raising more than 250% above projected direct savings.
- **Audits** of providers where they appear to have claimed in a sustained way that breaches health program requirements. In 2024–25, the department identified over 800 cases for audit or non-statutory action.
- **Peer and professional review** by reviewing practitioners and corporate entities where potential inappropriate practice (servicing or prescribing behaviour) is identified. In 2024–25, the department conducted 264 peer interviews under the Practitioner Review Program (PRP) and referred 116 cases to the Professional Services Review (PSR) for investigation. The PSR completed 114 reviews, resulting in $27.29 million in debts raised.
- **Fraud and criminal investigations** into allegations of fraud by health providers and their staff. Through tip-offs and intelligence signals, the department referred 8 Briefs of Evidence to the Commonwealth Director of Public Prosecutions. During the same period, 4 prosecutions resulted in convictions. Court outcomes included sentences by way of fines through to significant terms of imprisonment, such as up to 7 years' incarceration. As at 30 June 2025, 5 matters were before the criminal courts, with an estimated detriment to the Commonwealth of $9.6 million. For further information on broader fraud activities, please refer to **Part 3.1 Corporate Governance** of this annual report.

The current performance measure covers reporting on post-payment audit, PRP and investigation success rates. The development of the new Benefits Integrity Operating Model undertook comprehensive analysis of this current measure. It encourages a focus on high probability action and underrepresents the value of program integrity activity. As part of implementation of the new operating model, alternative measures are being developed to better capture the effectiveness of this program. These will explore a range of metrics that together will better measure health benefits integrity performance for the department.

Program 2.7: Assistance through Aids and Appliances

Program Objective

Improve health outcomes for the Australian community through the provision of targeted assistance for aids and appliances.

The National Diabetes Services Scheme (NDSS) is an initiative of the Australian Government that commenced in 1987. The NDSS aims to enhance the capacity of people with diabetes to better understand and self-manage their life with diabetes. The NDSS assists people with diabetes to access diabetes programs, services and subsidised products, and access health professionals.

The NDSS provides subsidised access to the following products for the management of diabetes:

- syringes and needles
- blood glucose test strips
- urine test strips
- insulin pump consumables
- continuous glucose monitoring products.

In 2024–25, the department continued to implement new initiatives and source new technologies to effectively supply and distribute products. The department completed an Approach to Market to refresh the range of products available through the NDSS.

The NDSS also provides support services and diabetes health resources under a multi-year grant agreement with Diabetes Australia. This helps people living with diabetes to access services and information to allow them to manage their diabetes effectively. This included online and in-person programs, including Diabetes in Schools, the Aboriginal and Torres Strait Islander Program, the Culturally and Linguistically Diverse Program,[158] in addition to health professional communication and engagement. Specific programs run by the NDSS are KeepSight,[159] which promotes regular eye checks, and Foot Forward,[160] which raises awareness of foot health.

Further information can be found at Diabetes Australia annual report[161] and the NDSS website.[162]

[158] Further information on support programs is available at: **www.ndss.com.au/services/support-programs/**
[159] Available at: **www.keepsight.org.au/about**
[160] Available at: **www.footforward.org.au/**
[161] Available at: **www.diabetesaustralia.com.au/about-us/annual-reports/**
[162] Available at: **www.ndss.com.au**

Key Activity 2.7A: Deliver the National Diabetes Services Scheme, with the assistance of Diabetes Australia. Source: *Health and Aged Care Corporate Plan 2024–25, p.63*	
Performance Measure 2.7A: Number of people accessing subsidised products through the National Diabetes Services Scheme. Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.86 and Health and Aged Care Corporate Plan 2024–25, p.63*	
2024–25 Planned Performance	**2024–25 Result**
>750,000	752,659
	Result: Achieved ●
Data Source and Methodology: The NDSS Central IT System manages NDSS product ordering and supply. This data is used to identify the number of NDSS registrants who have ordered product in the past year.	

The department achieved the planned performance, with 752,659 people accessing NDSS subsidised products throughout 2024–25.

To ensure a broader choice of products for people with diabetes, a request for expressions of interest was released in November 2024 to secure future supply arrangements for the NDSS, including broader product distribution, more supply and related administration.

While the number of people newly registered with the NDSS remained stable in 2024–25 compared to the previous 12 months to 30 June 2024, it is anticipated that more Australians may rely on NDSS services and products in future years.

Cost-of-living pressures appear to be having an impact on people's choices in accessing NDSS subsidised products. The department will continue to monitor the impact arising from cost-of-living pressures with assistance from primary care general practitioners and other health professionals supporting individuals with diabetes.

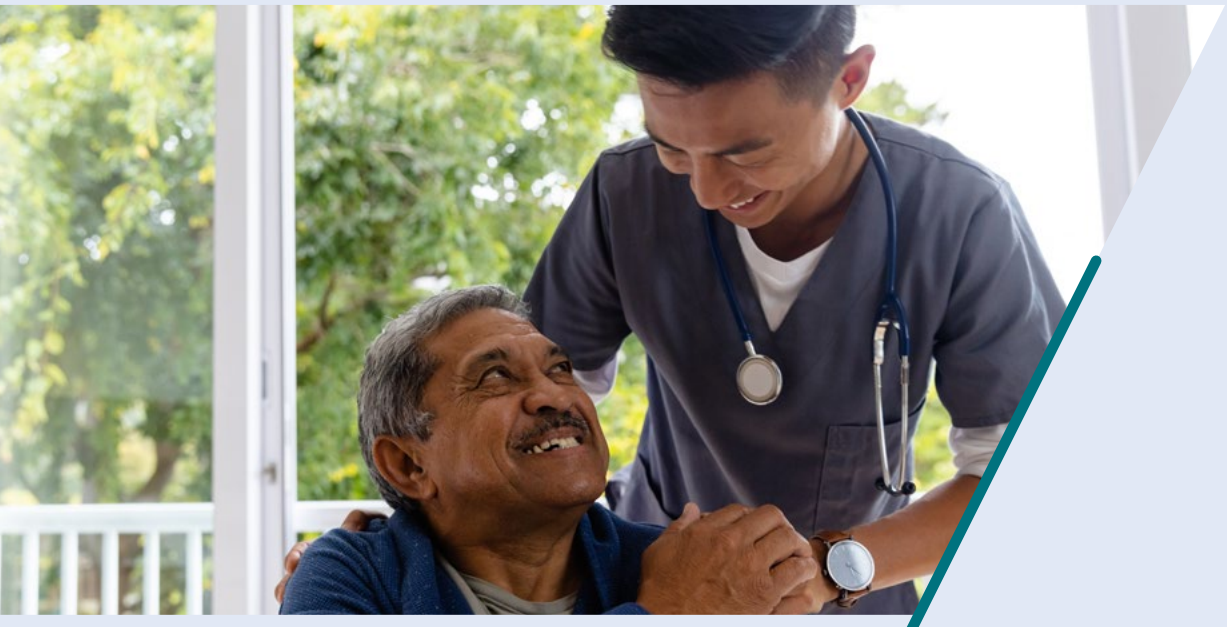
Outcome 3: Ageing and Aged Care

Improved wellbeing for older Australians through targeted support, access to appropriate, high-quality care, and related information services.

Programs contributing to Outcome 3

	Summary of results against performance criteria			
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**
Program 3.1: Access and Information	-	-	2	-
Program 3.2: Aged Care Services	1	2	1	-
Program 3.3: Aged Care Quality	1	-	-	-
Total	**2**	**2**	**3**	**-**

The Outcome 3 program structure and performance measures for 2026–27 are currently being reviewed to align with the 1 November 2025 implementation of the *Aged Care Act 2024*.



Program 3.1: Access and Information

Program Objective

My Aged Care provides older people and their support networks with reliable and trusted information about aged care services. It provides timely and appropriate assessments aligned to needs and goals, appropriate referrals and equitable access to aged care services. Navigation services support vulnerable people who are not able to access aged care without this help.

In addition to the information detailed within Program 3.1, other work undertaken throughout 2024–25 demonstrates the breadth of work delivered as part of the Program. This includes programs such as the Aged Care Volunteer Visitors Scheme[163] (previously the Community Visitors Scheme). This scheme continued to support volunteer visits aimed at providing friendship, companionship and helping to develop social connections for older people. The National Aged Care Advocacy Program[164] supported older people with access to free, independent and confidential advocacy services, information on aged care rights and assistance in understanding and accessing aged care.

My Aged Care continually seeks opportunities to improve user experience through helping older people and their support networks to understand, navigate and access aged care. Improvements are made based on user feedback from surveys and other feedback mechanisms. In 2024–25, a range of improvements were made to My Aged Care, including:

- increasing the number of agents in the My Aged Care contact centre to manage volumes, handle complaints and investigations, and support case management
- updating key tools on the My Aged Care website,[165] including the *'Fee estimator'*,[166] *'Apply for an assessment'*[167] and *'Make a Referral'*[168] tools. These tools support implementation of reforms and provide useful, accessible information about upcoming changes
- reviewing the My Aged Care Welcome Pack to understand how older people and representatives interact with this and identifying improvements to enhance user engagement and satisfaction.

My Aged Care provides input annually into the *Report on the Operation of the Aged Care Act 1997*,[169] covering activities undertaken by Program 3.1. This demonstrates how the department is working to achieve program objectives and outcomes.

As part of the recently implemented Single Assessment System,[170] a new quality assurance program will be implemented. The program will include delivery of desktop assurance activities to test the quality of assessments at different points in an older person's assessment journey. Assurance measures will focus on delivery of accurate, nationally consistent and fit-for-purpose Support Plans. The assurance measures will ensure consistency and quality of assessments are upheld. Independent assurance assessors will conduct 'shadow' aged care assessments alongside contracted assessors. The program will strengthen the Single Assessment System reforms already implemented, the introduction of the Integrated Assessment Tool and the commissioning of the assessment workforce.

Complementary data on access to, and information on, aged care services can be found in the Aged Care Quality and Safety Commission's Sector Performance Reports.[171]

[163] Further information is available at: **www.health.gov.au/our-work/aged-care-volunteer-visitors-scheme-acvvs/about**
[164] Further information is available at: **www.health.gov.au/our-work/national-aged-care-advocacy-program-nacap**
[165] Available at: **www.myagedcare.gov.au**
[166] Available at: **www.myagedcare.gov.au/how-much-will-i-pay**
[167] Available at: **www.myagedcare.gov.au/assessment/apply-online**
[168] Available at: **www.myagedcare.gov.au/make-a-referral**
[169] Available at: **www.health.gov.au/resources/publications/2023-24-report-on-the-operation-of-the-aged-care-act-1997**
[170] Further information is available at: **www.health.gov.au/our-work/single-assessment-system**
[171] Available at: **www.agedcarequality.gov.au/news-publications/reports/sector-performance**

These reports also provide insight into the sector's performance in compliance with the Aged Care Quality Standards[172] and complaints made concerning assessments, choice and access to supports. The 2023–24 *Report on the Operation of the Aged Care Act 1997* provides details on how older people access different services, such as the Commonwealth Home Support Program or Home Care Packages through the Regional Assessment Service. This also includes the total number of people who accessed these services. The report highlights how My Aged Care provides access for people and how they can seek support, including through the National Aged Care Advocacy Program.

Key Activity 3.1A:

Facilitate access to aged care services.

Source: *Health and Aged Care Corporate Plan 2024–25, p.66*

Performance Measure 3.1A:

Older people and their support networks have access to reliable and trusted information through My Aged Care.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.93 and Health and Aged Care Corporate Plan 2024–25, p.66*

2024–25 Planned Performance	2024–25 Result	2023–24
a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care website ≥65%.	a. 64.1%	a. 56.3%
b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre >95%.	b. 94.8% **Result**: Not achieved ○	b. 95.1%

Disclosures:

Data used for reporting against this measure is sourced from data captured, stored and provided by third parties.

Data Source and Methodology:

My Aged Care website:

The data source for this measure is responses from users of the My Aged Care website to a voluntary onsite survey. Satisfaction is determined by an aggregate score from multiple questions which measure key indicators of website satisfaction, including helpfulness, usefulness, clarity and ease of use. The data is verified to ensure its reliability.

My Aged Care Contact Centre:

The data source for this measure is customer satisfaction survey responses from a random and representative sample of My Aged Care Contact Centre users. The survey is conducted through an independent market research company. Data is verified to ensure the accuracy of both customer details and their choice to participate in the survey. 'Satisfied' callers to the contact centre are those who give the contact centre a score of 6 to 10 on a scale of zero to 10 in response to the survey.

[172] Further information on the Aged Care Quality Standards is available at: **www.agedcarequality.gov.au/providers/quality-standards**

The department routinely monitors consumer feedback through the survey to inform continuous improvement efforts across My Aged Care services.

My Aged Care website:

The department continued to closely monitor consumer feedback through the survey to inform improvements to the My Aged Care website. During 2024–25, enhancements were made including:

- introduction of a new semantic search logic to the website search tool to improve the quality and usefulness of search results
- updates to key interactive tools to support the implementation of aged care reforms
- publication of new information, resources and tools to communicate upcoming changes to the aged care system.

A comprehensive review of website content and interactive tools was undertaken with a refreshed website scheduled to launch on 1 November 2025. This update will ensure that older people and their support networks can continue to use the website to help understand, navigate and access aged care.

The website has remained stable over the past 12 months. The department has focused on continuing to ensure accuracy, usefulness and useability of website content and interactive tools. This includes changes made to support the implementation of the aged care reform agenda and informing users about upcoming changes. Feedback received during 2024–25 indicates ongoing concerns regarding assessment and service wait times, as well as the complexity of the aged care system.

Satisfaction with the My Aged Care website in 2024–25 was 64.1% which is marginally below the target of ≥65%. Performance of the website has increased on previous years with 2024–25 seeing the highest level of satisfaction recorded since its introduction.

Survey responses indicate that higher satisfaction can be attributed to the ongoing improvements to the usefulness of website content and useability of interactive tools. Increasing levels of digital confidence amongst website users has also supported increased satisfaction. Feedback continued to be provided through survey free text responses,[173] which has raised issues outside the scope of the website. These concerns were similar with those raised through the contact centre regarding wait times for assessments and services.

My Aged Care Contact Centre:

Processes and scripting were reviewed in 2024–25 and, where appropriate, updated ahead of the commencement of the new *Aged Care Act 2024* (new Act).[174]

Reforms which impacted contact centre operations include:

- Single Assessment System for aged care – the new system will make it easier for older people to access government-funded aged care services as their needs change
- Support at Home program – will ensure a simpler and more equitable system for older people that helps people to stay at home for longer
- the new supporter framework – to help embed supported decision-making across the aged care system.

The contact centre has a robust capability program including induction training, training huddles, updates, escalation and team lead support. Ongoing monitoring has ensured that issues are responded to in a timely manner and, where required, additional personnel were engaged to support surge activities. This has enabled wait times for calls to remain low and the high level of satisfaction with contact centre support to remain high. Monthly reports continue to be reviewed as part of the governance forums with the contact centre vendor.

[173] Survey free text responses refers to users providing raw unfiltered comments and feedback in their own words.
[174] Further information on the new rights-based Aged Care Act can be found at: **www.health.gov.au/our-work/aged-care-act/about**

Single Assessment System and increased wait times for Home Care Packages:

Wait times for older people in having their needs assessed impacts the timeliness of accessing approved services. Contact centre interactions have increased as older people seek resolution on multiple occasions, contrasting with the previous approach of first call resolution.

The contact centre continues to achieve high consumer satisfaction. Increased communications regarding forthcoming reforms to My Aged Care has increased the number of enquiries to the contact centre. Frustration with Home Care Package wait times and confusion over the reforms may be reflected in contact centre results. The proportion of respondents from the sector who normally have the higher ratings has significantly reduced over the reporting period. In July 2024, the sector accounted for 43% of respondents with an average Contact Centre Customer Satisfaction (CC CSAT) yearly rating of 97% when compared with consumer ratings of 94.5%. By March 2025, the sector proportion of respondents had decreased to 6.6%. The reduction in sector respondents has been attributed to difficulties in accessing the specific personnel in organisations.

Satisfaction with the contact centre in 2024–25 was 94.8%, just short of the >95% target. The department will continue to monitor the ongoing performance via routine reporting and governance forums. The department is also reviewing the CC CSAT, the survey measuring performance, to identify if there is scope for process improvements, including industry survey methodologies.

Contact centre service satisfaction has reduced by 0.3% compared to 2023–24, in part attributed to a 19.3% increase in the number of calls handled in 2024–25. During 2024–25:

- Wait times for Home Care Packages have increased over the previous 12 months, impacting people's overall experiences with My Aged Care. Although program related matters are outside its remit, the My Aged Care Contact Centre remains the main contact for inquiries.
- The increase in calls is a result of more older people and their representatives seeking information on policy and reform that had not been finalised at the time of contact. The service could not provide granular detail to callers on what certain changes meant for them.

A new My Aged Website Customer Satisfaction survey was implemented on 1 July 2024. This change in survey questions will be considered when comparing the results to previous years.

Key Activity 3.1B:

Facilitate access to aged care services.

Source: *Health and Aged Care Corporate Plan 2024–25, p.68*

Performance Measure 3.1B:

Older people are assessed for service need.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.94 and Health and Aged Care Corporate Plan 2024–25, p.68*

2024–25 Planned Performance	2024–25 Result
a. Home Support assessments completed within the allocated priority timeframes (≥ 90%): I. High priority: 10 calendar days II. Medium priority: 14 calendar days III. Low priority: 21 calendar days	a. I. 68.8% II. 66.3% III. 69.6%
b. Comprehensive Community-based assessments completed within the allocated priority timeframes (≥ 90%): I. High priority: 10 calendar days II. Medium priority: 20 calendar days III. Low priority: 40 calendar days	b. I. 32.5% II. 71.9% III. 50.0%
c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥ 90%): I. High priority: 5 calendar days II. Medium priority: 10 calendar days III. Low priority: 15 calendar days	c. I. 88.2% II. 98.7% III. 91.8% **Result**: Not achieved ○

Disclosures:

Data extracted from the Ageing and Aged Care Data Warehouse reflects a specific point in time after the reporting period. Data was extracted on 7 July 2025. As the dataset is dynamic and updated asynchronously—due to ongoing transactional changes by assessors—future extracts may include updated records. However, given the large sample sizes, these updates are unlikely to significantly alter overall results.

Data used for reporting against this measure is sourced from the Aged Care Data Warehouse and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the Aged Care Data Warehouse which is planned to be completed in mid-2026.

Data Source and Methodology:

The **data source** for the 3.1B performance measure is the My Aged Care system. The system collects and manages the data entered by the assessors who conduct home support and comprehensive assessments for older people seeking aged care services.

The data is extracted and processed by the department from the Aged Care Data Warehouse and populating reports using SAS Enterprise and Qlik platforms. The data is refreshed and updated on a regular basis and is subject to quality assurance checks.

The **measure** is calculated as the percentage of assessments completed within the allocated priority timeframes, based on the referral acceptance date and the assessment completion date.

Methodology for the measure is contained in the build scripts for the SAS and Qlik reports and follows the contractual agreements with the assessment organisations.

The Single Assessment System[175] for aged care was launched on 9 December 2024, marking a significant reform milestone in aged care assessments. This was in response to Recommendation 28 of the Royal Commission into Aged Care Quality and Safety (Royal Commission).

Throughout 2024–25, the department has focused on embedding the new assessment system. The system simplifies access to government-funded services by consolidating the Regional Assessment Service (RAS), Aged Care Assessment Teams (ACAT), and Australian National Aged Care Classification (AN-ACC) assessment organisations.

Apart from medium and low priority hospital-based assessments, assessment organisations did not meet the planned performance in 2024–25. This is primarily attributed to the establishment of the Single Assessment System workforce.

Key challenges in 2024–25 included establishing new outlets, recruiting and training staff, and adapting to operational changes. Jurisdictions prioritised high-priority assessments during the establishment of the Single Assessment System. In-line with challenges listed, overall performance in the second half of the year was impacted and targets across 2024–25 were not met. The department is taking a flexible approach to enforcing KPIs until December 2025. The department encourages organisations to meet targets to avoid reallocation of assessments to other organisations after December 2025.

The department has expanded performance reporting in 2024–25 to include all assessment priority levels, supporting greater transparency and responsiveness in aged care assessment services.

Home support assessments within allocated priority timeframes

In 2024–25, a total of 291,241 home support assessments were conducted in community settings. The planned performance did not meet the ≥90% allocated priority target timeframes.

- Low priority – 69.6% were completed within 21 calendar days. This accounted for 85% of home support assessments.
- Medium priority – 66.3% were completed in 14 calendar days or less. This accounted for 14% of home support assessments.
- High priority – 68.8% were completed within 10 calendar days of referral acceptance. This accounted for 1% of home support assessments.

Comprehensive community-based assessments within allocated priority timeframes

In 2024–25, a total of 175,563 comprehensive assessments were conducted in community settings. The planned performance did not meet the ≥90% allocated priority target timeframes.

- Low priority – 50.0% were completed within 40 calendar days. This accounted for 88% of comprehensive community-based assessments.
- Medium priority – 71.9% were completed in 20 calendar days or less. This accounted for 10% of comprehensive community-based assessments.
- High priority – 32.5% were completed within 10 calendar days of referral acceptance. This accounted for 2% of comprehensive community-based assessments.

[175] Further information on the Single Assessment System for aged care is available at: **www.health.gov.au/our-work/single-assessment-system/about**

Comprehensive hospital-based assessments within allocated priority timeframes

In 2024–25, a total of 56,942 comprehensive assessments were conducted in a hospital setting. Two of the planned performance targets met the ≥90% allocated priority target timeframes.

- Low priority – 91.8% were completed within 15 calendar days, exceeding the ≥90% target timeframe.
- Medium priority – 98.7% were completed in 10 calendar days or less, exceeding the ≥90% target timeframe.
- High priority – 88.2% were completed within 5 calendar days of referral acceptance, just short of the ≥90% target timeframe.

During the Single Assessment System's establishment, some assessment organisations were not operating at full capacity, and new organisations were focused on recruitment and training. Organisations will operate at greater capacity in 2025–26. The commencement of the new Act on 1 November 2025 may affect performance as assessment organisations will need to train staff and transition to new systems.

Due to the sweeping nature of the reforms that have been implemented, direct comparisons cannot be made between 2023–24 and 2024–25.

Quality assurance program

As part of the recently implemented Single Assessment System reforms, a new quality assurance program is being implemented. The quality assurance program focuses on verifying that aged care needs assessments and support plans align with the needs of older Australians and that they are connected to the services they require. This includes delivery of a program of desktop assurance activities testing the quality of assessments at different points in an older person's assessment journey. In 2024–25, assessments and support plans have been identified for review on a risk basis, focusing attention on emerging and forecast issues. For the 2025–26 period this will include work to verify the accuracy of assessments underpinning access to services through the Support at Home program.

Assurance measures are complemented with stakeholder engagement and support activities, focused on delivery of accurate, nationally consistent and fit-for-purpose Support Plans.

Program 3.2: Aged Care Services

Program Objective

Provide a range of flexible aged care programs for older people who require assistance including support at home, residential care and respite care for those who need it. Provide individualised aged care services that are aligned to needs and goals and help older people live meaningful lives and sustain connections with community.

Within Program 3.2, the department provides a range of flexible aged care programs to support older people in Australia. This includes residential aged care, in-home care services (including the Commonwealth Home Support Program and the Home Care Packages program) and flexible care services, such as those that assist with day-to-day tasks and help an older person to maintain independence while living at home.

In addition to the information detailed within Program 3.2, other programs undertaken throughout 2024–25 demonstrate the breadth of work delivered through this Program. The Continence Aids Payment Scheme[176] provided payments to eligible people to help with some of the costs of buying continence products. The Continuity of Support and Disability Support for Older Australians programs[177] supported older people with disability who were not eligible for the National Disability Insurance Scheme. Funding to support care needs was provided for Flexible Care through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program[178] (NATSIFACP), Short-Term Restorative Care[179] and the Transition Aged Care[180] programs.

The information below provides greater information around the limitations in reporting on Program 3.2's performance measures. This being notably for performance measures 3.2A and 3.2C.

Within performance measure 3.2A, the explanation of outcomes for older people who do not live in residential care is not included as it is not in scope of the current data used to support this performance measure. The survey the data is derived from is designed to only represent the experiences of older people in residential aged care. The *2023–24 Report on the Operation of the Aged Care Act 1997* follows in line with the survey's data scope and provides more information on resident experiences.

In relation to performance measure 3.2C, the *2023–24 Report on the Operation of the Aged Care Act 1997* demonstrates that the government seeks to ensure balance in the provision of services between metropolitan, regional and remote locations. The report also notes the need for balance between differing levels of care required. This supply of aged care places is managed by specifying a national target provision ratio (the ratio) of subsidised aged care places. At 30 June 2024, the ratio was 71.4 operational aged care places for every 1,000 people aged 70 years and over. Complimentary data on access to aged care services can be found in the Aged Care Quality and Safety Commission's Sector Performance Reports.[181] These reports provide insights into the aged care sector's performance in compliance with the Aged Care Quality Standards and workforce regulation.

The department understands that improvement is needed, particularly regarding reporting against such broad performance measures. The intention of this measure is to assess the efficacy of improvements made to support older people in rural or remote areas, or those who are First Nations, accessing services. The intention of this measure is not to address access in suburban or urban areas, as access in these areas are higher than those in rural and remote areas.[182]

[176] Available at: **www.health.gov.au/our-work/continence-aids-payment-scheme-caps**
[177] Available at: **www.health.gov.au/our-work/dsoa**
[178] Available at: **www.health.gov.au/our-work/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program**
[179] Available at: **www.health.gov.au/our-work/short-term-restorative-care-strc-programme**
[180] Available at: **www.health.gov.au/our-work/transition-care-programme**
[181] Available at: **www.agedcarequality.gov.au/news-publications/reports/sector-performance**
[182] Available at: **www.gen-agedcaredata.gov.au/topics/people-using-aged-care#agedcareusebyremotenessareas**

Key Activity 3.2A:

Support older people to live active, self-determined and meaningful lives.

Source: *Health and Aged Care Corporate Plan 2024–25, p.69*

Performance Measure 3.2A:

Older Australians are treated with respect and dignity in receiving aged care services.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.95 and Health and Aged Care Corporate Plan 2024–25, p.69*

2024–25 Planned Performance	2024–25 Result	2023–24
Maintain or increase the average Residents' Experience Survey (RES) Score of 84% for residential aged care homes.	85.3%	84.4%
	Result: Achieved ●	

Disclosures:

2024–25 Result:

The result reported is for the period of 1 February 2024 to 31 October 2024, as the RES is conducted on a calendar year basis. The RES only surveys older people living in Commonwealth-funded residential aged care homes and does not include older people receiving other types of care services. For example, older people in the Multi-Purpose Services Program (MPSP), NATSIFACP services and older people receiving home care are not included within this performance measure.

Data Source and Methodology:

Data source for the measure 3.2A is survey results from aged care residents responding to the RES, which is an annual survey conducted by an independent third-party organisation, using a randomisation methodology to select and interview at least 10% of residents in each participating home, with an overall sample of around 20% of older people living in residential aged care homes across Australia.

The data quality and reliability are assured by:

- the survey design, the quality and assurance checks by the vendor and the department
- the external assurance feedback from the department's external assurance provider
- the planned performance justification and targets.

As part of the quality assurance process, the vendor and the department review the raw data, the survey results, and the calculation methodology. The data is also assured by the data assurance record for performance measure 3.2A, which documents the data type, source, items, acquisition, extraction, processing, frequency, storage, risks, and governance.

Methodology for the measure is calculated by averaging the RES scores (the 12 Likert scale questions in the survey) of all participating residential aged care homes and converting the average to a percentage. The performance measure is justified by the alignment with the program objective of ensuring respect, care and dignity in delivering aged care services, and the planned performance targets are based on the baseline data and the expected improvement over time.

The RES results are published on the My Aged Care website[183] and contribute to a residential aged care service's Star Ratings. Publication of the RES results has encouraged providers to make improvements to the delivery of their services, in line with survey findings. The RES is dependent on the experiences of older people receiving residential aged care. The performance measure is influenced by external factors surrounding the quality of care provided by providers within the residential aged care homes they operate.

There has been close to a 1% improvement in the average RES from the previous year's performance. This continues an upwards trend above the original performance baseline. The baseline score started at a high percentage of 82%, which was the RES score achieved in the 2022 round of the survey. A score of 84.4% was achieved in 2023–24 and 85.3% in 2024–25. Continued year-on-year increases may be incremental. The 2025 RES and the planned 2025–26 performance result will use a sampling methodology of a minimum of 20% of residents surveyed across all residential aged care homes.

[183] Available at: **www.myagedcare.gov.au/quality/what-residents-think**

Key Activity 3.2B:

Support older people to live active, self-determined and meaningful lives.

Source: *Health and Aged Care Corporate Plan 2024–25, p.69*

Performance Measure 3.2B:

Older people receive residential care services that contributes to their quality of life.

a. Establish measurement baseline for 'Quality of Life' indicator.

b. Maintain a sector-wide average of 200 minutes of care per resident per day, including 40 minutes of direct care by a registered nurse (RN) per day.

c. All non-exempt residential aged care facilities of approved providers have at least one RN on-site and on duty 24 hours a day, 7 days a week.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.96 and Health and Aged Care Corporate Plan 2024–25, p.71*

2024–25 Planned Performance	2024–25 Result	2023–24
a. Establish measurement baseline for 'Quality of Life' indicator. b. Maintain a sector-wide average of 200 minutes of care per resident per day, including 40 minutes of direct care by a registered nurse per day. c. All non-exempt residential aged care facilities of approved providers have at least one registered nurse on-site and on duty 24 hours a day, 7 days a week.	a. The baseline average of care recipients reporting 'Good' or 'Excellent' for the Quality of Life Quality Indicator reflects 74.06%. b. Weighted sector average of 213.22 minutes per resident per day of total care minutes including 43.11 RN minutes per resident per day. c. The average RN coverage from non-exempt facilities was 99.14%.	a. Data not available, as this year contributed to establishing a baseline. b. Weighted sector average of 202.6 minutes per resident per day of total care minutes including 39.68 RN minutes per resident per day. c. The average RN coverage from non-exempt facilities was 98.58%.
	Result: Substantially achieved ◗	

Disclosures:

2024–25 Result:

a. This result is based on 8 quarters of data (quarter 1 financial year 2023–24 to quarter 4 financial year 2024–25) to support the establishment of a meaningful baseline for this quality indicator. The baseline result captures the average percentage of care recipients who completed the Quality of Life Aged Care Consumer Survey (QOL-ACC) and reported a score of 'excellent' or 'good'. Care recipients can choose whether or not they want to complete the survey.

b. The reported result is for the period July 2024 to March 2025 and does not include the April to June 2025 quarterly data as this will not be available until October 2025.

c. 24/7 RN data for June 2025 may not include data for some facilities due to late submissions, due on the 7th of each month.

2023–24 Result:

a. Data for the 2023–24 result is not available. An analysis has confirmed 8 quarters of data would be required to support the establishment of a meaningful baseline for this quality indicator.

b. The 2023–24 result for performance measure b. has been revised to reflect the final result for the period July 2023 to June 2024. The result for the period July 2023 to March 2024 published in the 2023–24 Annual Report was 200.76 care minutes and 39.02 RN minutes per resident per day.

c. Data for 4 facilities which undertake manual reporting has not been included in the result. Manual reporting is undertaken due to operating across multiple sites and is excluded from the performance result due to manual data being held in an alternative system compared to the rest of the 24/7 RN reporting.

Data Source and Methodology:

The **data source for measure 3.2B(a)** is the National Aged Care Mandatory Quality Indicator Program (QI Program), which requires approved providers of residential aged care to submit quarterly quality indicator data, including for quality of life. The QOL-ACC tool is the quality-of-life assessment tool used for the purposes of the QI Program.

The quality-of-life quality indicator results are calculated based on the number of care recipients who report 'excellent' and 'good' categories across 3 completion modes (self-completion, interviewer facilitated completion[184] or proxy-completion).[185] The baseline for the quality indicator will be established in the 2024– 25 reporting period and will be used to set targets for future years.

The data is reported quarterly by residential aged care providers through the Quality Indicators App within the Government Provider Management System (GPMS). The data is then stored in the Aged Care Data Warehouse and transferred to the Australian Institute of Health and Welfare (AIHW) via Defigo for analysis and publication.

The data quality is assessed through quality assurance checks, in-built data validations in GPMS and through the AIHW for data validation. The data governance is guided by the National Aged Care Data Strategy,[186] the *Aged Care Act 1997*, and the QI Program Manual.

The **data source for measure 3.2B(b)** is the Quarterly Financial Report (QFR), which requires approved providers of residential aged care to submit quarterly financial and care time data in respect of each of their services. Specifically, the direct care hours of registered nurses, enrolled nurses and personal care workers/ assistants as well as the occupied bed day data are used in the calculation of this measure. This reporting is completed through the QFR app within GPMS. Data validation checks are performed on this data prior to acceptance. In addition, the department performs detailed assurance checks on a sample of this reporting each year through the care time reporting assessment program.

The **data source for measure 3.2B(c)** is 24/7 registered nurse reporting where all approved providers report all times, when a registered nurse was not onsite and on duty for each of their residential aged care facilities. This reporting is completed monthly through the registered nurse application on GPMS. While providers are required to report in respect of their exempt facilities, exempt facilities are excluded from the calculation of the performance measure. The 24/7 RN reporting is not validated prior to acceptance but like the **data for measure 3.2B(b)** a sample of the reporting is checked through the care time reporting assessment program.

3.2B(a) – Quality of Life indicator:

The planned performance established a baseline for the 'Quality of Life' indicator using 8 quarters of data.

An external factor influencing performance is the care and services delivered by the residential aged care provider. These directly impact the quality of life results reported by the care recipients through the Quality of Life Aged Care Consumer Survey.

Aggregate data for the 'Quality of Life' quality indicator is reported as part of the AIHW QI Program reporting.[187] This does not establish a baseline and simply reports data over the quarters.

[184] 'Interview facilitator completion' is when a care recipient requires additional support to complete the survey. The interviewer does not influence the scoring.

[185] 'Proxy-completion' is when a care recipient is unable to answer on their own behalf. The person acting as the proxy must know the care recipient well and see them regularly and should answer based on their knowledge of the care recipient and their quality of life at the time of survey.

[186] Available at: **www.health.gov.au/resources/publications/department-of-health-and-aged-care-data-strategy-2022-25**

[187] Available at: **www.gen-agedcaredata.gov.au**

3.2B(b) – care minutes:

The sector maintained an average above 200 total care minutes and 40 minutes of registered nurse (RN) time per day for the first 3 Quarters of 2024–25.

External factors influencing this include workforce shortages. Some providers, particularly those operating in rural and remote locations, experiencing challenges in recruiting and retaining a sufficient workforce to meet their care minutes responsibility.

Performance was influenced by a new benchmark for care minutes. On 1 October 2024, the requirement increased from 200 minutes of care per resident per day to 215 minutes.

3.2B(c) – 24/7 RN:

The sector had average RN coverage from non-exempt facilities of 99.14% across 2024–25.

External factors influencing this include RN shortages, particularly in rural and remote locations. This impacts providers experiencing challenges recruiting and retaining enough workers to meet the 24/7 RN responsibility.

For measures 3.2B(b) and (c) it is legislated that providers meet their care minutes and 24/7 RN responsibilities, with an increase on performance from 2023–24.

Key Activity 3.2C:

Support older people to live active, self-determined and meaningful lives.

Source: *Health and Aged Care Corporate Plan 2024–25, p.69*

Performance Measure 3.2C:

Older people with diverse backgrounds and life experiences or who live in rural and remote areas can receive culturally safe and equitable aged care services where they live.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.97 and Health and Aged Care Corporate Plan 2024–25, p.74*

2024–25 Planned Performance	2024–25 Result	2023–24
a. Older people who are (self-identified as) First Nations peoples are receiving aged care services at rates comparable with their representation in Australian population estimates: Target 3.5% b. Older people in rural and remote areas are receiving aged care services at rates comparable with their representation in Australian population estimates: Target 11.2%	a. • At 30 June 2025, 1.2% of permanent residents accessing care in mainstream residential aged care. • At 30 June 2025, 3.4% of people accessing services under the Home Care Package (HCP) program. • Across 2024–25 financial year, 3.0% of people using any Commonwealth Home Support Program (CHSP) supports. b. • At 30 June 2025, 7.6% of permanent residents accessing care in mainstream residential aged care. • At 30 June 2025, 9.8% of people accessing services under the HCP program. • Across 2024–25 financial year, 12.1% of people using any CHSP supports.	a. First Nations identification amongst older people accessing aged care is estimated as follows: • As of 30 June 2024, 1.3% of permanent residents accessing care in mainstream residential aged care. • As of 30 June 2024, 3.4% of people accessing services under the HCP program. • Across 2023–24 financial year, 3.0% of people using any CHSP supports. b. Older Australians in rural and remote areas as a proportion of all people accessing care is estimated as follows: • As of 30 June 2024, 7.7% of permanent residents accessing care in mainstream residential aged care. • As of 30 June 2024, 8.9% of people accessing services under the HCP program. • Across 2023–24 financial year, 12.4% of people using any CHSP supports.
	Result: Not achieved ○	

Disclosures:

For a. and b. data used for reporting against these measures is sourced from the Aged Care Data Warehouse and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the Aged Care Data Warehouse which is planned to be completed in mid-2026.

2024–25 Result:

a. The population target of 3.5% is applicable to each of the individual percentage results recorded for:

- mainstream residential aged care
- HCP program
- CHSP.

Data for First Nations identity is dependent on self-reported data by First Nations peoples and presents a limitation in reporting on the outcome of the measure.

b. The population target of 11.2% is applicable to each of the individual percentage results recorded for:

- mainstream residential aged care
- HCP program
- CHSP.

The 2024–25 result for both a. and b. is preliminary financial year data as of 30 June 2025 (or 2024–25, for CHSP) and does not include data on flexible aged care programs including Multi-Purpose Services Program (MPSP)[188] and the National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC)[189] Program.

For b., the result reflects the location of the HCP recipient, compared to past years where the location of the HCP service delivering care was reported. This represents a break in the series but improves the relevance of this indicator as the location of the recipient of the care delivered is better represented.

2023–24 Result:

a. The population target of 3.5% is applicable to each of the individual percentage results recorded for:

- mainstream residential aged care
- HCP program
- CHSP.

Data for First Nations identity is dependent on self-reported data by First Nations peoples and presents a limitation in reporting on the outcome of the measure.

b. The population target of 11.2% is applicable to each of the individual percentage results recorded for:

- mainstream residential aged care
- HCP program
- CHSP.

The 2023–24 result for both a. and b. is preliminary financial year data as of 30 June 2024 and does not include data on flexible aged care programs including MPSP and the NATSIFAC Program.

Data Source and Methodology:

Data source is the department's internal administrative data, which records the number and proportion of older people who access aged care services and identify as First Nations peoples, or live in rural and remote areas. This data is verifiable by the department's data governance framework, which ensures that the data is reliable, accurate, valid and consistent. It is also verifiable by the external assurance feedback from the department's external assurance provider, who reviews the draft performance reports and provides feedback to the department.

Methodology for the measure is calculated by dividing the number of older people, who access aged care services and either identify as First Nations peoples or live in rural and remote areas, by the estimated population of older people who access aged care services and multiplying by 100 to get the percentage. The performance measure is justified by the alignment with the program objective of providing culturally safe and equitable aged care services for older people with diverse backgrounds and life experiences. The planned performance targets are based on the population estimates and the expected growth of service provision.

[188] The MPSP delivers residential and home care services in MM 5 to 7 locations. Further information is available at: **www.health.gov.au/our-work/multi-purpose-services-mps-program/about-the-multi-purpose-services-mps-program#who-can-access-the-program**

[189] The NATSIFACP provides culturally safe and appropriate care for older Aboriginal and Torres Strait Islander peoples, particularly in the more remote areas of Australia. Further information is available at: **www.health.gov.au/our-work/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program**

The department is committed to building an aged care system that delivers high-quality, culturally safe and responsive aged care services for Aboriginal and Torres Strait Islander people. This will help ensure they can age well, with dignity, respect and connection to community and culture.

Successful delivery would increase access to services for older people in these communities at rates comparable with their representation in Australian population estimates. Work already underway to achieve this includes:

- supporting Aboriginal Community Controlled Organisations (ACCOs) to expand delivery of culturally safe, place-based and tailored aged care services to their respective communities
- developing targeted cultural safety training resources for workers across the aged care system
- building the Aboriginal and Torres Strait Islander aged care workforce, including through programs such as the Indigenous Employment Initiative
- rolling out Aboriginal and Torres Strait Islander assessment organisations in the second half of 2025 to deliver culturally safe assessments
- continuing the Elder Care Support Program, which has already assisted more than 5,000 older Aboriginal and Torres Strait Islander people to access services.

The department is also committed to improving access to services for older people in rural and remote areas. Initiatives already in place to achieve this include:

- better mainstream funding outcomes for providers in these areas through, for example:
  - additional Australian National Aged Care Classification (AN-ACC) funding for residential care homes in rural and remote locations
  - viability supplements for home care providers delivering services in rural and remote areas.
- ongoing support for, and reform of, existing thin market programs, such as MPSP and NATSIFACP
- funding for workforce, professional and viability supports as well as infrastructure funding, for example:
  - the Aged Care Capital Assistance Program which supports the construction, upgrade and expansion of aged care services and staff accommodation in thin market settings
  - workforce programs, including the Regional, Rural and Remote Home Care Workforce Support program and the Rural Locum Assistance Program (Aged Care).

The department also recognises the need to ensure supports are properly targeted and reach the communities that need them. To support this, the department commenced a review of the Modified Monash Model (MMM) and other rural and remote policy levers in 2024–25. The department also continued to explore innovative place-based solutions to deliver services across the care and support sectors where there are areas of shortage. This includes through the Care Together Program and the Integrated Care and Commissioning initiative.

Importantly, the Statement of Rights in the new Act will embed the right to culturally safe aged care and to equitable access to be assessed for funded aged care services.[190] The new Statement of Principles[191] also recognises the aged care system should offer accessible, culturally safe and appropriate, trauma-aware and healing-informed services. This should be the case regardless of a person's location, background and life experiences. Strengthened Aged Care Quality Standards[192] will also require providers in registration categories 4 to 6 to deliver culturally safe and appropriate services.

[190] Further information on the Statement of Rights is available at: **www.health.gov.au/resources/publications/a-new-aged-care-act-for-the-rights-of-older-people**

[191] Further information on the Statement of Principles is available at: **www.health.gov.au/our-work/aged-care-act/about#statement-of-principles**

[192] Further information on the Strengthened Quality Standards is available at: **www.agedcarequality.gov.au/providers/quality-standards/strengthened-quality-standards**

The rate at which Aboriginal and Torres Strait Islander people accessed aged care services during 2024–25 was below the department's expectations. A combination of factors has created barriers in access to the aged care system. These arise from ongoing impacts of colonisation and prolonged discrimination, social and economic disadvantage. Complexity within the system and a limited Aboriginal and Torres Strait Islander workforce also continues to impact access rates. The 2024–25 target for older people who self-identify as Aboriginal or Torres Strait Islander person accessing permanent mainstream residential aged care was not achieved (1.2% vs target of 3.5%). This was also the case for people accessing care via the HCP program (3.4% vs target of 3.5%) and the CHSP (3.0% vs target of 3.5%). The results were more positive for home-based aged care programs.

The rate at which older people living in rural and remote Australia accessed aged care services during 2024–25 was below the department's expectations. In some areas, this could be linked to geography and distance impacting access rates. In other areas, this could be due to workforce challenges impacting service availability, service delivery costs or other localised factors. For older people living in rural and remote areas, overall, the 2024–25 target was not achieved. There were positive results for the CHSP (12.1% vs target of 11.2%). Targets were not achieved for the permanent residential care (7.6% vs target of 11.2%) and the HCP program (9.8% vs target of 11.2%).

Aged care access rates for Aboriginal or Torres Strait Islander people have not significantly increased between 2023–24 and 2024–25. This indicates further work is required to create an aged care system that is culturally safe and adequately supportive of older Aboriginal and Torres Strait Islander people. Access rates remain lower than desired, despite a higher burden of disease, lower life expectancy and an increased likelihood of requiring aged care at a younger age.

The number of individuals accessing services in rural and remote areas continued to increase. However, similarly, aged care access rates for older people in these areas have not significantly increased between 2023–24 and 2024–25. This is despite significant investment to support providers in these areas. Further work is required to ensure that access rates are comparable with the broader Australian population. Policy settings will be reviewed to ensure that investment is targeted to reach the communities most in need.

The exclusion of both MPSP and NATSIFACP data is significant when considering the above performance results. At 30 June 2025, NATSIFACP had 1,829 operational places across Australia and the MPSP assisted approximately 5,000 older people across residential and home settings. The results therefore underestimate the number of older people from rural and remote areas and Aboriginal and Torres Strait Islander communities accessing aged care services.

The target population for Aboriginal and Torres Strait Islander people is aged 50 years and over, compared to 65 years and over for other population groups. Aboriginal and Torres Strait Islander people can access aged care services at a younger age, due to a higher burden of disease and disability and an increased need for services earlier in life. Reporting for this group relies on self-reporting and may not accurately reflect the true numbers of Aboriginal and Torres Strait Islander people accessing services. Status may not be reported because people feel uncomfortable in disclosing their status, or it is not accurately captured through registration and assessment processes. The accuracy of this data will improve as the cultural safety of aged care is increased. The Integrated Assessment Tool will additionally strengthen the capture of this information.

Key Activity 3.2D:

Support older people to live active, self-determined and meaningful lives.

Source: *Health and Aged Care Corporate Plan 2024–25, p.69*

Performance Measure 3.2D:

Older people receive care and support at home that contributes to quality of life.

a. Number of allocated Home Care Packages.

b. Number of clients that accessed Commonwealth Home Support Program services.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.98 and Health and Aged Care Corporate Plan 2024–25, p.55*

2024–25 Planned Performance	2024–25 Result	2023–24
a. Number of allocated Home Care Packages (Target 305,897)[193]	a. 308,244	a. 287,404
b. Number of clients that accessed Commonwealth Home Support Program services (Target 840,000)	b. 838,694	b. 834,981
	Result: Substantially achieved ◗	

Disclosures:

2024–25 Result:

Data submissions for the previous financial year remain open throughout July to allow providers sufficient time to finalise their reporting. As a result, the dataset is not considered complete until after this period, and annual performance reporting may be subject to a delay of one to 2 months. While this delay ensures more comprehensive data collection, late or missing submissions can still lead to underreporting. Despite these 2 limitations, the overall margin error is considered low and does not have an impact on the ability to rely on the result. Existing quality assurance processes, including Data Exchange (DEX) guidance, system validation and internal reviews ensure that the data remains sufficiently reliable for performance reporting.

For b. data used for reporting against this measure is sourced from the Aged Care Data Warehouse and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the Aged Care Data Warehouse which is planned to be completed in mid-2026.

Data Source and Methodology:

Data source is the department's internal administrative data, which records the number of allocated Home Care Packages and the number of clients who accessed Commonwealth Home Support Program services.

Methodology for the measure is calculated by counting the number of allocated Home Care Packages and the number of clients who accessed Commonwealth Home Support Program services in a given financial year. The performance measure is justified by the alignment with the program objective of supporting older people to receive care and support at home that contributes to their quality of life. The planned performance results are to be confirmed based on the demand and supply of home care services.

[193] The 2024–25 Corporate Plan planned performance target for 3.2D(a) was 299,700. The target was updated to 305,897 during the 2024–25 Mid-Year Economic and Fiscal Outlook.

Home Care Packages (HCPs):

HCPs provide older people in Australia with more complex needs access to clinical care, personal care and support services which assist with day-to-day activities while living at home. Increased allocations of HCPs not only benefit the people who receive them, but also their family members, friends, and carers as their care obligations are complimented with care delivered through the HCP Program.

In 2024–25, the department released 30,300 additional HCPs, extending the one-off increase of 9,500 HCPs in 2023–24. This, along with effective sector communication, has supported current HCP recipients, and allocated new packages for care recipients who have joined the Program.

There is an increased demand for in-home aged care services because of the continued growth in the population of those over 65 in Australia. As people age, there is an increased preference to age in their own homes. As people age many also require additional support to live independently. This has led to an increase in demand for HCPs.

The waitlist for HCPs has increased significantly from 68,586 as of 30 June 2024 to 96,709 as of 30 June 2025. The number of people approved to receive a HCP is exceeding the number of available packages.

At 30 June 2025, 308,244 people had been allocated a HCP, providing access to care and services to support them to continue living at home.

The number of allocated HCPs has grown from 287,404 as at 30 June 2024 to 308,244 as at 30 June 2025. This increase means that more people have access to a broader range of services that support their care needs and ability to live independently.

Commonwealth Home Support Program (CHSP):

The CHSP provides services nationally to clients with a lower assessed level of need, with a focus on delivering activities that support their independence, wellness and reablement.

In 2024–25, the department increased compliance activity under the CHSP, engaging with approximately 130 CHSP contracted providers regarding performance against their contracts. A combination of service delivery improvement plans, contractual variations and funding adjustments have driven an increase in service delivery against contracted outputs. This will lead to an increase in clients accessing services during 2025–26.

During 2024–25, CHSP service providers were impacted by a variety of issues in their ability to deliver services outlined in their contract. Workforce recruitment along with lower referrals from My Aged Care for respite services resulted in some service types under-delivering during 2024–25. Providers have reported the cost of delivering services, including increases in the cost of fuel, wages and utilities, against provided funding has affected their ability to deliver contracted outputs. The department is working with providers where services have been affected to enable a greater understanding of the impacts of reported increasing costs. Providers have also reported difficulties in obtaining client contributions, which has impacted the overall delivery of services against Commonwealth contracted funding. Providers can apply under a Grant Opportunity (GO7393) when these impacts result in critical need and viability concerns. This ensures that older people's continuity of care is not disrupted.

At 31 May 2025, an estimated 814,358 clients have accessed these services, achieving 97% of the planned performance target of 840,000.

The number of clients accessing the CHSP has grown from 816,132 in 2022–23 to over 838,000 in 2024–25. Current projections indicate a further increase to approximately 840,000 in 2025–26. This growth is accompanied by a stronger emphasis on reporting and compliance. This is ensuring that funding is aligned with service delivery and driving an increase in services provided by contracted providers.

Program 3.3: Aged Care Quality

Program Objective

Older people receive safe and high-quality services which are free from discrimination, mistreatment and neglect through regulatory activities, collaboration with the aged care sector. Provide support to the aged care sector through targeted awareness raising and capacity building activities to ensure standards of care are upheld.

The work of this Program addresses Recommendation 75 1.a. of the Royal Commission.[194] Specifically, to obtain up to date data every 2 years about the aged care workforce. Information about the aged care workforce informs policy planning to strengthen the aged care workforce. The capacity and capability of the aged care workforce directly impacts on safety and quality of care delivered to older people. The quality of Australian Government-funded aged care is assessed against a set of Aged Care Quality Standards by the Aged Care Quality and Safety Commission (ACQSC).

Substandard quality and safety of care due to the workforce being 'understaffed, underpaid and undertrained' was identified as a systemic problem by the Royal Commission. Initiatives to improve aged care workforce capacity and capability to deliver safe and high-quality care for older people have included:

- investment in building, training and supporting the aged care workforce
- initiatives to reduce reliance on agency staff
- funding to support award wage increases for aged care workers, resulting from the Fair Work Commission's decisions under the Aged Care Work Value Case
- improved transparency and accountability in financial reporting by aged care providers. Star Ratings for staffing in residential aged care and Quarterly Financial Snapshots of the aged care sector are publicly available from the department's website.[195]

Research literature has also highlighted the impact of the aged care workforce on the safety and quality of care provided to older people. Workforce turnover is recognised internationally as a quality indicator. The AIHW reports workforce turnover quarterly, as one of the National Aged Care Mandatory Quality Indicators in residential aged care. The Program addresses recommendations from the Royal Commission to improve the quality of aged care services provided to older people through reporting on 14 quality indicators.[196] Quarterly workforce turnover for all eligible staff shows a downward trend from 7.0% to 5.1% from Quarter 4 2022–23 to Quarter 1 2024–25 ($p \geq 0.05$). Eligible staff include service managers, nurse practitioners or registered nurses, enrolled nurses, and personal care workers or assistants in nursing.

This quarterly reporting does not include aged care programs outside of residential aged care. Annual workforce turnover rates for direct care workers in residential aged care, home care, MPSP, NATSIFACP and the CHSP are reported in the biennial Aged Care Provider Workforce Surveys.

[194] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 258, is available at: **www.royalcommission.gov.au/aged-care/final-report**

[195] Star Ratings quarterly data extract May 2025 available at: **www.health.gov.au/resources/publications/star-ratings-quarterly-data-extract-may-2025** and Data extract from the Quarterly Financial Snapshot reports of the aged care sector: **www.health.gov.au/resources/publications/data-extract-from-the-quarterly-financial-snapshot-reports-of-the-aged-care-sector**

[196] National Aged Care Mandatory Quality Indicator Program. Available at: **www.health.gov.au/our-work/qi-program**

An undertrained workforce was identified as a systemic problem by the Royal Commission.[197] Worker qualifications are a focus of multiple initiatives to upskill the aged care workforce. These initiatives are listed in the *Professional Framework – to build and strengthen the aged care workforce* (Professional Framework).[198] The Aged Care Provider Workforce Survey includes questions about direct care workers qualifications, to monitor the aged care workforce skills range over time. Aged Care Worker satisfaction also contributes to quality and safety of care delivered for older people. Satisfied workers are more likely to remain working, which provides continuity of care and strengthened relationships with older people who receive care. The Aged Care Worker Survey reports overall satisfaction, and elements of work that contribute to workers' satisfaction and dissatisfaction.

Key Activity 3.3A:

Enable safe and high-quality aged care.

Source: *Health and Aged Care Corporate Plan 2024–25, p.64*

Performance Measure 3.3A:

Aged care workforce is available and appropriately skilled to deliver safe and high-quality care to older people.

Source: *Health and Aged Care Portfolio Budget Statements 2024–25, p.99 and Health and Aged Care Corporate Plan 2024–25, p.64*

2024–25 Planned Performance	2024–25 Result	2023–24
a. Establish baseline for staff turnover through the biennial Provider Workforce Survey. b. Establish baseline for worker qualification through the biennial Provider Workforce Survey. c. Establish baseline for worker satisfaction through the biennial Aged Care Worker Survey.	a. Baseline workforce turnover is 84,908 (27%) of all directly employed nursing, personal care and clinical care manager staff left their employment in the 12-months since March 2022. b. Baseline for worker qualifications is: 48.0% of all directly employed Personal Care Workers hold a Certificate III or higher in a field of study related to their aged care work. c. Baseline worker satisfaction is: 64.7% of survey respondents of the Worker Survey are satisfied with their overall employment in their main job in aged care.	a. Workforce turnover: 84,908 (27%) of all directly employed nursing, personal care and clinical care manager staff left their employment in the 12-months since March 2022. b. Workforce qualifications: 48.0% of all directly employed Personal Care Workers hold a Certificate III or higher in a field of study related to their aged care work. c. Workforce satisfaction: 64.7% of survey respondents of the Worker Survey are satisfied with their overall employment in their main job in aged care.
	Result: Achieved (Baseline established) ●	

Disclosures:

2024–25 Result:

Baseline has been established for 2024–25 and is the same as that reported in 2023–24, because the Aged Care Provider Workforce Survey is a biennial survey, last conducted in 2023. As the results have not changed for 2024–25, the disclosure information remains the same as for 2023–24, described below for a. and b. The workforce satisfaction measure c. should be interpreted with caution, as it reflects only the views of survey respondents who answered the satisfaction question—not the entire aged care workforce. For c. data used for reporting against this measure is sourced from the Aged Care Data Warehouse and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the Aged Care Data Warehouse which is planned to be completed in mid-2026.

[197] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 2, p 211, is available at: **www.royalcommission.gov.au/aged-care/final-report**

[198] Available at: **www.health.gov.au/professional-framework**

2023–24 Result:

For a. and b. the 2023 Aged Care Provider Workforce Survey, headcount estimates may overstate the size of the workforce where staff work for multiple providers or across different service care types. Services were asked to provide information relevant to the first fortnightly pay period in March 2023.

The result for b. Workforce qualification was calculated as the proportion of Personal Care Workers whose highest level of education completed in a field related to aged care work is a Certificate III or higher, noting the denominator includes 'unknown' responses. Please note the high proportion of 'unknown' responses on this question (47% overall), indicating that these results should be interpreted with caution.

Data Source and Methodology:

Measure a. Workforce turnover

Calculation methodology for staff turnover is derived from:

Numbers of directly employed staff in first fortnightly pay period in March 2023, minus number of new directly employed workers who commenced at the facility since 1 March 2022, plus number of directly employed workers who have left the facility since 1 March 2022.

Measure b. Workforce qualification

Workforce qualifications is directly sourced from the Aged Care Workforce Provider Survey (input to output) with no calculations undertaken to produce these estimates.

Measure c. Worker satisfaction

Workforce satisfaction will be directly sourced from the Aged Care Worker Survey (input to output) with no calculations undertaken to produce these data. The survey captures 12 measures of worker satisfaction and includes overall job satisfaction, satisfaction with level of support from employer, and satisfaction with training and promotional opportunities.

Data source: Aged Care Workforce Provider Survey 2023 - providers responding to the Aged Care Provider Workforce Survey.

Data type: Survey responses weighted to the population.

Data acquisition: Contact data for providers is extracted from the Aging and Aged Care Data Warehouse (ACDW) and given to the Social Research Centre (SRC) at Australian National University (ANU).

Data extraction and processing

The raw data in Excel format is extracted from the Health Data Portal by Aged Care Workforce Branch and stored in the ACDW.

Internal quality assurance

During the analysis process the data undergoes assurance cross checks by the Australian Institute of Health and Welfare (AIHW) and the department. The process is documented in the Data Quality Statement.

Data extraction and methodology – workforce satisfaction:

Data source: Aged Care Worker Survey 2024 - opt in survey of all direct care aged care workers.

Data type: Survey responses only (not weighted to the target population).

Data acquisition: Advertised the survey on the department's social media pages and sector newsletters. These advertisements had a survey QR and direct weblink included. Forms

Administration Pty Ltd were procured to email aged care providers the survey and to encourage providers to forward the survey onto their staff to complete.

Internal quality assurance

The department's quality assurance includes checks for missing data or duplicate data, logic check of data in related variables, data outlier checks and recoding of qualitative responses to quantitative responses.

The Australian Government is continuing to invest in building, training and supporting the aged care workforce. A key component of lifting the standard of aged care in Australia is to recognise the contribution and value that aged care workers deliver. The government is investing in initiatives including Fee-Free TAFE, more university places, Commonwealth Prac Payments (CPP) and a new visa pathway to attract new workers. These will also help to build the skills of current workers.

To guide this, the government has published the Professional Framework.[199] This framework was developed with stakeholder input and sets the strategic direction for workforce actions that support the needs and rights of older people.

Reporting for the aged care workforce is affected by biennial survey data collection timing cycles. There is more frequent routine reporting for some programs. Recommendation 75 1.a. from the Royal Commission[200] recommends that up-to-date data about the aged care workforce be collected every 2 years. The last Aged Care Provider Workforce Survey was conducted in 2023, and the results were published in 2024. The next survey is due to take place in the second half of 2025 and the results will be available in 2026. These will be referenced in performance measures a. and b for 2025–26.

There are no further data updates available for performance measure c. on worker satisfaction to observe trends at this point in time.

Aged Care reforms in response to the Royal Commission included structural changes affecting funding for the aged care workforce. Increased funding for residential aged care occurred with the introduction of case mix adjusted, activity-based care. The pricing of this was set by the Independent Health and Aged Care Pricing Authority. The introduction of mandated requirements for 24/7 RN coverage and care minutes has increased the demand and supply of RNs in residential aged care. The Fair Work Commission's Aged Care Work Value case resulted in increases to the award wages for aged care workers. This was supported by increased government funding to cover these and other labour cost increases in aged care in 2024–25.

The biennial cycle of aged care workforce survey reporting was considered in planning for 2024–25 performance reporting. Establishment of baseline measures was planned for 2024–25, for measures a. workforce turnover, b. workforce qualifications and c. workforce satisfaction. Aged Care Worker Survey data, including worker satisfaction, was collected in 2023–24 (March to April 2024) and published in late 2024. Baseline measures are now established in 2024–25 for all measures (a, b and c).

2024–25 results are identical to 2023–24 reporting. This is because results from the Aged Care Provider Workforce 2023 and Aged Care Worker Survey 2024 are the most recent results. Although trend data is not yet available for the 3 measures due to biennial survey data collections timing cycles, there is indication that quarterly workforce turnover in residential aged care is steadily reducing. This trend is reported from National Aged Care Mandatory Quality Indicators in Residential Aged Care.[201]

[199] Available at: **www.health.gov.au/professional-framework**

[200] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 258, is available at: **www.royalcommission.gov.au/aged-care/final-report**

[201] Available at: **Quality in aged care - AIHW Gen**

Outcome 4: Disability and Carers

Supporting the independence of people with disability and carers by providing targeted supports.

Programs contributing to Outcome 4

	Summary of results against performance criteria			
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**
Program 4.1: Disability and Carers	2	1	1	-
Program 4.2: National Disability Insurance Scheme	3	-	-	1
Total	**5**	**1**	**1**	**1**

Program 4.1: Disability and Carers

Program Objective

To support people with disabilities and carers to actively participate in community and economic life.

2024–25 represents the fifth full year of operation for the Carer Gateway program. Monitoring improvement in carer wellbeing is a longer-term outcome, and the proportion of carers experiencing improved wellbeing is an important measure of the impact of this program. Reporting carer wellbeing outcomes for clients measures the department's performance in providing support for carers, and in 2022–23 replaced the previous measure 'annual increase in number of people accessing Carer Gateway'.

In addition to access and quality of carer supports, a range of other factors influence wellbeing for carers, including the circumstances of their caring relationship and employment. Qualitative evidence indicates that regardless of effective support, the caring role is taxing and maintenance of wellbeing could also be considered a success. Ongoing analysis of program data indicates that percentage of carers with improved wellbeing is plateauing the longer the program runs. This observation has been reflected in the out year targets.

Carer Gateway is the support program which provides the largest reach and the broadest range of services to unpaid carers. In 2024–25, the number of carers assisted through Carer Gateway service providers continued to increase compared to previous years.

In December 2024, the Minister for Social Services, the Hon Amanda Rishworth MP, released the National Carer Strategy 2024–2034[202] (the Strategy) to support Australia's unpaid carers. The Strategy provides a framework for co-designing, developing and delivering a suite of actions to holistically improve the lives of carers. The accompanying National Carer Strategy Action Plan 2024-2027 (the Action Plan) outlines early actions, with a number already completed or in train.

- Additional funding has been allocated to Carer Gateway to increase access to phone counselling for carers up to an additional 10,000 sessions per year. Additional counsellors have been recruited, and a marketing campaign has commenced with hospitals and rural medical facilities. The program is on track to reach the target of 10,000 additional counselling sessions by September 2025.
- The Tristate Carer Vocational Outcomes Program Pilot ceased on 30 June 2025, and pre-employment supports in Queensland, South Australia and Tasmania transitioned to delivery via Carer Gateway from 1 July 2025. Pre-employment supports will be expanded to a national model from 1 July 2026.
- Complementary programs were extended to support Carer Gateway as an ongoing measure, with the Carer Inclusive Workplace Initiative extended to 30 June 2026, and the Young Carer Bursary Program and Young Carer Network extended to 30 June 2027.

On 3 December 2021, Australia's Disability Strategy 2021–2031[203] (ADS) was launched by all levels of governments. ADS enables coordinated and joined-up action across all levels of governments to fulfill the vision of an inclusive and accessible Australia to enable people with disability to reach their potential as equal members of their communities. It recognises that all levels of government are responsible for supporting people with disability, and the need for collaboration across governments to achieve this vision.

Following a review conducted in 2024, ADS was updated and published on ADS Hub.[204] A revised ADS Data Improvement Plan was also published on ADS Hub in December 2024.[205]

[202] Available at: **www.health.gov.au/resources/publications/national-carer-strategy-2024-2034**
[203] Available at: **www.health.gov.au/our-work/australias-disability-strategy**
[204] Available at: **www.disabilitygateway.gov.au/ads**
[205] Available at: **www.disabilitygateway.gov.au/document/10981**

ADS delivers against 7 Outcome Areas that people with disability told us needed to improve to achieve the vision for ADS: Employment and Financial Security; Inclusive Homes and Communities; Safety, Rights and Justice; Personal and Community Support; Education and Learning; Health and Wellbeing; and Community Attitudes.

One of the key improvements introduced with the launch of ADS was the implementation of the Outcomes Framework (OF),[206] to enhance government accountability by measuring and reporting on outcomes. Reporting against the ADS OF measures allows policy makers and non-government organisations to see the policy areas, services and programs that are tracking well and those which are not. This is important in informing the design and implementation of ongoing policies and programs to improve the outcomes of people with disability over the life of ADS.

The department leads the implementation and reporting of ADS across Commonwealth agencies and state and territory governments, which have responsibility under their respective portfolios and jurisdictions to implement policies, programs and supports to improve the lives of people with disability.

To support the implementation of ADS across Australian Government portfolios, the department uses a collaborative leadership approach. The collaborative leadership approach means that all ministers with disability responsibility are responsible for delivering on different Policy Priorities under ADS, to drive better outcomes for the one in 5 Australians who live with disability.

The Disability Reform Ministerial Council (DRMC) provides a forum for the Commonwealth and state and territory ministers responsible for disability policy to drive national reform in disability policy and implementation, including through ADS.

State and territory governments are responsible for driving implementation of ADS in their jurisdictions, including collecting and sharing data to better monitor and report outcomes for people with disability. Each state and territory government provide regular reporting against their own disability plans.

The establishment of ADS Advisory Council coincided with the launch of ADS in 2021. ADS Advisory Council is made up entirely of people with disability, who provide ministers and governments independent advice on ADS implementation and progress. The Council's role is to advise Australian, state and territory Disability Ministers and governments, through DRMC, on the implementation elements of ADS.

A further element of the governance and engagement approach under ADS is the direct engagement of Disability Representative Organisations to support ADS implementation. This forum consists of a range of organisations representing the disability sector and people with disability and is a key consultation point for the Australian Government to seek advice and feedback on ADS implementation activities.

The Royal Commission into Aged Care Quality and Safety (Royal Commission) found that residential aged care is generally not an appropriate setting for people under the age of 65 years, noting the aged care system is designed to support the needs of older people.

Younger people in residential aged care (YPIRAC) is a complex issue and requires extensive one-on-one support and regular conversations with individuals, their families/guardians and service providers across the disability, aged care, health and housing sectors at all levels of government.

In collaboration with the National Disability Insurance Agency (NDIA), the Department of Health, Disability and Ageing (the department) oversees cross-agency actions to:

- prevent younger people from entering into and/or residing in residential aged care, except in exceptional circumstances
- support younger people currently residing in residential aged care and have no goal to move
- provide resources to younger people living in residential aged care who have a goal to move with resources to assist them in locating more appropriate accommodation.

[206] Available at: **www.disabilitygateway.gov.au/ads/strategy#toc-the-outcomes-framework**

It is recognised that there are some circumstances where younger people under 65 years may be eligible to receive care and support in residential aged care, either on a temporary or permanent basis. Where it is their preference, this currently includes:

- a person from an Aboriginal or Torres Strait Islander community aged 50 to 64 years
- a person who is homeless, or at risk of becoming homeless, and aged 50 to 64 years
- maintaining family connections (e.g. a person who has been cared for by ageing parents who are now moving into aged care).

The Australian Government remains committed to reducing the number of YPIRAC and to supporting younger people to access alternative, age-appropriate accommodation and supports.

Key Activity 4.1A:

Disability and Carer Support.

Source: *Department of Social Services 2024–25 Corporate Plan, page 61*

Performance Measure 4.1A:

Extent to which wellbeing of carers who are registered with Carer Gateway local service providers is assessed as improved.

Source: *Department of Social Services 2024–25 Corporate Plan, page 62*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period.	a. 31.4%	a. 29%	a. 32%
b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved level of carer wellbeing since the program commenced.	b. 34.2%	b. 34%	b. 34%
	Result: Substantially achieved ◗		

Disclosures:

a. In the current reporting period from 1 July 2024 to 30 June 2025, 49.2% of carers registered with Carer Gateway with an assessment in the period, were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

b. In the cumulative reporting period from 1 January 2020 to 30 June 2025, 49.6% of carers registered with Carer Gateway were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

Data Source:

Carers Star™ 'needs assessments' conducted by Carer Gateway service providers and entered into the Department of Social Services Data Exchange (DEX).

Methodology:

The methodology for each of the targets is:

- The target result of the number of carers assessed as having improved wellbeing within the performance reporting period is calculated using Carers Star™ needs-assessments data, where an assessment is reported in the current reporting period. A previous assessment must have occurred in either the same reporting period or a previous period.
- The target result of carers assessed as having improved wellbeing for all registered carers since the program commenced is calculated using data from Carers Star™ needs-assessments, across all reporting periods from 1 January 2020 to the end of the current reporting period.

Data results are produced using DEX QLIK Sense reporting of client outcomes. QLIK Sense pairs available earliest and latest SCORE data entered in DEX for each client in each reporting period and produces the percentage of carers who are assessed as having improved wellbeing.

The Carer and Early Childhood Branch is working with Carer Gateway Service Providers to support increased compliance with Carer Star™ assessments and quality of reporting, as well as options to simplify measurement of carer wellbeing, particularly for carers exiting the program.

A Key Performance Indicator framework has been implemented for Carer Gateway providers that will help to improve service impact, strengthen wellbeing outcomes for carers, and further incentivise coverage of Carer Star™ assessments and improved data quality. Since the framework was implemented, the program has seen significant improvements in the rate of carers considered fully assessed. Results from other analyses such as regular performance monitoring reports and, findings from the Integrated Carer Support Service Impact Evaluation and actions from the National Carer Strategy continue to inform focus areas for improvement.

The National Carer Wellbeing Survey 2024 (the Survey) demonstrates that carers are more than twice as likely to have low levels of wellbeing compared to the average Australian adult and indicates that carer wellbeing has been trending down since at least 2021. The Survey notes a number of factors driving low carer wellbeing, most of which are either directly or indirectly related to increased cost-of-living pressures, including reduced finances, under- or unemployment, unsupportive workplaces, and access to medical treatments. Many of these factors are not able to be influenced by Carer Gateway services and improvements are reliant on other service systems, which often do not have the same objective to improve client wellbeing.

The measured performance in lifting wellbeing is close to the targets but still below. This may be due to measurement and data collection problems, including low numbers of fully assessed carers, and assessments being focused on case management rather than reporting purposes.

In the reporting period from 1 January 2020 to 30 June 2025, 49.6% of carers registered with Carer Gateway were considered fully assessed (undertaken at least 2 Carers Star™ assessments). This is the highest seen in the program to date and continues to increase as the program matures and will continue to provide more accurate measures.

Carers Star™ is designed as a case management tool to identify caring issues, inform case plan goals, and as an instrument to measure and report carers progress and achievement of outcomes. Anecdotal evidence suggests that carers with increased wellbeing are more likely to disengage from the program and not complete a follow-up Carers Star™ to confirm improvement, as they no longer require intensive case management to access services. It is also a known limitation that carers with high wellbeing entering the program cannot further improve their wellbeing and therefore count against the target, despite maintenance of high wellbeing tending to indicate program success for those clients.

Program impact on carer wellbeing seems to be plateauing the longer the program runs, both within the current reporting period, and as a cumulative measure. This is likely due to stabilising client turnover as the program matures, with numbers of new carers accessing Carer Gateway each reporting period similarly seeming to plateau.

Key Activity 4.1B: Disability and Carer Support. Source: *Department of Social Services 2024–25 Corporate Plan, page 61*	
Performance Measure 4.1B: Extent to which the evidence base is built for Australia's Disability Strategy. Source: *Department of Social Services 2024–25 Corporate Plan, page 63*	
2024–25 Planned Performance	**2024–25 Result**
Increase measures under ADS 2021–2031 Outcomes Framework with data reported. (≥55 measures 2023–2024 baseline).	As of 30 June 2025, ADS Outcomes Framework has a total of 88 ADS OF measures of which 56 have data reported on.
	Result: Achieved ●
Data Source: All measures - Australian Institute of Health and Welfare: **www.aihw.gov.au/australias-disability-strategy/outcomes/all-measures** **Methodology**: Determining the total number of measures reported under ADS Outcomes Framework involves counting the outcomes measures that have data available at the end of the relevant financial year. The measure aims to increase transparency through increasing the number of ADS measures that are reported on above the 2023–24 baseline of 55 of the 85 measures. The 2024 Data Improvement Plan outlines tangible next steps to support the ongoing improvement of disability data and reporting. The focus is on developing and collecting data on those measures (future measures) that are currently not being reported.	

ADS Outcomes Framework (OF)[207] tracks and measures whether the experiences of people with disability are improving across the 7 outcomes areas in ADS. Quarterly and annual reporting against ADS OF measures show what progress is being made over the life of ADS.

Increasing the measures under ADS OF that have data available is a key delivery of ADS.
As of 30 June 2025, ADS OF has a total of 88 ADS OF measures of which 56 have data reported on.

ADS OF are publicly available and includes a list of all measures,[208] including if data is available. ADS OF measures that do not have data available are indicated by 'Future data development'.

The department leads discussions with relevant Commonwealth agencies and state and territory governments on the development of data collection activities for future measures under ADS as part of the commitment across all levels of government to improve ongoing data and reporting. Agreement by these stakeholders to implement data collection activities for ADS OF measures that currently do not have data will help to increase the number of measures under ADS OF with data reported.

Implementing new data collections activities to increase the number of ADS OF measures with data is a decision for each state and territory government and relevant Commonwealth agencies, and the department is limited in its influence over these activities. The department continues to work with all governments to negotiate improved data collection.

The National Disability Data Asset[209] is being designed as a long-term national asset containing linked, de-identified Australian, state and territory government data on all Australians. Several ADS OF measures are expected to use data from the National Disability Data Asset for reporting. One of the key priorities for the National Disability Data Asset is the provision of data to improve the reporting under ADS OF.

[207] Available at: **www.disabilitygateway.gov.au/document/3121**
[208] Available at: **www.aihw.gov.au/australias-disability-strategy/outcomes/all-measures**
[209] Available at: **www.ndda.gov.au**

Once implemented, the National Disability Data Asset will be used to gradually increase the number of ADS OF measures with available data (as well as improve the data and reporting for ADS OF measures that are already reported on). However, the breadth of the data available in the National Disability Data Asset will considerably depend on government data custodians' agreement to share and link their data.

In some instances, the department may be able to source data to report on ADS OF measures from other comparable linked data assets or surveys.

The ADS Data Improvement Plan was originally endorsed by Disability Reform Ministers and published on ADS Hub in December 2022. As part of the broader ADS Review work, a revised Data Improvement Plan was published on 3 December 2024. The 2024 Data Improvement Plan outlines tangible next steps to support the ongoing improvement of disability data and reporting. It outlines key actions that demonstrate how and what the Commonwealth is doing to drive improvements in disability data.

The number of measures that have data reported on in ADS Outcomes Framework increased from 55 in the 2023–24 period to 56 in the 2024–25 period. One measure was replaced with a new measure using improved data.

Key Activity 4.1C:

Disability and Carer Support.

Source: *Department of Social Services 2024–25 Corporate Plan, page 61*

Performance Measure 4.1C:

Extent to which the department contributes to attracting, recruiting, and retaining more people with disability in the Australian Public Service.

Source: *Department of Social Services 2024–25 Corporate Plan, page 64*

2024–25 Planned Performance	2024–25 Result
That the Department of Social Services' workforce includes at least 7% of people identifying with disability.	7.1%
	Result: Achieved ●

Disclosures:

This result is extracted from the Department of Social Services Essentials HR reporting system. Staff are encouraged and supported to self-identify as a person with disability, but it is important to note that this is voluntary and as such the reported percentage may not reflect the actual number of staff with disability in the department.

Data Source:

The percentage of staff within the department who self-identify as a person with disability is tracked through the department's Essentials HR reporting system.

Methodology:

As a steward of ADS, the Department of Social Services has a role in leading by example and increasing the employment of people with disability. As of 30 June 2024, the department employs 6.3% of people with disability. Noting that 1 in 5 (or around 21%) of people in Australia have a disability, further increases and representation in the workplace is required and achievable (Survey of Disability, Ageing and Carers 2022). The percentage of staff within the department who self-identify as a person with disability is tracked through the department's Essentials HR reporting system. Staff are encouraged and supported to identify but it is important to note this is voluntary and as such the reported percentage may not reflect the actual number of staff with disability in the department.

Australia's Disability Strategy 2021–2031 (ADS) is a national framework that all Australian governments have signed up to. It sets out a plan for continuing to improve the lives of people with disability in Australia over 10 years. The vision is for an inclusive Australian society that ensures people with disability can fulfil their potential, as equal members of the community, through improved inclusion, accessibility and economic participation.

All levels of government play a role in services, supports and infrastructure for people with disability. As the steward of ADS in 2024–25, the Department of Social Services contributed to the Australian Public Service targets through employing 7.1% of people identifying with disability during 2024–25. This is an increase on the 6.3% of people with disability employed in the department during 2023–24.

Key Activity 4.1D:

Disability and Carer Support.

Source: *Department of Social Services 2024–25 Corporate Plan, page 61*

Performance Measure 4.1D:

Progress towards the target relating to younger people in residential aged care (YPIRAC).

Source: *Department of Social Services 2024–25 Corporate Plan, page 65*

2024–25 Planned Performance	2024–25 Result	2023–24	2022–23
No people under 65 years living in residential aged care by 2025 apart from in exceptional circumstances.	959 people under the age of 65 excluding First Nations young people aged 50 to 64 years were living in residential aged care at 31 March 2025.	1,381 people under the age of 65 excluding 244 First Nations young people aged 50 to 64 years were living in residential aged care at 31 March 2024.	2,423 people under the age of 65 were living in residential aged care at 31 December 2022.
	Result: Not achieved ○		

Data Source:

- National Disability Insurance Agency's (NDIA's) National Disability Insurance Scheme (NDIS) Quarterly Report to Disability Ministers.
- Australian Institute of Health and Welfare (AIHW) Gen Aged Care Reports.

Methodology:

The number of people aged under 65 years living in residential aged care is sourced from AIHW Gen Aged Care Reports. AIHW reports are considered the authoritative source for publicly available YPIRAC figures and are published on a quarterly basis.

In collaboration with the NDIA, the department oversees activities delivered and coordinated to prevent the entry and facilitate the exit of younger people in residential aged care.

The Royal Commission into Aged Care Quality and Safety recommended that no younger people remained in residential aged care by January 2025 (the target). While the target was not met, there has been significant work progressed to reduce the number of younger people in residential aged care.

As part of the 2023–24 Budget, the government funded the Department of Social Services (DSS) to develop targeted education and training packages focused on younger people in residential aged care (YPIRAC) who currently do not have a goal to move out.

The YPIRAC toolkit was published in January 2025.[210] The toolkit addresses the challenges faced by younger people in Australia living in residential aged care by providing information on age-appropriate housing, care and support. With a focus on empowerment and collaboration, the toolkit provides families and carers with helpful tips for supporting younger people through the process of moving out of residential aged care.

The NDIA has a team of dedicated aged care planners and accommodation officers who work with participants who have a goal to move. NDIA aged care planners also regularly check in with participants who do not have a goal to move, to explore alternative options.

The department funded Ability First Australia[211] (AFA) to establish a national network of YPIRAC System Coordinators. The coordinators engage with younger people aged under 65 years living in, or at risk of entry to, residential aged care to find suitable accommodation and supports.

The AIHW reports on progress on reducing the number of younger people living in residential aged care. Commencing from 1 November 2025, the *Aged Care Act 2024* (the Act) will provide very limited circumstances in which a person under the age of 65 will be able to access Commonwealth-funded aged care services.

The approach recognises that people aged 50 to 64 years, who have care needs and are Aboriginal or Torres Strait Islander and/or homeless or at-risk of homelessness, will continue to be able to access individual needs assessments for Commonwealth-funded aged care services in the same way as people aged over 65 years. These cohorts have been identified as eligible for aged care services on the basis that they are more likely to experience premature ageing. Under the Act, there will be no other circumstances in which people aged under 65 years can access Commonwealth-funded aged care services, including in emergency situations.

Despite significant reductions in the number of younger people in residential aged care, the YPIRAC target of 1 January 2025 was not met. This is mainly the result of the marked decline in younger people entering residential aged care, as well as the effect of the under 65 cohort 'ageing out' (turning 65) or passing away. Some younger people have moved to age-appropriate care arrangements, but not yet in sufficient numbers to meet the target.

While the reasons younger people enter residential aged care are complex and varied, a common theme is that they do not have access to sufficient services from other systems to remain living at home. In some cases, this also means they do not have access to any other appropriate residential setting in which to receive care. This means transitioning younger people from residential aged care can be complex and faces significant barriers including:

- they have been living in aged care for a long time and are not seeking alternative care arrangements
- families or guardians may be reluctant to agree to change their loved one's living arrangements
- they are living in rural and regional areas where alternative accommodation and support may be limited
- they are not eligible for the NDIS or other Commonwealth funded support, there may be limited community access to mainstream supports and services and may fall into a service gap for housing and support services, which is the responsibility of state and territory governments.

[210] Available at: **www.dss.gov.au/news/new-toolkit-support-younger-people-residential-aged-care**
[211] Available at: **abilityfirstaustralia.org.au**

A further challenge to achieving zero YPIRAC includes the remaining number of NDIS participants with no goal to move out of residential aged care. Of the 734 younger people who were NDIS participants as at 31 March 2025, 157 had an identified goal to move out of residential aged care. Although coordinated efforts continue to offer all young people in residential aged care with more age appropriate accommodation, the choice to remain in residential aged care or relocate remains with the younger person.

There is a continued downward trend in the number of younger people in residential aged care. As at 31 March 2025, there were 959 people aged under 65 years living in permanent residential aged care in Australia (this excludes Aboriginal and Torres Strait Islander people aged 50 to 64 years who are eligible for residential aged care). Of the 959 people, 15 were aged under 45 years.

There continues to be a steady decline of this cohort, with a decrease of 4,364 people (82%) since March 2019 and a 30% decrease from 31 March 2024. Three hundred and six of the younger people living in residential aged care were not NDIS participants.

During January to March 2025, 37 people aged under 65 years were admitted into permanent residential aged care in Australia, for the first time (this excludes Aboriginal and Torres Strait Islander people aged 50 to 64 years who are eligible for residential aged care).

Admissions into permanent residential aged care continue to reduce, with a 90% decrease when compared to January to March 2019. However, the number of admissions can vary on a quarterly basis as some younger people continue to enter aged care where no suitable alternative option can be found.

The AIHW YPIRAC data dashboard presents national quarterly data against the YPIRAC targets. Included in the dashboard webpage is a factsheet, and a detailed data download containing additional demographic data. Aboriginal and Torres Strait Islander people aged 50 to 64 years are excluded from the total YPIRAC counts and reported separately in the detailed data download, due to their eligibility under the Exceptional Circumstances Policy.

Data on younger people aged 50 to 64 years who are homeless or at risk of homelessness is limited. As a result, this cohort is currently included in the YPIRAC counts and is not separately reported. The department is continuing to work with AIHW to separately report on the YPIRAC aged 50 to 64 years who are homeless/at risk of becoming homeless, for future data releases.

Program 4.2: National Disability Insurance Scheme

Program Objective

To improve the wellbeing and social and economic participation of people with disability, and their families and carers, by building a NDIS that delivers individualised support through an insurance approach. This program also includes the Jobs and Market Fund.

National Disability Insurance Scheme (NDIS) Transition is a key activity of the NDIS Program which aims to support national implementation of the NDIS in accordance with intergovernmental agreements.

The completion of transition is defined by:

- the execution of full scheme bilateral agreements between the Commonwealth and all states and territories (target = full scheme agreements signed with all states and territories by 30 June 2025).

The department's role is to facilitate transition to the NDIS, including:

- execute full scheme bilateral agreements with all states and territories
- administer intergovernmental agreements about the NDIS, governing state financial contributions to the scheme, including the recognition of in-kind provision of services by states and territories, and commitments to phase these out
- monitor the implementation of the NDIS in each state and territory through trilateral governance arrangements with the National Disability Insurance Agency (NDIA) and state and territory governments.

Oversight of the NDIS market is a shared responsibility between the Commonwealth, the NDIA, the NDIS Quality and Safeguards Commission (NDIS Commission), and state and territory government partners.

The department plays an enabling role in supporting the effective functioning of the NDIS by providing policy advice and driving initiatives that strengthen the capacity, responsiveness and sustainability of the provider market and workforce. This includes advising on and/or delivering initiatives that promote continuity of supports, service quality, provider viability, and system-wide responsiveness.

In 2024–25, the department continued to strengthen market stewardship for the NDIS through the design and delivery of targeted initiatives under Program 4.2 National Disability Insurance Scheme. These initiatives were designed to strengthen market capability, improve provider responsiveness and address thin market challenges. They support the growth of a diverse, responsive and sustainable disability sector, with a focus on improving outcomes for NDIS participants.

The department's work spanned pricing and payment reform, workforce data and planning, commissioning trials and developing market stewardship arrangements. These efforts contributed to the Australian Government's broader care and support economy reform agenda and aligned with the implementation of the Independent Review of the NDIS's recommendations.

The department worked closely with the NDIA, the NDIS Commission, states and territories, and sector stakeholders, including through forums such as the Disability Reform Ministers Council (DRMC), and interagency working groups. This collaborative approach ensured alignment with broader system reform and enabled responsive market stewardship.

The NDIS supports the independence and social and economic participation of people with disability. The NDIS provides funding directly to people with disability, moving away from the previous system of providing block funding to agencies and community organisations.

The NDIS gives participants choice and control in the pursuit of their goals and the planning and delivery of their reasonable and necessary supports, including early intervention supports where this can enable social and economic participation and reduce the impact of disability for eligible people including children.

The NDIS is co-governed by Commonwealth and state and territory Disability Ministers via the DRMC and administered by the NDIA.

The department has policy responsibility for the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act) and subordinate legislation (rules made under the NDIS Act) (NDIS Rules), which underpin the governance and operations of the NDIA's role in the NDIS.

The department's role, in addition to enabling the ongoing functioning of the NDIS, includes monitoring and the performance, outcomes and financial sustainability of the NDIS. A range of agencies and entities work closely with the department, each playing a part in the delivery of the NDIS, these include the NDIA, states and territories and the NDIS Commission.

Key Activity 4.2A:

NDIS Transition.

Source: *Department of Social Services 2024–25 Corporate Plan, page 67*

Performance Measure 4.2A:

The department works with states and territories and the NDIA to support national implementation of the NDIS in accordance with inter government agreements.

Source: *Department of Social Services 2024–25 Corporate Plan, page 67*

2024–25 Planned Performance	2024–25 Result	2023–24
Full scheme agreements signed with all states and territories by 30 June 2025.	Full scheme agreements have been signed with all states and territories.	Full scheme agreements have been signed with all states and territories, except for Western Australia (WA).
	Result: Achieved ●	

Data Source:

Signed full scheme agreements with all jurisdictions.

Methodology:

Signed copies of the full scheme agreements are the primary artefacts created as a result of negotiations with states and territories. These signed agreements are the authoritative source to assess the measure.

The department works with states and territories and the NDIA to support the implementation of the NDIS and has a particular role to negotiate full scheme agreements with all states and territories. This is part of the department's enabling role for the operation of the NDIS.

On 17 June 2025 after successful negotiations between the Commonwealth and WA, the full scheme agreement was signed. The planned performance has been met and the measure is considered complete as all states and territories now have a full scheme agreement in place.

In 2024, the Commonwealth and state and territory governments focused on progressing critical NDIS and disability reforms in response to the NDIS Review and decisions of the National Cabinet in December 2023. Due to the increased focus on these reforms, negotiations with WA remained ongoing during 2024, with the full scheme agreement executed on 17 June 2025.

Key Activity 4.2B:

Sector Development Fund and Jobs and Market Fund.

Source: *Department of Social Services 2024–25 Corporate Plan, page 69*

Performance Measure 4.2B:

The extent to which the department is advising on and/or delivering market initiatives that influence the development of the market and workforce for NDIS participants.

Source: *Department of Social Services 2024–25 Corporate Plan, page 69*

2024–25 Planned Performance	2024–25 Result
Number of market initiatives advised on and/or delivered by the department to develop the market and workforce (Target: 8).	8 initiatives have been progressed with various output measures achieved.
	Result: Achieved ●

Disclosures:

Data counts reflect only initiatives for which planning, design or delivery milestones occurred during the 2024–25 financial year. Additional activities related to sector development may fall below this threshold and are excluded.

Data Source:

The department's Electronic Documents and Records Management System (ARC).

Methodology:

The department will report an output measure on the count of market intervention and workforce development projects and initiatives advised on and/or delivered by the department in 2024–25.

The department will advise on and/or deliver in collaboration and/or consultation with care and support economy stakeholders where necessary. This will be through a range of channels and forms dependent on who is being advised, including the Australian Government, other government entities, state and territory jurisdictions.

Market initiatives to be advised on and/or delivered in collaboration with other government agencies:

- Pricing and Payments Framework development
- Blended Payments trials
- Integrated Care and Commissioning trials
- Alternative Commissioning pilots
- Market Stewardship Framework development
- HumanAbility Workforce Plan development

Market initiatives to be delivered by the department but developed in consultation with other government agencies:

- Market Monitoring and Workforce Insights development
- Care Sector Demand Map development.

In 2024–25, the department met the planned performance by advising on and/or delivering 8 initiatives designed to support development of the NDIS market and workforce. These initiatives contributed to the development of a more responsive, capable and sustainable NDIS market, in alignment with the department's stewardship role and broader government reform directions.

The 8 initiatives focused on a range of structural and operational challenges, including provider viability, commissioning models, workforce capability, demand forecasting and continuity of support mechanisms. Collectively, they advance policy, tools and governance needed to respond to thin markets, workforce shortages, provider viability concerns and system complexity.

Initiatives were selected based on alignment with the performance measure and were assessed as having achieved relevant planning, design or delivery milestones during the reporting period. There was no significant variance from the planned performance. The department's delivery approach remained flexible and responsive to reform timelines, stakeholder capacity and interjurisdictional coordination needs.

Key internal contributions included:

- progressing the Market Stewardship Framework, providing a strategic foundation for system-wide market oversight
- leading design work for Alternative Commissioning Pilots and Blended Payment trials to explore more flexible, place-based funding and service models
- advancing work on the Provider of Last Resort (PoLR) policy to ensure continuity of supports in the event of market failure
- progressing work to revise the NDIA pricing and payments regulatory framework to support better participant outcomes, provider sustainability and well-functioning markets
- supporting development of the Care Sector Demand Map, providing future visibility of demand patterns across care sectors
- partnering with the sector to support workforce development through initiatives like the Ability First Australia Diploma of Leadership
- collaborating on early implementation of Integrated Care and Commissioning trials to test locally tailored service models.

All initiatives were documented and tracked via the department's governance processes and electronic recordkeeping systems. These activities were coordinated across multiple branches in collaboration with the NDIS, DSS, NDIS Commission and Prime Minister and Cabinet (PM&C).

Performance in 2024–25 was influenced by a number of external factors:

- the release of the NDIS Review Final Report (December 2023) provided direction for the future of the Scheme, including recommendations related to pricing, commissioning, stewardship and provider regulation. The department progressed initiatives in a way that aligned with the NDIS Review's anticipated reform directions
- the Australian Government's response to the Disability Royal Commission (released September 2024) also influenced policy work, particularly around safeguarding, provider oversight and continuity of support. This was especially relevant to the development of PoLR work and informed broader stewardship initiatives aimed at improving quality, safety and reliability of supports for people with disability
- ongoing provider exits, viability pressures and thin markets in certain regions and support types continues to present risks to continuity of supports. This has reinforced the importance of progressing PoLR arrangements, commissioning pilots and proactive monitoring
- broader care and support workforce shortages and cost pressures continued to shape market conditions and sector responsiveness.

Despite these pressures, the department maintained strong progress across the portfolio of initiatives, with collaborative governance and flexible implementation approaches supporting delivery.

This performance measure was revised in 2023–24, limiting direct comparability. However, compared to prior years, the 2024–25 period saw:

- an increase in the breadth and depth of coordinated market stewardship activity
- a shift from diagnostic and advisory work toward pilot implementation and structured cross-sector engagement
- greater alignment with broader care economy reforms and cross-jurisdictional collaboration, particularly on pricing and commissioning.

Several initiatives form part of multi-year reforms and are expected to continue or scale in 2025–26. The department's role in these initiatives is often advisory, enabling or coordinating in nature, and formal delivery may sit with another agency or tier of government.

There are sensitivities associated with market interventions, particularly where pricing, commissioning, or PoLR arrangements intersect with existing regulatory and operational frameworks. The department continues to mitigate these through careful consultation and strong governance.

For 2024–25 the department is reporting on output measures on 8 market intervention and workforce development projects and initiatives advised on and/or delivered by the department. This is through a range of channels and forms dependent on who is being advised, including the Australian Government, other government entities, state and territory jurisdictions.

- **Pricing and Payments Framework Development**: The department, in consultation with the NDIA and NDIS Commission is progressing work to revise the NDIA pricing and payments regulatory framework to support better participant outcomes, provider sustainability and well-functioning markets.
- **Blended Payments Trials**: The department and NDIA are trialling blended payment models that combine an enrolment and outcome-based payment to incentivise quality and innovation. Co-design has been completed with implementation planned for early 2026.
- **Integrated Care and Commissioning**: The department has engaged a consultant to undertake evaluation of all trial sites. The project work plan has recently been endorsed, and a desktop review is currently underway. Findings will inform future work and policy.
- **Alternative Commissioning Pilots**: The department has engaged Australian National University (ANU) to undertake an evaluation of these pilot projects. The NDIA has provided the department with a report on engagement activities across pilot sites. ANU delivered their final evaluation report. Outcomes and recommendations from the report will inform broader care and support sector reform strategies. A closure report is expected to be completed by August 2025.
- **Market Stewardship Framework Development**: A Market Stewardship Framework (MSF) is being collaboratively developed by the department, NDIA and the NDIS Commission. The MSF aims to determine objectives for market stewardship, clear roles and responsibilities across government entities, support proactive and strategic oversight of provider markets, embed coordination mechanisms for market monitoring and intervention, and enable data-sharing and performance measurement to ensure accountability. This work also includes the departments lead PoLR with foundational work underway in collaboration with state and territory governments to progress a nationally agreed PoLR framework.
- **HumanAbility Workforce Plan development**: The department continues to provide feedback on future iterations on the HumanAbilty Workforce Plan and participates in workshops where appropriate. The department provides formal policy advice, and strategic guidance.
- **Market Monitoring and Workforce Insights development**: The department is developing an interactive market monitoring tool for policy development that will increase the government's ability to understand market gaps and emerging issues. The department worked with the Australian Taxation Office (ATO) on data linkage to develop insights into the NDIS workforce.
- **Care Sector Demand Map development**: The new Care Sector Demand Map is now available. The map helps providers understand the supply and demand for NDIS and aged care services.

Key Activity 4.2C: NDIS Participant Plans. Source: *Department of Social Services 2024–25 Corporate Plan, page 71*		
Performance Measure 4.2C: National Disability Insurance Scheme cost growth is sustainable. Source: *Department of Social Services 2024–25 Corporate Plan, page 73*		
2024–25 Planned Performance	**2024–25 Result**	**2023–24**
Annual growth target in the total costs of the Scheme of no more than 8% by 1 July 2026, with further moderation of growth as the Scheme matures. (Projected scheme costs for 2026–27 and each subsequent year, as reported in the 2024–25 Portfolio Budget Statements, are no more than 8% higher than the year prior).	N/A **Result**: Data not available —	N/A
Disclosures: Reporting for this target will commence from 2026–27. In 2024–25 and 2025–26 the department will report against projected scheme costs for 2026–27 and subsequent years as reported in the Portfolio Budget Statements. A link to the Department of Social Services' (DSS) 2024–25 Portfolio Budget Statements can be found at: www.dss.gov.au/budget-and-additional-estimates-statements/resource/portfolio-budget-statements-2024-25-budget-related-paper **Data Source**: Projected scheme costs for 2026–27 as obtained from the DSS's Portfolio Budget Statements. **Methodology**: In 2024–25 and 2025–26 the department will report against projected scheme costs for 2026–27 and subsequent years as reported in the Portfolio Budget Statements. Tracking projected scheme costs for 2026–27 and subsequent years across the years will show if the 8% target is still expected to be met.		

National Cabinet committed to a NDIS Financial Sustainability Framework (Framework) on 28 April 2023.

The Framework provides for an annual growth target in total costs of the NDIS of no more than 8% from 1 July 2026, with further moderation of growth as the Scheme matures.

Meeting the target will ensure the NDIS can continue to provide life-changing outcomes for future generations of Australians with permanent and significant disability.

The *National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No.1) Act 2024*[212] (the Amending Act) was introduced on 27 March 2024 and passed the Parliament on 22 August 2024, commencing on Thursday, 3 October 2024.

Key changes introduced by the Amending Act laid the foundation for new NDIS rules to improve the experience of participants and improve the long-term sustainability of the NDIS. A number of factors are likely contributing to the reduction in growth, including:

- a strong focus on providing clarity about what NDIS funding can and cannot be spent on through the introduction of a new NDIS supports rule
- changes made by rules to clearly specify the total amount of funding and the time period during which it can be used
- prevention of fraud through the Fraud Fusion Taskforce and crackdown on fraud
- improvements in planning to provide more consistent, transparent and fair outcomes for participants.

[212] Available at: **www.legislation.gov.au/C2024A00081/asmade/text**

The government, in collaboration with state and territory governments and in consultation with the disability community, has been progressively introducing new NDIS rules.

There has been significant consultation on NDIS reforms, which will continue throughout 2025 and into 2026. This included policy roundtables with disability representative organisations, peak bodies, and disability officials, in line with the DRMC NDIS rules engagement strategy. Clear communication and, where possible, public engagement processes will be essential to mitigate community concerns about significant reforms to NDIS planning, budget setting, access and foundational supports.

Key Activity 4.2D:

NDIS Participant Plans.

Source: *Department of Social Services 2024–25 Corporate Plan, page 71*

Performance Measure 4.2D:

Legislative amendments developed for government.

Source: *Department of Social Services 2024–25 Corporate Plan, page 74*

2024–25 Planned Performance	2024–25 Result	2023–24
Criterion is met if 3 of the 3 progress milestones are delivered.	100%	100%
	Result: Achieved ●	

Data Source:

1. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability – Reports and papers.[213]
2. The Final Report of the Independent Review of the National Disability Insurance Scheme (NDIS).[214]
3. Consultation report on draft lists of NDIS supports[215]
4. Disability Reform Ministerial Council communiques.[216]
5. Explanatory Memorandum and Second Reading Speech.[217]
6. NDIS Act (Bill No.2) – What we heard report.[218]

Methodology:

1. Develop policy advice and drafting instructions to support the Office of Parliamentary Counsel prepare a parliamentary bill.
2. Engagement with stakeholders (state and territory jurisdictions on legislation).
3. Develop supplementary materials to accompany the bill for introduction.

Criterion is met if all 3 of the 3 progress milestones are delivered.

[213] Available at: **www.disability.royalcommission.gov.au**
[214] Available at: **www.health.gov.au/news/release-of-the-final-report-of-the-independent-review-into-the-ndis**
[215] Available at: **www.engage.dss.gov.au/consultation-on-draft-lists-of-ndis-supports/**
[216] Available at: **www.health.gov.au/committees-and-groups/disability-reform-ministerial-council**
[217] Available at: **www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7181**
[218] Available at: **www.ndiscommission.gov.au/about-us/ndis-commission-reform-hub/ndis-act-rules-and-standards**

The Amending Act was introduced on 27 March 2024 and passed by the Parliament on 22 August 2024. The Amending Act commenced on 3 October 2024.

The Amending Act made changes in response to the 2023 Independent Review into the NDIS. The Amending Act sets out the framework for a new planning framework and gives additional powers to the NDIS Quality and Safeguards Commissioner.

While some legislative changes came into effect on commencement of the Amending Act, many of the changes rely on new rules that will be implemented in stages. This will happen while other key reforms, like the development and implementation of foundational supports, are established.

The measures in the Amending Act are expected to moderate growth of the NDIS by $14.4 billion over 4 years from 2024–25, compared to the previous budget.

On 28 October 2024, the Australian Government announced a second tranche of legislative amendments to the NDIS Act – Getting the NDIS Back on Track Bill No. 2 (Bill No.2).

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and the Independent Review of the NDIS highlighted the quality and safeguarding challenges that exist for people with disability. The intent of Bill No.2 is to strengthen regulatory powers and introduce stronger information gathering and banning powers for the NDIS Commission.

The department and the NDIS Commission have undertaken consultation with government departments and agencies, state and territory governments and the disability sector on the intent of the amendments. The timing of the bill is a decision of government.