



Carer Gateway Service Provider Operating Manual

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Version 1 Published 10 Dec, 2019

Updated: V1.1 April 2020

Updated: V1.2 March 2021

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1 Introduction

1.1 Purpose

The Carer Gateway Service Provider Operating Manual provides guidance to organisations engaged by the Department of Social Services to perform the role of Carer Gateway service provider (service provider) under the Australian Government's Integrated Carer Support Service. The service provider Operating Manual forms part of the Grant Agreement and should be read in conjunction with the Grant Agreement, Standard Grant Conditions and Supplementary Terms and Conditions.

Specifically, the service provider Operating Manual defines:

1. **HOW** service providers are required to operate;
2. **WHAT** activities service providers are required to deliver;
3. **WHO** activities are intended for;
4. **WHY** activities are being delivered; and
5. **HOW** success will be measured.

The service provider Operating Manual is not intended to provide organisations with a prescriptive model of operation. Instead it is designed to identify the core operational elements and the department's associated requirements, considered essential to achieving the Australian Government's objectives for Carer Gateway.

1.2 Feedback

This Manual is a living document and will be updated as required. Service providers will be notified when any updates occur.

Feedback on the document can be sent to §47E(d) @dss.gov.au

2 Background

21 Carer Gateway Overview

The Integrated Carer Support Service focuses on services designed specifically for carers. It is designed to make the Government's carer supports and services easier to navigate and more accessible. More importantly, it is designed to increase the Australian Government's investment in services proven to improve a carer's quality of life and ability to perform their caring role.

The Integrated Carer Support Service Blueprint (**Appendix A**) outlines the Carer Gateway business model and service pathways.

22 Carer Gateway Services

Carer Gateway introduces a range of tailored supports and services to help carers manage their daily challenges, reduce stress and plan for the future. This includes national and regionally based services.

At a national level, some services will be delivered centrally and the system as a whole will be supported by national infrastructure and managed by the Australian Government. National services include:

- the Carer Gateway website
- phone counselling
- online self-guided coaching
- an online peer support community forum, and
- online skills courses.

At a regional level, service providers will respond to the specific needs of their communities by providing:

- carer support planning
- in-person peer support
- in-person counselling (individual and group)
- in-person carer coaching
- carer directed support,
- emergency respite care
- information and advice, and
- assistance with navigating relevant, local services available to carers through federal, state and local government and non-government providers, including the National Disability Insurance Scheme (NDIS), My Aged Care and palliative care.

23 Achieving the Carer Gateway Vision

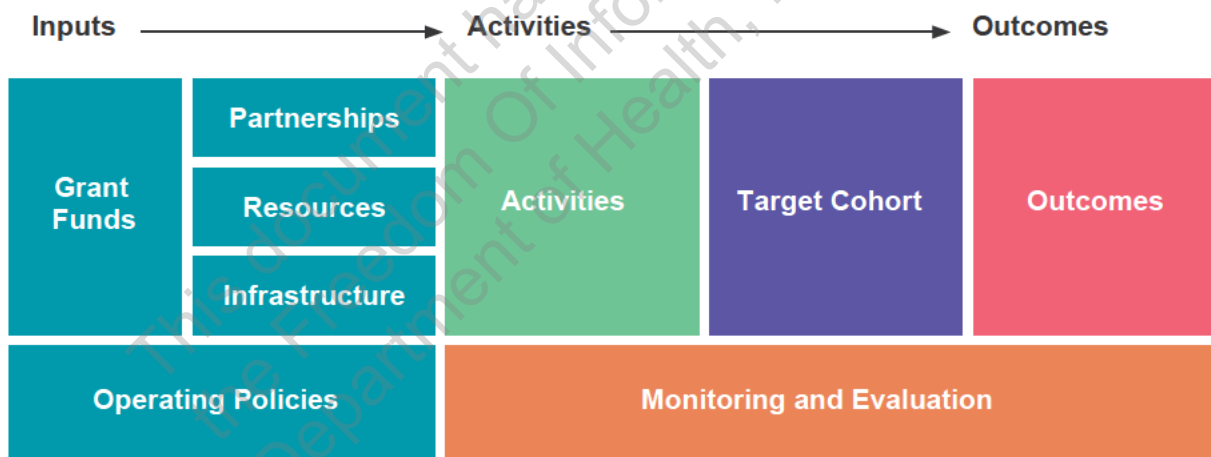
Achieving the Carer Gateway vision is dependent on the contribution of commissioned organisations to the following outcomes:

- Awareness – carers, their family and friends along with the general community are aware of carers and the support and services available to them
- Knowledge – carers are better informed about the caring role and the associated stresses,
- Skills – carers gain skills to manage stress associated with the caring role
- Policy – prioritise investment towards carers most in need, and low-cost, preventative services
- Support – carers are better supported with new services and able to access crisis services when needed, and
- Economic – improve the effectiveness of supports and services available to carers.

By undertaking the activities specified in this Operating Manual and the Commonwealth Grant Agreement, service providers are expected to make the greatest contribution to Carer Gateway outcomes.

24 Service Provider Operating Model

The service provider Operating Model provides a framework that takes an input (Commonwealth funding) and describes how it is converted, through activities, into client outcomes.



The components of the Carer Gateway Service Provider Operating Model are described in more detail below.

Purpose	Component	Building Block Description
Define HOW service providers are required to operate	Grant Funds	Describes how Grants must be managed, including spending and accounting for Grants.
	Partnerships	Describes the network of organisations essential to the successful operations of the service provider.
	Resources	Describes the human resources required to be in place to support the delivery of activities.
	Infrastructure	Describes the basic physical facilities and installations required to be in place to support the delivery of activities e.g. offices, IT systems, transportation, and service delivery channels.
	Operating Policies	Describes the business rules and procedures essential to the successful operations of the service provider.
Define WHAT activities service providers are required to deliver	Activities	Describes the activities service providers are required to deliver to support carers in their allocated Service Areas.
Define WHO activities are intended for	Target Cohort	Defines the cohort of carers that service provider should target.
Define WHY activities are being delivered	Outcomes	Defines the results the Australian Government is seeking to achieve through its investment in service providers.
Define HOW success will be measured	Monitoring and Evaluation	Describes the data collection and reporting mechanisms the department will use to determine the degree to which Carer Gateway outcomes have been achieved.

3 Grant Funds

3.1 Funding allocations

Funding for each of the 16 designated service areas, across 2019-24, is based on estimates of the number of carers in the region (based on the ABS 2015 Survey of Disability, Ageing and Carers) and includes weighting for delivery of services in remote areas (using Accessibility/Remoteness Index of Australia scale used by the Australian Bureau of Statistics).

Funding is split into administration and service delivery costs. Ancillary activities are to be accounted for under the administration costs associated with the grant.

Establishment costs for the service providers have been included in the first year of funding and will cover those activities required for an organisation to reach a state of operational readiness (i.e. set-up technological infrastructure).

3.2 Use of grant funds

Grants paid to service providers must only be used for delivering the activities described in the Operating Manual and the Grant Agreement.

As part of delivering the specified services, service providers can use the Grant to pay for:

- resources, operational policies, infrastructure to establish their business model
- operating the business model in a way that maximises contribution to the outcomes the Australian Government is seeking to achieve through its commissioning of Carer Gateway
- staff salaries and on-costs that can be directly attributed to the provision of activities in the allocated service area
- employee training for paid and unpaid staff including Committee and Board members, and
- operating and administration expenses directly related to the delivery of Carer Gateway activities. Examples include:

- computer/ IT/website/software
- insurance
- utilities
- postage
- stationery and printing
- accounting and auditing
- travel/accommodation costs for domestic travel for staff directly relating to the delivery of services
- assets as defined in the Terms and Conditions that can be reasonably attributed to meeting agreement deliverables, and
- up to ten per cent of the Grant can be used to invest in continuous improvement activities (such as trialing new services that will contribute to Carer Gateway outcomes).

Service providers **cannot** use the grant funding for the following activities:

- purchase of land
- major capital expenditure (e.g. the purchase of motor vehicles)
- costs incurred in the preparation of a grant application or related documentation
- subsidy of general ongoing administration costs such as electricity, phone and rent (that are not directly related to the administration of Carer Gateway services)
- major construction/capital works
- overseas travel, and
- the covering of retrospective costs.

If a service provider is unsure whether a proposed use of a Grant is appropriate, it should contact its Funding Arrangement Manager (FAM) for clarification.

3.3 Activity Work Plan and Budget

Prior to the commencement of each financial year, service providers must submit an Activity Work Plan and Budget to their FAM for approval. This document will be used by the department to obtain a clear understanding of the activities and funding allocations planned by the service provider for the coming financial year, including for specific resources such as the young carer support worker. An Activity Work Plan template is provided in **Appendix B**, and a Budget template is provided in **Appendix C**.

The completed Activity Work Plan and Budget should be submitted to the FAM by the dates specified in the Grant Agreement for each year of the grant.

The department may, at its discretion, approve or reject a revised Activity Work Plan or Budget. If an Activity Plan or Budget is rejected by the department, providers are required to incorporate advice from the department and resubmit the Activity Work Plan or Budget within four weeks of the initial submission date. The department's approval may be granted subject to conditions.

3.4 Financial Reporting

Service providers are required to supply annual independently audited financial reports, as specified in the Grant Agreement. This report is an income and expenditure statement for the grant, verifying that the department grant funding was spent to perform the activity(ies) as set out in the grant agreement. If relevant, the financial acquittal report must include details of any unspent funds.

Details on who can audit these reports are included in the Grant Conditions.

3.5 Unspent funds and carry-overs

There will not be automatic carry-over of Unspent Funds into the next year. If relevant, service providers must seek approval from their FAM to use all or a proportion of Unspent Funds as additional income for the proceeding year. When making their decision to approve carry-over of funds, the FAM will take into account the reason for the underspend and how the funds are proposed to be used in the following year. Approved Unspent Funds must be spent on services outlined in the Grant Agreement.

A request to carry-over Funds must be in writing detailing how the service provider intends to use Unspent Funding. Service providers should submit a request for carry-over by 31 March (i.e. no later than three months before the end of the financial year). This allows sufficient time for consideration by the department. It also allows the service provider to have sufficient time to expend prior to the end of the financial year. Only in exceptional circumstances will a carry-over request be considered after 31 March.

If Unspent Funds are not approved or only partially approved for carry-over, the remaining Unspent Funds will be recovered by reducing the next available grant payment through a funding variation. If no further grant payments are due, the department will raise an invoice to recover Unspent Funds.

3.6 Variations

Either party may suggest a variation to the services outlined in the Grant Agreement, based on an evidence-based approach to accommodate changing local or regional needs. The department is not liable for any additional work undertaken, or expenditure incurred, unless the variation or expense has been agreed to, in writing, by the department before the work is undertaken.

3.7 Indexation

The department will provide written notification to the service provider of increases to funding due to indexation. Payments for indexation will be paid according to departmental guidelines and policies.

3.8 Assets

Service providers must maintain a register of assets purchased with grant funds. Assets purchased by funds disposed of, sold or written off, must be included in the relevant financial statements forwarded to the department. Disposal of Assets acquired with grant funds, and use of any proceeds from such disposal, requires prior approval in writing from the department. Should the service outlet close down during the Activity Period, any Assets acquired with grant funding must be dealt with as notified by the department. Upon closure of the service, providers must consult the department regarding potential to transfer those Assets to a new outlet to ensure continuity of care and those Assets, which would otherwise revert to the Commonwealth.

Assets purchased with alternative funding sources outside the service provider funding may be used for the delivery of service provider services at the service providers. Where these Assets are individual items with a value of \$10,000 or more (including GST), they should also be recorded in the relevant section of the service provider's Assets Register.

Service providers should note that the department will not approve the use of funding for purchasing of Assets if a service provider has already received funding for the same purpose under any other Government program.

3.9 Transition Out Planning

A Transition Out Plan (TOP) must be maintained by the service provider and should only be submitted to the department upon request. The aim of the TOP is to ensure that the obligations of both parties to the Agreement, upon termination or expiry of the Agreement, are acknowledged and agreed, and that where applicable, there will be minimal disruption of service delivery to clients. The TOP should address issues that enable the orderly transition of the services from the service provider to the department or its nominated provider on termination or expiry of the grant agreement. TOP Guidelines are provided at **Appendix D**

3.10 Liaison with department staff

Community of Practice

As part of the Grant Agreement, a Community of Practice (COP) involving the Chief Executive Officer of each service provider should be maintained. The aim of the COP is to establish professional connections as a group, share knowledge and expertise, and assist each other with problem solving to issues as they arise.

All service providers are required to participate in each COP meeting

This forum will be self-managed by the service providers.

- It is expected these meetings will be held four times per year (each quarter) (noting additional meetings may be arranged if required).

Liaison with the department on the Grant Agreement

Grant Agreements will be monitored on an on-going basis by the FAM assigned by the department. The FAM will monitor completion of and performance against the milestones and performance indicators in the Grant Agreement.

Each service provider is expected to maintain regular contact through their FAM. Service providers are required to notify the FAM if there is a change in the name, title, location, address, phone number, email, or facsimile number, of the service provider's organisation, project, or finance contact.

All service providers are required to participate in the following:

- ongoing operational meetings (as required) chaired and coordinated by the department to review and discuss overall progress, performance, and any issues and risks for escalation.

- annual bi-lateral contract meetings with the department for the purposes of reviewing progress and trends against the service provider's performance data as recorded in the Data Exchange and annual needs assessments and regional planning activities, and
- other meetings of an operational or strategic nature as identified from time to time by the department or as requested by the service provider.

Service providers may participate in meetings with the department by teleconference, videoconference, or in person.

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4 Partnerships

Service providers may, with the department's approval, enter into two types of formal partnership arrangements:

- Memorandum of Understanding (supported by subcontract arrangements): for those service providers operated by a consortium¹,
- subcontract arrangements: where the service provider seeks to contract other organisations to deliver core services, for example in-person counselling services.

Any changes to partnership arrangements should be notified to the FAM. Details of the new partner organisation and their role in delivering Carer Gateway services must be provided.

At all times, service providers are responsible for the quality of the activities they are funded to provide. Their staff will be acting as public officials when undertaking their duties. Service providers are responsible for the quality of services provided under any partnership arrangements.

4.1 Memorandum of Understanding

The Memorandum of Understanding (MOU) defines how a service provider's consortium shall work together, and must include:

- the date of the MOU and the period for which it is to operate
- the purpose of the consortia, its scope and key objectives
- the management structure in place including frequency of meetings and process for communication of decisions
- an outline of the relevant experience and/or expertise of the consortium members
- the roles/responsibilities of consortium members and the resources they will contribute (if any)
- a plan on how fraud will be managed, including detection, prevention and reporting
- an outline of the dispute resolution mechanisms which will be put in place
- a disclaimer statement indicating that all activities that take place under the MOU must be in compliance with the Grant Guidelines
- confirmation that subcontract arrangements are in place between the lead organisation and each of the consortia partners where the consortia partners are delivering services, and
- details of a nominated management level contact officer (for each of the consortium members).

A copy of the signed MOU and any updates made during the grant period, must be sent to the FAM.

¹ A consortium is defined as two or more organisations who work together formally (through subcontracting arrangements) to combine their capabilities to perform the role of service provider. Only the lead organisation will enter into a Department of Social Services Grant Agreement with the Commonwealth and will be responsible for the ensuring Grant, including all elements of performance, reporting and financial management is adhered to.

4.2 Subcontractor arrangements

In accordance with the terms of the Commonwealth Standard Grant Agreement, service providers must not subcontract any part of the performance of the Activity without the department's prior written consent. The department may impose any conditions it considers reasonable and appropriate when giving its consent. Changes to subcontracting arrangements should be emailed to the FAM.

Service providers are responsible for the performance outcomes of any tasks undertaken by subcontractors and it is the service provider's responsibility to ensure that its subcontractors operate in accordance with the Grant Agreement including meeting reporting obligations (DEX and Partnership Approach). The service provider is responsible for ensuring the subcontractor is trained and supported to enable them to meet their reporting obligations in full and within required timeframes.

Service providers must have processes in place to closely monitor that the subcontractor is delivering activities in accordance with the Grant Agreement, these must be provided to the department upon request (within 20 business days). This could be through regular communication or reporting processes which monitor key requirements such as police checks for staff providing care, or that staff have relevant qualifications. Feedback from clients receiving services should also form part of the service provider's monitoring processes of sub-contractor arrangements. Service providers should also monitor other aspects of their agreements. e.g. that the subcontractor does not subcontract service to another organisation / provider.

If at any time a service provider or the department is not satisfied that the subcontractor is operating within the terms of the Grant Agreement, it is the service provider's responsibility to hold the subcontractor to the terms of the Grant Agreement, including consideration of whether it would be appropriate to discontinue use of that subcontractor.

4.3 Brokerage arrangements

There may be instances where subcontracting arrangements may not be appropriate to secure services, with service providers required to broker services through a commercial arrangement that does not involve a contract. For example, one off services such as purchasing a laptop or educational courses or for emergency respite situations.

Service providers are responsible for the performance outcomes of any services/tasks undertaken by brokered service providers.

Service providers must have processes in place to closely monitor that the brokered service is delivering activities in accordance with the Grant Agreement. This could be through regular communication or requesting key requirements such as police checks for staff providing care, or that staff have relevant qualifications. Feedback from clients receiving brokered services should also form part of the service provider's monitoring processes of the brokered arrangements. Service providers should also monitor other aspects of the agreements. e.g. that the brokered service does not broker the service to another organisation / provider.

At all times, service providers are responsible for the quality of the activities they are funded to provide including the quality of the service provided under any brokerage arrangements.

4.4 Subcontracting/brokering services from the service provider's organisation

In general, where service providers need to secure services (through subcontracting or brokerage arrangements) they should do so from organisations other than those managed by their own funding body. However, in limited circumstances, service providers may seek permission from the department to subcontract/broker services from organisations managed by their own funded organisation. Service providers need to provide a written explanation of the circumstances underpinning the request and details of:

- why this is the most appropriate service for the Client
- why the subcontracting/brokerage of services is needed if the organisation is already receiving Government funding, and
- if there would there be any community perception of bias and how this will be addressed by the service provider.

Such requests should be forwarded to the relevant FAM and may trigger specific additional reporting.

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5 Resources

5.1 Staffing

The service providers must engage the resources necessary to deliver the required services and activities in accordance with the Grant Agreement, including:

- front-line staff – i.e. those staff engaged directly with clients in the delivery of Activities e.g. managing incoming calls from the national 1800 Carer Gateway number or delivering the carer coaching program,
- young carer support workers - a dedicated young carer support worker to develop, tailor and implement specific supports and assistance for young carers,
- supervisors – responsible for managing the quality of activities performed by front-line staff, and
- in-house counsellors – to provide specialised support to clients.

The service provider is responsible for all staff recruitment and for ensuring that staff understand, and agree to abide by, all policies and guidelines relating to the provision of activities under the Grant Agreement. Service providers must retain details of all staff employed and provide these to the department on request.

Service providers must keep records of staff members in compliance with policies and procedures relating to the provisions of activities under this Grant Agreement and provide to the department upon request.

5.2 Registration, accreditation and professional development

Service providers are responsible for ensuring staff and volunteers have appropriate skills, knowledge and supervision, and receive adequate training with an emphasis on quality service provision. Service providers are responsible for ensuring staff members act in accordance with the organisations code of conduct and applicable laws and will respect the privacy and dignity of clients.

Service providers must be aware of any registration, accreditation or licensing requirements for the professions from which they draw their workforce and must ensure their personnel (and any subcontractors) comply with these requirements.

Service providers must also be aware of relevant accreditation frameworks and requirements associated with particular service types.

All service providers should provide a learning environment to their staff and support them to undertake vocational and other formal education and training to enhance the skill base of the service provision workforce.

Service providers must keep records of all professional accreditations for staff and provide to the department upon request.

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5.3 Volunteers

Service providers may use volunteers in the delivery of the service provider activities. If volunteers are used, service providers must ensure that volunteers have the necessary knowledge and skills to undertake their duties. Service providers who use volunteers must have policies and procedures in place regarding management of their volunteer workforce, including in relation to Working with Vulnerable People and police checks. Volunteer management policies and procedures must include any policy relating to volunteer reimbursement. Policies should reflect the circumstances of the service provider, such as remoteness, isolation, and other regional differences that can affect their capacity to attract and retain volunteers.

5.4 Vulnerable people, police checks and criminal offences

The service provider is responsible for ensuring that all staff, volunteers and executive decision makers are suitable for the roles they are performing, and should undertake thorough background checks to select staff in accordance with their levels of access to vulnerable people. Service providers must ensure they are compliant with state-based legislation in regards to vulnerable people, young people and any other relevant cohorts.

5.5 Guidance documents

Service providers are provided with guidance documents for relevant programs, such as In-Person Peer Support trainer manuals, guidelines and session plans; In-person Carer Counselling guidelines; and In-person Carer Coaching guidelines (from 2021-22) and workbooks.

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6 Infrastructure

6.1 Departmental provided infrastructure

To support the delivery of activities by the service providers, the Australian Government will manage the following infrastructure which is available to all service providers.

6.1.1 Carer Gateway website

The Carer Gateway website (www.carergateway.gov.au) provides a primary source of clear, consistent and reliable information that helps carers navigate the system of support and services available. An online form (hosted on the Carer Gateway website) enables a carer to request a call back from their local service provider.

6.1.2 Carer Gateway 1800 number

A national Carer Gateway toll free number (1800 422 737) that will be used to route incoming Carer Gateway calls to the appropriate service provider.

All other call types, including transferring calls to other service providers, calls to other service providers on behalf of carers who require information about other regions, outbound calls or retrieval of messages, must be made from the service provider's telephone system (See service provider Specialised Infrastructure).

The department will fund the Carer Gateway national 1800 number setup to a suitable existing phone line, service charges (of the Carer Gateway national 1800 number component) and any subsequent relocation (of the Carer Gateway national 1800 number component) at the end of the grant agreement. Calls from the previous Commonwealth Respite and Carelink Centre (CRCC) and Carers Australia 1800 numbers will be automatically re-routed to the Carer Gateway service.

6.1.3 Online Learning Management System

The department will provide all service providers with access to an online learning management system (LMS). This will include online training support modules for all service provider staff

Each service provider will be required to identify an LMS Administrator who will be required to set up end users and assign appropriate courses. The LMS Administrator will only be required to possess basic computer skills such as ability to use Microsoft Excel, and to navigate, and upload documents to a simple web based application.

The LMS Administrator will need to undertake a brief training session to understand how to use the system, as well as the processes, contacts and responsibilities related to the role.

A training manual will be provided to support this role and a helpdesk will be available.

6.1.4 Translating and Interpreting Services (TIS)

The department funds access to Translating and Interpreting Services (TIS)² and relay access for callers to 131 450. Further information is provided at parts 7.18 and 7.19.

² <https://www.tisnational.gov.au>

6.1.5 Data Exchange

The Data Exchange (DEX)³ is the Australian Government platform for reporting of service data contractually required of funded organisations to record performance across the life of the agreement. Further information is provided at part 13.5.

6.2 Service provider infrastructure

To support the delivery of activities, service providers must provide the following infrastructure:

- office space (including high-speed internet access) for those service provider staff that need to be co-located e.g. staff managing incoming calls from the national 1800 number
- telephones
- desktop computers
- laptops (equipped with access to the service provider's IT systems) and mobile phones for service provider staff working under flexible work arrangements e.g. working remotely
- software to support basic office functions (e.g. word processing, email, internet browsing)
- software to support the management of the service provider's finances, human resources and Activity delivery (e.g. scheduling of staff performing client in-home visits)
- software and hardware to provide information security and privacy
- service delivery outlet accommodation (which may take any appropriate form for the client(s) and the Services being performed), and
- transportation arrangements (either through service provider managed vehicles or on a travel reimbursement basis) for those service provider staff required to travel in the delivery of work based activities.

6.3 Service provider specialised infrastructure

In addition to the general infrastructure, service providers must also provide the following specialised infrastructure:

6.3.1 Client Relationship Management System (CRMS)

The service providers must supply their own Client Relationship Management (CRM) system to support the capture, retention and reporting of their interactions with carers.

The CRM system must be:

- secure, appropriate to the data and Personal Information collected, used, transferred and stored by the service provider
- able to be used in accordance with the service provider's approved policies
- able to prepare and/or submit accurate data to the Data Exchange as per the requirements in the grant agreement

³ <https://dex.dss.gov.au/data-exchange-protocols>

- designed and implemented appropriately for the service provider's consortium partners and subcontractors, if any are required to use it, and
- accessible to the required service provider staff, regardless of their location.

6.3.2 Telephony system

The service providers must supply their own telephony system to manage incoming Carer Gateway national 1800 number calls. The telephony system must:

- have a caller menu system (either an Automated Attendant system or Interactive Voice Response system) that enables identification, segmentation and routing of callers to the most appropriate staff member within the service provider
- have customisable greetings, messages and prompts
- be able to forward calls based on configurable business rules (e.g. calls received after 6pm are forwarded to the service provider's after-hours number)
- offer callers who would like to avoid the waiting queue the option to have an agent call them back instead, and
- offer callers the option to leave a voicemail message when all staff are busy and the queues are full.

Service providers are responsible for providing a suitable phone system to manage incoming calls routed from the Carer Gateway national 1800 numbers.

6.4 Service provider infrastructure not required

Service providers are not required to provide the following infrastructure:

- shopfronts i.e. a physical location that clients and potential clients can access [see note⁴], and
- individual websites – the Carer Gateway website⁵ is the single online entry point for carers seeking information and access to the service provider's services.

4 Services with an in-person component e.g. In-Person Peer Support and the Carer Coaching Service (in the facilitated format) could be delivered in the carer's home or in an easily accessible public location such as school, community meeting centre etc, therefore a shopfront is not required.

5 <https://www.carergateway.gov.au>

7 Operating requirements and policies

7.1 Service areas

Each service provider must operate in its designated Service Area and is required to support the entire Service Area it has been allocated. The national distribution of Service Areas is provided at Appendix E. For ease of administration it is expected that the service provider's workforce will be supported by a central hub.

7.2 Policies and procedures

Each service provider must develop policies and procedures to support high quality service provision in their service area to cover all activities delivered by their organisation, consortia and/or sub-contractors. These documents must be supplied to the department if requested (within 20 business days).

At a minimum, service providers must have documented governance and operational policies and procedures that address the following:

- operating in accordance with key legislative and regulatory requirements including the *Carer Recognition Act 2010*, the NDIS Quality and Safeguarding Framework⁶, the New Charter of Aged Care Rights⁷ and the Aged Care Quality Standards⁸
- operating in accordance with applicable standards and charters
- a clinical governance framework that identifies and documents the credentialing of specialist workforce of the service provider and its subcontractors
- the management of client records, and handling personal information
- the management of obtaining consent to handle, use, store and transmit personal information about carers and care recipients
- transferring personal data outside of the service provider's organisation (including among subcontractors and consortium partners)
- performance reviews of subcontractors arrangements to ensure quality subcontracted services
- managing all phone calls, including after hours and transferring to emergency services (additional guidance at 7.16)
- managing concerns about client welfare or suspected abuse/neglect (additional guidance at 7.11)

⁶ <https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/ndis-quality-and-safeguarding-framework>

⁷ <https://agedcare.health.gov.au/quality/single-charter-of-aged-care-rights>

⁸ <https://www.agedcarequality.gov.au/providers/standards>

- managing complaints and feedback about the service provider's activities, including those delivered by subcontractors and brokered services (additional guidance at 7.9)
- managing serious incidents including escalation to the department (note this policy must be agreed to by the department)
- managing fees and client contributions (additional guidance at 7.15)
- managing work health and safety for staff, clients and visitors (including for flexible work arrangements, client in-home visits and emergency respite)
- managing reporting and data
- detecting, managing, reporting and preventing fraud
- managing cross-border/cross Service Area issues, developed in consultation with neighbouring service providers, and
- providing inclusive services for vulnerable groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, young people, older Australians and LGBTQI communities.

Service providers should also ensure that when brokering services, they use services accredited within the relevant and appropriate framework. For example, the NDIS Quality and Safeguarding Framework (for emergency respite for people with a disability) and Aged Care accredited providers (for people over 65 years of age).

7.3 Confidentiality and Privacy

Each service provider must comply with relevant legislation such as the *Privacy Act 1988 (Cth)* (Privacy Act). Service providers are also required to adhere to state-based privacy legislation in their areas of operation.

The service provider must ensure the protection of all personal information from loss, damage or misuse and the protection of privacy in accordance with *Australian Privacy Principles*.

When dealing with personal information in delivering their services and activities, the service provider agrees to ensure that all service provider's staff or contractors who deal with personal information practice the requirements of the Privacy Act. For example, staff or contractors who have access to personal information about clients may be required to sign a Deed, or other legal instrument, which requires them to collect, store and disclose personal information in accordance with the Privacy Act.

For more information regarding the Privacy Act please consult the Office of the Australian Information Commissioner⁹.

If a service provider, consortium partner or a subcontractor requires personal information (including sensitive information) **about care recipients** from carers, they should:

- determine whether the carer has authority to consent to the collection (and any subsequent use or disclosure) of the care recipient's personal information, and

⁹ <https://www.oaic.gov.au>

- if the carer does not have the authority to give consent, either:
 - obtain the care recipient’s consent (directly, or via the carer), or
 - if that is not practicable, only record sensitive information about the care recipient in a de-identified form (if at all). In carrying out the service provider’s services, the service provider agrees not to send any personal information outside of Australia without the carer’s and (if relevant) the care recipient’s express consent (this includes online services and CRM systems which may offer overseas hosting arrangements).

Service providers are required to immediately notify the department of:

- any privacy complaints related to the service provider’s services, and
- actual or possible breaches of privacy.

The department retains the right to conduct audits related to privacy and privacy complaints.

7.4 Secure referral

Service providers are required to use secure means of referral between themselves and other service providers for carers’ and care recipients’ personal information. Service providers should not use unsecure email to transfer any personal information. For all referrals performed by service providers, the recommended secure referral application is SendSafely¹⁰.

Service providers should specify to SendSafely that: they require “*SendSafely to store their account’s data in an Australian-region hosted S3 bucket*” when they commence their organisation’s subscription to this service.

SendSafely may offer service providers a discount on their fee – so service providers should alert SendSafely that they are a department provider.

Service providers should not use SendSafely to send any data to the department.

7.5 Secure communication to the department

Service providers are required to use **Kiteworks** to send any sensitive or personal information to the department (or any other Australian Government agency). Service providers are required to make contact with the department via the ^{s47E(d)} [redacted]@dss.gov.au email address first, to explain the reasons why they need to send any sensitive or personal information to the department. **Only if agreed** will the department then create a secure Kiteworks link for the service provider to use to perform the transfer.

Service providers should not use unsecure email to transfer sensitive or personal information.

7.6 Disclosure

Service providers should inform clients that their de-identified information will be used to evaluate and improve carer services and that the department (and its contractors) has access to the information. Information will be used by the department only for statistical, planning and evaluation purposes.

¹⁰ <https://www.sendsafely.com>

The data will not be matched, in whole or in part, with any other information for the purposes of identifying individuals. Any statistical information about clients will not publicly identify individuals. Information may be used as part of a compliant, compliance or fraud investigation.

Client information should remain confidential and not be provided to other parties unless it lawful to provide the information these parties. Personal information collected by the service provider should not be used for marketing purposes in any circumstances.

7.7 Record keeping

In accordance with the Grant Agreement, service providers must develop and implement policies, procedures and systems for the management of client records.

Service providers are required to comply with the *Archives Act 1983*, the *Freedom of Information Act 1982*, and other relevant legislation which authorises, or limits, access to records held by the organisation.

7.8 Freedom of Information

Any request received by a service provider under the FOI Act relating to services funded by the department must be handled by the department. If a service provider (or service provider from which it obtains services) receives a FOI access request, it must advise the requestor that requests must be made directly to the department as the FOI Act does not apply to bodies such as a service provider.

If the department receives a request under the FOI Act for information which may be held by a service provider or subcontracted provider, the department will provide written notice to the service provider to provide the document. The department will not make a decision to release any document without first consulting the service provider for its views on possible release.

7.9 Complaints

Service providers must establish and publicise the existence of a complaints process, which must be used to deal with any complaints. The following practices should be implemented:

- create and maintain a Complaints Register which includes the following materials and information:
 - details of all complaints received directly by the service provider
 - details of all complaints referred to the service provider by, or through, the department
 - each record in the Complaints Register should include:
 - details of the parties to the complaint, including the name of the complainant (if provided) and if relevant, the name of the person being complained about
 - any subcontractor or consortium parties involved in the complaint
 - the name of the staff member(s) handling the complaint
 - the date(s) upon which the complaint was made
 - the nature of the complaint

- whether the complaint was referred between the service provider and any government agency (including the department)
- details of contact with the complainant
- the action taken, including dates and details
- the outcome of any action taken (including any investigation)
- the date of finalisation or resolution of the complaint
- any follow-up action required, and
- any changes to policies, or procedures, or other action to be taken, resulting from the complaint.

Each service provider must ensure that its partners and subcontractors/brokered services have these policies in place and understand how to practice these procedures.

The service provider must supply information on the nature of complaints, action taken and dates if requested by the department. The department retains the right to conduct audits related to privacy and privacy complaints.

7.10 Child safety

Service providers are required to comply with all child safety obligations included in the Grant Agreement. Irrespective of the child safety obligations in the Grant Agreement all service providers must always comply with the respective Commonwealth and state and territory legislative requirements for working with children and mandatory reporting.

Subject to the level of involvement of the service with children, or for any activities delivered by the service provider, consortia partner or their subcontractors/brokered services involving contact with children that is a usual part of, and more than incidental to, the funded activity, it is a requirement that the National Principles for Child Safe Organisations are implemented in full. Where relevant, this commitment and associated activities must be articulated in the Activity Work Plan and an annual Statement of Compliance submitted to the department as part of meeting compliance obligations.

7.11 Suspected abuse, harm and neglect

Service providers must have a policy about how to respond if they suspect abuse is occurring or are concerned about a risk of harm to, or neglect of any person.

Key considerations that must be addressed in a service provider's policy include:

- appropriate identification, reporting and risk assessment of the suspected risk of abuse or harm (this may include discussion with the carer and/or the person they care for to understand the situation so that appropriate intervention or assistance can be arranged)
- prompt provision of emergency respite care and linkage with other support services such as counselling, health services and social support, and
- if appropriate, contact with emergency services such as police, ambulance, crisis mental health team, or other relevant services.

7.12 Risk of self-harm by a carer (or the person they care for)

Service provider staff should report situations where they believe a client (or their care recipient) is at risk of self-harm or in instances of emergency call 000.

In situations where the service provider receives a call from an unidentified caller who threatens self-harm (or harm to another person), the service provider should call the police who will have procedures in place that authorise Telstra or the relevant phone provider to trace the call.

Service providers should contact their state/territory police service to formalise procedures for such situations.

7.13 Notifying the department about serious incidents

Service providers are required to report serious incidents (including allegations) arising in the context of service provider services and supports including (for example):

- the death of a person receiving services
- serious injury of a person receiving services, and
- abuse or neglect of a person receiving services.

Service providers must report events within 24 hours of being made aware of the event, with a more detailed report about the incident and actions taken in response to be provided within five (5) business days to the contact person specified in the grant agreement.

7.14 Emergency call telephone instructions for police, fire or ambulance

Service providers must develop a procedure for handling emergency calls which come to the service provider via the national 1800 number.

Service providers may need to consult their telephony system provider about what instructions should be used to transfer calls to 000, and about Caller Line Identification (CLI). Service providers should develop a procedure for emergency calls to include:

- calling 000 and introduce yourself as a service provider and inform the operator that you have a caller on the line from another location who requires assistance
- informing the operator of the state/territory, the town, and the emergency service required (i.e. Police, Fire or Ambulance), and
- if requested by 000 or emergency service personnel, providing the CLI.

7.15 Client financial contributions for emergency respite care and carer directed support services

Inability to contribute cannot be used as a basis for refusing a service to carers who are assessed as requiring a service.

Service providers must have a policy about fees and assessment of a carer's capacity to contribute

to the cost of Emergency Respite Care and Carer Directed Support services only. This policy must be provided to the department on request.

In addition to information required for data elements of the Data Exchange, service providers can request other information from carers to assess their capacity to contribute.

The assessment of capacity to contribute should be undertaken in respect of the person who benefits from the service provided. The person to be assessed could be either the carer or the person who is cared for, but not both.

Carer Gateway Client Financial Co-contribution should not be greater than 15 per cent (15%) of the service cost. When developing their policy on client financial contribution, service providers should consider the following:

- the carer's financial situation
- thresholds/levels of contributions, including assessment criteria
- public availability of the policy and proactive provision of the policy to carers,
- agreement on the amount the carer will contribute to the cost of services before the service is provided
- potential reviews – for example if a carer's financial situation changes during the period of receiving services
- if a carer cancels a service after their contribution is received by the service provider
- refund terms and conditions for when a carer changes their decision to contribute after receiving a service, and
- the procedure to resolve contribution disputes.

7.16 Opening hours and after hours service

Service providers must be available to the public during normal business hours (Monday – Friday, 8am– 5pm), with an after-hours service for callers who require respite care in emergency or unplanned situations. Service providers have the flexibility to operate outside of the normal business hours.

Callers after business hours must always be able to reach someone who can assist them. While the department acknowledges that service providers may manage this differently from Service Area to Service Area, it expects service providers to regularly review the effectiveness of after-hours service arrangements.

The options for after-hours service which service providers may use include:

- diverting the national 1800 number after hours to a mobile phone held by an on-call service provider staff member, or
- using an external agency to take after hours calls.

The following greeting is an example to direct people to after-hours care through an answering machine:

After Hours message (on answering machine)

“You have called Carer Gateway about carer support services. If you require emergency respite support, press 1. If you are calling for assistance with other carer support services, please leave your name and contact telephone number and your call will be returned within x period of time.”

The use of a subcontractor to manage after hours service calls is possible but it is expected that service provider will communicate the need for consistent greetings to these organisations and agree on a greeting in line with the branding advice.

7.17 Managing phone calls from the 1800 national Carer Gateway number

Calls to the national 1800 number will be routed by the department's telephony provider:

- fixed calls (i.e. calls from landlines) will be routed depending on call location. Call location will be determined using Census Collection Districts (CD)¹¹. CDs are designed not to cross Statistical Area Level boundaries, maximising the accuracy of fixed call routing (particularly for those calls originating from locations near the boundaries of Service Areas).
- mobile calls will be routed depending on call location with two caveats –
 - call location will be determined by the Telstra's 208 catchment areas for mobile users (not a caller's location) – in comparison there are 38,200 CDs throughout Australia, and
 - mobile calls originating from city catchment areas will be routed to the service provider supporting that area.

See section 7.20 for anomalies identified in the direction of 1800 number calls.

If a caller is directed to a service provider that does not provide services in the caller's Service Area, the service provider must assist the caller by transferring the call to the correct service provider. The same approach should be taken if a service provider is contacted by a caller who requires information on behalf of a person living in another Service Area. If the person is close to the boundary between Service Areas, the service provider should determine which service provider is the most appropriate to support that person based on their knowledge of the service network.

If it is more appropriate that the caller is referred to the service provider in an adjoining Service Area, the service provider should offer to transfer the call without the carer having to hang up. To avoid confusion for callers – and for service providers, Service Area boundary procedures must be established between service providers. These must be provided to the department on request.

When answering calls received through the 1800 number, service providers must identify themselves as a Carer Gateway service provider.

7.18 Translation and Information Service (TIS)

The department will cover the costs of translation and interpreter services for carers contacting service providers. Information and numbers to call for TIS services is available at <https://www.tisnational.gov.au/en/Help-using-TIS-National-services/Contact-TIS-National>

In the case where a service provider books a TIS session and is notified in advance that the carer will not be available, the service provider must contact TIS to cancel the booking.

¹¹ The Census Collection District (CD) is the second smallest geographic area defined in the Australian Standard Geographical Classification (ASGC), the smallest being the Mesh Block. CDs are defined for each Census and are current only at Census time.

7.19 Assistance for hearing impaired and or speech impaired callers

Service providers can arrange for a 24 hour telephone access service (relay call) for people who are hearing impaired and/or speech impaired.

A relay call allows an individual to communicate with a hearing person who is using a phone even if you can't hear or don't use your voice.

The National Relay Service (NRS)¹² has specially trained staff called relay officers who are the central link in each relay call.

The relay officer converts voice to text or text to voice. Sometimes they convert from sign language to English.

Relay officers stay on the line throughout each call to help it go smoothly, but don't change or interfere with what is being said.

Depending on an individual's hearing and speech, they can choose from one or more relay call channels such as internet, SMS, teletypewriter (TTY) and phone relay,

For further help, contact the National Relay Service Helpdesk:

Phone: 1800 555 660

Fax: 1800 555 690

SMS 0416 001 350

Email: helpdesk@relayservice.com.au

7.20 Telephony helpdesks

Service providers should contact their telephony service provider for problems with phone lines (e.g. outages), additional lines, relocation or other issues not related to the national 1800 number. If a service provider experiences problems with the phone line, they should contact their telephony service provider first, and then notify the department as soon as possible.

For problems with 1800 call routing (e.g. a 1800 call should have been sent directly to another service provider), the service provider should contact the department in the first instance on ^{s47E(d)} or at ^{s47E(d)} @dss.gov.au, providing details of the town/suburb that the call originated from (if known), the caller's full telephone number, and the date and time of the call. The department will then work with Telstra to investigate the 1800 call direction and advise the service provider about the cause of the problem.

If a service provider plans to relocate their office, or make other major changes to the telephony system, they should contact the department via the FAM. A minimum of two weeks' notice should be provided where possible.

7.21 Insurance

Service providers are required under the Grant Agreement to undertake a risk assessment of their operations to identify the risks associated with undertaking the required activities and services. This risk assessment must be undertaken at/or prior to establishment of activity and then reviewed periodically during the course of the Grant Agreement.

¹² <https://internet-relay.nrscall.gov.au>

The onus is on the service provider to purchase and maintain appropriate insurance to mitigate risks they have identified from the risk assessment.

The department may require the service provider to provide a copy of the risk assessment and insurance policies.

7.22 Branding and Marketing

Service providers must, in all publications, and in all promotional, publicity and advertising materials or activities of any type undertaken by, or on behalf of, the service provider relating to the activities in the Grant Agreement:

- comply with any promotion and style branding guidelines issued by the department from time to time.
- undertake branding in the manner outlined in the provided style guide branding guidelines. For service providers, this includes:
 - (i) use badging and signage for Carer Gateway and permitted co-brand in line with the branding guidelines;
 - (ii) acknowledge Carer Gateway is a national service funding by the Australian Government as per style guide;
 - (iii) deliver to the department (at the department's request and at the service provider's own cost) copies of all promotional, publicity, and advertising materials the service provider has developed for the purpose of the grant agreement, in accordance with the department's policies and procedures;
 - (iv) the service provider must actively market and promote the Carer Gateway service as required by the department;
 - (v) the service provider must provide at their own cost Carer Gateway name badges to front line staff. Design to be supplied by the department with service providers to order directly from your preferred supplier in line with the branding guidelines.
 - (vi) the service provider may provide at their own cost a uniform to front line staff comprising of a t-shirt. The design will be supplied by the department;
 - (vii) all service providers must have a physical corporate asset (shop front and / or branded vehicles). The department will provide the design specifications in line with the branding guidelines;
 - (viii) the service provider must use Carer Gateway branding on business cards and signature blocks branded Carers Gateway designs as specified in the branding guidelines;
 - (ix) the service provider must comply with the style branding guidelines when using Carer Gateway trade marks in its badging and signage;
 - (x) the service provider will provide yearly communication survey results. The Department will provide a participant survey which must be used by the service provider with a minimum response of 50. The Department will provide the survey in advance of this timeframe.

Subcontractor/brokered services may operate either under an independent brand or under the Carer Gateway brand.

The department may require any service provider, consortia partner or subcontractor/brokered service to rectify incorrect usage of Carer Gateway branding elements (at their own cost).

7.23 Ordering printed publications and resources

Service providers should order printed publications and resources to promote Carer Gateway services for carers via:

- the online publication portal (on the Carer Gateway Website)¹³
- by calling s47E(d) (Department of Social Services Publications).

Service providers can encourage other organisations (e.g. doctors' surgeries, healthcare providers, aged care providers, NDIS providers, community organisations, schools, workplaces etc) to use the publications and resources to promote services for carers. Service providers are encouraged to submit publications feedback and suggestions to s47E(d)@dss.gov.au

7.24 Licences to use Carers Star™

The Carers Star™ is central to the **Carer Support Planning Process** that service providers will use to plan services and supports with the carer. Use of the Carers Star™ is mandatory for service providers and all service providers must be correctly licensed.

The department pays for service providers (and if required, their consortium partners) to hold licences to use the Outcomes Stars™. An Outcomes Star™ licence includes a Carers Star™ licence. Licences are held by the organisation. The Outcomes Stars™ are licenced by Triangle Consulting Social Enterprise Ltd (Triangle) a UK company.

Under each licence there are compliance requirements that are the responsibility of the service provider, irrespective of the fact that the department has paid the licence fees in advance.

The department has contracted Unique Outcomes Pty Ltd (Unique Outcomes) as its Carers Star™ training provider to deliver training to three identified staff from each Gateway service provider.

The service provider must:

- obtain an organisational licence [licenced under the department agreement (reference:90011444)]
- agree to the standard *Triangle Licence, Training and Services Agreement*
- comply with the terms of the *Triangle Licence, Training and Services Agreement*
- provide suitable candidates to the department and Unique Outcomes Pty Ltd to be trained as **Licensed Trainers**
- afford the **Licensed Trainers** the flexibility and support required to train the carer support workers (the front-line workforce) in the Carer Support Planning Process including the use of the Carers Star™

¹³ <https://publications.carergateway.gov.au>

- afford the **Licensed Trainers** the flexibility and support required to maintain their currency (in being accredited Licensed Trainers)
- notify the department and Unique Outcomes Pty Ltd of its carer support workers (the front-line workforce), who intend to use the Outcomes Stars™ under the service provider's licence
- update the department and Unique Outcomes Pty Ltd promptly of any change in its front-line workforce
- confirm that all its front-line workforce have been correctly trained before using the Carer Support Planning Process including the use of the Carers Star™
- only nominate their front-line workers who have a genuine client service role within the Carer Support Planning Process to be official users under any licence paid for by the department.

Service providers are to note that Triangle offers software which is hosted overseas. Service providers are advised that the department does not endorse the transfer of any personal information to Triangle.

7.25 Young Carer Bursary

The Young Carer Bursary Program assists eligible young carers aged 12 to 25 years to continue or return to study. The Program aims to relieve the financial pressure on young carers to reduce the need to undertake part-time work in addition to their educational and caring responsibilities. The bursary is paid to the young carer throughout the calendar year. The Program is delivered by Carers Australia on behalf of the department.

The number of bursaries to be granted each calendar year is 1,000 and it is expected that Carers Australia actively work with the young carers to refer both the successful and unsuccessful recipients through to their local service provider. It is strongly advisable for service providers to form a good working relationship with Carers Australia as this will be a strong referral point for young carers and will provide opportunities to connect with and provide any additional service needs to this important carer group.

8 Target Cohort

8.1 Carers Definition

The target cohort for service provider services is carers, as defined in the *Carer Recognition Act 2010*, which states under Section 5, as follows:

- (1) For the purpose of this Act, a carer is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:
 - (a) has a disability; or
 - (b) has a medical condition (including a terminal or chronic illness); or
 - (c) has a mental illness; or
 - (d) is frail and aged.
- (2) An individual is not a carer in respect of care, support and assistance he or she provides:
 - (a) under a contract of service or a contract for the provision of services; or
 - (b) in the course of doing voluntary work for a charitable, welfare or community organisation; or
 - (c) as part of the requirements of a course of education or training.
- (3) To avoid doubt, an individual is not a carer merely because he or she:
 - (a) is the spouse, de facto partner, parent, child or other relative of an individual, or is the guardian of an individual; or
 - (b) lives with an individual who requires care.

Within the cohort of carers, service providers should prioritise their activities (using the defined Carer Support Planning Process described in Section 9) towards those carers most at risk of not being able to continue in their caring role.

Carer Gateway services are available to **all** types of carers as per the definition including:

- The primary carer. The service provider should focus on supporting primary carers.
- Couples. Service providers can assist couples who both need support, where the roles of carer and person receiving care may shift over time. A couple may provide mutual support, and one may take a more active carer role at different times depending on the other person's needs.
- Multiple carers. Service providers can assist multiple carers. Sometimes in a family situation where two or more family members share the caring responsibilities, it might be difficult to consider carer arrangements separately. Service providers may need to tailor support services accordingly, taking care to preserve the integrity of the family unit and the existing caring relationships.
- Young Carers. Young carers are people aged up to 25 who meet the definition of a carer above. Service providers should recognise the unique challenges faced by young carers. They should develop and provide tailored supports, including financial support packages, which seek to reach this often hidden carer group, and facilitate continued engagement in education or employment.
- Carers of people in residential or accommodation facilities eg. aged care, palliative

8.2 Eligibility Considerations

The service provider should consider eligibility to receive Carer Gateway services based on the carer conforming to the definition of carer in the *Carer Recognition Act 2010* (see above section).

In addition to considering the carer's role there are some specific eligibility rules that the service provider should also apply:

- Ongoing care. To be eligible for services, the carer's role must be ongoing, or likely to be ongoing, for at least **six months**. This expectation of six months or more does not apply to a carer of a person who needs palliative care.
- Overseas visitors, permanent residents and others who are not Australian citizens. There is no citizenship, residency or specific visa requirement to be eligible for service provider services.
- Carers who receive free board and lodging. A carer who is not paid or employed by the person who receives care and who receives free board and/or lodging in return for providing care, is eligible for assistance provided they meet the other eligibility requirements.
- Carers who are recipients of other government supports are eligible to access service provider services and should be appropriately assessed to identify carer needs. Carer Gateway funding is independent of other government supports.
- End of care role. Transition out of a care role can be emotional, complex and challenging. While Carer Gateway is primarily aimed at unpaid carers who are actively caring, the provision of support can also be provided in a situation where a person's caring role ends.

If the service provider is uncertain about eligibility, the FAM should be contacted for advice.

This document has been released under
the Freedom Of Information Act 1982 by
the Department of Health, Disability and Ageing

9 Service Provider Services and Activities

Service providers are responsible for delivering the following Services and activities in their designated Service Area.

9.1 Carer Support Planning

Carers can contact their service provider by:

- completing an online form (via Carer Gateway Website) and requesting a call back from their local service provider
- calling the Carer Gateway national 1800 number (which will automatically route the caller to their local service provider)
- contacting the service provider directly (in-person), or
- transfer from another service.

On first contact with a carer, service providers are responsible for determining if the carer requires:

- emergency Respite Care, as a matter of urgency
- information only (e.g. how to apply for the Carer Payment), and
- other Carer Gateway services, as determined through the Carer Support Planning Process.

Carer Support Planning Process

The Carer Support Planning Process provides guidance to ensure that carers receive a consistent experience when seeking support. The process includes, but is not limited to:

- intake
- registration
- needs assessment (incorporating Carers Star™)
- support planning
- coordination
- support, and
- monitoring.

For detailed information on Carer Support Planning, please refer to the *Carer Support Planning Framework* at Appendix F.

9.1.1 Available Resources and Support

- Carer Support Planning Framework (Appendix F)
- Carer Support Planning Framework online learning modules
- Carers Star™ training, licensing and support
- Carers Star™ online learning module
- User Journeys (see Appendix G).

9.2 In-Person Peer Support

The In-Person Peer Support service is a free facilitated peer support forum specifically designed to assist carers to:

- connect with people in similar circumstances;
- learn from their peers through the sharing of lived experiences, and
- experience relief from carer stress through forming personal connections and sharing of personal stories and experiences.

Service providers have two roles in the delivery process:

- to act as a registration point for the service, and
- to coordinate and facilitate the peer support groups.

The In-Person Peer Support includes four structured facilitated sessions. In some cases, a peer support group may evolve into a self-organising community of carers that no longer rely on the service provider to schedule and facilitate meetings. Service providers may support informal groups by covering basic meeting costs e.g. venue hire.

Service providers will be responsible for ensuring there is maximum coverage across their Service Area to limit the need for long commuting and wherever possible, support carers to gain access to sessions.

Service providers may also refer carers to In-Person Peer Support Groups run by other organisations which they are aware of within their Service Areas.

Service providers may also consider providing carers with a Carer Directed Package to support carers attending the sessions by providing access to planned respite.

9.2.1 Available Resources and Support

- *In-Person Peer Support Service Design and Guidelines* (Appendix I)



Case Study 1: Mrs Clarke

Mrs Clarke is a full time carer for her husband who has late stage chronic heart failure. She assists her husband with everyday living tasks, accompanies him to all of his medical appointments, and coordinates all of his care needs.

Mrs Clarke wishes to seek additional support to better understand end-of-life planning and her legal obligations at this stage in her caring journey. She would also like some guidance about getting her finances in order and wishes to engage with other carers who may be in similar situations.

Mrs Clarke visits the Carer Gateway website and uses the online form to request a call back.

A service provider Care Support Worker in Mrs Clarke's region contacts her and they agree to meet in person at the hospital while Mr Clarke is undertaking one of his medical treatments. Together, Mrs Clarke and the Carer Support Worker complete the Carers Star and discuss Mrs Clarke's carer situation and needs.

Based on the Carers Star™ results and discussion with Mrs Clarke, the Carer Support Worker suggests that they develop an Action Plan, which includes a facilitated coaching on finances, and joining an in-person peer support group. Mrs Clarke agrees with this approach and the Carer Support Worker makes the necessary arrangements for Mrs Clarke to receive coaching and join a support group.

Mrs Clarke is also directed to information about end-of-life planning and legal matters, which is available on the Carer Gateway website. She is also advised that free in-person or telephone counselling is available to her should she wish to use it.

The Carer Support Worker agrees to follow up with Mrs Clarke in approximately six weeks to see how she is going.

9.3 In-Person Counselling

The In-Person Counselling service is a free counselling service for carers who are experiencing difficulties with anxiety, stress, depression and low mood as a result of their caring role. The service will assist carers to manage their own health in order to remain effective in their caring role and avoid crisis events through in-person counselling sessions with a professional counsellor. The service offers individual (one-on-one) counselling sessions as well as group counselling sessions.

Carers can access the Service by registering for a call back online or by calling the Carer Gateway 1800 number, with the service providers acting as the referral point for entry into the service. The service can be delivered either by in-house service provider qualified counsellors, or by third-party counsellors subcontracted/ brokered by the service providers.

To maximise consistency, service providers should refer to the *In-Person Counselling Delivery Guidelines* (Appendix H), which describe the different types of counselling that should be made available to carers through the service and set the expectations for service delivery with subcontracted/brokered counsellors.

Service providers delivering counselling needs assessments and sessions in-house, must ensure their counsellors:

- are accredited within a relevant Australian professional association (Australian Counselling Association, Psychotherapy and Counselling Federation of Australia, Australian Association of Social Workers)
- are a qualified counsellor, psychotherapist or social worker for relevant service modes (qualifications recognised in Australia), and
- have minimum three years' work experience in Australia.

Service providers may also consider providing carers with a Carer Directed Package to support carers attend the sessions by providing access to planned respite.

9.3.1 Available Resources and Support

- In-Person Counselling Delivery Guidelines (Appendix H).



Case Study 2: Mary

Mary is a carer for her two elderly parents, who currently live with her. She also lives with her husband and two children. She works full-time.

Mary is experiencing considerable stress at home and sometimes feels overwhelmed in trying to balance the needs of her caring role, her relationship with her husband, and the needs of her children. She would really like to talk to someone about how she can build strategies to improve her own wellbeing and that of her family.

Mary heard about her local service provider at a community fair and decides to contact them directly. She is assessed by a Carer Support Worker and together they develop an Action Plan which includes in-person counselling. The Carer Support Worker discussed the choice to undertake counselling by phone (national digital service) or in-person through the service provider, and Mary preferred to meet with a Counsellor in person.

The support worker sets up the initial counselling session for Mary with a counsellor based on her prioritised needs. The Carer Support Worker also provides Mary with additional information about the online services that Mary might wish to access from home. The Support Worker seeks Mary's permission to check in with her again next week to see how she is going after her first counselling session.

Mary attends her first counselling session and is assessed using the DASS21 clinical tool. The service is provided in line with Carer Gateway In-person Counselling Guidelines.

Mary is contacted by her service provider Carer Support Worker six weeks later to see how she is going and if she requires any further support.

9.4 Facilitated Carer Coaching

The Carer Coaching service is a free, in-person psycho-educational service specifically designed to assist carers to acquire the skills and resilience needed in their caring role.

In conjunction with two selected service providers, the department will pilot the Carer Coaching service before making the service available nationally through all service providers. The Facilitated Carer Coaching Pilot and evaluation will be conducted from August 2020 to June 2021. It is anticipated that national roll-out of the service will commence in the 2021-2022 financial year.

During facilitated coaching, carers will engage with a coach (a service provider staff member/contractor) across a defined period of time, to build and develop skills identified during consultation with the coach.

Engagement may be in-person, via telephone and/or through online channels.

Modules and content for the facilitated coaching sessions align with the online self-guided carer coaching modules. Service provider clients will therefore be able to choose to do a combination of facilitated and self-guided modules in accordance with their individual circumstances.

Service providers may also consider providing carers with a Carer Directed Package to support carers attend the sessions by providing access to planned respite.

9.4.1 Available Resources and Support

Training and resources for facilitated coaching will be provided to service providers following the conclusion of the pilot and prior to national roll out of the service.

9.5 Carer Directed Support

The Carer Directed Support service is a consumer directed approach to supporting carers in their caring role. It gives carers a greater say and more control over the design and delivery of the support provided to them and the person/s they care for.

Carers who receive this funding in one year, are not guaranteed funding in subsequent years.

Support may be offered in one of two forms:

9.5.1 One-off practical support

This service is for one-off practical support (up to an amount of \$1,500) that enables carers, without the need for ongoing assistance and/or multiple supports, to access support.

It is expected that support of this kind would take the form of a tangible item that directly contributes to supporting the client in their caring role or supporting the client to access education/employment.

One off practical support might be used for items and services such as:

- purchase of small asset items to assist carers continue education. Eg. laptop
- payment for training courses.

One off practical support **should not** be used for items and services such as:

- carer holidays
- leisure activities
- entertainment items such as movie tickets
- restaurant meals.

Carers who choose to access one-off support will not be eligible for a Carer Directed Package in the same 12 month period. Service providers have the discretion (taking into account the carer's situation and the service provider's budget) to provide further support to a carer with a Carer Directed Package.

9.5.2 Carer Directed Packages

Carer Directed Packages can be directed towards a range of practical supports to assist carers in their role. The total value of the package, to which each carer is entitled, is \$3,000 over a 12-month period (the 12 month period is from the time the package is allocated and does not have to fall within a financial year). It is expected that each carer would use the full package amount (i.e. \$3,000), however carers with fewer/ simpler needs may only require a part-package (i.e. a package with a value less than \$3,000).

Service providers have the discretion (taking into account the carer's situation and the service provider's budget) to consider whether a carer would benefit from a Carer Directed Package which may exceed the \$3000 amount. This may include additional funding for planned respite to support a carer's attendance at in-person counselling, in-person peer support or in-person coaching sessions.

Carer Directed Packages are assessed on a carer's individual requirements, and are not limited to one per-household, each carer is to be assessed for their own package independently.

Carers with the same or similar needs should receive comparable allocations of budgets and services by each service provider.

Carer Directed Packages might be used for items and services such as:

- planned respite
- cleaning services
- assistance with shopping
- cooking
- assistance with transport such as paying a taxi for transport to medical appointments or shopping.

Carer Directed Packages **should not** be used for items and services such as:

- household goods that do not directly relate to care needs
- holidays
- entertainment items such as movie tickets
- dining out
- general transport needs.

9.5.3 Service Provider Role

To meet the Carer Gateway outcomes, service providers are responsible for:

- **Selection of carers** – service providers should select carers on the basis of the carers' support needs and their suitability and willingness to participate in the service. Priority access to the Carer Directed supports should be given to those carers experiencing the highest level of need based on their Carer Support Planning, and not currently accessing alternative sources of funding or services. Special consideration should also be given to ensuring young carers are included in service providers selection of carers.
- **Care assessment and planning** – The service provider will be required to undertake an assessment of each participating carer's needs and work with the carer to develop an agreed individual plan. In formulating the plan, the service provider will provide the carer with clear information about the services available in the local region, and the potential uses for their package budget and the costs per item. When choosing supports, carers should not be limited to those supports offered directly by the service provider; additional supports can be subcontracted/ brokered on behalf of the carer by the service provider.

- **Administration of carer supports** – the service provider will administer the budget for each Carer Directed Support Package (including one-off supports). This includes arranging and coordinating the provision of services as agreed to by the carer. Notwithstanding, where the carer is able to, they should be encouraged to actively manage the supports themselves (for example, booking of identified services).

The service provider should provide the carer with a quarterly account balance of their Carer Directed Package listing the following (if applicable):

- carry over balance
 - expenditure itemised including date of service and service provided /or provider, and
 - the remaining allocated funds of the 12 month package (noting that if assessed for \$2000 worth of package funding, remainder of that \$2000 not the \$3000 that is allowable)
- **Engagement with service providers**, where required – this will include:
 - subcontracting/brokering services as directed by the carer (and within the limits of the support package)
 - making payments from the package budget as confirmed and authorised by the carer within the limits of the package
 - providing the carer with a quarterly account balance, listing yearly expenditure to date and funds remaining, and
 - where necessary, liaising with subcontracted/brokered service providers in partnership with the carer (for example, to assist the carer negotiate the provision of in-home respite at a time that suits them).
 - **Flexible service delivery** – service providers will need to be flexible in their approach to assisting support recipients, including assisting carers to access services from providers with which the service provider does not have an existing relationship.

The department has not set targets for the number of carers accessing each type of service. It is up to the service provider to determine how they distribute funds across all Carer Gateway services based on their understanding of the cohorts and carer needs within their service areas. A part of their annual activity planning process, service providers must provide anticipated annual service volumes.

Service providers should also seek to link appropriate carers to other relevant supports such as aged care packages and the Young Carers Bursary Program.

9.6 Support for Young Carers

Targeted supports should be offered to the young carer cohort by allocating up to 25 per cent of targeted financial carer support packages to this group. Specifically, young carers who self-identify as recipients of income support payments, and can provide evidence of this, would be prioritised to receive a package. As part of a mutual obligation approach, young carers on income support payments would be able to access respite and other supports to enable their engagement and ongoing participation in education and/or employment.

Service providers are to engage a dedicated Young Carer Support Worker in each Carer Gateway service area to manage young carers in receipt of packages to ensure their engagement and ongoing participation in education, training or employment is supported, including the requirement that they undertake a needs assessment and develop a care plan.

The Young Carer Support Worker will need to identify and engage with young carers through intensive outreach services with schools and tertiary institutions, youth services, vocational training organisations and employers. Additionally, the Young Carer Support Worker should engage with and refer to already existing supports for young carers including the Young Carer Bursary Program and the Young Carers Network.



Case Study 3: Josie

Josie is a 17 year old primary carer of her 60 year old mother, who has advanced Parkinson's Disease. She lives in a rural community and is currently completing year 12 at school. Josie is feeling stressed as she is trying to manage her caring responsibilities and her study. She also feels isolated as she is one of only a few young carers in her small rural community.

Josie does not have a computer at home and often has to travel to her local community library to undertake her studies. This causes Josie considerable stress as she does not like leaving her mother unattended for long periods of time. Josie does not currently hold a part-time job due to her caring responsibilities and cannot afford to buy a computer.

Josie already receives counselling through her local service provider and has relatives who sometimes support her when she needs a break. Her service provider support worker has identified that purchase of a laptop computer would particularly assist Josie with her studies, upcoming search for employment and would also support her to participate in the online carer Community Forum, which has a specific group for young carers.

Working with Josie and her individual needs, the service provider supports Josie through the purchase of a laptop computer which she can use at home to complete her studies while caring for her mother. Josie also uses the laptop to access the Carer Gateway self-guided carer coaching and an online young carers support group, which is available through the Carer Gateway Community Forum. This helps Josie feel less stressed, more supported, and less alone in her role as a young carer.

The service provider Carer Support Worker also provides Josie with information about the Young Carer Bursary Program and Young Carer Network (YCN), both managed by Carers Australia.



Case Study 4: Mrs Smith

Mrs Smith is a 75 year old carer of her elderly husband, who has advanced dementia. She is a very social and independent women, who likes to manage her own affairs.

Mrs Smith is generally coping well but often finds her caring role emotionally draining and sometimes also struggles to balance her caring role with everyday tasks such as cleaning and shopping. She is increasingly feeling that her caring role is having a negative impact on her own wellbeing and often feels angry that her caring role prevents her from doing some of the things that she really wants to do, such as attending social events or her grandchildren's school events. Mrs Smith is particularly concerned that her declining mood is impacting her ability to care for her husband. She decides to contact her local service provider for some support.

A Carer Support Worker assessed Mrs Smith's situation and deems that while she does not require emergency respite, she would benefit from some regular breaks from her caring role. The service provider determines that Mrs Smith is high priority for receiving a Carer Directed Package.

Together, Mrs Smith and the Carer Support Worker devise a plan, which includes planned respite episodes, whereby on set dates and times a care worker will come into the home to care for her husband. It also includes a period of residential respite.

The Carer Support Worker also helps Mrs Smith to arrange an Aged Care Assessment to see what other supports she and her husband can access.

9.7 Emergency Respite Care

The Emergency Respite Care service is designed to offer support to carers who are experiencing an urgent, unplanned and imminent event/situation that temporarily restricts their ability to continue caring when no other services are available, for example:

- an unplanned event or situation that prevents the carer from providing care required by the care recipient
- an unplanned event or situation that threatens the health and safety of the care recipient, or
- an unplanned event or situation that threatens the health and safety of the carer (including extremely high levels of strain and anxiety impacting the carer and care recipient relationship).

The service is delivered or subcontracted/brokered by the service provider (on behalf of the carer) to secure replacement care for the care recipient in circumstances where all other options have been exhausted. Service providers may use the funding to contribute the full cost of care or part of the cost where a carer can afford to make a contribution (wherever possible, carers are expected to contribute a portion of the cost of replacement care subject to the capacity of a carer to contribute). Funds used through the service are intended to be used in times of emergency only and all other types of planned respite care should be funded through other support services.

The funding available for Emergency Respite Care can be used to access services for either the care recipient or carer (e.g. adult day care, in-home care and residential care). After the event, service providers will be expected to undertake the Carer Support Planning Process with the carer to determine if underlying issues can be addressed through other supports (such as the Carer Directed Support Service). It is also expected that the service providers will coordinate with other carer service providers (such as Aged Care, NDIS) if a need is identified.

Assessment of the carer and their care recipient's needs must be conducted to determine what respite needs are required. Specifically, service providers need to take account of:

- the carer's needs
- the care recipient's needs
- the risk of relationship breakdown between the carer and care recipient and the strengths of the relationship
- the carer's priority for services relative to other carers in that target population
- isolation and social connectedness for both the carer and care recipient
- current support provided to support the carer, both formal and informal
- last period of respite provision, and
- ability to partner with other services.

In an emergency, assessment may be brief however the quality of respite care must not be compromised. Once the emergency has passed, the service provider is to make contact to re-assess the carer's needs to gain a better understanding of the carer's situation and their respite and support needs in the future.



Case Study 5: Mrs Rose

Mrs Rose is a primary carer for her 55 year old husband who has advanced multiple sclerosis and requires assistance with everyday tasks such as dressing, eating and bathing. She has a daughter living approximately two hours away, who is a single mother of two young children.

Mrs Rose's daughter unexpectedly becomes very unwell and is admitted to hospital. As next of kin, Mrs Rose is called and asked if she can take the children.

Mrs Rose calls the 1800 Carer Gateway number seeking assistance with care for her husband so that she can tend to her daughter and grandchildren. She is put in contact with her local service provider Carer Support Worker who assess her as being in need of emergency respite care services.

The Carer Support Worker works with Mrs Rose to find a temporary respite care solution for her husband, for an initial period of two nights. Mrs Rose is encouraged to help choose the care provider and arrangements that she thinks will best meet her and her husband's needs. The service is subcontracted/ brokered by the service provider and it is agreed that Mrs Rose will pay a contribution for the respite service.

Upon her return home, Mrs Rose is contacted by the service provider and the service provider intake and assessment process is completed in full. Mrs Rose is provided with additional information on available services for carers and indicates that she is interested in checking out the online services as these would fit best into her busy schedule. She does not wish to take up any in- person services.

10 National Carer Services

The department has available online services to enable carers to access forms of support, without having to meet in-person. Service providers are responsible for actively promoting these services to clients based on their needs.

10.1 Carer Gateway website

Carer Gateway website¹⁴ is a website for carers. It provides clear, practical advice to help carers with the challenges of their role. Carer Gateway website also provides the channels by which carers can find and select the national online services that they wish to use. The Carer Gateway website is designed so carers will want to share the content to other carers, and have a feeling of being 'in the same boat' as many others like them¹⁵.

- service providers must link Carer Gateway website as the primary online resource for carers whenever this is appropriate
- service providers should refer carers to Carer Gateway website whenever they feel this is going to help the carer.

If there are any **feedback, questions, complaints** or **suggestions** from anyone about the website then they should use the feedback form¹⁶.

10.2 Community Forum (online peer support)

The Community Forum is a free online peer support forum (accessible via the Carer Gateway website) for carers who are over 18 years old. The Forum is specifically designed to support carers to:

- connect with people in similar circumstances
- learn from their peers through the sharing of lived experiences, and
- aid in decreasing carer strain through the connection and sharing of personal circumstances and experiences.

14 <https://www.carergateway.gov.au>

15 Social proof is a psychological phenomenon where people reference the behavior of others to guide their own behavior.

16 <https://www.carergateway.gov.au/feedback>

Australian Government | Carer Gateway

Search

Home | Help and advice | Respite | Financial help | Do you need to call someone?

Practical advice and support for carers. We're here for you.

Carer support

- Phone counselling**
Get one-on-one support with a professional counsellor over the phone if you feel stressed or overwhelmed.
[Ask for a counsellor](#)
- Connect with other carers**
Register to join the online forum and be part of a supportive community with other carers. Share stories and advice and learn from each other in a safe space.
[Join the Forum](#)
- Self-guided coaching**
Explore online carer coaching sessions. You can reflect on how you are going, how you will be, and how you might take steps towards making that happen.
[Find out more](#)
- Skills courses**
Use these short downloadable PDFs or Word documents to help you to learn new skills in caring for someone and yourself.
[Explore the courses](#)

Connect with other carers

www.carergateway.gov.au

The screenshot displays the Carer Gateway Community Forum website. At the top, the Australian Government logo and Carer Gateway branding are visible. A search bar is positioned on the right side of the header. Below the header, a navigation menu includes links for HOME, GETTING STARTED, DISCUSSIONS, CARER GROUPS, FACT SHEETS, CONTACT US, and DO YOU NEED TO CALL SOMEONE?. A 'LOGIN | JOIN' link is also present. The main content area features a 'FEATURED' section with a grid of topic cards: INTRODUCTIONS, SOCIAL SPACE, SELF CARE, RELATIONSHIPS, PARENTING, MONEY & WORK, MANAGING HEALTH, TOUGH TIMES, and GOOD RESOURCES. To the right of this grid is a video player titled 'Introducing the Carer Gateway Community Forum'. The video description states: 'Caring for a loved one can bring joy but some days it can be lonely or a little bit confusing. The Carer Forum provides a safe, anonymous space to connect with other carers and support each other.' A link to view the transcript is provided below the description.

<https://forum.carergateway.gov.au/s/>

The Community Forum is hosted by a specialist organisation contracted by the department. Carers have two options to participate in the online peer support forum. They can:

- participate as a viewer or observer only, or
- participate as a member and contribute to online discussion threads.

The following table will assist with handling enquiries you might receive relating to the Community Forum:

Calls relating to	Response
I have forgotten my password...	Direct them to the Forum login page, and follow the "Forgot your password?" link.
I am having difficulties using the Community Forum website.	Direct them to the website feedback link in the footer of the website (forum.carergateway.gov.au) to lodge feedback.
Query relating to posting on the Community Forum.	Advise the caller to look under the "Getting Started" menu on the Community Forum for helpful information.
Query relating to moderation of a post on the Community Forum.	Advise the caller to look under the "Getting Started" menu on the Community Forum for helpful information.

10.3 National Telephone Counselling Service

The National Telephone Counselling Service is a free short-term counselling service for carers experiencing difficulties with anxiety, stress, depression and low mood. The service will assist carers to manage their own health in order to remain effective in their caring role and avoid crisis events.

In order to deliver high quality, therapeutic counselling specifically aimed at carers, the service offers two types of interventions:

- an intervention designed to help carers over a longer period who require more intensive support to achieve the outcomes, and
- an intervention, delivered over a shorter period, for those carers who may not need as much support to achieve the outcomes.

Carers can access the service directly via the Carer Gateway website or via the national 1800 number (and selecting Phone Counselling option – Option 2).



www.carergateway.gov.au



https://counselling.carergateway.gov.au/s/

On the Carer Gateway Counselling webpage (<https://counselling.carergateway.gov.au/s/>), carers receiving counselling can log in to manage appointments and find useful information from their counsellor. Carers who are receiving counselling will be provided login access as a part of the over the phone intake process (by the contractor).

Carers accessing the National Phone Counselling service will undertake a counselling-specific assessment which will be used to prioritise their needs.

Telephone counselling is generally capped at six sessions and the duration will be determined by the Phone Counsellor.

Carers who have received counselling through the National Phone Counselling Service are also eligible to receive in-person counselling through their local service provider.

The following table will assist with handling enquiries you might receive relating to the Phone Counselling Service:

Calls relating to	Response
Caller is interested in accessing Phone Counselling...	<ul style="list-style-type: none"> advise the caller that you will transfer them to the Phone Counselling service call s47E(d) (phone counselling number) and cold transfer.
A "Request a call back" is related to accessing phone counselling.	<ul style="list-style-type: none"> phone s47E(d) and relay the web form details to the Phone Counselling Service the Phone Counselling Service staff will follow up the request.
I have forgotten my password...	<ul style="list-style-type: none"> direct them to the Carer Portal login page, and follow the "Forgot your password?" link.
I am having difficulties logging in / using the Carer Portal...	<ul style="list-style-type: none"> advise the caller that you will transfer them to the Phone Counselling service call s47E(d) and warm transfer, identifying that you are a Carer Gateway Contact Centre operator and the nature of the call.
I want to change my Phone Counselling appointment...	<ul style="list-style-type: none"> advise the caller that you will transfer them to the Phone Counselling service call s47E(d) (phone counselling number) and cold transfer.

Note: Do not provide the direct phone counselling number to callers. Carers should access all services via the national Carer Gateway 1800 number (option 2).

10.4 Carer Coaching (online self-guided format)

Self-guided Carer Coaching is a free online service for carers to:

- learn skills to assist them in their caring role
- build their capacity to self-identify needs and goals
- build their capacity to self-manage, and
- provide them with support and advice on a large range of issues relating to their caring role.

The Self-Guided Carer Coaching Service complements the Facilitated Carer Coaching Service that will be delivered by service providers, and carers may choose to do a combination of modules and formats.

Carers can access this service directly via the Carer Gateway website or may be referred to the self-guided format by the service provider following the Carer Support Planning Process.

The screenshot shows the Carer Gateway website interface. At the top, there is the Australian Government logo and the Carer Gateway logo. A navigation bar includes links for Home, Help and advice, Respite, and Financial help, along with a search bar and a button that says "Do you need to call someone?". Below the navigation bar, a banner features the text "Making sure you get the help you need. We're here for you." and a photo of a woman. The main content area is titled "Carer support" and contains four service cards: "Phone counselling", "Connect with other carers", "Self-guided coaching", and "Skills courses". The "Self-guided coaching" card is highlighted with a red border and contains the text: "Explore online carer coaching sessions. You can reflect on how you are going, how you'd like things to be, and how you might take steps towards making that happen." Below this text is a "Find out more" button. A red line extends from the bottom of the "Self-guided coaching" card down to the URL "www.carergateway.gov.au" at the bottom of the page.

www.carergateway.gov.au

Coaching Service

Do you need to call someone?

Carer Coaching

Listen

The carer coaching service provides an opportunity for you to explore the impacts of your caring role on your life. Designed in partnership with carers, each coaching session will get you thinking about how you are going, how you'd like things to be and how you might be able to take steps towards making that happen. Each session includes evidence supported information, practical tips, resources, reflection activities and stories from real Australian carers.

There are eight coaching sessions available:



Your health and wellbeing



Understanding the caring journey



What makes for good support?



Understanding inclusion and advocacy



Work, study and volunteering



Getting your finances in order



Everyday Life



How do you feel?

<https://coaching.carergateway.gov.au>

11 Service Provider Ancillary Activities

In support of the client services, the service provider is responsible for the delivery of the following ancillary activities.

11.1 Service Area Mapping

Service providers are required, on an annual basis, to undertake a service area mapping exercise of their Service Area. The purpose of this mapping is to identify organisations delivering services which may be of benefit to carers, and to develop relationships with these organisations for the purpose of referring carers to these services. It is expected that service providers will need to utilise a wide range of existing service providers in order to meet the needs of carers.

Service providers will need to work with organisations such as the Primary Health Network (PHN) and NDIS Local Area Coordinator Partners, to understand the needs of carers within their area. Emerging trends and patterns will need to be identified and understood.

Service Area Mapping should include:

- identification of available services
- high level carer needs analysis
- assessment of service capacity to meet current and anticipated future needs
- identification of any gaps in services, and any opportunities to improve coordination and collaboration and the responsiveness of care
- identification of opportunities for innovation, and
- planning for services.

Service providers should determine the most appropriate Service Mapping methods as relevant to their particular service area. This could include activities such as service provider engagement activities, surveys, desktop data analysis, and community consultations.

Annual Service Mapping should inform future service providers service delivery and be evidenced in their annual Activity Work Plan, which must be provided to the department on request.

11.2 Outreach

Service providers are responsible for undertaking promotional and profile raising activities, including outreach activities to targeted groups such as young carers, which aim to reduce the barriers that prevent disconnected or hidden carers from accessing the services they need. This should include outreach activities within local communities and with local service providers. Examples of outreach and service promotion activities could include engaging local communities through leaflets, newsletters, stalls and dedicated events (e.g. a presentation to a local school).

Outreach activities should also include promotion of online Carer Gateway services such as the Self-guided Carer Coaching service, online Carer Skills Courses, and the online Community Forum.

The department provides service providers with marketing materials to support their outreach and promotion activities (refer to Publications section).

11.3 Other Service Provider Activities

Service providers or the department may propose additional activities for service providers to deliver.

If new activities are funded by the department and the new activities substantially alter the terms of the Grant Agreement, a Deed of Variation may be required.

Service providers are encouraged to seek additional funding from other sources to support their activities, as long as these additional services do not prevent the service provider's compliance with the Grant Agreement.

This document has been released under
the Freedom Of Information Act 1982 by
the Department of Health, Disability and Ageing

12 Department Ancillary Activities

12.1 National carer awareness communication activities

In addition to the ancillary activities delivered by the service provider, the department will develop and deliver national communications activities to raise awareness of carers, and the services and supports available through Carer Gateway (including the service providers).

Marketing of information about Carer Gateway or access to services for carers, will be conducted by the department. Any marketing material for the Carer Gateway 1800 number will be produced by the department and available from the Carer Gateway website. Service providers should inform carers about respite services and carer support through their outreach activities and using existing targeted local publications.

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13 Monitoring and Evaluation

13.1 Carer Gateway Outcomes Framework

Carer Gateway as a whole will create a coherent support environment for carers by bringing a coordinated approach to a range of existing carer support services.

The Carer Gateway Outcomes Framework outlines three primary areas of benefit from Carer Gateway. These are to:

1. **Improve carer wellbeing, increase their capacity and support their participation, socially and economically** – more carers gain required skills, better understand the caring role they are in, and plan their life using available supports.
2. **Reinforce carer resilience through effective preventative support services** – more carers are informed of the new preventative support services available to them and utilise these services.
3. **Restructure investment in carer support to increase cost effectiveness** – carers value the services provided to them and the Government is facilitates delivery of those services in the most cost-effective way.

The Outcomes Framework at Appendix J illustrates how the activities in the program will drive these benefits.

13.2 Service provider self-evaluation

Service providers are required to analyse their own performance in achieving Carer Gateway outcomes. Service providers are expected to implement service improvements based on their own analysis. This analysis must be provided to the department on request.

The annual Activity Work Planning process and reporting works to drive service improvement and to refine the service provider's understanding of carers' real needs (refer to Appendices B and R).

13.3 Service provider support to Carer Gateway evaluation

Service providers are required to contribute to monitoring and evaluation activities performed by the department (or its contracted evaluators). At a minimum, this includes:

- collecting and reporting client service delivery data – as per the Data and Reporting requirements and the DEX protocols
- supporting an organisation appointed by the department to survey a sample of clients accessing services delivered by the service provider
- providing reports and data as specified by the department, and
- regular communication with the department's staff.

13.4 Service provider reporting framework

Service providers are required to submit reports in accordance with the reporting section of the Grant Agreement.

13.5 Data Exchange

Performance information (e.g. client characteristics and service delivery information) will be required to be collected by service providers at the client level and entered directly into the department's performance reporting solution, the Data Exchange.

The performance information reported through the Data Exchange includes:

- client identity characteristics (given and family names, date of birth, gender and residential address)
- client demographic characteristics (indigenous status, cultural and linguistic diversity, and disability status, impairment or condition)
- service delivery information (outlets, cases, sessions), and
- client outcomes.

Refer to Section E of the Grant Agreement for details on timeframes for performance reporting milestones. Failure to submit accurate data within the specified timeframes will be considered to be a breach of the grantee's funded obligations.

Information must be provided in accordance with the Data Exchange Protocols¹⁷ which are mandated under the Grant Agreement.

Please note that for Carer Gateway, service providers are required to enter data quarterly as per the grant agreement. This requirement overrides the six monthly reporting periods outlined in the Data Exchange Protocols. In addition to quantitative data entered into DEX, the service provider is required to adopt the Partnership Approach and input comprehensive qualitative information on the delivery of funded services.

The Data Exchange Technical Specifications¹⁸ are available online. A dedicated the Data Exchange helpdesk is available via [dssdataexchange.s47E\(d\)@dss.gov.au](mailto:dssdataexchange.s47E(d)@dss.gov.au) or [s47E\(d\)@dss.gov.au](mailto:s47E(d)@dss.gov.au). Additionally, there is a range of other training and support material¹⁹ to help service providers use the Data Exchange.

¹⁷ <https://dex.dss.gov.au/data-exchange-protocols/>

¹⁸ <https://dex.dss.gov.au/access/>

¹⁹ <https://dex.dss.gov.au/training-resources/>

Acronyms and Terms

CLI	Caller Line Identification
CRM	Client Relationship Management system
DEX	The Data Exchange
FAM	Funding Arrangement Manager
FOI	Freedom of Information
IPPS	In-Person Peer Support
LMS	Learning Management System
NRS	National Relay Service
the department	refers to the Australian Government Department of Social Services
TIS	Translation and Information Services
TOP	Transition Out Plan

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Appendix A – Carer Gateway Blueprint

Refer Disability and Carers section of the department’s website.

<https://www.dss.gov.au/disability-and-carers-carers-icss-implementation/icss-service-blueprint>

ICSS Service Blueprint



Australian Government
Department of Social Services

ICSS Service Blueprint

Version Number: 1.3
Date: 11 December 2018
Purpose: This document is a blueprint for the Australian Government’s Integrated Carer Support Service. Its purpose is to describe the different service components (and their relationship) required to commission and operate the Integrated Carer Support Service.

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Appendix B – Activity Work Plan Template



Instructions

To complete the Activity Work Plan please complete cells that are not shaded.

The populated activity deliverables are not exhaustive and rows can be added to the following tables as required.

A budget for the financial year must also be attached as part of the Activity Work Plan. The budget template is at *Appendix C of the Carer Gateway Operating Manual* and must be used for this purpose.

Activity Work Plan

Organisation name	Grant Activity Name		Grant Activity ID			
ACTIVITY DETAILS						
Activity Start Date		Activity End Date	<dd/mm/yyyy>	Total Activity Funding	\$xxx,xxx total amount in agreement	
Activity Requirement:	Include as specified in the activity description in the agreement.					
This Activity Work Plan covers the following period	Activity Work Plan Start Date	<dd/mm/yyyy>	Activity Work Plan End Date	<dd/mm/yyyy>	Current Financial Year Funding	\$xxx,xxx
ACTIVITY DELIVERABLES						
Objective	Deliverable and location		Timeframes	Measures of success		
<i>List objectives/requirements which clearly relate to the outcomes of the activity</i>	<i>Specify the scope of the deliverable/requirement</i>		<i>Specify the timeframe for delivery</i>	<i>Specify the success metrics for the deliverable/requirement, including quality expectations</i>		

<p>Carer Support Planning</p>	<p><i>Elaborate on activities that are undertaken during the carer support planning process that are not able to be reported into DEX</i></p> <p><i>e.g. number of carer support planners required, system navigation support, connection with other services and supports and referrals to other services and supports.</i></p> <p><i>Note: This is not an extensive list and you are not required to report on all aspects.</i></p>		
<p>Establish a regional presence to support the entire service area ensuring Carers of all cohorts are reached</p>	<p><i>Specify activities that will be undertaken at different locations to support carer cohorts including ATSI, CALD, LGBTIQ+ and mental health carers.</i></p> <p><i>How are you targeting specific cohorts in your peer support, counselling and coaching services?</i></p>		
	<p><i>Specify planned communication activities that will be undertaken within the service area to raise awareness of Carer Gateway and reduce barriers, which prevent disconnected or hidden carers accessing services.</i></p>	Ongoing	
	<p><i>Specify activities that will be undertaken within the service area, including the activities of the Young Carer Support Worker to work with and identify young carers.</i></p>	Ongoing	
	<p><i>Specify activities for mapping of services in the service area, which are of benefit to carers – refer to section 11.1 Service Mapping in the Carer Gateway Operating Manual for further information.</i></p>	Annually as part of AWP due 30 June each year	

Demand	<i>Specify activities to manage increased demand for carer services</i>	Ongoing	
Conduct outreach activities, and link to social, health, education, community and cultural groups, to better understand regional and rural needs	<i>Specify planned outreach activities within service area including regional, rural and remote locations to obtain local intelligence of carer needs</i>	Ongoing	
Continued service improvement including innovation	<i>Specify planned activities to contribute to service improvement including organisational e.g. staff training, internal processes or upgrading CRM/phone system and planned innovation</i>	Ongoing	
Collect 1800 phone number statistics	<p>The following Carer Gateway 1800 phone number statistics collected, broken down month by month and reported in the six (6) monthly Activity Work Plan report</p> <ul style="list-style-type: none"> ○ total number of calls ○ average call wait time ○ longest call wait time ○ number of abandoned calls ○ average length of call ○ number of incorrect calls coming through to the 1800 number ○ number of call back requests received and completed through the website by month 	Six monthly as part of AWP Report	<p>Monthly breakdown of statistical data provided to the department for periods:</p> <ul style="list-style-type: none"> ○ 1 July to 31 December ○ 1 January to 30 June

RISK MANAGEMENT (please note any predicted risks & related mitigation strategies)

Risk	How the Risk will be Managed

STAKEHOLDERS		
Stakeholder	Interest or Impact	Engagement Strategy
	<p><i>You are not required to report on your key stakeholders here. This requirement will be met by undertaking your stakeholder mapping activities.</i></p> <p><i>As per the Carer Gateway Operating Manual, you are required to keep an up to date sub-contractor list and provide it to your FAM.</i></p>	

This Activity Work Plan is to be finalised, or reviewed and renewed, by the Activity Work Plan End Date specified above.

<Legal Organisation Name>

Department of Social Services

Signed for and on behalf of

Position

Chief Executive Officer

Funding Arrangement Manager

Date

____/____/____

____/____/____

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Appendix C – Budget Template

Budget – specify amounts to be allocated using the budget template below (Total anticipated income should equal total estimated expenditure). It is expected that services received by carers and resources for carers will take up the largest percentage of the budget outlay and that expenditure attributed to overheads, administration and other costs will be tightly managed within acceptable limits negotiated between the provider and the department dependent on service location.

The split between administration and service delivery costs submitted per your grant application will be used to monitor the levels applied against in your budget each year.

This is to be included with the AWP.

Income for the year of 20	
Source	GST exclusive (in whole dollars only)
Service Provider Funding – the department	
Anticipated interest received on Funds	
Anticipated fees	
Other	
Total anticipated income	

Expenditure for the year of 20	
Direct Costs (Service Delivery)	GST exclusive (in whole dollars only)
Employee expenses	
Subcontracting/brokering expenses	
Insurance	
Travel	
Carer resources	
Other	
Total direct costs	
Support and Administration Costs	GST exclusive (in whole dollars only)
Employee expenses	
Training costs	
ICT and telephony costs	
Premises and Accommodation costs	
Depreciation (excluding Assets)	

Expenditure for the year of 20	
Promotion and advertising costs	
Management fees	
Other	
Total administration costs	
<u>TOTAL ESTIMATED EXPENDITURE</u>	

Forecast Volumes for 20../..

Services	Forecast Volumes for 20../..
Carer Support Planning	
In-Person Counselling	
In-Person Peer Support	
Carer Directed Support	
Emergency Respite	
In-person Coaching	
Total	

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Appendix D – Transition Out Plan Guidelines

1.0 Aim

The aim of the Transition Out Plan (TOP) is to ensure that the obligations of both parties upon termination or expiry of the grant agreement are acknowledged and agreed.

The TOP is intended to assist in a smooth transition of services and ensure minimal disruption of services to clients and carers upon termination or expiry of a Grant Agreement. In this regard, developing a TOP is evidence of good management practice and organisational planning.

- The TOP should address issues that enable the orderly transition of the services from the participant to the Commonwealth or its nominee on termination or expiry of the Grant Agreement. Once the TOP has been agreed upon, the service provider must comply with each element, unless the department notifies the service provider that it is not obliged to comply
- with a particular element of the Transition Plan.

The following are matters that should be considered for inclusion in the TOP; however, these are intended as guidance only. The list is neither exhaustive nor prescriptive and TOPs will depend on each organisation's individual arrangements and the outcome of any negotiations.

2.0 Service provider contact information

Please provide relevant contact details for the service provider and identify to which program the contact relates. Please provide:

- position
- address
- phone
- email.

3.0 Program descriptions

Briefly describe the program(s) and activities to which the TOP relates. Include information about organisations and service providers with which the service provider has linkages, and their contact details (positions only and contact details for the positions including phone and email; do not include names as these are subject to change).

4.0 Organisational arrangements

Please provide:

- information/description of organisation-specific administrative policies
- processes and procedures
- operational procedures.

5.0 Timeframe for transition

Specify the transition out period (assume a period of one to three months before the date of termination or expiry of the Grant Agreements, to be negotiated and agreed with the department at the time of termination/expiry).

Provide a timetable for the transition, including events and milestones. Set out what steps the service provider will undertake within days/weeks of notification of the Grant Agreement expiry/termination and contact details for certain steps/tasks.

6.0 Transition of clients

The TOP is intended to assist in a smooth transition of services and ensure minimal disruption of services for clients and carers upon termination or expiry of the Grant Agreement.

Provide an outline of how this transition process will be managed and communicated to clients, carers and/or representatives.

7.0 Notification

The service provider must inform relevant stakeholders of the termination/expiry of the Grant Agreement. Relevant stakeholders may include:

- advisory committees and/or
- regular forums/networks attended.

8.0 Staffing arrangements

Include staffing details and the basis on which staff are employed (eg. full time, part-time, award levels) for the service provider and identify under which program the staff are employed. Specify arrangements for transition of staff to a new participant (subject to the agreement of the new participant).

While there is provision in Activity funding for staff entitlements, the TOP should address conditions and arrangements for staff not wishing to transfer, eg. redeployment, redundancy.

9.0 Organisation property/accommodation

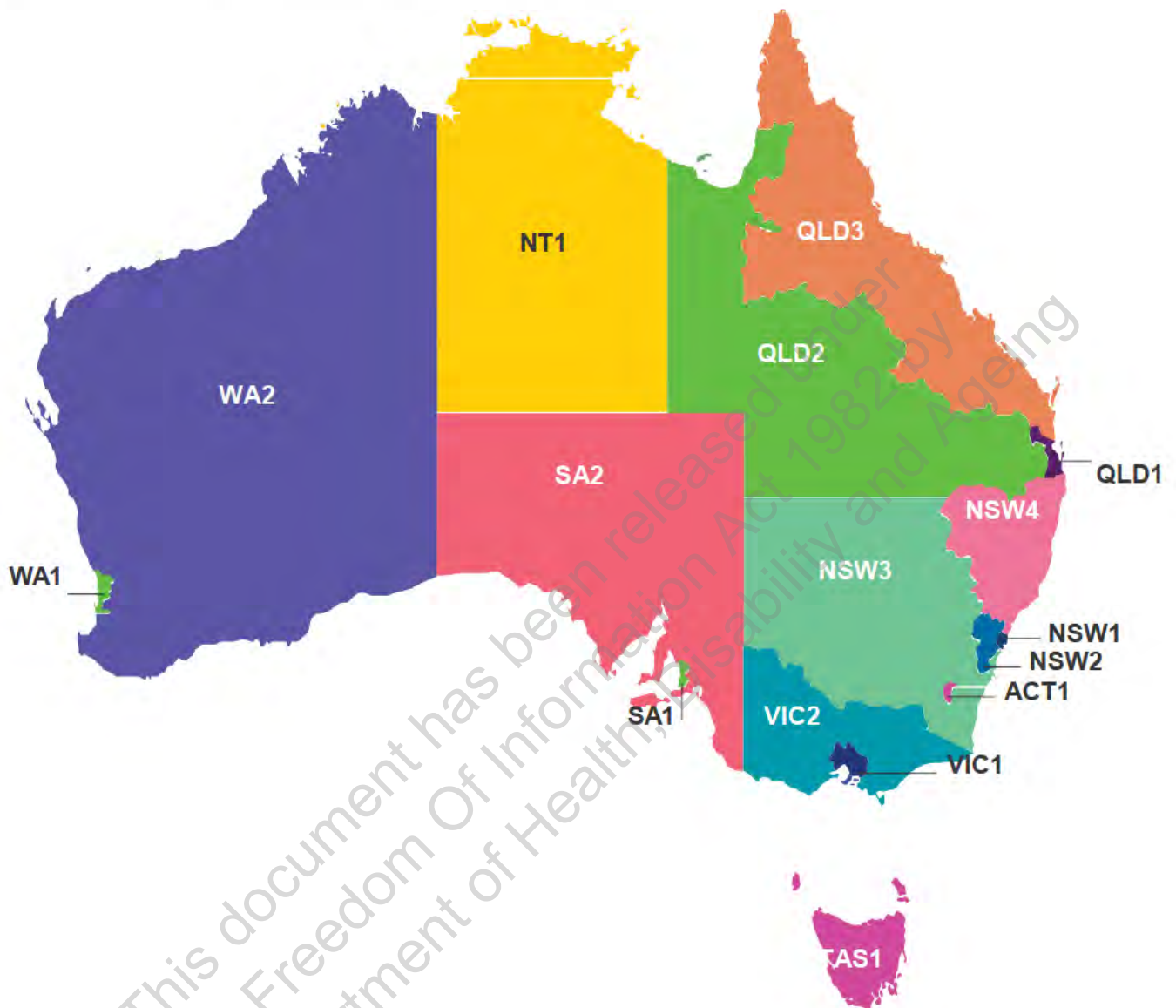
Include information about what accommodation arrangements exist for premises currently occupied by the service provider.

10.0 Assets

Assets including any item of personal, real or intangible property, with a price or value of \$10,000 or more, inclusive of GST, and which has been created, acquired or leased wholly or in part with the Grant. Service providers must maintain and submit upon request an Asset register for Assets purchased in whole, or in part, with Commonwealth funds, and for Assets purchased with other funds that are used for the delivery of service provider services for which the service provider claims depreciation. The Asset register must include

- Asset description
- percentage of the Asset that is Commonwealth funded
- serial number (if available)
- whether the Asset is purchased or leased
- acquisition date
- estimated useful life of the Asset (or lease life)
- total Asset value
- total depreciation per financial year on non-Commonwealth share of the Asset
- cumulative depreciation on the non-Commonwealth share of the Asset
- depreciated value of the non-Commonwealth share of the Asset
- disposal date (for Assets purchased in whole or part with Commonwealth funds).
- residual/Sale Value of the Commonwealth share of the Asset.

Appendix E – Carer Gateway Service Areas



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Carer Gateway Service Areas

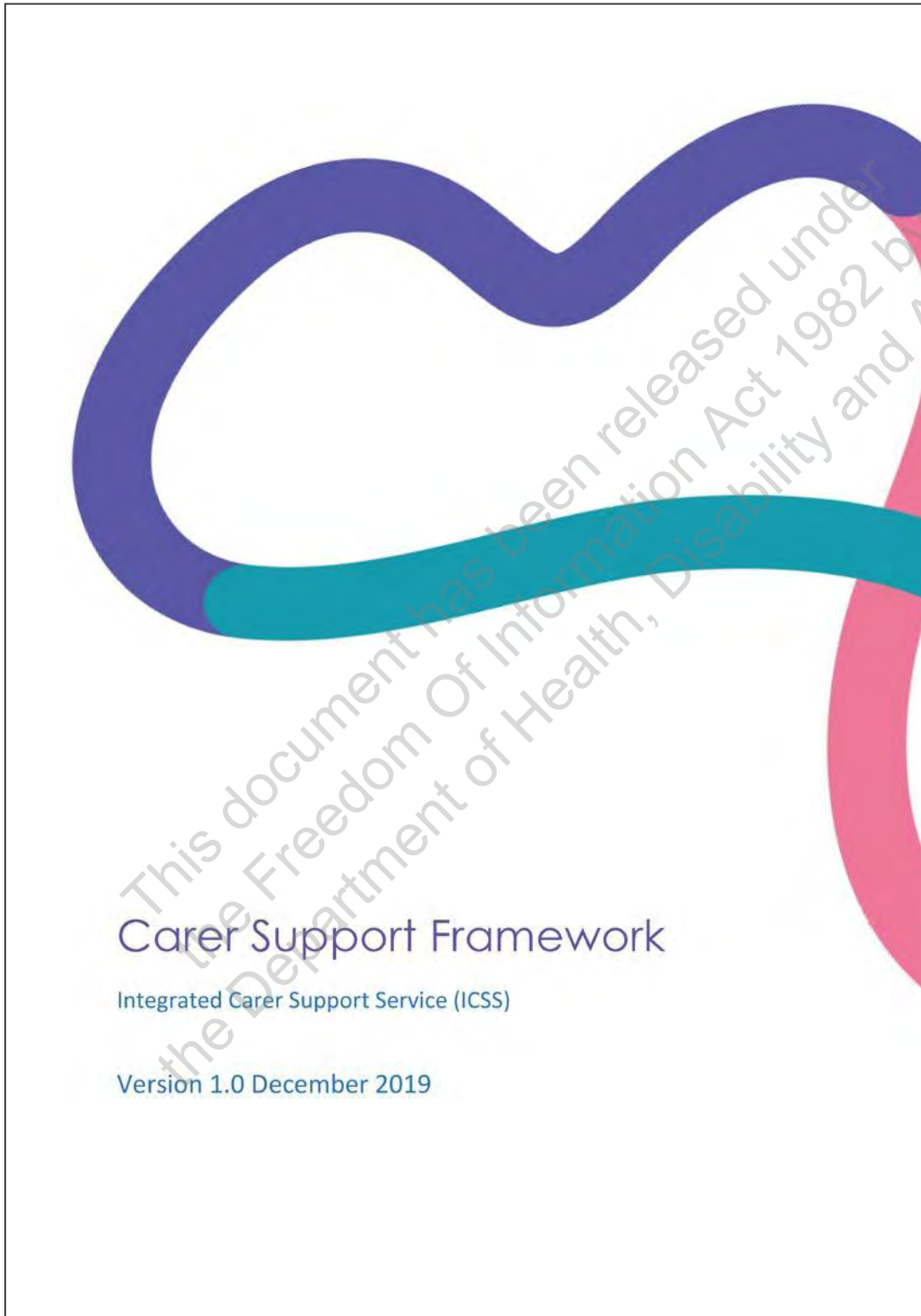
Service Area	Corresponding	Carer Population*
ACT 1	31 – ACT	44,700
NSW 1	1 – Central and Eastern Sydney 2 – Northern Sydney 3 – Western Sydney	345,054
NSW 2	4 – Nepean Blue Mountains 5 – South Western Sydney	175,074
NSW 3	6 – South Eastern NSW 7 – Western NSW 10 – Murrumbidgee	167,783
NSW 4	8 – Hunter New England and Central Coast 9 – North Coast	215,535
QLD 1	17 – Brisbane North 18 – Brisbane South 19 – Gold Coast	253,254
QLD 2	20 – Darling Downs and West Moreton 21 – Western Queensland	64,741
QLD 3	22 – Central Queensland, Wide Bay, Sunshine Coast 23 – Northern Queensland	163,130
VIC 1	11 – North Western Melbourne 12 – Eastern Melbourne 13 – South Eastern Melbourne	526,051
VIC 2	14 – Gippsland 15 – Murray 16 – Western Victoria	216,939
SA 1	24 – Adelaide	177,676
SA 2	25 – Country SA	66,116
WA 1	26 – Perth North 27 – Perth South	149,032
WA 2	28 – Country WA	54,570
TAS 1	29 – TAS	85,508
NT 1	30 – NT	11,520
Total		2,716,683

* The carer population data is based on the Australian Bureau of Statistics, Survey Disability Ageing and Carers data 2015.

Appendix F – Carer Support Planning Framework

Refer to the Program Materials section of the Carer Gateway Learning Management System.

<http://providers.carergateway.org.au/docs/Carer-Support-Framework.pdf>



Appendix G – User Journeys

Refer to the Program Materials section of the Carer Gateway Learning Management System.

<http://providers.carergateway.org.au/docs/Carer-Journeys.pdf>

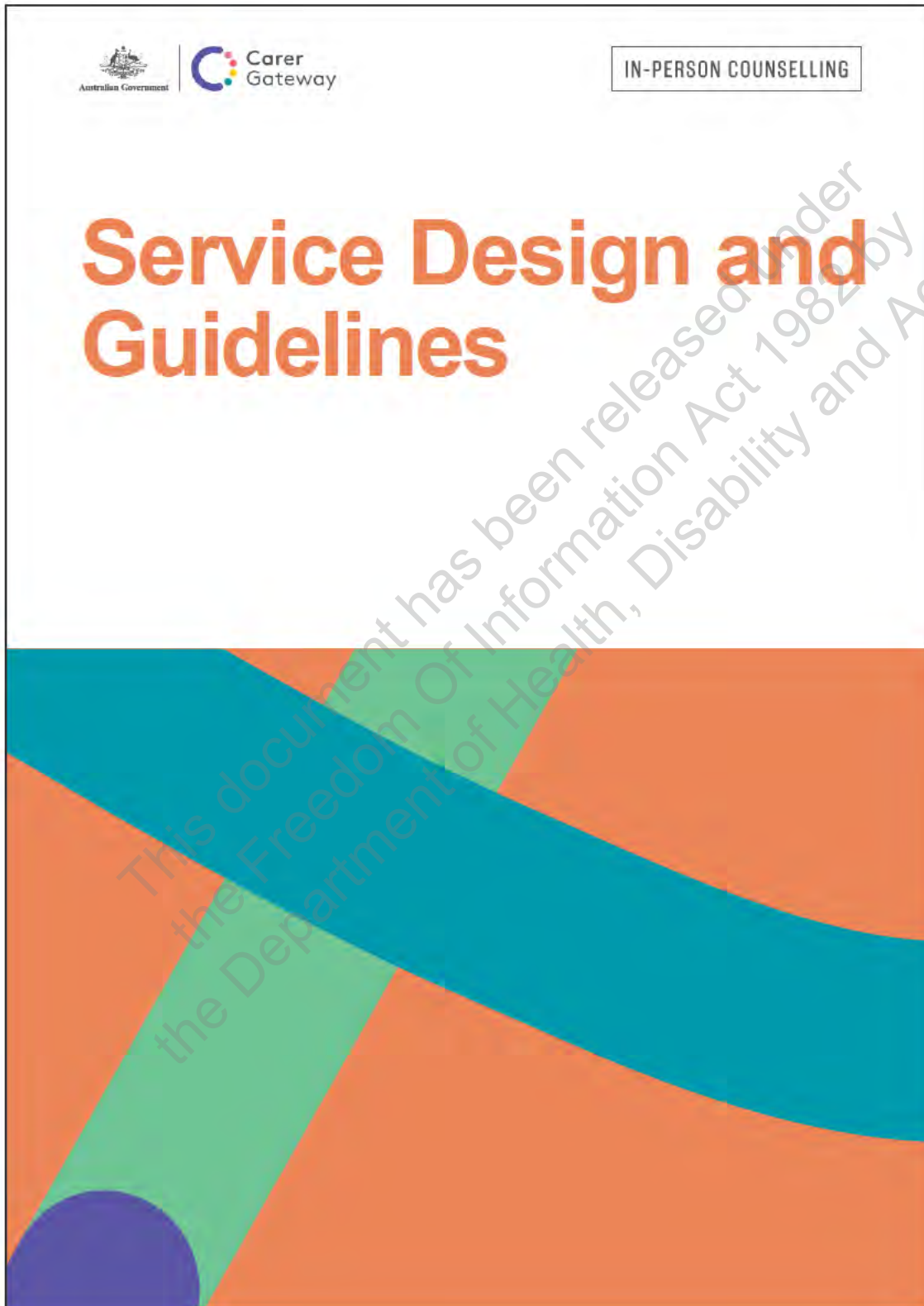


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Appendix H – In-Person Counselling Service Design and Guidelines

Refer to the Program Materials section of the Carer Gateway Learning Management System.

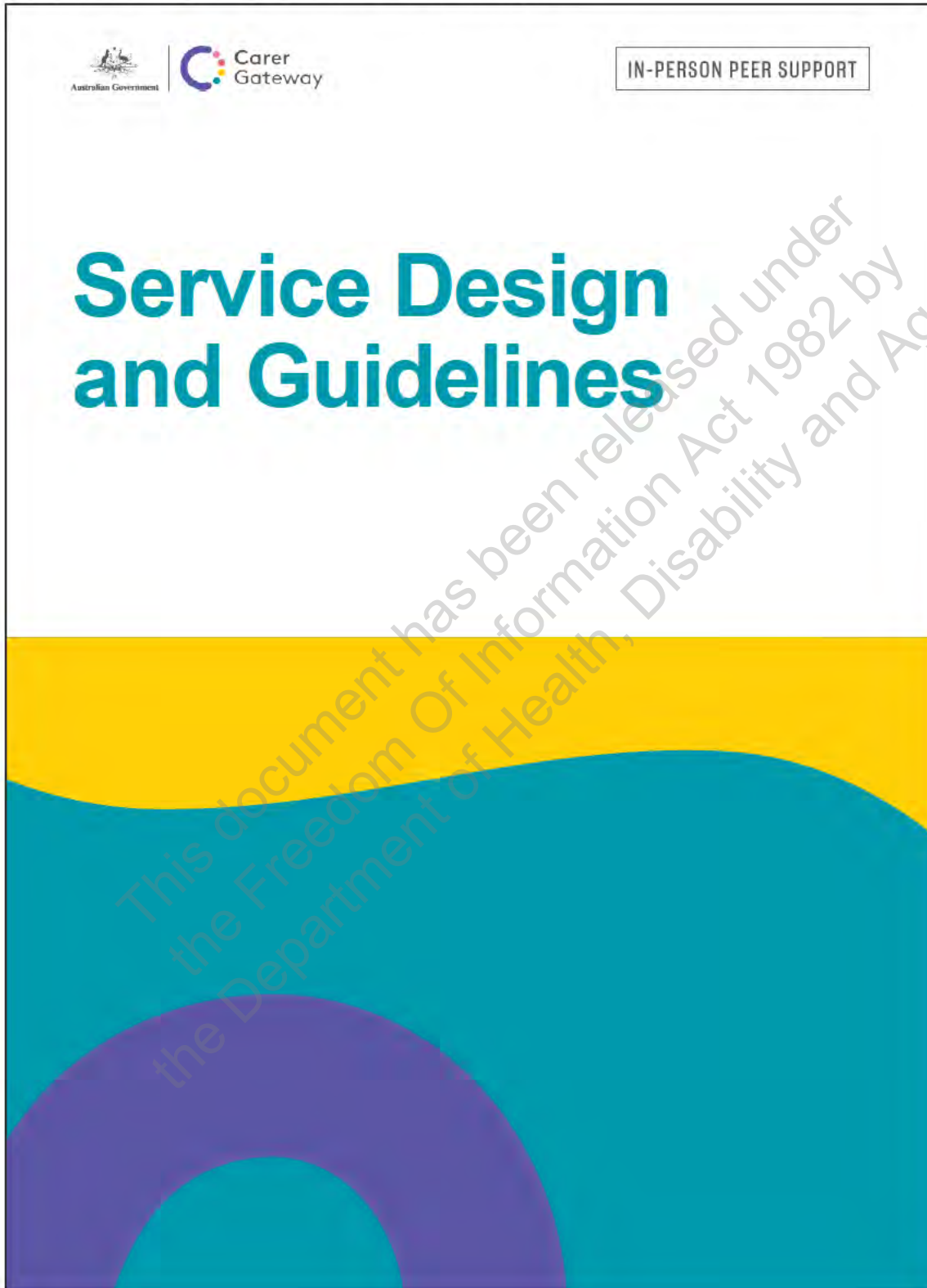
<http://providers.carergateway.org.au/docs/IPC-Guidelines.pdf>



Appendix I – In-Person Peer Support Service Design and Guidelines

Refer to the Program Materials section of the Carer Gateway Learning Management System.

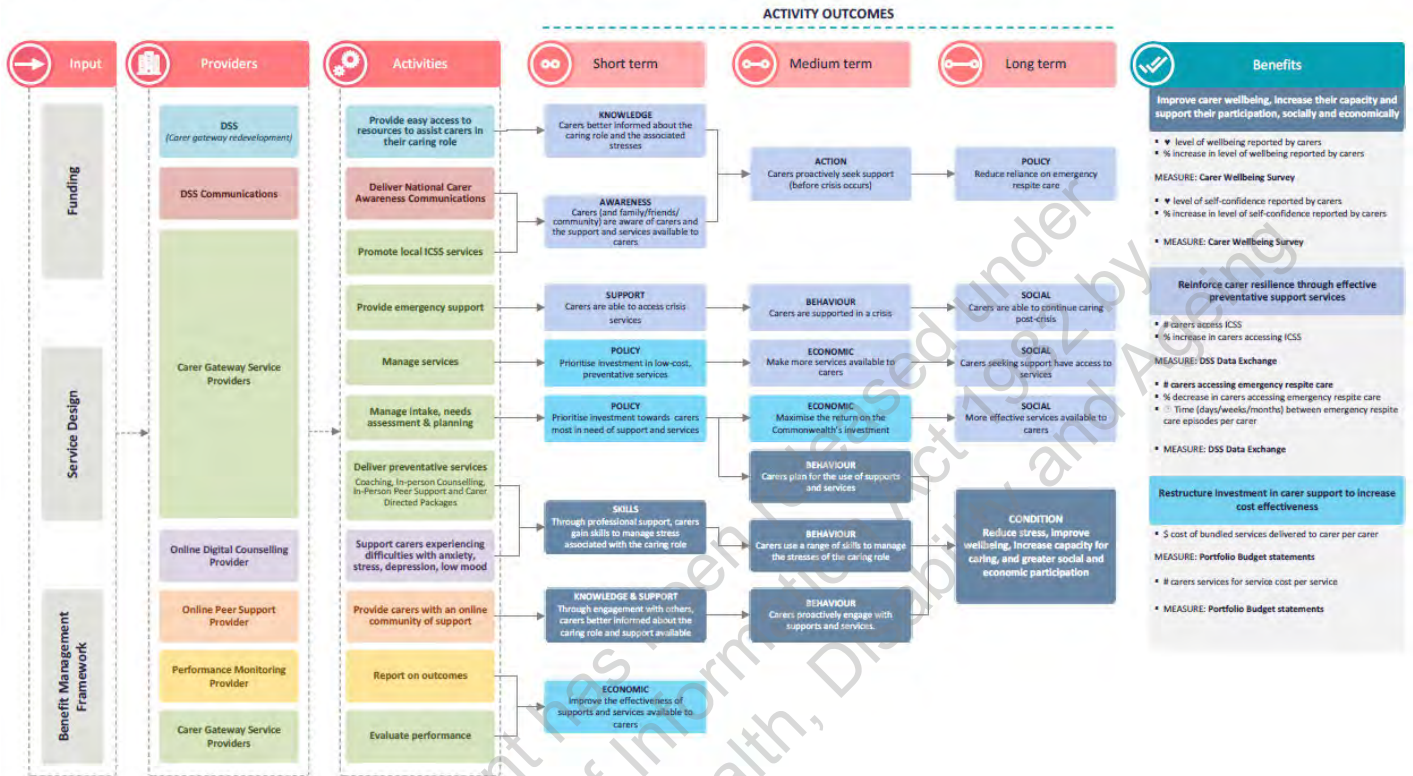
<http://providers.carergateway.org.au/docs/IPPS-Guidelines.pdf>



Appendix J – Outcomes Framework

Integrated Carer Support Service - Outcomes framework

Caring can be stressful and can impact on the relationship between the carer and the person they care for. It can also impact carers' ability to participate in everyday activities such as education and employment. The purpose of the ICSS is to improve carer wellbeing, increase their capacity and support their participation, socially and economically.

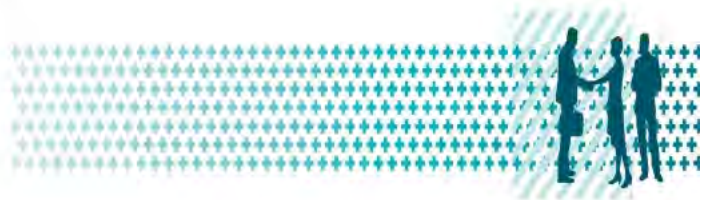


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Appendix K – Activity Work Plan Report Template



**Community
Grants Hub**
Improving your grant experience



Activity Work Plan Report

Instructions

To complete the Activity Work Plan Report you will need a copy of your approved Activity Work Plan.

Most text boxes in this form will be populated by copying the text in your Activity Work Plan. You will need to report against each line item in the text boxes on the right hand side of the form.

For further guidance on completing this form go to the [Website](#)

Add rows to the following tables as required.

Activity Deliverables

Objective	Deliverable <i>Note: Copy the activities from your AWP</i>	Timeframes <i>Note: Copy the timeframes from your AWP</i>	Measures of SUCCESS <i>Note: Copy the measures of success from your AWP</i>	Status	Progress Report
Carer Support Planning					
Establish a regional presence to support the entire service area ensuring Carers of all cohorts are reached					
Demand					
Conduct outreach activities, and link to social, health, education, community and cultural groups, to better understand					

Objective	Deliverable <i>Note: Copy the activities from your AWP</i>	Timeframes <i>Note: Copy the timeframes from your AWP</i>	Measures of success <i>Note: Copy the measures of success from your AWP</i>	Status	Progress Report
regional and rural needs					
Continued service improvement including innovation					

1800 Carer Gateway Number Statistics

	<month>	<month>	<month>	<month>	<month>	<month>	Comments
Total number of calls							
Average call wait time							
Longest call wait time							
Number of abandoned calls							
Average length of call							
Number of incorrect calls coming through to the 1800 number							
Number of call back requests received and completed through the website by month							

Risk Management (please note any predicted risks & related mitigation strategies)

Risk	How the Risk will be Managed	Report
<i>From AWP</i>	<i>From AWP</i>	

Budget - as per AWP Budget

Items	Budgeted Amount	Expended Amount
Employee Expenses	<i>From Appendix C</i>	
Subcontracting Expenses	<i>From Appendix C</i>	
Insurance	<i>From Appendix C</i>	
Travel	<i>From Appendix C</i>	
Carer resources	<i>From Appendix C</i>	
Other	<i>From Appendix C</i>	
Employee Expenses	<i>From Appendix C</i>	
Training Costs	<i>From Appendix C</i>	
ICT and telephony costs	<i>From Appendix C</i>	
Premises and Accommodation costs	<i>From Appendix C</i>	
Depreciation (including Assets)	<i>From Appendix C</i>	
Promotion and advertising costs	<i>From Appendix C</i>	
Management Fees	<i>From Appendix C</i>	
Other	<i>From Appendix C</i>	
Total expenditure	<i>From Appendix C</i>	

Stakeholder

Stakeholder	Interest or Impact	Engagement Strategy	Progress Report
<i>From AWP</i>	<i>From AWP</i>	<i>From AWP</i>	

Further Comments

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[youtube.com: Carer Gateway](https://www.youtube.com/Carer-Gateway)

WW-ICSS-V1.2



Australian Government
Department of Health,
Disability and Ageing



20
24

25

Annual
Report



Welcome to the Department of Health, Disability and Ageing Annual Report 2024–25

The department's 2024–25 Annual Report provides a transparent account to the public and Parliament of the activities undertaken by the department throughout the financial year. We report against our planned performance expectations, as outlined in the *2024–25 Health and Aged Care Portfolio Budget Statements* and *2024–25 Corporate Plan*, providing readers with financial and performance information about the work undertaken to achieve our vision of better health and wellbeing for all Australians, now and for future generations.

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Acknowledgement of Country

We, the Department of Health, Disability and Ageing, proudly acknowledge the Traditional Owners and Custodians of Country throughout Australia, and pay respect to those who have preserved and continue to care for the lands and waters on which we live and work, and from which we benefit each day. We recognise the strengths and knowledge Aboriginal and Torres Strait Islander peoples provide to the health, disability and aged care systems and thank them for their ongoing contributions to those systems and the wider community. We extend this gratitude to all health, disability and aged care workers who contribute to improving health and wellbeing outcomes with, and for, First Nations peoples and communities.

Department of Health, Disability and Ageing Annual Report 2024–25

ISSN: 2204-5716 (Print)

ISSN: 2204-5724 (Online)

ISBN: 978-1-76007-100-4 (Print)

ISBN: 978-1-76007-101-1 (Online)

Publication number: DT0004931

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This Annual Report is available online at:
www.health.gov.au/resources/publications/department-of-health-annual-report-2024-25

Further information about the Department of Health, Disability and Ageing is also available online at: www.health.gov.au

Cover and Internal Design

Department of Health, Disability and Ageing

Printing

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Letter of Transmittal



Australian Government
**Department of Health,
 Disability and Ageing**

Secretary

The Hon Mark Butler MP
 Minister for Health and Ageing
 Minister for Disability and the National Disability Insurance Scheme
 Deputy Leader of the House

Parliament House
 CANBERRA ACT 2600

Dear Minister

I am pleased to present the Annual Report of the Department of Health, Disability and Ageing for the year ended 30 June 2025. This report has been prepared in accordance with section 46 of the *Public Governance, Performance and Accountability Act 2013*, for presentation to the Parliament.

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

- *National Health Act 1953* (**Appendix 3 – Processes Leading to the Pharmaceutical Benefits Advisory Committee Consideration – Annual Report for 2024–25**)
- *Industrial Chemicals Act 2019* (**Appendix 4 – Report on the operation of the Australian Industrial Chemicals Introduction Scheme for 2024–25**)
- *Public Governance, Performance and Accountability Rule 2014* (**Appendix 5 – Australian National Preventive Health Agency Financial Statements**)
- *Work Health and Safety Act 2011* (**Appendix 7 – Work Health and Safety**)
- *Environment Protection and Biodiversity Conservation Act 1999* (**Appendix 8 – Environment Protection and Biodiversity Conservation**)
- *Carer Recognition Act 2010* (**Appendix 9 – Compliance with the Carer Recognition Act 2010**)
- *Human Services (Medicare) Act 1973* and *Tobacco Plain Packaging Act 2011* (**Part 3.6 – External Scrutiny and Compliance**).

The department's fraud control arrangements comply with section 10 of the *Public Governance, Performance and Accountability Rule 2014* (for certification, refer **Part 3.1: Corporate Governance** of this Annual Report).

Yours sincerely

Blair Comley PSM

25 September 2025

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Secretary's Review

Blair Comley PSM

Welcome to the 2024–25 Annual Report for the Department of Health, Disability and Ageing. The new department name reflects the Machinery of Government changes that were announced on 13 May 2025, bringing responsibility for people living with disability and their carers into the portfolio.

During 2024–25, we achieved several key milestones and continued to support important reforms in:

- strengthening Medicare so it is affordable for Australians
- ensuring Australians have access to the best medicines, cheaper at the point of sale
- ensuring Australia is attracting and retaining a high-quality health workforce, and that they are working to their full scope of practice
- delivering a simpler, fairer and more targeted mental health system
- closing the gap on poor health outcomes for First Nations people
- enhancing the aged care system to better support older Australians.

Many policies and plans developed in recent years successfully transitioned into delivery during 2024–25.

Strengthening Medicare

An additional 29 Medicare Urgent Care Clinics were delivered from 1 July 2024. There are now 87 clinics across Australia which treated 1.1 million patient visits during the 2024–25 financial year.

Registrations for MyMedicare (which opened in October 2023) continued to rise during 2024–25. As at 30 June 2025, there were more than 3 million patients and 6,600 practices registered. MyMedicare is delivering greater continuity of care, improving management of chronic conditions by care teams and supporting better use of telehealth.

The best medicines, cheaper

New measures were implemented to further reduce the price of medicines for Australians. From 1 January 2025, Pharmaceutical Benefits Scheme (PBS) co-payments were frozen, meaning that the cost of medicines would not increase with indexation in 2025.

Changes to the PBS were underpinned by strategic agreements within the pharmacy sector, including approved pharmacies, the pharmacist profession, wholesalers, consumer groups, the community-controlled sector and other interested stakeholders.



Growing our health workforce

The Unleashing the Potential of our Health Workforce – Scope of Practice Review was released in November 2024. It found too many health professionals face restrictions which prevent them doing the full range of work for which they are qualified. The department established a taskforce in January 2025 to work with stakeholders on options to respond to this and other workforce reviews.

Public consultation was undertaken on the National Nursing Workforce Strategy and the National Allied Health Workforce Strategy. Final reports are expected later in 2025.

Initiatives to grow the general practitioner (GP) workforce saw close to 1,800 prevocational doctors start their Commonwealth-funded GP training in 2025 – a record high.

Mental health system

By the end of 2024–25, 38 of the 61 Medicare Mental Health Centres announced in May 2024 were open nationally, providing free, mental health information, services and supports. Tele-psychology and tele-psychiatry services were also announced in May 2024, to boost the clinical capacity of Medicare Mental Health Centres. Rural Health Connect will commence service delivery to Medicare Mental Health Centres via a phased approach from August 2025.

Closing the gap

Our efforts to improve the health and wellbeing of First Nations people focused on early intervention strategies, education programs, improving access to culturally safe health services and expanding the First Nations health workforce. We established a First Nations Governance Group to ensure the department and the sector are accountable for delivery by outcome.

Aged Care reform

The department advanced critical reforms for the aged care sector, including responding to the recommendations of the Royal Commission into Aged Care Quality and Safety. This included supporting wage increases for approximately 400,000 aged care workers after the Fair Work Commission's decisions on the Aged Care Work Value Case.

The new *Aged Care Act 2024* was passed by Parliament on 25 November 2024 after complex policy work and negotiations. The new Act emphasises the rights of older people receiving care, including the right to dignity, respect, and quality care. Commencement of the Act was deferred to 1 November 2025 to give providers more time to transition to the new arrangements.

The department also undertook extensive preparations in 2024–25 for the start of the new Support at Home aged care program which will also commence on 1 November 2025.

Disability and carers

With responsibility for Disability and Carers coming into the department from 13 May, it is important to acknowledge achievements in these areas in 2024–25.

Australia's Disability Strategy was updated to include 3 new targeted action plans as well as a revised data improvement plan. This followed a review of the strategy which was completed in late 2024.

The National Carer Strategy 2024–2034 was released on 10 December 2024, representing a 10-year commitment to the 3 million unpaid carers who provide vital support to family members, friends and loved ones every day. The strategy was designed and created with carers. It sets out a national agenda to recognise, value and empower carers with the support they need to participate fully in society and fulfil their caring role.

Australia's first National Autism Strategy was launched in January 2025, after consultation with autistic people, their families and carers, experts, researchers, and the broader disability sectors. It outlines a national approach to improving understanding and acceptance of autism and the almost 300,000 individuals diagnosed with autism living in Australia.

Significant progress was made on restoring the National Disability Insurance Scheme (NDIS) to its original intent. Changes to the *National Disability Insurance Scheme Act 2013* (NDIS Act) were passed in Parliament on 22 August 2024. The legislation enables reforms to planning based on needs assessments, more flexible budgets and clearer guidance on the supports participants can access.

Additional achievements

Another priority reform for the department was action to prevent and reduce the harms from tobacco smoking and vaping, especially among young people. New laws came into effect on 1 July 2024, with further changes on 1 October 2024. Importation and domestic manufacture of non-therapeutic vapes were banned. Enforcement efforts by the Therapeutic Goods Administration (TGA) and Australian Border Force (ABF) have led to the seizure of more than 9.5 million vaping products, between 1 January 2024 to the end of June 2025.

Progress was also made in discussions with the states and territories on a new National Health Reform Agreement to support investment in public hospitals, ease pressure on emergency departments and help clear elective surgery backlogs.

Considerable work continued to reduce inequity in the health system for women. A new package of measures announced in February 2025 included funding for 11 new Endometriosis and Pelvic Pain Clinics, taking the total to 33. Changes to Medicare and the PBS also improved access to contraception and menopause care and treatments.

Implementation of the capability review

Our response to the capability review continued within the department. The priority has been on lifting our strategic policy capability, deepening our engagement with the community and stakeholders, and unlocking our Executive Leader potential.

Looking ahead

Bringing responsibility for disability, carers and the NDIS into the portfolio is a significant change for the years ahead. It brings opportunities to improve the experience of people living with disability across the health, aged care and disability sectors. A more connected approach to improvements across each sector will strengthen their ability to keep pace with the needs of Australians for generations to come.

I also take this opportunity to thank and farewell colleagues from the Office for Sport who moved to the Department of Infrastructure, Transport, Regional Development, Communication, Sport and the Arts under the machinery of government changes. We will continue to work closely with them to advance participation in sport, noting the benefits this has for the health and wellbeing of Australia.

I acknowledge the work and dedication of all department staff through 2024–25. Together, we will continue to deliver on important reforms to the health, disability and aged care sectors, to improve performance in terms of both outcomes and value for money.



Blair Comley PSM
Secretary



Chief Medical Officer's Report

Professor Michael Kidd AO

Introduction

This financial year was a period of transition for the position of Chief Medical Officer (CMO). In October 2024, Professor Paul Kelly retired from the role and also as Head of the Interim Australian Centre for Disease Control (CDC).

Professor Tony Lawler, Deputy Secretary of the Health Products Regulation Group, took over as CMO in October 2024. At the same time, responsibility for the Interim Australian CDC moved to Deputy Secretary Mary Wood.

I took up the position of CMO on 1 June 2025. This report, therefore, covers activities under the leadership of all 3 incumbents over the course of the year. I thank my predecessors for their dedication and achievements during 2024–25.

Role of the CMO

I chair the Australian Health Principal Committee (AHPC) which includes the Chief Health Officer from each state and territory. In 2024–25 the AHPC met 10 times, focusing on respiratory diseases, mpox, syphilis, Japanese Encephalitis Virus (JEV), and preparations for Highly Pathogenic Avian Influenza. The committee provided advice to governments on mpox and syphilis and supported the development of the *National Immunisation Strategy for Australia 2025–2030*, which was released in June 2025.

The National Health Emergency Management Sub-committee (NHEMS), a subcommittee of the AHPC, was involved in assisting Australians return safely from the Middle East in October 2024. Additionally, the NHEMS Australian Medical Assistance Teams were deployed twice during the year, providing emergency health response to the Vanuatu Earthquake in December 2024 and Myanmar Earthquake in April 2025.

In September 2024, the CMO delivered a statement to the United Nations General Assembly High-Level Meeting on Antimicrobial Resistance, calling for immediate action to address this significant threat. The meeting subsequently approved a declaration setting clear targets and actions to address Antimicrobial Resistance and reduce the estimated 4.95 million human deaths associated with it.

The CMO also played an increasing role in developing and bringing together medical officers across the department. Professional development for medical officers has been boosted and an orientation course for new medical officers is helping them to make the shift from clinical to public service roles.



Interim Australian CDC

During 2024–25, preparatory work continued to establish an Australian CDC as an independent statutory agency, including defining its roles, responsibilities, governance and accountabilities.

The independent COVID-19 Response Inquiry report, released in October 2024, found that many of the gaps identified and lessons learned from the COVID-19 pandemic could be addressed by establishing a new agency dedicated to disease prevention and control.

The department worked closely with states and territories and other stakeholders to understand how the agency could best work as a national public health institution. Dedicated One Health and Health Security units were created, reflecting the centrality of the One Health approach to the agency's work.

In May 2025, the Interim Australian CDC conducted *Exercise Heavy* with the AHPC and NHEMS. The exercise simulated national coordination during a significant medicines supply chain disruption, confirming that events other than disease outbreaks can constitute a national health emergency.

Work continued to implement the National Health and Climate Strategy which aims to achieve healthy, climate-resilient communities, and a sustainable, resilient, high-quality, net zero health system.

Public Health Issues

Vaccination and infectious diseases

Vaccination coverage continued to decline across multiple vaccines and population groups in 2024–25, especially First Nations peoples. For children aged one, 2 and 5 years, Australia has fallen below the 95% threshold which is critical for maintaining herd immunity. Our research indicates this is due to a number of factors including vaccine fatigue, reduced confidence in childhood immunisation, misinformation and competing demands on parents.

The *National Immunisation Strategy for Australia 2025–2030* aims to help increase and sustain immunisation uptake in Australia over the next 5 years.

By the end of 2024–25, 8.1 million Australians had received a 2025 influenza vaccination, a 2.1% increase compared to the previous year.

Measles

After a substantial decline in measles cases during the COVID-19 pandemic, 83 measles notifications were reported in Australia in the first half of 2025. This follows 57 notifications in the 2024 calendar year and reflects a return to pre-pandemic levels of international travel and large measles outbreaks overseas. The Interim Australian CDC monitors global measles activity and, with the Communicable Diseases Network Australia, routinely monitors cases in Australia.

Mpox

Mpox is an infectious disease caused by the monkeypox virus. In 2024, 1,409 cases of mpox were notified in Australia, peaking in September. Following the World Health Organization's declaration of a Public Health Emergency of International Concern in August 2024, the CMO activated the National Incident Centre to coordinate Australia's response. The response has included the procurement of 2 mpox vaccines and the use of antiviral treatments for selected cases. In 2025, the number of mpox cases dropped significantly, with only 148 cases notified to 30 June 2025. No deaths have been recorded during 2024–25.

Tuberculosis

The rate of tuberculosis cases in Australia remained among the lowest in the world. More than 90% of cases were reported among people born overseas in 2024–25. The disease does, however, have a disproportionate impact on Aboriginal and Torres Strait Islander people and communities.

The Interim Australian CDC worked with the AHPC and its sub-committees to improve long-term outcomes for communities impacted by outbreaks, and to improve access to medicines for priority populations.

Syphilis

2024 saw a slight improvement in the number of infectious and congenital syphilis cases in Australia, down from record highs in 2023. The AHPC coordinated a national response, and progress was made toward updating national guidelines with relevance for syphilis prevention, testing and management, in alignment with priority actions in the *National Syphilis Response Plan 2023–2030*.

Japanese encephalitis virus

Japanese encephalitis is a nationally notifiable disease. There were 6 confirmed human locally acquired JEV infections notified to the National Notifiable Diseases Surveillance System in the first quarter of 2025. The Interim Australian CDC worked closely with state and territory health and animal health departments to monitor the risk of JEV in Australia. This included updating public health advice for the community and health professionals, as well as reviewing vaccine eligibility criteria through the Communicable Diseases Network Australia.

Other health issues

On 12 December 2024, the Australian Government responded to the Senate Community Affairs References Committee into the assessment and support services for people with Attention Deficit Hyperactivity Disorder (ADHD).

In early 2025, the CMO, Therapeutic Goods Administration and the Commonwealth Chief Psychiatrist met with representatives of all states and territories to discuss the issues, achieving agreement on the need for a nationally consistent approach to ADHD prescribing. In June, Health Ministers acknowledged that a uniform approach would improve access and affordability. Work in this area will continue to be a priority in 2025–26.

Global supply chain issues created shortages of vital intravenous (IV) fluids in Australia's health care system in 2024–25. This was exacerbated in September 2024 when Hurricane Helene forced the closure of the largest manufacturing facility in the United States. To combat this, the Australian Government launched the IV Fluids Program in March 2025, including investment in Australia's largest and only onshore domestic manufacturer.

In February 2025, new regulations came into effect allowing the Gene Technology Regulator to undertake inspections and audits of laboratories in Australia that hold poliovirus. In May 2025, the Interim Australian CDC agreed to provide qualified inspectors for the audit of Australia's designated Poliovirus Essential Facility. This will ensure inspections are conducted in accordance with international standards and by appropriately trained personnel.

Australia's National Microbial Genomics Framework for Public Health was also updated in 2024–25, informed by extensive stakeholder consultation. This included engagement with public health laboratories, communicable disease experts, jurisdictional health departments, and national governance bodies. It provides a consistent, national and strategic approach to integrating microbial genomics into the Australian public health system, while also identifying key policy issues and challenges requiring coordinated attention. The AHPC will continue to provide advice on implementation of the framework, ensuring ongoing national consistency and transparency.

My predecessors as CMO have played an active role in helping to address workforce shortages across the health system, and I continue to do this. This includes working with universities, specialist medical colleges and regulatory bodies on implementation of the National Medical Workforce Strategy and new pathways for specialist international medical graduates to work in Australia. I am focused on upholding standards and supporting policies and programs that distribute Australian trained doctors to the specialties and locations most needed.





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Part 1:

About the Department

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This document has been released under the Freedom Of Information Act 1982 by the Department of Health, Disability and Ageing

Part 1.1: Health, Disability and Ageing Portfolio¹

The Health, Disability and Ageing Portfolio includes 17 entities and 4 statutory office holders. These entities help us deliver the Australian Government's health, disability and aged care policies and programs.

As at 30 June 2025, the following Ministers were responsible for the Health, Disability and Ageing Portfolio and its entities.

Minister for Health and Ageing	The Hon Mark Butler MP
Minister for Disability and the National Disability Insurance Scheme	
Minister for the National Disability Insurance Scheme	Senator the Hon Jenny McAllister
Minister for Aged Care and Seniors	The Hon Sam Rae MP
Assistant Minister for Mental Health and Suicide Prevention	The Hon Emma McBride MP
Assistant Minister for Rural and Regional Health	
Assistant Minister for Health and Aged Care	The Hon Rebecca White MP
Assistant Minister for Indigenous Health	
Assistant Minister for Women	
Special Envoy for Men's Health	Mr Dan Repacholi MP

¹ Following the Machinery of Government changes, the Department of Health and Aged Care was renamed the Department of Health, Disability and Ageing taking effect from 13 May 2025.

Changes in ministerial responsibilities during the reporting period

- From 1 July 2024 until 28 July 2024, Senator the Hon Malarndirri McCarthy held the position of Assistant Minister for Indigenous Australians and Assistant Minister for Indigenous Health.
- From 1 July 2024 until 13 May 2025, The Hon Anika Wells MP held the position of Minister for Aged Care and Minister for Sport.
- From 1 July 2024 until 13 May 2025, The Hon Ged Kearney MP held the position of Assistant Minister for Health and Aged Care.
- From 28 July until 13 May 2025, Senator the Hon Kate Thwaites held the position of Assistant Minister for Ageing.



Part 1.2: Portfolio Structure

As at 30 June 2025, the Health, Disability and Ageing Portfolio consisted of:

Department of State

Department of Health, Disability and Ageing

Secretary: Blair Comley PSM²

Portfolio Entities

Aged Care Quality and Safety Commission	Commissioner Liz Hefren-Webb
Australian Commission on Safety and Quality in Health Care	Chief Executive Officer Conjoint Professor Anne Duggan
Australian Digital Health Agency	Chief Executive Officer Amanda Cattermole PSM
Australian Hearing Services (Hearing Australia)	Managing Director Kim Terrell
Australian Institute of Health and Welfare	Chief Executive Officer Dr Zoran Bolevich
Australian Radiation Protection and Nuclear Safety Agency	Chief Executive Officer Dr Gillian Hirth AO
Cancer Australia	Chief Executive Officer Professor Dorothy Keefe PSM MD
Food Standards Australia New Zealand	Chief Executive Officer Dr Sandra Cuthbert
Independent Health and Aged Care Pricing Authority	Chief Executive Officer Professor Michael Pervan
National Blood Authority	Chief Executive Officer John Cahill
National Disability Insurance Agency	Chief Executive Officer Rebecca Falkingham
National Health Funding Body	Chief Executive Officer Shannon White
National Health and Medical Research Council	Chief Executive Officer Professor Steve Wesselingh
NDIS Quality and Safeguards Commission	Commissioner Louise Glanville
Office of the Inspector-General of Aged Care	Inspector-General Natalie Siegel-Brown
Organ and Tissue Authority (Australian Organ and Tissue Donation and Transplantation Authority)	Chief Executive Officer Lucinda Barry AM
Professional Services Review	Director Associate Professor Antonio Di Dio

² Mr Blair Comley PSM was the department's accountable authority for the period of this report.

Statutory Office Holders

Aged Care Quality and Safety Commissioner	Liz Hefren-Webb
Australian Industrial Chemicals Introduction Scheme	Executive Director Graeme Barden
Office of the Gene Technology Regulator	Dr Raj Bhula
Office of the National Rural Health Commissioner	Professor Jenny May AM



Part 1.3: Departmental Overview

The Department of Health, Disability and Ageing is a Department of State.

Our History

The department's origins date back to 1921, when the Department of Health was first established in response to the Spanish influenza pandemic. Over the past century, it has evolved through various restructures and name changes, adapting to the changing health and social needs of Australians.

In May 2025, a machinery of government established the Department of Health, Disability and Ageing, expanding the former Department of Health and Aged Care. This change reflects the Australian Government's commitment to a more integrated and inclusive approach to health, disability, and ageing policy. The department now leads national efforts in delivering high-quality health care, aged care services, and disability support, including the administration of Medicare, the Pharmaceutical Benefits Scheme, and the National Disability Insurance Scheme. The 2025 rebranding marks a significant milestone in the department's history, unifying key portfolios to better support Australians across all stages of life and ability.

Our Vision

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

Our Purpose

We support the Government to lead and shape Australia's health, disability and aged care systems and outcomes through evidence-based policy, well targeted programs, and best practice regulation.



Part 1.4: Department-Specific Outcomes

Outcomes are the government's expected results, benefits or consequences for the Australian community. The government requires the department to use outcomes as a basis for budgeting, measuring performance and reporting. Annual administered funding is appropriated on an outcome basis.

Listed below are the outcomes relevant to the department, and the programs managed under each outcome in 2024–25.

<p>Outcome 1: Health Policy, Access and Support</p>	<p>1.1: Health Research, Coordination and Access 1.2: Mental Health 1.3: First Nations Health 1.4: Health Workforce 1.5: Preventive Health and Chronic Disease Support 1.6: Primary Health Care Quality and Coordination 1.7: Primary Care Practice Incentives and Medical Indemnity 1.8: Health Protection, Emergency Response and Regulation 1.9: Immunisation</p>
<p>Outcome 2: Individual Health Benefits</p>	<p>2.1: Medical Benefits 2.2: Hearing Services 2.3: Pharmaceutical Benefits 2.4: Private Health Insurance 2.5: Dental Services 2.6: Health Benefit Compliance 2.7: Assistance through Aids and Appliances</p>
<p>Outcome 3: Ageing and Aged Care</p>	<p>3.1: Access and Information 3.2: Aged Care Services 3.3: Aged Care Quality</p>
<p>Outcome 4³: Disability and Carers</p>	<p>4.1 Disability and Carers 4.2 National Disability Insurance Scheme</p>

³ On 13 May 2025, through Machinery of Government changes, the department's previous work in Sport and Physical Activity was moved to the Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts. Details about this work will appear in their 2024–25 Annual Report. The department's new Outcome 4 – Disability and Carers, includes responsibilities that were transferred from the Department of Social Services, which are covered in this Annual Report.



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the Department of Health, Disability and Ageing

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Part 2:

Annual Performance Statements

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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

Outcome	Summary of results against performance criteria			
	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	<p>The data source Numerator and Denominator were updated to reflect the date the data was extracted. The methodology was updated to include:</p> <ol style="list-style-type: none"> Numerator: Reporting financial year service data, rather than a lagged reference period of 1 April to 31 March. 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	<p>The Performance Measure was updated to reflect <i>Patients using Medicare-subsidised mental health services per 100,000 population</i>. This update better reflects the proportion of the population who are receiving mental health support through the Medicare Benefits Schedule (MBS).</p> <p>The data source Numerator and Denominator were updated to reflect the date the data was extracted. The methodology was updated to include:</p> <ol style="list-style-type: none"> Numerator: Reporting the number of patients who received Medicare-subsidised mental health care services, rather than the number of services used. 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	<p>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:</p> <ol style="list-style-type: none"> 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. 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	<p>The 2024–25 planned performance target was updated to confirm the design phase relates to the National Suicide Prevention Outcomes Framework.</p>

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	<p>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.</p> <p>The data source and methodology has been updated for 1.3A to further enhance detail around the methodology.</p>
1.4A – Health Workforce	<p>The data source has been revised for measure e. to confirm the sources that inform this measure.</p>
1.5A – Preventive Health and Chronic Disease Support	<p>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.</p>
1.5B – Preventive Health and Chronic Disease Support	<p>The data source and methodology were updated to refine the National Bowel Cancer Screening Program and the National Cervical Screening Program screening results process.</p>
1.5C – Preventive Health and Chronic Disease Support	<p>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.</p>
1.6B – Primary Health Care Quality and Coordination	<p>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.</p>
1.8A – Health Protection, Emergency Response and Regulation	<p>The planned performance target for 2024–25 was updated from 98% to 100%.</p> <p>The methodology was updated to include a reference to the <i>Therapeutic Goods Act 1989</i>.</p>
2.5A – Dental Services	<p>The methodology was updated to confirm the measure reports the total number of eligible notified children.</p>
3.2D – Aged Care Services	<p>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.</p>
4.2A – National Disability Insurance Scheme	<p>The methodology was updated to reflect full scheme agreements in place with all states and territories.</p>
4.2D - National Disability Insurance Scheme	<p>The data source was updated for the ‘Legislative amendments developed for government’ measure that inform the measure.</p>

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

Program	Summary of results against performance criteria			
	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 billion⁵ long-term investment supporting Australian health and medical research and innovation. Under the MRFF 3rd 10-year Investment Plan⁶, 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 Board¹¹ 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 *Australian 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 2020–25¹³ (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

- 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.

2024–25 Result

- 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 Plan¹⁷ (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 Opportunities¹⁸ covering each theme under the MRFF 3rd 10-year Investment Plan. Grant opportunity guidelines and the forecast calendar¹⁹ are published on GrantConnect²⁰ and on the department's website²¹, 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 NHMRC²² and the BGH²³ 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 Account²⁴ 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:

- 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.
- 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:

$100,000 \times (\text{Numerator} \div \text{Denominator})$

- **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-Referral 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:

$100,000 \times (\text{Numerator} \div \text{Denominator})$

- **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.

headspace⁴⁴ 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.

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

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

2024–25 Planned Performance

Design phase of the National Suicide Prevention Outcomes Framework to be completed 30 June 2025.⁵⁰

2024–25 Result

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.

Result: Achieved ●

Data Source and Methodology:

Date of release.

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 Suicide⁵³ 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 Programme⁵⁴ 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 Reforms⁵⁸ 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

47%

2024–25 Result

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 Choices⁶⁶ 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 billion⁶⁷ 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.

- Full time equivalent (FTE) Primary Care General Practitioners (GPs) per 100,000 population.⁷⁰
- FTE non-general practice medical specialists per 100,000 population.⁷¹
- FTE primary and community nurses per 100,000 population.⁷²
- FTE primary and community allied health practitioners per 100,000 population.⁷³
- 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 Program⁷⁷ 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 2017–2026⁸⁰ (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 2021–2030⁸² 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 Program⁸⁸ 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.

- Percentage of adults who are daily smokers.
- Percentage of population who drink alcohol in ways that put them at risk of alcohol related disease or injury.
- 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%.	a. 10.7%	a. 10.6%	a. 10.1%
b. Progressive decrease of harmful alcohol consumption towards <28.8%.	b. 30.7%	b. 30.7%	b. N/A ⁹⁹
c. Progressive decrease of recent illicit drug use towards <13.94%.	c. 17.9%	c. 17.9%	c. 17.9%
	Result: Not achieved ○		

Disclosures:**2024–25 Result:**

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

⁹⁹ 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 Platform⁹⁴
- 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.

- Prevalence of insufficient physical activity amongst children, adolescents, and adults.
- Prevalence of obesity in adults (18+).
- 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
<ol style="list-style-type: none"> Progressive decrease of prevalence towards 15%. Progressive decrease of prevalence. Progressive decrease towards a reduction of prevalence by at least 5%. 	<ol style="list-style-type: none"> 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. 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. 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 <input type="radio"/>

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/m² 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 <input type="radio"/>			

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

1,107,913¹⁰⁶

2024–25 Result

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.

¹⁰⁶The 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) ●

Data 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 Care¹¹¹ (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 <input type="radio"/>		

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 Report¹¹⁸ which is published on the OGTR website¹¹⁹ 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 <input type="radio"/>			

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 $\geq 98\%$. 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
$\geq 95\%$	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.

This document has been released under
the Freedom Of Information Act 1982 by
the Department of Health, Disability and Ageing

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 2025–2030¹²⁸ 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 $\geq 95\%$, 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 $\geq 90\%$ 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 vaccination¹³¹ 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

Program	Summary of results against performance criteria			
	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.pdf, 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 Australia¹³⁵ 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.

