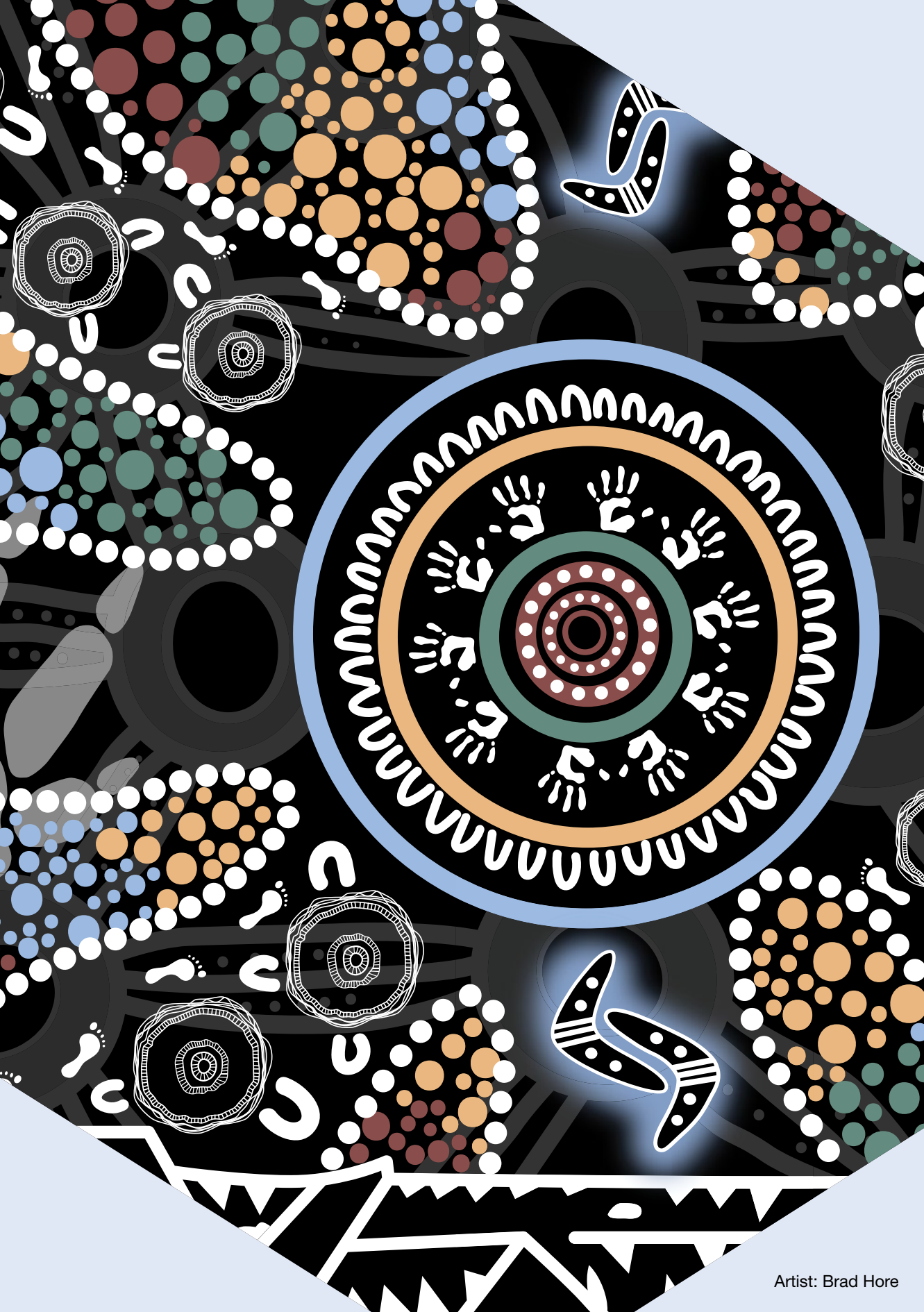
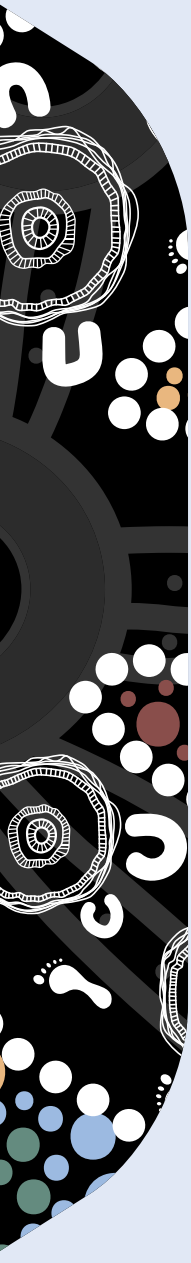
Australian Government

Department of Health, Disability and Ageing

Annual Report 2025–26



Artist: Brad Hore



Welcome to the Department of Health, Disability and Ageing Annual Report 2025–26

This report details the activities and performance of the Department of Health, Disability and Ageing for the financial year 2025–26. We report against our planned performance expectations, as outlined in the 2025–26 Health and Aged Care Portfolio Budget Statements and the 2025–26 Health, Disability and Ageing Corporate Plan.
This report has been prepared to meet legislated reporting requirements under section 46(1) of the *Public Governance, Performance and Accountability Act 2013*.

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, Aboriginal and Torres Strait Islander peoples and communities.

Department of Health, Disability and Ageing Annual Report 2025–26

ISSN: 2204-5716 (Print)

ISSN: 2204-5724 (Online)

ISBN: 978-1-76007-908-6 (Print)

ISBN: 978-1-76007-909-3 (Digital)

Publication number: DT0005232

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Contact Information

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

The Editor

Annual Report 2025–26

Australian Government

Department of Health, Disability and Ageing

GPO Box 9848

CANBERRA ACT 2601 AUSTRALIA

Email: **annrep@health.gov.au**

This Annual Report is available online at: **www.health.gov.au/resources/publications/department-of-health-and-aged-care-annual-report-2025-26**

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

National Mailing and Marketing Pty Limited

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 financial year ended 30 June 2026.

This report has been prepared under section 46 of the Public Governance, Performance and Accountability Act 2013 (PGPA Act), which requires that an annual report be given to the entity's responsible Minister for presentation to the Parliament.

This report also includes additional requirements that are specified in the enabling legislation, including the:

- *National Health Act 1953* **(Appendix 3 – Processes Leading to the Pharmaceutical Benefits Advisory Committee Consideration – Annual Report for 2025–26**)
- *Industrial Chemicals Act 2019* **(Appendix 4 – Report on the operation of the Australian Industrial Chemicals Introduction Scheme for 2025–26)**
- *Work Health and Safety Act 2011* **(Appendix 6 – Work Health and Safety)**
- *Environment Protection and Biodiversity Conservation Act 1999* **(Appendix 7 – Environment Protection and Biodiversity Conservation)**
- *Carer Recognition Act 2010* **(Appendix 8 – Compliance with the Carer Recognition Act 2010)**
- *Human Services (Medicare) Act 1973* **(Part 3.6 – External Scrutiny and Compliance)**
- *Public Health (Tobacco and Other Products) Act 2023* **(Part 3.6 – External Scrutiny and Compliance)**
- *Aged Care Act 2024* **(Part 3.6 – External Scrutiny and Compliance)**
- *Future Made in Australia Act 2024* **(Part 3.6 – External Scrutiny and Compliance)**.

This report includes the entity's audited annual financial statements as required by subsection 43(4) of the PGPA Act. It also includes the entity's annual performance statements as required under section 39 of the PGPA Act.

In accordance with section 10, and as required by subsection 17AG(2), of the Public Governance, Performance and Accountability Rule 2014, I certify that:

- the department prepared fraud and corruption risk assessments and fraud and corruption control plans
- the department had appropriate mechanisms to prevent, detect, investigate, record and confidentially report suspected fraud and corruption
- I took all reasonable measures to appropriately deal with fraud relating to the department.

Yours sincerely



Blair Comley PSM
25 September 2026

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Secretary's Review



Blair Comley PSM

I am pleased to present the 2025–26 Annual Report for the Department of Health, Disability and Ageing.

This year marked an important step in the department's evolution. Bringing together health, aged care and disability policy opens opportunities to improve system connections and support better access and outcomes for Australians. Our focus in this first year has been strengthening the foundations for this expanded role while continuing to deliver major reforms.

The department is operating in a dynamic environment with population ageing, increasing rates of chronic conditions and changing consumer expectations driving care needs and demand. We can see the opportunities to improve integration and harness advances in digital technology, health and medical science, and care delivery. We are pursuing these in the context of global supply chain disruptions and emerging disease threats, requiring ongoing surveillance and risk planning.

Within the department, we have focused on increasing our capability to deliver evidence-based policy, collaboration, and purposeful innovation. The capability of our workforce continues to grow and expand, supporting us to effectively steward the systems for which we are responsible.

Progress in our key areas of reform and delivery is outlined below.

Strengthening Medicare

We partnered with state and territory governments and Primary Health Networks to deliver a further 50 Medicare Urgent Care Clinics. This completed the planned network of 137 Clinics, which will now be a permanent fixture in the primary care system. There have been more than 3.3 million presentations to Medicare Urgent Care Clinics by the end of June 2026, improving access to primary care and reducing pressure on emergency departments.

The 2025–26 Budget expanded eligibility for general practitioner (GP) bulk billing incentives to cover all Australians from 1 November 2025. It also established the Bulk Billing Practice Incentive Program, which supports GPs to bulk bill all Medicare-eligible patients for eligible services. As a result, bulk billing rates have started to recover.

More than 3,800 general practices had registered with the program by 30 June 2026, committing to expanded bulk billing.

Delivering cheaper and better medicines

We exceeded our target for new Pharmaceutical Benefits Scheme (PBS) listings in 2025–26. All new medicines recommended by the Pharmaceutical Benefits Advisory Committee were listed within 6 months of agreement with sponsor companies.

Access to 60-day prescriptions continued to expand to new medications, allowing patients to receive 2 lots of medication for one script.

From 1 January 2026, the maximum cost of PBS prescription medicines for general patients was reduced from $31.60 to $25. Alongside this, a freeze on the concessional co-payment will see the maximum cost remain at $7.70 until 2030.

Together, these measures make more medicines even more affordable for millions of Australians.

Aged care reform

Major reforms to aged care continued this year, including the new Aged Care Act and the Support at Home program rolled out on 1 November 2025. We also launched the redesigned My Aged Care website on 1 November 2025 to coincide with the commencement of the new legislation.

The Single Assessment System launched in December 2024. Over 550,000 assessments were completed nationally across all aged care need types in 2025–26 – the highest number for any year. This was achieved at a time when assessment organisations had to train staff and transition to new systems.

The Residents' Experience Survey reflects the lived experiences of older people in residential aged care. The 2025 survey sample size was lifted from 10 to 20% of residents to make it more representative. The overall survey score increased to 86.3%, from 85.3%, indicating greater satisfaction among residents.

These results are published on the enhanced My Aged Care website and contribute to each residential aged care service's Star Ratings.

We supported the Fair Work Commission's decision on the aged care industry's work value case through funding increases. Registered and enrolled nurses working in aged care, and other aged care workers, received another award wage increase from 1 October 2025.

Disability and carers

The addition of disability policy and functions to the portfolio, including the National Disability Insurance Scheme (NDIS), united key care and social systems.

Our role is to support system-level stewardship and governance, in conjunction with the states and territories.

Our work on NDIS integrity measures culminated in the passing of the *NDIS Amendment (Integrity and Safeguarding) Act 2026* in April. This expanded the NDIS Quality and Safeguards Commission's powers and introduced a clearer definition of what could be funded by the NDIS.

Fraud and integrity measures were also expanded, including the Fraud Fusion Taskforce and the Crack Down on Fraud program.

A plan to restore the NDIS to its original intent of supporting people with permanent and significant disability was announced in April. We will continue to implement the plan to secure the Scheme for future generations.

Our strong and productive partnership with the National Disability Insurance Agency and the NDIS Quality and Safeguards Commission, will help drive further reform and improve outcomes for people with disability.

Growing our health workforce

Increasing the national health workforce to meet Australians' growing health care needs remains a priority.

This year saw substantial growth in numbers in general practice, nursing, midwifery and allied health practitioners. These increases were experienced across all city and rural areas, driven by investments and reforms to improve supply, distribution and use of the health workforce.

The GP workforce grew through better entry, training and retention pathways. These included expansion of the Australian General Practice Training program and introduction of the GP Training Incentive Payments for GP and rural generalist registrars. Reform of the Bonded Medical Program also improved long-term distribution by directing Australian-trained medical practitioners to areas of need.

Reforming our mental health system

Evidence shows that mental health is an ongoing challenge in Australia, particularly among young people. In response, reforms to the national mental health system have continued to improve access across the continuum of care.

More than 264,000 care sessions were provided through Medicare Mental Health Centres across 2025–26. We developed a further 16 centres in partnership with Primary Health Networks, bringing the total to 55 and progressing towards the target of 92 by June 2030.

The new national digital Medicare Mental Health Check In service launched on 1 January, filling a long-standing service gap for people with less critical needs. It expanded in May to a full-service model, allowing people to work through low-intensity cognitive behavioural therapy independently or guided by a qualified mental health practitioner.

We established 3 new headspace services for young people aged 12 to 25 years bringing the total to 175 services nationally, including 94 in regional Australia. headspace services had more than 645,800 client contacts during the year.

Closing the Gap on First Nations health

We are committed to transitioning as many services as possible that are delivered through non-Indigenous organisations to Aboriginal Community Controlled Health Organisations (ACCHOs).

This year, the percentage of annual Indigenous Australians' Health Programme funding directed to ACCHOs rose to 77%, exceeding our target. ACCHOs used this funding to deliver culturally safe care across a range of population health programs and clinical services, tailored to community needs.

Additional achievements

On 1 January 2026, the Australian Centre for Disease Control (CDC) became a permanent and independent entity with responsibility for monitoring and assessing public health risks and preparing Australia for emerging crises.

The department remains responsible for national operational responses to public health threats. The department and the CDC have worked closely to respond to risks posed by international outbreaks of hantavirus and Ebola, and the re-emergence of diphtheria in Australia.

We also activated the department's National Incident Centre to coordinate and prepare for potential health and care risks associated with the conflict in the Middle East.

Within the department

Within the department, we continued to modernise our workplace and digital systems, with a strong focus on sustainability.

We increased the use of artificial intelligence tools to support policy and operations. Copilot was rolled out on a trial basis to support operating efficiency before being released to all staff in June 2026, with a strong focus on safe, ethical and responsible use.

Looking ahead

Fiscal sustainability and better integration across aged care, disability and health systems are central to our delivery of government priorities next year. This will include a larger focus on NDIS reform, along with implementation of Thriving Kids.

We will continue our strong collaboration with state and territory governments, service providers, consumers, peak bodies and international partners, in the delivery of better systems of care and support.

Underpinning our achievements is the knowledge, dedication and innovation of our staff, who again made me proud to lead this department.



Blair Comley PSM
Secretary

01

Part 1:
About the Department

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Part 1.1: Health, Disability and Ageing Portfolio

The Health, Disability and Ageing Portfolio includes 18 entities and 5 statutory office holders. These entities help us deliver the Australian Government's health, disability and aged care policies and programs.

As at 30 June 2026, the following Ministers were responsible for the Health, Disability and Ageing Portfolio and its entities:

Minister for Health and Ageing Minister for Disability and the National Disability Insurance Scheme	**The Hon Mark Butler MP**
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 Assistant Minister for Rural and Regional Health	**The Hon Emma McBride MP**
Assistant Minister for Health and Aged Care Assistant Minister for Indigenous Health Assistant Minister for Women	**The Hon Rebecca White MP**
Special Envoy for Men's Health	**Mr Dan Repacholi MP**

Part 1.2: Portfolio structure

As at 30 June 2026, the Health, Disability and Ageing Portfolio consisted of:

Department of State

Department of Health, Disability and Ageing
Secretary: Blair Comley PSM[1]

Portfolio Entities

Aged Care Quality and Safety Commission	Commissioner Liz Hefren-Webb
Australian Centre for Disease Control[2]	Director-General Professor Zoe Wainer
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 Institute of Health and Welfare	Chief Executive Officer Dr Zoran Bolevich
Australian Radiation and 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
Hearing Australia	Managing Director Kim Terrell
Independent Health and Aged Care Pricing Authority	Chief Executive Officer Professor Michael Pervan
National Blood Authority	Chief Executive Officer Adjunct Professor Adriana Platona PSM
National Disability Insurance Agency	Chief Executive Officer Graeme Head AO
National Health and Medical Research Council	Chief Executive Officer Professor Steve Wesselingh
National Health Funding Body	Chief Executive Officer Shannon White
NDIS Quality and Safeguards Commission	Commissioner Louise Glanville

[1] The accountable authority of the Department of Health, Disability and Ageing for the reporting period was Mr Blair Comley PSM, Secretary.
[2] The Australian Centre for Disease Control was established on 1 January 2026.

Office of the Inspector-General of Aged Care	Inspector-General Natalie Siegel-Brown
Organ and Tissue Authority	Chief Executive Officer Lucinda Barry AM
Professional Services Review	Director Associate Professor Antonio Di Dio

Statutory office holders

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

Part 1.3: Departmental overview

Our history

The Commonwealth Department of Health was established on 7 March 1921. The government created the department in response to the devastating effects of the 1919 Spanish influenza pandemic. It was also shaped by the vision of Dr John Howard Cumpston, the first head of the department.

At first, we looked after quarantine, reporting infectious diseases, public health research laboratories, and occupational health. However, the *Pharmaceutical Benefits Act 1944* enabled the government to subsidise medications and establish programs such as Medibank, Medicare, and the Pharmaceutical Benefits Scheme. All of which Australians continue to access today.

We have continued to evolve, and have undergone a number of changes in name, function and structure through the years. In 2025, we expanded to include the disability portfolio. We now lead national efforts in delivering high-quality disability support, including the administration of the National Disability Insurance Scheme.

Our vision

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

Our purpose

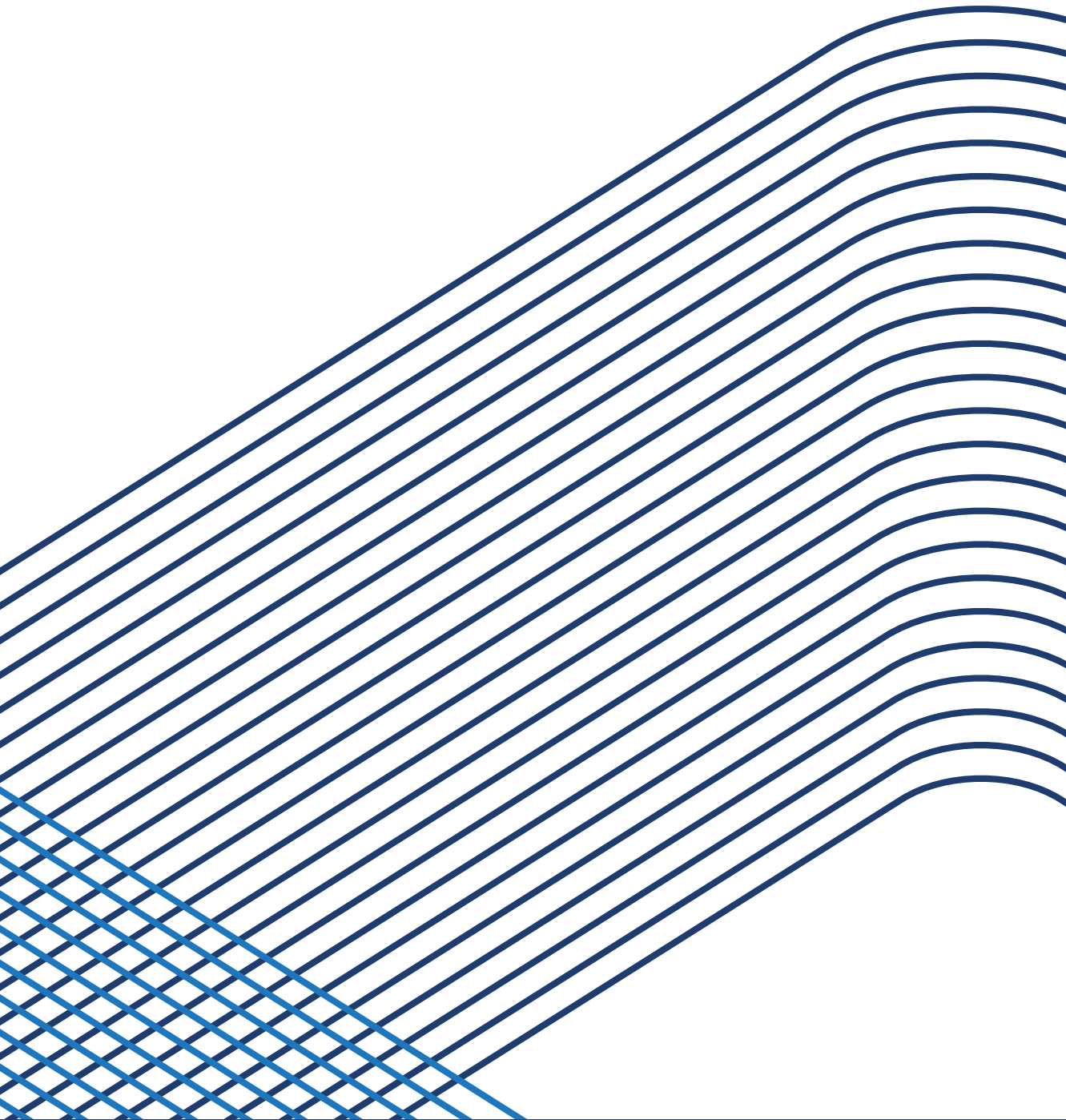
We support the government to lead and shape Australia's health, disability and aged care systems through evidence-based policy, well targeted programs and best practice regulation.

Part 1.4: Department-specific outcomes

Outcomes are the government's expected results, benefits or consequences for the Australian community. The government requires us to use outcomes as a basis for budgeting, measuring performance and reporting.

Our 2025–26 Corporate Plan outlined how we will achieve and measure the success of these key priorities.

Outcome 1: Health Policy, Access and Support	1.1 Health Research, Coordination and Access 1.2 Mental Health and Suicide Prevention 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
Outcome 2: Individual Health Benefits	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
Outcome 3: Ageing and Aged Care	3.1 Access and Information 3.2 Aged Care Services 3.3 Aged Care Quality
Outcome 4: Disability and Carers	4.1 Disability and Carers 4.2 National Disability Insurance Scheme (NDIS)



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Part 2: Annual Performance Statements

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Outcome 3: Ageing and Aged Care 94

Outcome 4: Disability and Carers 121

Part 2.1: 2025–26 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 2025–26 Annual Performance Statements for the department, as required under paragraph 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 (PGPA Rule). 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 2025–26 Annual Performance Statements. I am aware the ANAO has formed the view of limitations with the requirements of section 16EA of the PGPA Rule for components of certain measures.

The department remains committed to continuously improving its performance reporting processes.



Blair Comley PSM

Secretary
25 September 2026

Introduction

As required under the PGPA Act, this report contains the Department of Health, Disability and Ageing's Annual Performance Statements for 2025–26. The Annual Performance Statements detail results achieved against planned performance criteria set out in the Department of Health, Disability and Ageing 2025–26 Corporate Plan.

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 planned performance targets. Each chapter contains results and discussion against each planned performance target.

A materiality and completeness assessment was undertaken against the department's Outcomes and Programs to identify key activities to support the department's performance measurement and reporting process. The department's performance reporting materiality and completeness policy contains the following criteria to determine key activities:

- funding levels
- public and stakeholder interest
- impact on Health, Disability and Ageing.

Performance measures have been included for key activities in the reporting period. Further information about the departments work can be found at www.health.gov.au and through our Portfolio Agencies' websites.

The measurement and assessment of the key activities and performance measures as outlined in our 2025–26 Corporate Plan are aligned to our 2025–26 Annual Performance Statements. To enable a comparative analysis, the department has included prior year results back to the 2023–24 financial year where the performance information is consistent across the years.

Results Key

Achieved	The result achieved the planned performance for 2025–26.
Substantially achieved	The result substantially achieved the planned performance for 2025–26 (where applicable).
Not achieved	The result did not achieve the planned performance for 2025–26.
Data not available	Data is not available to report a result for the 2025–26 financial year.
Not applicable	For measures 1.1B, 1.2A, 1.2B, 2.2A and 2.5A the program is demand driven and did not set a planned performance target for the 2025–26 financial year. For 4.2B, the measure is on track with the planned performance target.

2025–26 departmental results overview

In 2025–26, there were a total of 43 performance measures with 62 planned performance targets.

	Summary of results against planned performance targets				
Outcome	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**	**Not applicable**
Outcome 1: Health Policy, Access and Support	12	12	4	-	3
Outcome 2: Individual Health Benefits	5	4	-	-	2
Outcome 3: Ageing and Aged Care	5	2	6	1	-
Outcome 4: Disability and Carers	3	-	2	-	1
Total: 62	**25**	**18**	**12**	**1**	**6**

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 43 performance measures, a total of 28 have disclosures.

Key changes for 2025–26

A summary of key changes to performance information following the publication of the 2025–26 Corporate Plan is provided below:[3,4]

Measure number/Program	Summary
1.4A, B and C – Health Workforce	Update to data sources for 1.4A, B and C to reflect the data period used to report the 2025-26 result.
1.5C – Preventive Health and Chronic Disease Support	Update to data source to confirm the source data for all planned performance targets is the National Cancer Screening Register.
1.8A – Health Protection, Emergency Response and Regulation	The methodology for the 2025-26 result has been updated to include clarity of the 6 measure components included. The changes do not impact the calculation of the result.
1.8D – Health Protection, Emergency Response and Regulation	The target for the 2025-26 period has been increased from 95% to 100% to align with the obligations of the Australian Industrial Chemicals Introduction Scheme (AICIS) under the *Industrial Chemicals Act 2019* and its historical performance.
2.3B – Pharmaceutical Benefits	Update to Substantially achieved and Not achieved categories in assessment scale. Substantially achieved: From '$7.00 to <$7.50' to '>$7.50 to $8.50'. Not achieved: From '<$7.00' to '>$8.50'. Update to data source to confirm the source data is claims data.
3.1A(a) – Access and Information	The 'Not achieved' category in the assessment scale has been updated to ensure full coverage of results' ranges. From: a. 55% to 59.9%. to: a. <60%.

[3] 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.

[4] As changes from the 2025–26 Health and Aged Care Portfolio Budget Statements were reported in the Department of Health, Disability and Ageing's 2025–26 Corporate Plan, the key changes in the 2025–26 Annual Performance Statements reconcile to the 2025–26 Corporate Plan.

Measure number/Program	Summary
3.1B – Access and Information	The 'Not achieved' category in the assessment scale has been updated to ensure full coverage of results' ranges. From: 70% to 79% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes. to: <80% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes.
3.2B(c) – Aged Care Services	The 'Substantially achieved' category in the assessment scale has been updated to N/A. The 'Not achieved' category in the assessment scale has been updated to: Average percentage of reported hours an RN was on-site and on duty is below 100.00%.
3.2C – Aged Care Services	The methodology was updated to reflect the commencement of the Support at Home program from 1 November 2025, which replaced the former Home Care Packages program under the *Aged Care Act 2024*.
3.2D(a) – Aged Care Services	The data source has been revised for component a., reflecting changes with the commencement of the Support at Home program from 1 November 2025, which replaced the former Home Care Packages program.
3.2D(b) – Aged Care Services	The 'Not achieved' category in the assessment scale has been updated to ensure full coverage of results' ranges. From: b. 840,000 to 849,999. to: b. <850,000.
4.2B – National Disability Insurance Scheme	Updates to assessment scale, data source and methodology to improve clarity and reflect the reporting against the Health, Disability and Ageing Portfolio Budget Statements 2026–27.
4.2C – National Disability Insurance Scheme	The data source has been revised to confirm the sources that inform this measure.

Outcome 1: Health Policy, Access and Support

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

Programs contributing to Outcome 1

	Summary of results against planned performance targets				
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**	**Not applicable**
Program 1.1: Health Research, Coordination and Access	2	-	-	-	1
Program 1.2: Mental Health and Suicide Prevention	-	-	-	-	2
Program 1.3: First Nations Health	1	1	-	-	-
Program 1.4: Health Workforce	-	3	-	-	-
Program 1.5: Preventive Health and Chronic Disease Support	2	8	-	-	-
Program 1.6: Primary Health Care Quality and Coordination	1	-	1	-	-
Program 1.7: Primary Care Practice Incentives and Medical Indemnity	1	-	-	-	-
Program 1.8: Health Protection, Emergency Response and Regulation	4	-	1	-	-
Program 1.9: Immunisation	1	-	2	-	-
Total	**12**	**12**	**4**	**0**	**3**

Program 1.1: Health Research, Coordination and Access

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, Disability and Ageing Corporate Plan 2025–26, p.29

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, Disability and Ageing Corporate Plan 2025–26, p.29

2025–26 Planned Performance	2025–26 Result	2024–25 Result
a. Disburse at least 99% of MRFF funds available in 2025–26 towards grants of financial assistance. b. 100% of grants awarded in 2025–26 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.	a. As at 30 June 2026, the program has disbursed 99.9% of MRFF funds available in 2025–26 towards grants of financial assistance. b. As at 30 June 2026, 100% of grants awarded in 2025–26 address one or more of the Australian Medical Research and Innovation Priorities in force.	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.[5]
	Result: a. Achieved b. Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. 99% of MRFF funds available in 2025–26 towards grants of financial assistance.
b. 100% of grants awarded in 2025–26 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.

Substantially achieved:

a. 94% to 98.99% of MRFF funds available in 2025–26 towards grants of financial assistance.
b. N/A.

Not achieved:

a. <94% of MRFF funds available in 2025–26 towards grants of financial assistance.
b. N/A.[6]

[5] 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.

[6] Under the *Medical Research Future Fund Act 2015*, the Health Minister must take into account the Australian Research and Innovation Priorities that are in force at the time. All MRFF research grants must therefore address one or more of the Australian Medical Research and Innovation Priorities.

Data Source:

For a. the data used for reporting is sourced from the department's Administered Reporting Information by Program (ARIP) system under Priority 4 (the MRFF) in 2025–26.

For b. the source data is held by the MRFF grant hubs, the National Health and Medical Research Council (NHMRC) and Business Grants Hub in their online grants management systems and is provided directly to the department.

Methodology:

For a. the data used for reporting is 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 b. the data used is the applications for funding provided directly to department by the NHMRC and BGH grant hubs. These applications describe the health priorities that will be addressed by the research should they be successful in obtaining funding.

The legislated purpose of the MRFF is to provide grants of financial assistance to support research and innovation 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). The Priorities are informed by national consultation and are publicly available.[7] This performance measure demonstrates the extent to which the department has achieved its legislated requirements under the MRFF Act. Under the MRFF 3rd 10-year Investment Plan[8] (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, ensuring that they address the Priorities.

Funding for grants commencing in 2025–26 was delivered through 23 grant opportunities across all themes of the MRFF 3rd 10-year Investment Plan. Grant opportunity guidelines and the forecast calendar are published on GrantConnect[9] and on the department's website.[10] This provides potential applicants with advance notice of opportunities.

The NHMRC[11] and the Business Grants Hub[12] provide services for the conduct and administration of MRFF grant opportunities. This includes management of grants, as agreed with the department. In 2025–26, the department continued to work collaboratively with the grant hubs to successfully deliver all grant opportunities as planned.

The department continued work with stakeholders in 2025–26 to improve alignment and co-ordination with the NHMRC's Medical Research Endowment Account through the joint NHMRC-MRFF committees. The Australian Government released the National Health and Medical Research Strategy[13] in May 2026. It provides national guidance to build on Australia's strengths in the health and medical research sector.

Consistent with the 2024–25 result, the department achieved the planned performance targets for 2025–26. The department disbursed 99.9% of the funding allocation for the patient, research missions, researchers and research translation themes under the MRFF 3rd 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.

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[7] Available at: **www.health.gov.au/our-work/mrff/about/strategy-and-priorities**

[8] Available at: **www.health.gov.au/our-work/mrff/about/10-year-investment-plan**

[9] Available at: **www.grants.gov.au/**

[10] Available at: **www.health.gov.au/our-work/mrff/grant-opportunities-calendar**

[11] Available at: **www.nhmrc.gov.au**

[12] Available at: **www.industry.gov.au/government-government/business-grants-hub**

[13] Available at: **www.health.gov.au/our-work/national-health-and-medical-research-strategy**

Reports and reviews on how the MRFF is performing against MRFF health Priorities, strategies and research include:

Financial assistance to support the Australian Medical Research and Innovation Priorities 2022–2024 (published August 2025)

The latest Report on MRFF activities and funding when the Australian Medical Research and Innovation Priorities 2022–2024 were in force is available at **www.health.gov.au/resources/publications/financial-assistance-to-support-the-australian-medical-research-and-innovation-priorities-2022-2024**

Statutory review of the *Medical Research Future Fund Act 2015* (published September 2025)

The Departments of Finance and Treasury have undertaken a statutory review of the MRFF Act. This occurred in consultation with the Department of Health, Disability and Ageing and the Future Fund Management Agency and is available at **www.health.gov.au/resources/publications/statutory-review-of-the-medical-research-future-fund-act-2015**

Review of the Medical Research Future Fund Dementia, Ageing and Aged Care Mission | Australian Government Department of Health, Disability and Ageing (published August 2025)

A report on the review of the Medical Research Future Fund's Dementia, Ageing and Aged Care Mission is available at **www.health.gov.au/resources/publications/review-of-the-medical-research-future-fund-dementia-ageing-and-aged-care-mission**

Medical Research Future Fund Report on Aboriginal and Torres Strait Islander health research and researchers – February 2026 (published February 2026)

A report on how the MRFF is supporting research to improve the health of Aboriginal and Torres Strait Islander people is available at **www.health.gov.au/resources/publications/medical-research-future-fund-report-on-aboriginal-and-torres-strait-islander-health-research-and-researchers-february-2026**

Key Activity 1.1B: Fund the National Blood Authority to provide a safe supply of blood and blood related products, and blood fractionation for the benefit of all Australians. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.31**	
Performance Measure 1.1B: Funds are provided to the National Blood Authority to deliver an uninterrupted national supply of blood and blood products that meet clinically appropriate demand. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.31**	
2025–26 Planned Performance	**2025–26 Result**
Program is demand driven.	Funding of $1.3 billion was provided to the National Blood Authority (NBA) as part of the 2025–26 Budget payments.
	Result: N/A
Data Source: The department's Financial Statements as reported in the Annual Report. **Methodology:** The department's Financial Statements will provide the total funds provided to the NBA in 2025–26 for the national supply of blood and blood related products under the Special Appropriation.	

The department provides policy advice and contributes to the agreement of the National Supply Plan and Budget each year, which determines the funding amount for the Program. The department also works with both the NBA and state and territory governments to reconcile the National Supply Plan and Budget each year. This process ensures the required funding is expended and refines the approach to determining the budget for following years.

Following the approval of the 2025–26 National Supply Plan and Budget by all health ministers, the department worked with the NBA and state and territory governments to monitor costs and global demand pressures to provide early and clear advice to all governments to enable fiscal planning.

Funding of $1.3 billion provided to the NBA by the department in 2025–26 effectively supported the NBA, under the National Blood Agreement,[14] to deliver an uninterrupted national supply of blood and blood products to meet clinically appropriate demand. Blood and blood products treat many health conditions and save the lives of patients, with one in three Australians needing blood at some point in their life. The performance measure is demand-driven, and funding was provided to the NBA to deliver an uninterrupted national supply of blood and blood products to meet clinically appropriate demand as part of the 2025–26 Budget payments. All governments continue to work collaboratively with the NBA to drive efficiencies and improvements in the delivery of blood and blood related products and services to achieve value for money.

More information on the outcomes of the activities of the NBA is available in the latest NBA Annual Report which can be found at: **www.blood.gov.au/annual-report**

The supply of blood and blood fractionation related products is safe and benefits Australians. The red blood cells, platelets and plasma are separated from blood donations and used individually depending on the condition required. Plasma is made into various products, such as immunoglobulin and albumin, using a process called blood fractionation. These products are used in surgery, to treat burns, immune disorders, susceptible contacts of certain infectious diseases, and to reduce the risk or severity of infection for people who have had certain transplants.

[14] Available at: **www.blood.gov.au/supply-system/supply-system**

Program 1.2: Mental Health and Suicide Prevention

Key Activity 1.2A: Facilitate the delivery of services for mental health across the continuum of care.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.32

Performance Measure 1.2A: Number of mental health service contacts.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.32

2025–26 Planned Performance	2025–26 Result
Program is demand driven.	Component A: There were 1,617,365 Primary Health Network-commissioned mental health service contacts. Component B: There were 264,184 Medicare Mental Health Centre (MMHC) service contacts. Component C: There were 645,862 headspace service contacts.
	Result: N/A

Disclosures:

The Australian Institute of Health and Welfare (AIHW) supports the department to assure the Primary Mental Health Care Minimum Data Set (PMHC MDS) data used for this measure and works with Primary Health Networks (PHNs) to support compliance with the department's PMHC MDS data requirements. To assist with interpretation of the measure data, note:

Component A: PHN-commissioned mental health service contacts may be under-reported due to some service providers being exempt from reporting data to the PMHC MDS.

Component B: MMHC service contacts are likely to be under-reported in the PMHC MDS for several reasons. The PMHC MDS only captures contacts delivered as part of a formal episode of care, meaning brief interventions and other contacts that are not linked to an active episode are not recorded. Service contacts may also be under-reported due to PMHC MDS reporting exemptions that apply to all interim services and two permanent services (one in South Australia and one in the Northern Territory).

Component C: Data is for service contacts ('occasions of service') for headspace Primary program (including the headspace Work and Study in Centres program). Data is sourced from official headspace National financial year data as published in their Annual Report (note that the 2025–26 headspace Annual Report will be published after the department's Annual Report).

The timing of PMHC MDS data extraction for the Annual Report affects reporting completeness. Data for components A and B was extracted on 22 July 2026. The PMHC MDS is updated daily as service contacts are entered or amended by PHNs or Service Providers. In addition, the AIHW's 2025 Data Quality Assessment of PMHC MDS data found that for 2024–25, 58% of service contacts had been uploaded within the required 31-day timeframe and 80% provided within 7 weeks.

Data Source:

The 3 components of the measure are:

a. The total number of PHN-commissioned mental health service contacts.

b. The total number of Medicare Mental Health Centre service contacts.

c. The total number of headspace service contacts.

The data source for each component is:

a. 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.

b. The same as a. (PMHC MDS).

c. headspace National headspace Application Platform Interface. The department requests a custom extract of service contacts for 12–25-year-olds (i.e. occasions of service delivered by headspace services) directly from headspace National.

Methodology:

The methodology for each component of the measure is:

a. PHN-commissioned mental health services are delivered to clients. PHNs and service providers supply data to the PMHC MDS. The department obtains the number of PHN-commissioned mental health service contacts from a standard PMHC MDS report. The number is obtained for the current year (2025–26) and previous year (2024–25) in order to understand service use over time using the best available data from the administrative system.

b. As per a. for Medicare Mental Health Centre service contacts.

c. headspace services are delivered to clients. headspace National enters data to the headspace Application Platform Interface. headspace National provides a custom report to the department of the total number of headspace service contacts for 12–25-year-olds (inclusive). The number is obtained for the current year (2025–26) and previous year (2024–25) in order to understand service use over time using the best available data from the administrative system.

Component A: PHN-commissioned mental health service contacts

The performance measure provides a high-level indication of PHN-commissioned mental health services accessed across Australia. The 2025–26 number of PHN-commissioned mental health service contacts (1,617,365) is less than 2024–25 (1,662,830). While it is useful to monitor trends, mental health service utilisation is predominantly demand-driven and shaped by a range of external factors. Given the inherent variability in demand, selecting a target for service usage is not considered a practicable or meaningful measure of performance.

Many factors influenced PHN service delivery during 2025–26, including the transition of commissioned service providers, workforce availability and capability, significant weather events affecting some regions, and data quality and system issues.

The department monitors the performance of PHNs through the PHN Program Performance Measurement and Reporting Framework.[15] Data from PHNs helps to identify improvement opportunities, and the department works with PHNs to support action in these areas. This includes having PHN activities guided by Australian Government key priorities.[16]

Latest information on PHNs Program Performance for the 2022–23 and 2023–24 financial years is available at: **www.health.gov.au/resources/publications/primary-health-network-program-annual-performance-report-2022-23-and-2023-24**

A collection of audits providing independent advice on the PHNs compliance with financial and performance obligations is available 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.[17]

[15] Available at: **www.health.gov.au/resources/publications/primary-health-network-program-performance-measurement-and-reporting-framework-2025?language=en**

[16] Available at: **www.health.gov.au/our-work/phn/how-we-support-PHNs#key-priorities**

[17] A list of all PHNs is available at: **www.health.gov.au/our-work/phn/your-local-PHN**

Component B: Medicare Mental Health Centres service contacts

The performance measure provides a high-level indication of Medicare Mental Health Centres (MMHCs) accessed across Australia. The 2025–26 number of MMHC service contacts (264,184) is more than 2024–25 (158,600). An increase in the number of service contacts in 2025–26 reflects the continued expansion of the MMHC network. At the end of 2024–25 there were 39 operational MMHCs, at the end of 2025–26 there are 55.

The Australian Government is establishing a national network of 92 MMHCs by 30 June 2030. The 2025–26 Mid-Year Economic and Fiscal Outlook provided $267.3 million over four years (2025–26 to 2028–29) to establish 32 new and upgraded MMHCs.[18]

MMHCs provide a welcoming place where everyone can access free mental health information, services and supports. MMHCs are staffed by qualified mental health professionals and people with lived experience of mental health challenges who work together to offer immediate supports; short-to-medium term care; and connection with ongoing or longer-term or low-cost support that aligns with individual needs and goals.

To support access to these services and help people understand what is available, the department has also developed a comprehensive suite of communication products and an accompanying communications strategy to build awareness as the MMHC network expands.

Component C: headspace occasions of service

The performance measure provides a high-level indication of headspace services accessed across Australia. The 2025–26 number of headspace service contacts (645,862) is more than 2024–25 (612,176).

An increase in the number of service contacts in 2025–26 reflects the continued expansion of the headspace network and that service capacity and access is improving. The number of headspace services available to young Australians has increased to 175 at the end of 2025–26, compared to 172 at the end of 2024–25.

headspace is a service young Australians know and trust. Latest available data confirms in 2024–25, 86% of young people reported being satisfied with headspace and 91% of young people would recommend headspace.[19]

headspace[20] 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 3 new headspace services during 2025–26. As at 30 June 2026, there were 175 headspace services operating nationally, including 94 headspace services located across regional Australia (RA2-RA5[21]). headspace centres and satellites have variable opening hours across the network to ensure they meet demand.

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

External factors influencing performance for components A, B and C

Different service types are designed to deliver different models of care and, as a result, are expected to record different numbers of service contacts. For example, psychosocial services (Component A) typically provide ongoing support over a longer period and therefore record a higher number of contacts per consumer. In contrast, MMHCs (Component B) generally provide short-term assessment, triage and treatment services, resulting in fewer contacts per consumer. These differences in service design influence reported activity levels and should be considered when interpreting performance results.

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[18] Available at: **Mid-Year Economic and Fiscal Outlook 2025–26** p.253.

[19] Available at: **headspace.org.au/assets/Reports/Annual-reports/Annual-Infographic_2025_DIGI_final.pdf**

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

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

Service use is influenced by both demand for and availability of services. Demand for mental health services is driven by population need and can be affected by factors such as the prevalence of mental ill health, social and economic conditions, natural disasters and other emergencies, and significant domestic or international events. The availability of services can also influence service use, particularly where workforce shortages, recruitment challenges or capability constraints affect service capacity. As a result, changes in service contacts may reflect changes in demand and service availability, rather than service performance alone.

Complete continuum of care

As part of complete continuum of care, the Australian Government has invested in a simpler, fairer and more targeted mental health and suicide prevention system. Efforts have been focused on addressing national service gaps, increasing accessible and affordable care options, and making sure Australians get the right help when and where they need it.

The department facilitates delivery of mental health services across the continuum of care. While no single service can meet all mental health and wellbeing needs, services are required to establish and maintain strong referral networks to support integrated, person-centred care. Referrals help ensure consumers receive the right care at the right time, particularly when they require specialised, ongoing, or non-clinical supports that cannot be provided directly by the service.

Mental health services provided by PHNs includes services to individuals across the stepped care continuum, including low to moderate intensity face-to-face and digital services, and psychological therapies for rural and remote, and/or under-serviced and/or hard to reach populations. PHNs must commission a continuum of primary mental health services within a person-centred stepped care approach to ensure a range of service types, making best use of available workforce and technology, are available within local regions to align individual and local population needs.

Key Activity 1.2B: Facilitate the implementation and delivery of suicide prevention initiatives.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.34

Performance Measure 1.2B: Number of service contacts for Universal Aftercare[22] services.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.34

2025–26 Planned Performance	2025–26 Result
Program is demand driven.	There were 114,194 Universal Aftercare service contacts.
	Result: N/A

Disclosures:

The Australian Institute of Health and Welfare (AIHW) supports the department to assure the Primary Mental Health Care Minimum Data Set (PMHC MDS) data used for this measure and works with PHNs to support compliance with the department's PMHC MDS data upload requirements. To assist with interpretation of the measure data, note that Universal Aftercare service contacts are under-reported due to:

- Some service providers are exempt from reporting data to the PMHC MDS. This includes all Victorian Universal Aftercare data under bilateral schedule arrangements.

The timing of PMHC MDS data extraction for the Annual Report affects reporting completeness. Data was extracted on 22 July 2026. The PMHC MDS is updated daily as service contacts are entered or amended by PHNs or Service Providers.

In addition, the AIHW's 2025 Data Quality Assessment of PMHC MDS data found that for 2024–25, 58% of service contacts had been uploaded within the required 31-day timeframe and 80% provided within 7 weeks.

Data Source:

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.

Methodology:

Universal Aftercare services are delivered to clients. PHNs and commissioned service providers supply data to the PMHC MDS. The department obtains the number of Universal Aftercare service contacts from a standard PMHC MDS report. The number is obtained for the current year (2025–26) and previous year (2024–25) in order to understand service use over time using the best available data from the administrative system.

The performance measure provides a high-level indication of Universal Aftercare services accessed across Australia. The result indicates that in 2025–26 the number of Universal Aftercare service contacts (114,194) increased in comparison to 2024–25 (93,638). An increase in servicing by Universal Aftercare services in 2025–26 aligns with an increase in the number of operational Universal Aftercare services available to Australians. At the end of 2024–25 there were 64 operational Universal Aftercare services, compared to a total of 95 at the end of 2025–26.

While it is useful to monitor trends, suicide prevention service utilisation is predominantly demand-driven and shaped by a range of external factors. Given the inherent variability in demand, selecting a target for service usage is not considered a practicable or meaningful measure of performance.

It is estimated that 3.3% of Australians experienced suicidal thoughts or behaviours in the previous 12 months. This includes 0.3% who had attempted to take their own life.[23]

[22] Under the National Mental Health and Suicide Prevention Agreement, the Australian Government is working with states and territories to implement universal aftercare services, to support people discharged from hospital following a suicide attempt or suicidal crisis, and trial expanded referral pathways for aftercare services outside the hospital system.

[23] **National Study of Mental Health and Wellbeing, 2020-2022 | Australian Bureau of Statistics**

An additional 31 aftercare sites were implemented in 2025–26, expanding availability and coverage. Aftercare services are now available in every state and territory. In addition, the trial of expanded referral pathways outside of hospital continues to support the accessibility of aftercare and earlier intervention, including before distress escalates to suicidal crisis or attempt.

Suicide prevention 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 suicidality 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. To improve the lived experience capability of the suicide prevention workforce, the department funds Roses in the Ocean, a national suicide prevention organisation led by people with lived experience of suicide.[24]

In addition to Universal Aftercare services, the government provides funding for the delivery of a range of suicide prevention services, some of which are bilaterally funded through the National Mental Health and Suicide Prevention Agreement.[25] This includes postvention and the Distress Brief Support trial. In addition, the department provides funding for a range of initiatives through the National Suicide Prevention Leadership and Support Program (NSPLSP).[26] The NSPLSP offers support and resourcing to organisations across Australia working to build organisational and community capacity to prevent suicide across a range of priority populations and contexts, as well as programs to improve the lived experience capability of the suicide prevention workforce.

[24] More information is available at: **www.rosesintheocean.com.au**

[25] Available at: **The National Mental Health and Suicide Prevention Agreement | Federal Financial Relations**

[26] Available at: **www.health.gov.au/our-work/national-suicide-prevention-leadership-and-support-program?language=en**

Program 1.3: First Nations Health

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.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.35

Performance Measure 1.3A: Increase the percentage of annual Indigenous Australians' Health Programme (IAHP) funding directed to ACCHOs.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.35

2025–26 Planned Performance	2025–26 Result	2024–25 Result
74%	77%	76%
	Result: Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: ≥74%
Substantially achieved: 72.1% to 73.9%
Not achieved: ≤72%

Data Source:
Financial data is drawn from the department's Administered Reporting Information by Program (ARIP) financial reporting system.

Methodology:
The result is calculated using:
Numerator: Grant recipients classified as ACCHOs.
Denominator: Total expenditure for the IAHP (Program 1.3).

The 2025–26 performance result achieved the planned performance target.

Performance measure 1.3A contributes to the department's implementation of Priority Reform 2 (building the community controlled sector) of the National Agreement on Closing the Gap.[27] ACCHOs are an integral part of Australia's health system and support better health outcomes for Aboriginal and Torres Strait Islander people. IAHP funding is provided to ACCHOs to deliver a range of population health programs and clinical services that are tailored to the health needs and priorities of their communities.

Culturally appropriate health care is critical to improving health outcomes for Aboriginal and Torres Strait Islander people. Increasing the percentage of IAHP funding directed to ACCHOs strengthens the community controlled health sector and enables the delivery of culturally appropriate comprehensive primary health services. This is a contributor to Closing the Gap targets 1 (Close the Gap in life expectancy within a generation, by 2031) and 2 (By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%).

Planned performance was forecasted in line with the ongoing commitment to transition, where appropriate, services currently delivered through non-indigenous organisations to ACCHOs. This includes work undertaken as part of the department's First Nations Health Funding Transition Program.[28]
During 2025–26, under the Northern Territory Pathways to Community Control Program, three (3) primary health care clinics managed by NT Health were successfully transitioned to community control.
In addition to providing funding to ACCHOs, the department provides targeted supports during emergency events (e.g. natural disasters) to ensure impact on service delivery is minimal.

[27] The National Indigenous Australian Agency's latest report on Closing the Gap outcomes is available at: **www.niaa.gov.au/resource-centre/commonwealth-closing-gap-2025-annual-report-and-2026-implementation-plan**
[28] Available at: **www.health.gov.au/our-work/first-nations-health-funding-transition-program-fnhftp**

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.**

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.37

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.[29]

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.37

2025–26 Planned Performance	2025–26 Result	2024–25 Result
49%	47.9%	47.9%
	Result: Substantially achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: ≥49%
Substantially achieved: 47.1% to 48.9%
Not achieved: ≤47%

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:

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.

Performance measure 1.3B contributes to Closing the Gap Targets 1 and 2.[30] Target 1 (Close the Gap in life expectancy within a generation, by 2031) is showing improvement but is not on track to be met. Target 2 (By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%) is showing no change from the baseline.

A 715 health check provides an entry point to comprehensive primary health care. It supports Aboriginal and Torres Strait Islander people, families and communities by identifying whether an adult or child is at risk of illnesses or chronic conditions and connects patients with referrals to support prevention and management of risk.

[29] Aboriginal and Torres Strait Islander people 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**

[30] More information on the National Agreement on Closing the Gap socio-economic outcome areas and targets is available at: **www.pc.gov.au/closing-the-gap-data/dashboard/**

Detection, prevention and management can have a direct positive impact on life expectancy (Closing the Gap Target 1), improve maternal and child health outcomes, prevent disease and support chronic disease management. For children and young people, it can support healthy development and early access to services.

For adults and older people, it can help people stay well, manage existing conditions and positively impact life expectancy.

Increasing awareness and promoting 715 health checks can contribute to Closing the Gap Target 1 by improving health and wellbeing outcomes across the life course. The department funds community-led promotion activities to support this work, including the Institute for Urban Indigenous Health's expansion of the Deadly Choices[31] program. The program leverages partnerships with sporting organisations to promote positive health messages and encourage more Aboriginal and Torres Strait Islander people to get their 715 health check.

Following a decline in 2022, uptake of 715 health checks increased and then stabilised. Uptake rose from 40.7% in 2022 to 43.4% in 2023, before reaching 47.9% in 2024 and remaining at that level during 2025. This indicates uptake has recovered from the COVID-19 decline, with results now higher than pre-COVID levels:

- 2020 - 46.8%
- 2021 - 45.2%
- 2022 - 40.7%
- 2023 - 43.4%
- 2024 - 47.9%
- 2025 - 47.9%.

[31] Further information on the Deadly Choices program is available at: **www.deadlychoices.com.au**

Program 1.4: Health Workforce

Key Activity 1.4A: Fostering a sustained growth of the health workforce.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.39

Performance Measure 1.4A: Annual change in headcount across the health workforce.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.39

2025–26 Planned Performance				**2025–26 Result**			
Location by Modified Monash Model (2023)[32]	Number of Primary Care General Practitioners	Number of Nurses & Midwives	Number of Allied Health Practitioners	Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners [33]	Number of Nurses & Midwives[34]	Number of Allied Health Practitioners [35]
MM1	28,052	285,440	167,179	MM1	28,430	299,636	175,724
MM2	4,763	40,453	18,538	MM2	5,077	42,212	19,538
MM3	4,013	30,010	13,334	MM3	4,276	31,158	14,131
MM4	2,823	13,668	6,820	MM4	2,950	14,180	7,134
MM5	3,630	14,617	5,887	MM5	3,748	15,072	6,292
MM6	1,090	4,063	1,614	MM6	1,091	4,257	1,662
MM7	1,327	2,646	865	MM7	1,319	2,785	892
				Result: Substantially achieved			

The assessment scale for the 2025–26 planned performance is:

Achieved: Each figure achieves ≥100% of its target.
Substantially achieved: Each figure achieves ≥95% of its target, but not all figures achieve ≥100% of their targets.
Not achieved: Any figure achieves <95% of its target.

Disclosures:
Due to data availability timing across all datasets, there is a lag for the results reported in this measure, as data is not available until 4 to 12 months after the end of the calendar/financial year.
Number of Primary Care General Practitioners: Data for the 2025–26 Result reports Calendar Year 2024 data.
Number of Nurses and Midwives; Number of Allied Health Practitioners: Data for the 2025–26 Result reports 2024 data, collected at a point in time in 2024.

[32] Geography: Cities (MM1) and rural (MM2–7) based on Modified Monash Model (2023). Further information is available at: **www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en**

[33] Medicare Benefits Schedule (MBS) dataset, CY2024

[34] National Health Workforce Dataset (NHWDS), 2024

[35] National Health Workforce Dataset (NHWDS), 2024. Allied health practitioners include Aboriginal and Torres Strait Islander Health Practitioners, Chinese Medicine Practitioners, Chiropractors, Dental Practitioners, Medical Radiation Practitioners, Occupational Therapists, Osteopaths, Paramedicine Practitioners, Pharmacists, Physiotherapists, Podiatrists and Psychologists.

Data Source:

Number of Primary Care General Practitioners:

Medicare Benefits Schedule (MBS) dataset, **Calendar Year 2024** (latest available across all datasets) for 2025–26 Result. This administrative dataset capturing Medicare services is owned by the department in partnership with Services Australia.

Number of Nurses, Midwives and Allied Health Practitioners: National Health Workforce Dataset (NHWDS), **2024** (latest available across all datasets) for 2025–26 Result.

This dataset is comprised of practitioner registration and survey response information collected by the Australian Health Practitioner Regulation Agency (Ahpra) and is processed and owned by the department.

Methodology:

To inform the total number of health professionals (headcounts) over a given year:

GP Headcount: a workforce-specific method has been used to identify primary care GPs working in Australia. The method uses elements from the MBS dataset to accurately count when, where and by what type of practitioner GP services are delivered. Providers may work in multiple locations, and are counted in each location they work in.

Headcounts for Nurses, Midwives and Allied Health Practitioners[36] counts the number of practitioners employed in the relevant profession (nursing, midwifery and allied health). Location is informed by the practitioners' main place of work and excludes practitioners without a known location. Practitioners employed in multiple allied health professions are counted for each profession they have indicated they are employed in.

The department's 2025–26 planned performance results reflect substantial achievement in workforce growth across general practice, nursing, midwifery and allied health. The results are driven by a coordinated package of targeted investments and reforms to improve supply, distribution and utilisation of the health workforce. In 2025–26, 20 out of 21 targets were met. Increasing headcount in MM7 (Number of Primary Care General Practitioners) will continue to be a focus area for the department.

Growth in the General Practitioner (GP) workforce was supported through strengthened entry, training and retention pathways. Key contributors include expansion of the Australian General Practice Training (AGPT) Program and introduction of the GP Training Incentive Payments for GP and Rural Generalist registrars. In addition, 160 new medical Commonwealth-Supported Places commencing from 2026 will help increase the future supply of medical graduates. The expansion of the Australian Primary Care Prevocational Program is also increasing exposure to general practice and rural careers earlier in training. The Workforce Incentive Program (WIP) Doctor and Rural Advanced Skills Streams have also improved the attraction and retention of GPs in rural and remote areas. The WIP Practice Stream has continued to support multidisciplinary team care across the country by providing flexible funding to practices to employ a range of health professionals. In parallel, reforms under the Bonded Medical Program, are improving long-term distribution by directing Australian trained medical practitioners to areas of need. Medical workforce initiatives continue to be guided by the National Medical Workforce Strategy.

Workforce gains in nursing and midwifery have been underpinned by investments in education, training and workforce flexibility. Expansion of Commonwealth-Supported Places in nursing and midwifery, alongside targeted scholarship programs, has increased the pipeline of qualified nurses and midwives. These efforts have been complemented by initiatives to support nurses and midwives working to their full scope of practice, consistent with national workforce reform directions, resulting in an improvement for both workforce capacity and service accessibility.

Allied health growth has been driven by a stronger focus on multidisciplinary care models and expanded training and placement.

[36] Allied health practitioners include Aboriginal and Torres Strait Islander Health Practitioners, Chinese Medicine Practitioners, Chiropractors, Dental Practitioners, Medical Radiation Practitioners, Occupational Therapists, Osteopaths, Paramedicine Practitioners, Pharmacists, Physiotherapists, Podiatrists and Psychologists.

The WIP Practice Stream component continues to play a central role by supporting practices to employ allied health professionals such as physiotherapists, psychologists and non-dispensing pharmacists. Additional support through rural placement programs and university expansion has increased graduate numbers and improved geographic distribution. Broader reforms to scope of practice, aligned with recommendations from national reviews, are also enabling allied health professionals to deliver more services directly, improving productivity and access to care.

In addition to the data reported, the department supported First Nations health workforce growth through a range of initiatives. The First Nations Health Worker Traineeship program delivered by National Aboriginal Community Controlled Health Organisations has enrolled 613 trainees as at 25 June 2026 with 204 completions. The Indigenous Health Workforce Traineeships program has enrolled 226 trainees, with 52 completions. In line with the government's Closing the Gap commitments, the management of Indigenous Health Scholarship Program transitioned to a First Nations-led organisation, Indigenous Allied Health Australia.

Key Activity 1.4B: Distributing Primary Care General Practitioners to facilitate equitable access to health care.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.41

Performance Measure 1.4B: Number of Primary Care General Practitioner FTE per 100,000 population (by Modified Monash Model).

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.41

2025–26 Planned Performance		**2025–26 Result**	
Location by Modified Monash Model (2023)[37]	Primary Care GP FTE per 100,000 population	Location by Modified Monash Model (2023)	Primary Care GP FTE per 100,000 population[38]
MM1 – Metropolitan	111.9	MM1 – Metropolitan	111.4
MM2 – Regional centres	107.5	MM2 – Regional centres	111.8
MM3 – Large rural towns	124.5	MM3 – Large rural towns	128.8
MM4 – Medium rural towns	125.8	MM4 – Medium rural towns	128.2
MM5 – Small rural towns	77.8	MM5 – Small rural towns	80.6
MM6 – Remote communities	66.8	MM6 – Remote communities	67.6
MM7 – Very remote communities	70.6	MM7 – Very remote communities	72.3
Australia total	109.6	Australia total	110.2
		Result: Substantially achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: Each figure achieves ≥100% of its target.
Substantially achieved: Each figure achieves ≥95% of its target, but not all figures achieve ≥100% of their targets.
Not achieved: Any figure achieves <95% of its target.

Disclosures:

Due to data availability timing across all datasets, there is a lag for the results reported in this measure. Data is not available until 4 to 12 months after the end of the calendar/financial year.

Primary Care GP FTE: Data for the 2025–26 Result reports Calendar Year 2024 data.

Population: Data for the 2025–26 Result reports 30 June 2024 data.

Data Source:

Primary Care GP FTE: Medicare Benefits Schedule (MBS) dataset, **Calendar Year 2024** (latest available across all datasets) for 2025–26 Result. This administrative dataset capturing Medicare services is owned by the department in partnership with Services Australia.

[37] Geography: Cities (MM1) and rural (MM2–7) based on Modified Monash Model (2023). Further information is available at: **www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en**

[38] Medicare Benefits Schedule (MBS) dataset, CY2024; ABS Estimated Resident Population (ERP), 30 June 2024.

Population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP), **30 June 2024** (latest available across all datasets) for 2025–26 Result. These figures are estimated by the ABS based on Census results and provided to the department at a granular level.

Methodology:

To inform the total number of GP FTE by population over a given year:

GP FTE: a workforce-specific method is used to identify Primary Care GPs working in Australia.[39] The method uses elements from the MBS dataset to accurately count when, where and by what type of practitioner GP services are delivered. Providers may work in multiple locations, and are counted in each location they work in.

Population: ABS publish the ERP based on Census results and provide these estimates to the department at a granular level (Statistical Areas Level 1). These estimates are aggregated to the MMM classifications. **Primary Care GP FTE per 100,000 population is then calculated as:** 100,000 * GP FTE / Population.

The department's 2025–26 planned performance results reflect substantial achievement in the distribution of Primary Care General Practitioner FTE relative to population. While the MM1 target for Primary Care GP headcount was achieved under Performance Measure 1.4A, the MM1 result for Performance Measure 1.4B was below target. The department will continue to strengthen the GP workforce pipeline, including Primary Care GPs in active training in MM1.

Growth in the GP workforce was supported through strengthened entry, training and retention pathways. The transition of the Australian General Practice Training (AGPT) to a GP college-led training model in 2023 was largely successful. Despite a drop in application numbers for the 2023 calendar year, significant growth in demand was seen for the 2024 and 2025 calendar years, contributing to the overall growth in the GP workforce relative to population. The results are expected to further increase in the coming years due to the expansion of the AGPT and Remote Vocational Training Scheme (RVTS) programs, as well as the continuation of strong demand for GP training. Data indicates that the total number of GPs in training increased by approximately 2.4% from 2023 to 2024 and at least 6.0% from 2024 to 2025. The largest intake of commencing registrars ever was recorded in 2026.

Retention and participation were key contributing factors. Data from 2025 shows increased uptake and utilisation of the Workforce Incentive Program. Practices are using funding to embed multidisciplinary teams and there has been an increase in payments to doctors providing services in MM3–7 locations.

External conditions further supported performance such as stabilisation in international recruitment and return to practice trends contributed additional GP supply.

During 2025–26, the department progressed national health workforce reforms in the regulation space. This included supporting workforce registration improvements for internationally qualified practitioners. These reforms have contributed to a more efficient, transparent and responsive regulatory system while maintaining public safety.

[39] Further information on the workforce-specific method to identify primary care GPs is available at: **hwd.health.gov.au/resources/information/methods-gp-workload.html**

Key Activity 1.4C: Training the next generation of Primary Care General Practitioners.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.43

Performance Measure 1.4C: Number and distribution of General Practice trainees undertaking active training in the Australian General Practice Training (AGPT), Rural Generalist Training Scheme (RGTS) and Remote Vocational Training Scheme (RVTS) programs by Modified Monash Model.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.43

2025–26 Planned Performance		**2025–26 Result**	
Location by Modified Monash Model (2023)[40]	Number of Primary Care General Practitioners FTE active training	Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners FTE active training[41]
MM1 – Metropolitan	1,571.4	MM1 – Metropolitan	1,671.0
MM2 – Regional centres	529.2	MM2 – Regional centres	579.6
MM3 – Large rural towns	414.1	MM3 – Large rural towns	446.8
MM4 – Medium rural towns	328.9	MM4 – Medium rural towns	329.4
MM5 – Small rural towns	300.0	MM5 – Small rural towns	343.9
MM6 – Remote communities	106.9	MM6 – remote communities	106.0
MM7 – Very remote communities	60.6	MM7 – Very remote communities	72.7
Australia total	3,311.4	Australia total	3,549.3
		Result: Substantially achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: Each figure achieves ≥100% of its target.
Substantially achieved: Each figure achieves ≥95% of its target, but not all figures achieve ≥100% of their targets.
Not achieved: Any figure achieves <95% of its target.

Disclosures:

Due to data availability timing across all datasets, there is a lag for the results reported in this measure. Data is not available until 4 to 12 months after the end of the calendar/financial year. The GP Training Minimum Dataset is updated 6-monthly as training information are amended by the GP colleges in subsequent submissions. If updates result in amendments to the Number of Primary Care General Practitioners FTE active training, this will be reported in the 2026–27 Annual Report.

AGPT and RGTS: Data for the 2025–26 Result reports Calendar Year 2024 data.
RVTS: Data for the 2025–26 Result reports December 2024 data.

[40] Geography: Cities (MM1) and rural (MM2–7) based on Modified Monash Model (2023). Further information is available at: **www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en**

[41] GP Training Minimum Dataset (GPT MDS) AGPT and RGTS, CY2024; RVTS December 2024 report. RVTS registrars are assumed to be working 1 full-time equivalent (FTE).

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.

Data Source:

The Number of Primary Care GP FTE active training is comprised of 3 programs: the Australian General Practice Training (AGPT), the Rural Generalist Training Scheme (RGTS), and the Remote Vocational Training Scheme (RVTS).

For AGPT and RGTS: GP Training Minimum Dataset (GPT MDS), Calendar Year 2024 (latest available complete data across all datasets). This dataset is compiled based on program information provided by GP Colleges, the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners, and is provided twice per year, in April and October.

For RVTS: Program data submitted to the department in December 2024. The reports are provided bi-annually, in June and December.

Methodology:

To calculate the total FTE in active training:
For AGPT and RGTS: FTE is reported by the GP Colleges by unit and apportioned to the relevant period based on the number of days in the unit. Active training excludes leave units. Totals include unknown locations; hence totals may not equal the sum of their parts.
For RVTS: High-level program data is provided to the department, identifying the MMM location the registrars are training in. As hours in training is not available, RVTS registrars are estimated to be training 1 FTE. The FTE is then summed between the 2 data sources to obtain the final result.

In 2025–26 the department substantially achieved an increase in actively training GP registrars (FTE) in Modified Monash (MM) classifications 1 to 5 and 7. MM6 experienced a minor reduction of less than one per cent. These generally strong results were driven by strong demand and expansion of training capacity under Commonwealth funded GP training programs, which commenced in the 2026 training year. Additional Commonwealth funded GP training places are being delivered across the AGPT and RVTS programs from 2026, resulting in over 2,000 registrars expected to commence training in the 2026 calendar year. This increase has been supported by the successful transition to a GP college-led training model for the AGPT program since 2023.

The growth in GP registrars is expected to continue in coming years with further increases in training places through to 2028. Strong demand already led to oversubscription of the AGPT program in both 2025 and 2026. Early feedback indicates that new GP Training Incentive Payments have been a driver in the increased interest in GP training in 2026. The requirement that at least 50% of training under the AGPT program is undertaken in MM2–7 locations and the use of greater evidence to underpin the geographic allocation of training places by the GP Colleges will continue to support improvements in the geographic distribution balance of AGPT registrars, including in MM6 locations. The consolidation of the RGTS program into the AGPT program from 2026 streamlined pathways to better support registrars training for rural generalist subspecialisation.

The RVTS continued to play a critical role in achieving performance in rural, remote, and Aboriginal and Torres Staits Islander communities. This is through the Aboriginal Medical Services pathway (MM2–7 locations) and Remote pathway (MM4–7 locations). RVTS supported a stable and geographically distributed cohort of trainees embedded in remote communities, enabling participants to remain in place while completing training. This model delivered consistent coverage in many locations that traditionally face persistent workforce shortages, contributing directly to improved distribution metrics. The further expansion of the RVTS program from 2026 to 2028 will further support training outcomes in remote communities.

Program 1.5: Preventive Health and Chronic Disease Support

Key Activity 1.5A: Health promotion and education activities to support smoking and nicotine cessation and prevention.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.45

Performance Measure 1.5A: Achieve preventive health target for smoking through reducing percentage of adults who smoke daily.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.45

2025–26 Planned Performance	2025–26 Result	2024–25 Result
Progressive decrease of daily smoking prevalence towards <5%	10.3%	10.7%
	Result: Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: Decrease on 2024–25 Result.
Substantially achieved: N/A
Not achieved: Increase or same result as 2024–25.

Disclosures:

The 2025–26 result utilises the latest available data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey, from Wave 24, collected between 30 July 2024 and 9 March 2025. The 2024–25 result utilised data from Wave 23.

There are sensitivities associated with attributing changes in smoking prevalence to any single activity, given the result reflects the combined effect of Commonwealth, state and territory, community and health sector action, as well as broader social and market factors.

Data Source:

Household, Income and Labour Dynamics in Australia (HILDA).[42]

Methodology:

Daily smoking prevalence reported through HILDA among adults aged ≥18 years.

The department's approach to tobacco and e-cigarette control comprises a comprehensive and sustained suite of evidence-based measures to reduce the prevalence of smoking and nicotine dependence, prevent uptake, support people to quit and reduce tobacco-related harms. This approach aligns with the National Tobacco Strategy 2023–2030,[43] which provides the framework to reduce tobacco use and its associated health, social and economic costs, and complements the National Preventive Health Strategy 2021–2030.[44]

Australia has made long-term progress in reducing smoking rates and has one of the lowest smoking rates internationally. However, tobacco use remains a leading cause of preventable death and disease, and further reductions are required to meet the National Tobacco Strategy 2023–2030 target of 5% or less daily smoking prevalence among adults by 2030.

[42] Further information is available at: **www.dss.gov.au/long-term-research/living-australia-household-income-and-labour-dynamics-australia-hilda-survey**

[43] Available at: **www.health.gov.au/resources/publications/national-tobacco-strategy-2023-2030**

[44] Available at: **www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030**

The 2024–25 Annual Report included progress against the then-current national target to reduce adult daily smoking prevalence to 10% or less by 2025. Consistent with the National Tobacco Strategy 2023–2030, future annual reporting, from 2025–26 onwards, will focus on the subsequent target to reduce adult daily smoking prevalence to 5% or less by 2030.

In 2025–26, the department progressed a number of activities that support the National Tobacco Strategy priority areas. Activities included strengthening regulation, improving public awareness of harms, supporting cessation, reducing exposure to advertising and promotion, and working with states and territories and non-government organisations to support coordinated implementation. During 2025–26, the department undertook the following initiatives to contribute towards the progressive decrease of daily smoking prevalence.

Implementation of the *Public Health (Tobacco and Other Products) Act 2023* (the Tobacco Act)

The Tobacco Act and associated regulations commenced on 1 July 2025, modernising and simplifying previous tobacco legislation and introduced new measures to discourage smoking and tobacco use. This included progressing changes to tobacco product and packaging requirements, tobacco advertising and sponsorship restrictions and extending advertising restrictions to e-cigarettes. In 2025–26, the department focussed on expanding compliance-related activity and developed a compliance strategy to support implementation of the new regulatory framework.

Delivery of prevention programs - including public health communication campaigns

Continued delivery of prevention programs and public health campaigns complemented regulatory reforms, by supporting awareness of the health harms associated with smoking and vaping and promoting access to evidence-based cessation support. This was driven by the delivery of the next phases of the 'Give Up For Good' campaigns from January to June 2026, integrating Phase 3 of the Youth Vaping Education Campaign and Phase 2 of the National Tobacco and E-cigarette Campaign. Operating collectively in-market, the campaigns maximised audience reach to increase awareness of health harms and nicotine addiction risks and deter product switching, while connecting Australians to support services. The OurFutures Vaping Prevention Education program continued national roll-out, available for free to all secondary schools in Australia. More than 1,200 secondary schools have enrolled in the program since launching in 2025.

Support for cessation

The department delivered programs to provide targeted quit support to people that smoke and vape, through increased education and expanded access to cessation services, and to assist health professionals providing cessation care. This included:

- Ongoing funding to states and territories to expand Quitline and other quit services.
- Continued enhancement of the National Cessation Platform, including the release of tailored and personalised content in 2025–26.
- Further promotion and redevelopment of the My QuitBuddy app, which provides updated smoking and vaping cessation content and improved quit-tracking tools. There have been more than 88,000 new downloads of the app in the first half of 2026 bringing the total new downloads in 2025–26 to over 148,300. This is a 78% increase compared to last year (over 83,200 total downloads in 2024–25).
- Continued funding for the Quit Centre to deliver best-practice training, tools and resources for frontline health professionals.
- Additional updates to clinical guidance on smoking cessation for pharmacists, alongside guidance for health professionals.

E-cigarettes and emerging nicotine products

Following the 2024 reforms to the regulation of e-cigarettes, the focus during 2025–26 was on implementation, compliance and enforcement activity, led by the Therapeutic Goods Administration (TGA) and supported by relevant Commonwealth, state and territory regulatory and enforcement agencies. E-cigarettes and other emerging nicotine products continue to present challenges for tobacco and nicotine control efforts, particularly among young people. The department continued to monitor emerging evidence and support public health activities to reduce uptake, nicotine dependence and related harms.

Impact of illicit trade in tobacco and vapes

The increase of illicit trade in tobacco and e-cigarettes presents a risk to tobacco and nicotine control efforts as the availability of cheap products can undermine public health measures designed to reduce smoking and nicotine dependence. During 2025–26, the department contributed to the government's response through activities aimed at reducing demand for tobacco and nicotine products, including public education, cessation support and implementation of regulatory reforms. Funding was provided to states and territories to improve their compliance and enforcement capacity and capability to tackle the illicit market, and the TGA worked alongside Australian Federal Police, Australian Border Force and state and territory health and police agencies to enforce the vaping reforms and address illicit trade of vapes.

Addressing tobacco-related health inequities

The department continued to support targeted tobacco control activities, including through the Tackling Indigenous Smoking program,[45] to contribute to reductions in smoking and vaping among First Nations people and reduce tobacco-related health inequities.

External factors that may influence performance include the emergence of new nicotine products and commercial product design and marketing practices, the expansion of illicit trade in tobacco and vapes, changing patterns of nicotine use, and demographic and socioeconomic differences in smoking prevalence. Progress towards reducing smoking prevalence also relies on complementary action by states and territories, including implementation, compliance and enforcement activities, as well as delivery of cessation and public health initiatives.

The department's activities during the reporting period were consistent with the program objective to promote smoking and e-cigarette cessation, prevent uptake and encourage healthy lifestyles.

[45] Available at: **www.tacklingsmoking.org.au/**

Key Activity 1.5B:
Alcohol and other drug treatment services.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.47

Performance Measure 1.5B:
Support access to alcohol and other drug treatment services through:

a. Executing grant funding agreements on time.

b. Ensuring treatment service provider key performance indicators are achieved.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.47

2025–26 Planned Performance	2025–26 Result
a. Grant agreements with treatment service providers are executed on time. b. Treatment service providers meet their identified key performance indicators.	a. 100% b. 98.5% **Result:** a. Achieved b. Substantially achieved

The assessment scale for the 2025–26 planned performance is:

Achieved:
a. 100%
b. 100%
Substantially achieved:
a. 90% to 99.9%
b. 90% to 99.9%
Not achieved:
a. <90%
b. <90%

Disclosures:

Grant agreements with treatment service providers are executed on time.

- Results are based on data recorded in the Grant Payment System. While incomplete or delayed data entry at the time of reporting could affect the completeness of the dataset, reconciliation and quality assurance activities did not identify any material omissions or discrepancies. Any identified issues were not considered material to the reported result. The number of grant agreements within scope may change during the reporting period due to new or varied agreements.
- Agreements or variations cancelled or not offered to the organisation are not included in the results.
- Notices of Change are not included in the results as they are not considered to be focused on core grant and variation activities.

Treatment service providers meet their identified key performance indicators.

- Results report 2024–25 provider data, as complete data for 2025–26 is not available until 3 to 6 months after the end of each financial year.
- Results are based on provider-reported data from the most recent complete reporting period available at the time of reporting. This reduces the risk of reporting delays affecting the accuracy of the result. While variations in the completeness or accuracy of provider reporting may affect reliability, departmental assessment, reconciliation and quality assurance activities did not identify any material issues that would be expected to materially affect the reported result.
- Not all funded organisations are subject to the same key performance indicators, as some organisations do not deliver treatment services directly and are therefore not required to meet all applicable treatment service reporting and quality requirements. Results are based only on providers required to report against the applicable performance indicators and should be interpreted in that context.

- Primary Health Networks (PHNs) are excluded from the final calculation as the National Quality Framework accreditation and Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) reporting requirements assessed through this measure do not apply to PHNs. PHNs are managed under separate performance and reporting arrangements. The reported result therefore reflects only funded treatment service providers to which the applicable key performance indicators apply.

Data Source:

a. The Grant Payment System (GPS) contains executed grant agreements for each treatment service provider.

b. The GPS contains performance reports and annual reports for each treatment service provider.

Methodology:

a. Calculate the number of grants expected to be executed/the number of grants actually executed, and report as a percentage per financial year.

b. Calculate the number of service providers meeting their key performance indicators/the total number of service providers, and report as a percentage.

1.5B.a – Grant agreements with treatment service providers are executed on time

In 2025–26, the department undertook a range of grant administration activities to support the timely execution of funding agreements. This included coordinating the development of grant agreements and variations, managing review and approval processes, and actively monitoring delivery timeframes.

The department works closely with the Community Grants Hub within the Department of Social Services (DSS) to support the timely execution of agreements and variations. The department is responsible for developing funding agreement requirements, obtaining policy approvals and providing advice on policy, contractual and grant-specific matters. The Community Grants Hub administers agreement processes, including issuing agreements, liaising with providers on administrative matters, updating grant records and progressing execution activities. Together, these complementary roles support the timely establishment and management of grant agreements.

The department achieved its planned performance for 2025–26, demonstrating effective management of grant processes and timely execution of funding agreements with 72 out of 72 treatment service provider grants executed on time.

The timing of grant execution was influenced by several factors, including:

- Administrative processes managed by the Community Grants Hub within DSS, such as processing, validation and approval workflows.
- Provider responsiveness, including the timely provision of required documentation, which can affect the department's ability to execute agreements within expected timeframes.
- The timing of organisational updates, where processing may be delayed if updated details are provided at the point of variation rather than being communicated earlier through funding arrangement managers.

Grant funding agreements support access to alcohol and other drug (AOD) treatment services by enabling funded providers to deliver treatment services to target populations. During the reporting period, 59 grant agreements were in place, enabling 74 activities and supporting the delivery of services across 48 unique providers. The timely execution of these agreements ensures that funding is available to support the delivery and continuity of treatment services.

1.5B.b – Treatment service providers meet their identified key performance indicators (KPIs)

In 2024–25, the department focused on contract management and performance monitoring of funded providers. This included providing guidance to service providers on KPI requirements, monitoring performance reports submitted under funding agreements, and engaging with providers through Funding Arrangement Managers to support compliance with reporting expectations.

Clear articulation of KPI requirements during the establishment phase supported consistent provider reporting and reduced the need for subsequent clarification or correction of reported data.

Treatment service providers are required to meet 2 KPIs specified in their funding agreements. These are listed below:

1. Compliance with the National Quality Framework for Drug and Alcohol Treatment Services.[46]
2. Alcohol and Other Drug Treatment Services National Minimum Data Set[47] (AODTS-NMDS) collection and reporting requirements.

Results indicate that 136 of 138 applicable KPI requirements (98.5%) were met across 48 in-scope treatment service providers[48] during the reporting period.

These KPIs provide assurance that providers are delivering and reporting on treatment services in accordance with agreed national standards and contractual requirements. Reporting to the AODTS-NMDS supports consistent, nationally comparable data collection on alcohol and other drug treatment services, including information on service delivery, client characteristics (such as age and gender), treatment episodes and treatment type. This enables monitoring of service provision, program oversight and contributes to national reporting by the AIHW.

Together, the timely execution of grant agreements and variations, and providers' achievement of KPI requirements, demonstrate that treatment services are being delivered and reported on in line with agreed requirements. This provides assurance that services are operating in accordance with agreed requirements, supporting the ongoing availability of treatment services.

A range of external factors influenced provider performance, including:

- **Workforce availability and organisational capability**, particularly in regional and remote settings, which may affect providers' capacity to meet KPI requirements and maintain consistent service delivery.
- **Variability in provider capability and operating environments**, including differences in service demand and organisational systems, which may influence performance against KPI requirements.
- **Administrative arrangements with delivery partners**, where the timeliness and completeness of provider reporting may be affected by how and when support, advice and emerging issues are identified and communicated.

Performance is assessed against the expectation that all in-scope providers meet their identified key performance indicators. Most providers met their KPIs in 2024–25; however, a small number did not achieve all applicable requirements during the reporting period. The department applies a risk-based approach to performance oversight, with detailed and targeted review, feedback and engagement focused on medium and high-risk providers, while lower-risk providers are monitored through standard reporting processes.

This approach enables the department to prioritise areas of greatest risk and supports improved provider performance. The department will continue to strengthen data quality through Funding Arrangement Managers by reinforcing the importance of clear and consistent performance data and reporting, contributing to improved data quality over time. The department will monitor processes to support earlier identification of emerging issues, enabling timely engagement and corrective action where required.

Through the Drug and Alcohol Program, the department provides funding for prevention projects, withdrawal management and rehabilitation services, treatment services, activities to prevent and address Fetal Alcohol Spectrum Disorder, and research and data projects. Activities under the program address the 3 pillars of the National Drug Strategy 2017–2026 (harm, demand and supply reduction).

Funded treatment service providers are required to meet KPIs relating to compliance with the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) reporting requirements and the National Quality Framework for Drug and Alcohol Treatment Services.

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[46] Available at: **www.health.gov.au/resources/publications/national-quality-framework-for-drug-and-alcohol-treatment-services?language=en**

[47] Available at: **www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services**

[48] A single provider may hold multiple grant agreements and deliver multiple funded activities. KPI results are reported against applicable requirements across all in-scope activities.

Achievement of these requirements provides assurance that providers maintain appropriate quality, governance and reporting arrangements that support the ongoing availability and delivery of treatment services in accordance with agreed standards.

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 seeks 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.

Key Activity 1.5C: Administer the 3 cancer screening programs in accordance with the National Preventive Health Strategy 2021–2030 and the National Strategy for the Elimination of Cervical Cancer in Australia.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.49

Performance Measure 1.5C:
Administer the 3 cancer screening programs:
- National Bowel Cancer Screening Program.
- National Cervical Screening Program.
- National Lung Cancer Screening Program.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.49

2025–26 Planned Performance	2025–26 Result
a. 1) Correspondence (pre/invitations) sent of correspondence due to be sent (%) 2) Bowel test kits sent of kits due to be sent (%) 3) Follow up contacts made of contacts due to be made (%). b. 1) Correspondence (invitations) sent of correspondence due to be sent (%) 2) Follow up contacts made of contacts due to be made (%). c. 1) Correspondence sent of correspondence due to be sent (%) 2) Follow up contacts made of contacts due to be made (%).	a. 1) 99.8% 2) 99.3% 3) 99.5% b. 1) 99.6% 2) 99.0% c. 1) 99.8% 2) 99.6% **Result:** a. 1) Substantially achieved 2) Substantially achieved 3) Substantially achieved b. 1) Substantially achieved 2) Substantially achieved c. 1) Substantially achieved 2) Substantially achieved

The assessment scale for the 2025–26 planned performance is:

Achieved:
1. Correspondence sent/due to be sent
   a. 100.0% – a. b. and c.
2. Bowel test kits sent/due to be sent
   a. 100.0% – a.
3. Follow up contacts made/due to be made
   a. 100.0% – a. b. and c.

Substantially achieved:
1. Correspondence sent/due to be sent
   a. 97.0% to <100% – a. b. and c.
2. Bowel test kits sent/due to be sent
   a. 97.0% to <100% – a.
3. Follow up contacts made/due to be made
   a. 97.0% to <100% – a. b. and c.

Not achieved:
1. Correspondence sent/due to be sent
   a. ≤92.0% to <97.0% – a. b. and c.
2. Bowel test kits sent/due to be sent
   a. ≤92.0% to <97.0% – a.
3. Follow up contacts made/due to be made
   a. ≤92.0% to <97.0% – a. b. and c.

Disclosures:

The measures are based on operational register data. Some operational processes (such as production of correspondence) will commence during the reporting period, but in some cases may not be concluded in order to be counted in the result. The reported result is not materially impacted where operational processes were not concluded.

Data Source:

a. National Bowel Cancer Screening Program.

b. National Cervical Screening Program.

c. National Lung Cancer Screening Program.

1. Correspondence sent/due to be sent - National Cancer Screening Register Service Provider (a. b. and c.).
2. Bowel test kits sent/due to be sent - National Cancer Screening Register Service Provider (a.).
3. Follow up contacts made/due to be made - National Cancer Screening Register Service Provider (a. b. and c.).

All measures extracted from the National Cancer Screening Register (NCSR), delivered under the NCSR Services Agreement.

Methodology:

1. Correspondence sent/due to be sent – the proportion of correspondence sent of correspondence due to be sent (a. b. and c.).

2. Bowel test kits sent/due to be sent – the proportion of kits sent of kits due to be sent (a.).

3. Follow up contacts made/due to be made – the proportion of follow up contacts made of contacts due to be made (a. b. and c.).

a. During 2025–26 the following activities were undertaken to increase the number of Australians completing bowel cancer screening.[49]

- Promotion of the program and the bowel cancer care to healthcare providers via approved training events, online training, webinars and resources, with more than 1,000 providers signed up for an event or online module.
- The National Bowel Cancer Screening Program (NBCSP) transitioned to new campaign activity following the conclusion of the Get2it campaign in November 2025.
- A new campaign, ‘Bowel cancer waits for no one’, launched in June 2026 in partnership with Cancer Council Australia, will run until November 2027. This builds on earlier initiatives, including the Get behind it! Roadshow, which concluded in October 2025.
- Updated community engagement approaches, including ‘Loo Post’ and the ‘Catch it early café’, are underway alongside ongoing partnerships with Supercars and the Penrith Panthers to reach under-screened populations.

The department is exploring a range of solutions to improve participation, including through a randomised control trial targeted at identifying opportunities to increase participation in persistent never-screeners, and considering opportunities for program design changes. The Program participation rate is at 42%[50] which is an improvement on the previous year’s result of 41.7%.

Participation rates in bowel screening remain lower than other screening programs due to a range of external factors. Since the NBCSP began in August 2006, 17,378 bowel cancers have been detected through the program.

[49] All Australians aged 50–74 are sent a kit every two years; noting that people aged 45-49 years may opt in to the program.

[50] For the period January 2023 to December 2024, available at: **www.aihw.gov.au/reports/cancer-screening/nbcsp-monitoring-2026/contents/about**

Further information on research, evaluation and reports is available at: **www.health.gov.au/our-work/national-bowel-cancer-screening-program/about-the-national-bowel-cancer-screening-program#research-evaluation-and-reports**

b. During 2025–26 the following activities were undertaken to increase the number of Australians completing cervical screening:

- The National Cervical Screening Program (NCSP) successfully delivered the 'Own It campaign' (May 2024 to September 2025), which targeted under-screened groups including First Nations, culturally and linguistically diverse, LGBTQ+ communities and people with disability. The campaign reached over 5.5 million people on social media and delivered 33.6 million video views, while engaging more than 10,000 healthcare providers to support the self-collection option.
- Community engagement activities attracted over 27,000 participants, with 346 people completing a Cervical Screening Test at pop-up events. Evaluation showed strong impact, with awareness increasing in priority areas and awareness of self-collection rising by 45%.
- Community engagement will continue in 2026 through partnerships with ACON and the Australian Multicultural Health Collaborative, with a focus on pop-up screening, workforce training and tailored resources. Additional resources for First Nations women are in development, with delivery expected from mid- to late-2026.

The department continues to see an increased uptake of the recently introduced self-collect option (as opposed to clinician-collected samples) and is continuing to explore opportunities to increase participation to ensure equity of access across priority population groups.

The definition of participation for cervical screening was also redefined and first published in the 2025 Cervical Screening Monitoring Report. Participation from this report is defined as the number of participants aged 25–74 who had an HPV test over 5.5 years as a proportion of the number of eligible females aged 25–74 in the population. The Program participation rate is at 77.9%, which is a slight decrease against previous years' results of 63.5%.

The NCSP has a five-year screening cycle, with program participation results continuing to be impacted by the lower screening rates seen during the COVID-19 pandemic. Further program data and monitoring reporting is available at: **www.health.gov.au/our-work/national-cervical-screening-program/about-the-national-cervical-screening-program#program-data**

c. The National Lung Cancer Screening Program (NLCSP) commenced on 1 July 2025 and uses low-dose computed tomography (low-dose CT) scans to look for lung cancer in high-risk people without any symptoms.

During 2025–26 the following activities were undertaken to increase the number of Australians participating in lung cancer screening.[51]

- The NLCSP launched the *It's Good to Know* campaign in October 2025 to support equitable awareness and access to screening. Early results included over 10 million video plays, 44,000 search-driven clicks and more than 430,000 website visits, supported by media coverage reaching around 8 million people. Campaign activity will continue throughout 2026, with year two commencing in July 2026 and expanded community engagement targeting priority populations.

Over 100,000 Australians screened in the first year of the Program, with an average of 286 people enrolling in the program daily. Program participation reporting for the NLCSP is not yet available due to the infancy of the program. First participation rates in the program will be presented in the AIHW's first program monitoring report in 2027.

[51] People are eligible for the NLCSP if they are aged between 50 and 70 years old and show no signs or symptoms suggesting they have lung cancer (that is, they are asymptomatic); currently smoke or have quit smoking in the past 10 years; and have a history of tobacco cigarette smoking of at least 30 pack-years.

The department supported delivery of the following work relevant to cancer screening:

- In 2025–26, the department led the development of the BreastScreen Australia Strategic Framework in partnership with state and territory governments. The Strategic Framework responds to the findings from the BreastScreen Australia Review and will guide the future direction of the program over the next 10 years. BreastScreen Australia is progressing new resources to support participation among culturally and linguistically diverse women and women with disability, with materials expected for release in October 2026. The department has also expanded the 'Screen with your sistas' initiative, with additional resources to support conversations about breast screening among First Nations women to be distributed from late August 2026.
- National Skin Cancer Prevention campaigns ran from November 2025 to March 2026, targeting young Australians (18–30 years) and men aged 40 and over. A fully integrated approach across media channels, supported by influencer and media partnerships, delivered the strongest results to date, with record reach (52% and 58%) and strong action rates (43% and 34%) across both audiences.
- The department continued to manage the funding agreement with the Melanoma Institute of Australia for the Development of a Roadmap for a Targeted Melanoma Screening Program, which is anticipated to be finalised in 2028.

The department will continue to build on these activities across all programs, with a focus on increasing awareness and participation among under-screened populations. Further information on program monitoring and evaluation is available at: **www.health.gov.au/our-work/nlcsp/about#program-monitoring-and-evaluation**

Program 1.6: Primary Health Care Quality and Coordination

Key Activity 1.6A: Supporting Primary Health Networks (PHNs) to increase the efficiency, effectiveness, accessibility, and quality of primary health care services through the delivery of key national programs.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.52

Performance Measure 1.6A: PHNs are meeting delivery objectives for national programs.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.52

2025–26 Planned Performance	2025–26 Result
28	20
	Result: Not achieved

The assessment scale for the 2025–26 planned performance is:

Achieved: 28
Substantially achieved: 26 to 27
Not achieved: ≤25

Disclosures:

1. At the establishment of the measure in the 2025–26 Corporate Plan, all data was anticipated to be available and suitable for reporting. However, data from the Mental Health - headspace program was subsequently determined to be a sub-optimal measure of Primary Health Network (PHN) performance as responsibility for outcomes does not rest solely with PHNs but is shared with headspace National. headspace data is for service contacts ('occasions of service') for headspace Primary program (including the headspace Work and Study in Centres program). Data is entered into the headspace Application Platform Interface in the headspace Centres and then collated by headspace National. headspace National provides a custom report to the department of the number of occasions of service for 12–25-year-olds (inclusive) for each headspace service. The number is obtained for the current year (2025–26) and previous year (2024–25) to understand service use over time using the best available data from the administrative system. The data has been collated to reflect occasions of service within PHN regions.
2. At the establishment of the measure in the 2025–26 Corporate Plan, all data was anticipated to be available and suitable for reporting. Data from the Aged Care – Care Finder program ceased on 31 December 2025 as a response to changes to the Aged Care Act. The reported result is based on 6 months of data only which should be considered when interpreting the result. Of the 910 care finder providers active during the period, 8 failed to provide an activity report by the required deadline.
3. The count of alcohol and other drug treatment services includes all publicly-funded government and non-government services, not only those funded by PHNs. Data for drug and alcohol treatment services is subject to a time lag. The result reported is based on comparison of 2024–25 data against 2023–24 data.

Data Source:

Data for the measure is sourced as follows:

1. Mental Health: This data is collected from headspace clinics and collated to PHN areas.
2. Aged Care: This data is collected through an evaluation consultancy acting on behalf of the department.
3. Drug and Alcohol Treatment: Data is collected annually by the Australian Institute of Health and Welfare.

The measure is composed of these 3 components as detailed below.

Methodology:

Each PHN is assessed against each of the 3 performance criteria for Mental Health, Aged Care and Drug and Alcohol treatments, and is determined to have either 'met' or 'not met' each of the 3 KPIs as follows:

1. Mental Health – maintenance or increase in the total number of service contacts.
2. Aged Care – at least 90% of clients are among the target audience of older people who need intensive support to access aged care services. Support may be required for a range of reasons including isolation, communication barriers, disability or mental ill health.
3. Drug and Alcohol Treatment – maintenance or increase in the number of closed treatment episodes.

The total number of PHNs to have met 2 or more of the 3 KPIs is reported.

The department funds and works closely with 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 state and territory governments and Local Hospital Networks (or equivalent) to improve service integration.

While it is useful to monitor trends, mental health service utilisation is predominantly demand-driven and shaped by a range of external factors. In addition, the headspace Program operates under a multi-layered governance framework designed to deliver nationally consistent, youth focused, mental health care, while maintaining flexibility for local needs. The overall number of headspace service contacts increased from 570,000 in 2024–25 to 640,000 in 2025–26. The number of contacts was maintained or increased in 20 of 31 PHN areas.

Whilst PHNs have commissioning responsibilities for headspace services, oversight and service planning is a shared responsibility between headspace National and PHNs. headspace National ensures headspace services provide safe and quality services to young people through the requirements of the headspace model and frameworks. This complexity should be considered when interpreting the results and considering suitability of the data for assessing PHN performance.

Data for the number of closed drug and alcohol treatment services is available for 2024–25 and indicates that across all PHN regions the rate of closed treatment services per 100,000 population decreased between 2023–24 and 2024–25. This would suggest that broader factors may have influenced results beyond the effects of individual PHN activities.

Prior to the cessation of reporting, the care finder program was providing services to more than 90% of the target audience across all PHNs. Following increased clarity about eligibility for care finder services resulting from commencement of the *Aged Care Act 2024,* collection of this data ceased.[52]

The Australian Government continues to invest in the PHN Program as a key mechanism for improving the efficiency, effectiveness, accessibility and quality of primary health care services across Australia. Through regional planning, commissioning and system integration activities, PHNs work with local health providers, communities and stakeholders to identify priority health needs and deliver services tailored to local populations.

In 2025–26, PHNs continued to support access to primary and mental health care, after-hours services, workforce initiatives and other locally responsive programs. Through these activities, PHNs addressed local service gaps, improved access to care for priority populations and contributed to a more connected, equitable and patient-centred primary health care system.

The PHN Program produces annual performance reports which outline how the department's activities are helping achieve objectives each financial year. It is assessed across the priority areas identified in the Performance and Quality Framework. PHN Program annual performance reports are available at: **www.health.gov.au/resources/collections/primary-health-network-program-annual-performance-reports**

[52] The care finder program is subject to ongoing independent evaluation to assess the program's implementation, appropriateness and effectiveness, including the role of PHNs in commissioning and managing care finder services. Evaluation reports including details on KPI's relating to other aged care finder services are available on the department's website: **www.health.gov.au/resources/collections/implementation-of-the-care-finder-program-reports?language=en**

Key Activity 1.6B: Support state and territory governments and PHNs to deliver Medicare Urgent Care Clinics (UCCs).
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.54

Performance Measure 1.6B: Number of Medicare UCC presentations that report they otherwise would have gone to an ED or called an ambulance if the Medicare UCC was not available.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.54

2025–26 Planned Performance	2025–26 Result
Establish baseline.	462,584
	Result: Achieved

The assessment scale for the 2025–26 planned performance is:

Achieved: Baseline is established for 2025–26.
Substantially achieved: N/A
Not achieved: No baseline is established for 2025–26.

Disclosures:

A further 50 clinics were established in the 2025–26 financial year, primarily between December 2025 and June 2026. These clinics are not included in the 2025–26 baseline result as newly established clinics typically experience a ramp-up period before reaching steady throughput, which may affect observed performance within the baseline year.

Overall presentation throughput is reliant on accurate and complete use of the UCC Module and inconsistencies in Module usage may result in underreporting of actual activity.

Patients must provide consent for their information to be collected, including their responses to questions related to this performance measure. If consent is not provided, this will reduce the number of presentations with recorded responses to the question. Temporary clinic closures due to workforce shortages, severe weather events or other reasons has the effect of reducing the number of presentations that can respond to the question.

- Mount Gambier Medicare UCC had an extended closure from January 2025 due to operator liquidation, reopening in January 2026 under a new provider.
- Severe weather events such as cyclones in Queensland and Western Australia in 2025–26 saw some Medicare UCCs temporarily close.

Data Source:

- Medicare UCCs where patients have responded either ‘Local ED’ or ‘Ambulance’ to the following question: ‘Where would patient have gone if the Medicare UCC was not available?’
- The Medicare UCC Module forms the Medicare UCC Dataset. The Module data is completed daily by participating Medicare UCCs and collected weekly by a third-party provider on behalf of the department. The dataset is securely stored in the department.
- Data is only extracted for patients who have consented to share their deidentified data with the department and only collected from Medicare UCCs with compatible IT where the Module is installed (currently excludes 5 Australian Capital Territory and 6 remote Northern Territory clinics).

Methodology:

1. The relevant question on the Module is ‘Where would patient have gone if the Medicare UCC was not available?’ The patient is provided 7 options to choose from: ‘ambulance’, ‘general practitioner’, ‘local ED’, ‘other health professional’, ‘telephone or virtual triage service e.g. Healthdirect’, ‘would not have sought medical care’ or ‘other’.

2. The department will collate the combined number of presentations where a patient responded to the question with ‘local ED’ or ‘ambulance’ to report on the performance measure.

The baseline result of 462,584 presentations for 2025–26 incorporates data from 76 Medicare Urgent Care Clinics that offer walk-in and bulk-billed urgent care, 7 days a week for extended hours. The baseline result for presentations will increase in 2026–27 as the number of clinics included in the measure will increase to 126.[53]

As at 29 June 2026, there have been over 3.3 million presentations across 137 Medicare UCCs since the first clinics were implemented in June 2023. The Medicare Urgent Care Clinics Program Evaluation: Second Interim report estimates the annualised cost of a Medicare UCC presentation is around $206.00 per presentation.[54] 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.[55]

Internal activities contributing to performance

- Medicare UCCs continued to provide free, walk-in urgent care during extended operating hours, improving access to care for patients who may have otherwise attended an emergency department.
- Updated the Medicare UCC Operational Guidance, with changes including, but not limited to, more clearly outlining mandatory program requirements (such as Medicare UCCs operating 14 hours per day, seven days per week), strengthening triage and demand management requirements, and enhancing workforce flexibility through the inclusion of paramedics in minimum staffing arrangements. These changes strengthened program consistency and supported the delivery of timely urgent care services as an alternative to Emergency Departments.
- These changes have supported Medicare UCCs to grow towards capacity. The 2nd interim report of the independent evaluation of the program found that due to clinics growing towards capacity, the cost per Medicare UCC presentation has reduced from $216 to $206. It also found that Medicare UCCs are achieving their purpose in reducing equivalent ED presentations by around 10% (noting that the result varies depending on the methodology used).
- During the 2025–26 financial year, the department commenced implementation of the Medicare UCC performance based funding model in the 50 newest clinics. Under this model, clinics receive a base operating grant that provides a minimum level of funding, supplemented by additional loadings and incentive payments, including opening-hours loadings, MMM loadings, throughput incentives, and incentives for ancillary services (diagnostic imaging and pathology). Collectively, these funding elements support clinic accessibility, service capacity and patient throughput, strengthening the ability of Medicare UCCs to manage urgent but non-life-threatening conditions and reduce pressure on EDs.
- A set of Data FAQs issued to Commissioners in August 2025, providing Medicare UCCs guidance on how to consistently ask the question *'Where would the patient otherwise have gone*', to mitigate risk of potential survey bias.
- The department provides monthly reports to Commissioners demonstrating presentation throughput and Module completion of specific questions, including *'Where would patient have gone if the Medicare UCC was not available?'*. The reports support Commissioners to engage with the clinic to ensure the UCC Module is completed.

[53] This will include the 50 Medicare UCCs opened in 2025–26 that will be open for all of 2026–27. It will also exclude the 11 Medicare UCCs (5 ACT Walk in Centres and 6 remote NT clinics) that do not report through the Module due to IT compatibility issues.

[54] Available at: **www.health.gov.au/sites/default/files/2026-02/medicare-urgent-care-clinics-program-evaluation-second-interim-report_0.pdf**

[55] In line with the ACT Federal Funding Agreement for Medicare UCCs, the 5-nurse led ACT Walk-in-Centres do not hold s19(2) exemptions and cannot claim s19(2) eligible MBS items.

- The department's contract with the data extraction provider ensured weekly data was collected from Medicare UCCs with compatible IT where the Module is installed. The contractor provided support to the Medicare UCCs if there were any issues with use of the UCC Module. The department's weekly data ingestion and transformation process includes built in quality checks to confirm data completeness. This includes checking for unmapped clinics and exclusion of full and partial duplicates.

External factors influencing performance

- Clinics increasing opening hours to meet demand and better align with the Medicare UCC Program Operational Guidance has the effect of increasing the number of presentations that can respond to the question.
    - Industrial action in Tasmania saw additional funding provided to Tasmanian Medicare UCCs from the Tasmanian Government to open for extended hours in 2025–26.
- Increased awareness of Medicare UCCs can result in an increase in the number of presentations that can respond to the question.
    - The announcement of a further 50 clinics to be opened in 2025–26 increased visibility of the program with the public which may have increased patients accessing their nearest Medicare UCC.
    - A national communications campaign about Medicare UCCs ran from April to June 2026, which increased awareness of the program.
- Clinics which have been open for at least a year in 2025–26 would not be impacted by the 'ramp-up' period with presentation throughput being more stable when contributing to the baseline result.
- Responses to the question in the UCC Module, '*Where would the patient have gone if the Medicare UCC was not available?*' are influenced by several factors. These include regular UCC Module reporting from clinics, patient consent rate, and the absence of the UCC Module in some clinics due to incompatible IT infrastructure.

Program 1.7: Primary Care Practice Incentives and Medical Indemnity

Key Activity 1.7A: Providing Practice Incentive Program (PIP) payments to eligible general practices.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.56

Performance Measure 1.7A: The percentage of general practices accredited under the NGPA Scheme participating in PIP.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.56

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
≥95%	97.9%	93.2%	92.7%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:
Achieved: ≥95.0%
Substantially achieved: ≥92.5% to 94.9%
Not achieved: <92.5%

Disclosures:
The result is calculated using Q4 – May PIP payment data for the number of general practices participating in PIP, received from Services Australia along with 13 May 2026 data on the number of general practices accredited under the NGPA Scheme, received from the Australian Commission on Safety and Quality in Health Care.

PIP payments do not align to standard financial years. PIP Years are comprised of 4 payment quarters with specific service reference periods for each quarter across 2024–25 and 2025–26 financial years as follows:

Quarter	Service Reference Period
Q1 – August	1 May to 31 July
Q2 – November	1 August to 31 October
Q3 – February	1 November to 31 January
Q4 – May	1 February to 30 April

The Australian Commission on Safety and Quality in Health Care update the published list of accredited practices under the NGPA scheme every month.[56]

Data Source:
Services Australia (PIP participation data). Australian Commission on Safety and Quality in Health Care (ACSQHC) (NGPA Scheme data).

Methodology:
Data is received from Services Australia and the ACSQHC to inform the department regarding the percentage of general practices accredited under the NGPA Scheme participating in PIP.
Numerator: Data on the number of general practices participating in PIP is received from Services Australia.

[56] Available at: **www.safetyandquality.gov.au/your-health-service/register-accredited-general-practices-and-aboriginal-medical-services**

Denominator: Data on the number of general practices accredited under the NGPA Scheme is received from the ACSQHC. The number of general practices participating in PIP (**numerator**) divided by the number of general practices accredited under the NGPA Scheme (**denominator**) and multiplied by 100 to calculate the percentage of general practices accredited under the NGPA Scheme participating in PIP.

The department continued to provide policy and operational support for the Practice Incentives Program (PIP) throughout 2025–26.

The department utilised management arrangements and accountability measures to ensure the availability of appropriate resourcing and funding, monitoring delivery of intended benefits, stakeholder communication and risk mitigation as well as adherence to frameworks and policies to ensure planned performance was achieved.

General practices are private businesses with diverse operating structures and employment models. Participation in PIP and accreditation under the NGPA Scheme are voluntary for general practices.

General practice accreditation remains a mandatory requirement for participation in the 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. 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.

Accreditation against the Royal Australian College of General Practitioners Standards for general practices (5th edition) (the RACGP Standards) is valid for 3 years. The NGPA Scheme is managed by the Australian Commission on Safety and Quality in Health Care (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.

Program 1.8: Health Protection, Emergency Response and Regulation

Key Activity 1.8A: Regulating therapeutic goods to ensure safety, efficacy, performance and quality.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.58

Performance Measure 1.8A: Percentage of therapeutic goods evaluations that meet statutory timeframes.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.58

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
100%	99.47%	99.35%	99.93%
	Result: Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved: 100%

Substantially achieved: N/A

Not achieved: <100%

Data Source:

Data for this measure is sourced from internal systems which track evaluation start and completion dates to ensure alignment with statutory requirements. Data is analysed and maintained internally by the department.

Methodology:

The 6 TGA program areas contributing to this measure are those conducting evaluations under statutory timeframes. They calculate the total number of evaluations that met statutory timeframes as a proportion of the total number of evaluations completed, as defined for that program. The data for the reporting period is then converted into a percentage showing the performance of individual program areas.

The overall performance against Activity 1.8A is calculated using the total number of evaluations completed within the statutory timeframe (**numerator**) divided by the total number of evaluations subjected to the statutory timeframe (**denominator**).

This performance measure is a consolidation of 6 distinct areas of work within the Therapeutic Goods Administration (TGA). In 2025–26, the 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, listed medicines ingredients, registered complementary medicines, assessed listed medicines, medicine devices conformity assessments, and medical devices preliminary assessments. All 6 areas are subject to statutory evaluation timeframes that are specific to each class of therapeutic good.

The TGA completed 98.8% of prescription medicine evaluations within statutory timeframes for the reporting period. The TGA completed over 570 Category 1 and 2 applications, which are more complex and 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. While these applications for variations have lower data requirements, they also have a shorter legislated timeframe of 45 days, making the target harder to meet.

The number of Category 1 and 2 applications received in 2025–26 represented a 14% increase on 2024–25. While the TGA aims to complete all prescription medicine applications within legislated timeframes, the increased number and complexity of applications meant the TGA did not meet its planned performance target of 100% for 2025–26.

Ongoing improvements to business systems and reporting will support the TGA to manage the increasing volume and complexity of applications. Prescription medicines saw a slight 0.4% decrease in the proportion of on-time applications compared to 2024–25.

The TGA completed 93.3% of listed medicine ingredient evaluations within statutory timeframes for the reporting period. This is a 6.7% decrease compared to the long-standing record of listed medicine ingredient evaluations meeting 100% since the introduction of statutory timeframes. The TGA received 28 applications for 2025–26, an increase of 55% on the 18 received in 2024–25. In 2025–26, 25 applications were completed in comparison to 8 in the previous year. The applications received for the reporting period were more complex, with 9 of these not conforming to the conventional nature of applications. These applications were submitted under the IN1[57] category, which has a shorter evaluation timeframe of 70 business days. The applications required extensive consideration, placing further pressure on available resources and impacting the timeliness of completion. A team of case managers provided ongoing support for the assessment of applications that were non-conventional. Ongoing improvements to business systems and reporting will reduce the number of applications that exceed legislated timeframes and progressively improve performance against this measure.

The TGA completed 100% of registered complementary medicine and assessed listed medicine evaluations within statutory timeframes for the reporting period, consistent with the previous year's result. This outcome was achieved through improvements in processes, trained and experienced evaluators, and the quality of the applications as supported by close communication between TGA evaluators and applicants.

The TGA also completed 100% of medical device conformity assessment applications within statutory timeframes for the reporting period, consistent with the previous year's result. The number of applications decreased by 17% in 2025–26 compared to the previous year. The TGA established an improved case management process for TGA conformity assessment applications in 2024, reducing processing times and ensuring applications are completed within statutory timeframes. Regulation changes from 1 July 2024 for medical devices containing medicinal, microbial, recombinant or animal origin substances have reduced the demand for TGA conformity assessment certificates.

The TGA completed 99.8% of medical device preliminary assessment applications within statutory timeframes and continues to improve how it assesses these applications. Recent internal reviews have helped to align processes with the new application audit framework. This work has enabled the TGA to manage an increasing number of applications in recent years without additional staff or significant impacts on performance. The TGA has also strengthened its systems for tracking performance against statutory timeframes and improving the quality of performance data. These improvements help to identify and resolve issues earlier, supported by process changes and staff training. Stronger internal processes are helping staff to make decisions on applications within the 20-day statutory timeframe.

The 99.8% result shows the TGA maintained strong performance despite receiving 6% more medical device ARTG applications in 2025–26, following a 19% increase in 2024–25. Only 11 applications exceeded the 20-day timeframe. Following investigation of these cases, the TGA has taken corrective action to reduce the risk of recurrence.

The TGA has changed how it measures and reports compliance for medical device preliminary assessments. Reporting is now based on applications decided during the reporting period, rather than applications received, and is supported by improved data fields and invoice checks to strengthen reporting accuracy. Ongoing improvements continue to focus on data quality, compliance and timely assessment decisions.

Further performance on the TGA is available in the TGA Performance Reports, available at **www.tga.gov.au/resources/publication/corporate-reports/performance-reports**

[57] Applications for evaluation of a substance to be used in listed medicines are categorised into 4 application levels- IN1, IN2, IN3 and IN4. Each application category has defined submission requirements and evaluation timeframes ranging from 70 days for IN1 to 180 days for IN4.

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, Disability and Ageing Corporate Plan 2025–26, p.60

Performance Measure 1.8B: Number of completed inspections of licence holders under the *Narcotic Drugs Act 1967.*

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.60

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
32	33	33	31
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved: ≥32

Substantially achieved: N/A

Not achieved: <32

Data Source:

The ODC Monitoring and Compliance Section maintains an inspection schedule, which is a spreadsheet database of the compliance and initial inspections it undertakes.

Methodology:

The data is extracted from the inspection schedule report. The number of completed inspections is determined based on records for each licence holder and captured in the inspection schedule. An inspection is counted as completed following inspection outcome reports being generated and sent to the licence holder. The cost of an inspection is also charged to the licence holder in line with ODC's cost recovery framework.

In 2025–26, the Office of Drug Control (ODC) achieved the planned performance, completing 33 inspections against a target of 32. The ODC met 94% of its 2-month timeliness standard, which requires inspection reports and associated activities to be completed within 60 calendar days of the inspection. Where the timeliness standard was not met, this was primarily due to complexity of the matters involved and staff availability. The results demonstrate effective planning, prioritisation and delivery of the inspection program, while ensuring timely regulatory oversight and accountability to regulated entities.

Performance was supported by a risk-based inspection program, including ongoing refinement of inspection timing and allocation of resources to higher-risk regulated entities. This enabled the ODC to target regulatory effort where it was most needed and maintain the timeliness and quality of inspection activities.

Performance in 2025–26 was consistent with the previous year, during which 33 inspections were completed, a slight increase on the 31 inspections completed in 2023–24. Stabilising inspection volumes reflects the relatively steady number of licensed and permitted sites subject to regulation by the ODC, while the continued achievement of inspection targets demonstrates sustained regulatory capability and operational maturity.

In addition to undertaking inspections, the ODC continued to provide regulatory advice and guidance on the import, export, cultivation, production and manufacture of controlled drugs, including medicinal cannabis. These activities support industry understanding of regulatory requirements and contribute to broader compliance outcomes. Further information on the ODC's functions, regulatory responsibilities, guidance materials and licensing activities is available on the Department of Health, Disability and Ageing's Office of Drug Control website.[58]

[58] Available at: **www.odc.gov.au**

Key Activity 1.8C: Administering the National Gene Technology Scheme by evaluating applications and issuing approvals as appropriate, and by conducting routine inspections of certified facilities and licensed activities with genetically modified organisms (GMOs).

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.61

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, Disability and Ageing Corporate Plan 2025–26, p.61

2025–26 Planned Performance	2025–26 Result	2024–25 Result
a. ≥98% b. ≥98%	a. 100% b. 100%	a. 100% b. 100%
	Result: a. Achieved b. Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. ≥98%

b. ≥98%

Substantially achieved:

a. 90% to <98%

b. 90% to <98%

Not achieved:

a. <90%

b. <90%

Data Source:

a. The date a new application is received by the Office of Gene Technology Regulator (OGTR) is entered into the OGTR information management system and a statutory decision date is automatically generated based on the legislated timeframes. The statutory due date is revised to take into account any non-processing (stop clock) days when the Regulator cannot proceed with decision making. The application decision date is entered into the database by the delegate once the decision has been made. Relevant supporting documents are retained to enable validation of all data.

b. Primary reported non-compliance metrics data consists of the date of receipt of a report or allegation of non-compliance with the conditions of authorisations and the date of assessment of the report or allegation of non-compliance with the conditions of authorisations. This is a measure of whether all reports of non-compliance with the conditions of an authorisation have been assessed.

All reported non-compliance (with the conditions of authorisations) metrics data is recorded in the OGTR's internal monitoring and compliance information management system.

Methodology:

a. Views and reports are used with the OGTR information management system to analyse our data and show whether decisions were made within statutory timeframes. Application and assessment documents are retained to allow independent verification of submission, and decision dates. The data is filtered to display only applications with statutory decision date or application decision date within the reporting timeframe. Withdrawn applications are removed as they no longer have a statutory decision date. The **numerator** comes from all applications within the filtered data that have an Application Decision Date that is before the Decision Due Date. The **denominator** comes from the total count of applications that have a Decision Due Date or an Application Decision Date within the period, i.e. in the latter the decision due date falls outside the reporting period. Measure result is presented as a percentage.

b. A report is run in OGTR's monitoring and compliance information management system which lists the reports or allegations (incidents) received. This report includes information about the incident including whether a date assessed has been recorded. The number of incidents received that are reports or allegations of non-compliance with the conditions of an authorisation, and the number of incidents of this type that have the 'Date Assessed' field completed are used to determine the percentage of received reports or allegations that have been assessed (or triaged).

For a., in 2025–26 the Office of the Gene Technology Regulator (OGTR) completed 100% of statutory decisions within timeframes, achieving the planned performance target of ≥98%. Resourcing prioritisation, staff expertise and training contributed to making statutory decisions within timeframes during this period.

Applications can be received at any time, affecting starting decision timeframes and defining decision due dates. OGTR is unable to predict the number or timing of applications received. Timeframes begin at the time of receipt of complete applications, with decisions due as determined by the legislated timeframe for the application type. Licence applications require greater time, effort and expertise from OGTR staff compared to other statutory applications.

For b., in 2025–26 the OGTR assessed 100% of reported non-compliance with the conditions of GMO approvals, achieving the planned performance target of ≥98%. Resourcing prioritisation, staff expertise and training contributed to meeting assessments of reported non-compliance with the conditions of GMO approvals.

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.

The *Gene Technology Act 2000* requires the Gene Technology Regulator to report annually on their operations. The reports are produced for the Minister as soon as practicable after the end of each financial year. These reports are available on the OGTR website.[59]

[59] Available at: **www.ogtr.gov.au/resources/collections/annual-reports-operations-gene-technology-regulator**

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, Disability and Ageing Corporate Plan 2025–26, p.63

Performance Measure 1.8D: Proportion of Industrial chemical risk assessments completed within statutory timeframes.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.63

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
100%	100%	100%	100%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved: 100%

Substantially achieved: ≥90% to 99%

Not achieved: <90%

Data Source:

Administrative data records are stored within the AICIS Information Technology (IT) System (D365 CRM), and the International Uniform Chemical Information Database (IUCLID) contains scientific data and information. Unique identifiers are used to relate data between the 2 databases.

Methodology:

To determine the Planned Performance Result, the following calculation is applied:

a = number of certificate applications, b = number of authorisation applications, and c = number of evaluations

$$\text{Result} = \frac{{}^{a}\text{completed within timeframe} + {}^{b}\text{completed within timeframe} + {}^{c}\text{completed within timeframe}}{{}^{a}\text{total completed} + {}^{b}\text{total completed} + {}^{c}\text{total completed}}$$

To protect human health and the environment, the Australian Industrial Chemicals Introduction Scheme (AICIS) undertakes both pre-market and post-market risk assessments of industrial chemicals. Pre-market risk assessments of applications for certificates and commercial evaluation authorisations (CEA) identify potential risks before introduction and recommend risk management measures to support the safe use of industrial chemicals while enabling innovation and regulatory compliance.

Post-market risk assessments (evaluations) assess risks associated with chemicals already in use, including where conditions of use have changed, new information becomes available, or emerging concerns are identified.

During 2025–26, AICIS completed:

- 16 pre-market risk assessments (including 15 assessed introductions and 1 CEA) covering 16 unique industrial chemicals
- 19 post-market risk assessments (evaluations) covering 1,057 unique industrial chemicals.

The target for the 2025–26 period was increased from 95% to 100% to align with the obligations of the AICIS under the *Industrial Chemicals Act 2019* and its historical performance. The planned performance for 2025–26 was achieved, with 100% of risk assessments completed within statutory timeframes. Risk assessment quality was maintained through internal peer review processes, seeking feedback from applicants on draft assessment statements, and undertaking public consultation on draft evaluation statements.

Stakeholder engagement and timely input from stakeholders supports the completion of risk assessments within statutory timeframes. Applicants provide information and respond to information requests during pre-market assessments, while public consultation and calls for information informs post-market evaluations.

Pre-market risk assessments are demand-driven and dependent on the number and nature of assessment applications submitted by industry. Variations in application volumes and complexity can influence assessment workloads and performance results from year to year.

Timely completion of risk assessments enables AICIS to identify and communicate risks to human health and the environment and provide recommendations to support the safe introduction and use of industrial chemicals in Australia. Timely completion of pre-market assessments also provides regulatory certainty for industry participants seeking to introduce industrial chemicals onto the Australian market.

Program 1.9: Immunisation

Key Activity 1.9A: Increase immunisation coverage rates by implementing the National Immunisation Program.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.64

Performance Measure 1.9A:
Immunisation coverage rates:

a. For children at 5 years of age are increased to the protective rate of 95% and then be maintained.
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, Disability and Ageing Corporate Plan 2025–26, p.64

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
a. ≥95.00% b. Progressive increase towards ≥95.00% c. Progressive increase towards ≥90.00%	a. 92.92% b. 89.71% c. 79.55% (females) 76.52% (males)	a. 93.27% b. 89.61% c. 81.50% (females) 78.44% (males)	a. 93.85% b. 90.29% c. 84.75% (females) 82.03% (males)
	Result: a. Not achieved b. Achieved c. Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:
a. ≥95.00%
b. Increase on 2024–25 result.
c. Increase on 2024–25 result.

Substantially achieved:
a. N/A
b. N/A
c. N/A

Not achieved:
a. <95.00%
b. Decrease or same result as 2024–25.
c. Decrease or same result as 2024–25.

Disclosures:

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:

The Australian Immunisation Register (AIR).

Methodology:

- a. and b. coverage rates are calculated as the proportion of children in a cohort that are fully immunised in the AIR.
- c. coverage rates are calculated as the proportion of 15-year-olds listed as receiving HPV vaccinations in the AIR.

Australia continued to maintain a strong publicly funded immunisation program and relatively high coverage in 2025–26. However, while overall coverage remains strong coverage has declined or plateaued in recent years and remains below the level needed to meet key national coverage objectives.

In 2025–26:

a) vaccination coverage for children fully immunised at 5 years of age remained below the 95% target (result: 92.92%)
b) vaccination coverage for First Nations children fully immunised at 12-15 months increased on the previous year's result to close the gap with non-First Nations children (result: 89.71%, change: +0.1%)
c) Human Papillomavirus (HPV) vaccination coverage for adolescents aged 15 years did not increase on the previous year's result and remained below the 90% target (results: 79.55% females, 76.52% males).

Childhood coverage at 5 years of age is a key indicator of protection against highly transmissible vaccine-preventable diseases, with the 95.00% target supporting community protection. First Nations childhood coverage reflects the importance of equity in immunisation outcomes and the need to close the gap in coverage between First Nations and non-First Nations children. HPV vaccination coverage at 15 years of age is a nationally significant adolescent vaccination indicator and a key contributor to Australia's commitment to eliminating cervical cancer by 2030.

The department supported immunisation coverage through national leadership of the immunisation system, including policy settings, funding, program stewardship, communications, data monitoring and partnerships with state and territory governments and delivery partners. This included funding vaccines from birth through to adulthood through the National Immunisation Program (NIP), supporting vaccination delivery through general practice, Aboriginal Community Controlled Health Services and community pharmacy, funding catch-up vaccines for eligible cohorts, implementing targeted communications and awareness activities, and working with states and territories through the Essential Vaccines Schedule to support improved vaccination coverage.

The 2025–26 results should be considered in the context of broader challenges affecting immunisation uptake. Compared with previous years, the results are consistent with a broader trend of high but declining or plateauing childhood and adolescent vaccination coverage. This shows that sustained coverage requires coordination across governments, immunisation providers, schools, Aboriginal Community Controlled Health Services, community organisations and other partners across the immunisation system.

Research through the National Vaccination Insights project indicates that declining childhood vaccination coverage is driven by a complex combination of behavioural, social and access-related factors.[60] In 2025, parents reported greater concerns about vaccine safety and lower trust in vaccine information, while access barriers remained important for some families. Improving vaccination coverage will require action to reduce barriers and strengthen community confidence in vaccination.

For First Nations children aged 12–15 months, the result indicates the gap with non-First Nations children was not closed in 2025–26. Continued partnership with Aboriginal Community Controlled Health Services, states and territories, and First Nations communities remains essential to support culturally safe, accessible and trusted vaccination services.

HPV vaccination coverage remained below the 90% target, reflecting ongoing challenges since the COVID-19 pandemic, including disruption to school-based delivery programs, increased school absenteeism and persistent inequities in coverage between population groups. National reporting demonstrates a broader decline in adolescent HPV vaccination coverage in recent years, reinforcing the need for sustained action to improve school-based delivery, catch-up vaccination and engagement with priority populations.

Through the 2026–27 Budget, the government will take targeted action to address declining childhood vaccination coverage, improve access and strengthen vaccine confidence.

[60] Available at: **www.ncirs.org.au/our-work/national-vaccination-insights-project**

Measures will support childhood immunisation uptake by continuing national communications to address misinformation and build vaccine confidence, improving access to NIP vaccines for young children through community pharmacy; and progressing Australian Immunisation Register SMS and push notification reminders for parents and carers when childhood vaccinations are overdue. These actions support the broader implementation of the National Immunisation Strategy 2025–2030 (NIS), which aims to improve coverage, equity, access, confidence and system resilience.

Immunisation delivery is a shared responsibility. The Commonwealth funds vaccines, sets national policy, supports national communication and data systems, and works with delivery partners. States and territories manage key delivery arrangements, including school-based vaccination programs. Healthcare providers, Aboriginal Community Controlled Health Services, community pharmacies, schools and community organisations also play a central role in delivering vaccines and supporting informed decision-making.

The 3 indicators provide consistent annual indicators of immunisation system performance: childhood coverage, First Nations childhood coverage, and adolescent HPV coverage. The indicators reflect key points across the life course, equity considerations and nationally recognised disease-prevention goals.

The measures provide an important indicator of performance, however do not capture all cohorts monitored through the immunisation system. Additional coverage measures are routinely monitored for other age groups and priority populations, including children at 1 and 2 years of age, First Nations children at other assessment milestones, older Australians and other cohorts eligible for NIP vaccines.

Detailed reporting on these cohorts is available through Australian Immunisation Register reporting, accessible via the Department's Immunisation Dashboards,[61] NCIRS coverage reports[62] and other national reporting mechanisms. The Monitoring, Evaluation and Learning (MEL) Framework[63] for the NIS, developed by the Australian Centre for Disease Control, includes a broader suite of indicators to monitor immunisation coverage, equity, access, confidence and system performance across the life course.

Immunisation coverage is a leading indicator of the program's contribution to reducing the impact of vaccine-preventable diseases. The department contributes to this outcome by funding NIP vaccines, supporting national immunisation policy and program stewardship, maintaining national data and communication systems, and working with states and territories and delivery partners to support vaccine access and uptake. The impact of immunisation on vaccine-preventable disease incidence is best assessed over time, using coverage data alongside disease surveillance, epidemiological reporting and the broader indicators established through the MEL Framework of the NIS 2025–2030.

[61] Available at: **www.health.gov.au/topics/immunisation/immunisation-dashboards**

[62] Available at: **www.ncirs.org.au/publications/reports**

[63] Available at: **www.cdc.gov.au/resources/publications/monitoring-evaluation-and-learning-framework-national-immunisation-strategy-australia-2025-2030**

Outcome 2: Individual Health Benefits

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

Programs contributing to Outcome 2

	Summary of results against planned performance targets				
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**	**Not applicable**
Program 2.1: Medical Benefits	1	2	-	-	-
Program 2.2: Hearing Services	-	-	-	-	1
Program 2.3: Pharmaceutical Benefits	1	1	-	-	-
Program 2.4: Private Health Insurance	2	-	-	-	-
Program 2.5: Dental Services	-	-	-	-	1
Program 2.6: Health Benefit Compliance	1	-	-	-	-
Program 2.7: Assistance through Aids and Appliances	-	1	-	-	-
Total	**5**	**4**	**0**	**0**	**2**

Program 2.1: Medical Benefits

Key Activity 2.1A: Provide access to subsidised health services.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.68

Performance Measure 2.1A: Percentage of Australians accessing MBS services.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.68

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
>90%	87.8%	88.0%	88.6%
	Result: Substantially achieved		

The assessment scale for the 2025–26 planned performance is:
Achieved: >90%
Substantially achieved: 87% to 90%
Not achieved: <87%

Disclosures:
The denominator used for performance measure 2.1A is the Estimated Resident Population (ERP) as at the 30 June 2025. While use of 31 December ERP would be technically preferable, as it represents the midpoint of the financial year, the 30 June ERP is used to maintain consistency with historical statistical reporting. The performance threshold was also established using 30 June ERP.

If the measure had been calculated using the 31 December ERP, the result would have been 87.2% rather than 87.8%. This difference is not material and does not affect the performance assessment for 2025–26.

Data Source:
Medicare claims data is sourced directly from Services Australia which processes Medicare claims on behalf of the department. Two data sources inform this measure:

1. The number of people accessing MBS services is calculated using Medicare claims data.
2. The Estimated Resident Population (ERP) from the Australian Bureau of Statistics, National, state and territory population, Excel workbook "Population – states and territories", Sheet "Data1", Column: Estimated Resident Population: Persons: Australia", ERP as at 30 June.[64]

Methodology:
Numerator: The number of people with at least one Medicare service processed in the reporting period.
Denominator: The ERP from the Australian Bureau of Statistics. The latest release of ERP available when the measure is produced is used. For the 2025–26 measure this will be the ERP as at 30 June 2025. The numerator is divided by the denominator to calculate the proportion of people with at least one Medicare service processed in the reporting period.

The Medicare Benefits Schedule (MBS) is the main mechanism through which Australians access subsidised health services. Service utilisation under the MBS is determined by the behaviour of consumers and health practitioners. The decline in bulk billing rates up to 2022–23 and rise in out-of-pocket costs, coupled with increasing cost-of-living pressures, has continued to present a barrier for some patients accessing the care they need.

[64] Further information can be found at: **www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-downloads**

Lower patient demand for MBS services can also reflect positive changes, such as greater access to services provided by other health professionals. For example, patients may obtain clinical certificates for work absences from pharmacists, and some states are trialling other pharmacy-delivered services. Patients may also access non-MBS funded care through privately funded services, or through other government programs, such as the Department of Veterans' Affairs.

The percentage of Australians accessing MBS services has declined from year to year from 88.6% in 2023–24 to 88.0% in 2024–25 and then to 87.8% in 2025–26. However, the rate of decline from year to year has slowed, with a decline of 0.2 percentage points in 2025–26, compared to the previous year.

The total Medicare bulk billing rate sharply declined through 2022–23 and early 2023–24. With the introduction of increased GP bulk billing incentives from 1 November 2023 and further expansion of eligibility for the GP bulk billing incentives to all patients receiving relevant service from 1 November 2025, bulk billing rates have started to recover.

From 2024–25 to 2025–26, the total Medicare bulk billing rate has increased by 0.7 percentage points to 76.0%. The total number of MBS services provided grew by 1.5% in 2025–26 to 482.5 million, compared to 3.4% in 2024–25. Performance against the target is anticipated to improve as bulk billing rates increase.

The government invested $7.9 billion in the 2025–26 Budget to expand eligibility for GP bulk billing incentives to cover all Australians from 1 November 2025 and at the same time established the Bulk Billing Practice Incentive Program (BBPIP). These measures are designed to support GPs to bulk bill all Medicare-eligible patients for eligible services.

Although the performance target was not achieved, government measures introduced to improve access to bulk billing supported the 2025–26 result. From 1 November 2025, eligibility for GP bulk billing incentives was expanded to all Medicare-eligible patients for eligible services, complemented by the introduction of the BBPIP. These initiatives contributed to increased bulk billing rates following a decline during 2022–23 and early 2023–24. As bulk billed services do not incur out-of-pocket costs for patients, increasing bulk billing rates may improve affordability and support greater access to MBS services over time.

Broader environmental factors, such as the severity of the seasonal influenza outbreaks, can also affect the number of patients accessing MBS services each year.

Medicare guarantees all Australian residents and some overseas visitors[65] access to 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 out-of-hospital healthcare, with the Australian Government fully or partially subsidising the cost of a wide range of health services.

MBS service utilisation is influenced by the behaviour of consumers and health practitioners. General Practitioners (GPs) consultations (often referred to as attendances) are typically the first point of contact for patients using MBS-funded services and are a key driver of overall MBS utilisation.

In 2025–26, the MBS subsidised 482.5 million healthcare services across Australia, including 165.7 million GP attendances. The MBS paid $35.0 billion in benefits for services claimed, covering 74.1% of the total fees charged for services during the year.

The introduction of the tripled GP bulk billing incentives on 1 November 2023 influenced the GP bulk billing rate. Bulk billed services are provided with no out-of-pocket cost to the patient, with the fee covered by the MBS.

[65] 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**

Following a decline in GP bulk billing rates during 2022–23 and early 2023–24 the introduction of tripled GP bulk billing incentives from 1 November 2023 contributed to a stabilisation and subsequent increase in bulk billing. The 2023–24 Budget provided $3.5 billion to support bulk billing for children under 16 years of age and Commonwealth concessional cardholders attending the most common GP services.

The Jurisdictional Strengthening Medicare and Primary Care Planning Forum (the Forum) has played an important role in improving the implementation of Strengthening Medicare reforms by facilitating collaboration between Commonwealth, state and territory health officials. Outcomes have included enhanced information sharing, earlier identification of emerging issues, improved policy and implementation decision-making, and stronger alignment between national reform objectives and jurisdictional delivery considerations. The Forum has also provided valuable insights to inform ongoing primary care policy development and priorities.

Strengthening Medicare and ensuring all Australians have access to affordable primary care services remains a priority for the Australian Government. Medicare Urgent Care Clinics (UCCs) provide an alternative care pathway for patients with urgent but not life-threatening need for care, and to help reduce pressure on hospital emergency departments. The government collaborates and works closely with state and territory governments and Primary Health Networks to establish and implement Medicare UCCs, supported through regular bilateral engagements and forums.

A range of Medicare statistics are regularly published by the Department of Health, Disability and Ageing as part of ongoing monitoring and reporting activities.[66] Additional Medicare data are also published by Services Australia[67] and the Australian Institute of Health and Welfare.[68]

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

Key Activity 2.1B: Patient visits to Medicare-subsidised General Practitioners. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.70**	
Performance Measure 2.1B: Percentage of Australians who had a GP Non-Referred Attendance claimed through the MBS. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.70**	
2025–26 Planned Performance	**2025–26 Result**
>85%	83.6%
	Result: Substantially achieved
The assessment scale for the 2025–26 planned performance is: **Achieved:** >85% **Substantially achieved:** 82% to 85% **Not achieved:** <82%	
Disclosures: The denominator used for performance measure 2.1B is the Estimated Resident Population (ERP) as at the 30 June 2025. While use of 31 December ERP would be technically preferable, as it represents the midpoint of the financial year, the 30 June ERP is used to maintain consistency with historical statistical reporting. The performance threshold was also established using 30 June ERP. **Data Source:** Medicare claims data is sourced directly from Services Australia which processes Medicare claims on behalf of the department. Two data sources inform this measure: 1. The number of eligible Australian residents and visitors who had a GP Non-Referred Attendance is calculated using Medicare claims data. 2. The Estimated Resident Population (ERP) from the Australian Bureau of Statistics, National, state and territory population, Excel workbook "Population – states and territories", Sheet "Data1", Column: Estimated Resident Population: Persons: Australia", ERP as at 30 June.[69] **Methodology:** **Numerator:** The number of people who had at least one Medicare subsidised GP Non-Referred Attendance service processed in the reporting period. **Denominator:** The ERP from the Australian Bureau of Statistics. The latest release of ERP available when the measure is produced is used. For the 2025–26 measure this will be the ERP as at 30 June 2025. The numerator is divided by the denominator to calculate the proportion of people with at least one GP Non-Referred Attendance service processed through Medicare in the reporting period.	

Service utilisation under the Medicare Benefits Schedule (MBS) is determined by the behaviour of consumers and health practitioners. The 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.

Reductions in demand could also be due to services being obtained from other health professionals (e.g. clinical certificates for work absences obtained from pharmacists and some states are trialling other services to be delivered via pharmacies); services which are non-MBS funded may be obtained through privately funded services (e.g. online clinics), or through other government programs (e.g. Department of Veterans' Affairs).

[69] Further information can be found at: **www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-downloads**

The percentage of Australians accessing MBS funded GP Non-Referred Attendance (GP NRA) has fallen in recent years and was 83.8% in 2024–25 and 83.6% in 2025–26. However, in line with other trends, the decline has slowed down with a decline of 0.6 percentage point in 2024–25 to 0.2 percentage point in 2025–26.

The GP NRA bulk billing rate sharply declined through 2022–23 and early 2023–24. With the introduction of increased GP bulk billing incentives from 1 November 2023 and further expansion of bulk billing incentives to bulk bill all patients from 1 November 2025, bulk billing rates began to slowly recover. Performance against the target is anticipated to improve as bulk billing rates increase.

From 2024–25 to 2025–26, the GP NRA bulk billing rate has increased by 3.1 percentage points to 80.9%. Overall service utilisation for GP NRA decreased by 1.2% in 2025–26.

Although the performance target was not achieved, in line with other trends, the number of patients accessing GP NRA has steadily increased from 1.2% in 2024–25 to 1.3% in 2025–26.

The government has invested $7.9 billion in the 2025–26 Budget to expand eligibility for GP bulk billing incentives to cover all Australians from 1 November 2025 and at the same time established the Bulk Billing Incentive Program. These measures are designed to support GPs to bulk bill all Medicare-eligible patients for eligible services.

Broader environmental factors, such as the severity of the influenza season, can also affect how many patients access MBS services each year.

Key Activity 2.1C: Support access to bulk billed General Practice (GP) attendances. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.71**	
Performance Measure 2.1C: GP Non-Referred Attendance Bulk Billing Rate. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.71**	
2025–26 Planned Performance	**2025–26 Result**
≥78.5%	80.9%
	Result: Achieved
The assessment scale for the 2025–26 planned performance is: **Achieved:** ≥78.5% **Substantially achieved:** 78.0% to <78.5% **Not achieved:** <78.0%	
Data Source: Medicare claims data is sourced directly from Services Australia which processes Medicare claims on behalf of the department. **Methodology:** This measure is calculated using Medicare claims data in the Department of Health, Disability and Ageing Enterprise Data Warehouse (EDW). The bulk billing rate is defined as bulk billed services divided by total services. **Numerator:** Number of GP Non-Referred Attendance services Bulk Billed. A standard script is run on Medicare claims data in the Department of Health, Disability and Ageing EDW to calculate the number of GP Non-Referred services that are bulk billed. Bulk billed services can be accurately identified as they use a distinct claiming channel that is flagged by Services Australia in the claims data. **Denominator:** Total Number of GP Non-Referred Attendance services billed. A standard script is run on Medicare claims data in the Department of Health, Disability and Ageing EDW to calculate the total number of GP Non-Referred services. Divide the Number of GP Non-Referred Attendance services Bulk Billed (numerator) by Total Number of GP Non-Referred Attendance services (denominator) and multiply by 100 to calculate the Bulk Billing rate for GP Non-Referred attendances.	

The performance target for GP Non-Referred Attendance (GP NRA) Bulk Billing Rate in 2025–26 was achieved. This result was supported by government measures to improve access to bulk billing, including the expansion of GP bulk billing incentives to all Medicare-eligible services and introduction of the Bulk Billing Practice Incentive Program from 1 November 2025. These initiatives contributed to increased bulk billing rates following a decline during 2022–23 and early 2023–24. As bulk billed services do not incur out-of-pocket costs for patients, higher bulk billing rates supported the affordability and accessibility of primary care. The 2025–26 Budget further reinforced this approach through a $7.9 billion investment to support GP bulk billing.

Reduced demand for MBS services may also reflect positive changes in service delivery models and introduction of other government programs. For example, patients can obtain clinical certificates for work absences from pharmacists, and some jurisdictions are trialling other pharmacy-delivered services. Patients may also access care outside the MBS through privately funded services or other government programs, such as those provided by the Department of Veterans' Affairs.

The GP NRA Bulk Billing Rate has increased since 2023–24, following a sharp decline during 2022–23. The rate increased by 0.6 percentage points in 2024–25, and a further 3.1 percentage points in 2025–26.

Program 2.2: Hearing Services

Key Activity 2.2A: Administration of the Hearing Services Program.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.72

Performance Measure 2.2A: The number of program clients that receive at least one hearing service in the reporting period.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.72

2025–26 Planned Performance	2025–26 Result
Program is demand driven.	850,740 voucher clients 68,896 Community Service Obligations (CSO) clients.
	Result: N/A

Disclosures:
The count of clients may vary from previous published reports due to retrospective claiming or correction of invalid claims. Any variance to the 2025–26 final result will be published in the 2026–27 Annual Report.

Data Source:
The department's Hearing Services Online (HSO) Portal and Hearing Australia's client management system.

Methodology:
HSO Portal Voucher scheme data and Hearing Australia CSO client data is extracted and filtered to include only those clients that received at least one service in the reporting period.

The outcome for the voucher program reflects the number of active clients increased from 840,000 in 2024–25 to 850,740 in 2025–26. Performance is dependent on the number of eligible people who choose to access hearing support services through a program provider during the reporting period.

The number of Community Service Obligations (CSO) clients increased from 67,575 in 2024–25 to 68,896 as at 29 July 2026. This indicates stable demand for services. In 2025–26, the department supported delivery of CSO services through program administration and ongoing engagement with Hearing Australia. This included management of the Memorandum of Understanding and monitoring of service delivery and performance to ensure compliance with program and legislative requirements.

The department undertook legislative amendments to the Australian Hearing Services (Declared Hearing Services) Determination and continued to refine policy settings to support delivery of CSO services.

Performance of the CSO component is influenced by external factors, including client uptake of services, and the complexity and cost of specialised hearing services. As services are delivered within a capped budget, changes in demand, clinical need, and the cost of devices and services may affect the number of clients supported each year.

Service delivery may also be impacted by unforeseen local emergencies or natural events, including flooding, bushfires, workforce shortages.

Program 2.3: Pharmaceutical Benefits

Key Activity 2.3A: Ensure timely listing of prescription medicines on the Pharmaceutical Benefits Scheme.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.73

Performance Measure 2.3A: Percentage of new medicines recommended by the Pharmaceutical Benefits Advisory Committee (PBAC) that are listed on the Pharmaceutical Benefits Scheme within 6 months of in principle agreement to listing arrangements.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.73

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
≥85%	100%	100%	100%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved: ≥85%

Substantially achieved: 80% to <85%

Not achieved: <80%

Data Source:

Data is sourced from internal departmental records and through the Medicine Status Website.[70] Data sources include the number of new medicines identified to be 'new drugs', the date of listing and the date of in-principle agreement.

Methodology:

To determine the percentage of new medicines recommended by PBAC that are listed on the Pharmaceutical Benefits Scheme within 6 months of in-principle agreement to listing arrangements, the following statistics are used:

- **the number of new medicines identified to be 'new drugs'** in the Explanatory Statement accompanying each amendment to the National Health (Listing of Pharmaceutical Benefits) Instrument 2024 (PB 26 of 2024)
- **the date of listing** is based on the first appearance of that medicine in the National Health (Listing of Pharmaceutical Benefits) Instrument 2024 (PB 26 of 2024)
- **the date of agreement of in-principle agreement** to listing arrangements is the date when the relevant in-principle pricing outcome letter is sent to the sponsor, this is also published on the Medicine Status Website as the date 'Government processes' commence.

The department achieved the 2025–26 planned performance, with 100% of new medicines recommended by the Pharmaceutical Benefits Advisory Committee (PBAC) listed on the Pharmaceutical Benefits Scheme (PBS) within 6 months of in-principle agreement to listing arrangements. This exceeds the 2025–26 planned performance threshold of ≥85% and is consistent with the 100% result reported for this measure in 2024–25 and 2023–24. The result reflects the department's focus on ensuring timely access to new medicines while balancing value for money and sustainability of the PBS.

The result was supported by established PBS listing processes and regular monitoring of medicines progressing through the post-PBAC listing pathway. Following a positive PBAC recommendation and in-principle agreement to listing arrangements, the department worked to progress the remaining steps required for PBS listing. These include pricing and budget impact matters, government approval processes, and implementation through monthly PBS Schedule updates.

[70] Further information can be found at: **www.pbs.gov.au/medicinestatus/home.html**

The department also continued to work with medicine sponsors to support timely finalisation of listing arrangements. This included engagement on pricing, utilisation and financial matters necessary to progress medicines to listing while maintaining the requirements of the PBS listing process.

PBS listing timeframes can be impacted by factors outside the department's direct control. These include the complexity of pricing negotiations with medicine sponsors, government approval requirements, possible further PBAC consideration, alignment with related listing processes, and sponsor readiness to supply the medicine from the proposed listing date.

The department managed these dependencies through established PBS listing processes and ongoing engagement with medicine sponsors to ensure achievement of the result in 2025–26.

Shorter listing timeframes support timely access to subsidised medicines by reducing the time between agreement to listing arrangements and the medicine becoming available through the PBS. This supports eligible Australians to access new subsidised medicines sooner, rather than waiting longer following listing arrangement agreements.

The department works with medicines sponsors throughout the post-PBAC listing process to support timely listing. This includes working with sponsors to resolve pricing, utilisation, budget impact and implementation matters while ensuring PBS listing requirements are met. These activities support timely access to subsidised medicines while maintaining the integrity, cost-effectiveness and affordability of the PBS.

Key Activity 2.3B: Provide affordable access to subsidised prescription medicines on the Pharmaceutical Benefits Scheme (PBS).

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.75

Performance Measure 2.3B: Average cost for prescriptions by consumer for PBS medicines.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.75

2025–26 Planned Performance	2025–26 Result
$7.50	$7.95
	Result: Substantially achieved

The assessment scale for the 2025–26 planned performance is:

Achieved: $7.50

Substantially achieved: >$7.50 to $8.50

Not achieved: >$8.50

Disclosures:

Pharmaceutical Benefits Scheme (PBS) claims data extracted on 12 August 2026. Figures are subject to change due to late claims and adjustments by pharmacies and may differ slightly to other 2025–26 financial year reports.

Data Source:

Pharmaceutical Benefits Scheme (PBS) claims data maintained by the Department of Health, Disability and Ageing, processed by Services Australia.

Methodology:

The following method is applied to calculate average patient contribution cost:

Average cost for prescriptions by consumer for PBS medicines = Total Patient Contributions (by costs) / Total PBS subsidised prescriptions (for Financial Year).

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

From 1 January 2025, the Government introduced a one-year freeze on indexation of the maximum patient cost for PBS medicines. This means co-payments remain at 2024 levels, at $31.60 for general patients and $7.70 for concessional patients. From 1 January 2026, the general patient co-payment was further reduced to $25. For pensioners and Commonwealth concession card holders, the freeze will remain in place for 5 years, until 1 January 2030. This change has helped make medicines more affordable and supports Australians with cost-of-living pressures.

Access to 60-day prescriptions continued to expand to new items, following the initial three-stage rollout. This initiative allows patients to receive double the quantity per script, reducing the frequency of pharmacy visits and further lowering costs. Eligibility for 60-day prescriptions remains unchanged. Together with the co-payment reduction and freeze, these measures help Australians save both time and money.

Program 2.4: Private Health Insurance

Key Activity 2.4A: Assessment of private health insurer premium change applications.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.76

Performance Measure 2.4A: Percentage of applications to the Minister from private health insurers to set premiums charged under a compliant health insurance product that are assessed within approved timeframes.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.76

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
100%	100%	100%	100%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:
Achieved: 100%
Substantially achieved: N/A
Not achieved: <100%

Data Source:
Internal - number of compliant applications received from insurers and assessed by the department within approved timeframes.

Methodology:
The methodology to calculate this measure is:
The number of compliant applications assessed within approved timeframes divided by the number of compliant applications received from private health insurers. The department uses the following definitions when calculating the number of applications assessed within approved timeframes:
• 'assessed' means that advice has been provided to the Minister to decide on an insurer's proposed premium changes
• 'approved timeframe' is 60 days prior to the price change on 1 April, plus 2 weeks for the Minister to consider the submission
• a 'compliant submission' is in the approved form; received within the timeframes published on the department's website; and where any material errors or omissions identified by the department or APRA are rectified by the insurer within a deadline set by the department.

In the 2026 Premium Round, the department received premium change applications from 28 private health insurers. All applications were processed within the approved timeframes, leading to 100% performance in line with the performance measure. This demonstrates processes continue to be robust and enable assessment within approved timeframes.

Timely assessment of insurer premium change application ensures sufficient time for Ministerial consideration and approval and for insurers to inform consumers of the approved premiums prior to 1 April 2026. Notice to consumers enables them to compare products ahead of the premium implementation date.

In 2025–26 the department increased transparency and clarity surrounding Ministerial expectations of insurer applications through the 2026 Statement of Expectations,[71] resulting in an improved quality in applications. The Statement of Expectations provided additional context and information on the specific matters the Minister would consider as part of the 2026 Premium Round. This includes maintaining the PHI value proposition for consumers, and supporting an appropriate balance of market powers and equitable funding arrangements in the private healthcare industry. This will ensure consumer choice.

To achieve the result, the department undertook close consultation with stakeholders including private health insurers, peak bodies, and the Australian Prudential Regulation Authority (APRA) to ensure complete and timely assessment, supporting the Minister's regulatory role under section 66-10 of the *Private Health Insurance Act 2007*.

The private health sector has faced continued external financial pressures. These include the Nurses and Midwives Fair Work Commission case, increasing claims pressures from private hospitals and continued concerns about the financial sustainability of gold tier hospital products. These concerns increased the complexity of insurer applications as well as increased media and public scrutiny of premium changes overall. Through the application form, insurers are asked to explain if, and how, any of the external financial pressures above impact their application.

The department seeks independent advice on any prudential concerns from APRA as part of the assessment of insurer applications. The department works closely with APRA on timeliness to ensure complete and timely assessment for the Minister.

The Health Legislative Amendment (Improving Choice and Transparency) Bill 2026 (the Bill) was introduced to Parliament on 12 February 2026. The Bill increases Ministerial oversight of product premiums by requiring insurers to seek approval for new products and certain changes to products.

[71] **www.health.gov.au/resources/publications/phi-7525-attachments-2026-private-health-insurance-premium-round-statement-of-expectations**

Key Activity 2.4B: Implementation of private health insurance clinical category and procedure type classifications for Medicare Benefits Schedule (MBS) item changes. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.78**	
Performance Measure 2.4B: The percentage of PHI clinical category and procedure type classifications[72] which are implemented concurrently with associated MBS item changes.[73] **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.78**	
2025–26 Planned Performance	**2025–26 Result**
100%	100%
	Result: Achieved
The assessment scale for the 2025–26 planned performance is: **Achieved**: 100% **Substantially achieved**: N/A **Not achieved:** <100%	
Data Source: Data is sourced from the MBS XML files, published on the Medicare Benefits Schedule (MBS) Online website[74] and the Private Health Insurance files, published on the department's website.[75] **Methodology:** • The department undertakes a comparative analysis between the published MBS XML file and the draft Private Health Insurance file. This process identifies new, amended or deleted MBS items which have not been classified for private health insurance. • Congruence between the published MBS XML file and the Private Health Insurance files is used as evidence of a 100% performance achievement. • If, during quality assurance processes, the files are found to contain different data indicating that less than 100% of changes have been captured, the department resolves the error/s and undertakes further quality assurance processes. • The finalised Private Health Insurance files are published on health.gov.au.	

Continued information sharing of draft MBS legislation in 2025–26 supported engagement with the private health sector and early notification of PHI classifications. This ensured information relevant to the PHI clinical category and procedure type classification of MBS changes was available to the department to facilitate the assessment process.

Streamlining administrative processes also contributed to timely publication of the PHI classification documentation, enabling the sector to enact system changes prior to the implementation date.

Following consultation with the private health sector, the department implemented changes to the PHI files. The new format reduces duplication with the MBS XML file**,** improves visibility of changes between versions and streamlines implementation processes for insurers and other stakeholders.

[72] Further information on clinical categories for private health insurance hospital product tier arrangements can be found at: **www.health.gov.au/resources/publications/private-health-insurance-clinical-category-definitions-1-july-2025**

[73] Further information on MBS items can be found at: **www.mbsonline.gov.au/**

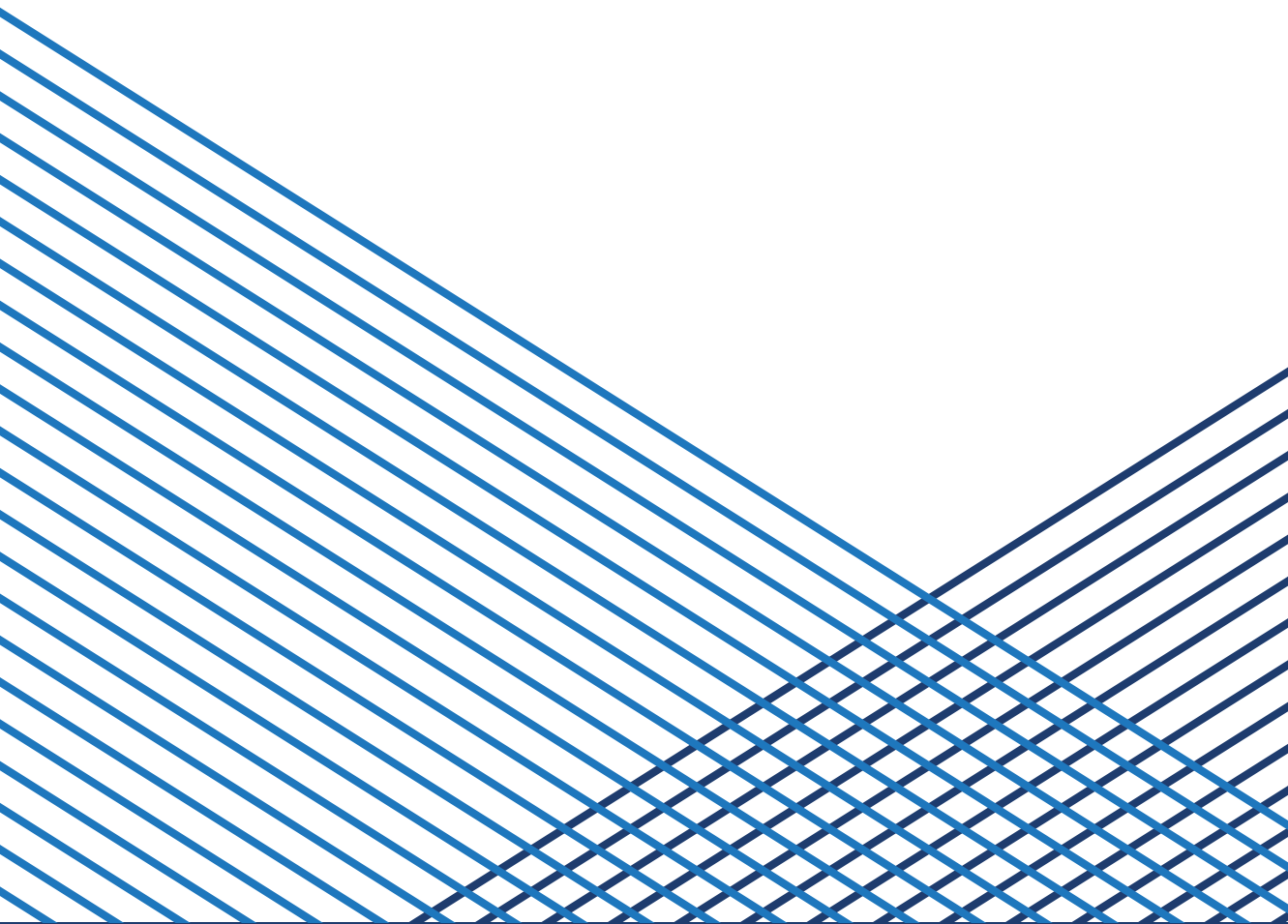
[74] Further information can be found at: **www.mbsonline.gov.au/**

[75] Further information can be found at: **www.health.gov.au/resources/collections/private-health-insurance-clinical-category-and-procedure-type**

Classifying MBS items against PHI clinical categories and procedure types determines the benefits payable by private health insurers for medical treatments and hospital accommodation.

Clinical category classifications assist consumers in selecting their desired level of private health insurance cover and allow private health insurance eligibility checking to facilitate informed financial consent for medical treatments.

The clinical category and procedure type classifications provide surety to patients regarding their private health insurance coverage, their minimum benefits payments and their potential out-of-pocket costs.



Program 2.5: Dental Services

Key Activity 2.5A: Continuing to work with Services Australia to increase uptake of the CDBS program to support eligible children to access essential dental health services. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.79**	
Performance Measure 2.5A: The percentage of eligible children[76] accessing essential dental health services through the Child Dental Benefits Schedule. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.79**	
2025–26 Planned Performance	**2025–26 Result**
Program is demand driven.	39.3%
	Result: N/A
Disclosures: The CDBS is a demand-driven program. The result reports 2025 calendar year uptake and notified eligible children data, with children who made multiple claims counted once. **Data Source:** CDBS Service Data (collected by Services Australia). **Methodology:** Data provided by Services Australia on CDBS utilisation.	

The Child Dental Benefits Schedule (CDBS) is jointly administered by the Department of Health, Disability and Ageing and Services Australia under the *Dental Benefits Act 2008* and the Dental Benefits Rules 2026.

The CDBS is a demand driven program that supports eligible children to access dental services. Services Australia notifies eligible children and their families by post or through myGov. The department works with Services Australia to support increased CDBS utilisation.

CDBS utilisation depends on when eligible children access dental services over the two-calendar-year benefit period. In the 2025 calendar year, 956,073 eligible children accessed dental services, representing 39.3% of the 2,429,490 children notified of eligibility.

In the 2024–25 financial year, 2,341,799 children were notified of their eligibility for CDBS. In the 2024 calendar year, 954,792 eligible children accessed CDBS funded dental services. This represents uptake of 40.7%. Differences in data collection methods between reporting periods may affect year-on-year comparisons.

CDBS performance depends on eligible children accessing dental services and claiming benefits under the program. Previous analysis indicates that demand for CDBS services can be influenced by external factors, including health-related issues, uncertainty about eligibility, potential out-of-pocket costs and cost-of-living pressures.

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

In response to recommendations from the Fifth Review of the *Dental Benefits Act 2008*, the department continued to work with Services Australia to raise awareness and increase uptake of the CDBS. Activities in 2025–26 included:

- Updating eligibility letters to simplify messaging and increase engagement with stakeholders.
- Promoting CDBS through social media channels.
- Working with state and territory health departments to increase awareness and uptake of the CDBS through the public dental system.
- Updating the bulk billing patient consent form, which advises parents, carers and guardians that there are no out-of-pocket costs for basic dental services within a public dental clinic.

CDBS uptake is expected to remain relatively stable as program improvements continue to support greater awareness, access and claiming by notified eligible children and their families.

Program 2.6: Health Benefit Compliance

Key Activity 2.6A: Identify incorrect claiming and investigate for non-compliance.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.81

Performance Measure 2.6A: Percentage of completed audits, practitioner reviews and investigations that find non-compliance.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.81

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
>80%	92.6%	>97%	>95%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:
Achieved: >80%
Substantially achieved: 70% to 80%
Not achieved: <70%

Data Source:
Internal departmental records of cases which have been investigated and closed. The specific case types that are used to report against this measure are audits, practitioner reviews and investigation.

Methodology:
The rate of non-compliance is determined by: the number of non-compliant outcomes (**Numerator**) divided by the total included outcomes (compliant + non-compliant) (**Denominator**).

The cost of managing the compliance program in 2025–26 was $64.9 million. During 2025–26, compliance actions resulted in $59.4 million of invoices being issued (an increase of $5.3 million from the previous year) and $49.4 million collections received during the same period. Additional compliance benefits include significant behavioural savings of $300.4 million. The department uses an agreed methodology to calculate behaviour saves and reductions in health payment expenditure following a compliance treatment.

The department uses two primary pathways to identify potential non-compliance: intelligence-derived signals and information received through tip-offs. Compliance concerns may be identified through referrals from stakeholders and other government agencies, targeted data analysis, intelligence gathering activities, reviews conducted by health professionals and compliance officers, and engagement with peak medical bodies. In 2025–26 the department actioned 2,154 tip-offs.

A risk-based methodology is used to assess and prioritise compliance concerns. Consideration is given to the nature and source of the issue, the scale of impact, the likelihood of recurrence, the effectiveness of existing legislative, policy and system controls, and the overall compliance risk rating.

To address non-compliance, the department applies a range of treatment strategies proportionate to the level of risk. These include education and engagement activities to improve understanding of program requirements, early intervention letters where claiming concerns are identified, and audits that may involve requests for information or documentation to determine whether claims met applicable requirements. During 2025–26, the department continued activities to identify Medicare Benefits Schedule (MBS) claims for services that appear to have been provided while the claiming provider was overseas. This included a phased program of audit and compliance letter activities focused on specialist services for which providers are required to be located in Australia at the time the service is delivered. In addition, AskMBS continued to support compliant billing practices by providing tailored, authoritative guidance on MBS item interpretation and application in response to 8,323 healthcare provider enquiries. Where non-compliance is confirmed, debts may be raised.

The department also administers specialised compliance programs, including the Practitioner Review Program (PRP), where reviews are conducted by qualified health professionals to identify and address potential inappropriate practice. Two hundred and forty-six practitioners were interviewed and 124 requests were made to the Director of the Professional Services Review for their further review under the PRP in the 2025–26 financial year. Nine referrals have been made to the Pharmaceutical Services Committee of Inquiry where concerns arise regarding breaches of Pharmaceutical Benefits Scheme approval conditions. Investigations into prohibited practises involving pathology and diagnostic imaging services may result in civil penalties or referral to the Medicare Participation Review Committee, which has considered 3 matters in 2025–26.

Where serious concerns regarding fraud are identified, the department's dedicated investigators assess allegations on their individual merits and undertake investigations as appropriate. Matters are prioritised according to program risk, and the nature of the alleged fraud. Investigation powers provided under the *Human Services (Medicare) Act 1973* and the *Aged Care Act 2024* support this work. Where appropriate, matters are referred to the Commonwealth Director of Public Prosecutions for consideration of prosecution under the *Criminal Code Act 1995* or other relevant health legislation.

During the reporting period, the department received 1,149 allegations of fraud, had carriage of 96 investigations (of which 58 are continuing as at 30 June 2026), and managed 12 matters before the courts involving approximately $10.0 million. Investigations included matters relating to Medicare payment programs and also included 8 matters relating to Aged Care and 3 relating to the Disability grant programs.

The department works closely with Services Australia to protect the integrity of the Medicare system. This chapter should be read in conjunction with their reporting for a comprehensive view of Medicare compliance reporting. Services Australia is responsible for processing payments and managing fraud and non-compliance involving members of the public, while the department is responsible for managing fraud and non-compliance by medical practitioners and their staff. Information, intelligence and data are shared between agencies to support a coordinated compliance framework. The department has also increased investment in education, behaviour change initiatives and preventative controls through an integrity-by-design approach.

Established on 1 July 2023, the Medicare Integrity Taskforce concluded on 30 June 2026 after delivering significant reforms that strengthened Medicare integrity, improved risk identification and enhanced preventative controls. These reforms have strengthened the department’s ability to identify, prevent and respond to integrity risks across Medicare and related health programs.

Legislative reform remained a key focus in 2025–26, with the successful passage of two bills that strengthened the framework supporting Medicare integrity. Portfolio amendments supported information sharing across government and relevant regulators, streamlining investigation of serious non-compliance, improving information gathering powers, and enabling the recovery of payments where there was no entitlement to receive funds. Legislation changes also reduced the period in which bulk-billed Medicare and dental services claims can be made, addressing a known fraud risk and supporting strengthened integrity controls.

Throughout 2025–26, the department expanded engagement across the health sector, working with peak bodies to deliver provider support, education and awareness activities that improved understanding of Medicare requirements. In total, 20 face-to-face education sessions were delivered, with a further 8 sessions scheduled for the remainder of 2026. These activities helped build compliance capability among healthcare providers and practice administration staff.

During the reporting period, the department commenced revision of the compliance performance framework to provide a more comprehensive, outcomes-focused view of program performance. The revised approach is designed to better demonstrate the full value of compliance activities by measuring performance across the end-to-end compliance value chain—from the quality of risk detection and targeting, through the effectiveness of interventions, to the overall impact and efficiency of the program.

The framework will place greater emphasis on lead indicators that assess whether the right risks are being identified and prioritised, alongside measures of behavioural change, prevention, recovery and deterrence outcomes. It will also strengthen reporting on system-wide impacts by recognising both pre-payment prevention and post-payment treatment activities, while tracking improvements in productivity and cost-effectiveness. This update will focus performance measurement towards how compliance efforts protect program integrity, support the use of public funds, and deliver sustainable outcomes for the Australian community.

Program 2.7: Assistance through Aids and Appliances

Key Activity 2.7A: Provide targeted assistance for aids and appliances to support Australians to manage diabetes.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.82

Performance Measure 2.7A: Number of people accessing subsidised products through the National Diabetes Services Scheme.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.82

2025–26 Planned Performance	2025–26 Result	2024–25 Result
>750,000	727,499	752,659
	Result: Substantially achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: >750,000

Substantially achieved: 725,000 to 750,000

Not achieved: <725,000

Data Source:

Data is obtained from NDSS registration data collected by Diabetes Australia and reported to the department under Grant Funding Agreement.

Methodology:

The NDSS Administrator (Diabetes Australia) provides data from the NDSS Central IT System to the department, for the purposes of reporting on the result. Verification is undertaken of the period of reporting and data range provided.

In 2025–26, 727,499 people with diabetes registered with the National Diabetes Services Scheme (NDSS) accessed subsidised diabetes products. This was lower than the anticipated number of people. This reflects the demand-driven nature of the program through choice to access subsidised products, largely based on clinical requirements.

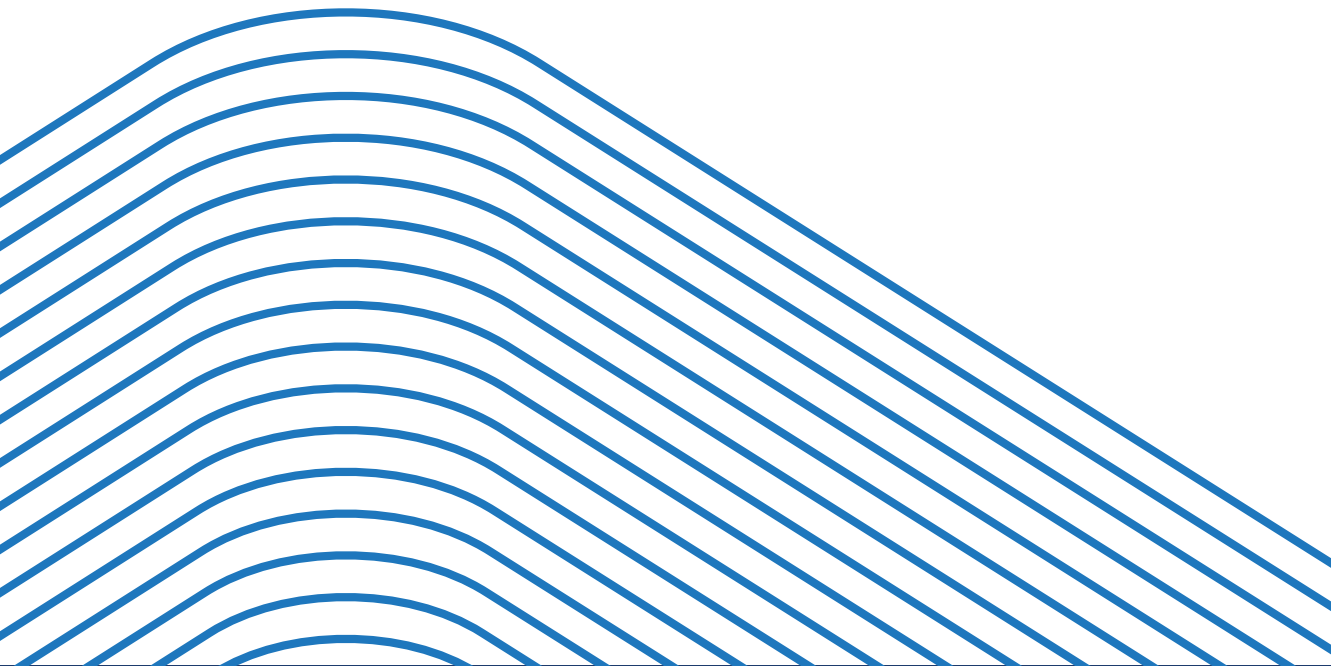
The department is working with Diabetes Australia to understand the underlying drivers for this change.

A number of factors may have contributed to the result, including:

- Difficulties accessing products, such as limited access to community pharmacies or product supply shortages. However, no issues of this nature were identified during the year.
- Reduced clinical need for products, where changes in an individual's clinical circumstances reduce their need for products to manage their condition. This may reflect improved diabetes management and prevention, including the expanded use of GLP-1 inhibitors and the positive impact of public health programs.
- The expanded use of GLP-1 inhibitors and the success of public health programs may be contributing to lower demand for NDSS products. At present, there is insufficient data to determine the extent to which these potential factors have influenced the need for NDSS products.

The department works closely with Diabetes Australia, the Administrator of the NDSS, to ensure the program supports the needs of Australians with diabetes. This includes ongoing monitoring of program performance to ensure products and services are delivered in a timely and efficient manner and that any operational issues are resolved effectively. Ongoing management of the program has not identified any issues of concern which would prevent people registered with the scheme from accessing subsidised products.

The number of people accessing products is determined by the individual choices and clinical needs of people registered with the scheme and the department's key focus is ensuring people who require products can access them when needed. The department will continue to work with Diabetes Australia to support access to products and monitor scheme performance.



Outcome 3: Ageing and Aged Care

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

Programs contributing to Outcome 3

	Summary of results against planned performance targets				
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**	**Not applicable**
Program 3.1: Access and Information	1	1	3	-	-
Program 3.2: Aged Care Services	4	1	3	-	-
Program 3.3: Aged Care Quality	-	-	-	1	-
Total	**5**	**2**	**6**	**1**	**0**

Program 3.1: Access and Information

Key Activity 3.1A: Facilitate access to aged care services through My Aged Care and navigation services.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.86

Performance Measure 3.1A: Older people and their support networks have access to information through My Aged Care.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.86

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Website: ≥65%. b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: >95%.	a. 51.7% b. 94.1%	a. 64.1% b. 94.8%	a. 56.3% b. 95.1%
	Result: a. Not achieved b. Substantially achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. ≥65%

b. >95%

Substantially achieved:

a. 60% to 64.9%

b. 90% to 95%

Not achieved:

a. <60%

b. 85% to 89.9%

Disclosures:

2025–26 Result:

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

b. The minimum survey sample size of 1% of calls was based on projected call volumes. While this threshold was met against projections, the final survey sample represented less than 1% of actual call volumes due to higher-than-anticipated demand.

2024–25 Result:

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

Data Sources:

a. My Aged Care website

User responses of the My Aged Care website to a voluntary onsite survey which focuses on user satisfaction.

b. My Aged Care Contact Centre

Responses to a survey from users of the My Aged Care Contact Centre Consumer Line and the My Aged Care Contact Centre Industry Line.

Methodology:

a. My Aged Care website

The data used to report against this performance measure is the percentage of satisfied users of My Aged Care website services - noting that 'users' refers to 'visitors' to the My Aged Care website. 'Satisfied' visitors to the website are calculated from an aggregate of user responses to 4 questions within the survey that measure key indicators of website satisfaction. The 4 survey questions are designed to measure satisfaction with 5 key indicators, namely: usability; clarity; helpfulness; intent; and overall satisfaction. The satisfaction percentage is determined by aggregating the responses to the survey questions. Specifically, this involves converting the responses to the 5-point rating scale ('Strongly disagree', 'disagree', 'neither agree nor disagree', 'agree', 'strongly agree') to be either satisfied, neutral or dissatisfied. The frequency and percentages for each type of response are then divided by the number of responses to that question. The total number of 'satisfied' responses are divided by the total number of responses to produce a 'satisfied' percentage score and that is the reported result. The survey data is verified independently and by the department to ensure its reliability, completeness and accuracy.

b. My Aged Care Contact Centre

The data used to report against this performance measure is a survey of user satisfaction of the My Aged Care Contact Centre. Users call the My Aged Care Contact Centre and are given the opportunity to opt out of being surveyed through a response to a telephone prompt. A random sample of users is taken to support user satisfaction, and the minimum sample size is 1% of projected calls to the Consumer Line and the Industry Line. For consumers, surveys are conducted within 24 to 48 hours of the caller interaction with the Contact Centre. For the Industry Line, callers are transferred from the Contact Centre to a specified telephone number. 'Satisfied' callers to the My Aged Care Contact Centre are those who give the contact centre a score of 6–10 on a scale of 0–10 in response to the My Aged Care Customer Satisfaction Survey question: 'How satisfied were you overall with your experience?'. The percentage of satisfied users is calculated by taking the number of responses with a score of 6–10 and dividing it by the total number of responses then multiplying it by 100. The survey is conducted and verified for reliability and accuracy through an independent third-party market research company.

My Aged Care website:

The My Aged Care website[77] is the starting point to access Australian Government-funded aged care services and information. It provides information on aged care service options, eligibility, assessments, service providers, and costs, supporting older people, their families and carers to navigate the aged care system.

During 2025–26, the implementation of the new *Aged Care Act 2024*, continued aged care reforms and the launch of a redesigned My Aged Care website resulted in substantial changes to the way consumers access and navigate aged care services. Feedback continued to be received through survey free text responses,[78] with many comments relating to issues beyond the scope of the website itself.

To support the commencement of the new Act, a redesigned My Aged Care website was launched on 1 November 2025, with approximately 80% of website content updated to reflect the reforms.

Significant enhancements included new content, interactive tools and improved navigation features designed to help people find the information and access services they need.

Satisfaction with the My Aged Care website in 2025–26 was 51.7%. While consumer satisfaction results for 2025–26 are below the planned performance of ≥65%, satisfaction ratings are improving month to month. Previous years' results were due to stability in user experience with increasing satisfaction results with the My Aged Care website performance. Improvements are anticipated to increase consumer satisfaction in 2026–27.

[77] Available at: **www.myagedcare.gov.au**

[78] Survey free text responses refer to users providing raw unfiltered comments and feedback in their own words.

Website satisfaction results provide an indication of whether older people and their support networks can access, understand and act on information needed to navigate aged care services. Usage and behavioural data indicate that users are increasingly engaging with key information and service pathways, offering potential insights into improvements in 2026–27. Despite the lower 2025–26 satisfaction results following the launch of the new website, user behaviour demonstrates strong and growing engagement with information and decision-support tools.

My Aged Care Contact Centre:

The My Aged Care Contact Centre provides older persons, their supporters and the general public with eligibility, and service information about My Aged Care and direct service referral support to enable older persons to access available services to support their needs. The Contact Centre satisfaction levels are used to measure the quality and outcomes for My Aged Care clients seeking information about My Aged Care and how to access services. Satisfaction with the My Aged Care Contact Centre in 2025–26 was 94.1%, just short of the planned performance target of >95%.

During 2025–26, major aged care reforms were implemented, resulting in substantial changes to aged care operations and the services available through My Aged Care. These changes contributed to increased call volumes and complexity for the Contact Centre, which may have influenced overall customer satisfaction ratings. Compared with the previous year, call volumes increased by 19% in 2024–25 and a further 13% in 2025–26, while average handling times increased by 3% and 6%, respectively. In addition, broader sector challenges, including longer wait times for aged care services and provider availability constraints, may have affected customers' overall experience and satisfaction, despite these issues being outside the Contact Centre's direct control.

The department is reviewing its customer satisfaction processes and methodology to ensure alignment with good practice standards and to identify opportunities for continuous improvement in measuring and enhancing the client experience.

Key Activity 3.1B: Facilitate access to aged care services: Eligibility/need assessments.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.89

Performance Measure 3.1B: Older people are assessed for service need.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.89

2025–26 Planned Performance	2025–26 Result	2024–25 Result
a. Home Support assessments completed within the allocated priority timeframes (≥90%): I. High priority: 10 calendar days II. Medium priority: 14 calendar days III. Low priority: 21 calendar days.	a. I. 40.5% II. 45.7% III. 58.6%	a. I. 68.8% II. 66.3% III. 69.6%
b. Comprehensive Community-based assessments completed within the allocated priority timeframes (≥90%): I. High priority: 10 calendar days II. Medium priority: 20 calendar days III. Low priority: 40 calendar days.	b. I. 35.5% II. 50.6% III. 58.5%	b. I. 32.5% II. 71.9% III. 50.0%
c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥90%): I. High priority: 5 calendar days II. Medium priority: 10 calendar days III. Low priority: 15 calendar days.	c. I. 93.4% II. 99.3% III. 94.6%	c. I. 88.2% II. 98.7% III. 91.8%
	Result: a. Not achieved b. Not achieved c. Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. Home Support assessments: ≥90%:
   High priority: 10 calendar days
   Medium priority: 14 calendar days
   Low priority: 21 calendar days.
b. Comprehensive Community-based assessments: ≥90%:
   High priority: 10 calendar days
   Medium priority: 20 calendar days
   Low priority: 40 calendar days.
c. Comprehensive Hospital-based assessments: ≥90%:
   High priority: 5 calendar days
   Medium priority: 10 calendar days
   Low priority: 15 calendar days.

Substantially achieved:

- 80% to 89% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes.

Not achieved:

- <80% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes.

Disclosures:

2025–26 Result:

Data extracted from the Aged Care Data Warehouse (ACDW) reflects a specific point in time after the reporting period. Data was extracted on 6 July 2026. As the dataset is dynamic and updated asynchronously—due to ongoing transactional changes by assessors—future extracts may include updated records. However, given the large sample sizes, these updates are unlikely to significantly alter overall results.

Data used for reporting against this measure is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the ACDW which is planned to be completed in mid-2026.

2024–25 Result:

Data extracted from the ACDW reflects a specific point in time after the reporting period. Data was extracted on 7 July 2025. As the dataset is dynamic and updated asynchronously—due to ongoing transactional changes by assessors—future extracts may include updated records. However, given the large sample sizes, these updates are unlikely to significantly alter overall results.

Data used for reporting against this measure is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the ACDW which is planned to be completed in mid-2026.

Data Source:

Data is logged by assessors in the My Aged Care system, stored in the ACDW. Data is analysed and maintained internally by the department.

Methodology:

The measure is calculated as the percentage of assessments completed within the allocated priority timeframes (by assessment type; a. to c.), based on the referral acceptance date and the assessment completion date.

Older Australians are supported to access assessments through My Aged Care, which acts as a single point of entry for assessments, with an online process that gives the older person control of the process. Vulnerable Australians have access to one-on-one assistance through the Care Finder Program[79] to help navigate and access aged care, including the single assessment process.

The Single Assessment System for aged care was launched on 9 December 2024 in response to Recommendation 28 of the Royal Commission into Aged Care Quality and Safety.

The unified approach of the Single Assessment System is designed to improve an older person's aged care experience by:

- providing a single assessment pathway for older people so that if their needs change, they don't have to change assessment providers
- improving access to assessments in regional, remote and rural areas
- providing a consistent and equitable assessment experience.

In 2025–26, a total of 553,795 assessments were completed nationally across all aged care needs assessment types. This was greater than 2024–25 (523,771 assessments) and is the highest annual volume of completed aged care needs assessments.

Home support assessments within allocated priority timeframes:

In 2025–26, a total of 235,514 home support assessments were conducted in community settings. The planned performance did not meet the ≥90% allocated priority target timeframes.

There were fewer home support assessments (which typically result in approvals for entry-level in-home care, like the Commonwealth Home Support Program (CHSP)) completed in 2025–26 than 2024–25. The commencement of the *Aged Care Act 2024* and CHSP becoming an Act-based program brought changes to how home support assessments operate. The assessment workforce undertaking assessments adapted to these changes, which had implications for timeliness completion in 2025–26.

[79] Further information is available at: **www.health.gov.au/our-work/care-finder-program**

The department acknowledges the need to improve timeframes for home support assessments. To address this issue, the department is taking actions to improve performance of assessment operations.

Comprehensive community-based assessments within allocated priority timeframes:

In 2025–26, a total of 261,226 comprehensive assessments were conducted in community settings. The planned performance did not meet the ≥90% allocated priority target timeframes.

Comprehensive hospital-based assessments within allocated priority timeframes:

In 2025–26, a total of 57,055 comprehensive assessments were conducted in a hospital setting. The planned performance met the ≥90% allocated priority target timeframes.

Comprehensive hospital-based assessment Key Performance Indicators (KPIs) were achieved, while community-based comprehensive assessment KPIs improved for both high and low priority assessments. These results were delivered in the context of substantially increased demand for comprehensive assessments and the ongoing transition of assessment organisations to new system reforms.

Overall analysis

KPI results for the Single Assessment System in the 2025–26 period show an increase in assessments delivered within priority timeframes for most comprehensive assessments, but a decrease for home support assessments. The median wait time for community-based comprehensive assessments in 2025–26 was 38 days, lower than it was in 2024–25 before the introduction of the Single Assessment System (when the median wait time was 43 days). Comprehensive hospital-based assessments are now meeting the allocated priority timeframe (≥90 days), but other KPI targets have not been met.

The implementation of aged care reforms, including digital improvements, continues to affect assessment performance. A critical operational factor in this period was the commencement of the *Aged Care Act 2024* on 1 November 2025. Assessment organisations trained staff and transitioned to new systems. This resulted in a temporary dip in assessments delivered within timeframes with fewer assessments delivered in the October quarter. This is on top of adaptation of the sector to the commencement of the Single Assessment System workforce on 9 December 2024. In addition, the system is seeing changes in the assessment mix, with pressure from a higher proportion of comprehensive assessments. This is feeding an ongoing need for workforce recruitment and training in assessment organisations.

External circumstances outside the control of both the department and assessment organisations can influence assessment timeframes, in particular availability of clients and/or their representatives. Delays may arise from client unavailability, hospital admissions, lack of response to contact attempts or delays in scheduling appointments. The onboarding of new assessors requires an initial training period, during which assessors generally operate at a reduced capacity. Consequently, there may be a delay between an increase in workforce numbers and the realisation of higher assessment throughput.

The department does not have a direct association with the individuals conducting aged care needs assessments, but rather contracts assessment organisations to deliver the assessments. Where KPIs are not achieved, the department works with assessment organisations to understand the issues and ensure remediation strategies are put in place.

In 2025–26, the department undertook quality assurance activities to verify that aged care needs assessments were accurate, complete and aligned with the needs of older people. This included a broad program of desktop reviews to examine the quality, consistency and alignment of over 2,500 individual aged care needs assessments against the Aged Care Assessment Quality Framework[80] and the Aged Care Assessment Manual.[81]

Common themes and patterns identified through quality assurance assessment reviews were communicated to assessment organisations to reinforce quality expectations and support continuous improvement. Review findings also informed updates to policy settings, assessor guidance, and future system refinements.

[80] Available at: **www.health.gov.au/resources/publications/aged-care-assessment-quality-framework**

[81] Available at: **www.health.gov.au/resources/publications/my-aged-care-assessment-manual**

In March 2026, the department reviewed all assessment referrals that had been outstanding for over 365 days. This review finalised 1,689 outstanding referrals, reducing the backlog of long-term outstanding assessments.

As part of the department's ongoing stewardship of the program, work continues to identify opportunities to refine processes and policies, and to implement improvements that support better outcomes for older people and promote system stability. Further information on assessment for and access to aged care services can be found at myagedcare.gov.au[82]

[82] Available at: **www.myagedcare.gov.au/how-get-assessed** and **www.myagedcare.gov.au/find-a-provider**

Program 3.2: Aged Care Services

Key Activity for Program 3.2: Enable the delivery of residential care and home care services that support older people.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.91

Performance Measure 3.2A: Older people are treated with respect and dignity in receiving aged care services.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.91

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
Increase the average Residents' Experience Survey (RES) Score for residential aged care homes by at least one percentage point from 2024–25.	86.3%	85.3%	84.4%
	Result: Achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved: One percentage point increase from 2024–25.

Substantially achieved: N/A.

Not achieved: Less than one percentage point increase from 2024–25.

Disclosures:

2025–26 Result:

The result reported is for the period of 21 January 2025 to 11 December 2025, as the RES is conducted on an annual calendar year basis. The RES only surveys older people living in Commonwealth-funded residential aged care homes and does not include older people receiving other types of care services. For example, older people in the Multi-Purpose Services Program (MPSP), National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) services and older people receiving home care are not included within this performance measure.

In the 2025 round, the RES survey sampling threshold was increased from 10% to 20% of residents to produce a more reliable representation of the aged care resident cohort.

2024–25 Result:

The result reported is for the period of 1 February 2024 to 31 October 2024, as the RES is conducted on an annual calendar year basis. The RES only surveys older people living in Commonwealth-funded residential aged care homes and does not include older people receiving other types of care services.

For example, older people in the MPSP, NATSIFACP services and older people receiving home care are not included within this performance measure.

Data Source:

The performance measure is calculated using quantitative survey data collected annually through the RES by an independent consortium contracted by the department. The consortium conducts the survey across all Commonwealth-funded residential aged care homes in Australia and collects a minimum 20% sample nationally with a minimum sample of 20% of residents at each residential aged care home.

Methodology:

The measure is calculated by averaging the RES scores (the 12 Likert scale questions in the survey) of all participating residential aged care homes and converting the average to a percentage.

Each Likert scale response corresponds to a numerical value, for example: 'Always' corresponds to 4 points, 'Most of the time' corresponds to 3 points, 'Some of the time' corresponds to 2 points and 'Never' corresponds to 1 point. Therefore, each resident who answers all 12 Likert scale questions can provide a score ranging from a minimum of 12 points to a maximum of 48 points. Note that only results from participants who responded to all 12 questions are utilised for the calculation of Performance Measure 3.2A.

A Service Average Total Score for each service is calculated by first calculating the Sum Service Total Score. The Sum Service Total Score is calculated by adding all total individual resident scores for

each individual service and dividing by the number of residents who participated in RES at that service. Service Average Total Score = (Sum Service Total Score) / (Number of participating residents at the service).

The Sum of all Service Average Total Score (numerator) is then calculated by summing all Service Average Total Scores and then dividing by the number of services that participated in RES (denominator).

The performance result is subsequently calculated by taking the Sum of all Service Average Total Score (numerator) and then dividing by the maximum total score of 48 and converting the result into a percentage.

The planned performance for 2025–26 was to achieve an increase of at least one percentage point in the average RES score for residential aged care homes compared to 2024–25. This target was achieved, with the RES score increasing by one percentage point from the previous year. This result continues a consistent upward trend above the original performance baseline. The baseline was established at 82% in the 2022 survey. Subsequent results show steady improvement, with scores of 84.4% in 2023–24, 85.3% in 2024–25, and 86.3% in 2025–26.

The department's aged care reform program[83] has contributed to a shift in aged care provider behaviour, placing residents' quality of care at the centre of service improvement activities. The RES results are published on the My Aged Care website[84] and contribute to a residential aged care service's Star Ratings. Publication of the RES results has created an incentive for providers to make improvements to the delivery of their services, in line with survey findings.

The RES reflects the lived experiences of older people in residential aged care. The results are inherently influenced by external factors, surrounding the quality of care provided by aged care providers within the residential aged care homes they operate. Sector-wide developments have also played a role. For example, providers' preparation for the new *Aged Care Act 2024* may have influenced performance in the RES program, as organisations strengthened practices to align with forthcoming regulatory expectations.

The RES includes questions relevant to residents' autonomy, choice and day-to-day experience of care. Improved RES scores may therefore provide an indication of whether residents are experiencing care that supports dignity, independence and participation. However, the RES survey should not be presented as a comprehensive measure of whether all older people are able to live active, self-determined and meaningful lives, because it only reflects surveyed residents in Commonwealth-funded residential aged care homes.

The higher sampling threshold implemented in 2025 improves the generalisability of the RES findings to the broader residential aged care cohort, noting the findings are limited to Commonwealth-funded residential aged care homes.

[83] Further information can be found at: **www.health.gov.au/our-work/aged-care-reforms**

[84] Available at: **www.myagedcare.gov.au/quality/what-residents-think**

Key Activity for Program 3.2: Enable the delivery of residential care and home care services that support older people.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.93

Performance Measure 3.2B: Older people receive residential care services that contribute to their quality of life.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.93

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
a. Maintain or increase percentage of care recipients who completed the Quality of Life–Aged Care Consumers instrument (QOL-ACC)[85] and who report 'good' or 'excellent' quality of life in residential care (QIs) in comparison to 2024–25 baseline. b. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by a registered nurse (RN) per day. c. All non-exempt residential aged care facilities of approved providers have at least one RN on-site and on duty 24 hours a day, 7 days a week.	a. Results reflect an average of 76.82% based on Q1 2025–26 to Q4 2025–26 reported data. b. Weighted sector average of 220.99 minutes per resident per day of total care minutes including 44.76 RN minutes per resident per day. c. The average RN coverage from non-exempt facilities was 99.43%.	a. The baseline average of care recipients reporting 'Good' or 'Excellent' for the Quality-of-Life Quality Indicator reflects 74.06%. b. Weighted sector average of 214.66 minutes per resident per day of total care minutes including 43.53 RN minutes per resident per day. c. The average RN coverage from non-exempt facilities was 99.14%.	a. Data not available, as this year contributed to establishing a baseline. b. Weighted sector average of 202.6 minutes per resident per day of total care minutes including 39.68 RN minutes per resident per day. c. The average RN coverage from non-exempt facilities was 98.58%.
	Result: a. Achieved b. Achieved c. Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. Maintain or increase in comparison to 2024–25 baseline.

b. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by a RN per day or more.

c. All non-exempt residential aged care facilities of approved providers have at least one RN on-site and on duty 24 hours a day, 7 days a week.

Substantially achieved:

a. N/A.

b. N/A.

c. N/A.

[85] Further information on the QOL-ACC can be found at: **www.qol-acc.org**

Not achieved:

a. Decrease in comparison to 2024–25 baseline.
b. Sector-wide average of below 215 minutes per resident per day, including 44 minutes of direct care by a RN per day.
c. Average percentage of reported hours an RN was on-site and on duty is below 100.00%.

Disclosures:

2025–26 Result:

a. This result is based on 4 quarters of data (Q1 2025–26 to Q4 2025–26).

   It is a requirement of the National Aged Care Quality Indicator Program for residential aged care homes to offer the QOL-ACC survey to all residents (or their proxies) for completion quarterly. However, it is not a requirement for residents (or their proxies) to complete the survey.
b. The reported result is for the period July 2025 to March 2026 and does not include the April to June 2026 quarterly data as this will not be available until October 2026.
c. 24/7 RN data for May 2026 may not include data for some facilities due to late submissions, with data from providers due on the 7th of each month. 24/7 RN data for June 2026 will not be submitted to the department until 7 July 2026 and will not be included.

2024–25 Result:

a. This result is based on 8 quarters of data (Q1 2023–24 to Q4 2024–25) to support the establishment of a meaningful baseline for this quality indicator. The baseline result captures the average percentage of care recipients who completed the QOL-ACC survey and reported a score of 'excellent' or 'good'. Care recipients can choose whether or not they want to complete the survey.
b. The 2024–25 result for performance measure b. has been revised to reflect the final result for the period July 2024 to June 2025. The result for the period July 2024 to March 2025 published in the 2024–25 Annual Report was 213.22 minutes per resident per day of total care minutes including 43.11 RN minutes per resident per day.
c. The 2024–25 result for performance measure c. now reflects the final result for the period July 2024 to June 2025 but is unchanged from the 2024–25 Annual Report.

2023–24 Result:

a. Data for the 2023–24 result is not available. An analysis has confirmed 8 quarters of data would be required to support the establishment of a meaningful baseline for this quality indicator.
b. The 2023–24 result for performance measure b. has been revised to reflect the final result for the period July 2023 to June 2024. The result for the period July 2023 to March 2024 published in the 2023–24 Annual Report was 200.76 care minutes and 39.02 RN minutes per resident per day.
c. Data for 4 facilities which undertake manual reporting has not been included in the result. Manual reporting is undertaken due to operating across multiple sites and is excluded from the performance result due to manual data being held in an alternative system compared to the rest of the 24/7 RN reporting.

Data Sources:

a. Data is collected by residential aged care services and transposed into the Government Provider Management System (GPMS). This information in GPMS is available for providers view and is also copied into the ACDW daily with any changes or updates made by providers also updated in ACDW.
b. Residential Aged Care providers report direct care hours worked by in-scope workers and occupied bed days through the Quarterly Financial Report (QFR) application on GPMS in respect of each of their approved residential aged care homes (homes). This enables the department to calculate the care minutes delivered per resident per bed day for each home. The data reported in the QFR application in GPMS is made available/ synchronised in the ACDW through the extract, transform and load (ETL) process.
c. Residential aged care providers report gaps in RN coverage through the RN application on GPMS for each of their homes. The RN data is made available/synchronised in the ACDW through the ETL process.

Methodology:

a. Quality of Life (QOL) Aged Care Consumers (ACC) Survey

The department compiles national QI Program data submitted by providers and provides a copy to the Australian Institute of Health and Welfare (AIHW) to compile and analyse. The department then approves AIHW publishing QI Program data at national, state and territory levels which is used to calculate the result.

b. Care Minutes

Sector average RN care minutes per resident per day are calculated by:

1. Summing the RN hours delivered by both employees and agency staff across all homes
2. Converting the total hours to total minutes
3. Dividing the total minutes by the occupied bed days delivered across all homes.

Sector average total direct care minutes per resident per day are calculated by:

a. Summing the RN, Enrolled Nurse (EN) and personal care worker hours delivered by both employees and agency staff across all homes
b. Converting the total hours to total minutes
c. Dividing the total minutes by the occupied bed days delivered across all homes.

c. RN 24/7

The average availability of a RN for the RN 24/7 measure for each facility is calculated by dividing the total minutes an RN was on-site and on duty by the total monthly minutes the facility was operational:

1. Calculate the total unavailable minutes for the month (across all reporting facilities) and divide by the total monthly operational minutes (across all reporting facilities).
2. Multiply the result from step 1 by 100 to convert to a percentage.

Quality of Life quality indicator:

The 2025–26 planned performance to maintain or increase the percentage of care recipients who completed the QOL-ACC and who report 'good' or 'excellent' quality of life in residential care (QIs) in comparison to 2024–25 baseline was achieved.

The 2025–26 result of 76.82% is based on 4 quarters of data (Q1 2025–26 to Q4 2025–26). The 2024–25 result of 74.06% established a baseline for the 'Quality of Life' indicator using 8 quarters of data for effective trend analysis.

The department's aged care reforms are focused on improving the quality, safety, and accessibility of care for older people in response to the Royal Commission into Aged Care Quality and Safety.[86] The department is working to build, train and support the aged care workforce and providers to engage in activities that improve residents' quality of life. Residential aged care homes are able to review the residents' responses in the QOL-ACC each quarter, to consider how and where they are able to make improvements to support care quality.

The key factors influencing this performance measure is the quality of care delivered by the residential aged care home, the impact of that care on residents, and how both the care and its impact are perceived by residents or their proxies. These factors are external to the department and are not within its direct control. Additionally, it is not mandatory for residents (or their proxies) to complete the survey.

[86] Available at: **www.royalcommission.gov.au/aged-care**

Care minutes:

The sector maintained an average above 215 total care minutes delivered per resident per day, including more than 44 minutes of direct care by a RN per day for the first 3 Quarters of 2025–26, delivering 220.99 total care minutes and 44.76 RN minutes.

Changes to care minutes funding for approved residential care homes in metropolitan areas commenced from April 2026.[87] Throughout 2025–26, the department undertook engagement activities with registered providers to support implementation of the changes, including reminding providers of the impact that performance in previous quarters may have on the level of funding provided.

External factors influencing performance include location specific workforce shortages and unplanned changes in operational environments. Some providers, particularly those operating in rural and remote locations, continue to experience challenges in recruiting and retaining a sufficient workforce to meet their care minutes responsibility.

Since 1 October 2024, providers can meet up to 10% of their RN care minutes target with care time delivered by ENs.[88] However, the reported RN care minutes performance results exclude EN care minute contributions.

24/7 RN:

The sector had average RN coverage from non-exempt facilities of 99.43% across 2025–26. 24/7 RN coverage remains consistent with 2024–25.

The 24/7 RN supplement was adjusted in October 2025 to reflect average RN costs. The supplement supports homes with 50 residents or fewer to meet the 24/7 RN requirement by funding the gap between the RN funding provided through the Australian National Aged Care Classification and the cost of having an RN 24/7.[89]

External factors influencing this include RN shortages, particularly in rural and remote locations. This impacts providers experiencing challenges recruiting and retaining enough workers to meet the 24/7 RN responsibility.

For measures 3.2B(b) and (c) it is legislated that providers meet their care minutes and 24/7 RN responsibilities.

[87] Further information on care minutes funding changes is available at: **www.health.gov.au/resources/publications/care-minutes-funding-changes-april-2026**

[88] Further information can be found in the Care minutes guide at: **www.health.gov.au/resources/publications/care-minutes-and-247-registered-nurse-requirements-guides-for-registered-providers-of-residential-care-homes**

[89] Further information on the 24/7 RN supplement for residential aged care can be found at: **www.health.gov.au/topics/aged-care/providing-aged-care-services/funding-for-aged-care-service-providers/247-registered-nurse-supplement**

Key Activity for Program 3.2: Enable the delivery of residential care and home care services that support older people. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.96**			
Performance Measure 3.2C: Older people who are Aboriginal or Torres Strait Islander, or who live in rural and remote areas, access Commonwealth funded aged care services at rates comparable with the broader Australian population. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.96**			
2025–26 Planned Performance	**2025–26 Result**	**2024–25 Result**	**2023–24 Result**
a. i. Older people aged 50-64 years, who are self-identified as Aboriginal and Torres Strait Islanders are accessing aged care services at rates comparable with their representation in Australian population estimates: Target 2.7% ii. Older people aged 65 years and over, who are self-identified as Aboriginal and Torres Strait Islanders are accessing aged care services at rates comparable with their representation in Australian population estimates: Target 1.3%. b. Older people in rural and remote areas are accessing aged care services at rates comparable with their representation in Australian population estimates: Target 10.6%.	**a. Older Aboriginal and Torres Strait Islander people** **i. 50 to 64 years:** **Residential care:** at 30 June 2026, 24.4% of residents aged 50-64 years accessing services in mainstream residential care. **Support at Home:** at 30 June 2026, 81.6% of people aged 50-64 years accessing ongoing services under the Support at Home program. **CHSP:** in 2025–26, 79.0% of people aged 50-64 years accessing any services under the CHSP. **ii. 65 years and over:** **Residential care:** at 30 June 2026, 1.1% of residents aged 65 years and over accessing services in mainstream residential care. **Support at Home:** at 30 June 2026, 2.5% of people aged 65 years and over accessing ongoing services under the Support at Home program. **CHSP:** in 2025–26, 2.0% of people aged 65 years and over access any services under the CHSP.	a. • At 30 June 2025, 1.2% of permanent residents accessing care in mainstream residential aged care. • At 30 June 2025, 3.4% of people accessing services under the Home Care Package (HCP) program. • Across 2024–25 financial year, 3.0% of people using any CHSP supports. b. • At 30 June 2025, 7.6% of permanent residents accessing care in mainstream residential aged care. • At 30 June 2025, 9.8% of people accessing services under the HCP program. • Across 2024–25 financial year, 12.1% of people using any CHSP supports.	a. First Nations identification amongst older people accessing aged care is estimated as follows: • As of 30 June 2024, 1.3% of permanent residents accessing care in mainstream residential aged care. • As of 30 June 2024, 3.4% of people accessing services under the HCP program. • Across 2023–24 financial year, 3.0% of people using any CHSP supports. b. Older Australians in rural and remote areas as a proportion of all people accessing care is estimated as follows: • As of 30 June 2024, 7.7% of permanent residents accessing care in mainstream residential aged care. • As of 30 June 2024, 8.9% of people accessing services under the HCP program. • Across 2023–24 financial year, 12.4% of people

	b. Older people in rural and remote areas **Residential care:** at 30 June 2026, 7.5% of residents aged 65 years and over accessing services in mainstream residential care. **Support at Home:** at 30 June 2026, 9.8% of people aged 65 years and over accessing ongoing services under the Support at Home program. **CHSP:** in 2025–26, 11.8% of individuals aged 65 years and over accessing any services under the CHSP.		using any CHSP supports.
	Result: a. Substantially achieved b. Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. i. ≥2.7%
   ii. ≥1.3%
b. ≥10.6%

Substantially achieved:

a. i. >2.2% to <2.7%
   ii. >1.0% to <1.3%
b. >8.5% to <10.6%

Not achieved:

a. i. ≤2.2%
   ii. ≤1.0%
b. ≤8.5%

Disclosures:

3.2C(a):

- Results are compared to population data computed in a comparable fashion as available. For example, the results for the 50 to 64 years age group of Aboriginal and Torres Strait Islander people using aged care services is compared to population data for the same age group nationally.
- Older Aboriginal and Torres Strait Islanders people are defined as those aged 50 years and over (grouped as people aged 50 to 64 years and people aged 65 years and over). For non-Aboriginal and Torres Strait Islanders people, older people are defined as those aged 65 years and over only. This difference reflects the earlier onset of age-related conditions among Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians.
- In this indicator, population and aged care service access data are grouped into 50 to 64 years, and 65 years and older age groups, avoiding measurement bias by comparing within age groups on equivalent terms.

Client records are excluded from the analysis if the person's Aboriginal and Torres Strait Islander status has not been recorded, is unclear, has been inadequately described or is unknown. This ensures the results are not biased by incomplete or missing data.

3.2C(b):

- Older people are considered to be aged 65 years and over.
- Rural and remote includes records classified as Outer Regional, Remote, and Very Remote, as per the ABS Australian Statistical Geography Standard Remoteness Areas structure.

Client records without sufficient location information to determine a remoteness category are excluded from the analysis. This ensures the results are not biased by incomplete or missing data.

2025–26 Result:

For a. and b. data used for reporting against these measures is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department continuing to work on data improvement, including the incorporation of data from the Support at Home program, which commenced on 1 November 2025, in part replacing the former HCP program.

a. The population targets of 2.7% (part i, for people aged 50 to 64 years) and 1.3% (part ii, for people aged 65 years and over) is applicable to each of the individual percentage results recorded for:
    - mainstream residential aged care (permanent residents)
    - Support at Home (ongoing participants)
    - CHSP.

For a., data for Aboriginal and Torres Strait Islander identity is dependent on self-reported data and presents a limitation in reporting on the outcome of the measure.

Data for all 3.2C(a) is not directly comparable with prior years' results, as the 2025–26 result is presented by age cohort.

The indicator has been improved from prior years by dividing the measure and targets into 2 groups; for people aged 50 to 64 years (part i.) and for people aged 65 years and over (part ii.). This approach addresses an issue in past years where the target population measurement for the aged care target population (all people aged 65 years and over, and only those people in Australia identifying as an Aboriginal and Torres Strait Islander aged 50 to 64 years) was used, introducing a bias to the measurement of the result.

b. The population target of 10.6% is applicable to each of the individual percentage results recorded for:
    - mainstream residential aged care (permanent residents)
    - Support at Home (ongoing participants)
    - CHSP.

For b., the result reflects the location of the person accessing Support at Home or their home or dwelling for CHSP. This better reflects the location of care delivery, than using the location of the provider that is delivering services. The location of residential care residents is represented by the location of their residential care home.

The 2025–26 result for both a. and b. is based on preliminary data for residential care and Support at Home as at 30 June 2026, and for the financial year for CHSP.

Data does not include individuals accessing services through the MPSP[90] or the NATSIFACP.[91] Therefore the results underestimate the rates of aged care service access for older Aboriginal and Torres Strait Islander peoples and older people from rural and remote communities.

2024–25 Result:

For a. and b. data used for reporting against these measures is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the ACDW which is planned to be completed in mid-2026.

[90] Further information about the Multi-Purpose Service Program is available at: **www.health.gov.au/our-work/the-multi-purpose-service-program/about-the-multi-purpose-service-program#who-can-%20access-the-program**

[91] Further information is available at the NATSIFACP is available at: **www.health.gov.au/natsifacp**

a. The population target of 3.5% is applicable to each of the individual percentage results recorded for:
   - mainstream residential aged care
   - HCP program
   - CHSP.

Data for First Nations identity is dependent on self-reported data by First Nations peoples and presents a limitation in reporting on the outcome of the measure.

b. The population target of 11.2% is applicable to each of the individual percentage results recorded for:
   - mainstream residential aged care
   - HCP program
   - CHSP.

The 2024–25 result for both a. and b. is preliminary financial year data as of 30 June 2025 (or 2024–25 for CHSP) and does not include data on flexible aged care programs including the MPSP and NATSIFAC.

For b., the result reflects the location of the HCP recipient, compared to past years where the location of the HCP service delivering care was reported. This represents a break in the series but improves the relevance of this indicator as the location of the recipient of the care delivered is better represented.

Data Sources:

a. Older people accessing Australian Government funded aged care services who are identified as having a First Nations background or identity (based on self-identification or information provided by their support networks) through their My Aged Care personal client record and/or related processes (such as aged care assessment), or in other systems (for example, the Department of Social Services (DSS) Data Exchange (DEX) in the case of the CHSP).

b. Older people accessing Australian Government funded aged care services who live in rural and remote areas, as indicated by:
   - their address location as recorded in their My Aged Care personal client record or other systems (e.g. DSS DEX in the case of the CHSP).
   - the physical address of their provider as recorded in the GPMS.

Methodology:

Client counts are first extracted from the ACDW, which receives and platforms data from a range of aged care administrative systems.

Of relevance to this measure are data platformed in ACDW that are sourced from the Aged Care Gateway (ACG, being the systems behind the My Aged Care personal client record and data collected in needs assessment services); Services Australia system 'Aged Care Management Payment System' (ACMPS) for person- and episode-level attributes relating to recipients of residential aged care and of services under the Support at Home program; the DSS system DEX for person- and episode level attributes relating to recipients of basic support at home through the CHSP; the GPMS for attributes related to the aged care service that clients received care through.

The client counts extracted from the ACDW for reporting in this performance measure include relevant dimensions (i.e. identified as First Nations) for disaggregation.

The calculation used in this indicator in respect of client counts is by dividing the number of clients of the relevant age group for whom the client is identified as Aboriginal and Torres Strait Islander (for 3.2C(a)) or whose location information places them in a rural or remote area (for 3.2C(b)), by all clients of those programs. Note that any clients for whom Aboriginal and Torres Strait Islander identity is not known or is missing (for 3.2C(a)) or for whom location data are invalid or missing (for 3.2(b)) are excluded from these calculations.

Validity checks of the data extract, and any processing or summation are conducted. These include a comparison of the prepared summarised data outputs prior to data extractions or snapshots, and other published and unpublished sources, to ensure consistency over time. If differences are identified compared to different reporting periods, the basis of this difference is then examined to determine if any program data models have changed over reporting periods (for example, because new versions of assessment forms are impacting the data collected), or other trends are observed (such as changes in

client response or non-response rates to questions relating to their identification of Aboriginal and Torres Strait Islander origin, or inconsistency in responses for individuals over time). Spot checks are also conducted on individual records as necessary, which are compared to source systems to ensure consistency in the data platformed in the Warehouse.

This checking process includes remediation of any defects identified in the data preparation process, and, if necessary, raising a service ticket with the IT Division and/or interagency colleagues to repair defects of the data in the Warehouse or original systems.

The department is committed to improving access to culturally safe aged care that supports people to maintain connection to family, community, culture, and Country or Island Home as they age. Successful delivery of this measure is expected to increase access for older Aboriginal and Torres Strait Islander peoples at aged care services at levels comparable with their representation in the Australian population estimates.

Significant work towards this objective is progressing through implementation of the Aboriginal and Torres Strait Islander Aged Care Framework 2025–2035.[92] The commencement of the rights-based *Aged Care Act 2024* (the Act) in November 2025 further strengthened this objective by embedding the rights of older Aboriginal and Torres Strait Islander people to access culturally safe, culturally appropriate, trauma-aware and healing-informed aged care services.

During 2025–26, work progressed to improve equity of access and increase the representation of older Aboriginal and Torres Strait Islander peoples in the aged care system. This included:

- Investing in Aboriginal Community Controlled Organisations (ACCOs) to expand into aged care service delivery, recognising that ACCOs are best placed to deliver culturally safe, place-based and tailored care to their respective communities.
- Initiatives to create a more trusted entry point to the aged care system for Aboriginal and Torres Strait Islander peoples, such as:
  - a pilot enabling Aboriginal and Torres Strait Islander organisations to undertake aged care assessments, with the first organisation providing assessments from March 2026
  - the Elder Care Support program, delivered by the National Aboriginal Community Controlled Health Organisation through 97 ACCOs across the country, supporting over 10,000 older people.
- Strengthening the aged care workforce by supporting employment, training and career pathways to increase the provision of culturally safe, trauma-aware, healing-informed care for older Aboriginal and Torres Strait Islander people. This includes through the Indigenous Employment Initiative[93] which, as at 30 June 2026, had funded 80 providers to support the employment of 830 workers.
- Investing in capital infrastructure projects to improve access to quality, culturally safe aged care services for Aboriginal and Torres Strait Islander communities, enabling more people to access care on Country, through the Aged Care Capital Assistance Program (ACCAP). As at 30 June 2026, this program had allocated over $100 million to 14 projects.

The department also remains committed to improving access to aged care services for older Australians in rural and remote areas. This commitment is reflected in the Statement of Principles of the Act, which recognises that Commonwealth-funded aged care services should be accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed regardless of where a person lives, including in rural and remote Australia.

Initiatives and programs progressed in 2025–26 to support increased access to services and representation of older Australians in rural and remote areas in the aged care system included:

- Support at Home Thin Markets grant opportunities, designed to assist Support at Home Providers to deliver services in rural, remote and specialised markets.
- Ongoing additional Australian National Aged Care Classification funding for residential care homes in rural and remote locations, and flexible funding for specialist aged care program providers through the MPSP and the NATSIFACP.

[92] Available at: **www.health.gov.au/resources/publications/aboriginal-and-torres-strait-islander-aged-care-framework**

[93] Available at: **www.health.gov.au/our-work/indigenous-employment-initiative-program**

- ACCAP grants to build, expand, or upgrade aged care services and staff accommodation where older Australians have limited or no access.[94] Round 3 of ACCAP allocated $300 million to 66 projects outside of major cities in September 2025.
- Ongoing support for the Rural Local Assistance Program for Aged Care, which supports aged care providers to fill staffing gaps.
- Ongoing support for the Rural, Remote and First Nations Aged Care Service Development Assistance Panel, which has delivered capability building support to more than 30 projects in 2025–26 for providers in MM4 to 7 regions and those providing care to Aboriginal and Torres Strait Islander peoples.

To support more equitable access to aged care services for older people living in regional, rural and remote Australia, the department recognises the importance of ensuring that these supports are appropriately targeted to the communities with the greatest need. To support this, the department completed and published a review of the Modified Monash Model in March 2026.[95]

Work also progressed concurrently on the development of a new Regional, Rural and Remote Aged Care Policy framework, as well as reviews of the funding models for the MPSP and the NATSIFACP. These funding model reviews are targeted for completion in the next reporting period following further analysis, consultation and engagement with stakeholders. They will be informed by specialist advice from the Independent Health and Aged Care Pricing Authority. Implementation is expected to be phased with timeframes to be confirmed.

The rates at which Aboriginal and Torres Strait Islander peoples accessed aged care services during 2025–26 were above the planned performance targets, except for people aged 65 years and over accessing residential care.

With the changes introduced by the Act, only people who are homeless, at risk of homelessness, or Aboriginal and Torres Strait Islanders are able to enter the aged care system under the age of 65 years. Therefore, it would be expected that the rate of access by Aboriginal and Torres Strait Islander people far exceeds the overall access rates for this age cohort.

For older Australians who self-identified as Aboriginal and Torres Strait Islander people accessing mainstream residential aged care and were aged 65 years and over, the target for 2025–26 (1.3%) was not achieved (1.1%). The target was achieved for both the Support at Home program (2.5%) and the CHSP (2.0%).

Data for all 3.2C(a) is not directly comparable with prior years' results, as the 2025–26 result is presented by age cohort.

The rates at which older people living in rural and remote areas of Australia accessed aged care services during 2025–26 were below planned performance target (10.6%) except in the context of the CHSP (11.8%). Targets were not achieved for the Support at Home program (9.8%) and permanent residential care (7.5%).

There were slight reductions in residential care access rates for older people living in rural and remote between the 2023–24 and 2025–26 reporting periods. Access rates under the CHSP have also decreased slightly over this time, though still remain above the targets, while rates under the ongoing pathway in Support at Home, which commenced on 1 November 2025 and is reported in this indicator for the first time this year, was at comparable rates to the final full year of operation of the HCP program in 2024–25.

Overall, while the number of people accessing aged care services in regional, rural and remote areas continues to increase, particularly in very remote communities, further work is required to ensure that rates increase to a level comparable with the broader Australian population.

[94] Further information on ACCAP is available at: **www.health.gov.au/our-work/aged-care-capital-assistance-program**

[95] Available at: **www.health.gov.au/resources/publications/review-of-the-remoteness-classification-system-for-aged-care-final-report**

Access remains low in some areas due to factors such as geographic isolation, limited-service availability, workforce shortages, higher service delivery costs and other localised challenges. Thin market policy settings are continually reviewed to ensure that investment remains appropriately targeted, reaches the communities with the greatest need, and contributes to improved access and outcomes.

The exclusion of both the MPSP and NATSIFACP is significant when considering these results. Data for both the MPSP and NATSIFACP was not available for this financial year, and both provide significant supports in rural and remote areas. As of 30 June 2026, NATSIFACP had 1,944 operational places across Australia and the MPSP assisted approximately 5,000 older people across residential and at home settings. Therefore, the 2025–26 result underestimates the number of older people from rural and remote communities, including Aboriginal and Torres Strait Islander peoples, accessing aged care services.

Aged care eligibility for Aboriginal and Torres Strait Islander people is 50 years and over, compared to 65 years and over for other population groups. Aboriginal and Torres Strait Islander people can access aged care services at a younger age due to a higher burden of disease and disability resulting in an increased need for aged care services earlier in life. Reporting for this group relies on self-reporting and may not accurately reflect the true numbers of Aboriginal and Torres Strait Islander people accessing services. First Nations status may not be reported because people feel uncomfortable in disclosing their status, or it is not accurately captured through registration and assessment processes. The accuracy of this data will likely improve as the cultural safety of the aged care system is enhanced. The Integrated Assessment Tool will further strengthen the capture of this information.

Key Activity for Program 3.2: Enable the delivery of residential care and home care services that support older people.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.99

Performance Measure 3.2D: Older people receive home care services that support them.

a. Number of allocated Support at Home places (short-term and ongoing)

b. Number of clients that accessed Commonwealth Home Support Program services.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.99

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
a. 380,000 b. 860,000	a. 503,251[96] b. 813,670	a. 308,244[97] b. 838,694	a. 287,404[98] b. 834,981
	Result: a. Achieved b. Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. 380,000

b. 860,000

Substantially achieved:

a. 345,000 to 379,999

b. 850,000 to 859,999

Not achieved:

a. 310,000 to 344,999

b. <850,000

Disclosures:

2025–26 Result:

Data for 3.2D(a) is not directly comparable with prior years' results, with the Support at Home program replacing the HCP program and the Short-Term Restorative Care Program from 1 November 2025.

Data submissions for the previous financial year remain open throughout July to allow providers sufficient time to finalise their reporting. As a result, the dataset is not considered complete until after this period, and annual performance reporting may be subject to a delay of one to 2 months. While this delay ensures more comprehensive data collection, late or missing submissions can still lead to underreporting. Despite these 2 limitations, the overall margin error is considered low and does not have an impact on the ability to rely on the result. Existing quality assurance processes, including DEX guidance, system validation and internal reviews ensure that the data remains sufficiently reliable for performance reporting.

For 3.2D(b) data used for reporting against this measure is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the ACDW which is planned to be completed in mid-2026.

2024–25 Result:

Data submissions for the previous financial year remain open throughout July to allow providers sufficient time to finalise their reporting. As a result, the dataset is not considered complete until after this period, and annual performance reporting may be subject to a delay of one to 2 months. While this

[96] As at 30 June 2026, there were 503,251 non-distinct allocated Support at Home, Assistive Technology and Home Modifications, Restorative Care Pathway and End-of-Life places. This equates to 414,512 distinct people, as individuals may be allocated places across multiple sub-programs. Restorative Care Pathway and End-of-Life allocation counts are based on approvals and committed data only and do not account for subsequent withdrawals, deaths or exits.

[97] 2024–25 Result is based on the number of allocated Home Care Packages (Target 305,897).

[98] 2023–24 Result is based on the number of allocated Home Care Packages (Target >285,100).

delay ensures more comprehensive data collection, late or missing submissions can still lead to underreporting. Despite these 2 limitations, the overall margin error is considered low and does not have an impact on the ability to rely on the result. Existing quality assurance processes, including DEX guidance, system validation and internal reviews ensure that the data remains sufficiently reliable for performance reporting.

For 3.2D(b) data used for reporting against this measure is sourced from the ACDW and data provided by third parties. There are limitations with this data, with the department working to rectify issues related to management of the ACDW which is planned to be completed in mid-2026.

Data Sources:

a. Department of Health, Disability and Aging's My Aged Care data (Siebel). Services Australia provides the main data source for billing and administrative data and is stored in the ACDW.
b. DSS DEX where provider service delivery is reported. Data is transferred to the department's ACDW.

Methodology:

a. Data is extracted from the ACDW and transformed based on business rules to meet reporting requirements. Analysis will then identify the number of participants that are assigned or committed to a Support at Home place in the financial year of interest.
b. The calculation methodology is the number of clients that had one or more CHSP sessions for a CHSP service in the given financial year.

Support at Home:

The Support at Home program commenced on 1 November 2025, replacing the HCP program and the Short-Term Restorative Care Program under the *Aged Care Act 2024*. This represented a significant reform to Australia's in-home aged care system and required the successful transition of existing HCP recipients, providers and assessment arrangements to the new program.

The Support at Home program has 8 classifications for ongoing services and 3 short-term classifications: the Restorative Care Pathway, the End-of-Life Pathway, and the Assistive Technology and Home Modifications scheme.

During 2025–26, the department undertook a range of activities to support the successful implementation of the Support at Home program, including:

- Transitioning existing HCP recipients to the Support at Home program while maintaining funding equivalent to their previous HCP level.
- Working closely with assessment organisations to monitor referral pathways, assessment volumes and assessment wait times.
- Implementing the Single Assessment System reform to increase assessment capacity and provide access to multiple assessment organisations within service areas where required.
- Identifying and progressing system improvements to reduce assessment wait times and improve participant access to services.
- Developing and publishing a comprehensive suite of guidance materials, including the Support at Home Program Manual, Provider Transition Guide, Claims and Payments Business Rules Guidance and a monthly statement template.
- Providing regular updates and communications through departmental websites and other communication channels.
- Hosting face-to-face engagement sessions with older people, families, carers and providers through the department's state and territory office network.
- Delivering webinars with representatives from the department, the Older Persons Advocacy Network, the Council on the Ageing, and Ageing Australia to support understanding of the new Support at Home program.
- Engaging with the Aged Care Transition Taskforce and the Aged Care Transition Sector Working Group to support sector readiness and implementation.

These initiatives laid the foundations for a more streamlined, equitable and person-centred in-home aged care system.

The Government also established Support at Home Thin Market grants[99] to ensure the availability of aged care services in rural and remote Australia, and for people with diverse backgrounds and life experiences. These grants provide supplementary funding to providers operating in identified thin markets, supporting viability and access to safe, quality aged care services. Two grant rounds were completed in 2025–26, and applications for a third round will commence during 2026–27.

During 2025–26, the demand for in-home aged care services continued to increase significantly. The transition to the Support at Home program occurred during a period of growth in aged care demand, with more than 400,000 older people accessing home care services, compared with approximately 150,000 people 5 years earlier.

Government investment in additional HCPs contributed positively to performance. The release of 20,000 additional HCPs commencing in September 2025, followed by a further 63,000 Support at Home places between 1 November 2025 and 30 June 2026, increased access to care and supported implementation of the new program. The additional HCPs contributed to the Government's long-term objective of reducing average wait times and improving timely access to ongoing in-home aged care services.

Collaboration across the aged care sector further contributed to performance. The department worked closely with providers, peak bodies, advocacy organisations and assessment organisations throughout the transition to support implementation and sector readiness of the new legislative and program framework. Strong engagement across the sector helped ensure continuity of care for older people while embedding the new arrangements.

2025–26 was the first year of the Support at Home program, and direct comparisons with prior years are not possible on a like-for-like basis, as the program replaced the HCP and the Short-Term Restorative Care Program. Performance during 2025–26 was consistent with the department's planned objective of implementing the Support at Home program and improving access to in-home aged care services, to support older Australians.

At 30 June 2026, there were 503,251[100] allocated Support at Home places (including ongoing, short-term, Assistive Technology and Home Modifications, Restorative Care Pathway, and End-of-Life), exceeding the planned performance target of 380,000 places. The Support at Home program delivers Government-funded aged care services designed to help older Australians remain at home for longer.

The successful rollout of the Support at Home program provides a strong foundation for future improvements in the aged care system. The department will continue to monitor implementation and work closely with stakeholders to ensure older people continue to receive safe, high-quality and appropriate in-home aged care services.

Commonwealth Home Support Program (CHSP):

The CHSP program is the Australian Government’s entry-level aged care program designed to help older Australians remain living independently in their own homes and communities. It provides practical support for people who need assistance with everyday tasks but do not yet require higher-level aged care services. The program is based on a wellness and reablement approach, meaning it aims to help older people maintain or regain independence rather than creating reliance on services.

[99] Further information on the Support at Home Thin Markets grant is available at: **www.health.gov.au/news/apply-for-the-support-at-home-thin-markets-grant**

[100] As at 30 June 2026, there were 503,251 non-distinct allocated Support at Home, Assistive Technology and Home Modifications, Restorative Care Pathway and End-of-Life places. This equates to 414,512 distinct people, as individuals may be allocated places across multiple sub-programs. Restorative Care Pathway and End-of-Life allocation counts are based on approvals and committed data only and do not account for subsequent withdrawals, deaths or exits.

The CHSP became regulated under the *Aged Care Act 2024* (the Act) from 1 November 2025. Under the Act, all Commonwealth-funded aged care services are provided to eligible and approved clients who are registered with My Aged Care, have completed an aged care needs assessment and have been approved to receive the services provided. In addition, CHSP services have been aligned with the legislated Aged Care Service List.[101]

During 2025–26, CHSP providers were required to collect and report client My Aged Care IDs as part of the DEX managed by DSS. This requirement aims to strengthen data quality and monitoring, ensuring that all funded CHSP services are delivered to registered and approved clients.

CHSP registered providers must comply with their legislative obligations under the Act.[102] The department continued with performance and delivery compliance throughout 2025–26 to improve the efficiency of resource allocation within the CHSP.

Through the CHSP Emergency Grant (GO7393), the department has supported providers facing short term financial viability impacts or emergency events with additional funding to support more effective service delivery and ensure continuity of care.

During 2025–26, CHSP providers continued to be grant funded to deliver services within their funded Aged Care Planning Regions. The program remained accessible to large numbers of clients, supporting their independence through the provision of entry-level aged care services at a low cost. Demand for services remained high, particularly for domestic assistance, home maintenance and repairs, and allied health services, including occupational therapy. In some regions, this resulted in delays in access to services and providers delivering services above their funded outputs.

CHSP providers also reported increasing operational costs, which have placed pressure on service delivery. The department continues to work closely with providers where services have been affected to enable a greater understanding of the impacts of increasing costs. CHSP providers have continued to access flexibility provisions which allows a movement of funded services within their ACPRs and seeking client contributions to help meet increasing service demand from approved clients seeking access to services.

In 2025–26, 813,670 clients have accessed CHSP services, achieving 94.61% of the planned performance target of 860,000.

[101] Available at: **www.health.gov.au/resources/publications/guide-to-aged-care-law/chapter-1-introduction/aged-care-service-list**

[102] Further information on the responsibilities of CHSP providers can be found at: **www.health.gov.au/our-work/chsp/responsibilities-of-providers**

Program 3.3: Aged Care Quality

Key Activity 3.3A: Deliver programs that support the growth of the aged care workforce.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.101

Performance Measure 3.3A: Aged care workforce is available and appropriately skilled.
Source: Health, Disability and Ageing Corporate Plan 2025–26, p.101

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
Progressive decrease towards 25% or less for staff turnover in the aged care sector.	Data not available.	Baseline workforce turnover is 84,908 (27%) of all directly employed nursing, personal care and clinical care manager staff left their employment in the 12-months since March 2022.	Workforce turnover: 84,908 (27%) of all directly employed nursing, personal care and clinical care manager staff left their employment in the 12-months since March 2022.
	Result: Data not available		

The assessment scale for the 2025–26 planned performance is:
Achieved: Progressive decrease towards 25% or less for staff turnover in the aged care sector.
Substantially achieved: N/A.
Not achieved: An increase in staff turnover in the aged care sector from the 2024–25 baseline.

Disclosures:

2025–26 Result:

Results for 2025–26 will be available in May 2027 and will be derived from the 2026 Aged Care Provider Workforce Survey. Services were asked to provide information relevant to the first fortnightly pay period in February 2026. The 2023 Aged Care Provider Workforce Survey measured turnover in March 2023, resulting in a different reference period for comparison. Any time series analysis should be interpreted with caution due to the differing data collection time periods.

2024–25 Result:

Baseline has been established for 2024–25 and is the same as that reported in 2023–24, because the Aged Care Provider Workforce Survey is a biennial survey, last conducted in 2023.

The 2023 Aged Care Provider Workforce Survey headcount estimates may overstate the size of the workforce where staff work for multiple providers or across different service care types. Services were asked to provide information relevant to the first fortnightly pay period in March 2023.

Data Source:

Aged Care Provider Workforce Survey. This is a biennial survey, last conducted in 2023.

Methodology:

Based on the 2023 Aged Care Workforce Provider Survey, the annual turnover rate is calculated as the percentage of employees who left since March 2022 using staffing numbers at March 2022 as the denominator.

Turnover Rate = (The number of directly employed staff who left since March 2022 / (Number of Employees as at March 2022) x 100.

The 2026 Aged Care Provider Workforce Survey (the survey) collected information on workforce size and composition from a select sample of aged care services between February and April 2026. The survey included providers delivering services across the following 5 aged care service types:

- residential aged care services
- the Support at Home program
- the CHSP
- Multi-Purpose Services (MPS)
- the NATSIFACP.

The survey was conducted following the implementation of the *Aged Care Act 2024* and the transition of HCP providers to the Support at Home program. These changes may have affected providers' capacity to participate in a voluntary survey, potentially impacting response rates. However, survey weighting methods will be applied to help mitigate the effects of lower response rates on the overall estimates.

The survey was pilot tested with a selected number of aged care services to refine question clarity and improve usability. This process supported high-quality data collection by identifying and resolving issues prior to the commencement of data collection.

Findings from this survey will be published on the AIHW website[103] in May 2027. A full Data Quality Statement, including data caveats, will be released alongside the survey results.

Workforce turnover is used as a proxy for workforce availability and provides insight into whether there are the right number of workers to meet the needs and rights of clients. Lower workforce turnover may indicate increased staff retention and improved continuity of care, contributing to higher quality care for recipients.

The Government has invested $17.7 billion to support award wage increases for aged care workers, a result of the Fair Work Commission decisions under the Aged Care Work Value Case. This relates to Recommendation 84 from the Royal Commission into Aged Care Quality and Safety[104] to increase award wages.

The growth of the workforce is further supported through the delivery of other programs. The Government has invested a further $88.4 million over 3 years through the 2024–25 Budget to support and develop the aged care workforce. This includes:

- $21.6 million for the Regional, Rural and Remote Home Care Workforce Support Program which focuses on rural and remote areas with acute workforce needs.
- $57.0 million to continue workforce development programs supporting career development for aged care nurses.

The turnover rate is a measure of progress towards Recommendation 86 of the Royal Commission into Aged Care Quality and Safety and the aged care sector's capacity to meet mandatory care minutes, 24/7 registered nurse coverage, and appropriate workforce skill mix requirements.

The quality of Australian Government-funded aged care is assessed against a set of Aged Care Quality Standards by the Aged Care Quality and Safety Commission (ACQSC). Further information on aged care quality can be found in the ACQSC's Sector Performance Reports.[105]

[103] Results will be published on the AIHW website at: **www.aihw.gov.au/**

[104] Royal Commission, Final Report - List of recommendations, can be found at: **www.royalcommission.gov.au/aged-care/final-report**

[105] Available at: **www.agedcarequality.gov.au/news-publications/reports/sector-performance**

Outcome 4: Disability and Carers

Supporting the independence of people with disability and carers by providing targeted supports.

Programs contributing to Outcome 4

	Summary of results against planned performance targets				
Program	**Achieved**	**Substantially achieved**	**Not achieved**	**Data not available**	**Not applicable**
Program 4.1: Disability and Carers	1	-	2	-	-
Program 4.2: National Disability Insurance Scheme	2	-	-	-	1
Total	**3**	**0**	**2**	**0**	**1**

Program 4.1: Disability and Carers

Key Activity for Program 4.1: Disability and Carer Support.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.105

Performance Measure 4.1A: Extent to which carers who are registered with Carer Gateway local service providers' wellbeing is assessed as improved.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.105

2025–26 Planned Performance	2025–26 Result	2024–25 Result	2023–24 Result
a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period. b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.	a. 29.7% b. 33.8%	a. 31.4% b. 34.2%	a. 29% b. 34%
	Result: a. Not achieved b. Not achieved		

The assessment scale for the 2025–26 planned performance is:

Achieved:

a. ≥30%

b. ≥35%

Substantially achieved:

a. N/A

b. N/A

Not achieved:

a. <30%

b. <35%

Disclosures:

2025–26 Result:

a. In the current reporting period from 1 July 2025 to 30 June 2026, 45.5% of carers registered with Carer Gateway with an assessment in the period, were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

b. In the cumulative reporting period from 1 January 2020 to 30 June 2026, 46.7% of carers registered with Carer Gateway were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

2024–25 Result:

a. In the current reporting period from 1 July 2024 to 30 June 2025, 49.2% of carers registered with Carer Gateway with an assessment in the period, were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

b. In the cumulative reporting period from 1 January 2020 to 30 June 2025, 49.6% of carers registered with Carer Gateway were considered fully assessed (undertaken at least 2 Carers Star™ assessments).

Data Source:

Carers Star™ 'needs assessments' conducted by Carer Gateway service providers and entered into the Department of Social Services Data Exchange.

Methodology:

The methodology for each of the targets is:

- The static target result of the number of carers assessed as having improved wellbeing within the performance reporting period is calculated using Carers Star™ needs-assessments data, where an assessment is reported in the current reporting period. A previous assessment must have occurred in either the same reporting period or a previous period.
- The increasing target result of carers assessed as having improved wellbeing for all registered carers since the program commenced is calculated using data from Carers Star™ needs-assessments, across all reporting periods from 1 January 2020 to the end of the current reporting period.

Data results are produced using Data Exchange QLIK Sense reporting of client outcomes. QLIK Sense pairs available earliest and latest SCORE data entered in DEX for each client in each reporting period and produces the percentage of carers who are assessed as having improved wellbeing.

2025–26 represents the sixth full year of operation for the Carer Gateway program. Monitoring improvement in carer wellbeing is a longer-term outcome, and the proportion of carers experiencing improved wellbeing is an important measure of the impact of this program.

In addition to access and quality of carer supports, a range of other factors influence wellbeing for carers, including the circumstances of their caring relationship and employment. Qualitative evidence indicates that regardless of effective support, the caring role is taxing, and maintenance of wellbeing could also be considered a success. Ongoing analysis of program data indicates that the percentage of carers with improved wellbeing is plateauing the longer the program runs. The historical Carer Gateway performance data has informed the current grant round.

Carer Gateway is the support program which provides the largest reach and the broadest range of services to unpaid carers. In 2025–26, the number of carers assisted through Carer Gateway service providers continued to plateau and is broadly consistent compared to previous years since the program stabilised in 2022.

The National Carer Strategy 2024–2034 (the Strategy)[106] provides a framework for co-designing, developing and delivering actions to improve the lives of carers. The accompanying National Carer Strategy Action Plan 2024–2027 (the Action Plan)[107] outlines the initial actions to support implementation of the Strategy. During 2025–26, the department progressed a range of commitments under the Action Plan. Action 1.1 to increase phone counselling capacity for carers by 10,000 sessions per year was delivered. The department also advanced elements of Action 5.1 through support for the Carer Inclusive Workplaces Initiative, the Young Carer Bursary, the Young Carer Network, and pre-employment support services delivered through Carer Gateway.

Several projects were established in 2025–26 to support delivery of Commitment 1. Commitments 1a and 1b in the Action Plan focus on improving specific services offered through Carer Gateway to improve the accessibility and inclusivity of Carer Gateway. Further information is available at the National Carers Strategy Annual Report 2025.[108]

An implementation plan to deliver these improvements has been developed and includes improvements to support geographic and demographic access, cultural accessibility and a blueprint for uplifting cultural capability of Carer Gateway service providers.

The Carers, Autism and Early Childhood Branch is working with Carer Gateway Service Providers to support increased compliance with Carer Star™ assessments and quality of reporting, as well as options to simplify measurement of carer wellbeing, particularly for carers exiting the program.

Following the implementation of the Carer Gateway Key Performance Indicator framework, the program has demonstrated sustained improvements in the proportion of carers considered fully assessed, indicating that the increased focus on assessment coverage and data quality has been effective.

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[106] Available at: **www.health.gov.au/resources/publications/national-carer-strategy-2024-2034**

[107] Available at: **www.health.gov.au/resources/publications/national-carer-strategy-action-plan-2024-2027**

[108] Available at: **www.health.gov.au/resources/publications/national-carer-strategy-annual-report-2025**

The continued improvement observed throughout 2025–26 suggests that the framework is contributing positively to assessment coverage, and the program's ability to measure and support carer outcomes.

During 2025–26, 6-monthly performance reporting conversations were held with Carer Gateway Service Providers to support attainment and continuation of KPI targets in their grant agreements. This included KPIs for numbers of carers considered fully assessed, as well as proportions of carers with improved or maintained wellbeing. Additionally, the department held an all-day workshop with providers, which included a deep dive into KPI performance nationally where providers shared insights, challenges, and best practices to achieve better outcomes.

The Carer Wellbeing Survey 2025 Report[109] (the Survey) found that carers continue to experience substantially poorer health and wellbeing outcomes than the broader Australian population. Carer wellbeing declined between 2024 and 2025, with only 38.9% of carers reporting healthy levels of wellbeing in 2025, compared with 66.4% of Australian adults. The Survey also found that the general health of carers has continued to decline since 2021, with only 15.3% of carers reporting very good or excellent health in 2025, compared with 43.8% of Australian adults. The Survey identifies a range of factors associated with poorer wellbeing outcomes for carers, including increased cost-of-living pressures, mental health impacts, social isolation, under- or unemployment, unsupportive workplaces, and access to medical treatments. Many of these factors are outside the direct influence of Carer Gateway services and improvements in wellbeing require support from broader service systems.

The measured performance in lifting wellbeing is close to the targets but still below. This may be due to measurement and data collection challenges, including a relatively low number of fully assessed carers, and assessment processes that have been focused on case management rather than performance reporting.

In the reporting period from 1 January 2020 to 30 June 2026, 46.7% of carers registered with Carer Gateway were considered fully assessed, having completed at least 2 Carers Star™ assessments. This represents the highest proportion recorded since the program commenced. Assessment rates continue to increase as the program matures, resulting in more accurate and reliable measures.

Carers Star™ is designed as a case management tool to identify caring issues, inform case plan goals, and measure and report on carers' progress and achievement of outcomes. Anecdotal evidence suggests that carers with increased wellbeing are more likely to disengage from the program and not complete a follow-up Carers Star™ assessment to confirm this improvement, as they no longer require intensive case management support to access services. It is also a known limitation that carers with high wellbeing on entry to the program cannot further improve their wellbeing and therefore count against the target, despite maintenance of high wellbeing tending to indicate program success for these clients.

The impact of the program on carer wellbeing remains consistent since the program stabilised in 2022, following delayed full implementation of the program due to COVID-19. This is likely associated with stabilising client turnover, with the number of new carers accessing Carer Gateway in each reporting period also remaining consistent. As a result, incremental gains in measured wellbeing may become less pronounced over time as the composition of the client cohort stabilises.

Carers care for a wide variety of individuals, including people with disability, older people, and those experiencing acute, chronic or complex health conditions. Supporting carer wellbeing is an important part of supporting people with disability and other care recipients. Evidence shows that carers with higher levels of wellbeing are better able to provide consistent and effective care, respond effectively to changing needs, and maintain positive caring relationships, leading to improved outcomes for people receiving care. Poor carer wellbeing is associated with increased risks of adverse outcomes for care recipients, including functional decline and an increased risk of requiring institutional or residential care.

Carer Gateway contributes to improved outcomes for people with disability by helping carers maintain their wellbeing and capacity to continue in their caring role. The program delivers evidence based early-intervention and preventative supports tailored to individual circumstances, including needs assessment and support planning, tailored support packages (with a focus on employment, education and respite), coaching, counselling and peer support, emergency respite, information and advice.

[109] Available at: **www.carersaustralia.com.au/carer-wellbeing-survey/**

Key Activity for Program 4.1: Disability and Carer Support. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.107**		
Performance Measure 4.1B: Extent to which the evidence base is built for Australia's Disability Strategy 2021–2031 (the Strategy). **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.107**		
2025–26 Planned Performance	**2025–26 Result**	**2024–25 Result**
The number of measures under the Australia's Disability Strategy Outcomes Framework (ADS OF) with data reported is an increase on the previous reporting year.	As of 30 June 2026, the ADS OF had 63 measures with reported data.	As of 30 June 2025, the ADS OF has a total of 88 ADS OF measures of which 56 have data reported on.
	Result: Achieved	
The assessment scale for the 2025–26 planned performance is: **Achieved:** Increase on previous year. **Substantially achieved:** N/A. **Not achieved:** Decrease or same result as previous year.		
Data Source: The data used for this performance measure is sourced by counting the number of measures on ADS OF webpages that have data available. The department accesses the ADS OF measures from ADS OF. AIHW maintains ADS OF. As data becomes available for new ADS OF measures, the webpages are updated to reflect the data, through quarterly updates. There is no data bias as there is either data available or there is not.		
Methodology: Determining the total number of measures reported under ADS OF involves counting the outcomes measures that have data available at the end of the relevant financial year. The measure aims to increase transparency through increasing the number of ADS measures that are reported on above the 2023–24 baseline of 55 of the 85 measures. A revised Data Improvement Plan was launched in December 2024 to improve the data needed to track progress against the ADS OF. The focus is on developing and collecting data on those measures (future measures) that are currently not being reported.		

The ADS OF[110] enables transparent and nationally consistent monitoring of progress across the 7 outcome areas of the Australia's Disability Strategy 2021–2031.[111]

Quarterly and annual reporting against the ADS OF measures shows progress over the life of the Strategy. Increasing the number of ADS OF measures with available data is a key Strategy deliverable. The department drives progress through the Strategy Implementation Plan, Targeted Actions Plans[112] and ongoing cross-agency work to improve national disability data collections.

Commonwealth agencies and state and territory governments share responsibility for disability data development. Many agencies own, collect and maintain relevant datasets. Data availability, coverage and timeliness are not fully within the department's control. Data custodians determine collection methods, definitions and reporting practices. These factors influence data quality. The department cannot address these issues alone.

[110] Available at: **www.disabilitygateway.gov.au/document/3121**

[111] Available at: **www.health.gov.au/our-work/australias-disability-strategy**

[112] Further information on Australia's Disability Strategy Targeted Action Plans is available at: **www.disabilitygateway.gov.au/document/13849**

The department leads discussions with Commonwealth agencies and state and territory governments on future data collection activities. These discussions support commitments to improve disability data and reporting. Stakeholder agreement and implementation of new collection activities will increase the number of measures with reported data. States, territories and relevant Commonwealth agencies decide whether to implement new data collection activities. The department continues to work with all governments to improve data collection.

The number of ADS OF measures with reported data increased from 56 in 2024–25 to 63 in 2025–26. The department reported data for 7 measures for the first time. These measures span 5 outcome areas: Health and Wellbeing (3); Education and Learning (1); Personal and Community Support (1); Safety, Rights and Justice (1) and Inclusive Homes and Communities (1). The department also replaced one measure in the Inclusive Homes and Communities outcome area with a measure based on improved data. Wave 2 of Australia's Disability Strategy Survey[113] collected data for these measures during 2024–25. The survey will run for 2 additional waves during the Strategy period. Wave 3 is planned for 2027–28. Wave 4 is planned for 2030–31.

The increase from 56 to 63 measures has strengthened the evidence base. The additional data helps identify progress, stagnation and regression. The evidence helps governments target action and investment to improve outcomes for people with disability. The additional measures improve understanding of the experiences of people with disability across different life settings. They also increase the visibility of these experiences in national reporting.

Twenty-nine measures had their status updated during 2025–26 with:

- 11 showing improvement,
- 7 showing no change, and
- 11 showing regress.

Seven measures were reported for the first time, establishing a baseline to track future progress.[114]

Of previously reported measures, one was replaced due to an improved data source, and one was recalculated by the data custodians, resetting these 2 measures with a new baseline. The data for one measure was replaced with data from an ongoing service program.

Improved reporting identifies where systems and services support participation. It also identifies where reform can remove barriers to economic participation, social inclusion and equal opportunity. The department continues to seek data for 16 future measures through cross-agency and inter-intergovernmental processes.

An independent evaluation of the Strategy will occur in 2026–27. The department will also complete an internal review of the ADS OF in 2026. Recommendations from these reviews may change ADS OF measures, future measures and total number of measures.

[113] Australia's Disability Strategy Survey, Wave 2 Report, is available at: **www.disabilitygateway.gov.au/sites/default/files/documents/2025-10/9411-ads-wave-2-report.pdf**

[114] Further information on ADS OF reporting can be found at: **www.aihw.gov.au/australias-disability-strategy**

Program 4.2: National Disability Insurance Scheme

Key Activity 4.2A: Sector Development Fund and Jobs and Market Fund.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.108

Performance Measure 4.2A: The extent to which the Department of Health, Disability and Ageing is advising on and/or delivering market initiatives that influence the development of the market and workforce for NDIS participants.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.108

2025–26 Planned Performance	2025–26 Result	2024–25 Result
The department has advised on and/or delivered 8 market initiatives to develop the market and workforce.	9 initiatives have been progressed with various output measures achieved.	8 initiatives have been progressed with various output measures achieved.
	Result: Achieved	

The assessment scale for the 2025–26 planned performance is:

Achieved: 8 market initiatives are advised on and/or delivered.

Substantially achieved: 7 market initiatives are advised on and/or delivered.

Not achieved: ≤6 market initiatives are advised on and/or delivered.

Disclosures:

2025–26 Result:

Data counts reflect only initiatives that met the department's documented inclusion and achievement criteria during the 2025–26 reporting period. Initiatives were required to demonstrate a substantive departmental role, intended impact on market and/or workforce development, and measurable progress during the reporting period. Progress was evidenced through documented outputs and activities, including milestone advancement or completion, deliverables, governance activities, stakeholder engagement, policy development, or other evidence of initiative progression. Activities that did not meet these criteria were excluded from the final count.

2024–25 Result:

Data counts reflect only initiatives for which planning, design or delivery milestones occurred during the 2024–25 financial year. Additional activities related to sector development may fall below this threshold and are excluded.

Data Source:

The department’s Electronic Documents and Records Management System, Content Manager.

Methodology:

The department will report an output measure on the count of market intervention and workforce development projects and initiatives advised on and/or delivered by the department in 2025–26.

The department will advise on and/or deliver in collaboration and/or consultation with care and support economy stakeholders where necessary. This will be through a range of channels and forms dependent on who is being advised, including the Australian Government, other government entities, state and territory jurisdictions.

Market initiatives to be advised on and /or delivered in collaboration with other government agencies:

- Blended Payment Trials
- Provider of Last Resort Policy Development
- Market Stewardship Framework Development.

Market initiatives to be delivered by the department but developed in consultation with other government agencies:

- Care Sector Demand Map Development
- Integrated Care and Commissioning Trials
- Pricing and payments Regulatory Framework Development
- Ability First Australia Diploma of Leadership Management.

The department achieved the planned performance target in 2025–26 by advising on and/or delivering 9 market and workforce development initiatives, compared with a target of 8 initiatives.

The department expanded its stewardship, market intervention and workforce development activities. New initiatives included:

- Supported Independent Living (SIL) Commissioning.
- WA Regional and Remote Joint Work Program.

The department also progressed existing multi-year initiatives. These included the Market Stewardship Framework, Provider of Last Resort policy development, Integrated Care and Commissioning, and Blended Payment Trials.

The department refined its approach to identifying, validating and evidencing initiatives. The approach uses standardised methodologies, initiative checklists, evidence registers and centralised reporting processes.

Initiatives included a mix of advisory, stewardship, workforce and delivery activities. The department identifies initiatives through work plans, governance materials and stakeholder engagement activities. The department records initiatives in a central register. The department assesses each initiative against documented inclusion and achievement criteria. Assessment uses a mandatory initiative checklist. To qualify, an initiative must demonstrate a substantive departmental role. It must also show market or workforce impact, supporting evidence, measurable progress during the reporting period and independent validation. The department excluded initiatives that did not meet these requirements.

Many of the initiatives captured by this measure are multi-year reforms. The department counts and assesses initiatives based on progress achieved during the reporting period. The department does not assess overall project completion. This approach supports consistent reporting of long-term reforms across years. It also reflects the department's advisory, stewardship and delivery contributions. The department counts each eligible initiative once during the reporting period.

Key internal contributions included the following initiatives:

- **Blended Payment Trials**: This initiative is exploring the feasibility and practicality of implementing blended and outcome-based payment approaches to improve participant outcomes, provider incentives for quality service delivery, and NDIS sustainability. Following the outcomes of the co-design phase conducted in 2024, and the consideration of the operating environment for payment trials within the NDIS market, a decision of Government was made to discontinue live trials under the measure. During 2025–26, the department worked with the National Disability Insurance Agency (NDIA), the NDIS Commission, and the University of New South Wales to progress evaluation and future implementation options, with co-design findings informing ongoing policy development.
- **Market Stewardship Framework Development**: This initiative is developing a nationally consistent approach to NDIS market stewardship to improve oversight of market supply, pricing, quality and provider behaviour. During 2025–26, the department worked with the NDIA and NDIS Commission to progress governance arrangements, market monitoring approaches, stewardship roles and responsibilities, and Ministerial consideration of the framework.
- **Provider of Last Resort Policy Development**: This initiative is developing arrangements to support continuity of participant services when providers exit or markets fail. During 2025–26, the department worked with the NDIA, NDIS Commission, states and territories and the Disability Reform Ministers Council to progress policy design, governance arrangements, stakeholder engagement and future implementation options.
- **Care Sector Demand Map Development**: This initiative provides demand and workforce intelligence across the disability and aged care sectors to support provider investment, service planning and workforce development. During 2025–26, the updated Care Sector Demand Map was completed and released by the department in collaboration with the NDIA and aged care stakeholders, providing improved visibility of future service demand.
- **HumanAbility's Workforce Plan Development**: This initiative supports development of a skilled and sustainable care and support workforce through workforce planning and vocational education and training reform. During 2025–26, the department provided policy advice and strategic input to HumanAbility and the Department of Employment and Workplace Relations (DEWR) to support ongoing workforce planning and sector engagement activities.

- **Ability First Australia Diploma of Leadership in Disability Services**: This initiative aims to strengthen leadership capability, retention and career pathways within the disability workforce. During 2025–26, the department continued its stewardship of the Diploma of Leadership in Disability Services, with Ability First Australia managing the qualification under a grant agreement. As part of this work, the department also engaged with HumanAbility, the Australian Skills Quality Authority and DEWR to progress accreditation renewal activities and support ongoing workforce capability development.
- **Integrated Care and Commissioning Trials**: During 2025–26, the department supported exploration, design and testing of integrated care delivery and commissioning models through a partnership led by Aged Care across disability, aged care, health and veterans' services in thin-market regional and remote communities. As a non-operational delivery partner, the department provided local-level market analysis, workforce, supply and demand policy advice on the impacts of NDIS reforms and needs assessment guidance. The department worked with national partners and local stakeholder advisory groups to share evidence, generate insights and identify knowledge gaps. These activities informed local capacity-building initiatives and supported development of future joint commissioning approaches to improve service integration and respond to community needs.
- **SIL Commissioning**: This initiative is exploring potential commissioning approaches to strengthen the quality of supports for participants, encourage innovative housing and care models, support provider viability, and enhance market oversight within parts of the SIL market experiencing ongoing challenges. During 2025–26, the department worked with the NDIA and NDIS Commission to undertake provider viability analysis, develop policy options, and progress early design work for potential commissioning arrangements and future stakeholder consultation.
- **WA Regional and Remote Joint Work Program**: This initiative aims to improve participant access, service coordination and market capability across regional and remote Western Australia through place-based market and workforce interventions. During 2025–26, the department, the WA Government and the NDIA established the Joint Work Program covering 5 priority regions, including its scope, governance arrangements, rollout approach and respective responsibilities. The department's role includes providing market analysis and strategic policy advice to inform targeted market activities.

The department documented and tracked all initiatives through governance processes and electronic recordkeeping systems. The department provided policy advice, strategic guidance, stakeholder coordination, stewardship activities, project oversight, commissioning design, workforce initiatives and market intelligence. Multiple branches coordinated these activities. The department collaborated with the NDIA, Department of Social Services, NDIS Commission, Department of the Prime Minister and Cabinet, states, territories and other stakeholders.

External factors influenced performance in 2025–26. These factors affected the NDIS market and broader care and support economy. Provider viability concerns, workforce capability challenges and service gaps in thin markets increased the need for stewardship and commissioning initiatives. NDIS reforms also reinforced this need. Many initiatives relied on external stakeholders. Government decisions, consultation activities and reform priorities also influenced progress. The department progressed a broad portfolio of initiatives and exceeded the planned target.

The result reflects the department's focus on market sustainability, workforce capability, provider viability, continuity of supports, stewardship arrangements and market intelligence. The department adapted its delivery approach to reform timelines, stakeholder capacity and interjurisdictional coordination needs.

These initiatives improve wellbeing and social and economic participation. They support a sustainable NDIS market, strengthen workforce capability, improve stewardship and address market gaps. They also support service continuity and improve visibility of market conditions.

Key Activity 4.2B: NDIS Participant Plans.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.110

Performance Measure 4.2B: NDIS cost growth is sustainable.

Source: Health, Disability and Ageing Corporate Plan 2025–26, p.110

2025–26 Planned Performance	2025–26 Result	2024–25 Result
Annual growth in the total cost of the Scheme tracking to achieve the target of no more than 8% by 1 July 2026, with further moderation of growth as the Scheme matures.	Projected annual growth of Scheme costs is on track to achieve the target of no more than 8% by 1 July 2026.	Projected annual growth of Scheme costs is on track to achieve the target of no more than 8% by 1 July 2026.
	Result: Not applicable	

The assessment scale for the 2025–26 planned performance is:

Reporting for this target will commence from 2026–27. In 2025–26 the department will report against projected scheme costs for 2026–27 as reported in the Department of Health, Disability and Ageing Portfolio Budget Statements 2026–27.

Disclosures:

2025–26 Result:

Reporting for 2025–26 is on projected cost growth for 2026–27. The reporting of actual growth in payments for 2026–27, and subsequent years, will commence from 2026–27.

The projected reduction in NDIS payments assume the policy measures land as intended.

2024–25 Result:

Reporting for 2024–25 is on projected cost growth for 2026–27. The reporting of actual growth in payments for 2026–27, and subsequent years, will commence from 2026–27.

The projected reduction in NDIS payments assume the policy measures land as intended.

Data Source:

Projected scheme costs for 2026–27 as obtained from the Health, Disability and Ageing Portfolio Budget Statements 2026–27 (NDIA Chapter, Table 2.1.1, page 373).

Methodology:

In 2024–25 and 2025–26 the department will report against projected scheme costs for 2026–27 as reported in the Department of Health, Disability and Ageing Portfolio Budget Statements 2026–27. Tracking projected Scheme costs for 2026–27 across the years will show if the target is still expected to be met.

National Cabinet committed to a NDIS Financial Sustainability Framework (the Framework) on 28 April 2023. The Framework provides an annual growth target in total costs of the NDIS of no more than 8% from 1 July 2026. The Framework also seeks to moderate growth further as the Scheme matures. National Cabinet acknowledged in January 2026 the need for continued reforms to secure the future of the NDIS. National Cabinet sought to ensure the Scheme remains sustainable and continues to support future generations of Australians with disability. National Cabinet also agreed to target annual Scheme cost of 5 to 6% or lower.

The Minister for Disability and the National Disability Insurance Scheme announced on 22 April 2026 that projections for NDIS spending were now no longer expected to meet the 8% growth target. The announcement highlighted the need for further reforms.[115]

Over the course of 2025–26, the department's contribution to ensuring annual growth is on track to be no more than 8% by 1 July 2026 has been the development of the Government's Securing the National Disability Insurance Scheme for Future Generations plan. The plan outlines the Government's approach to Scheme sustainability. The plan aims to slow cost growth, clarify eligibility requirements and maintain quality services and supports and will:

- reinforce the boundary between the NDIS and mainstream services
- more consistently assess if the NDIS is the appropriate system of support and if treatment can alleviate or remedy an impairment
- strengthen guidance around what is reasonable and necessary
- introduce standardised, evidence-based assessments of a person's functional capacity to determine access to the NDIS
- remove diagnosis lists as the means of entry to the NDIS
- end plan rollovers and stop unspent funds being rolled over to ensure plans align with reasonable and necessary decision making
- tighten the criteria around unscheduled reassessment requests, while ensuring people with significant changes in support needs can still request plan variations.[116]

The 2026–27 Budget projected that the measure would reduce NDIS payment growth by $37.8 billion over 4 years from 2026–27 ($38.1 billion in expense terms). These measures are expected to reduce average NDIS growth to below 2% over the period.[117] The Government introduced the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 in May 2026 to enable these reforms. The bill was passed by Parliament in August 2026.

The reforms announced in 2026 build on work undertaken during 2025–26 to improve NDIS sustainability. The *National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No.1) Act 2024* (the 2024 Amending Act) commenced on 3 October 2024. This Amending Act established the foundation for new NDIS Rules. These Rules improve participant experiences and support long-term Scheme sustainability. The Government implemented changes to NDIS Rules and other legislative instruments throughout 2025. The Rules changed plan management, variation and reassessment processes. The Rules also introduced new funding safeguards. These reforms influenced NDIS cost growth during 2025–26.

The 2024 Amending Act enabled New Framework Planning. New Framework Planning seeks to deliver more equitable and consistent participant budgets. The model introduces a new support needs assessment process and budget methodology. The department consulted people with disability, families, carers and advocates throughout 2025–26. The department will continue working with states, territories and the disability community to develop new framework planning rules.

The Government funded fraud and integrity measures throughout 2025–26. These measures included the Fraud Fusion Taskforce, the Crack Down on Fraud program and NDIA payment integrity activities. The 2025–26 Budget provided additional funding for these activities. Fraud detection and prevention support Scheme sustainability. These activities protect participant funding and improve participant wellbeing.

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[115] Read Minister Butler's speech to the National Press Club on securing the NDIS for future generations at: **www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-butler-speech-at-the-national-press-club-22-april-2026**

[116] Further information on the NDIS Amendment Act 2026 is available at: **www.health.gov.au/securingtheNDIS**

[117] Further information on the contribution of specific policy measures to the $37.8 billion reduction in NDIS payments is available at: **www.aph.gov.au/Parliamentary_Business/Tabled_Documents/16585**. The actual NDIS payments for the financial year are reflected in the NDIA annual report typically published in October or November following the end of the financial year.

The department progressed NDIS integrity measures throughout 2025–26. Parliament passed the *NDIS Amendment (Integrity and Safeguarding) Act 2026* in April 2026. The amendment expands the NDIS Quality and Safeguards Commission's powers. The NDIS Commission can better detect, prevent and respond to breaches of obligations under the Act.

The department supports Scheme sustainability through policy and legislative advice. The department also supports system stewardship and intergovernmental governance arrangements. The NDIA and the NDIS Quality and Safeguards Commission hold responsibility for Scheme delivery, compliance and regulation. Final Scheme cost growth for 2025–26 will be published in the NDIA's annual report.[118]
A sustainable NDIS improves participant wellbeing and social and economic participation. It also secures the Scheme for future generations.

[118] The NDIA's annual reports are available at: **www.ndis.gov.au/publications/annual-report**

Key Activity 4.2C: NDIS Participant Plans. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.111**			
Performance Measure 4.2C: Legislative amendments developed for Government. **Source: Health, Disability and Ageing Corporate Plan 2025–26, p.111**			
2025–26 Planned Performance	**2025–26 Result**	**2024–25 Result**	**2023–24 Result**
Criterion is met if 3 of the 3 progress milestones are delivered.	100%	100%	100%
	Result: Achieved		
The assessment scale for the 2025–26 planned performance is: **Achieved:** 3 of the 3 milestones have been achieved within the reporting year. **Substantially achieved:** 2 of the 3 milestones have been achieved within the reporting year. **Not achieved:** Fewer than 2 of the 3 milestones have been achieved within the reporting year.			
Data Source: Drafting instructions/email(s) to the Office of Parliamentary Council. Disability Reform Ministerial Council (DRMC) and Disability Senior Officials Group (DSOG) papers. Records of stakeholder meetings (including DRMC and DSOG). Tabling submission pack, including Explanatory Memorandum, background/legislation briefing pack, Second Reading Speech, Q&As.			
Methodology: Milestones: 1. Develop policy advice and drafting instructions to support the Office of Parliamentary Counsel prepare a parliamentary bill. 2. Engagement with stakeholders (state and territory jurisdictions on legislation). 3. Develop supplementary materials to accompany the bill for introduction.			

In 2025–26, the department achieved the planned level of performance through the successful delivery of all 3 milestones.

The department measured achievement against delivery of 3 milestones:

1. policy development and drafting instructions to support legislative reform
2. engagement with stakeholders, including state and territory governments
3. development of materials to support the passage and implementation of legislative instruments.

The department completed the following work during 2025–26:

- Development of policy advice and drafting instructions - the department progressed policy advice and drafting instructions for subordinate legislation enabled by the *NDIS Amendment (Getting the NDIS Back on Track No. 1) Act 2024.* The department also developed policy advice and drafting instructions to support implementation of the *NDIS Amendment (Integrity and Safeguarding) Act 2026.*
- Comprehensive stakeholder engagement - the department engaged with state and territory jurisdictions through the DRMC and the DSOG. The department also engaged with the public, the disability sector and the Reform Advisory Committee (RAC).

The department undertook extensive policy development and prepared Drafting Instructions for subordinate legislation (Rules) and primary legislation to achieve Milestones 1, 2 and 3.

The department developed detailed policy proposals and drafting instructions for Rules associated with the *NDIS Amendment (Getting the NDIS Back on Track No. 1) Act 2024* to achieve Milestone 1. The department supported Milestone 2 through ongoing engagement with state and territory jurisdictions at DSOG and DRMC meetings and workshops. The department also completed similar policy development and consultation activities to support implementation of the *NDIS Amendment (Integrity and Safeguarding) Act 2026.*

The department achieved Milestone 3 by developing implementation, communication and legislative support materials.

Outputs from key stakeholders provide evidence of achievement against the milestones. The work is iterative because NDIS policy continues to evolve. The department refines legislative approaches as policy develops. The department updates policy and drafting instructions to reflect new evidence, stakeholder feedback and Government priorities.

The department achieved all milestones through sustained internal collaboration. This approach supported coherent and integrated reform. The complexity of NDIS policy and legislation requires close coordination with disability and whole-of-government areas.

External factors influenced achievement of all milestones. These factors included Government priorities and decisions during 2025–26. They also included negotiations on Foundational Supports, collaboration with the NDIA, and participant engagement.

The department relied on ongoing engagement with the NDIA throughout this work. The NDIA is responsible for NDIS delivery. The department and the NDIA worked closely on policy development and drafting instructions. Established governance arrangements supported joint activities. These arrangements aligned work with Government priorities and incorporated stakeholder insights into legislation.

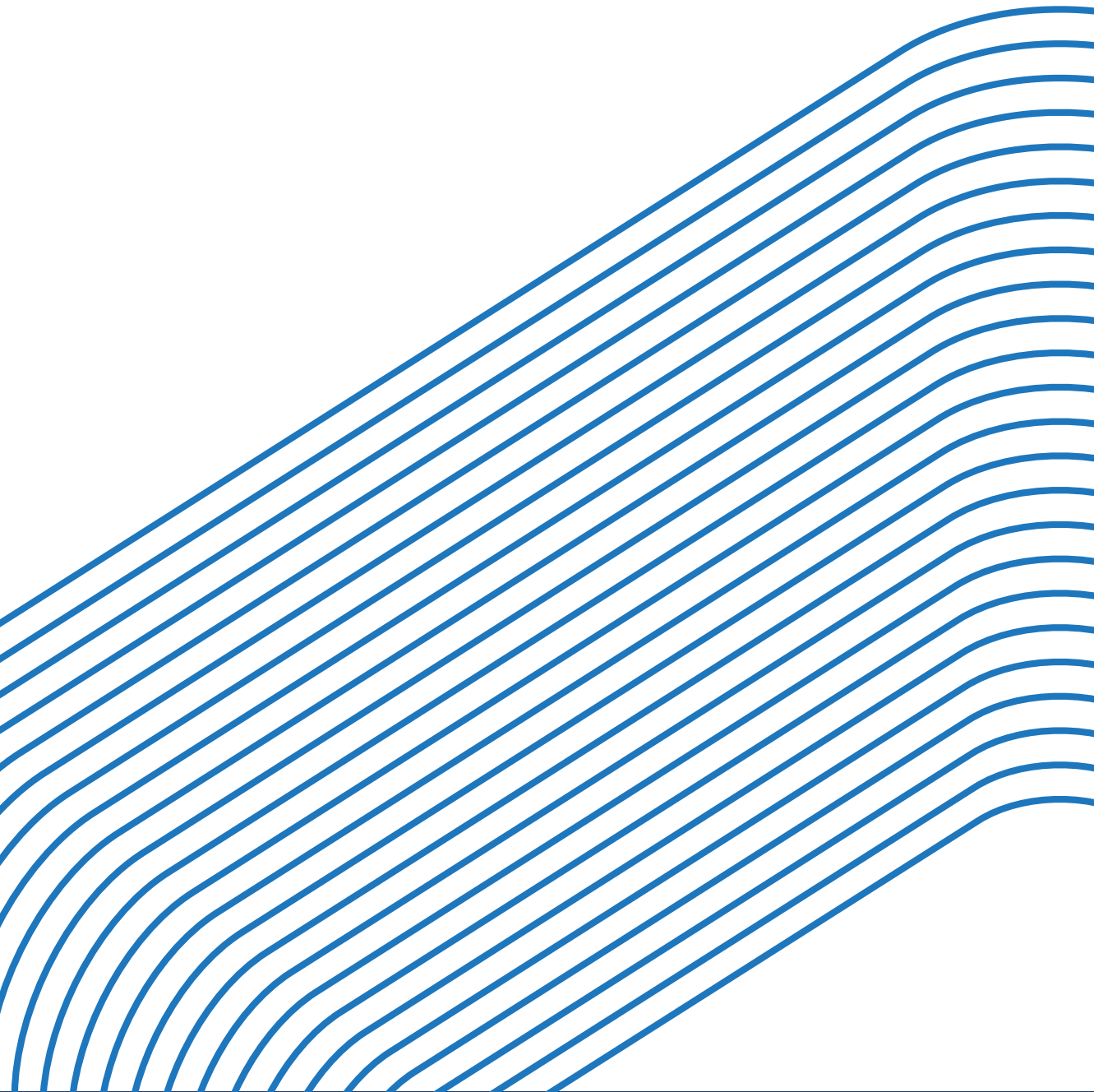
The department and the NDIA work closely to achieve critical outcomes for NDIS participants, their carers and families. The department develops policy and legislation for the Scheme. The NDIA is responsible for implementation, assurance and service delivery.

The department maintained regular engagement with states and territories through the DSOG and DRMC. These forums allowed the department to update jurisdictions on policy and legislative development. The forums also supported policy testing and feedback on disability reform initiatives. The department also conducted targeted public consultations on specific policy elements. The RAC provided additional feedback. The RAC includes disability representative organisations and other stakeholders.

Performance remained stable compared with previous years. These activities support complex NDIS reform. Government priorities and direction may change during the reporting period and influence performance.

The department's initiatives support wellbeing and social and economic participation. The initiatives contribute to a fairer NDIS and long-term Scheme sustainability. The completed milestones advance recommendations from the NDIS Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

The second tranche of amendments in the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 supports long-term Scheme sustainability through access changes. The NDIS Bill 2026 secures the NDIS for future generations through amendments to the *National Disability Insurance Scheme Act 2013*. The Bill protects the NDIS for people with permanent and significant disability. The Bill also supports long-term sustainability. The Bill updates governance and administrative arrangements. The Bill also seeks to moderate growth in expenditure and participant numbers. The Bill strengthens fraud controls, provider regulation and governance arrangements. The Bill facilitates new framework planning arrangements and establishes transitional arrangements.



03

Part 3: Management and Accountability

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Part 3.1: Corporate Governance

The department's corporate governance plays an integral role in ensuring we deliver Australian Government priorities and program outcomes efficiently and effectively.

Senior governance committees

Six senior governance committees provide advice and make recommendations to the Executive and the Secretary, as the accountable authority, on strategic portfolio issues. These committees focus on:

- improving the performance of health, disability and aged care systems
- organisational performance
- delivery of administered programs
- implementation of our most complex and highest risk change projects.

Figure 3.1.1: Senior governance committee structure

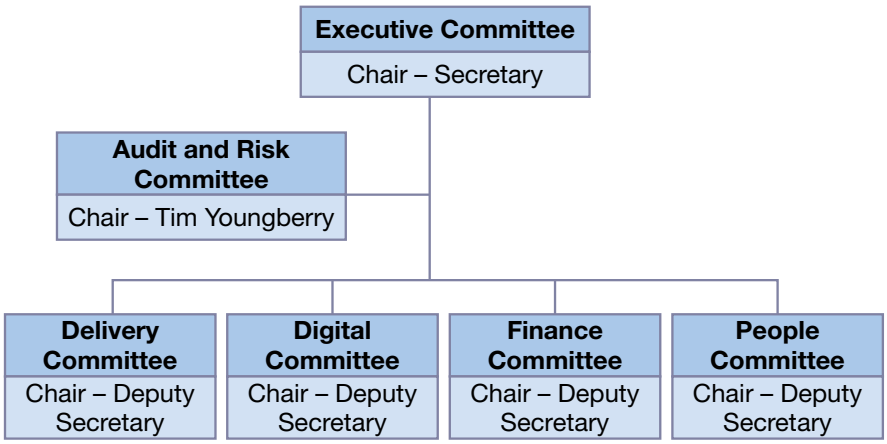


Table 3.1.1: Senior governance committees

Committee	Role
Executive Committee	Provides strategic direction and leadership to ensure outcomes documented in Portfolio Budget Statements (PB Statements) and the Corporate Plan are achieved. Operates in an advisory capacity to the Secretary, as the accountable authority.
Audit and Risk Committee	Provides independent advice and assurance to the Secretary on the appropriateness of our financial reporting, systems of internal control, performance reporting, and systems of risk oversight and management.
People Committee	Oversees the department's Workforce Strategy, and other strategic workforce matters. Provides direction on people and culture matters, including integrity, and advises and makes recommendations to the Executive Committee.
Delivery Committee	Oversees assurance reviews on existing sub-programs and implementation of new initiatives. Provides visibility to the Executive Committee on the management and ongoing viability of the department's tier 1 (highest risk/complexity) projects and portfolios.
Finance Committee	Advises and makes recommendations to the Secretary and the Executive Committee on strategic financial management policy initiatives and issues.
Digital Committee	Oversees the department's digital, data, information and communications technology (ICT) functions and capabilities. Considers both the sustainment of existing capabilities and transformation programs, to drive strategic digital enablement across the department and the systems it stewards.

National Agreement on Closing the Gap

The department is committed to changing the way we work in line with the 4 Closing the Gap Priority Reforms.

There are 19 socio-economic targets with three that are health specific. We report our performance on the Closing the Gap targets through the Productivity Commission's Closing the Gap Dashboard. The Productivity Commission released the latest update to the Dashboard in July 2026. The three health specific targets are not currently on track.

- Target 1 (life expectancy): Aboriginal and Torres Strait Islander people are living longer than 15 years ago but the life expectancy target is unlikely to be achieved by 2031.
- Target 2 (healthy birthweight): In 2023, 88.9% of Aboriginal and Torres Strait Islander babies were born at a healthy birthweight. While this remains a high proportion, the latest Productivity Commission reporting indicates there has been no change from the baseline (88.8% in 2017) and the target is not currently on track to be met by 2031.
- Target 14 (suicide reduction): Efforts continue toward achieving a significant and sustained reduction in suicide rates among Aboriginal and Torres Strait Islander people. The target is currently not on track, and this is still a critical area of focus for ongoing support and intervention.

In 2025–26, our internal Closing the Gap Steering Committee (Steering Committee) worked to strengthen implementation of the National Agreement on Closing the Gap. The Steering Committee met 5 times during 2025–26 and played a key role in driving a strategic, outcomes-focused approach to implementation of the Priority Reforms across the department.

A major focus for the Steering Committee was the structural, cultural, behavioural and policy barriers affecting implementation of the Priority Reforms. The Committee also oversaw development of our Closing the Gap Program Logic. The Program Logic identified opportunities to strengthen coordination, accountability, capability and engagement across the department. Through these initiatives, the Committee is increasing its focus on organisational and system-level reform.

In addition to the work of the Steering Committee, we extended our efforts to address the targets directly.

Target 2 (healthy birthweight)

- The government announced and the department started implementing new investment of more than $170 million over 4 years (2025–26 to 2028–29) in culturally safe, community-led maternal and child health care, such as Birthing on Country Programs.
    - This investment strengthens community control, advances self-determination, and enables First Nations organisations and communities to design and deliver maternal and child health services that reflect local priorities and needs.
    - Evidence from current sites, shows First Nations-led continuity of maternal and infant healthcare models, such as Birthing on Country, contribute to improved outcomes for First Nations mothers and babies.

Target 14 (suicide reduction)

The government:

- extended the Social and Emotional Wellbeing Policy Partnership for 2 years ($4.66 million over 2 years from 2026–27). The department co-chairs the Policy Partnership with Gayaa Dhuwi (Proud Spirit) Australia.
- extended funding for Gayaa Dhuwi (Proud Spirit) Australia ($1.95 million for 2026–27) to enable them to support cultural safety across mental health services, with appropriate referral pathways for First Nations people.
- are providing new funding of $13.9 million over 3 years from 2026–27 and an additional $5 million per year (ongoing) to 13YARN to support growing demand for the 24/7 phone service. The additional funding will enable a new, culturally safe text service, which will help young people and others who may face barriers to accessing voice-based support.

National Aboriginal and Torres Strait Islander Health Collaboration

The government formally established the National Aboriginal and Torres Strait Islander Health Collaboration (Health Collaboration) in 2023 to advise the Health Chief Executives' Forum and Health Ministers Meeting on matters relating to Aboriginal and Torres Strait Islander health. The Health Collaboration brings together:

- First Nations health sector representatives
- the Commonwealth health officials
- state and territory government health officials.

The Health Collaboration supports co-design and shared decision making between governments and the First Nations health sector. It advances community-identified priorities and embeds the Priority Reforms across the health system, ensuring Aboriginal and Torres Strait Islander peoples have a direct voice in health policy and program development.

The Health Collaboration leads key national reform initiatives, including implementation of the National Review of First Nations Health Care in Prisons (2023–24). Between December 2025 and April 2026, the Health Collaboration oversaw an extensive stakeholder engagement process to inform implementation of the Review's recommendations.

In 2025–26, they also led the development of the Aboriginal and Torres Strait Islander health schedule to the National Health Reform Agreement. These reform initiatives support more culturally safe, equitable and responsive health systems for Aboriginal and Torres Strait Islander peoples.

First Nations Health Governance Group

We demonstrate our commitment to Aboriginal and Torres Strait Islander self-determination through our partnerships across the First Nations health sector. This includes the First Nations Health Governance Group, which the department established in November 2024 to:

- share decision-making on Commonwealth health policy and reform
- hold the department accountable for delivering on commitments to improve First Nations health outcomes.

The Secretary and a First Nations health representative, selected by the First Nations members of the group, co-chair the Governance Group. Membership includes leaders from across the First Nations health sector, as well as departmental representatives. Members are selected based on their expertise and experience across priority areas. Membership also includes representatives from key national Aboriginal and Torres Strait Islander organisations and independent First Nations health experts.

In 2025–26, the First Nations Health Governance Group considered a broad range of First Nations health priorities, including:

- mental health
- data governance and sovereignty
- the Health Plan Accountability Framework
- the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan
- implementation of Priority Reforms
- ways to eliminate systemic racism.

Framework for Governance of Indigenous Data

In 2025–26, we began implementing the Framework for Governance of Indigenous Data.[119] The Executive Committee endorsed an implementation plan in July 2025.[120] The department developed the plan in partnership with a First Nations-led Working Group. We have also incorporated the implementation plan within our Data Governance Framework and began including governance of Indigenous data principles in our data policies and processes. We collaborate on the development and sharing of best practice approaches through participation in Australian Public Service committees and forums. This work is a critical enabler of:

- Closing the Gap Priority Reform 3: Transforming Government Organisations
- Closing the Gap Priority Reform 4: Shared access to data and information at a regional level.

[119] NIAA (National Indigenous Australians Agency), **Framework for Governance of Indigenous Data**, NIAA, May 2024, accessed August 2026.

[120] Department of Health, Disability and Ageing, **Governance of Indigenous Data Implementation Plan**, Department of Health, Disability and Ageing, January 2026, accessed August 2026.

First Nations Health Funding Transition Program

The First Nations Health Funding Transition Program directly supports the government's commitments in the National Agreement on Closing the Gap. It supports Priority Reform 2 by increasing Aboriginal and Torres Strait Islander leadership in health funding and service delivery. In 2025–26, we transitioned 2 further programs to Aboriginal and Torres Strait Islander-led organisations: the Indigenous Health Scholarship Program and the Aboriginal and Torres Strait Islander Lived Experience Centre. This brings the total number of completed transitions to 4. The co-chaired First Nations Health Funding Transition Advisory Group guides the program by providing strategic advice on transition priorities, implementation risks and program readiness.

During 2025–26, we also progressed related work to strengthen future transition activity. This included analysis of reporting requirements for Aboriginal Community Controlled Health Services, consideration of disability and carers programs for possible transition, and work to improve consistency across funding arrangements. These activities support more culturally responsive funding and service delivery while also building a stronger evidence base for future transitions.

Reconciliation Action Plan

In 2025–26, our Reconciliation Action Plan (RAP) Action Group supported the development, implementation and monitoring of a Stretch RAP. Our Stretch RAP builds on our established reconciliation practices. It includes further ambitious, measurable actions to embed reconciliation across business strategy, governance and everyday operations. The department launched its Stretch RAP on 18 September 2025.[121]

Aboriginal and Torres Strait Islander Partnership and Engagement Framework

The Aboriginal and Torres Strait Islander Partnership and Engagement Framework enables us to embed partnership across our work in line with the Closing the Gap Priority Reforms, particularly Priority Reform 1. It outlines actionable steps staff can take to plan, engage and partner with First Nations stakeholders to build and strengthen culturally safe, responsive, and genuine partnerships. This, in turn, helps ensure our programs and services meet the needs of Aboriginal and Torres Strait Islander people. To progress adoption of the Framework in 2025–26, we focused on:

- building partnership capability of department staff
- providing advice and support to business areas in partnering with the Aboriginal and Torres Strait Islander health sector to develop policy and programs
- raising awareness of Priority Reform 1 and the Partnership and Engagement Framework across the department, to strengthen partnership practices and support consistent application.

[121] Department of Health, Disability and Ageing, **Reconciliation Action Plan 2025-2028**, Department of Health, Disability and Ageing, September 2025, accessed August 2026.

Audit and Risk Committee membership

The Audit and Risk Committee's (ARC's) functions are set out in its Charter.[122]

During 2025–26, the following sub-committees supported the ARC:

- Financial Statements Sub-Committee (FSSC), chaired by Geoff Knuckey
- Performance Reporting Sub-Committee (PRSC), chaired by Nick Baker.

In 2025–26, the ARC met 4 times, the FSSC met 4 times, and the PRSC met 3 times. In addition, the ARC held one joint meeting with the FSSC and the PRSC.

Table 3.1.2: ARC Member Remuneration

Chair/Member	ARC	FSSC	PRSC	Joint ARC/FSSC	Joint ARC/PRSC	Remuneration (GST inclusive)
Tim Youngberry	4	0	0	1	1	$80,000
Nick Baker	4	0	3	1	1	$36,575
Geoff Knuckey	4	3	0	0	0	$34,100
Liz Cosson	3	0	3	0	0	$25,575
Kerrie-Anne Luscombe	4	4	0	1	1	$39,050

Tim Youngberry
ARC Chair – Canberra

Mr Youngberry is an international consultant specialising in public financial management, a Fellow of CPA Australia and a Fellow of Chartered Accountants Australia and New Zealand. He has worked with federal and state governments in Australia as well as being a subject matter expert on public financial management with the International Monetary Fund, the World Bank, the Organisation for Economic Co-operation and Development and other international aid organisations. Mr Youngberry's expertise covers all aspects of public finance and the systems needed to support better public financial management. Mr Youngberry has extensive experience in public sector management with senior executive roles in the Department of Finance, as well having been the Chief Financial Officer at a number of large government entities. He has served on the ARC since January 2021.

Nick Baker
ARC Member and PRSC Chair – Canberra

Mr Baker is a Fellow of CPA Australia and a member of the Australian Computer Society. He was a senior partner at KPMG Australia for 20 years before retiring. He has extensive audit and risk committee experience across public sector agencies, including in the Australian Competition and Consumer Commission, Department of Social Services, Services Australia, NDIS Quality and Safeguards Commission and the Domestic, Family and Sexual Violence Commission. He has expertise in finance, assurance, information technology and security. Mr Baker has served on the ARC since January 2019.

[122] Department of Health, Disability and Ageing, **Audit and Risk Committee Charter**, Department of Health, Disability and Ageing, December 2025.

Elizabeth Cosson
ARC and PRSC Deputy Chairs – Canberra

Ms Cosson is the former Secretary of the Department of Veterans' Affairs and was also President of the Repatriation Commission and Chair of the Military Rehabilitation and Compensation Commission. She previously worked in the department as Deputy Secretary and Chief Operating Officer. Before joining the APS in 2010, she served for 31 years in the Australian Army, including as the first woman promoted to the rank of Major General. Ms Cosson has experience in strategic leadership, governance, policy development, communication and engagement, client service, and organisational reform. Ms Cosson has previously worked as an independent member of audit and risk committees with Canberra Girls Grammar School and the Department of Communications. Ms Cosson has served on the ARC since July 2024.

Geoff Knuckey
ARC Member and FSSC Chair – Canberra

Mr Knuckey is a Fellow of CPA Australia and has been a registered company auditor since 1995. He worked with Ernst & Young for 32 years, where he was admitted as a senior partner in 1995. Since retiring in 2009, he has held a range of board, audit committee and non-executive appointments across the private and public sectors. He has expertise in internal audit, corporate governance, risk management and financial statement audit. Mr Knuckey has served on the ARC since July 2025.

Kerrie-Anne Luscombe
ARC Member and FSSC Deputy Chair – Canberra

Ms Luscombe is a lawyer and has held external board member appointments that have provided more than 30 years' experience in legal, audit and governance matters in large, complex organisations. She previously worked in the department as Chief Counsel and she has also worked as the Chief Counsel, Chief Audit Executive and Chief Risk Officer at the Department of Veterans' Affairs. Her executive experience spans Australian Securities Exchange 20 and public sector boards, a not-for-profit board, advisory boards, audit committees and independent reviews. She has expertise in Commonwealth funding arrangements and public sector accountability framework requirements, as well as cybersecurity, privacy and IT program governance. Ms Luscombe has served on the ARC since August 2024.

Organisational planning

Corporate Plan

The Corporate Plan is our primary strategic planning document and a core element of our performance framework. It sets out our program objectives and key activities to help us achieve our purpose over the next 4 years. The Corporate Plan also provides information on:

- our operating context
- capability
- corporate governance arrangements
- our approach to managing risks
- how we work with our partners to achieve our purposes and outcomes.

Additionally, it details how we will measure our performance in delivering a modern, sustainable health, disability and aged care system for all Australians. We prepared the Corporate Plan to meet requirements of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and the Public Governance, Performance and Accountability Rule 2014 (PGPA Rule).

Business and risk planning

We undertake annual business and risk planning at the divisional level. We use business and risk planning in our internal budget allocation process to enable us to deliver our outcomes and priorities, as outlined in our Portfolio Budget Statements[123] and Corporate Plan.[124]

Risk management

Our Enterprise Risk Management Policy and Framework guide how we identify, assess and manage risks that could affect the achievement of strategic and operational outcomes. They align with the Commonwealth Risk Management Policy 2023 and support our compliance with the requirements of the PGPA Act.

During 2025–26, we enhanced our enterprise risk management approach by:

- strengthening risk governance arrangements through the Chief Risk Officer Update to the ARC to ensure enterprise-significant risks are appropriately escalated, actively monitored and effectively managed
- enhancing risk reporting by providing a strategic overview of group level risks to provide senior governance committees with timely, accurate and actionable insights into the department's risk profile
- driving greater consistency and maturity in risk management practices across groups, divisions and functions through improved reporting, education, and improved risk management artefacts
- having matured the integration of risk management into business and risk planning cycles to better align strategic priorities, resources and risk treatments
- fostering a proactive risk culture that supports informed decision-making, early intervention and improved organisational outcomes through environmental scanning.

We oversee enterprise risks through established governance arrangements, including regular reporting to the accountable authority and the ARC. We keep a focus on finding emerging risks, changing risk exposures and finding opportunities for improvement.

We also continued to mature our risk management capability through targeted improvement initiatives, benchmarking and continuous review. These efforts support stronger organisational resilience, informed decision-making, and the effective delivery of outcomes for the Australian community.

[123] Department of Health, Disability and Ageing, **Budget 2025–26: Health and Aged Care Portfolio Budget Statements**, Department of Health, Disability and Ageing, July 2026, accessed July 2026.

[124] Department of Health, Disability and Ageing, **Corporate Plan 2025–26**, Department of Health, Disability and Ageing, August 2025, accessed July 2026.

Integrity

Building on the foundations established in 2024–25, we strengthened our integrity measures in 2025–26, to increase transparency, accountability and public trust.

Our second Integrity Maturity Self-Assessment showed improvements in integrity awareness, staff engagement, access to resources, integrity reporting, and the application of integrity policies and practices.

Key achievements included:

- launching the Integrity Strategy and Framework
- strengthening leadership through the Deputy Secretary Integrity Champion
- expanding the Integrity Community of Practice
- continuing the Integrity Hub and improving our quarterly Integrity Dashboard reporting.

We also delivered our annual awareness campaign, Focus on Integrity 2026, which promoted integrity conversations, delivered education activities, and strengthened staff capability to identify and manage integrity risks.

Countering fraud and corruption

We are committed to protecting the integrity of our programs, services and information through a robust fraud and corruption control framework.

In 2025–26, we continued to strengthen our approach to preventing, detecting and responding to fraud and corruption in accordance with the PGPA Rule and the Commonwealth Fraud and Corruption Control Framework 2024. Appropriately qualified and trained fraud and integrity personnel undertook these activities. Supported by strong governance, risk oversight and assurance arrangements, we monitored key risks and implemented controls to protect public resources and keep the integrity of our operations.

These efforts reinforced our fraud and corruption control environment and supported public confidence in the delivery of government programs and services.

Prevention

Throughout 2025–26, we strengthened our fraud and corruption control framework through risk assessment, assurance, monitoring and continuous improvement activities.

We updated our Enterprise Fraud and Corruption Risk Assessment, which identifies 10 enterprise fraud and corruption risks. We also established and documented our fraud and corruption risk appetite and tolerance to support consistent, risk-based decision-making.

We strengthened our fraud and corruption control environment through risk-based assurance activities, cross-government collaboration and workforce capability initiatives. These efforts enhanced our ability to identify, prevent and respond to fraud and corruption risks, helping to protect the integrity of our programs and services.

Detection and tip-offs

We maintain multiple confidential reporting channels to enable members of the public, staff and stakeholders to report suspected fraud or corruption. We encourage everyone to share tip-off information with us by:

- completing the online reporting form[125]
- emailing ReportFraudorCorruption@health.gov.au
- phoning the Fraud Hotline on 1800 829 403.

We have a Public Interest Disclosure (PID) policy and readily available procedures and training for all staff on our intranet, including on how to make a PID. We have also published information on our external website. Through the Fraud Fusion Taskforce, we continue to work with partner agencies to prevent, detect and disrupt fraud and criminal activity targeting government payments.

Tip-offs are an important source of fraud intelligence. In 2025–26, we received 1,149 external fraud tip-offs. Following assessment, we accepted 38 matters for further investigation and consideration of potential criminal or administrative action. A further 7 allegations were incorporated into existing investigations.

In 2025–26, the department received 129 allegations of internal fraud, corruption or serious misconduct. We commenced 6 investigations and finalised 63 assessments and one investigation.

Response

Qualified investigators conduct investigations in accordance with the Australian Government Investigations Standards. Where appropriate, they refer matters to law enforcement or other agencies or manage them through administrative or compliance action. Where sufficient evidence is available, the department refers matters to the Commonwealth Director of Public Prosecutions (CDPP) for it to consider whether to pursue a criminal prosecution.

In 2025–26, we referred 7 Briefs of Evidence to the CDPP relating to alleged fraud against the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS).

During the year, 2 matters resulted in successful prosecutions, with each offender receiving a custodial sentence of at least 4 years. The convictions related to MBS fraud with a combined value of $1.4 million. The CDPP discontinued one external fraud matter.

As at 30 June 2026, 9 matters related to alleged external fraud against the MBS and the PBS, with an estimated value of $8.77 million, were before the courts. Additionally, there was one internal fraud and corruption matter before the courts, with an estimated value of $10,800.

[125] Department of Health, Disability and Ageing, **Report suspected fraud online form**, Department of Health, Disability and Ageing, January 2026, accessed August 2026.

Compliance reporting

Potential breaches of Section 83 of the Constitution

Section 83 of the Australian Constitution provides that no amount may be paid out of the Consolidated Revenue Fund except under an appropriation made by law.

The department has primary responsibility for administering legislation related to health care. In 2025–26 payments totalling approximately $103.1 billion were authorised by the Parliament against special appropriations, including special accounts, in accordance with a range of complex legislation. Services Australia administers most of the payments on behalf of the Department.

The administration of large-scale payment programs operating under complex legislative frameworks inherently carries some risk of section 83 breaches. Program legislation generally includes compliance mechanisms, such as information-gathering and debt recovery powers, to identify, investigate and address non-compliance. If an overpayment occurs, a breach of section 83 could result, despite future payments being adjusted to recover the overpayment.

Consistent with the obligations under the *Public Governance, Performance and Accountability Act 2013* and the Commonwealth Fraud Control Framework, we have implemented controls to assess risks and prevent, detect and respond to fraud and other forms of non-compliance.

We are committed to implementing measures to ensure the risk of breaches of section 83 is as low as possible.

Section 83 breaches generally arise from:

- payments made based on information or estimates provided by claimants to calculate and pay entitlements that later proves incomplete or incorrect leading to overpayments
- misalignment between the legislative framework and administrative practices authorising a particular decision, process or payment mechanism
- limitations in existing systems applying complex legislative requirements or not all information being available at time of payment.

We have developed an approach for assessing the alignment of payment processes with legislation. During 2025–26 we:

- assessed the risk of program compliance with relevant legislation
- included consideration of processes to minimise the risk of section 83 breaches as part of any review of legislation or administrative processes
- received assurance from Services Australia that action had been undertaken to detect and prevent any potential breaches of section 83
- obtained legal advice, as appropriate, to resolve questions of potential non-compliance
- identified legislative/procedural changes to reduce the risk of non-compliance in the future.

We will continue to monitor the implementation of remediation arrangements and assess their effectiveness in mitigating the risk of future breaches.

Information from payment recipients to inform decisions

Aged Care

Residential Aged Care – Review process

In 2022–23, we reported that Services Australia's quarterly review process did not align with the *Aged Care Act 1997*. The process retrospectively validates recipients' maximum entitlement to aged care subsidies paid in arrears. In 2023–24, Services Australia moved to a monthly review process.

Breaches of section 83 of the Constitution may arise when monthly subsidy payments exceed a recipient's maximum entitlement. This can occur when a recipient's circumstances change during the review period. Services Australia makes subsidy payments before it completes the review process, so some payments may lack legislative authority.

For 2025–26, the estimated overpayments from the review process total $68.2 million (2024–25: $83.1 million).

The Parliament passed legislation in the form of the new *Aged Care Act 2024* to mitigate this breach. We continue to work with Services Australia as these new provisions are embedded into administrative processes and we developed some refinements to legislation in 2025–26.

Home Care – Unspent home care funds

Prior to the 2021 home care payment reforms, given effect by the *Aged Care Legislation Amendment (Improved Home Care Payment Administration No.2) Act 2021*, home care providers received Commonwealth subsidies in advance and retained any unspent subsidy amounts in their own accounts. When the reforms commenced, providers could either return these unspent amounts to the Commonwealth for crediting to a care recipient's home care account or retain them as the Commonwealth portion of a care recipient's unspent funds. Under the *User Rights Principles 2014*, providers that retained these funds were required to return the Commonwealth portion of any unspent funds within 70 days after a care recipient ceased receiving care from the provider.

In 2025–26, we became aware a provider had been incorrectly over-reporting provider held unspent home care funds when care recipients exited care. This resulted in subsidy underpayments to the provider and excess amounts being credited to affected home care accounts. Consequently, subsequent subsidy payments may have exceeded recipients' legislative entitlements, resulting in expenditure that was not authorised under the relevant legislative framework and gave rise to breaches of section 83.

We worked collaboratively with Services Australia and the provider to investigate the reporting error, determine the extent of the affected home care accounts, and implement appropriate corrective actions.

Remediation activities have now been completed. Of the 563 affected care recipient records, 350 were successfully verified against Services Australia claims data for claim periods between 2022 and 2024. This review identified over-reported amounts totalling $2,164,380 that were payable to the provider.

The review also identified 75 care recipient records where funds were owed to the Commonwealth, and 132 care recipient records where no financial adjustment was required. The remaining six records could not be verified.

Following the completion of remediation activities during 2025–26, the net payment payable to the provider was calculated at $2,055,063.

No further remediation activity is required and the matter is considered finalised and resolved.

Continence Aids Payment Scheme

The Continence Aids Payment Scheme (CAPS), established under the *National Health Act 1953*, provides annual payments to eligible individuals to assist with the costs of purchasing continence products.

Breaches of section 83 may arise where a CAPS payment is made to a person who is no longer eligible to participate in the scheme.

During 2025–26, 3 payments totalling $1,793 were made to recipients after their participation in the scheme had ceased and were therefore not authorised under the *National Health Act 1953.*

Services Australia has implemented additional business process controls to reduce the risk of payments being made after a participant's eligibility ceases.

Misalignment between administrative arrangements and legislative authority

Medical Benefits Scheme

Telehealth assignment of benefits

In 2022–23, the department reported circumstances in which payments of Medicare benefits could result in breaches of section 83.

Under the *Health Insurance Act 1973*, Medicare benefits are generally payable to the person who incurs the medical expense for a professional service. This is unless that person has assigned their entitlement to another person, such as a healthcare provider. Prior to amendments to the *Health Insurance Act 1973* made by the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024*, which commenced on 1 July 2026, the assignment of a Medicare benefit was required to be made in an approved form and, among other requirements, was required to be signed by the patient and a copy of the agreement provided to the patient.

Breaches of section 83 may arise where Medicare benefits are paid directly to healthcare providers in circumstances where a valid assignment of benefit has not been obtained in accordance with section 20A of the *Health Insurance Act 1973*.

We have assessed potential section 83 breaches qualitatively. We cannot reliably quantify the financial impact of these breaches because we are unable to identify, with sufficient certainty, the extent of historical instances where assignment of benefit requirements were not satisfied for telehealth services.

Following the ANAO's report, *Expansion of Telehealth Services*[126] released on 19 January 2023, we commenced reform of the assignment of Medicare benefits. This included arrangements relating to the verbal assignment of benefits.

The amendments to the *Health Insurance Act 1973* and the *Health Insurance Regulations 2018* that commenced on 1 July 2026 modernised the assignment of benefit framework to better align with contemporary healthcare delivery and digital service arrangements.

These legislative reforms have substantially reduced the risk of future non-compliance with section 83 by aligning legislative requirements with established healthcare and telehealth practices.

[126] ANAO, **Expansion of Telehealth Services**, ANAO, 2023, accessed September 2026.

Private health insurance assignment of benefits

Subsection 20A(2A) of the *Health Insurance Act 1973* permits Medicare benefits to be paid directly to private health insurers and approved billing agents or other entities where an eligible person has validly assigned their entitlement to the benefit. If a valid assignment is not in place, payments may be made without the legislative authority required by the *Health Insurance Act 1973*, creating a risk of expenditure that is not authorised by law.

During 2025–26, we confirmed that Services Australia's systems and processes did not demonstrate a clear intention by patients to assign their Medicare benefits to a private health insurer. Where Medicare benefits were paid directly to a private health insurer without a valid assignment of benefit, those payments may not have been authorised under the *Health Insurance Act 1973* and may give rise to breaches of section 83 of the Constitution.

We have assessed the occurrence of potential section 83 breaches qualitatively. As this work is ongoing, we are unable to reliably quantify the value of any associated unauthorised payments at this time.

Amendments to the *Health Insurance Act 1973* and the *Health Insurance Regulations 2018*, which commenced on 1 July 2026, have addressed the underlying legislative issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

Automated allocation of Medicare Provider Numbers

In 2024–25, we reported that, during implementation of the Independent Review of Overseas Health Practitioner Regulatory Settings, it was identified that the *Health Insurance Act 1973* did not contain an express legislative basis for the automated allocation of Medicare Provider Numbers (MPNs).

Breaches of section 83 of the Constitution may arise where payments are made for services provided by health practitioners holding MPNs that were allocated through computer-based decisions not expressly authorised by legislation.

Since 2009, Services Australia has allocated some MPNs through automated decision-making processes. Payments for dental services made where the dental provider held an MPN allocated through a computer-based decision may not have been authorised under the *Dental Benefits Act 2008*. Similarly, Medicare Benefits Schedule payments for services rendered by health professionals holding MPNs allocated through a computer-based decision may not have been authorised under the *Health Insurance Act 1973*.

We have assessed the occurrence of potential section 83 breaches qualitatively. The financial impact of payments associated with services provided by health practitioners holding MPNs allocated through computer-based decisions cannot be reliably quantified.

Amendments under the *Health Legislation Amendment (Miscellaneous Measures No. 1) Act 2025* will commence in November 2026 and will establish a legislative basis for the automated allocation of MPNs. This legislation will also validate MPNs previously allocated through computer-based decision-making processes since 2009.

In addition, the *Human Services (Medicare) Amendment (Allocation of Identification Numbers) Regulations 2026* enables the Chief Executive Medicare to take additional matters into account when deciding whether to allocate an MPN.

These legislative reforms will address the underlying legislative basis and substantially reduce the risk of future non-compliance with section 83.

Approved Medical Deputising Services Program

The Approved Medical Deputising Services (AMDS) program, administered under the *Health Insurance Act 1973*, allows prescribed medical practitioners to provide specified after-hours services on behalf of other medical practitioners. It also supports them to claim Medicare benefits for those services.

In 2025–26, we confirmed that breaches of section 83 of the Constitution may have occurred in relation to certain telehealth services provided by AMDS practitioners between 1 July 2021 and 19 August 2025.

During this period, changes to the relevant legislative instruments resulted in uncertainty as to whether certain telehealth services provided by AMDS practitioners were eligible for Medicare benefits. Consequently, Medicare benefits may have been paid in circumstances not authorised under the *Health Insurance Act 1973*.

We estimate that Medicare benefits of approximately $14.5 million were paid between 1 July 2021 and 19 August 2025 in circumstances that may not have been authorised under the *Health Insurance Act 1973*.

The Health Insurance Legislation Amendment (Usual Medical Practitioner) Determination 2025 commenced on 20 August 2025 and expressly provided for the eligibility of relevant telehealth services delivered by AMDS practitioners for Medicare benefits.

These legislative amendments have addressed the underlying legislative issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

General Practice in Aged Care Incentive Program

The General Practice in Aged Care Incentive (GPACI) program provides incentive payments to eligible general practitioners and practices for delivering ongoing primary care services to residents of aged care homes.

During 2025–26, we confirmed that subsection 19(2) of the *Health Insurance Act 1973* applies to GPACI arrangements. As a result, Medicare benefits may not have been payable for services provided under arrangements between general practitioners and providers participating in the GPACI program.

Services Australia estimates that Medicare benefits of approximately $116.7 million were paid between 1 July 2024 and 30 June 2026.

We have since put in place a subsection 19(2) direction to enable Medicare benefits to be payable under the GPACI program from 20 August 2026. The direction has addressed the underlying legislative issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

Integrated Team Care Program

The Integrated Team Care (ITC) program supports Aboriginal and Torres Strait Islander people with chronic conditions to access coordinated and culturally appropriate health care services. The program is funded under the Indigenous Australians' Health Programme.

During 2025–26, we received confirmation that subsection 19(2) of the *Health Insurance Act 1973* (HI Act) applies to certain specialist service arrangements operating under the ITC program. As a result, Medicare benefits may not have been payable for some services provided under those arrangements.

To the extent that Medicare benefits were paid for professional services rendered under affected ITC program arrangements, those benefits may not have been paid in accordance with Part II of the HI Act. This may have resulted in payments being made without sufficient legislative authority and therefore constitutes a potential breach of section 83 of the Constitution.

We have assessed the occurrence of potential section 83 breaches qualitatively. We are unable to reliably quantify the value of any associated unauthorised payments due to limitations in the available data and the complexity of identifying affected services at this time.

We are considering options to clarify the intended interaction between the ITC program and the Medicare benefits framework.

Public Private Partnership Agreements

The National Health Reform Agreement provides Commonwealth funding for public hospital services delivered to public patients. Under clauses A12 and J20 of the National Health Reform Agreement and subsection 19(2) of the *Health Insurance Act 1973*, services funded through public hospital arrangements are generally not eligible for Medicare benefits unless a specific exemption applies.

During 2025–26, we confirmed that some radiation oncology services delivered under state and territory funding arrangements may also have been claimed through Medicare. Where a service has already been funded under a Public Private Partnership arrangement and through another funding mechanism such as state payments or National Health Reform Agreement public hospital funding, any Medicare benefit paid for the same service may represent expenditure not supported by the relevant legislative authority and may give rise to breaches of section 83 of the Constitution.

We have assessed the occurrence of potential section 83 breaches qualitatively. We are unable to reliably quantify the value of any associated unauthorised payments at this time.

The Health Insurance (Medicare Benefits Payable in Respect of Professional Services – Radiation Oncology and Nuclear Medicine) Direction 2026 was made in March 2026. This Ministerial Direction has addressed the underlying issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

Pharmaceutical Benefits Scheme

Supply of s100 Highly Specialised Drugs Program Complex Authority Required drugs above the maximum quantity

In 2024–25, we reported that some medicines classified as Complex Authority Required (CAR) medicines under the National Health (Highly Specialised Drugs Program (HSD)) Special Arrangement 2021 (HSD Special Arrangement) were prescribed and claimed with quantities or repeats above the maximum values specified in the relevant PBS listings.

This was inconsistent with section 22 of the HSD Special Arrangement, which is a legislative instrument made under section 100 of the *National Health Act 1953*. Section 22 overrode regulation 30 of the National Health (Pharmaceutical Benefits) Regulations 2017. Regulation 30 otherwise permits variations to maximum quantities or repeats for a PBS benefit. Section 22 provided that no variation to the maximum quantity or maximum number of repeats may be authorised for a HSD pharmaceutical benefit containing a CAR drug.

Breaches of section 83 of the Constitution may have arisen where payments were made to pharmacies under the HSD Special Arrangement for the supply of CAR medicines in quantities or repeats above the legislated maximums. The issue is understood to have affected claims processed under the HSD Special Arrangement and previous HSD special arrangements since at least 1 April 2005.

For 2025–26, the estimated value of overpayments associated with claims for CAR medicines supplied above the applicable maximum quantities or repeats is $45.0 million (2024–25: $88.4 million).

The National Health (Highly Specialised Drugs Program) Special Arrangement Amendment (Increases in Maximum Quantity and Number of Repeats for Complex Authority Required (CAR) Medicines) Instrument 2026 commenced on 1 February 2026. The amendment authorises increased maximum quantities and repeats for specified CAR medicines, reducing the risk of future overpayments.

Supply of s100 Highly Specialised Drugs Program Complex Authority Required (CAR) Drugs and Rituximab from Medication Chart Prescriptions

In 2024–25, we reported that medicines defined as Complex Authority Required (CAR) medicines under the HSD Special Arrangement, and rituximab, were prescribed and claimed using PBS Hospital Medication Charts (PBS HMCs). This was inconsistent with subsection 18(1) of the HSD Special Arrangement, which prohibited medication chart prescriptions for HSD pharmaceutical benefits containing CAR drugs or rituximab.

Breaches of section 83 of the Constitution may have arisen where payments were made to pharmacies for claims under the HSD Special Arrangement based on PBS HMC prescriptions for CAR medicines or rituximab. The issue related to the form of prescription used, not patient eligibility for the pharmaceutical benefit.

For 2025–26, the estimated value of payments associated with claims for CAR medicines and rituximab supplied on the basis of PBS HMC prescriptions is $0.3 million (2024–25: $0.3 million).

The National Health (Highly Specialised Drugs Program) Special Arrangement Amendment (Medication Charts for Complex Authority Required (CAR) and rituximab Pharmaceutical Benefits) Instrument 2026 commenced on 1 February 2026. The amendment permits medication chart prescriptions for HSD pharmaceutical benefits containing CAR drugs and rituximab. This reduces the risk of future payments being made without legislative authority.

Exemption process for Authority Required prescriptions

In 2024–25, we reported that, over several years, exemptions from Pharmaceutical Benefits Scheme (PBS) Authority Required restrictions were granted in circumstances that were not consistent with the *National Health Act 1953*.

Breaches of section 83 of the Constitution may arise where subsidised medicines are supplied and paid for under the PBS when legislated approval criteria are not met. The issue relates to exemptions granted outside the statutory framework. This resulted in some medicines being accessed without all legislative requirements being satisfied.

We have assessed the occurrence of potential section 83 breaches has been assessed qualitatively. The financial impact of the breaches cannot be reliably quantified.

Services Australia ceased the exemption process on 12 June 2025.

Payments may continue for repeat prescriptions that were authorised under the former exemption process before it ceased and have not yet been presented for claiming, as well as for certain continuing treatment prescriptions. We continue to monitor the residual risk associated with these prescriptions.

S100 Efficient Funding of Chemotherapy Program

The PBS s100 Efficient Funding of Chemotherapy (EFC) Program provides subsidised access to chemotherapy medicines administered by injection or infusion at public and private hospitals under section 100 of the *National Health Act 1953*. The National Health (Efficient Funding of Chemotherapy) Special Arrangement 2024 (EFC Special Arrangement) sets out the method for calculating the mark-up for an EFC Program pharmaceutical benefit. This forms part of the reference price used to determine the Commonwealth subsidy payable for chemotherapy pharmaceutical benefits supplied by approved pharmacists and medical practitioners.

During 2025–26, we identified that the mark-up amounts specified in the EFC Special Arrangement for chemotherapy medicines other than trastuzumab had not been updated since 2024, despite higher mark-up rates being paid from 1 July 2024. Consequently, approved suppliers received payments that exceeded the amounts specified in the EFC Special Arrangement between 1 July 2024 and 31 July 2026.

Breaches of section 83 of the Constitution may have arisen where payments to approved suppliers exceeded the legislated subsidy payable. The issue relates to the amount of subsidy payable, not supplier eligibility for the pharmaceutical benefit.

We have assessed the occurrence of potential section 83 breaches has been assessed qualitatively. The financial impact of the breaches cannot be reliably quantified at this time.

The National Health (Efficient Funding of Chemotherapy) Special Arrangement Amendment (August Update) Instrument 2026 was made on 1 August 2026. The legislative amendments have addressed the underlying legislative issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

S100 Growth Hormone Program

The PBS Growth Hormone Program provides subsidised access to growth hormone medicines for eligible patients under section 100 of the *National Health Act 1953*. Certain strengths of the brands Saizen® and SciTropin A® of the medicine somatropin were listed as pharmaceutical benefits but were omitted from the schedules to the National Health (Growth Hormone Program) Special Arrangement 2025 (GH Special Arrangement). This created uncertainty as to whether payments for those products were supported by the required legislative authority, noting the medicine (somatropin) was included in the schedules.

The GH Special Arrangement establishes the conditions under which growth hormone products may be supplied as pharmaceutical benefits under the PBS Growth Hormone Program.

During 2025–26, we became aware that breaches of section 83 of the Constitution may have arisen where payments were made to pharmacies for claims under the GH Special Arrangement in relation to the supply of these products.

The estimated value of payments associated with claims for Saizen® that were omitted from the schedules to the GH Special Arrangement for the period 1 November 2023 to 31 March 2026 is $2,014,516. The estimated value of payments associated with claims for SciTropin A® that were omitted from the schedules to the GH Special Arrangement for the period 1 October 2025 to 30 June 2026 is $324,454.

Amendments to the GH Special Arrangement took effect on 1 April 2026 in relation to relevant Saizen® brand somatropin products and on 1 July 2026 in relation to relevant SciTropin A® brand somatropin products to ensure the affected products were appropriately reflected within the legislative framework supporting the Growth Hormone Program. These amendments addressed the underlying legislative issue and substantially reduced the risk of future non-compliance with section 83 of the Constitution.

Private Health Insurance

Payment of private health insurance rebates

In 2023–24, we identified that payments of Private Health Insurance (PHI) rebates to insurers under the *Private Health Insurance Act 2007* could, in certain circumstances, result in breaches of section 83.

Breaches of section 83 may arise where PHI rebate claims are paid despite being lodged outside the 3-year statutory limitation period under the *Private Health Insurance Act 2007*. Breaches may also arise where the correctness or reasonableness of a claim was not considered before payment, and the claimed amounts recoverable under the *Private Health Insurance Act 2007*. The current electronic claims processing system does not prevent insurers from submitting claims outside the statutory limitation period.

We have assessed the occurrence of potential historical section 83 breaches qualitatively. We cannot reliably quantify such breaches.

Legislative amendments introduced through the *Health Legislation Amendment (Miscellaneous Measures No. 1) Act 2025* commenced on 1 April 2026 and addressed this issue so there are no ongoing breaches of section 83. It also strengthened the registration and claims framework supporting the PHI rebate scheme and reduced the risk of future non-compliance with section 83 of the Constitution.

System limitations and information availability

Aged Care

Home care – crediting of unspent funds

In 2024–25, we reported that the Services Australia system credits home care accounts with the Commonwealth provider-held portion of unspent funds on behalf of care recipients who transfer between providers. Under the current system configuration, the credit is applied 70 days after the recipient leaves their previous provider.

There is no legal authority to credit unspent funds to the accounts of care recipients who notify their former provider that they have commenced care with a new provider within one to 56 days of departure. In some circumstances, an overpayment and a breach of section 83 of the Constitution may arise where the credited funds are subsequently used to offset claims for home care services.

The estimated value of overpayments arising from the application of the 56-day rule is $27,587,098 for the period 1 September 2021 to 31 October 2025.

Legislative reforms through the *Aged Care Act 2024* have reduced the risk of future overpayments. The delegate waived debts arising from the application of the 56-day rule in accordance with the *Aged Care Act 1997*.

Home care – 70 days rule

In 2024–25, we reported that the system used to process home care subsidy claims automatically zeroed out claims submitted by providers for care recipients who had left their care more than 70 days earlier. This resulted in claims that were otherwise payable being automatically zeroed out and care recipient home care account balances being higher than they should have been had the zeroed-out claims been paid.

Overpayments and breaches of section 83 of the Constitution may arise where subsequent home care subsidy payments are made which are in excess of the care recipient's lawful entitlement.

The estimated value of overpayments arising from the application of the 70-day rule is $102,893 for the period 1 September 2021 to 31 October 2025.

Legislative reforms introduced through the *Aged Care Act 2024* have reduced the risk of future overpayments. Debts arising from the application of the 70-day rule have been waived in accordance with the *Aged Care Act 1997*.

Residential respite subsidy

Residential respite care subsidies and supplements are paid to aged care providers to support the delivery of short-term residential care. Eligible individuals may receive up to 63 days of subsidised respite care each financial year, with extensions of up to 21 additional days available where approved by an aged care assessor.

In 2025–26, we confirmed, due to system limitations, we may pay residential respite care subsidies before complete information about a care recipient's subsidy entitlement is available. Where subsequent claims establish that the applicable respite care subsidy cap has been exceeded, payments may have been made in excess of the recipient's legislative entitlement and therefore may not have been authorised under the *Aged Care Act 1997* or the *Aged Care Act 2024*. These circumstances may give rise to breaches of section 83 of the Constitution.

We have assessed the occurrence of potential section 83 breaches qualitatively. The department and Services Australia are currently assessing the financial impact of the potential breaches. We are unable to reliably quantify the value of any associated overpayments at this time.

We are working with Services Australia to identify and implement options to address the underlying system limitations, remediate identified instances of non-compliance, and reduce the risk of future occurrences.

Grant payment related to an insolvent provider

We entered into an arrangement to support the continuity of aged care services and disability services delivered under the NDIS following the insolvency of a service provider. We provided the funding to ensure continuity of care and service delivery during the transition period. Due to the integrated nature of the provider's operations, we could not readily distinguish activities funded under the various programs.

In 2025–26, we confirmed that a breach of section 83 of the Constitution was likely to have occurred to the extent that the funding supported the continuity of a state government disability program. Section 83 was not breached to the extent that the funding supported the continuity of aged care services and NDIS services.

We have assessed the occurrence of potential section 83 qualitatively. Due to the integrated nature of the provider's operations, we are unable to reliably determine the extent to which expenditure is attributable to individual programs at this time.

We have assessed the circumstances surrounding the expenditure and determined that there is no evidence of a systemic failure in internal controls. Additional quality assurance measures have been implemented to strengthen governance and oversight arrangements.

Approval of access to funded aged care services

Access approvals are made under section 65 of the *Aged Care Act 2024* and enable an eligible person to receive specified Commonwealth-funded aged care services following an assessment of their care needs. The *Aged Care Act 2024* requires a new decision to be made regarding a person's existing services when they are reassessed for new or additional services.

In 2025–26, we identified that, due to misalignment between the legislation and the policy intent, along with system limitations, some existing access approvals do not remain legally effective following a reassessment for new or additional services. As a result, subsidies have been paid in circumstances where a valid access approval was not in place as required under the *Aged Care Act 2024*. Payments made in these circumstances are not authorised under the legislative framework and give rise to breaches of section 83 of the Constitution.

We have assessed the occurrence of potential section 83 breaches qualitatively. The department and Services Australia are currently assessing the financial impact of the potential breaches. We are unable to reliably quantify the value of any associated unauthorised payments at this time.

We are working with Services Australia to identify and implement options to remediate the identified issue, address any affected approvals, and reduce the risk of future occurrences.

Medical Benefits Scheme

Medicare Easyclaim program

In 2015–16, we reported that payments made through the Easyclaim program could, in certain circumstances, result in breaches of section 83 of the Constitution. Easyclaim is an electronic transaction system that facilitates Medicare benefit payments under the *Health Insurance Act 1973*. It reimburses financial institutions for amounts paid to patients through EFTPOS terminals at the point of service. Reimbursements may include erroneous payments to patients by financial institutions that are not consistent with the *Health Insurance Act 1973*.

For 2025–26, the estimated value of overpayments arising from the operation of the Easyclaim program is $10,777 (2024–25: $21,285).

Services Australia is working with the department to identify ways to reduce these transactions and strengthen Easyclaim payment controls.

Compliance reporting

Compliance with finance law

Section 19 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) requires accountable authorities to notify their responsible minister of any significant issues that may have affected the entity. Agencies must also notify the Minister for Finance if any of those issues included non-compliance with Finance Law.

In 2025–26, there were no reportable instances of significant non-compliance with finance law to be reported to the Minister for Health and Ageing and Minister for Disability and the National Disability Insurance Scheme, the Hon Mark Butler, and the Minister for Finance, Senator the Hon Katy Gallagher, under paragraph 19(1)(e) of the PGPA Act.

Departmental framework

We maintain a risk-based approach to compliance, with a combination of self-reporting and focused review. The Audit and Risk Committee (ARC) considers application and adjustments to this methodology, with instances of non-compliance reported to the ARC and the Executive Committee. We minimise non-compliance through effective controls, including:

- training and the publication of legislation and rules
- delegation schedules
- Accountable Authority Instructions.

These are available to staff to inform decision-making.

Significant non-compliance issues with finance law

In 2025–26, there were no significant issues reported to the Minister under paragraph 19(1)(e) of the PGPA Act, which includes non-compliance with financial law.

Compliance framework

We maintain a risk-based approach to compliance, with a combination of self-reporting and focused review. Instances of non-compliance are reported to the ARC and the Executive Committee. The ARC considers application and adjustments to our methodology.

We minimise non-compliance through effective controls, including:

- training and publication of legislation and rules
- delegation schedules
- accountable authority instructions.

Certification of departmental fraud and corruption control arrangements

I, Blair Comley, certify that the department has:

- prepared fraud and corruption risk assessments and fraud control plans
- in place appropriate fraud and corruption prevention, detection, investigation, and reporting mechanisms that meet the specific needs of the department
- taken all reasonable measures to appropriately deal with fraud and corruption relating to the department.



Blair Comley
7 October 2026

Assurance and audit activities

In 2025–26, we conducted 21 audits through 4 specialist audit providers. This approach enabled our internal audit team to access targeted subject matter expertise, scale resources efficiently, and deliver a diverse program of assurance activities across the department's key risk areas.

Our internal audit function provides independent and objective assurance designed to strengthen our governance, risk management and internal control processes. We apply a comprehensive risk-based methodology when identifying and monitoring operational and financial risks and developing our Internal Audit Work Plan. This methodology draws on multiple sources, including:

- assurance mapping activities
- thematic insights from audit and assurance activities
- assessments of emerging risks
- consultation with senior leaders.

Part 3.2: Executive



Blair Comley PSM

Secretary

Blair commenced as the Secretary of the Department of Health, Disability and Ageing on 17 July 2023.

Blair has served as the Secretary of the Commonwealth Department of Climate Change and Energy Efficiency and the Secretary of the Commonwealth Department of Resources, Energy and Tourism. Blair has also served as Secretary of the NSW Department of Premier and Cabinet, NSW's most senior public servant.

Prior to these positions, Blair held senior leadership positions in Treasury including General Manager of the Indirect Tax Division, the Business Tax Division, the Macroeconomic Policy Division and the Acting Chief Executive of the Australian Office of Financial Management with responsibility for managing the Commonwealth's debt and derivative portfolio.

Blair also has significant private sector experience as a strategy consultant advising governments, not for profits, and corporates on a wide range of matters including climate, energy, human services, health, organisational leadership and design, governance and economic policy.

In 2012, Blair was awarded the Public Service Medal for outstanding public service in the development of public policy, particularly in the areas of carbon pricing and emissions trading, tax policy design and debt management.

Blair has a Bachelor of Economics (Hons), a Master of Economics and a Graduate Diploma of Legal Studies.



Professor Anthony (Tony) Lawler

Deputy Secretary of the Health Products Regulation Group

Professor Tony Lawler is the Deputy Secretary of the Health Products Regulation Group (HPRG) within the Australian Government Department of Health, Disability and Ageing.

HPRG, which includes the Therapeutic Goods Administration (TGA), works to safeguard and enhance the health of all Australians through effective, timely and risk-proportionate regulation of therapeutic goods, and the control of drug imports, exports and production.

Prior to joining the department in June 2023, Tony was the Chief Medical Officer and Deputy Secretary – Clinical Quality, Regulation and Accreditation, with the Tasmanian Department of Health. This role included providing leadership to health professionals, system-wide clinical governance oversight and the regulation of private health service establishments.

Since graduating from the University of Tasmania School of Medicine, Tony has worked in the health system as a Specialist Emergency Physician, Specialist Medical Administrator, and senior health public servant for almost 30 years. During the COVID-19 pandemic, Tony was the Tasmanian Health Service Emergency Operations Commander.

Tony has previously held positions as Commonwealth Chief Medical Officer, President of the Australasian College for Emergency Medicine, a member of the Board of the Australian Commission on Safety and Quality in Health Care and the Council of the National Health and Medical Research Council, and Deputy Head of the Tasmanian School of Medicine.

Tony holds Professorial appointments at the University of Tasmania and the Australian National University.



Professor Michael Kidd AO

Chief Medical Officer

In 2025, Professor Michael Kidd AO became Australia's Chief Medical Officer.

He is a general practitioner and a primary care and public health researcher. Michael has served as president of the Royal Australian College of General Practitioners and president of the World Organization of Family Doctors. He is an elected Fellow of the Australian Academy of Health and Medical Sciences.

Michael holds a joint academic appointment as the Foundation Director of the International Centre for Future Health Systems at the University of New South Wales, and as Professor of Global Primary Care with the Nuffield Department of Primary Care Health Sciences at the University of Oxford. He has held past research appointments at Monash University, the University of Sydney, Flinders University, the Australian National University, and the University of Toronto.



Rachel Balmanno

Chief Operating Officer

Rachel Balmanno commenced as the Chief Operating Officer of the Department of Health, Disability and Ageing in September 2025.

In her capacity as the Chief Operating Officer, she leads the Corporate Operations Group. This Group is responsible for the department's corporate and enabling services and manages functions for a diverse customer base, extending beyond the department to include our Portfolio agencies, Commonwealth partners, industry and the Australian public.

Rachel began her career at the Department of Health in 1995. Rachel has a deep understanding of the work of the department as a result of her 20 years of experience in policy and program roles across health, disability and aged care. This included senior leadership roles in population health, First Nations health and aged care.

Rachel also led the People, Communication and Parliamentary Division of the department where she leveraged her experience to improve the department's culture and capability. Highlights included leading the department's communication activities during the COVID-19 pandemic and guiding the department as it expanded its geographic footprint and embraced the widespread uptake of flexible work arrangements post-pandemic.

Rachel holds a Bachelor's Degree in Science (Psychology) and a Graduate Diploma in Applied Science (Health Psychology).



Dr Liz Develin

Deputy Secretary of the Primary Care, Community and First Nations Group

Dr Liz Develin has been with the Department of Health, Disability and Ageing since early 2024. She brings executive leadership experience across varied portfolios and all levels of government.

Her public service career began in the NSW Government and has included executive level roles across NSW Health, Premier and Cabinet, and the Planning portfolios. Her leadership roles have spanned areas including health promotion, health service planning, health infrastructure, national reform and intergovernmental relations, governance, urban planning, housing, energy and water.

Liz has held varied Deputy Secretary roles in the NSW Government, and CEO roles at both a state and national level.

Liz has a masters qualifications in human movement and public health, and a Doctorate of Business Administration that considered policy implementation in the NSW health system.



Penny Shakespeare

Deputy Secretary of the Health Resourcing Group

Penny Shakespeare was Deputy Secretary of the department's Health Resourcing Group in 2025–26. In this role, Penny leveraged her deep expertise in Australia's health system to lead Medicare and Pharmaceutical Benefits Scheme policy development and integrity functions, ensure Australia has a planned, highly-trained and well-distributed health workforce, advance digital health solutions and harness the potential of genomics.

Penny joined the department in 2006 and has served as First Assistant Secretary of the Technology Assessment and Access Division and Health Workforce Division. Penny has been a member of the Workplace Relations Ministers Advisory Council and the National Occupational Health and Safety Commission and represented the Commonwealth on the board of the National Blood Authority.

Before joining the department, Penny was an industrial relations lawyer in the Department of Employment and Workplace Relations and worked in regulatory policy roles, including as head of the Australian Capital Territory's Office of Industrial Relations.

Penny has a Bachelor of Laws, a Master's in international law and is admitted as a barrister and solicitor.



Sonja Stewart

Deputy Secretary of the Ageing and Aged Care Group

Sonja Stewart joined the department in December 2024 as the Deputy Secretary of the Ageing and Aged Care Group.

Sonja is a Yuin woman with extensive senior leadership experience across state and Commonwealth governments. She served as Deputy Secretary at the NSW Department of Premier and Cabinet and as Deputy Commissioner of the NSW Public Service Commission. Her more recent roles include CEO of the Law Society of NSW and CEO of Arrilla Indigenous Consulting.

Sonja has a Bachelor of Commerce and Bachelor of Laws from the University of NSW and the University of Alberta, Canada. Sonja has also completed the Advanced Management Program at Columbia University, New York. As a graduate of the Australian Institute of Company Directors, she has been a Director and Chair of government, academic and not for profit boards for over 20 years, including Chairperson of the Goodes O'Loughlin Foundation – which aims to improve educational outcomes of Aboriginal children and young people.



Celia Street PSM

Deputy Secretary of Systems Strategy Group

Celia Street PSM is Deputy Secretary of the Systems Strategy Group. Celia leads national strategy for Australia's health, disability and aged care systems to deliver a resilient, equitable and sustainable care economy. She also leads on matters relating to public and private hospitals, private health insurance and medical research.

Prior to her appointment as Deputy Secretary, Celia delivered major health policy reforms as a First Assistant Secretary in the department. Notably, Celia led the Australian Government's health response to COVID-19 from 2020 to 2022. Celia holds a Bachelor of Economics and Asian studies from the Australian National University.

Celia joined the department in 2012, following senior roles across the Australian Public Service.



Mary Wood

Deputy Secretary of Disability and Carers Group

Mary Wood is Deputy Secretary for the Disability and Carers Group. Mary leads disability and carer policy, including reforms to the National Disability Insurance Scheme (NDIS), Australia's Disability Strategy, the National Carer Strategy, and the response to the Disability Royal Commission. She oversees the NDIS Sustainability Taskforce, which is progressing reforms to improve scheme sustainability and outcomes for people with disability. She also oversees the Thriving Kids Taskforce which is working with states and territories to design and implement early developmental supports for children aged 8 and under with developmental delay and/or autism with low to moderate support needs.

Mary has deep experience in policy, strategy and communications, both within the Australian Public Service and in the non-government sector. Mary joined the department in 2021 from the Business Council of Australia, where she led corporate citizenship and member services. Prior to that Mary was Deputy Director-General for Policy and Intergovernmental Relations in ACT Health. Mary has also served as Chief of Staff to a federal minister.

Most recently, Mary led the establishment of the Australian Centre for Disease Control, a new statutory agency charged with safeguarding public health after COVID-19. Mary has an Honours in Law and English, and a Graduate Certificate of Public Administration from the Australian National University.

Executive changes during 2025–26

Executive changes within the reporting period:

- For the period of 1 July 2025 to 24 December 2025, Robyn Shannon was Deputy Secretary for Disability and Carers Group.
- For the period of 1 July 2025 to 8 August 2025, Charles Wann was Deputy Secretary for Corporate Operations Group.

Part 3.3: Organisational chart



Secretary
Blair Comley PSM

Chief Medical Officer
Prof. Michael Kidd AO

The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

Health Products Regulation
Prof. Tony Lawler

- **Chief Medical Advisor** — Prof. Robyn Langham
- **Regulatory Legal Services** — Dr. Bridget Gilmour-Walsh
  - **Legislation, Advice & FOI** — David Fintan
  - **Dispute Resolution, Compliance & Commercial** — Sascha Gelfand
- **Medicines Regulation** — Nick Henderson
  - **Prescription Medicines Authorisation** — Andrew Simpson
  - **Complementary & OTC Medicines** — Avinash Clarke
  - **Pharmacovigilance** — Dr. Tahli Fenner
  - **Scientific Evaluation** — Dr. George Vuckovic
  - **International Regulatory** — Dr. Felicity Jameson A/g
- **Medical Devices & Product Quality** — Tracey Duffy
  - **Medical Devices Authorisation** — John Jamieson
  - **Medical Devices Surveillance** — Dr. Marcelle Noja
  - **Laboratories** — Dr. Lisa Kerr
  - **Manufacturing Quality** — Hongxia Jin
- **Regulatory Practice & Support** — Chris Bedford
  - **Regulatory Engagement** — Sarah Syme
  - **Office of Drug Control** — Avi Rebera
  - **Regulatory Compliance** — Tracey Lutton
  - **Vaping Implementation & Enforcement** — Ashley McLachlan-Bent
  - **HPRG Transformation** — Cindy Toms

Systems Strategy
Celia Street PSM

- **Portfolio Strategy** — Ross Hawkins
  - **Strategic Policy** — Anthea Raven
  - **Budget Strategy** — Kelly Fisher
  - **International Strategies** — Matthew Short
  - **Private Hospital** — Brian Kelleher
  - **Private Health Strategy** — Paul McBride
  - **Public Hospital Strategy** — Caitlin O'Brien
- **Evidence & Research** — Duncan Young
  - **Modelling, Partnerships & Evaluation** — Dr. Nicholas Johnson
  - **Data & Analytics** — Kayla Jordan
  - **Health & Medical Research Office** — Natasha Ploenges
- **Office of the Chief Health Economist** — Prof. Emily Lancsar
  - **Health Economics** — Fifine Cahill
- **Health Professions Advisory**
- **Chief Nursing & Midwifery Officer** — Prof. Alison McMillan

Ageing & Aged Care
Sonja Stewart

- **Reform Implementation** — Josh Maldon A/g
  - **Assessment & Home Care Transition** — Erika Barnett A/g
  - **Digital Strategy & Business Assurance** — Toby Burgess A/g
  - **Financial Management & Reporting** — Nikolai Tsyganov
  - **New Aged Care Act Transition** — Maria Filardo A/g
  - **NACA Program Management** — Greg Keen
- **Access & Home Support** — Greg Pugh
  - **Support at Home Policy & Operations** — Jasmine Snow
  - **Home Support Operations** — Matthew Cartledge A/g
  - **Single Assessment System** — Rachel Blackwood
  - **Navigation & Access** — Aimee Chambers
- **Quality & Assurance** — Robert Day
  - **Regulatory Systems, Safeguards & Reviews** — Katie Holm
  - **Choice & Transparency** — Ingrid Leonard
  - **Legislative & Regulatory Design** — Stephen Bouwhuis
  - **Provider Payments Assurance** — Nisette Anderson
- **Dementia, Diversity & Residential Care** — Daen Dorazio
  - **Residential Care & Hotelling Reform** — Mark Shen
  - **Contributions & Accommodation Reform** — Julia Atkinson
  - **Residential Risk & Funding Operations** — Jason Lange
  - **Dementia, Diversity & Design** — Genevieve Donnelly
- **Market & Stewardship** — Luke Mansfield
  - **Thin Markets** — Megan Lancaster
  - **Market Intelligence** — Anna Morision A/g
  - **Ageing Policy, Systems & Evidence** — Travis Power
  - **First Nations Aged Care** — Cathy Milfull A/g
- **Service Delivery** — Kate Berry A/g
  - **Systems Strategy & Network Support** — Emma Parker A/g
  - **NSW/ACT State Manager** — Elsy Brammesan
  - **VIC/TAS State Manager** — Helen Kelly A/g
  - **QLD/NT State Manager** — Nicole Jarvis
  - **SA/WA State Manager** — Cassie Mason
- **Interim First Nations Aged Care Commissioner** — Jodi Cassar A/g

Health Resourcing
Penny Shakespeare

- **Workforce** — Natalie Bekis A/g
- **Deputy Chief Medical Officer** — Adj. Prof. Susan Wearne A/g
  - **Workforce Strategy** — Valerie Ramsperger A/g
  - **Workforce Training** — Mike Pope
  - **Workforce Distribution** — Stewart Webster
  - **Rural & First Nations Workforce** — Sean Lane
  - **Primary Care & Workforce Reviews Taskforce** — Nick Morgan
  - **Aged Care Workforce** — Stephanie Kaiser
- **Technology Assessment & Access** — Daniel McCabe
  - **Technology Assessment & Strategy** — Assoc. Prof. Anne-marie Boxall
  - **Pharmaceutical Assessment** — Andrew Rintoul
  - **Community Access Programs** — Rachelle Davis
  - **PBS Listing, Pricing & Policy** — Rebecca Richardson
- **Health Security & Immunisation** — Dr. Anna Peatt
- **Emergency Preparedness** — Helen Grinbergs
  - **National Immunisation Program** — Dave McNally
  - **Health Emergency Management** — David Ness
  - **Health Security & Medical Countermeasures** — Dr. Samira Hassan
- **Benefits Integrity** — Matthew Williams
  - **Health Professionals Compliance** — Anthony McEachran
  - **Risk Analysis & Management, Data & Enterprise Systems** — Alice Creelman, Luke Bricknell A/g
  - **Health Integrity Operations** — Narelle Smith
  - **Fraud & Integrity** — David Evenden
  - **Strategy, Policy & Governance** — Brigid Dohnt

Secondary Statutory Structures operating within our Department

- **Office of the Gene Technology Regulator** — Dr. Raj Bhula
- **Regulatory Practice & Compliance** — Neil Ellis
- **Australian Industrial Chemicals Introduction Scheme** — Graeme Barden
- **Regulatory Integrity & Governance** — Dr. Sarah Rumble
- **Regulatory Science** — Dr. Claire Larter
- **National Rural Health Commissioner** — Prof. Jennifer May AM

Senator the Hon Jenny McAllister
Minister for the National Disability Insurance Scheme

The Hon Sam Rae MP
Minister for Aged Care and Seniors

The Hon Emma McBride MP
Assistant Minister for Mental Health and Suicide Prevention
Assistant Minister for Rural and Regional Health

The Hon Rebecca White MP
Assistant Minister for Health and Aged Care
Assistant Minister for Indigenous Health
Assistant Minister for Women

Dan Repacholi MP
Special Envoy for Men's Health

- **Medicare Benefits & Digital Health** — Duncan McIntyre
- **Medical Officer** — Adj. Prof. Andrew Singer
- **MBS Policy & Specialist Programs** — Nigel Murray
- **Diagnostic Imaging & Pathology** — Mary Warner
- **MBS Policy & Reviews** — Louise Riley
- **Digital Health** — Simon Cleverley
- **Care Integration & Access** — Matthew Castle A/g
- **Genomics Australia** — Renaye Lucchese
- **Australian Health Genomics Commissioner** — Tiffany Boughtwood

Primary Care, Community & First Nations — Dr. Liz Develin

- **Population Health** — Trish Clancy
  - **Prevention & Equity** — Rhiannon Box
  - **Alcohol, Other Drugs & Food** — Ben Mudaliar
  - **Tobacco & E-Cigarette Control** — Karlie Brown
- **Chronic Conditions & Screening** — Ariane Hermann
  - **Screening Programs** — Perdi Mitchell
  - **Cancer & Palliative Care** — Jo Mond
  - **Screening Policy** — Jo Smith
  - **Chronic Conditions & Hearing** — Jessica Pratt
- **Primary Care** — Mark Roddam
  - **Primary Health Networks & Partnerships** — Tracy Creech
  - **MyMedicare & Bulk Billing Clinics** — Jo Da Rocha
  - **Primary Care Strategy** — Sam Peascod
  - **Urgent Care** — Tanya Manning A/g
- **Mental Health & Suicide Prevention** — Gavin Matthews
- **Chief Psychiatrist - Mental Health** — Dr. Sophie Davison
  - **Child, Youth & Priority Populations** — David Laffan
  - **System Enablers** — Krista Vanderheide
  - **Services** — Darius Everett
  - **System Policy** — Emma Gleeson
  - **Suicide Prevention** — Mel Caldow A/g
- **First Nations Health** — Melinda Turner
  - **Primary Health Care & Community Control** — Ben Barratt
  - **Policy, Partnerships & Performance** — Chantal Jackson
  - **Targeted Health Programs** — Thomas Lester
- **National Mental Health Commission** — David McGrath
  - **National Suicide Prevention Office** — Alex Hains A/g

Disability & Carers — Mary Wood

- **Carers, Autism, Markets & Safeguards** — Ross Schafer
  - **Quality & Safeguards Policy** — Susan Trainor
  - **Markets & Workforce Policy** — Alex Abel
  - **Carers, Autism & Early Childhood** — Lydia Ross
- **Disability Strategy, Supports & Inclusion** — Suzanne Muir A/g
  - **Australia's Disability Strategy** — John Vutgs A/g
  - **Advocacy & Inclusion Programs** — Anita Julien A/g
- **NDIS Strategy & Policy** — Erin Rule A/g
  - **NDIS Strategy & Governance** — Nerissa Stewart A/g
  - **NDIS Legislation, Policy & Engagement** — Sarah Hawke
  - **Disability Evidence** — Dr. Louise O'Rance
  - **NDIS Access** — Sarah Sinclair
- **Thriving Kids Taskforce** — Gabriela Pulczynski
  - **Thriving Kids Program Assurance & Reporting** — Layla Morrow
  - **Foundational Support Reforms** — Lisha Jackman
- **NDIS Sustainability Taskforce** — Anthea Long
  - **NDIS Sustainability Implementation** — Simon O'Brien
  - **NDIS Sustainability Strategy** — Larissa Lewis A/g
- **Chief Disability Advisor** — James MacIsaac

Corporate Operations — Rachel Balmanno

- **Financial Management & Assurance** — David Hicks
  - **Finance** — Anne Fleischer
  - **Financial Performance Advice & Analytics** — Cindy McGhie
  - **Corporate Financial Strategy & Services** — Stewart Munro
  - **Grants & Procurement** — Craig Chalmers
  - **Assurance** — Pat Janek
- **Legal** — Miriam Moore
  - **Litigation, Corporate & Commercial** — Danae Paxinos, Melissa Purdy A/g
  - **Legal Advice & Legislation** — Christina Johnston
  - **Commercial & Information Law** — Emma White
- **People, Communication & Parliamentary** — Amy Laffan
  - **Ministerial & Parliamentary Services** — Jo Hutchinson
  - **People** — Sam Hollins A/g
  - **Communication Strategies & Campaigns** — Leanne Ringwood
  - **Corporate Communication** — Jodie Grieve
  - **Workplace & Culture** — Rebecca Sexton A/g
  - **Integrity & Security** — Stefanie Janiec
- **Chief Digital Information Officer** — Fay Flevaras
  - **Digital Strategy, Architecture & Innovation** — Amanda Chesher
  - **Enterprise Portfolio Management & Commercials** — Amanda Smith
  - **Digital Business & Sector Engagement** — Janine Bennett
- **Information Technology** — Lisa Tepper
  - **Health Business Systems** — Jennifer Frisby
  - **Corporate Systems** — Reid Johnson
  - **Digital Operations** — Emma Hallam-Wilcock
  - **Data & Analytics Platform Services** — Damien Hobbin
  - **Cyber Security & Infrastructure** — Luke Johnson
- **Digital Transformation & Delivery** — Brian Schumacher
  - **Aged Care Digital Portfolio Management** — Petar Krajina A/g
  - **Aged Care Funding Reform & Systems** — Marguerite Gandini A/g
  - **Aged Care Provider Systems** — Marina Muttukumaru

Organisational Chart

30 June 2026

Part 3.4: People

Our Corporate Plan and Workforce Strategy guide our people projects and initiatives. They have helped us to align workforce activity with the department's purpose, priorities and performance expectations. We review our strategy each year to ensure it reflects our changing context, priorities and workforce needs.

Three years after the Australian Public Service Commission's 2023 capability review of the department, we're continuing to drive improvements against the 3 key themes of our Capability Review Response:

- lifting our strategic policy capability
- deepening our engagement with communities and stakeholders
- unlocking our executive leader potential.

In 2025–26, this included building leadership capability through the ELevate and Activate management programs.

Workforce composition

At 30 June 2026, we had a workforce of 7,288 ongoing and non-ongoing Australian Public Service staff, including staff on leave and secondment. This is a decrease from 7,429 at 30 June 2025.

Commencements and separations tightened in 2025–26. The ongoing staff turnover rate in 2025–26 was 8.3% (or 8.1% excluding voluntary redundancies).

At 30 June 2026:

- 98% of staff were ongoing and 2% were non-ongoing
- 16.2% of staff were employed on a part-time basis
- 70% of staff identified as women/female
- 2.2% of staff identified as Aboriginal and/or Torres Strait Islander
- 4.4% of staff identified as having a disability.

See Appendix 2: Workforce Statistics in this Annual Report for more information on our workforce statistics.

Workplace agreements

Our Enterprise Agreement 2024–2027 commenced operation on 25 January 2024 and nominally expires on 28 February 2027.

The Enterprise Agreement conditions are embedded in our policies and processes. We have also worked to improve manager and employee understanding of entitlements and support consistent application across the organisation.

We have improved our approach to change consultation to meet Enterprise Agreement obligations, ensuring consultation is genuine, timely, and aligned with best practice.

During 2025–26, we focused on:

- maturing our flexible work arrangements, including improving employee and manager understanding of their responsibilities and options, supported by written materials and tailored support
- renewing our strong commitment to learning and development including continuing professional development for our medical officers
- ensuring we use Individual Flexibility Arrangements (IFAs)[127] strategically. Our Enhanced Remuneration Principles[128] ensure we apply IFAs transparently, consistently, and in alignment with business needs.

Our employment arrangements are consistent with the *Public Service Act 1999*, the *Fair Work Act 2009* and the Public Sector Workplace Relations Policy.

Executive remuneration and performance pay

During 2025–26, our remuneration for Senior Executive Service (SES) employees was consistent with equivalent public sector entities. Base salaries and inclusions followed government policy and guidelines.

We use the parameters set out in the Public Sector Workplace Relations Policy and the APS Executive Remuneration Management Policy when considering remuneration for SES officers. Comprehensive terms and conditions of employment for departmental SES staff are set out in individual determinations made under section 24(1) of the *Public Service Act 1999.*

We negotiate individual SES salaries on commencement, with remuneration thereafter determined through the SES Performance Framework. We consider a variety of factors, including the employee's performance and contribution to our culture and capability, when deciding an SES employee's performance rating.

Our Secretary and Deputy Secretaries moderated all SES performance outcomes and performance-based salary adjustments in September 2025. In addition to performance-based increases, the Secretary approved a 3.4% general pay increase for SES officers in January 2026. This increase was in line with the increase delivered to non-SES officers under the Enterprise Agreement. No departmental staff received performance pay in 2025–26.

See Appendix 2: Workforce Statistics in this Annual Report for more information on our staffing numbers, workplace arrangements, remuneration, and salary structures.

[127] The Enterprise Agreement contains a flexibility term, enabling the department to make an IFA with a non-SES staff member. An IFA varies specified terms and conditions provided under the Enterprise Agreement for an individual where necessary and appropriate.

[128] The Enhanced Remuneration Principles are internal guidelines that govern the consideration and approval process of IFAs in line with the Enterprise Agreement.

Measures of leadership and culture

The Australian Public Service Commission ran the 2026 APS Employee Census (2026 Census) during May and June 2026. Our response rate in 2026 was 74%, a decrease from 75% in 2025. Unlike many agencies, our responses include our APS employees and contractors.

Our 2026 Census results show continued strong performance across all indices. Staff engagement is still high with an Employee Engagement Index score of 75. In 2026, 82% of respondents indicated they would recommend the agency as a good place to work and 82% were proud to work in the department. Results also show 82% believe our culture supports people to act with integrity, and 87% feel the agency supports and actively promotes an inclusive workplace culture.

Satisfaction with our leadership performance remains strong, with both our Immediate Supervisor and SES Manager index scores consistent with those from 2025. The Executive Level 2 (Director) cohort continues to receive the highest leadership performance satisfaction scores (83%) and 81% of respondents believe their Director demonstrates strong people management behaviour.

Sentiment around flexible working remains positive. Results show 84% of respondents access working away from the office arrangements and 93% of respondents were confident that if they request a flexible work arrangement, their supervisor would give reasonable consideration to the request.

A focus of our 2025 Census Action Plan was building capabilities for a modern workforce. In 2026, 80% of respondents felt their workgroup has the right skills, capabilities and knowledge to perform well. Results also show 81% of respondents feel their job gives them opportunities to use their skills.

We will continue to use these results to inform departmental initiatives and monitor the implementation of actions under our Workforce Strategy and Capability Review Response.

Workforce capability

Our Workforce Strategy outlines the approach to building a capable, agile and future ready workforce.

The People Committee and Executive Committee review the Workforce Strategy each year, so it responds to changes in the operating environment and stays aligned with government priorities.

Our People Committee oversees development and implementation of annual Workforce Strategy implementation plans. These plans outline the actions we will take to achieve our strategic objectives, workforce priorities and our desired future state.

During 2025–26, the 4 strategic objectives of the Workforce Strategy were:

- compete for talent
- grow our own
- support and build agility
- leadership and culture.

The implementation plan for 2025–26 focused on:

- the Employee Value Proposition
- the Stretch RAP and First Nations Recruitment and Retention Strategy
- the Inclusion Framework Action Plan
- understanding capability requirements to responsibly adopt artificial intelligence (AI)
- the Strategic Commissioning Framework
- supporting effective organisational design.

Learning and development

In 2025–26, we continued to strengthen our learning and development offering to support the Workforce Strategy, respond to the Capability Review, and build the capability needed for a changing operating environment. Staff continued to access learning through a mix of online, virtual and face-to-face delivery, including classrooms, eLearning, microlearning, curated learning pathways and targeted resources.

We maintained our partnerships with the APS Academy and APS Professions to grow APS Craft capability, including through centrally funded access to programs, seminars, resources and networking opportunities.[129] Our People Branch continued to deliver in-house and centrally funded offerings to reduce financial barriers to learning and support consistent access across the department.

We also continued to support professional development for medical officers, nursing officers and other staff with mandatory qualifications through financial support and paid leave. The Studybank scheme provided eligible staff with financial support and/or leave for approved study. Additional leave remained available to First Nations staff, staff from non-English speaking backgrounds and staff with disability.

We progressed key initiatives in line with our Learning and Development Roadmap 2025–26 including:

- continued delivery of the ELevate program to strengthen Executive Level capability, including 13 EL2 development program classes and 50 masterclasses, supporting 590 staff, with many staff attending more than one offering
- extending ELevate masterclasses to EL1 staff to support leadership capability earlier in the leadership pipeline
- commencing delivery of the Activate: management program, with pilot instructor-led training delivered from February 2026 and broader design continuing to support practical management capability, including managing self, people, business, risk, recruitment and workforce planning
- completing the Artificial Intelligence Training Needs Analysis, endorsed by the Executive Committee in March 2026, to guide AI capability uplift across beginner, intermediate, technical and agency leader cohorts
- launching and embedding the department-specific AI Fundamentals learning module, with strong completion across the workforce, and commencing curated AI learning pathways through LinkedIn Learning
- expanding APS Craft offerings in strategy, policy and evaluation
- piloting new Aboriginal and Torres Strait Islander cultural capability development options for EL2 and SES staff
- establishing a learning outreach approach to improve visibility of learning offerings and strengthen capability insights from business areas
- publishing the Learning Policy and commencing development of a broader Learning Operating Model
- using our annual retrospective learning report, APS Employee Census insights and culture pulse data to better understand barriers to learning uptake for Executive Level and SES staff, particularly time and budget constraints.

[129] APSC, **APS Craft**, Australian Public Service Academy, 2024, accessed August 2026.

Flexible working arrangements

Flexible work is central to our Employee Value Proposition and a positive driver of attraction and retention. Our staff continue to value access to a variety of flexible working options, helping them to balance their professional and personal commitments.

At 30 June 2025, we had 6,314 staff (85%) with formal working from home agreements in place. Many teams also have staff based in different cities as the proportion of departmental staff located outside Canberra continues to increase. Building effective hybrid working practices that combine office-based and remote work is therefore critical.

We support our staff and managers through a range of initiatives, including:

- improving technical resources, infrastructure, and digital collaboration tools and supporting staff to use these effectively
- expanding the policies, guidance and training for staff and their managers regarding hybrid and geographically dispersed teams
- guidance and support for staff and managers to maintain work health and safety when working remotely.

Workforce inclusivity and diversity

We value workplace diversity, inclusion and reconciliation because they strengthen decision-making, collaboration and the delivery of better health and wellbeing outcomes for Australians. An inclusive and culturally capable workforce supports the delivery of safe, accessible and responsive services.

During 2025–26, we progressed implementation of our RAP and our Inclusion Framework 2025–30.[130] We also refreshed our Inclusion Framework Action Plan, strengthening accountability and measurement and embedding a strategic focus.

Our key RAP implementation priorities included strengthening Aboriginal and Torres Strait Islander workforce participation, cultural capability and partnerships. As a key deliverable, we launched the First Nations Recruitment and Retention Strategy 2025–2028. During the financial year, we offered 10 Jawun[131] placements, and we offered 2 Aboriginal and Torres Strait Islander graduates ongoing employment opportunities. As of 30 June 2026, we have completed 44 RAP deliverables, with a further 27 in progress and on track. National Reconciliation Week and NAIDOC Week activities provided opportunities for staff to deepen cultural understanding and engagement, including an online weaving workshop attended by more than 300 participants.

[130] Department of Health, Disability and Ageing, **Inclusion Framework 2025–30**, Department of Health, Disability and Ageing, May 2026, accessed August 2026.

[131] The Jawun Program is a partnership initiative between the APS and Jawun, a not-for-profit organisation. Jawun arranges secondments from corporate and government partners to Indigenous regional organisations across Australia. The program places skilled professionals in Indigenous organisations to transfer knowledge and expertise, supporting Indigenous leaders to deliver on their strategies and vision.

Our staff-led diversity networks continued to provide representation, advocacy and peer support, with more than 2,700 memberships recorded across the networks. Supported by SES Diversity Champions, the networks informed inclusion initiatives and ensured we considered diverse lived experiences and perspectives in our decision-making.

The 6 staff-led diversity networks are:

- Culturally and Linguistically Diverse Network
- Disability and Carers Network
- Gender Equality Network
- Health Pride (LGBTIQA+) Network
- National Aboriginal and Torres Strait Islander Staff Network, including Friends of the National Aboriginal and Torres Strait Islander Staff Network
- Neurodiversity Network.

In 2025–26, we achieved Gold Employer status in the Australian Workplace Equality Index for the third consecutive year and implemented the Hidden Disabilities Sunflower Friendly Workplace commitment.[132]

Disability reporting

Australia's Disability Strategy 2021–2031 (Disability Strategy) is the overarching framework for inclusive policies, programs and infrastructure that will support people with disability to participate in all areas of life.[133] The Disability Strategy sets out, where practical, changes that will be made to improve the lives of people with disability in Australia. It acts to ensure we incorporate the principles underpinning the United Nations Convention on the Rights of Persons with Disabilities into Australia's policies and programs that affect people with disability, their families, and carers. All levels of government have committed to deliver more comprehensive and visible reporting under the Disability Strategy. We will also publish a range of reports on progress of the Disability Strategy's actions and outcome areas on the Disability Gateway.

The Australian Public Service Commission's State of the Service reports and the APS Statistical Bulletin also include disability reporting.

[132] The Hidden Disabilities Sunflower creates positive change by enabling individuals with non-visible disabilities, conditions, and chronic illnesses to use the Sunflower symbol to indicate they may need additional support, understanding, or time.

[133] Department of Social Services, **Australia's Disability Strategy 2021–2031: 2024 update, building a more inclusive Australia**, Disability Gateway, June 2025, accessed August 2026.

Our values and behaviours

The APS Values, Employment Principles, and Code of Conduct in the *Public Service Act 1999* set the standard of behaviour expected of all APS employees.

The APS Values are the foundation for everything, and we bring them to life for staff through practical guidance about what expected behaviours look like in the workplace. We embed APS Values into performance agreements, and revisit them during the year to ensure staff are familiar with the expected behaviours.

In 2025–26, we focused on building awareness of each staff member's obligations to support a culture where integrity is central to everything we do. We also promoted stewardship as a new APS Value and we have embedded this into performance agreements.

We are committed to creating a positive working environment that values diversity and is safe and free from all forms of workplace bullying, harassment, and discrimination. We have a suite of resources which sets out the responsibilities of staff and managers and provides user-friendly and practical tools to prevent, address or report bullying, discrimination and harassment incidents. There are multiple ways for staff to report incidents and access support, including a network of Harassment Contact Officers. Our framework is consistent with the Respect@Work recommendations and work health and safety laws.[134]

Consistent with our commitment to a positive and safe workplace, we treat all alleged breaches of the APS Code of Conduct seriously. Managers and employees are encouraged to engage constructively in resolving workplace concerns, with guidance and advice provided by human resource practitioners, as needed.

In the 2026 Census, 6% of respondents reported they experienced discrimination and 8% reported they were bullied or harassed. These results remained stable from 2025. Unfortunately, as in previous years, most staff who experienced these behaviours did not report the behaviour. Increasing reporting will remain an area of focus for us.

Career and succession

Performance management and development

All staff participate in our Performance Development Scheme, which supports a culture of high performance, capability development and continuous feedback. Through the Scheme, employees and managers set performance and development goals, undertake regular performance conversations, and complete formal mid-cycle and end-cycle reviews. We encourage ongoing feedback and development discussions throughout the performance cycle to support individual growth and organisational outcomes.

In 2025–26, we continued to strengthen performance management practices through a range of initiatives, including:

- progressing the refresh of the non-SES Performance Framework to align with APS reform priorities and strengthen the focus on capability, development and continuous performance conversations
- developing practical tools, guidance materials and conversation resources to support effective performance and feedback discussions across the department

[134] Australian Human Rights Commission, **Workplace sexual harassment guidance**, Australian Human Rights Commission, n.d., accessed August 2026.

- implementing 360-degree feedback for SES leaders to offer broader performance insights, support leadership development and strengthen performance conversations
- continuing to support managers through guidance, training and capability-building activities that promote constructive feedback and high performance.

We recognise the importance of supporting employees to achieve expected performance standards. When performance concerns arise, we support managers and employees to ensure expectations are clear, their capability needs are identified, and timely feedback and development opportunities are provided. If an employee's performance does not improve, we may start formal performance management processes, following departmental policy.

Entry level programs

Entry level recruitment programs help us to engage a diverse group of employees with both general and specific capabilities. During 2025–26, we took part in the following Career Pathways programs:

- Australian Government Graduate Program – HR Graduate stream
- Australian Government Graduate Program – Digital Graduate stream
- Australian Government Graduate Program – Data Graduate stream
- Australian Government Graduate Program – Accounting and Financial Management stream
- Australian Government Graduate Program – Economist stream
- Australian Government School Leaver Program
- Data Cadet Program
- Indigenous Apprenticeship Program
- Australian Government Apprentice Program.

We have a range of entry level programs, including the Indigenous Internship Program, targeted to support Aboriginal and/or Torres Strait Islander students to gain work experience in the APS while completing their degree. We also delivered the Department of Health, Disability and Ageing Graduate Program, which included recruitment through an Affirmative Measures process for First Nations people.

Work health and safety

See Appendix 6: Work health and safety for information on our work health and safety performance.

Part 3.5: Financial management and procurement

Financial accountability responsibilities

Our financial accountability responsibilities are set out in the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and subordinate legislation, collectively known as finance law.

In support of finance law, our Accountable Authority Instructions are issued in accordance with section 20A of the PGPA Act. We have also issued Finance Business Rules that clearly set out the rules and processes required for the financial administration of the department. Together, these documents provide a framework to ensure efficient, effective, economical, and ethical use of public resources.

The Executive Committee is responsible for monitoring and addressing performance and risks. The Chief Financial Officer provides monthly advice on financial matters, including administered, departmental, and capital expenditure. The Finance Committee supports this process. Further, the department's ARC provides independent advice to the accountable authority.

Finance law also mandates the production of audited financial statements prepared in accordance with the Australian Accounting Standards. We provide our 2025–26 financial statements in Part 4: Financial Statements of this Annual Report.

Managing our assets

We hold financial and non-financial assets. Financial assets include cash and receivables, which are subject to internal controls and regular reconciliations.

We hold non-financial assets for operational purposes. This includes:

- software and hardware
- leasehold improvements
- right-of-use assets
- furniture and fittings
- inventory.

We make decisions about whole-of-life asset management in the context of our broader strategic planning. This ensures that when we invest in assets, we are achieving the department's objectives as cost-effectively as possible.

We effectively managed the department's capital budget and non-financial assets by:

- including whole-of-life considerations in proposals for capital expenditure
- having the Executive Committee prioritise capital projects and major purchases across the department
- using the Digital, Data and Implementation Board and Digital Committee to oversee, advise on and assure digital, data, information and communications technology work programs across the department
- undertaking regular stocktakes of physical assets and inventory
- annually reviewing assets for indications of impairment and changes in expected useful lives.

Procurement

Purchasing

We undertake procurement activities in accordance with the Commonwealth Procurement Rules[135] and the broader Commonwealth resource management framework.[136] Through procurement practices, we seek to achieve value-for-money, encourage competition, and support transparency, accountability, and the efficient, effective, ethical, and economical use of Commonwealth resources.

During 2025–26, we entered into 1,716 new contracts:

- 1,303 contracts through standing offers
- 386 contracts through limited tender process
- 27 contracts through open tender processes.

We published a total of 1,766 contracts on AusTender during the financial year, and we achieved 94.85% compliance with the Commonwealth's 42-day publishing requirement.

During 2025–26, we updated our procurement policies and practices to reflect changes to the Commonwealth Procurement Rules (effective 17 November 2025), and to incorporate recommendations arising from the Australian National Audit Office Audit on the Administration of the Future Fit program.[137]

We undertake regular assurance activities to monitor compliance. When we identify instances of non-compliance, we record them through our financial management compliance system and address them including through training and process improvement initiatives.

During 2025–26, there were no contraventions recorded against the department under the Government Procurement Judicial Review.

[135] Department of Finance, **Commonwealth Procurement Rules**, Department of Finance, May 2026, accessed August 2026.
[136] Department of Finance, **Managing Commonwealth Resources**, Department of Finance, January 2025, accessed August 2026.
[137] ANAO (Australian National Audit Office), **Administration of the Future Fit Program**, ANAO, May 2025, accessed August 2026.

Initiatives to support small business

The Department of Health, Disability and Ageing supports small business participation in the Commonwealth Government procurement market. Small and Medium Enterprises (SMEs) and Small Enterprise participation statistics are available on the Department of Finance's website.[138] We support SMEs' participation through a range of procurement practices, including:

- embedding the Small Business Engagement Principles, as outlined in the government's Industry Innovation and Competitiveness Agenda
- implementing a supplier pay on-time policy, including 20-day payment terms for standard contracts, and 5-day payment terms for e-invoicing contracts
- ensuring we include SMEs in approaches to Mandatory Whole-of-Government panels (Management Advisory Services and People Panel)
- using the Commonwealth Contracting Suite for procurements up to $200,000 (GST inclusive)
- utilising Appendix A, Exemption 17 of the Commonwealth Procurement Rules, which allows limited tender procurements from SMEs valued at up to $500,000 (GST inclusive), where the tenderer can show value-for-money.

The Department of Health, Disability and Ageing recognises the importance of ensuring that small businesses are paid on time. The results of the Survey of Australian Government Payments to Small Business are available on the Treasury's website.[139] In 2025–26, we received a total of 4,083 e-invoices from suppliers, compared to 2,701 in 2024–25. We will continue to encourage supplier use of e-invoices and will continue to consult with the Australian Taxation Office on strategies for supplier engagement and increasing e-invoice volumes.

Indigenous Procurement Policy

We support Aboriginal and Torres Strait Islander business participation in the Commonwealth procurement market. The National Indigenous Australians Agency's Indigenous Procurement Policy aims to support economic participation and business growth for First Nations people.[140]

In 2025–26, we entered into 147 new contracts with Aboriginal and Torres Strait Islander businesses, with a total contract value of $102.77 million. This exceeded the Health, Disability and Ageing portfolio target of $70.26 million. This shows our ongoing commitment to increasing Aboriginal and Torres Strait Islander business participation in Commonwealth procurement.

Our RAP includes actions to increase awareness and recognition of Aboriginal and Torres Strait Islander suppliers and the value they bring to procurement activities. We support this by:

- promoting success stories
- reviewing and strengthening procurement practices
- attending supplier engagement events
- maintaining membership with Supply Nation.[141]

[138] Department of Finance, **Statistics on Australian Government Procurement Contracts**, Department of Finance, n.d., accessed August 2026.
[139] The Department of Treasury, **Pay on-Time Survey Performance Reports**, accessed September 2026.
[140] NIAA (National Indigenous Australians Agency), **Indigenous Procurement Policy (IPP)**, NIAA, May 2026, accessed August 2026.
[141] Supply Nation, **Supply Nation**, Supply Nation website, n.d., accessed August 2026.

Reportable consultancy contracts

We engage consultants when we require specialist expertise or independence. Examples include:

- investigating or diagnosing a defined issue or problem
- carrying out defined reviews or evaluations
- providing independent advice, information, or creative solutions to help the department in decision making.

Consultant engagements are in accordance with the PGPA Act and related regulations, including the Commonwealth Procurement Rules and internal policies.

Annual reports contain information about actual expenditure on reportable consultancy contracts. Information on the value of reportable consultancy contracts is available on the AusTender website.[142]

During 2025–26, 324 new reportable consultancy contracts were entered into involving total actual expenditure of $130.42 million. Actual expenditure against these contracts during the reporting period was $63.44 million. In addition, 308 ongoing reportable consultancy contracts were active during the period, involving total actual expenditure of $99.03 million.

Table 3.5.1: 2025–26 Reportable consultancy contracts

Reportable consultancy contracts	No. of Contracts	Actual 2025–26 spend (GST inclusive)
New contracts entered into during the reporting period	324	$63,448,751.01
Ongoing contracts entered into during a previous reporting period	308	$99,031,278.84
Total	**632**	**$162,480,029.85**

Table 3.5.2: 2025–26 Top 5 consultants (by value of expenditure)

2025–26 Top 5 Consultants		Actual 2025–26 spend (GST inclusive)	Proportion of 2025–26 total spend (%)
Entity Name	**ABN**		
Nous Group Pty. Ltd.	66086210344	$15,430,421.99	9%
Ernst & Young	75288172749	$12,002,071.30	7%
Ember Advisors Pty Ltd	73658212590	$6,282,343.50	4%
Accenture Australia Pty Ltd	49096776895	$5,976,792.52	4%
KPMG	51194660183	$5,923,658.01	4%

[142] AusTender, **AusTender**, AusTender Australian Government website, n.d. accessed August 2026.

Reportable non-consultancy contracts

During 2025–26, we entered into 1,392 new reportable non-consultancy contracts with a total contract value of $5.02 billion. Actual expenditure against these contracts during the reporting period was $1.62 billion. A further 1,934 ongoing reportable non-consultancy contracts were active during 2025–26, with an actual expenditure $1.97 billion during the reporting period.

Annual reports contain information about actual expenditure on reportable non-consultancy contracts. Information on the value of reportable non-consultancy contracts is available on the AusTender website.[143]

Table 3.5.3: 2025–26 Reportable non-consultancy contracts

Reportable non-consultancy contracts	No. of Contracts	Actual 2025–26 spend (GST inclusive)
New contracts entered into during the reporting period	1,392	$1,623,022,833.01
Ongoing contracts entered into during a previous reporting period	1,934	$1,972,679,643.85
Total	**3,722**	**$3,595,702,476.86**

Table 3.5.4: 2025–26 Top 5 non-consultancies (by value and expenditure)

2025–26 Top 5 non-consultancy contracts		Actual 2025–26 spend (GST inclusive)	Proportion of 2025–26 total spend (%)
Entity Name	ABN		
Glaxosmithkline Australia Pty Ltd	47100162481	$431,005,979.56	12%
Accenture Australia Pty Ltd	49096776895	$192,000,851.50	5%
Seqirus (Australia) Pty Ltd	66120398067	$156,975,201.02	4%
Australian Healthcare Associates Pty Ltd	82072790848	$135,110,952.63	4%
Pfizer Australia Pty Ltd	50008422348	$119,057,891.98	3%

Strategic Commissioning Framework

In 2025–26, we took steps to bring core work in-house in line with the APS Strategic Commissioning Framework. Our targets for 2025–26 aimed to bring $1,921,395 (GST exclusive) of core work in-house in the job families of:

- Accounting and Finance
- Administration
- Communications and Marketing
- Compliance and Regulation
- Policy, Portfolio, Program and Project Management
- Service Delivery.

We exceeded this target with an actual reduction of $4,948,995 (GST exclusive) in relevant supplier expenditure.

We will continue to promote greater reliance on the APS workforce instead of outsourcing, monitor new procurements for core roles and provide support to transition work and capability to the APS workforce.

[143] AusTender, **AusTender**, AusTender Australian Government website, n.d. accessed August 2026.

Exempt contracts

In 2025–26, 81 contracts greater than $10,000 (GST inclusive) were exempt from reporting on AusTender on the basis that publishing contract details would disclose exempt matters under the *Freedom of Information Act 1982* (FOI Act). This is an increase from 2024–25, where 76 contracts were exempt from reporting. We cannot publish further details from these contracts, as disclosure would reveal information that is exempt under the FOI Act.

Australian National Audit Office access clauses

Our standard contract and standing offer templates include provisions to allow the ANAO access to a contractor's premises. In 2025–26, there were no reportable contracts that excluded this provision.

Grants

We are the largest granting agency in the Commonwealth by grant value, administering 25,019 grant activities in 2025–26 at a total value of $11.79 billion.

Key grants programs in 2025–26 included:

- Commonwealth Home Support Program ($3.5 billion)
- Indigenous Comprehensive Primary Health Care ($666 million)
- Disability Support for Older Australians ($366 million)
- Medicare Urgent Care Clinics ($278 million)
- Rural Health Multidisciplinary Training Programme ($253 million).

We follow the mandatory requirements set out in the Commonwealth Grant Rules and Principles (CGRPs).[144] The CGRPs are a legislative instrument established by the Minister for Finance under section 105C(1) of the PGPA Act. The CGRPs detail the legislative and policy requirements relating to grants as well as better practice principles for grants administration.

We maintain a comprehensive suite of policy and procedural guidance (the Grant Toolkit). The Grant Toolkit supports policy and program areas across the department to undertake grants administration activities in accordance with the CGRPs. This is complemented by a monthly grants assurance program which tests for compliance with the CGRPs and the broader grants framework.

In 2025–26, we continued to strengthen our grant administration framework through reforms designed to improve governance, financial controls and compliance. We:

- strengthened our grants risk framework supporting early identification and management of fraud and corruption risks
- undertook structured engagement with grants partners across agencies to progress whole-of-government reforms
- improved our compliance response through systematic coordination with audit and assurance functions.

Information on grants awarded by the department during 2025–26 is available on the government's grant information system, GrantConnect.[145]

[144] Federal Register of Legislation, **Commonwealth Grants Rules and Principles 2024**, Office of Parliamentary Counsel, 2024, accessed August 2026.
[145] Grant Connect, **GrantConnect**, Department of Finance, n.d. accessed August 2026.

Part 3.6: External scrutiny and compliance

Parliamentary scrutiny

During 2025–26, we contributed to the work of parliamentary committees. This included the provision of evidence, submissions and engagement on the administration of health, disability and ageing policies and programs.

The portfolio's submissions, responses to questions taken on notice—written and taken during hearings—and transcripts of committee hearings are available on the Parliament of Australia website.[146]

Joint Committee of Public Accounts and Audit

In 2025–26, we provided submissions to 3 Joint Committee of Public Accounts and Audit inquiries and attended public hearings for 2 of these inquiries. As of 30 June 2026, all 3 inquiries remained ongoing:

- Inquiry into Commonwealth Financial Statements 2023–24 and 2024–25
- Inquiry into the administration of the National Disability Insurance Scheme
- Inquiry into the management of client privacy in the Australian public sector.

In 2025–26, the Joint Committee of Public Accounts and Audit did not table any inquiry reports relating to the department.

Senate Estimates hearings

During the reporting period, the Health, Disability and Ageing portfolio appeared before the Senate Community Affairs Legislation Committee on the following occasions:

- Supplementary Budget Estimates: 9–10 October and 3–4 December 2025
- Additional Budget Estimates: 11–12 February 2026
- Budget Estimates: 2, 3 and 5 June 2026.

Across these hearings, the portfolio registered 7,355 Questions on Notice.

[146] Parliament of Australia, **Home Page**, Parliament of Australia, n.d., accessed August 2026.

Parliamentary committee inquiries

We registered 117 Questions on Notice arising from parliamentary committee inquiries. We also provided evidence and/or submissions to the parliamentary committee inquiries listed below.

Committee	Inquiry Name
House of Representatives Standing Committee on Health, Aged Care and Disability	Inquiry into access to and affordability of medical specialists in Australia
House of Representatives Standing Committee on Health, Aged Care and Disability	Inquiry into the Thriving Kids Initiative
House of Representatives Standing Committee on Health, Aged Care and Disability	Inquiry into the health impacts of alcohol and other drugs in Australia
House of Representatives Standing Committee on Social Policy and Legal Affairs	Inquiry into the relationship between domestic, family, and sexual violence and suicide
House of Representatives Standing Committee on Regional Development, Infrastructure and Transport	Inquiry into local government funding
Senate Community Affairs References Committee	Inquiry into Aged Care Service Delivery
Senate Community Affairs References Committee	The Transition of the Commonwealth Home Support Program to the Support at Home Program
Senate Community Affairs References Committee	Impact of microplastics and other toxics on human health
Senate Community Affairs References Committee	Support at Home Program
Senate Community Affairs References Committee	Inquiry into epilepsy in Australia
Senate Community Affairs Legislation Committee	Aged Care (Accommodation Payment Security) Levy Amendment Bill 2025 and Aged Care and Other Legislation Amendment Bill 2025
Senate Community Affairs Legislation Committee	NDIS Amendment (Integrity and Safeguarding) Bill 2025
Senate Community Affairs Legislation Committee	Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026
Senate Community Affairs Legislation Committee	Inquiry into National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026
Senate Community Affairs Legislation Committee	Review of Aged Care Rules
Senate Community Affairs Legislation Committee	Australian Centre for Disease Control Bill 2025, and (Consequential Amendments and Transitional Provisions) Bill 2025
Senate Community Affairs Legislation Committee	Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026
Senate Community Affairs Legislation Committee	Health Insurance Amendment (Incentive Payments and Other Measures) Bill 2026

Committee	Inquiry Name
Senate Standing Committee on Legal and Constitutional Affairs Legislation	Inquiry into the illegal tobacco crisis in Australia
Senate Rural and Regional Affairs and Transport References Committee	Inquiry into opportunities for the development of a hemp industry in Australia
Senate Rural and Regional Affairs and Transport References Committee	Inquiry into rural, regional, and remote Medicare access and funding
Joint Standing Committee on the National Disability Insurance Scheme	Annual Report No.1 of the 48th Parliament Inquiry
Joint Standing Committee on the National Disability Insurance Scheme	Inquiry into the integrity of the NDIS
Joint Standing Committee on Treaties	Amendments to the International Health Regulations (2005)
Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs	Inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander people
Joint Committee of Public Accounts and Audit	Inquiry into Commonwealth Financial Statements 2023–24 and 2024–25
Joint Committee of Public Accounts and Audit	Inquiry into the administration of the National Disability Insurance Scheme
Joint Committee of Public Accounts and Audit	Inquiry into the management of client privacy in the Australian public sector

Freedom of Information

We received 1,123 Freedom of Information requests in 2025–26. We provide quarterly and annual statistical information relating to requests made under the FOI Act to the Office of the Australian Information Commissioner. These statistics are available at:

- www.oaic.gov.au
- www.transparency.gov.au
- www.data.gov.au.

The Information Publication Scheme is a program under the FOI Act that requires agencies to publish a broad range of information on their website. Our website sets out how we comply with the scheme.[147] This includes a link to our Freedom of Information disclosure log.[148] The TGA publishes a separate disclosure log, available on the TGA website.[149]

[147] Department of Health, Disability and Ageing, **Information Publication Scheme (IPS)**, Department of Health, Disability and Ageing, February 2026, accessed August 2026.
[148] Department of Health, Disability and Ageing, **FOI disclosure log**, Department of Health, Disability and Ageing website, n.d., accessed August 2026.
[149] TGA (Therapeutic Goods Administration), **TGA FOI disclosure log**, Department of Health, Disability and Ageing, n.d., accessed August 2026.

Australian National Audit Office audits

Tabled ANAO reports

During 2025–26, the ANAO tabled 3 performance audit reports related to the department:

- No. 11 of 2025/26 – Securing supply through onshore vaccine manufacturing capability
- No. 23 of 2025/26 – Suicide prevention policy development and monitoring
- No. 31 of 2025/26 – Effectiveness of the Commonwealth Home Support Program.

We agreed, or agreed in principle, to all 21 recommendations arising from the audits. Implementation activities for all recommendations are either underway or completed.

The ANAO also published reports into:

- Audits of the financial statements of Australian Government entities for the period ended 30 June 2025 on 18 December 2025. The department received one significant legislative breach finding as well as no significant, 2 moderate and 11 minor findings.
- Performance statements of major Australian Government entities – Outcomes from the 2024–25 audit program on 5 February 2026. The department received a qualified audit conclusion with an 'emphasis of matter'.
- Interim report on key financial controls of major entities on 25 June 2026. The department received one significant legislative breach finding as well as no significant, 2 moderate and 10 minor findings.

Status of ANAO recommendations

As of 30 June 2026, we had 23 open recommendations across 6 ANAO performance audit reports. We are implementing activities for all recommendations, and no recommendations are overdue.

Table 3.6.1: Status of ANAO recommendations as of 30 June 2026

	Recommendations				
ANAO Report	**Agreed**	**Agreed in principle**	**Closed**	**In Progress**	**Overdue[150]**
Management of Non-Compliance with the *Therapeutic Goods Act 1989* for Unapproved Therapeutic Goods Report No. 3 of 2023/24	6	0	5	1	0
Administration of the Pharmaceutical Benefits Scheme Report No. 19 of 2024/25	5	0	4	1	0
Administration of the Future Fit Program Report No. 37 of 2024/25	8	0	7	1	0
Securing Supply Through Onshore Vaccine Manufacturing Capability Report No. 11 of 2025/26	6	0	1	5	0
Suicide Prevention Policy Development and Monitoring Report No. 23 of 2025/26	3	3	0	6	0
Effectiveness of the Commonwealth Home Support Program Report No. 31 of 2025/26	9	0	0	9	0
Total	**37**	**3**	**17**	**23**	**0**

[150] The department defines overdue recommendations as recommendations that have had more than 2 extension requests, or an extension request that is greater than 12 months from the original due date.

Judicial decisions, decisions of administrative tribunals and decisions of the Information Commissioner

Notable decisions involving the department handed down in 2025–26

In 2025–26, there were no judicial decisions, decisions of administrative tribunals, or Australian Information Commissioner decisions, that have had, or may have, a significant effect on the operations of the department.

During 2025–26, the department was involved in:

- 6 matters in the Full Federal Court of Australia
- 28 matters in the Federal Court of Australia
- 2 matters in the Federal Circuit and Family Court of Australia
- one matter in the Supreme Court of New South Wales
- 2 matters in the Supreme Court of Queensland
- one matter in the Supreme Court of Western Australia
- one matter in the Magistrates Court of South Australia
- 49 matters in the Administrative Review Tribunal
- one matter in the Queensland Civil and Administrative Tribunal
- one matter in the State Administrative Tribunal of Western Australia
- 145 reviews with the Office of the Australian Information Commissioner.

Office of the Commonwealth Ombudsman

We continued to engage with the Office of the Commonwealth Ombudsman on complaints related to administrative activities.

In 2025–26, we received:

- 12 preliminary inquiries under section 7A of the *Ombudsman Act 1976*
- 5 investigations under section 8 of the *Ombudsman Act 1976*, including one own motion investigation
- one information request.

In 2025–26, the Office of the Commonwealth Ombudsman finalised 7 matters under section 12 of the *Ombudsman Act 1976*, none of which resulted in a finding of administrative deficiency.

Individuals who have concerns about the department's actions or decision-making may lodge a complaint with the Office of the Commonwealth Ombudsman. The Office of the Commonwealth Ombudsman assesses whether the department's conduct was wrong, unjust, discriminatory, or unfair.

Public Health (Tobacco and Other Products) Act 2023

We have responsibility to investigate and enforce the *Public Health (Tobacco and Other Products) Act 2023*. This legislation:

- prohibits advertising and sponsorship relating to tobacco and e-cigarette products and their use (with limited exceptions)
- regulates the appearance, physical features and contents of tobacco products, tobacco packaging and tobacco product accessories
- permanently bans certain tobacco products, such as chewing tobacco or oral snuff
- requires mandatory reporting from certain entities relating to tobacco product ingredients, tobacco product volumes, and marketing and promotional expenditure.

Pursuant to section 184 of the *Public Health (Tobacco and Other Products) Act 2023*, we report the following potential contraventions, and the action taken in response to those contraventions, during the 2025–26 financial year.[151]

Table 3.6.2: Reportable contraventions and actions taken under the *Public Health (Tobacco and Other Products) Act 2023*

	Contraventions identified	Action taken in response
Chapter 2 Advertising and sponsorship prohibitions	150 potential contraventions identified	48 warning letters sent 34 cases closed 164 cases under investigation
Chapter 3 Tobacco product requirements	188 potential contraventions identified	1 warning letter sent 25 cases closed 193 cases under investigation
Chapter 4 Permanent bans on certain tobacco products	3 potential contraventions identified	3 cases closed
Chapter 5 Reporting and information disclosure	52 potential contraventions identified	52 warning letters sent 52 cases under investigation

[151] Contraventions identified reflects new matters identified during 2025–26. Cases under investigation includes all active investigations at 30 June 2026, including matters carried over from previous financial years and where initial action may have already been taken. Consequently, these figures are not directly comparable.

Human Services (Medicare) Act 1973

The *Human Services (Medicare) Act 1973* allows the Chief Executive Medicare to authorise the exercise of powers requiring a person to:

- give information or to produce a document that is in the person's custody or under the person's control
- obtain a statutory report under section 42 of the *Human Services (Medicare) Act 1973*.

The table below outlines the number of times the Chief Executive Medicare exercised these powers in 2025–26.

	Section 42(1) paragraphs (a) to (h)	
(a)	the number of signed instruments made under section 8L	22
(b)	the number of notices in writing given under section 8P	55
(c)	the number of notices in writing given to individual patients under section 8P	0
(d)	the number of premises entered under section 8U	0
(e)	the number of occasions when powers were used under section 8V	0
(f)	the number of search warrants issued under section 8Y	4
(g)	the number of search warrants issued by telephone or other electronic means under section 8Z	0
(h)	the number of patients advised in writing under section 8Z	0

Future Made in Australia Act 2024

We did not provide any in-scope commitments or support under the Future Made in Australia initiative in 2025–26.

Aged Care Act 2024

We made 165 substituted decisions between 1 November 2025 and 30 June 2026, under subsection 582(4) of the *Aged Care Act 2024*.[152]

Each of these decisions provided participants with a higher priority for Support at Home services. We consider this to be a more favourable outcome. We made these decisions because the commencement of the *Aged Care Act 2024* led to unintended adverse impacts on participants who were already taking part in the assessment process.

[152] The *Aged Care Act 2024* commenced on 1 November 2025.

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Part 4:
Financial Statements

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Chief Financial Officer's Report



Departmental operating result

In 2025–26 the department recorded a consolidated operating loss of $41.8 million. After adjusting for unfunded depreciation and lease accounting impacts, the net cash operating surplus was $2.7 million. During 2025–26, revenue from government decreased by 1.9% to $1,711.9 million ($1,744.7 million in 2024–25). Revenue from other sources, including fees charged to industry by the Therapeutic Goods Administration (TGA) and the Australian Industrial Chemicals Introduction Scheme (AICIS), decreased by 1.9% to $259.0 million ($263.9 million in 2024–25). Departmental operating expenses decreased by 2.3% to $2,012.9 million ($2,060.9 million in 2024–25). Employee expenses increased by 3.6% to $1,072.8 million ($1,035.2 million in 2024–25). This primarily reflected the impact of wage increases and the transfer of disability and carers functions to the department following the Administrative Arrangements Order issued on 13 May 2025.

Departmental assets and liabilities

The department's total assets increased by $14.8 million to $1,458.1 million ($1,443.3 million in 2024–25). Trade and other receivables increased by $14.3 million to $468.4 million ($454.1 million in 2024–25), with all receivable balances expected to be settled within 12 months of the reporting date. Computer software increased by $37.7 million to $299.9 million ($262.2 million in 2024–25), reflecting continued investment in internally developed software and digital capability projects.

The department's total liabilities decreased by $29.1 million to $920.2 million ($949.3 million in 2024–25). This decrease was primarily due to lower lease liabilities associated with the department's office accommodation portfolio.

Administered revenue

In 2025–26 total administered revenue was $65.9 billion, compared to $54.4 billion in the prior year. Major items included:

- special accounts revenue, which primarily comprises revenue appropriated via special accounts to facilitate payments in relation to the Medicare Guarantee Fund ($57.5 billion) and the Medical Research Future Fund ($0.7 billion)
- recoveries, including $6.7 billion recovered under cost-sharing arrangements with pharmaceutical companies and $0.4 billion recovered from aged care activities.

Administered expenses

During 2025–26, the department administered expenses on behalf of the Commonwealth of $160.7 billion, an increase of 43.8% compared to expenses in the prior year of $111.7 billion. The increase was primarily driven by the first year administering National Disability Insurance Scheme payments since the transfer from the Department of Social Services in 2025. Major items included:

- Personal benefits expenses, including the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, private health insurance rebates and aged care support programs ($74.9 billion)
- Subsidies expenses, which primarily related to residential aged care services ($26.1 billion)
- Grants expenses attributable to investments in primary care, health workforce, mental health, health research, aged care and other health programs ($15.5 billion)
- Other expenses, which primarily related to National Disability Insurance Scheme participant plan payments through the National Disability Insurance Agency and contract-for-service arrangements ($44.1 billion).
- The department also recognised $0.4 billion in write-downs and impairment of non-financial assets ($0.8 billion in 2024–25), reflecting expired National Medical Stockpile and COVID-19 vaccine inventory and the write-off of prepaid inventory balances.

Key administered expenditure is illustrated in **Figures 1** and **2**.

Figure 1: Breakdown of administered expenditure

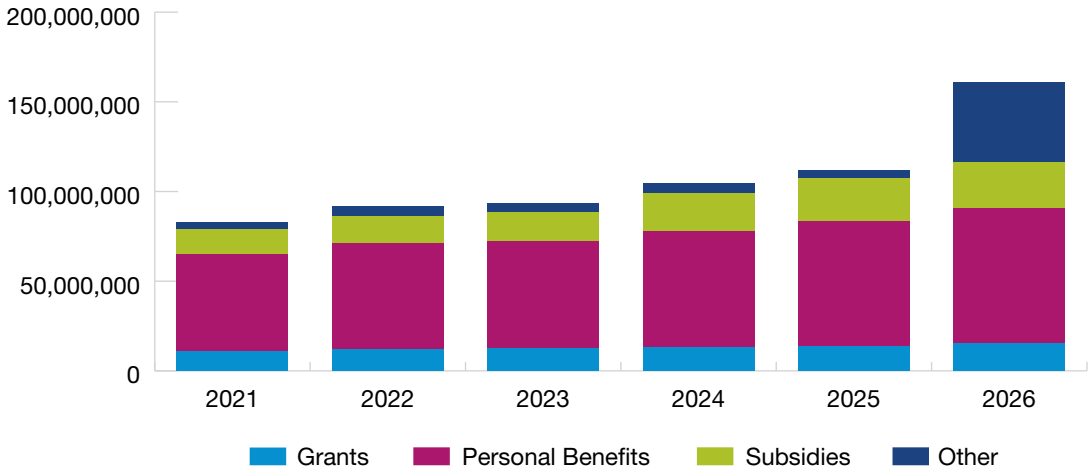
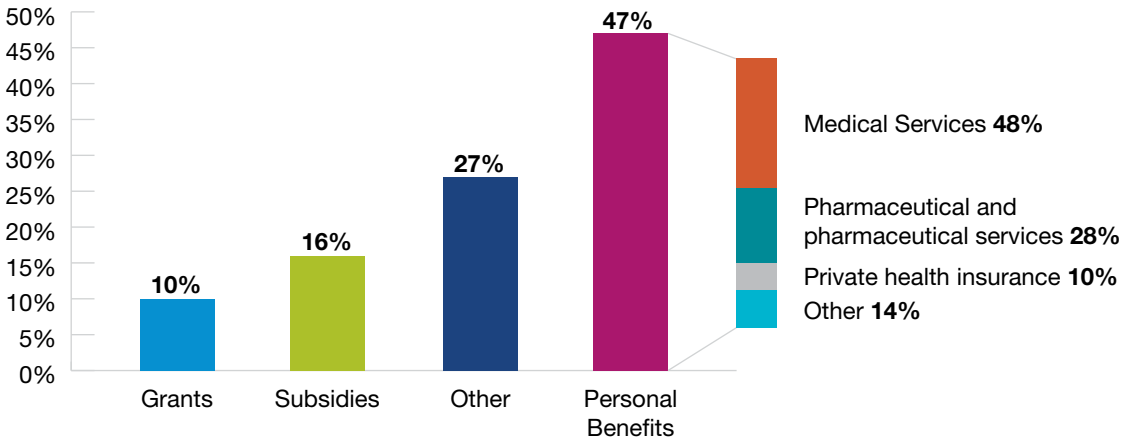
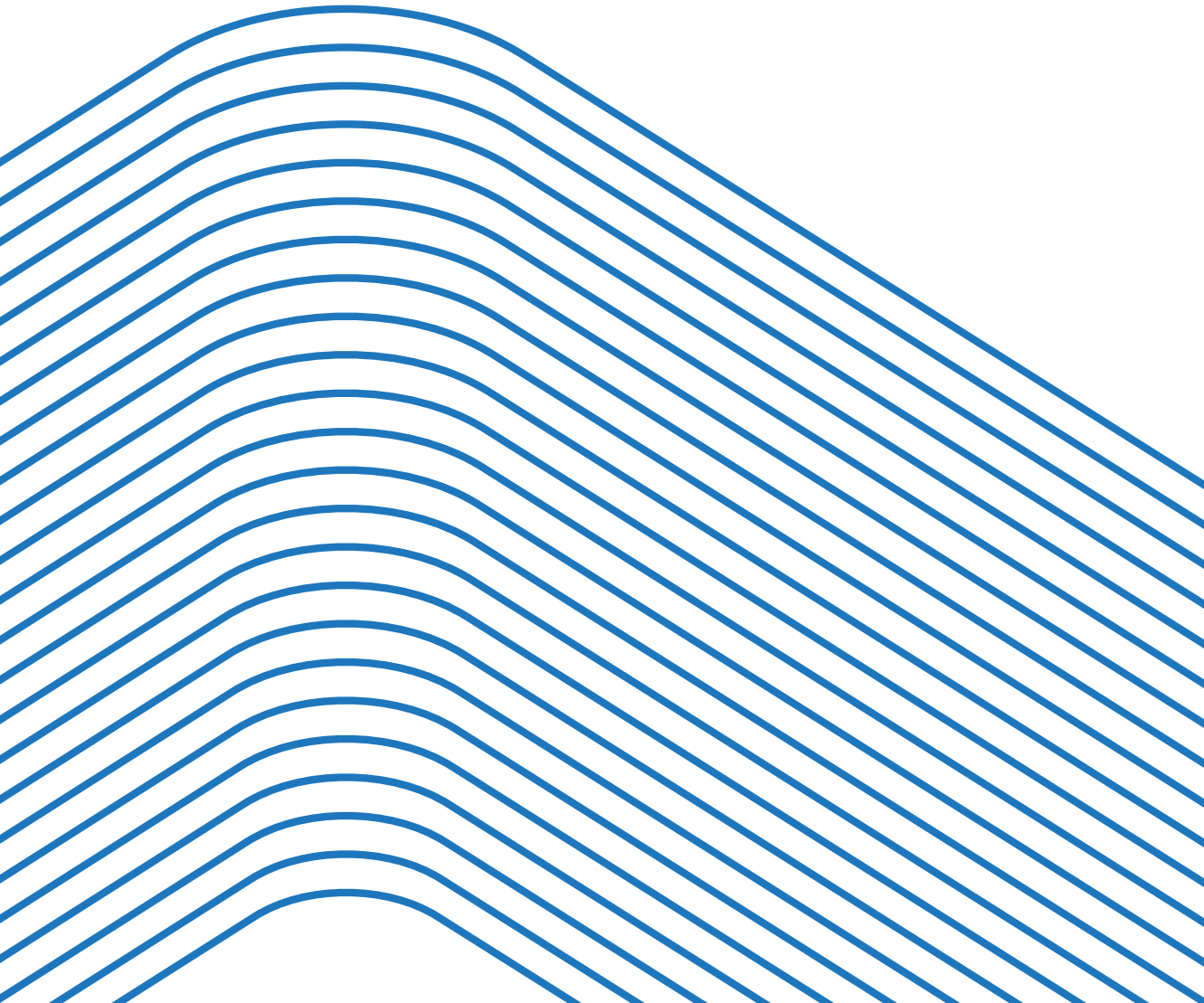


Figure 2: Administered expenditure by category



Administered assets and liabilities

Total administered assets increased to $10.3 billion, from $7.9 billion in the prior year. Cash holdings increased to $1.9 billion ($0.2 billion in 2024–25), largely attributable to the balance of the Medicare Guarantee Special Account at year end. Trade and other receivables increased to $3.8 billion ($2.5 billion in 2024–25) reflecting higher Pharmaceutical Benefits Scheme recoveries invoiced but not yet collected. Investments in portfolio entities increased to $3.0 billion ($2.8 billion in 2024–25), primarily reflecting changes in the net asset values of portfolio entities. Total administered liabilities increased to $5.2 billion ($4.7 billion in 2024–25), mainly due to increases in personal benefits liabilities, grants payable and administered provisions.



Part 4.1: Financial Statements Process

The *Public Governance, Performance and Accountability Act 2013* (PGPA Act) requires the department to prepare annual financial statements. The statements must follow the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 and Australian Accounting Standards. The Department of Finance has provided additional guidance through Resource Management Guide No.125.

In preparing the 2025–26 financial statements, we have applied professional judgement to ensure the financial statements fairly present the financial position, financial performance, and cash flows of the department.

We have aligned the format of our financial statements in 2025–26 to the primary reporting information management aid (PRIMA) issued by the Department of Finance. We have also included additional disclosures where, in the opinion of the Chief Financial Officer, these disclosures add value for the reader.

Our quality assurance framework applied to the financial statements includes independent advice from the Audit and Risk Committee to the Secretary on the preparation and review of the financial statements. The Financial Statements Sub-Committee oversees the comprehensive program of work supporting the preparation of financial statements.

The Australian National Audit Office audited the financial statements.

The colour coding in these statements intends to help the reader. Grey shaded items are items that the department administers on behalf of the government, unshaded items are departmental in nature and accounting policy has a blue background.

Part 4.2: 2025-26 Financial Statements

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Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Ageing

Opinion

In my opinion, the financial statements of the Department of Health, Disability and Ageing (the Entity) for the year ended 30 June 2026:

(a) comply with Australian Accounting Standards – Simplified Disclosures and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Entity as at 30 June 2026 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following as at 30 June 2026 and for the year then ended:

- Statement by the Accountable Authority and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement;
- Administered Schedule of Comprehensive Income;
- Administered Schedule of Assets and Liabilities;
- Administered Reconciliation Schedule;
- Administered Cash Flow Statement; and
- Notes to the financial statements, comprising material accounting policy information and other explanatory information.

Basis for opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Entity in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and their delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial statements of the current period. These matters were addressed in the context of my audit of the financial statements as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

GPO Box 707, Canberra ACT 2601
38 Sydney Avenue, Forrest ACT 2603
Phone (02) 6203 7300

Key audit matter	How the audit addressed the matter
Accuracy of personal benefits *Refer to Note 2.1B 'Personal benefits'* I considered the accuracy of personal benefits related to private health insurance, medical services, and pharmaceuticals and pharmaceutical services to be a key audit matter because these payments are: • calculated by multiple, complex information technology systems; and • based on the information provided by the recipients and may be significantly impacted by delays in recipients providing correct or updated information and/or the provision of incorrect information resulting in invalid payments. During the 2025-26 financial year, the Entity recognised personal benefits expenses of $74.9 billion.	I applied the following audit procedures to address this key audit matter: • tested the design, implementation and operating effectiveness of key business processes, controls and information technology systems related to the accurate calculation and processing of payments; • assessed the design, implementation and operating effectiveness of internal controls related to the accreditation and registration of medical providers and pharmacies; • evaluated the quality assurance and compliance processes within the Entity that support the integrity of payments; and • assessed, for a sample of benefits, the eligibility of the payment recipients and checked the accuracy of calculations in accordance with the requirements in relevant legislation.
Key audit matter	**How the audit addressed the matter**
Accuracy of subsidies *Refer to Note 2.1C 'Subsidies in connection with Aged care* The Entity reported $25.9 billion of subsidies in connection with aged care. I considered the accuracy of subsidies to be a key audit matter due to an increased risk of error as the payments are based on complex regulatory requirements which are calculated by complex information technology systems. In respect of the payment system, I identified weaknesses in relation to the internal controls over the information technology environment. These internal control weaknesses increased the risk that subsidies were not accurately calculated on behalf of residential aged care providers.	I performed the following procedures to address this key audit matter: • performed testing of information technology general and application controls implemented by Services Australia to process subsidies in accordance with the *Aged Care Act 1997* and the *Aged Care Act 2024*; • tested the design, implementation and operating effectiveness of internal controls related to confirm payments are made in accordance with legislative requirements; • tested the accuracy of aged care subsidy payments to providers and confirmed the accuracy of calculations in accordance with the requirements in the relevant legislation; and • evaluated the quality assurance and compliance processes that support the integrity of payments.
Key audit matter	**How the audit addressed the matter**
Valuation of personal benefits' provisions *Refer to Note 5.4B 'Personal benefits' provisions'* I considered this area a key audit matter due to the significant actuarial assumptions and judgements involved in estimating the personal benefits provisions. The significant judgements relate to the amount and timing of future claims, estimating the period over	I applied the following audit procedures to address this key audit matter: • tested the accuracy and completeness of the claims data used to calculate the provision, including assessing the quality assurance processes used by the Entity to confirm the integrity of data used for estimating the provision;

which these provisions are expected to be settled by the Entity. These judgements rely on the completeness and accuracy of the underlying historical data used in the estimation process. As at 30 June 2026, the personal benefits provisions were $1.4 billion.	• evaluated the appropriateness of the methodology used to estimate the outstanding claims liabilities; • confirmed the appropriateness of the key assumptions by assessing the analysis performed by the Entity for consistency with historical payment data; • assessed the reasonableness of the results of the valuation including the explanations for the changes in the estimate; and • evaluated the appropriateness of the disclosure of the significant assumptions applied and of the uncertainties that impact the key assumptions.

Accountable Authority's responsibility for the financial statements

As the Accountable Authority of the Entity, the Secretary is responsible under the *Public Governance, Performance and Accountability Act 2013* (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Simplified Disclosures and the rules made under the Act. The Secretary is also responsible for such internal control as the Secretary determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Secretary is responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result of an administrative restructure or for any other reason. The Secretary is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the assessment indicates that it is not appropriate.

Auditor's responsibilities for the audit of the financial statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My

conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern; and

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Accountable Authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

From the matters communicated with the Accountable Authority, I determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. I describe these matters in my auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in my report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Australian National Audit Office



Carla Jago
Deputy Auditor General
Delegate of the Auditor-General

Canberra
25 September 2026

Department of Health, Disability and Ageing
Statement by the Accountable Authority and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2026 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013 (PGPA Act)*, and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Department of Health, Disability and Ageing will be able to pay its debts as and when they fall due.



Signed:

Blair Comley PSM

Secretary

Date: 25/ 9/ 2026



Signed:

David Hicks

Chief Financial Officer

Date: 25/9/2026

Statement of Comprehensive Income
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Employee benefits	1.1A	**1,072,799**	1,035,192	943,799
Suppliers	1.1B	**841,043**	883,889	841,566
Depreciation and amortisation	3.2A	**86,084**	108,578	96,193
Finance costs	1.1C	**10,259**	10,390	9,909
Impairment loss on financial instruments		**262**	404	-
Write-down and impairment of other assets	1.1D	**2,453**	22,431	1,071
Other expenses		**-**	1	-
Total expenses		**2,012,900**	2,060,884	1,892,538
Own-source revenue				
Revenue from contracts with customers	1.2A	**247,577**	235,531	250,776
Rental income	1.2B	**8,483**	5,180	-
Other revenue	1.2C	**2,899**	23,167	1,847
Total own-source revenue		**258,959**	263,877	252,623
Gains				
Other gains		**244**	8,617	953
Total gains		**244**	8,617	953
Total own-source revenue		**259,203**	272,494	253,576
Net cost of services		**(1,753,697)**	(1,788,390)	(1,638,962)
Revenue from Government	1.2D	**1,711,892**	1,744,667	1,595,909
Deficit attributable to the Australian Government		**(41,805)**	(43,723)	(43,053)
OTHER COMPREHENSIVE INCOME				
Items not subject to subsequent reclassification to net cost of services				
Changes in asset revaluation reserve (net)	3.2A	**5,084**	2,890	-
Total other comprehensive income		**5,084**	2,890	-
Total comprehensive loss attributable to the Australian Government		**(36,721)**	(40,832)	(43,053)

The above statement should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Statement of Financial Position
as at 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	3.1A	**165,414**	141,978	131,057
Trade and other receivables	3.1B	**468,383**	454,112	262,882
Other financial assets	3.1C	**5,184**	18,905	11,965
Total financial assets		**638,981**	614,995	405,904
Non-financial assets[1]				
Land and buildings	3.2A	**479,034**	536,075	492,005
Plant and equipment	3.2A	**6,884**	6,858	17,895
Computer software	3.2A	**299,876**	262,192	471,614
Other non-financial assets	3.2B	**33,307**	23,139	37,034
Total non-financial assets		**819,101**	828,264	1,018,548
Total assets		**1,458,082**	1,443,259	1,424,452
LIABILITIES				
Payables				
Suppliers	3.3A	**137,168**	127,386	116,978
Employees	3.3B	**35,992**	31,670	30,902
Other payables	3.3C	**3,369**	1,973	60,566
Total payables		**176,529**	161,029	208,446
Interest bearing liabilities				
Leases	3.4A	**448,977**	513,405	478,444
Total interest bearing liabilities		**448,977**	513,405	478,444
Provisions				
Employee provisions	4.1A	**279,601**	262,619	242,151
Other provisions	3.5A	**15,049**	12,205	12,261
Total provisions		**294,650**	274,824	254,412
Total liabilities		**920,156**	949,258	941,302
Net assets		**537,926**	494,001	483,150
EQUITY				
Contributed equity		**1,209,144**	1,129,978	1,176,546
Reserves		**48,779**	43,694	40,981
Accumulated deficit		**(719,997)**	(679,671)	(734,377)
Total equity		**537,926**	494,001	483,150

The above statement should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

1. Right-of-use assets are included in the following line items: land and buildings, and plant and equipment.

Statement of Changes in Equity
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
CONTRIBUTED EQUITY				
Opening balance as at 1 July				
Balance carried forward from previous period		**1,129,978**	976,744	1,019,361
Adjusted opening balance		**1,129,978**	976,744	1,019,361
Transaction with owners				
Contribution by owners				
Equity injection - Appropriations		**130,659**	329,246	141,628
Departmental capital budget		**15,335**	21,449	15,557
Restructuring	8.2A	**-**	102	-
Distribution to owners				
Return of capital		**(66,828)**	(197,563)	-
Total transactions with owners		**79,166**	153,234	157,185
Closing balance as at 30 June		**1,209,144**	1,129,978	1,176,546
ACCUMULATED DEFICIT				
Opening balance as at 1 July				
Balance carried forward from previous period		**(679,671)**	(628,089)	(691,324)
Adjustment for errors		**-**	875	-
Adjusted opening balance		**(679,671)**	(627,214)	(691,324)
Comprehensive income				
Deficit for the period		**(41,805)**	(43,723)	(43,053)
Total comprehensive income		**(41,805)**	(43,723)	(43,053)
Transaction with owners				
Contribution by owners				
Restructuring	8.2A	**1,719**	1,772	-
Distribution to owners				
Return of appropriation - prior year		**(240)**	(10,506)	-
Total transactions with owners		**1,479**	(8,734)	-
Closing balance as at 30 June		**(719,997)**	(679,671)	(734,377)
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		**43,694**	40,803	40,981
Comprehensive income				
Other comprehensive income		**5,085**	2,890	-
Total comprehensive income		**5,085**	2,890	-
Closing balance as at 30 June		**48,779**	43,694	40,981

Statement of Changes in Equity
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		**494,001**	389,458	369,018
Adjustment for errors		**-**	875	-
Adjusted opening balance		**494,001**	390,333	369,018
Comprehensive income				
Deficit for the period		**(41,805)**	(43,723)	(43,053)
Other comprehensive income		**5,085**	2,890	-
Total comprehensive income		**(36,720)**	(40,832)	(43,053)
Transaction with owners				
Contribution by owners				
Equity injection - Appropriations		**130,659**	329,246	141,628
Departmental capital budget		**15,335**	21,449	15,557
Restructuring	8.2A	**1,719**	1,874	-
Distributions to owners				
Return of capital		**(66,828)**	(197,563)	-
Return of appropriation - prior year		**(240)**	(10,506)	-
Total transactions with owners		**80,645**	144,500	157,185
Closing balance as at 30 June		**537,926**	494,001	483,150

The above statement should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Accounting Policy

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) and Departmental Capital Budgets (DCBs) are recognised directly in contributed equity in that year.

Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Government entity under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

Cash Flow Statement

for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Appropriations		**1,952,253**	1,892,353	1,579,559
Sale of goods and rendering of services		**271,831**	259,650	258,361
GST received		**90,632**	65,846	65,977
Sublease rental income		**8,483**	4,676	2,847
Total operating cash received		**2,323,199**	2,222,524	1,906,744
Cash used				
Employees		**1,069,447**	999,046	937,986
Suppliers		**847,931**	871,615	834,454
GST paid		**90,305**	59,118	65,977
Section 74 receipts transferred to the Official Public Account		**235,910**	248,746	-
Interest payments on lease liabilities		**10,259**	10,390	9,909
Total operating cash used		**2,253,852**	2,188,915	1,848,326
Net cash from operating activities		**69,347**	33,609	58,418
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment and intangibles		**83,006**	58,185	167,885
Total investing cash used		**83,006**	58,185	167,885
Net cash used by investing activities		**(83,006)**	(58,185)	(167,885)
FINANCING ACTIVITIES				
Cash received				
Appropriations - Equity injection		**63,924**	58,656	142,530
Appropriations - Departmental capital budget		**16,796**	19,772	15,557
Total financing cash received		**80,720**	78,428	158,087
Cash used				
Principal payments of lease liabilities		**43,625**	51,804	53,049
Total financing cash used		**43,625**	51,804	53,049
Net cash from financing activities		**37,095**	26,624	105,038
Net increase/(decrease) in cash held		**23,436**	2,049	(4,429)
Cash and cash equivalents at the beginning of the reporting period		**141,978**	139,929	135,486
Cash at the end of the period	3.1A	**165,414**	141,978	131,057

The above statement should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Administered Schedule of Comprehensive Income
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Grants	2.1A	**15,538,627**	13,825,860	13,474,943
Personal benefits	2.1B	**74,907,706**	69,534,440	74,468,867
Subsidies	2.1C	**26,103,015**	24,176,673	27,166,787
Suppliers	2.1D	**40,736,748**	2,454,401	4,629,399
Payments to corporate Commonwealth entities	2.1E	**2,750,114**	790,497	806,112
Impairment loss on financial instruments	2.1F	**190,272**	92,948	-
Write-down and impairment of assets	2.1G	**424,669**	822,673	16,529
Depreciation and amortisation		**-**	1,457	16
Other expenses		**-**	9,070	7,133
Total expenses		**160,651,151**	111,708,019	120,569,786
Income				
Revenue				
Non-taxation revenue				
Revenue from contracts with customers	2.2A	**33,582**	37,241	36,367
Special accounts revenue	2.2B	**58,206,973**	46,681,890	56,257,498
Recoveries	2.2C	**7,311,066**	7,343,024	7,383,255
Other revenue	2.2D	**396,427**	330,090	446,022
Total non-taxation revenue		**65,948,048**	54,392,245	64,123,142
Total revenue		**65,948,048**	54,392,245	64,123,142
Total income		**65,948,048**	54,392,245	64,123,142
Net cost of services		**(94,703,103)**	(57,315,774)	(56,446,644)
Deficit		**(94,703,103)**	(57,315,774)	(56,446,644)
OTHER COMPREHENSIVE INCOME				
Items not subject to subsequent reclassification to net cost services				
Changes in administered investment reserves		**160,957**	70,734	-
Restructuring	8.2B	**7,438**	2,006,732	-
Total comprehensive loss		**(94,534,708)**	(55,238,308)	(56,446,644)

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Administered Schedule of Assets and Liabilities
as at 30 June 2026

	Notes	2026 $'000	2025 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	5.1A	**1,937,327**	245,490	5,308,736
Accrued recoveries revenue	5.1B	**913,507**	1,145,533	1,120,805
Trade and other receivables	5.1C	**3,774,317**	2,455,379	985,292
Investments in portfolio entities	5.1D	**2,966,063**	2,763,523	1,079,962
Other investments	5.1E	**180,602**	190,860	-
Total financial assets		**9,771,816**	6,800,785	8,494,795
Non-financial assets				
Inventories	5.2A	**554,343**	727,780	343,747
Other non-financial assets	5.2B	**-**	413,016	1,040,694
Total non-financial assets		**554,343**	1,140,797	1,384,441
Total assets		**10,326,159**	7,941,582	9,879,236
LIABILITIES				
Payables				
Suppliers	5.3A	**215,614**	278,951	217,897
Subsidies	5.3B	**108,035**	120,681	109,249
Personal benefits	5.3C	**2,351,001**	2,184,884	2,097,519
Grants	5.3D	**427,541**	253,172	559,794
Total payables		**3,102,191**	2,837,688	2,984,459
Provisions				
Subsidies	5.4A	**690,775**	635,640	623,959
Personal benefits	5.4B	**1,394,094**	1,233,289	1,204,819
Total provisions		**2,084,869**	1,868,929	1,828,778
Total liabilities administered on behalf of Government		**5,187,060**	4,706,618	4,813,237
Net assets		**5,139,099**	3,234,964	5,065,999

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Administered Reconciliation Schedule
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000
Opening assets less liabilities as at 1 July		**3,234,964**	6,489,782
Adjusted opening assets less liabilities		**3,234,964**	6,489,782
Net cost of services			
Income		**65,948,048**	54,392,245
Expenses			
Payments to entities other than corporate Commonwealth entities		**(157,901,037)**	(110,917,522)
Payments to corporate Commonwealth entities		**(2,750,114)**	(790,497)
Other comprehensive income			
Revaluations transferred to reserves		**160,957**	70,734
Restructuring	8.2B	**7,438**	2,006,732
Transfers (to)/from the Australian Government			
Appropriation transfers from Official public Account (OPA)			
Administered assets and liabilities appropriations			
Payments to entities other than corporate Commonwealth entities		**73,190**	84,974
Payments to corporate Commonwealth entities		**22,949**	46,128
Annual appropriations			
Payments to entities other than corporate Commonwealth entities		**54,043,485**	14,584,511
Payments to corporate Commonwealth entities		**2,750,114**	790,497
Special appropriations (limited)			
Refund of receipts (section 77 of the PGPA Act)		**1,228**	1,926
Special appropriations (unlimited)			
Payments to entities other than corporate Commonwealth entities		**46,205,928**	43,172,371
Net GST appropriations		**(18,332)**	13,734
Appropriation transfers to OPA			
Transfers to OPA		**(6,639,719)**	(6,710,651)
Closing assets less liabilities as at 30 June		**5,139,099**	3,234,964

The above schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Accounting Policy

Administered Cash Transfers to and from the Official Public Account

Revenue collected by the Department for use by the Government rather than the Department is administered revenue. Collections are transferred to the OPA maintained by the Department of Finance. Conversely, cash is drawn from the OPA to make payments under Parliamentary appropriation on behalf of the Government. These transfers to and from the OPA are adjustments to the administered cash held by the Department on behalf of the Government and reported as such in the schedule of administered cash flows and in the administered reconciliation schedule.

Administered Cash Flow Statement
for the period ended 30 June 2026

	Notes	2026 $'000	2025 $'000
OPERATING ACTIVITIES			
Cash received			
Recoveries		**5,958,929**	5,831,931
GST received		**1,062,286**	944,139
Special accounts receipts		**58,206,973**	46,681,890
Other		**435,379**	365,127
Total operating cash received		**65,663,567**	53,823,086
Cash used			
Grants		**16,431,773**	14,675,845
Subsidies		**25,990,356**	24,222,508
Personal benefits		**74,580,784**	69,760,065
Suppliers		**40,638,300**	2,186,190
Payments to corporate Commonwealth entities		**2,750,114**	790,497
Total operating cash used		**160,391,327**	111,635,105
Net cash used by operating activities		**(94,727,760)**	(57,812,018)
INVESTING ACTIVITIES			
Cash received			
Repayments of advances and loans		**12,077**	18,348
Total cash received		**12,077**	18,348
Cash used			
Equity injections to corporate Commonwealth entities		**22,950**	46,128
Investments		**8,375**	9,285
Total investing cash used		**31,325**	55,413
Net cash used by investing activities		**(19,248)**	(37,065)
Net decrease in cash held		**(94,747,008)**	(57,849,083)
FINANCING ACTIVITIES			
Cash from Official Public Account			
Appropriations		**103,000,756**	58,549,305
Capital appropriations		**96,139**	131,102
Administered GST appropriations		**1,069,591**	981,571
Total cash from Official Public Account		**104,166,486**	59,661,978
Cash to Official Public Account			
Return of GST appropriations to the Official Public Account		**1,087,922**	967,837
Other		**6,639,719**	6,710,651
Total cash to Official Public Account		**7,727,641**	7,678,488
Cash and cash equivalents at the beginning of the reporting period		**245,490**	6,111,083
Cash at the end of the period	5.1A	**1,937,327**	245,490

This schedule should be read in conjunction with the accompanying notes.

The balances and movements detailed are rounded which may result in discrepancies between totals and the sum of components.

Overview

Objectives of Department of Health, Disability and Ageing

The Department is a not-for-profit Australian Government controlled entity with its principal place of business located at Furzer Street, Phillip ACT. The objective of the Department is to develop and deliver evidence-based policy, well-targeted programs, and best practice regulation to achieve better health and wellbeing for all Australians, now and for future generations.

As at 30 June 2026 the Department was structured to meet the following outcomes:

Outcome 1: Health Policy, Access and Support
Outcome 2: Individual Health Benefits
Outcome 3: Ageing and Aged Care
Outcome 4: Disability and Carers

The continued existence of the Department in its present form and with its present programs is dependent on Government policy and on continuing funding by Parliament for the Department's administration and outcomes.

The Department's activities contributing toward these outcomes are classified as either departmental or administered.

Departmental activities involve the use of assets, liabilities, income and expenses controlled or incurred by the Department in its own right. Administered activities involve the management or oversight by the Department on behalf of the Government, of items controlled or incurred by the Government.

The Department is responsible for the following administered activities on behalf of the Government:

a) payment of subsidies for residential, aged care and community programs,
b) payment of personal benefits for Medicare and pharmaceutical services as well as for affordability and choice of health care initiatives,
c) payment of grants, with the majority of these made to not-for-profit organisations, and
d) payments to National Disability Insurance Agency in connection with participant plans.

Impact of Restructuring 2025-26

Administrative Arrangements Order of 13 May 2025

The Administrative Arrangements Order (AAO) was re-issued on 13 May 2025. In response:

- The Department was renamed to the Department of Health, Disability and Ageing,
- Responsibility for the disability and carers function, which supports the independence of, and economic participation by people with disability and carers by providing targeted support, was transferred to the Department from the Department of Social Services (DSS), and
- Responsibility for the sport and recreation policy and functions was transferred from the Department to the Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts (DITRDCSA).

Administered investments assets were transferred during 2024-25. The remaining transfers of assets, liabilities, employees and funding occurred during 2025-26 in order to align with determinations made under section 72 of the *Public Service Act 1999* to move staff between agencies, and under section 75 of the *Public Governance, Performance and Accountability Act 201*3 to transfer appropriation funding between agencies.

Transfers of associated departmental and administered assets and liabilities took effect as at 3 July 2025 for the DITRDCSA Machinery of Government change (MoG) and 31 July 2025 for the DSS MoG. Additionally, Sport and Recreation Special Account was transferred to DITRDCSA effective 1 September 2025.

Details of assets and liabilities transferred in both financial years to effect this MoG change are included in note 8.2.

Establishment of the Australian Centre for Disease Control

The Australian Centre for Disease Control (CDC) was established as an agency within the Health, Disability and Ageing portfolio effective 1 January 2026 following the passage of the *Australian Centre for Disease Control Act 2025*.

Responsibility for the key public health functions, including communicable disease surveillance, pandemic preparedness, human biosecurity and health protection, and environmental health, was transferred from the interim CDC within the Department to the CDC during 2025-26.

Transfers of employees and the associated employee provisions and funding occurred under section 72 of the *Public Service Act 1999* to move staff between agencies, and under section 75 of the *Public Governance, Performance and Accountability Act 201*3 to transfer appropriation funding between agencies.

Details of assets and liabilities transferred in both financial years to effect this MoG change are included in note 8.2.

The Basis of Preparation

The financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

The financial statements have been prepared in accordance with the:

a) *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015* (FRR), and
b) Australian Accounting Standards and Interpretations – including simplified disclosures for Tier 2 Entities under AASB 1060 *General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-For-Profit Tier 2 Entities* issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian dollars.

Items of a similar nature, together with disclosure of the relevant accounting policy, are grouped together in the notes to the financial statements.

The Department's financial statements include the financial records of the departmental special accounts, the Therapeutic Goods Administration (TGA), the Office of the Gene Technology Regulator (OGTR) and the Australian Industrial Chemicals Introduction Scheme (AICIS).

All transactions between the departmental ledgers have been eliminated from the departmental financial statements.

Comparative figures have been adjusted, where required, to conform to changes in presentation of the financial statements in the current year.

New Accounting Standards

Adoption of new Australian accounting standards requirements

The Department adopted all new, revised and amending standards and interpretations that were issued by the AASB prior to the sign-off date and are applicable to the current reporting period. The adoption of these standards and interpretations did not have a material effect, and are not expected to have a future material effect on the Department’s financial statements.

No accounting standard has been adopted earlier than the application date as stated in the standard.

Taxation

The Department is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office.

Reporting of Administered Activities

Administered revenues, expenses, assets, liabilities and cash flows are disclosed in the administered schedules and related notes.

Except where otherwise stated, administered items are accounted for on the same basis and using the same policies as for departmental items, including the application of Australian Accounting Standards.

Events After the Reporting Period

Transition of COVID vaccines to the National Immunisation Program

From 1 October 2026 responsibility for COVID vaccinations will transfer to the State and Territory Governments. Any COVID vaccines inventory still held by the Department as at 30 September 2026 will be transferred to the State and Territory Governments at book value.

Financial Performance

This section analyses the financial performance of the Department for the year ended 2026.

1.1 Expenses

	2026 $'000	2025 $'000
1.1A: Employee benefits		
Wages and salaries	**756,426**	725,997
Superannuation		
Defined contribution plans	**108,617**	102,173
Defined benefit plans	**42,224**	43,358
Leave and other entitlements	**162,813**	161,791
Separation and redundancies	**2,719**	1,874
Total employee benefits	**1,072,799**	1,035,192

Accounting Policy

Accounting policies for employee related expenses are contained in the 'People and Relationships' section.

1.1B: Suppliers		
Goods and services supplied or rendered		
Contractors and consultants	**293,943**	287,121
IT services	**228,564**	189,414
Contracted services	**201,424**	282,950
Property	**23,143**	19,858
Travel	**13,030**	14,498
Training and other staff related expenses	**7,609**	8,237
Legal	**14,348**	13,969
Committees	**5,752**	4,405
Other	**44,204**	55,383
Total goods and services supplied or rendered	**832,017**	875,834
Goods supplied	**67,347**	75,240
Services rendered	**764,670**	800,594
Total goods and services supplied or rendered	**832,017**	875,834
Other suppliers		
Workers compensation expenses	**7,912**	6,625
Short-term leases	**166**	757
Low value leases	**766**	490
Variable lease payments	**182**	183
Total other suppliers	**9,026**	8,055
Total suppliers	**841,043**	883,889

The Department has 2 short-term lease commitments as at 30 June 2026 (2025: Nil).

The above lease disclosures should be read in conjunction with accompanying notes 1.2B, 3.2A and 3.4A.

Accounting Policy

Short-term leases and leases of low value assets

The Department has elected not to recognise right-of-use assets and lease liabilities for short-term leases of assets that have a lease term of 12 months or less and leases of low value assets (less than $10,000). The Department recognises the lease payments associated with these leases as an expense on a straight-line basis over the lease term.

	2026	2025
	$'000	$'000
1.1C: Finance costs		
Interest on lease liabilities	**10,259**	10,390
Total finance costs	**10,259**	10,390

The above lease disclosures should be read in conjunction with the accompanying notes 3.2A and 3.4A.

Accounting Policy

All borrowing costs are expensed as incurred.

1.1D: Write-down and impairment of other assets		
Impairment of plant and equipment, and land and buildings	**1,034**	841
Impairment of intangible assets	**1,419**	21,591
Total write-down and impairment of assets	**2,453**	22,431

1.2 Own-Source Revenue and Gains

	2026	2025
	$'000	$'000
Own-Source Revenue		
1.2A: Revenue from contracts with customers		
Rendering of services	**247,577**	235,531
Total revenue from contracts with customers	**247,577**	235,531
Disaggregation of revenue from contracts with customers		
Activity / service line:		
Annual charges / licence fees	**127,087**	115,681
Application fees	**33,667**	32,672
Evaluation / assessment fees	**54,511**	57,812
Service delivery	**32,312**	29,365
	247,577	235,531
Timing of transfer of goods and services:		
Over time	**197,120**	191,918
Point in time	**50,457**	43,613
	247,577	235,531

Accounting Policy

Revenue

Revenue from the sale of goods and rendering of services is recognised when control has been transferred to the customer.

In relation to AASB 15 *Revenue from Contracts with Customers*, the Department has considered each revenue stream to identify the existence of an enforceable contract that requires the completion of sufficiently specific performance obligations in exchange for relevant consideration. If so, revenue is recognised either over time or at a point in time as performance obligations are completed and the Department has an enforceable right to payment for the performance completed to date.

Revenue items that are akin to a Non-Intellectual Property (Non-IP) licence in that they provide the customer with the right to perform an activity that they otherwise would not be entitled to perform are accounted for in accordance with AASB 15. For those activities where the charge relates to a period of 12 months or less, the expedients as they apply to short-term licences have been applied.

Revenue items not meeting the requirements of AASB 15 have been considered under AASB *1058 Income of Not-for-Profit Entities*. These transactions include those where the Department acquires or receives an asset (including cash) in exchange for consideration that is significantly less than fair value. Examples include cash grants and levies and fees received by the Department to further their objectives. Recognition occurs when the Department becomes entitled to the asset.

The principal activities from which the Department generates its revenue relate to:

a) The cost recovery activities of the Therapeutic Goods Administration (TGA). These cover the registration and listing of medicines and inclusion of medical devices, including in vitro diagnostic devices, and biologicals onto the Australian Register of Therapeutic Goods (ARTG) and the ongoing maintenance and surveillance of them.

b) Regulatory activities associated with the scientific assessment of new and existing industrial chemicals, monitoring and enforcement of statutory obligations under the *Industrial Chemicals Act* 2019, maintenance of the Australian Inventory of Chemical Substances, and implementing Australia's obligations under international arrangements relevant to industrial chemicals, and

c) The recovery of costs by the Department for the provision of corporate services provided to portfolio agencies.

The transaction price is the total amount of consideration to which the Department expects to be entitled in exchange for transferring promised goods or services to a customer. The consideration promised in a contract with a customer may include fixed amounts, variable amounts, or both.

Receivables for goods and services, which have 30 days terms (TGA: 28 days), are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at the end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

TGA special account annual charges

On 1 July 2015 the TGA introduced the Annual Charges Exemption (ACE) scheme to provide relief from annual charges until a product on the ARTG commences generating turnover. Sponsors of an entry on the ARTG (excluding export only entries) which meet the legislated criteria for exemption during a particular financial year will have until 22 July of the following year to apply for an exemption from the annual charges.

To be exempt from annual charges under the ACE scheme, an entry must meet the following criteria:

(i) the entry was new in the ARTG during the financial year, or

(ii) the entry was an existing ARTG entry on 1 July, the entry was qualified for ACE in the financial year, and a declaration of $0 turnover was made in relation to that financial year, and

(iii) the entry (whether a new or existing entry) did not commence generating turnover.

Sponsors who inadvertently fail to make a declaration of $0 turnover for an ACE entry during the declaration period 1 July to 22 July, may submit a late declaration between 23 July and 15 September of a financial year.

Under this scheme, some of the charges in respect of a financial year may not be known until the following year. While there is some resulting uncertainty in the revenue calculation for any given financial year, the uncertainty is reducing as the scheme progresses and annual data is accumulated. An estimate of the value of the exemptions is incorporated in each year's annual charges revenue.

	2026	2025
	$'000	$'000
1.2B: Rental income		
Subleasing right-of-use assets	**8,483**	5,180
Total rental income	**8,483**	5,180

The above lease disclosures should be read in conjunction with the accompanying notes 1.1B, 3.2A and 3.4A.

1.2C: Other revenue		
Resources received free of charge		
Remuneration of auditors	**1,300**	1,300
Comcover premium offset	**831**	1,039
Recovery of costs	**731**	20,824
Other revenue	**37**	3
Total other revenue	**2,899**	23,167

Accounting Policy

Resources Received Free of Charge

Resources received free of charge are recognised as revenue when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense. Resources received free of charge are recorded as either revenue or gains depending on their nature.

	2026	2025
	$'000	$'000
1.2D: Revenue from Government		
Appropriations		
Departmental appropriations	**1,711,892**	1,744,667
Total revenue from government	**1,711,892**	1,744,667

Accounting Policy

Revenue from Government

Amounts appropriated for departmental appropriations for the financial year (adjusted for any formal additions and reductions) are recognised as Revenue from Government when the entity gains control of the appropriation, except for certain amounts which relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned. Appropriations receivable are recognised at their nominal amounts.

Income and Expenses Administered on Behalf of Government

This section analyses the activities the Department does not control but administers on behalf of the Government. Unless otherwise noted, the accounting policies adopted are consistent with those applied for departmental reporting.

2.1 Administered – Expenses

	2026 $'000	2025 $'000
2.1A: Grants		
Public sector		
Australian Government entities (related parties)	**1,355,428**	1,223,643
Private sector		
Profit and Not-for-profit organisations	**14,183,199**	12,602,217
Total grants	**15,538,627**	13,825,860

Comparative figures have been updated to include a number of primary care practice incentives programs reclassified from personal benefits to grants in the current year. The reclassification increased comparative figures by $440.368m.

Accounting Policy

The Department administers a number of grant schemes on behalf of the Government. Grant liabilities (and expenses) are recognised to the extent that:

(i) the services required to be performed by the grantee have been performed, or

(ii) the grant eligibility criteria have been satisfied, but payments due have not been made. Settlement is made according to the terms and conditions of each grant. This is usually within 30 days of performance or eligibility.

When the Government enters into an agreement to make these grants and services, but services have not been performed or criteria satisfied, this is considered a commitment.

2.1B: Personal benefits		
Direct		
Private health insurance	**7,651,067**	7,379,969
Other	**6,676**	8,440
Indirect		
Medical services	**35,570,447**	32,872,892
Pharmaceuticals and pharmaceutical services	**21,164,885**	19,703,758
Hearing services	**589,833**	562,462
Targeted assistance	**124,576**	119,043
Aged care	**9,648,800**	8,778,113
Other	**151,422**	109,762
Total personal benefits	**74,907,706**	69,534,440

Comparative figures have been updated to exclude a number of primary care practice incentives programs reclassified from personal benefits to grants in the current year. The reclassification reduced comparative figures by $440.368m.

Accounting Policy

Personal benefits are the current transfers for the benefit of individuals or households, directly or indirectly, that do not require any economic benefit to flow back to Government. The Department administers a number of personal benefits programs on behalf of Government that provide a range of health care entitlements to individuals. These include, but are not limited to:

a) pharmaceutical benefits (the primary means through which the Australian Government ensures Australians have timely access to pharmaceuticals, including COVID-19 vaccines),

b) medical benefits (provide high quality and clinically relevant medical and associated services through Medicare),

c) private health insurance rebate (help make private health insurance more affordable, provides greater choice and accessibility to private health care options, and reduces pressure on the public health system),

d) targeted assistance (support the provision of relevant pharmaceuticals, aids and appliances),

e) hearing services (reduce the incidence and consequences of avoidable hearing loss in the community by providing access to high quality hearing services and devices), and

f) home care and support at home (provide aged care packages designed to help older Australians live independently at home through tailored clinical care, independence support and everyday services).

Personal benefits are assessed, determined and paid by Services Australia in accordance with provisions of the relevant legislation under delegation from the Department. In the majority of cases the above payments are initially based on the information provided by customers and providers. Both the Department and Services Australia have established review mechanisms to identify overpayments made under the various schemes. The recognition of receivables and recovery actions take place once overpayments are identified.

	2026	2025
	$'000	$'000
2.1C: Subsidies		
Subsidies in connection with		
Aged care	**25,875,543**	24,004,568
Medical indemnity	**175,636**	143,722
Other	**51,836**	28,383
Total subsidies	**26,103,015**	24,176,673

Accounting Policy

The Department administers a number of subsidy schemes on behalf of the Government. Subsidies expenses and corresponding liabilities are recognised to the extent that (i) the services required to be performed by the recipient have been performed; or (ii) the eligibility criteria have been satisfied, but payments due have not been made.

2.1D: Suppliers		
Goods and services supplied or rendered		
Consultants	**63,832**	67,941
Contract for services	**2,354,131**	2,261,243
Payments to National Disability Insurance Agency[1]	**38,216,437**	-
Travel	**1,938**	1,323
Inventory consumed	**46**	218
Communications and publications	**38,823**	14,334
Committee related expenses	**5,404**	5,838
Other	**56,137**	103,505
Total goods and services supplied or rendered	**40,736,748**	2,454,401
Goods supplied	**118,832**	123,147
Services rendered	**40,617,916**	2,331,254
Total goods and services supplied or rendered	**40,736,748**	2,454,401

1. Payments to the National Disability Insurance Agency are for the cost of participant plans funded under the National Disability Insurance Scheme during the year.

	2026	2025
	$'000	$'000
2.1E: Payments to corporate Commonwealth entities		
Australian Digital Health Agency	**305,605**	286,896
Australian Institute of Health and Welfare	**36,187**	36,489
Australian Sports Commission	**-**	449,257
Food Standards Australia New Zealand	**17,824**	17,855
National Disability Insurance Agency	**2,390,498**	-
Total payments to corporate commonwealth entities	**2,750,114**	790,497

Accounting Policy

Payments to corporate Commonwealth entities from amounts appropriated for that purpose are classified as administered expenses, equity injections or loans to the relevant portfolio entity. The appropriation to the Department is disclosed in Note 6.1A.

2.1F: Impairment loss on financial instruments		
Impairment of trade and other receivables	**190,272**	92,948
Total impairment loss on financial instruments	**190,272**	92,948

2.1G: Write-down and impairment of assets		
Impairment due to the write-off of inventory	**267,697**	626,531
Impairment due to the write-off of prepayments	**156,972**	196,142
Total write-down and impairment of assets	**424,669**	822,673

2.2 Administered – Income

	2026 $'000	2025 $'000
Revenue		
Non-Taxation Revenue		
2.2A: Revenue from contracts with customers		
Rendering of services	**33,582**	37,241
Total revenue from contracts with customers	**33,582**	37,241
Disaggregation of revenue from contracts with customers		
Activity / Service line		
Evaluation / assessment fees	**18,792**	22,266
Application fees	**9,175**	10,321
Listing fees / annual charges	**5,615**	3,721
Recovery of costs	**-**	932
	33,582	37,241
Timing of transfer of goods and services		
Over time	**25,492**	29,681
Point in time	**8,090**	7,560
	33,582	37,241
2.2B: Special accounts revenue		
Medical Guarantee Fund (Health) special account	**57,541,247**	46,000,000
Medical Research Future Fund special account	**650,000**	650,000
Other special accounts	**15,726**	31,890
Total special accounts revenue	**58,206,973**	46,681,890
2.2C: Recoveries		
Medical and pharmaceutical benefits and health rebate schemes	**218,978**	71,689
Pharmaceutical Benefit Scheme (PBS) drug recoveries	**6,726,439**	6,764,176
Aged care recoveries, cross-billings and budget neutrality adjustments	**365,471**	507,063
Other	**178**	96
Total recoveries	**7,311,066**	7,343,024
2.2D: Other revenue		
Levies	**13,321**	11,426
Interest from loans	**6,621**	7,133
Dividends	**11,405**	-
Recovery of unspent grant funding	**156,429**	148,240
Debts due to the Commonwealth	**58,907**	67,333
Other revenue	**149,744**	95,958
Total other revenue	**396,427**	330,090

Accounting Policy

All administered revenues are revenues related to the course of ordinary activities performed by the Department on behalf of the Australian Government. As such, administered appropriations are not revenues of the individual entity that oversees distribution or expenditure of the funds as directed.

Special accounts revenue is recognised when the Department gains control of the relevant amounts.

Financial Position

This section analyses the Department's assets used to conduct its operations and the operating liabilities incurred as a result. Employee related information is disclosed in the People and Relationships section.

3.1 Financial Assets

	2026 $'000	2025 $'000
3.1A: Cash and cash equivalents		
Cash in special accounts	**162,460**	140,376
Cash on hand or on deposit	**2,954**	1,602
Total cash and cash equivalents	**165,414**	141,978

Accounting Policy

Cash is recognised at its nominal amount. Cash and cash equivalents includes:

a) cash on hand, and

b) cash in special accounts, which includes amounts that are banked in the Australian Government's Official Public Account or held in a bank account.

	2026 $'000	2025 $'000
3.1B: Trade and other receivables		
Goods and services receivable		
Goods and services	**17,814**	15,500
GST receivables from the Australian Taxation Office	**8,264**	8,591
Total goods and services receivables	**26,078**	24,091
Appropriations receivable		
Appropriations receivable	**445,493**	433,925
Total appropriations receivable	**445,493**	433,925
Total trade and other receivables (gross)	**471,571**	458,016
Less expected credit loss allowance	**(3,188)**	(3,904)
Total trade and other receivables (net)	**468,383**	454,112

Credit terms for goods and services were: the Department – within 30 days (2025: 30 days), the TGA – within 28 days (2025: 28 days).

Accounting Policy

Trade receivables, loans and other receivables that are held for the purpose of collecting the contractual cash flows where the cash flows are solely payments of principal and interest that are not provided at below-market interest rates, are subsequently measured at amortised cost using the effective interest method adjusted for any credit loss allowance.

Appropriations receivable are appropriations controlled by the Department but held in the Official Public Account under the Government's just-in-time drawdown arrangements. Appropriations receivable are recognised at their nominal amounts.

Trade and other receivable assets at amortised cost are assessed for impairment at the end of each reporting period. The simplified approach has been adopted in measuring the impairment allowance at an amount equal to lifetime Expected Credit Losses.

	2026	2025
	$'000	$'000
3.1C: Other financial assets		
Contract assets	**5,184**	18,905
Total other financial assets	**5,184**	18,905

The contract assets from contracts with customers are associated with the activities outlined in detail at Note 1.2A.

Refer to Note 3.3A for information relating to contract liabilities.

3.2 Non-Financial Assets

3.2A: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment and Intangibles

Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment and Intangibles for 2026

	Land and Buildings[3,4,5]	Plant and Equipment	Computer Software	Total
	$'000	$'000	$'000	$'000
As at 1 July 2025				
Gross book value	821,155	7,171	587,231	1,415,557
Accumulated depreciation and impairment	(285,080)	(313)	(325,039)	(610,432)
Total as at 1 July 2025	536,075	6,858	262,192	805,125
Additions:				
By purchase	14,746	1,095	-	15,841
Internally developed	-	-	67,381	67,381
Right-of-use assets	3,359	-	-	3,359
Acquisition of entities or operations (including restructuring)	16,888	186	-	17,074
Revaluations and impairments recognised in other comprehensive income	4,909	175	-	5,084
Impairments recognised in net cost of services	(1,028)	(6)	(1,419)[2]	(2,453)
Depreciation and amortisation	(9,766)	(1,408)	(28,278)	(39,452)
Depreciation on right-of-use assets	(46,616)	(16)	-	(46,632)
Disposals	28	-	-	28
Other movements right-of-use assets	(39,561)	-	-	(39,561)
Total as at 30 June 2026	479,034	6,884	299,876[1]	785,794
Total as at 30 June 2026 represented by:				
Gross book value	757,250	8,162	650,013	1,415,425
Accumulated depreciation/amortisation and impairment	(278,216)	(1,278)	(350,137)	(629,631)
Total as at 30 June 2026	479,034	6,884	299,876	785,794
Carrying amount of right-of-use assets	378,590	69	-	378,659

1. The carrying amount of computer software of $299.9m relates entirely to internally developed software (IDS). Of the total computer software balance at 30 June 2026, $171.1m relates to IDS currently under development (2025: $142.5m).

2. The IDS impairment figure of $1.4m relates entirely to the Core Department.

3. In 2026 the carrying amount of land and buildings included $21.8m (2025: $35.1m) which relates to expenditure incurred in the course of construction.

4. $78.7m (2025: $87m) of total leasehold improvements refers to fit out assets which may not be disposed of without prior Ministerial approval.

5. No land and buildings (fit out) is expected to be disposed of within the next 12 months.

Revaluations of non-financial assets

Revaluations were conducted in accordance with the revaluation policy stated at Note 7.4. The last full revaluation was undertaken as at 30 June 2024 by an independent valuer (Jones Land LaSalle Public Sector valuations Pty Ltd (JLL)). A materiality review was conducted for the purpose of 2025-26 reporting.

Contractual commitments for the acquisition of property, plant, equipment and intangible assets

In 2026, the Department had no significant contractual commitments (2025: Nil) for the acquisition of property, plant, equipment and intangibles.

Accounting Policy

Acquisition of assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they are recognised in the transferor's accounts, immediately prior to the restructuring.

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases costing less than $500 (TGA: $2,000), leasehold improvements costing less than $50,000 (TGA: $10,000), and all other purchases costing less than $2,000, which are expensed in the year of acquisition (other than when they form part of a group of similar items which are material in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in property leases taken up by the Department where there exists an obligation to restore the property to its original condition. These costs are included in the value of the Department's leasehold improvements with a corresponding provision for restoration recognised.

Leased right-of-use (ROU) assets

Leased ROU assets are capitalised at the commencement of the lease and comprise of the initial lease liability amount, initial direct costs incurred when entering into the lease less any lease incentives received. These assets are accounted for by the Department as separate asset classes to corresponding assets owned outright, but included in the same column as where the corresponding underlying assets would be presented if they were owned.

On initial adoption of AASB 16 *Leases*, the Department has adjusted the ROU assets at the date of initial application by the amount of any provision for onerous leases recognised immediately before the date of initial application. Following initial application, an impairment review is undertaken for any ROU asset that shows indicators of impairment, and an impairment loss is recognised against any ROU asset that is impaired. Lease ROU assets continue to be measured at cost after initial recognition in the Department's financial statements.

Revaluations

Following initial recognition at cost, property, plant and equipment (excluding ROU assets) are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not differ materially from the assets' fair values at the reporting date. The regularity of independent valuations depends upon the volatility of movements in market values for the relevant assets.

The most recent independent valuation of all property, plant and equipment was carried out by JLL as at 30 June 2024. In 2026 a materiality review was conducted as at 30 June 2026. These reviews included qualitative, quantitative and uncertainty analysis.

When required, revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of Asset Revaluation Reserve except to the extent that it reversed a previous revaluation decrement of the same class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset is restated to the revalued amount.

Depreciation

Depreciable property, plant and equipment assets are written off to their estimated residual values over their estimated useful lives to the Department using, in all cases, the straight-line method of depreciation. Leasehold improvements are depreciated on a straight-line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease, including any applicable lease extension options available.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are made in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

a) buildings on freehold land: 20 to 25 years (2025: 20 to 25 years)

b) leasehold improvements: Lesser of useful life or lease term.

c) plant and equipment: 3 to 20 years (2025: 3 to 20 years), and

d) right-of-use assets: Lesser of useful life or lease term.

Impairment

All assets were assessed for impairment as at 30 June 2026. Where indicators of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs of disposal and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the entity were deprived of the asset, its value is taken to be its depreciated replacement cost.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

Intangibles

The Department's intangibles comprise internally developed software (for internal use) and purchased software. These assets are carried at cost less accumulated amortisation and accumulated impairment losses. The Department recognises internally developed software costing more than $100,000 and purchased software costing more than $500 (TGA: $100,000).

Software is amortised on a straight-line basis over its anticipated useful life.

The useful lives of the Department's software assets are:

a) internally developed software: 2 to 10 years (2025: 2 to 10 years), and

b) purchased software: 2 to 7 years (2025: 2 to 7 years).

All software assets were assessed for indications of impairment as at 30 June 2026.

	2026	2025
	$'000	$'000
3.2B: Other non-financial assets		
Prepayments	**33,307**	22,977
Investment in sublease	**-**	163
Total other non-financial assets	**33,307**	23,139
Other non-financial assets expected to be recovered		
No more than 12 months	**33,307**	23,139
Total other non-financial assets	**33,307**	23,139

No indicators of impairment were found for other non-financial assets.

3.3 Payables

	2026	2025
	$'000	$'000
3.3A: Suppliers		
Trade creditors and accruals	**98,703**	97,391
Contract liabilities	**38,465**	29,994
Total suppliers	**137,168**	127,386

The payment terms for goods and services were 20 calendar days from the receipt of a correctly rendered invoice (2025: 20 days).

Contract liabilities are primarily associated with unearned income related to the activities outlined in detail at Note 1.2A. Timeframes for the satisfaction of performance obligations are primarily in line with the legislative requirements associated with the various revenue streams and can range from 15 up to 351 days.

Refer to Note 3.1C for information relating to contract assets.

3.3B: Employees		
Wages and salaries	**28,770**	25,214
Superannuation	**7,222**	6,456
Total employees	**35,992**	31,670

3.3C: Other payables		
Other	**3,369**	1,973
Total other payables	**3,369**	1,973

3.4 Interest Bearing Liabilities

	2026	2025
	$'000	$'000
3.4A: Leases		
Lease liabilities	**448,977**	513,405
Total leases	**448,977**	513,405

Total cash outflow for leases for the year ended 30 June 2026 was $53.9m (2025: $62.2m).

The Department has a geographically dispersed lease portfolio related to property leases which are typically long term and contain both extension options and regular increases in rent, usually on the anniversary of the commencement date, for either a fixed amount or based on a market review as required by the contract.

Maturity analysis - contractual undiscounted cash flows		
Within 1 year	**53,942**	52,937
Between 1 to 5 years	**274,588**	268,603
More than 5 years	**169,718**	226,245
Total undiscounted leases	**498,248**	547,785
Discount	**(49,271)**	(34,380)
Total leases	**448,977**	513,405

The above lease disclosures should be read in conjunction with the accompanying notes 1.1B, 1.2B and 3.2A.

Accounting Policy

For all new contracts entered into, the Department considers whether the contract is, or contains a lease. A lease is defined as 'a contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration'.

Once it has been determined that a contract is, or contains a lease, the lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease, if that rate is readily determinable, or otherwise the Department's incremental borrowing rate is used. The Department's incremental borrowing rate is the rate at which a similar borrowing cost could be obtained from an independent creditor under comparable terms and conditions.

The weighted-average rate applied in 2026 was 2.24% (2025: 2.07%).

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification to the lease. When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset or profit and loss depending on the nature of the reassessment or modification.

3.5 Other Provisions

3.5A: Other provisions

	Provision for restoration	Total
	$'000	$'000
Carrying amount 1 July	**12,205**	**12,205**
Additional provisions made	**2,844**	**2,844**
Closing balance as at 30 June	**15,049**	**15,049**

The Department currently has 6 (2025: 6) agreements for the leasing of premises which have provisions requiring the Department to restore the premises to their original condition at the conclusion of the lease. The Department has made a provision to reflect the present value of this obligation.

Accounting Policy

Provision for Restoration Obligation

Where the Department has a contractual obligation to undertake remedial work upon vacating leased properties, the estimated cost of that work is recognised as a liability. An equal value asset is created at the same time and amortised over the life of the lease of the underlying leasehold property.

3.6 Therapeutic Goods Administration

The Therapeutic Goods Administration (TGA) contributes to Outcome 1: Health Policy, Access and Support. The TGA recovers the cost of all activities undertaken within the scope of the *Therapeutic Goods Act 1989* from industry through fees and charges.

Included below is financial information for the TGA special account. The balance of the special account represents a standing appropriation from which payments are made for the purposes of the special account. The TGA special account is reported in Note 6.2: Special accounts.

Therapeutic goods are regulated to ensure that medicinal products and medical devices in Australia meet standards of safety, quality and efficacy at least equal to that of comparable countries. These products and devices should be made available in a timely manner and the regulatory impact on business kept to a minimum. This is achieved through a risk management approach to pre-market evaluation and approval of therapeutic products intended for supply in Australia, licensing of manufacturers and post market surveillance.

The TGA receives payment for evaluation services in advance of service delivery, which can extend across financial years. The TGA estimates the stage of service completion and recognises the matching revenue. Revenue reported for 2025-26 includes an estimate for annual charges.

	2026	2025
	$'000	$'000
3.6A: Therapeutic Goods Administration		
TGA Comprehensive Income		
Expenses		
Employee benefits	**193,556**	181,175
Contractors and consultants	**12,487**	11,862
Corporate services	**44,680**	39,585
Other	**33,952**	45,644
Depreciation and amortisation	**2,991**	4,928
Write-down and impairment of assets	**588**	3,159
Total expenses	**288,254**	286,353
Revenues		
Sale of goods and rendering of services	**210,559**	206,526
Other revenues and gains	**1,452**	1,267
Total own-source revenue	**212,011**	207,793
Revenue from Government	**75,520**	74,327
Deficit on continuing operations	**(723)**	(4,233)
TGA Financial Position		
Assets		
Financial assets	**118,821**	99,948
Non-financial assets	**26,930**	28,852
Total assets	**145,751**	128,800
Liabilities		
Payables	**56,429**	43,332
Provisions	**44,428**	40,020
Total liabilities	**100,857**	83,352
Net assets	**44,894**	45,448
Equity		
Contributed equity	**2,029**	2,029
Asset revaluation reserve	**7,752**	7,581
Retained surplus	**35,113**	35,838
Total equity	**44,894**	45,448

People and Relationships

This section describes a range of employment and post-employment benefits provided to our people and our relationships with other key people.

4.1 Employee Provisions

	2026	2025
	$'000	$'000
4.1A: Employee provisions		
Leave	**277,956**	262,492
Separations and redundancies	**1,645**	126
Total employee provisions	**279,601**	262,619

Accounting Policy

Liabilities for 'short-term employee benefits' and termination benefits (as defined in AASB 119 *Employee Benefits*) due within 12 months of the end of the reporting period are measured at their nominal amounts.

Other long-term employee benefits are measured as the net total of the present value of the defined benefit obligation at the end of the reporting period minus the fair value at the end of the reporting period of plan assets (if any) out of which the obligations are to be settled directly.

Leave

The liability for employee benefits includes provisions for annual leave and long service leave. No provision has been made for personal / carers leave as all personal / carers leave is non-vesting and the average personal / carers leave taken in future years by employees of the Department is estimated to be less than the annual entitlement for personal / carers leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the Department's employer superannuation contribution rates to the extent that leave is likely to be taken during service rather than paid out on termination. The liability for long service leave and annual leave expected to be settled outside of 12 months of the balance date has been determined by reference to the work of an actuary as at December 2025. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation and considers relevant changes in the employee profile and leave taking patterns.

Separation and redundancy

The Department recognises a payable for separation and redundancy where an employee has accepted an offer of a redundancy benefit and agreed a termination date. A provision for separation and redundancy is recorded when the Department has a detailed formal plan for the payment of redundancy benefits. The provision is based on the discounted anticipated costs for identified employees engaged in the redundancy program.

Superannuation

Under the *Superannuation Legislation Amendment (Choice of Funds) Act 2004*, employees of the Department are able to become a member of any complying superannuation fund. A complying superannuation fund is one that meets the requirements under the *Income Tax Assessment Act 1997* and the *Superannuation Industry (Supervision) Act 1993*.

The Department's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), the PSS accumulation plan (PSSap), or other compliant superannuation funds.

The CSS and PSS are defined benefits schemes for the Australian Government. The PSSap and other compliant superannuation funds are defined contribution schemes. The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

The Department makes employer contributions to the employees' superannuation schemes at rates determined by the actuary to be sufficient to meet the current cost to the Government. The Department accounts for the contributions as if they were contributions to defined contributions plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the number of days between the last pay period in the financial year and 30 June.

4.2 Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Department, directly or indirectly. The Department has determined the key management personnel to be the Secretary, the Chief Medical Officer (CMO) and all Deputy Secretaries and equivalents. Key management personnel also include officers who have acted as the Secretary, CMO or Deputy Secretary and equivalents for a period of at least 4 weeks, and have exercised significant authority in planning, directing and controlling the activities of the Department. Key management personnel remuneration is reported in the table below:

	2026	2025
	$'000	$'000
Short-term employee benefits	**4,946**	4,180
Post-employment benefits	**671**	578
Other long-term employee benefits	**159**	138
Termination benefits	**-**	468
Total key management personnel remuneration expenses[1]	**5,776**	5,364

The total number of key management personnel included in the above table is 14 (2025: 16).

Remuneration information for executives and other highly paid officials is included in the annual report in part 3.4: People and Appendix 1: Workforce Statistics.

1. The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Ministers. The Portfolio Ministers' remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the Department.

4.3 Related Party Disclosures

Related party relationships

The Department is an Australian Government controlled entity. Related parties to the Department are key management personnel including the Portfolio Minister and Executive Government, and other Australian Government entities.

Transactions with related parties

Given the breadth of Government activities, related parties may transact with the government sector in the same capacity as ordinary citizens. Such transactions include receipt of a Medicare rebate, Medicare bulk billing provider payments, pharmaceutical benefits or a zero real interest loan for aged care providers. These transactions have not been separately disclosed in this note.

Significant transactions with related parties can include:

a) the payment of grants or loans,

b) purchases of goods or services,

c) asset purchases, sales transfers or leases,

d) debts forgiven, and

e) guarantees.

Giving consideration to relationships with related entities and transactions entered into during the reporting period by the Department, it has been determined that there are no related party transactions to be separately disclosed.

Assets and Liabilities Administered on Behalf of the Government

This section analyses assets used to conduct operations and the operating liabilities incurred as a result, which the Department does not control but administers on behalf of the Government. Unless otherwise noted, the accounting policies adopted are consistent with those applied for departmental reporting.

5.1 Administered – Financial Assets

	2026	2025
	$'000	$'000
5.1A: Cash and cash equivalents		
Cash in special accounts	**1,614,649**	156,306
Cash on hand or on deposit	**322,678**	89,183
Total cash and cash equivalents	**1,937,327**	245,490
5.1B: Accrued recoveries revenue		
Personal benefits		
Pharmaceutical benefits	**725,240**	949,570
Aged care	**102,196**	121,709
Medical benefits	**34,474**	13,746
Other personal benefits	**493**	457
Subsidies		
Medical indemnity	**6,346**	6,346
Aged care	**474,499**	421,659
Other subsidies	**49**	49
Total accrued recoveries revenue (gross)	**1,343,297**	1,513,536
Less impairment loss allowance	**(429,790)**	(368,003)
Total accrued recoveries revenue (net)	**913,507**	1,145,533
5.1C: Trade and other receivables		
Goods and services		
Goods and services receivables	**3,574,390**	2,233,692
GST receivable from the Australian Taxation office	**92,923**	85,618
Contract assets	**5,747**	5,946
Total goods and services receivables	**3,673,060**	2,325,256

The contract assets represent outstanding amounts relating to the licensing and evaluation services provided by the Department in connection with the Medicinal Cannabis Licensing program and functions of the Pharmaceutical Benefits Advisory Committee.

Advances and loans		
Aged care facilities		
Nominal value	**141,641**	153,718
Less: Unexpired discount	**(9,282)**	(11,348)
Total advances and loans	**132,359**	142,371
Total trade and other receivables (gross)	**3,805,419**	2,467,626
Less expected credit loss allowance	**(31,102)**	(12,248)
Total trade and other receivables (net)	**3,774,317**	2,455,379

Credit terms for goods and services were within 30 days (2025: 30 days).

Accounting Policy

Loans were made to approved providers under the *Aged Care Act 1997* for an estimated period of 12 years. No security is generally required. Principal is repaid in full at maturity. Interest rates are linked to the Consumer Price Index. Interest payments are due on the 21st day of each calendar month.

	2026	2025
	$'000	$'000
5.1D: Investments in portfolio entities		
Australian Commission on Safety and Quality in Health Care	**7,897**	7,833
Australian Digital Health Agency	**136,154**	156,731
Australian Institute of Health and Welfare	**34,000**	34,000
Food Standards Australia New Zealand	**9,524**	7,382
Independent Health and Aged Care Pricing Authority	**94,476**	76,040
National Disability Insurance Agency	**2,605,729**	2,400,097
Hearing Australia	**78,283**	81,440
Total investments in portfolio entities	**2,966,063**	2,763,523

The principal activities of each of the Department's administered investments in portfolio entities were:

a) The Australian Commission on Safety and Quality in Health Care works to lead and coordinate national improvements in safety and quality in health care across Australia.

b) The Australian Digital Health Agency has responsibility for the strategic management and governance for the national digital health strategy and the design, delivery and operations of the national digital healthcare system.

c) The Australian Institute of Health and Welfare informs community discussion and decision-making through national leadership and collaboration in developing and providing health and welfare statistics and information.

d) Food Standards Australia New Zealand protects and informs consumers through the development of effective food standards, in a way that helps stimulate and support growth and innovation in the food industry.

e) The Independent Health and Aged Care Pricing Authority determines the national efficient price and national efficient cost each year for healthcare services provided by public hospitals to inform decision makers in relation to funding of public hospitals.

f) The National Disability Insurance Agency is responsible for implementing and administering the National Disability Insurance Scheme (NDIS), including determining eligibility, developing individualised plans, managing funding and providing information, support and guidance to participants, their families and service providers.

g) Hearing Australia is a statutory authority constituted under the *Australian Hearing Services Act 1991*. Hearing Australia is the primary provider of hearing services funded by the Australian government.

Accounting Policy

Administered investments represent corporate Commonwealth entities and companies within the Health, Disability and Ageing portfolio. Administered investments in subsidiaries, joint ventures and associates are not consolidated because their consolidation is only relevant at the Whole-of-Government level.

Administered investments other than those held for trading are classified as fair value - other comprehensive income equity instruments and are measured at their fair value as at 30 June 2026. Fair value has been taken to be the Australian Government's proportional interest in the value of the net assets of each licensed investment fund, based on the latest available audited trust accounts increased by the value of new investments acquired during the reporting period.

	2026	2025
	$'000	$'000
5.1E: Other investments		
Biomedical Translation Fund - Brandon Capital Partners	**122,253**	131,215
Biomedical Translation Fund - OneVentures Management	**49,400**	28,543
Biomedical Translation Fund - BioScience Managers	**8,949**	31,102
Total other investments	**180,602**	190,860

The Biomedical Translation Fund (BTF) is an equity co-investment venture capital program announced in the National Innovation and Science Agenda to support the development of biomedical ventures in Australia. The BTF Program will help translate biomedical discoveries into high growth potential companies that are improving long term health benefits and national economic outcomes. It is delivered by the Department of Industry, Science and Resources (AusIndustry) on behalf of the Department through licensed private sector, venture capital fund managers.

Funding for the BTF Program is secured through the Biomedical Translation Fund Special Account. The above disclosures should be read in conjunction with note 6.2.

5.2 Administered – Non-Financial Assets

	2026	2025
	$'000	$'000
5.2A: Inventories		
Inventories held for distribution		
National Medical Stockpile (NMS) and COVID-19 vaccines & consumables		
Opening balance	**727,780**	1,135,543
Add: Purchases	**298,699**	518,044
Less: Deployments	**(186,266)**	(299,602)
Less: Inventory donated to other jurisdictions	**(21,533)**	-
Less: Write down & impairment	**(267,697)**	(626,531)
Add: Other adjustments	**3,360**	326
Total inventories held for distribution	**554,343**	727,780

During 2026 $475.496m of inventory held for distribution was recognised as an expense (2025: $926.133m).

5.2B: Other non-financial assets		
NMS and COVID-19 vaccines & consumables prepayments	**-**	413,017
Total other non-financial assets	**-**	413,017

Accounting Policy

The Department's administered inventories relate to:

a) The National Medical Stockpile (the NMS). The NMS is a strategic reserve of medicines, vaccines, antidotes and protective equipment available for use as part of the national response to a public health emergency. It is intended to augment State and Territory government reserves of key medical items in a health emergency, which could arise from terrorist activities or natural causes. Inventories held for distribution are valued at cost, adjusted for any loss of service potential.

b) COVID-19 vaccines and consumables. The Commonwealth has entered into multiple agreements to acquire doses of COVID-19 vaccines. Vaccines and consumables are held for distribution prior to being deployed to administration sites.

Costs in bringing each item to its present location and condition include purchase costs plus any other reasonably attributable costs, such as overseas shipping and handling and import duties, less any bulk order discounts and rebates received from suppliers.

Inventory is held at cost and adjusted where applicable for loss of service potential. The Department considers the current replacement cost is the most appropriate basis for loss of service potential for inventories.

Inventories that are damaged or have passed their use-by dates are written off on the basis that the service potential is nil.

Inventories acquired at no or nominal cost are measured at the current replacement cost at the date of acquisition. Any difference between acquisition costs and the value of these inventories is recognised as revenue.

Inventories are measured at weighted average cost, adjusted for obsolescence, other than vaccine stock which is measured using the costs specific for those items.

In determining impairment losses recognised in connection with the Department’s inventories, management have applied assumptions and judgment in determining the current cost estimate (CCE). The CCE is used as the basis for measuring impairment losses where the weighted average cost of inventories exceeds the CCE. The CCE is determined based on observable market evidence including prices for comparable products and other market trends impacting supply.

Inventory prepayments represent the value of inventory paid for but not yet delivered by the supplier or accepted by the Department.

5.3 Administered – Payables

	2026	2025
	$'000	$'000
5.3A: Suppliers		
Trade creditors and accruals	**208,297**	272,700
Contract liabilities	**7,317**	6,250
Total supplier payables	**215,614**	278,951

The payment terms for goods and services are 20 calendar days from the receipt of a correctly rendered invoice (2025: 20 days).

The contract liabilities are associated with the unearned portion of licensing and evaluation fee revenue collected predominantly in connection with the Medicinal Cannabis Licensing program and functions of the Pharmaceutical Benefits Advisory Committee.

5.3B: Subsidies		
Aged care	**85,773**	103,938
Medical indemnity	**22,262**	16,743
Total subsidies	**108,035**	120,681
5.3C: Personal benefits		
Direct personal benefits		
Private health insurance	**653,136**	603,795
Indirect personal benefits		
Medical services	**636,664**	610,602
Pharmaceuticals and pharmaceutical services	**324,895**	63,765
Aged care	**732,290**	828,333
Other	**4,016**	78,389
Total personal benefits	**2,351,001**	2,184,884
5.3D: Grants		
Australian Government entities (related entities)	**264**	1,554
Profit and non-profit organisations	**427,277**	251,618
Total grants	**427,541**	253,172

5.4 Administered – Other Provisions

5.4A: Subsidies

	Balance as at 30 June 2025	Claims paid	Schedule of Administered items impact	Balance as at 30 June 2026
	$'000	$'000	$'000	$'000
Medical Indemnity Liabilities				
Incurred but not reported scheme	6,076	(5,470)	2,882	3,488
High cost claims scheme	349,157	(87,991)	100,978	362,144
Run-off cover scheme	249,002	(32,737)	54,034	270,299
Total Medical Indemnity Liabilities	604,235	(126,198)	157,894	635,931
Midwife Professional Indemnity Liabilities	7,700	(667)	12,881	19,914
COVID-19 Vaccine Claims Liabilities	23,705	(20,797)	32,022	34,930
Total as at 30 June	635,640	(147,662)	202,797	690,775

Accounting Policy

Medical Indemnity Schemes

The Department administers the following medical indemnity schemes under the *Medical Indemnity Act 2002*:

a) Incurred But Not Reported Scheme (IBNRS)
b) High Cost Claims Scheme (HCCS)
c) Exceptional Claims Scheme (ECS)
d) Run-Off Cover Scheme (ROCS)
e) Premium Support Scheme (PSS)
f) Allied Health High Costs Claims Scheme (AHHCCS), and
g) Allied Health Exceptional Claims Scheme (AHECS).

The payments for medical indemnity are managed by Services Australia, the service delivery entity, on behalf of the Department through its Medicare program.

The Australian Government Actuary (AGA) estimated the provision for future payments for the medical indemnity schemes administered by the Department. At the reporting date, provision for future payments was recognised for IBNRS, HCCS, and ROCS. No provision was recognised for ECS, as to date no payment has been made against this scheme and it could not be reliably measured, and is therefore reported as a contingent liability in Note 7.1B. No provision was recognised for the PSS as the nature and timing of payments associated with the scheme are based on a relatively predictable pattern of annual payments that must be settled within 12 months of the end of the premium period.

AHHCCS and the AHECS were implemented from 1 July 2020. There is currently insufficient information to estimate their liabilities separately and the schemes are expected to be immaterial. Any associated liabilities of these new schemes are currently included in the liability estimates of the HCCS and the ECS respectively, until there is sufficient information to separately assess the liabilities of the new schemes.

The methods used by the AGA to estimate the liability under the different schemes are as follows:

General

The AGA has relied on projections that have been prepared by the appointed actuaries to the five medical indemnity insurers (MIIs) and provided to the Commonwealth under the relevant provisions of the *Medical Indemnity Act 2002*. Payment information from the Medicare program complemented the projection. Where appropriate, adjustments have been made to those projections as described below.

IBNRS

The IBNRS provides for payments to Avant Mutual Group for claims made in relation to its IBNR liability at 30 June 2002. Some claims that will be payable under the IBNRS may also be eligible for payment under the HCCS.

The AGA has carried out chain ladder modelling using the payments data. The results of this analysis have been compared to the projections prepared by the industry actuaries. The results closely match and, as a result, the AGA has largely relied on industry projections to estimate the liability.

ROCS

ROCS provides free run-off cover for specific groups of medical practitioners including those retired and over 65, on maternity leave, retired for more than three years, retired due to permanent disability or the estates of those that have died. This scheme is funded through the collection of support payments imposed as a tax on MIIs.

The AGA has developed an independent ROCS actuarial model which estimates the total annual accruing ROCS cost to the Australian Government. The model output is used to check against industry actuaries' projections. For the estimate of the outstanding ROCS liability as at 30 June 2026, the AGA has relied on the projections from the actuary of each of the MIIs, but has adjusted the IBNRS component on comparison with the projections from its own ROCS internal model. Given that the majority of the claims anticipated under this scheme have not yet been made, the AGA noted a relatively high level of uncertainty in the estimate.

HCCS

Under HCCS, the Government pays 50% of the cost of claims made to all MIIs that exceed a specified threshold, up to the limit of the practitioner's insurance. The threshold to be applied depends on the date of the notification of the claim as follows:

a) from 1 January 2003 to 21 October 2003 - $2m

b) from 22 October 2003 to 31 December 2003 - $0.5m

c) from 1 January 2004 to 30 June 2018 - $0.3m, and

d) on or after 1 July 2018 - $0.5m.

The AGA has relied on the projections of the industry actuaries but has made adjustments in respect of claims which are also eligible for the IBNRS and/or ROCS to ensure overall consistency of the estimates.

Material accounting judgements and estimates

The nature of the medical indemnity liability estimates is inherently, and unavoidably, uncertain. The uncertainty arises for the following reasons:

a) it is not possible to precisely model the claims process, and random variations in both past and future claims have or will have adverse consequences on the model,

b) there can be a long delay between incident occurrences, to notification and settlement, making the projection of timing very uncertain,

c) the nature and cause of injury is difficult to determine and prove,

d) the claims experience can be very sensitive to the surrounding factors such as technology, legislation, attitudes and the economy,

e) in general, these schemes have a small number of large claims which account for a substantial part of the overall cost. This is associated with large expected random variation. It follows that a wide range of results can be obtained with equal statistical significance which differs materially in the context of a schedule of assets and liabilities. This is a common situation with liabilities of this nature, and

f) medical indemnity claims costs tend to increase at a faster rate than general inflation.

The experience of the medical indemnity claims cycle indicates that claims and subsequent payments can take a number of years to mature and settle. The Department used a 4.5% per annum discount rate in the calculation of the estimate for the current year. This discount rate was derived from the information provided by the Australian Office of Financial Management based on the average observed liability duration of 5 years for the medical indemnity payments. A discount rate of 3.5% was used last year, which was derived using the same method.

A sensitivity analysis was undertaken by moving the discount rate either up or down to the nearest full percentage point. Increasing the discount rate to 5% would result in a discounted liability estimate which is about 2.5% ($16m) less than the base estimate. On the other hand, decreasing the discount rate to 4% would result in a liability estimate which is about 2.2% ($14m) higher than the base estimate.

	2025-26			2024-25
	discounted	discounted	discounted	discounted[1]
	4.0%	4.5%	5.0%	3.5%
	$m	$m	$m	$m
Incurred But Not Reported Scheme	4	4	3	6
High Cost Claims Scheme	368	362	356	349
Run-Off Cover Scheme	278	270	261	249
Total	**650**	**636**	**620**	**604**

1. 3.5% was used as the basis of the estimation in 2024-25.

Midwife Professional Indemnity Schemes

The Department administers the following midwife professional indemnity schemes under the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*:

a) Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS), and
b) Midwife Professional Indemnity Run-off Cover Scheme (MPIRCS).

Under the MPIS, the Commonwealth reimburses a specified percentage of the costs of claims notified to Medical Insurance Australia Pty Ltd (MIGA) on or after 1 July 2010. Reimbursements are calculated under a tiered approach where the Commonwealth reimburses MIGA for:

a) 0% of costs for claim costs up to $100,000,
b) 80% of costs for claim costs over $100,000 and up to $2,000,000, and
c) 100% of costs exceeding $2,000,000.

A small number of payments have been made to date by Services Australia under MPIS. There have been no payments or claims notified under MPIRCS. The AGA used the claims lodged with MIGA, adjusted for the actual payments made under MPIS, as the basis for calculating the provision. A discount rate of 4.5% per annum was used in the calculation of the estimate for the current year, consistent with the medical indemnity schemes.

No provision was recognised for MPIRCS, as to date no claims have been lodged with MIGA and a reliable estimate cannot be made in relation to the future claims.

COVID-19 Vaccine Claims

The Vaccine Claims Scheme is designed to operate on a no-fault basis for eligible Australians to claim compensation for certain recognised moderate to severe vaccine-related adverse events that involve losses or expenses of at least $1,000 as a direct result of an administered COVID-19 vaccine.

The potential liability for claims under the scheme was estimated by the AGA using the claims data provided by Services Australia, categorised into tiers based on the severity of eligible losses being claimed as follows:

a) Tier 1 - claims in the range of $1,000 - $20,000,
b) Tier 2 - claims in excess of $20,000, and
c) Tier 3 - claims involving a loss of life.

A tailored modelling approach was developed for each tier, reflective of the perceived level of subjectivity associated with the relevant claim type, with higher tiers requiring specialist assessment on a case-by-case basis, and the potential claim amount. Due to the recent claiming experience, this year's modelling approach further included $1 claims for the first time and assessed them as a separate category.

The scheme has closed to new applications in September 2024. Any adverse events occurring prior to the closure date but not lodged with the scheme prior to the closure date, and any adverse events resulting from vaccines administered after the closure date are not covered. The remaining liability relates to claims that had been lodged prior to scheme's closure but not yet finalised.

Material accounting judgements and estimates

The uncertainty arises for the following reasons:

a) the liability estimate is now based on a smaller cohort of claims and is therefore subject to increased uncertainty, as is common in the tail-end of a scheme,
b) the payment amount can vary significantly from the claim amount stated on the application and no reliable pattern can be derived from the data; in particular, a significant proportion of open claims have an initial claim amount of $1,
c) the assessment of claims is subject to a significant level of judgement, as each application is considered on a case-by-case basis; Tier 2 claims and some Tier 1 claims are referred to an expert panel, with no information being available around how decisions are made by the panel,
d) some Tier 1 claims can be upgraded to Tier 2, which involve multiple payment categories and entail a higher level of uncertainty,
e) claims data includes limited variables to assist with the valuation process, and
f) hospitalisation data lacks the granularity required to be of use in the valuation process.

Key assumptions and sensitivities

Certain assumptions were applied to the available data. The effects of discounting and inflation were assumed to offset each other, consistent with prior year's methodology. The claims administration costs incurred are funded separately to this scheme and are outside the scope of this valuation. There is also no allowance for the Department's costs of managing the scheme.

Due to the prevalent uncertainties, the liability estimate is particularly sensitive to the acceptance rate and the payment to claim ratio, including for $1 claims. A sensitivity analysis was undertaken on these factors to understand the overall impact on the ultimate liability being recognised:

Scenario	Liability Estimate ($'m)	Change
Baseline	34.9	
50% higher payments for open $1 claims	37.3	7%
50% lower payments for open $1 claims	32.5	-7%
50% higher payments for open >$5m claims	43.7	25%
50% lower payments for open >$5m claims	26.1	-25%

	2026	2025
	$'000	$'000
5.4B: Personal benefits		
Outstanding claims		
Medical services	**993,908**	925,202
Pharmaceuticals and pharmaceutical services	**400,186**	308,087
Total personal benefits	**1,394,094**	1,233,289

Accounting Policy

Material accounting judgements and estimates

Medicare payments processed by Services Australia on behalf of the Department are either reimbursements to patients, made after medical services have been received from a doctor, or payments made directly to doctors through the bulk billing system. At any point in time, there are thousands of cases where a medical service has been rendered, but the Medicare payment has not yet been made. Services Australia has been using the 'Winters' methodology to estimate the value of these outstanding claims.

Under the 'Winters' methodology, a number of models are used to estimate the outstanding Medicare claims liabilities. The model preferred by the industry, and consistently applied in past financial statements of the Department, is Model 5. Model 5 comprises two major components: chain ladder modelling and time series modelling.

Under Model 5, user defined parameters are applied to smooth the time series observations and make predictions about future payment values. As the parameters are user defined, it is reasonable to assume that different users of the model may make different choices, and therefore arrive at different estimates of the outstanding liability. In order to validate the parameters used, actual payment data has been compared to previous estimates using various parameters to predict the liability. The model weighs recent payment experience more heavily and is therefore self-adjusting for emerging trends.

Funding

This section identifies the Department's funding structure.

6.1 Appropriations

6.1A: Annual appropriations

Annual appropriations for 2026

	Annual Appropriation[1]	Adjustments to Appropriation[2]	Total Appropriation	Appropriations applied in 2026 (current and prior years)[5]	Variance[3]
	$'000	$'000	$'000	$'000	$'000
Departmental					
Ordinary annual services	1,760,850	194,031	1,954,881	1,940,385	14,496
Capital budget[4]	15,427	(92)	15,335	16,796	(1,461)
Other services					
Equity injections	141,628	(10,969)	130,659	63,924	66,735
Total departmental	1,917,905	182,970	2,100,875	2,021,105	79,770
Administered					
Ordinary annual services					
Administered items	28,194,767	27,869,398	56,064,165	54,372,378	1,691,787
Payments to corporate Commonwealth entities	2,750,114	-	2,750,114	2,750,114	-
Other services					
Administered assets and liabilities	223,648	(68,370)	155,278	73,189	82,089
Payments to corporate Commonwealth entities	22,949	-	22,949	22,949	-
Total administered	31,191,478	27,801,028	58,992,506	57,218,630	1,773,876

1. In 2026 departmental appropriations, $7.078m relating to ordinary annual services appropriations and $61.740m relating to equity injections appropriations were permanently withheld under Section 51 of the PGPA Act. In 2026 administered appropriations, $264.544m relating to ordinary annual services appropriations and $28m relating to other services appropriations were permanently withheld under Section 51 of the PGPA Act. A further $830.096m relating to ordinary annual services appropriations was temporarily quarantined for administrative purposes.

2. Departmental: adjustments to appropriations for ordinary annual services are an aggregate result of PGPA Act Section 74 receipts of $235.910m and Section 75 transfers of appropriations of $41.879m; adjustments to appropriations for the capital budget and equity injections relate entirely to Section 75 transfer of appropriations. Administered: adjustments to appropriations for ordinary annual services and administered assets and liabilities relate entirely to Section 75 transfer of appropriations.

3. The aggregate variance of $13.035m for departmental ordinary annual services and capital budget primarily represents the timing difference of payments to suppliers and employees. The variance of $66.735m for departmental equity is largely due to the 2026 appropriations funding permanently withheld under Section 51 of the PGPA Act but still reported as available. The variance in administered ordinary annual services of $1,691.787m reflects delays in granting activities experienced across a range of programs and the 2026 appropriations funding permanently withheld under Section 51 of the PGPA Act but still reported as available. The variance in administered assets and liabilities of $82.089m is due to the timing of replenishment activities for inventory purchasing and the 2026 appropriations funding permanently withheld under Section 51 of the PGPA Act but still reported as available.

4. Departmental and Administered Capital Budgets are appropriated through Appropriation Acts (No.1,3,5). They form part of ordinary annual services, and are not separately identified in the Appropriation Acts.

5. The following entities spend money from the Consolidated Revenue Fund (CRF) on behalf of this entity: Services Australia and Department of Industry, Science and Resources.

Annual appropriations for 2025

	Annual Appropriation[1]	Adjustments to Appropriation[2]	Total Appropriation	Appropriations applied in 2025 (current and prior years)[3,6]	Variance[4]
	$'000	$'000	$'000	$'000	$'000
Departmental					
Ordinary annual services	1,743,438	250,377	1,993,815	1,900,070	93,745
Capital budget[5]	21,449	6	21,455	19,773	1,682
Other services					
Equity Injections	329,246	-	329,246	58,656	270,590
Total departmental	2,094,133	250,383	2,344,516	1,978,499	366,017
Administered					
Ordinary annual services					
Administered items	15,973,015	1,432	15,974,447	14,630,694	1,343,754
Payments to corporate Commonwealth entities	790,497	-	790,497	790,497	-
Other services					
Administered assets and liabilities	100,213	-	100,213	84,974	15,239
Payments to corporate Commonwealth entities	46,128	-	46,128	46,128	-
Total administered	16,909,853	1,432	16,911,285	15,552,293	1,358,993

1. In 2025 departmental appropriations, $0.413m relating to ordinary annual services appropriations and $197.492m relating to equity injections appropriations were permanently withheld under Section 51 of the PGPA Act. A further $115.740m relating to equity injections appropriations was temporarily quarantined for administrative purposes. Departmental ordinary annual services appropriations include $1.202m of NMHC appropriations not subject to Section 75 transfers. In 2025 administered appropriations, $308.095m relating to ordinary annual services appropriations was permanently withheld under Section 51 of the PGPA Act and $60.597m was temporarily quarantined for administrative purposes. Administered ordinary annual services appropriations include $0.062m of NMHC appropriations not subject to Section 75 transfers.

2. Departmental: adjustments to appropriations for ordinary annual services are an aggregate result of PGPA Act Section 74 receipts of $248.641m, further Section 74 receipts funding of $0.093m relating to NMHC appropriations, and Section 75 transfer of appropriation from NMHC of $1.643m; adjustments to appropriations for the capital budget relate entirely to Section 75 transfer of appropriations from NMHC. Administered: adjustments to appropriations for ordinary annual services relate entirely to Section 75 transfer of appropriation from NMHC.

3. Departmental: amounts applied in relation to ordinary annual services include $2.708m of NMHC appropriations. Administered: amounts applied in relation to ordinary annual services include $0.236m of NMHC appropriations.

4. The aggregate variance of $95.428m for departmental ordinary annual services and capital budget primarily represents the timing difference of payments to suppliers and employees. The variance of $270.590m for departmental equity is largely due to the 2025 appropriations funding permanently withheld under Section 51 of the PGPA Act or quarantined for administrative purposes but still reported as available. The variance in administered ordinary annual services of $1,343.753m reflects delays in granting activities experienced across a range of programs. The variance in administered assets and liabilities of $15.239m is due to the timing of replenishment activities for inventory purchasing.

5. Departmental and Administered Capital Budgets are appropriated through Appropriation Acts (No.1,3,5). They form part of ordinary annual services, and are not separately identified in the Appropriation Acts.

6. The following entities spend money from the Consolidated Revenue Fund (CRF) on behalf of this entity: Services Australia and Department of Industry, Science and Resources.

6.1B: Unspent appropriations ('recoverable GST exclusive')

	2026 $'000	2025 $'000
Departmental		
Appropriation Act (No. 1) 2022-23[1]	-	500
Appropriation Act (No. 2) 2022-23[1]	-	48,400
Appropriation Act (No. 3) 2022-23[1]	-	121
Supply Act (No. 1) 2022-2023 - Departmental Capital Budget[1]	-	7
Supply Act (No. 2) 2022-23[1]	-	21
Supply Act (No. 3) 2022-23[1]	-	245
Supply Act (No. 3) 2022-2023 - Departmental Capital Budget[1]	-	14
Supply Act (No. 4) 2022-23[1]	-	29
Appropriation Act (No. 1) 2023-24[2]	**10,385**	191,348
Appropriation Act (No. 3) 2023-24[2]	**240**	240
Appropriation Act (No. 4) 2023-24[2]	**9,096**	17,377
Appropriation Act (No. 5) 2023-24[2]	**488**	3,253
Appropriation Act (No. 5) 2023-24 - Departmental Capital Budget[2]	**162**	-
Appropriation Act (No. 1) 2024-25[3]	**413**	16,732
Appropriation Act (No. 1) 2024-25 - Cash at Bank	-	1,602
Appropriation Act (No. 1) 2024-25 - Departmental Capital Budget	-	5,222
Appropriation Act (No. 2) 2024-25[4]	**267,212**	322,855
Appropriation Act (No. 3) 2024-25	-	88,381
Appropriation Act (No. 4) 2024-25[5]	**6,391**	6,391
Appropriation Act (No. 1) 2025-26[6]	**285,201**	-
Appropriation Act (No. 1) 2025-26 - Cash at Bank	**2,951**	-
Appropriation Act (No. 1) 2025-26 - Departmental Capital Budget	**3,599**	-
Appropriation Act (No. 2) 2025-26[7]	**75,115**	-
Appropriation Act (No. 3) 2025-26[8]	**18,882**	-
Appropriation Act (No. 5) 2025-26	**4,785**	-
Supply Act (No. 2) 2025-26	**55,544**	-
Total departmental[16]	**740,464**	702,738

	2026 $'000	2025 $'000
Administered		
Appropriation Act (No. 1) 2022-2023[1]	-	1,255,757
Appropriation Act (No. 2) 2022-2023[1]	-	532,498
Appropriation Act (No. 3) 2022-2023[1]	-	556,991
Supply Act (No. 1) 2022-2023[1]	-	587,003
Supply Act (No. 2) 2022-2023[1]	-	271
Supply Act (No. 3) 2022-2023[1]	-	1,990
Appropriation Act (No. 1) 2023-2024[2,9]	**778,414**	999,573
Appropriation Act (No. 3) 2023-2024[2,9]	**701,018**	929,230
Appropriation Act (No. 4) 2023-2024[2]	-	39,638
Appropriation Act (No. 5) 2023-2024[2,9]	**7,927**	67,226
Appropriation Act (No. 1) 2024-2025[9,10]	**1,112,359**	1,249,408
Appropriation Act (No. 2) 2024-2025	**10,835**	10,835
Appropriation Act (No. 3) 2024-2025[11]	**930,652**	545,760
Appropriation Act (No. 4) 2024-2025	**231**	4,404
Appropriation Act (No. 1) 2025-2026[12]	**1,246,653**	-
Appropriation Act (No. 2) 2025-2026[13]	**64,168**	-
Appropriation Act (No. 3) 2025-2026[14]	**313,841**	-
Appropriation Act (No. 5) 2025-2026	**39,595**	-
Appropriation Act (No. 6) 2025-2026	**20,000**	-
Supply Act (No. 1) 2025-2026[15]	**1,148,523**	-
Supply Act (No. 2) 2025-2026	**41,732**	-
Total administered[16]	**6,415,948**	6,780,584

1. In departmental appropriations a total of $49.337m in 2022-23 appropriations has lapsed on 1 July 2025. In administered appropriations a total of $2,934.510m in 2022-23 appropriations has lapsed on 1 July 2025.

2. In departmental appropriations a total of $20.371m in 2023-24 appropriations will lapse on 1 July 2026. In administered appropriations a total of $1,487.359m in 2023-24 appropriations will lapse on 1 July 2026.

[3] This amount has been permanently withheld under Section 51 of the PGPA Act.

[4] This amount includes $197.492m which has been permanently withheld under Section 51 of the PGPA Act.

[5] This amount includes $4.926m which has been permanently withheld under Section 51 of the PGPA Act.

[6] This amount includes $2.295m which has been permanently withheld under Section 51 of the PGPA Act.

[7] This amount includes $61.740m which has been permanently withheld under Section 51 of the PGPA Act.

[8] This amount includes $4.783m which has been permanently withheld under Section 51 of the PGPA Act.

[9] These 2024 and 2025 administered appropriation balances for ordinary annual services have been reduced by a total of $355.389m during 2026 to remediate the cash shortfall in the Medicare Guarantee Fund (Health) Special Account as at 30 June 2025 and the resulting activation of the special appropriation in the *Medicare Guarantee Act 2017.*

[10] This amount includes $398.057m which has been permanently withheld under Section 51 of the PGPA Act and another $234.632m which has been temporarily quarantined for administrative purposes.

[11] This amount includes $55.469m which has been permanently withheld under Section 51 of the PGPA Act and another $1m which has been temporarily quarantined for administrative purposes.

[12] This amount includes $152.493m which has been permanently withheld under Section 51 of the PGPA Act and another $217.669m which has been temporarily quarantined for administrative purposes.

[13] This amount includes $28m which has been permanently withheld under Section 51 of the PGPA Act.

[14] This amount includes $68.741m which has been permanently withheld under Section 51 of the PGPA Act and another $57.860m which has been temporarily quarantined for administrative purposes.

[15] This amount includes $43.310m which has been permanently withheld under Section 51 of the PGPA Act and another $554.567m which has been temporarily quarantined for administrative purposes.

[16] Prior years unspent departmental appropriations were increased by a total of $7.293m under Section 75 of the PGPA Act. Prior years unspent administered appropriations were increased by a total of $656.749m under Section 75 of the PGPA Act.

6.1C: Special Appropriations ('recoverable GST exclusive')

	Appropriation applied	
	2026	2025
Authority	**$'000**	$'000
Aged Care (Accommodation Payment Security) Act 2006	**-**	-
Aged Care Act 1997	**12,625,402**	32,458,769
Aged Care Act 2024	**22,873,214**	-
Health Insurance Act 1973	**-**	-
National Health Act 1953	**2,723,868**	2,493,856
Medical Indemnity Act 2002	**139,630**	75,146
Private Health insurance Act 2007	**7,613,134**	7,337,913
Dental benefits Act 2008	**361,357**	318,730
Medicare Guarantee Act 2017	**-**	355,389
Health and Other Services (Compensation) Act 1995	**-**	-
Medical Indemnity Agreement (Financial Assistance - Binding Commonwealth Obligations) Act 2002	**-**	-
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	**-**	-
Public Governance, Performance and Accountability Act 2013 s.77	**1,228**	1,926
Total special appropriations applied	**46,337,832**	43,041,730

Services Australia drew money from the Consolidated Revenue Fund on behalf of the Department against the following special appropriations:
a) *Aged Care Act 1997*
b) *Aged Care Act 2024*
c) *Health Insurance Act 1973*
d) *National Health Act 1953*
e) *Medical Indemnity Act 2002*
f) *Dental Benefits Act 2008*
g) *Private Health Insurance Act 2007*, and
h) *Medicare Guarantee Act 2017*

6.2 Special Accounts

Recoverable GST Exclusive	Services for Other Entities and Trust Moneys Account[1]		Australian Immunisation Register Account[2]		Sport and Recreation Account[3]	
	2026	2025	**2026**	2025	**2026**	2025
	$'000	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**82,909**	601,936	**7,859**	7,010	**182**	182
Increases						
Appropriation credited to special account	**11,717**	15,398	**4,009**	600	**-**	-
Other increases	**25,533**	18,798	**2,939**	6,875	**-**	-
Total increases	**37,250**	34,196	**6,948**	7,475	**-**	-
Available for payments	**120,159**	636,132	**14,807**	14,485	**182**	182
Decreases						
Administered	**48,346**	553,223	**6,933**	6,626	**182**	-
Total administered	**48,346**	553,223	**6,933**	6,626	**182**	-
Total decreases	**48,346**	553,223	6,933	6,626	182	-
Total balance carried to the next period	**71,813**	82,909	7,874	7,859	-	182
Balance represented by:						
Cash held in entity bank accounts	**60**	73	**1,041**	1,013	**-**	-
Cash held in the Official Public Account	**71,753**	82,836	**6,833**	6,846	**-**	182
Total balance carried to the next period	**71,813**	82,909	**7,874**	7,859	**-**	182

1. Appropriation: Public Governance, Performance and Accountability Act 2013; section 78
Establishing Instrument: Public Governance, Performance and Accountability Act 2013; section 78
Purpose:
The special account was established to enable the Department to hold and expend amounts for a range of purposes including for, on behalf of, or jointly with, other persons or entities, such as amounts held for joint activities with other governments, other Commonwealth entities, Commonwealth companies and other entities. The special account also enables the Department to hold and expend amounts held on trust, or for the benefit of another person, amounts in relation to agreements with other governments and amounts received that are permitted or required to be repaid.

2. Appropriation: Public Governance, Performance and Accountability Act 2013; section 78
Establishing Instrument: Public Governance, Performance and Accountability Act 2013; section 78
Purpose:

The special account was established to manage contributions from the Commonwealth, States and Territories to make incentive payments to accredited vaccination providers for providing immunisation for children up to seven years of age.

3. Appropriation: Public Governance, Performance and Accountability Act 2013; section 78
Establishing Instrument: Public Governance, Performance and Accountability Act 2013; section 78
Purpose:
The special account was established to manage contributions from the Commonwealth, States and Territories in support of activities and projects arising from and undertaken on behalf of the Meeting of Sport and Recreation. These contributions are to be used for payments for secretariat functions, the “Play by the Rules” program, and to undertake a range of projects beneficial to jurisdictions. This special account was transferred to the Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts effective 1 September 2025.

Recoverable GST Exclusive	Therapeutic Goods Administration Account[4]		Gene Technology Account[5]		Industrial Chemicals Account[6]	
	2026	2025	**2026**	2025	**2026**	2025
	$'000	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**92,805**	78,037	**8,536**	10,693	**39,035**	39,641
Increases						
Appropriation credited to special account	**75,520**	74,327	**8,173**	8,114	**1,936**	1,802
Other increases	**225,307**	202,003	**394**	198	**22,142**	20,633
Total increases	**300,827**	276,330	**8,567**	8,312	**24,078**	22,435
Available for payments	**393,632**	354,367	**17,103**	19,005	**63,113**	62,076
Decreases						
Departmental	**280,423**	261,562	**9,137**	10,469	**21,828**	23,041
Total departmental	**280,423**	261,562	**9,137**	10,469	**21,828**	23,041
Total decreases	**280,423**	261,562	9,137	10,469	21,828	23,041
Total balance carried to the next period	**113,209**	92,805	7,966	8,536	41,285	39,035
Balance represented by:						
Cash held in entity bank accounts	**277**	5,858	**1,075**	1,645	**1,051**	351
Cash held in the Official Public Account	**112,932**	86,947	**6,891**	6,891	**40,234**	38,684
Total balance carried to the next period	**113,209**	92,805	**7,966**	8,536	**41,285**	39,035

4. Appropriation: Public Governance, Performance and Accountability Act 2013; section 80
Establishing Instrument: Therapeutic Goods Act 1989
Purpose (as per section 45 of the Therapeutic Goods Act 1989):
a) to make payments to further the objects of the Act, and
b) to enable the Commonwealth to participate in the international harmonisation of regulatory controls on therapeutic goods and other related activities.

5. Appropriation: Public Governance, Performance and Accountability Act 2013; section 80
Establishing Instrument: Gene Technology Act 2000
Purpose:
for the receipt of all moneys and payment of all expenditures and disbursements related to all operations of the Gene Technology Regulator.

6. Appropriation: Public Governance, Performance and Accountability Act 2013; section 80
Establishing Instrument: Industrial Chemicals Act 2019
Purpose:
for the receipt of all moneys and payment of all expenditures and disbursements related to all operations of the Australian Industrial Chemicals Introduction Scheme.

Recoverable GST Exclusive	Medical Research Future Fund Account[7]		Medicare Guarantee Fund (Health) Account [8]		Biomedical Translation Fund Account[9]	
	2026	2025	**2026**	2025	**2026**	2025
	$'000	$'000	**$'000**	$'000	**$'000**	$'000
Balance brought forward from previous period	**26,885**	61,196	**-**	5,240,727	**38,472**	51,507
Increases						
Statutory credits	**650,000**	650,000	**57,541,247**	46,000,000	**-**	-
Other increases	**8,179**	5,545	**8,000**	-	**-**	-
Total increases	**658,179**	655,545	**57,549,247**	46,000,000	**-**	-
Available for payments	**685,064**	716,741	**57,549,247**	51,240,727	**38,472**	51,507
Decreases						
Administered	**653,104**	689,856	**56,072,530**	51,240,727	**12,188**	13,035
Total administered	**653,104**	689,856	**56,072,530**	51,240,727	**12,188**	13,035
Total decreases	**653,104**	689,856	**56,072,530**	51,240,727	**12,188**	13,035
Total balance carried to the next period	**31,960**	26,885	**1,476,717**	-	**26,284**	38,472
Balance represented by:						
Cash held in the Official Public Account	**31,960**	26,885	**1,476,717**	-	**26,284**	38,472
Total balance carried to the next period	**31,960**	26,885	**1,476,717**	-	**26,284**	38,472

7. Appropriation: Public Governance, Performance and Accountability Act 2013; section 80
Establishing Instrument: Medical Research Future Fund Act 2015
Purpose:
to provide grants of financial assistance to support medical research and medical innovation.
8. Appropriation: Public Governance, Performance and Accountability Act 2013; section 80
Establishing Instrument: Medicare Guarantee Act 2017
Purpose:
to secure the ongoing funding of the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.
9. Appropriation: Public Governance, Performance and Accountability Act 2013; section 78
Establishing Instrument: Public Governance, Performance and Accountability Act 2013; section 78
Purpose:
a) to provide capital to promote the commercialisation of biomedical discoveries in accordance with the Biomedical Translation Fund Programme Guidelines;
b) to carry out activities that are incidental to the purpose in paragraph a), including dealing with direct and indirect costs;
c) to repay amounts where a court order, Act or other law requires or permits the repayment of an amount received; and
d) to reduce the balance of the special account (and, therefore, the available appropriation for the special account) without making a real or notional payment.

6.3 Regulatory Charging Summary

	2026	2025
	$'000	$'000
Amounts applied		
Departmental		
Annual appropriations	**52,920**	45,835
Special appropriations (including special accounts)	**230,346**	226,089
Administered		
Annual appropriations	**14,527**	12,334
Total amounts applied	**297,792**	284,258
Expenses		
Departmental	**283,433**	280,985
Administered	**14,527**	19,734
Total expenses	**297,960**	300,719
External revenue		
Departmental	**230,346**	226,089
Administered	**41,328**	44,820
Total external revenue	**271,674**	270,909
Amounts written off		
Departmental	**634**	381
Administered	**122**	-
Total amounts written off	**757**	381

Regulatory charging activities:

Australian Industrial Chemicals Introduction Scheme (AICIS). Charges are levied for registration, assessment and regulation of the importation and manufacture of industrial chemicals in Australia.

Medicinal cannabis. Fees and charges for the regulation of the cultivation and manufacture of Australian produced medicinal cannabis products.

The **National Joint Replacement Registry** facilitates the collection of data that provides a prospective case series on all joint replacement surgery undertaken in Australia.

Pharmacy approvals. Pharmacists seeking to provide Pharmaceutical Benefits Scheme medicines by establishing a new pharmacy or relocating an existing pharmacy are charged a fee for service to recover the cost of approving these applications.

Listing of medicines on the Pharmaceutical Benefits Scheme for approval by the **Pharmaceutical Benefits Advisory Committee** and designated vaccines on the National Immunisation Program for approval by the **Australian Technical Advisory Group** on Immunisation are subject to regulatory charges.

Administered revenue only is recorded for the **Private Health Insurance Ombudsman Levy.**

Registration and approval of private hospitals under the **Private Health Insurance 2nd Tier Private Hospital Default Benefits** program are subject to regulatory charges.

The **Prescribed List** details medical devices and human tissue products for which health insurers must pay benefits if the patient has an appropriate health insurance policy. Regulatory charging activities include evaluation, listing and management services provided by the Department.

The **Therapeutic Goods Administration (TGA)** undertakes cost recovered activities to evaluate the safety, quality and efficacy of medicines, medical devices and biologicals available for supply in, or export from Australia.

Cost Recovery Implementation Statements for the above activities are available at:

AICIS: https://www.industrialchemicals.gov.au/about-us/how-we-are-funded#cost-recovery-implementation-statement-cris

Medicinal Cannabis: https://www.odc.gov.au/resources/publications/cost-recovery-implementation-statement-cris-regulation-medicinal-cannabis-2026-27

National Joint Replacement Registry: https://www.health.gov.au/sites/default/files/2026-03/cost-recovery-implementation-statement-australian-orthopaedic-association-national-joint-replacement-registry-2025-2029_0.pdf

Pharmacy Approvals: https://www.health.gov.au/resources/publications/cost-recovery-implementation-statement-2026-2027

PBAC: https://www.pbs.gov.au/industry/listing/elements/fees-and-charges/2026-27-PBS-NIP-Cost-Recovery-Implementation-Statement.PDF

Private Health Insurance second-tier default benefits: https://www.health.gov.au/resources/publications/cost-recovery-implementation-statement-cris-administration-of-private-health-insurance-second-tier-default-benefits?language=en

Prescribed List: https://www.health.gov.au/resources/publications/cost-recovery-implementation-statement-administration-of-the-prescribed-list-of-medical-devices-and-human-tissue-products-2026-2027?language=en

TGA: https://www.tga.gov.au/sites/default/files/2026-06/cost-recovery-implementation-statement-2026-27.pdf

6.4 Net Cash Appropriation Arrangements

	2026	2025
	$'000	$'000
Total comprehensive loss per the Statement of Comprehensive Income	**(36,721)**	(40,832)
Plus: depreciation/amortisation of assets funded through appropriations (departmental capital budget funding and/or equity injections)[1]	**39,452**	51,565
Plus: depreciation of right-of-use assets[3]	**46,632**	57,013
Less: cost recovered depreciation[2]	**(2,996)**	(8,012)
Less: lease principal repayments[3]	**(43,625)**	(51,804)
Net Cash Operating Surplus	**2,742**	7,929

The Government funds the Department on a net cash appropriation basis, where appropriation revenue is not provided for depreciation and amortisation expenses. Depreciation and amortisation is included in the Department's cost recovered operations to the extent that it relates to those activities.

1. From 2010-11, the Government introduced net cash appropriation arrangements where revenue appropriations for depreciation/amortisation expenses of non-corporate Commonwealth entities and selected corporate Commonwealth entities were replaced with a separate capital budget provided through equity appropriations. Capital budgets are appropriated in the period when cash payment for capital expenditure is required.

2. The Department excludes the cost of depreciation and amortisation related to the cost recovered activities outlined in Note 6.3.

3. The inclusion of depreciation/amortisation expenses related to ROU leased assets and the lease liability principal repayment amount reflects the impact of AASB 16 Leases, which does not directly reflect a change in appropriation arrangements.

Managing Uncertainties

This section analyses how the Department manages financial risks within its operating environment.

7.1 Contingent Assets and Liabilities

7.1A: Departmental - contingent assets and liabilities

Quantifiable Contingencies

	Claims for costs & penalties		Total	
	2026	2025	**2026**	2025
	$'000	$'000	**$'000**	$'000
Contingent assets				
Balance from previous period	**3,217**	23,273	**3,217**	23,273
New contingent assets recognised	**160**	1,545	**160**	1,545
Re-measurement	**300**	1,399	**300**	1,399
Assets realised	**(515)**	(23,000)	**(515)**	(23,000)
Assets expired	**(28)**	-	**(28)**	-
Total contingent assets	**3,134**	3,217	**3,134**	3,217
Contingent liabilities				
Balance from previous period	**3,510**	-	**3,510**	-
New contingent liabilities recognised	**160**	2,260	**160**	2,260
Re-measurement	**365**	1,250	**365**	1,250
Liabilities expired	**(100)**	-	**(100)**	-
Total contingent liabilities	**3,935**	3,510	**3,935**	3,510
Net contingent assets / (liabilities)	**(801)**	(293)	**(801)**	(293)

Unquantifiable contingencies

As at 30 June 2026, the Department was involved in a range of litigation matters before the courts, which potentially raise significant but unquantifiable contingent liabilities. These matters include civil penalty proceedings alleging contraventions of the *Therapeutic Goods Act 1989 (Cth)*, which, if successful may result in the court ordering the respondents to pay pecuniary penalties to the Commonwealth. If the Secretary is unsuccessful in the civil penalty proceedings, or other litigation, the Department may be ordered to pay the costs of the other parties. It is not possible to quantify either the amounts of any pecuniary penalties that may be payable to the Commonwealth or the sum of any costs that may be awarded against the Commonwealth and disclosure of estimates of these amounts could prejudice the Commonwealth's position in litigation or settlement negotiations.

The Department has provided indemnities to its transactional bankers in relation to any claims made against the bank resulting from errors in the Department's payment files. There were no claims made during the year.

Accounting Policy

Contingent liabilities and contingent assets are not recognised in the statement of financial position but are reported in the notes. These amounts may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

7.1B: Administered - contingent assets and liabilities

	Indemnities		Claims for damages or costs		Aged Care Accommodation Bond Guarantee Scheme		Total	
	2026	2025	**2026**	2025	**2026**	2025	**2026**	2025
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Contingent assets								
Balance from previous period	**-**	-	**7,275**	7,364	**-**	-	**7,275**	7,364
New contingent assets recognised	**-**	-	**180**	261	**-**	-	**180**	261
Re-measurement	**-**	-	**144**	814	**-**	-	**144**	814
Assets realised	**-**	-	**(88)**	(200)	**-**	-	**(88)**	(200)
Assets expired	**-**	-	**(65)**	(964)	**-**	-	**(65)**	(964)
Total contingent assets	**-**	**-**	**7,446**	**7,275**	**-**	**-**	**7,446**	7,275
Contingent liabilities								
Balance from previous period	**82,607**	79,000	**15,763**	7,227	**-**	-	**98,370**	86,227
New contingent liabilities recognised	**450**	-	**209**	249	**-**	-	**659**	249
Re-measurement	**(8,414)**	3,607	**-**	9,500	**-**	-	**(8,414)**	13,107
Liabilities realised	**-**	-	**-**	(813)	**-**	-	**-**	(813)
Liabilities expired	**-**	-	**(251)**	(400)	**-**	-	**(251)**	(400)
Total contingent liabilities	**74,643**	82,607	**15,721**	15,763	**-**	-	**90,364**	98,370
Net contingent liabilities							**(82,918)**	(91,096)

Quantifiable Administered Contingencies

The above table contains contingent liabilities in respect to:

a) Indemnities: $74.6m (2025: $82.6m). The amount largely relates to an estimate of the Department's liability in respect of medical indemnity payments under the High Cost Claims Scheme.

b) Claims for costs: The table reports a contingent asset of up to $7.4m (2025: $7.3m) and a contingent liability of up to $15.7m (2025: $15.8m) in respect of claims for costs.

Unquantifiable Administered Contingent Assets

At 30 June 2026, the Department has a number of items for which it was not possible to estimate the amounts of any eventual payments that may be received in relation to these claims. These items are outlined below but were not included in the above table.

Legal action seeking compensation

The Department is engaged in legal action against certain pharmaceutical companies seeking compensation for savings it claims were denied to the Commonwealth because interim injunctions granted to these companies in unsuccessful patent litigation delayed generic versions of drugs being listed on the Pharmaceutical Benefits Scheme, and thereby delayed statutory and price disclosure-related price reductions for these drugs.

Public Hospital Funding

The Auditor-General Report No. 26 2018-19 *Australian Government Funding of Public Hospital Services - Risk Management, Data Monitoring and Reporting Arrangements* identified the potential for duplicate payments for the same public hospital service through funding under the Medicare Benefits Schedule and through public hospital funding under the National Health Reform Agreement. The Department has agreed to identify and prevent potential duplicate payments, including Medicare Benefits Schedule payments, by the Australian Government for public hospital services, and identify and recover past duplicate payments to the maximum extent permitted by law.

The 2026-2031 Addendum to the NHRA notes that the Commonwealth and States are jointly responsible for the funding of public hospitals and working together on policy decisions or areas of the system that impact each other's responsibilities. The Addendum requires information to be shared between jurisdictions and the Commonwealth on a timely basis to support reconciliations of payments, data reporting and calculations of activities to ensure funding is accurate, transparent and accountable. In relation to the contingent asset for the recovery of overpayments, the nature of the contingency is such that the quantum of the potential asset is unknown at this stage.

Under the Addendum, the Administrator will determine the data matching business rules, with consultation of the Parties, to identify services funded by the Commonwealth through both this Addendum and other Commonwealth programs. The relevant Commonwealth officer responsible for compliance will notify, consult and validate with the States and Territories prior to undertaking any compliance activity relating to duplicate payments.

Unquantifiable Administered Contingent Liabilities

At 30 June 2026, the Department has a number of items for which it was not possible to estimate the amounts of any eventual payments that may be required in relation to these claims. These items are outlined below but were not included in the above table.

Aged Care Accommodation Bond Guarantee Scheme

A Guarantee Scheme has been established through the *Aged Care (Accommodation Payment Security) Act 2006* and *Aged Care (Accommodation Payment Security) Levy Act 2006*. Under the Guarantee Scheme, if a provider becomes insolvent or bankrupt and is unable to repay outstanding accommodation payment balances to aged care residents, the Australian Government will repay the balances owing to each resident. In return, the residents' rights to pursue the defaulting provider for recovery of the accommodation payment funds transfers to the Government. In the event the Government cannot recover the full amount from the defaulting provider, it may levy all providers holding accommodation payment balances to recoup the shortfall. It is not possible to quantify the Australian Government's contingent liability in the event the Guarantee Scheme is activated. The Department has implemented risk mitigation strategies which should reduce the risk of default and thereby activation of the Guarantee Scheme.

The new *Aged Care Act 2024* has introduced Financial and Prudential Standards aimed at strengthening financial governance and sustainability of aged care providers, which include maintaining sufficient liquidity to meet financial obligations, and manage investments responsibly, including Refundable Accommodation Deposits (RADs). From the latest available information, the maximum contingent liability, in the unlikely event that all providers defaulted, is $48.4 billion. Since the Guarantee Scheme was introduced, it has been activated 17 times with refunds of approximately $180.2 million (including interest) made to 541 residents or their estates. It is difficult to predict the frequency and size of future activations, although frequency has increased in the last 5 years. The Commonwealth's exposure through the Guarantee Scheme increases directly in line with an increase in Refundable Accommodation Deposit values and interest rate rises.

Diagnostic Products Agreement

The Australian Government has provided an indemnity to a review of certain matters in relation to Diagnostics Products Agreement. The indemnity provides certain specified members of the review the same level of indemnity as Australian Government officers for the purpose of the review. For the period ended 30 June 2026 no claims have been made (2025: Nil).

Medical Indemnity

Services Australia delivers the Exceptional Claims Scheme (ECS) for doctors and the duplicate scheme for allied health professionals on behalf of the Australian Government. Under these schemes, the Australian

Government reimburses medical indemnity insurers for 100% of the cost of private practice claims that are above the limit of their medical indemnity insurance contract, which is typically $20m. To be covered by the ECS, practitioners must have medical indemnity insurance cover to at least a threshold of $15m for claims arising from incidents notified between 1 January and 30 June 2003, and $20m for claims notified from 1 July 2003. As the Allied Health ECS commenced on 1 July 2020, only incidents on or from this date will be eligible.

As at 30 June 2026, the Department had received two Qualifying Claim Certificates, which may give rise to claims under the ECS. However, no payment has been requested, and the Department's liability remains uncertain and cannot be quantified.

Medical Rural Bonded Scholarship Waivers

The Department is using debt waivers to address the creation of statutory debts by participants of the Medical Rural Bonded Scholarship Scheme who inadvertently breached contractual arrangements. In 2025–26, the Department waived $77.07m in statutory debts, however further waivers may be required. The potential total value of the waivers cannot yet be quantified.

CSL Ltd

Under existing agreements, the Australian Government has indemnified CSL Ltd for certain existing and potential claims made for personal injury, loss or damage suffered through therapeutic and diagnostic use of certain products manufactured by CSL Ltd. For the period ended 30 June 2026 no claims have been made (2025: Nil).

The Australian Government has indemnified CSL Ltd for a specific range of events that occurred during the Plasma Fractionation Agreement from 1 January 1994 to 31 December 2004, where alternative cover was not arranged by CSL Ltd. For the period ended 30 June 2026 no claims have been made (2025: Nil).

Lifeblood

Under certain conditions, the Government and the state and territory governments may jointly provide indemnity for Lifeblood through a cost sharing arrangement for claims, both current and potential, regarding personal injury and loss or damage suffered by a recipient of certain blood products.

Deeds of Agreement between the Australian Red Cross Society and the National Blood Authority in relation to the operation of Lifeblood and the development of principal manufacturing sites in Sydney and Melbourne include certain indemnities and a limitation of liability in favour of Lifeblood. These indemnities cover defined sets of potential business, product and employee risks and liabilities. Certain indemnities for specific risk events that operate within the terms of the Deed of Agreement are capped and must meet specified pre-conditions.

Indemnities and limitation of liability only operate in the event of the expiry and non-renewal, or the early termination of the Deed, and only within a certain scope. They are also subject to appropriate limitations and conditions including in relation to mitigation, contributory fault, and the process of handling relevant claims.

For the period ended 30 June 2026 no claims have been made (2025: Nil).

Vaccines

Under certain conditions the Australian Government has provided indemnities to the manufacturer of a certain vaccine held by the Government, covering possible adverse events that could result from the use of the vaccine in an emergency situation. Indemnities have also been provided to a manufacturer of pandemic and pre pandemic influenza vaccines for the supply or future supply of influenza vaccines under certain conditions. For the period ended 30 June 2026 no claims have been made (2025: Nil).

The Australian Government has also provided indemnities to the suppliers of COVID-19 vaccines, for which the Australian Government has entered into Advance Purchasing Agreements, covering certain liabilities that could result from the use of the vaccines. These agreements support access to vaccines from AstraZeneca Pty Ltd, Pfizer Inc, Moderna Switzerland GmbH and Novavax, Inc. Information regarding any indemnity claims made by the suppliers of COVID-19 vaccines is not disclosed due to its highly sensitive nature.

mRNA manufacturing facilities

The Commonwealth has entered into a strategic partnership with Moderna Australia Pty Ltd (Moderna) to establish domestic mRNA vaccine manufacturing capacity and capability in Australia. Under the agreement between the Commonwealth and Moderna, the Commonwealth may enter into a pandemic vaccine advance purchase agreement with Moderna for locally manufactured mRNA vaccines in certain circumstances where an infectious disease pandemic is declared. Moderna will also have the capacity to supply the Commonwealth with non-pandemic vaccines through a non-pandemic vaccine supply agreement.

The Commonwealth does provide indemnities to Moderna under these arrangements to cover certain liabilities that could result from the implementation of the arrangement.

There are also indemnities provided by Moderna in favour of the Commonwealth for certain liabilities, which reflect risk sharing between the parties and are intended to limit financial exposure to the Australian Government.

7.2 Financial Instruments

	2026	2025
	$'000	$'000
7.2A: Categories of financial instruments		
Financial assets at amortised cost		
Cash and cash equivalents	**165,414**	141,978
Goods and services receivable	**17,814**	15,500
Less: Impairment allowance	**(3,188)**	(3,904)
Total financial assets at amortised cost	**180,040**	153,574
Total financial assets	**180,040**	153,574
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors	**98,703**	97,391
Total financial liabilities measured at amortised cost	**98,703**	97,391
Total financial liabilities	**98,703**	97,391

Accounting Policy
In accordance with AASB 9 *Financial Instruments*, the Department classifies its financial assets as financial assets measured at amortised cost. This classification is based on the Department's business model for managing the financial assets and contractual cash flow characteristics at the time of initial recognition.

Financial assets at amortised cost
Financial assets included in this category must meet two criteria:
a) the financial asset is held in order to collect the contractual cash flows, and
b) the cash flows are solely payments of principal and interest on the principal outstanding amount.

Amortised cost is determined using the effective interest rate method.

Impairment of financial assets
Financial assets are assessed for impairment at the end of each reporting period based on the ECL methodology, using the general approach which measures the loss allowance based on an amount equal to lifetime expected credit losses where risk has significantly increased, or an amount equal to 12-month expected credit losses if risk has not increased.

The simplified approach for trade, contract and lease receivables is used. This approach always measures the loss allowance as the amount equal to the lifetime expected credit losses.

A write-off constitutes a derecognition event where the write-off directly reduces the gross carrying amount of the financial asset.

Financial liabilities at amortised cost
Supplier and other payables are recognised at amortised cost to the extent that the goods or services have been received and irrespective of having been invoiced.

7.2B: Net gains or losses on financial assets		
Financial assets at amortised cost		
Impairment	**(262)**	(404)
Total financial assets at amortised cost	**(262)**	(404)
Total financial assets	**(262)**	(404)

7.3 Administered – Financial Instruments

	2026	2025
	$'000	$'000
7.3A: Financial Instruments		
Financial assets at amortised cost		
Cash and cash equivalents	**1,937,327**	245,490
Accrued recoveries revenue	**1,343,297**	1,513,536
Goods and services receivables	**3,574,390**	2,233,692
Advances and loans	**132,359**	142,371
Less: Impairment allowance	**(460,892)**	(380,251)
Total financial assets at amortised cost	**6,526,481**	3,754,837
Financial assets at fair value through other comprehensive income		
Other investments	**180,602**	190,860
Total financial assets at fair value through other comprehensive income	**180,602**	190,860
Total financial assets	**6,707,083**	3,945,697
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade creditors	**208,297**	272,700
Grants payable	**427,541**	253,172
Total financial liabilities measured at amortised cost	**635,838**	525,872
Total financial liabilities	**635,838**	525,872
7.3B: Net gains or losses on financial assets		
Financial assets at amortised cost		
Interest revenue	**6,621**	7,133
Impairment	**(190,272)**	(92,948)
Net losses on financial assets at amortised cost	**(183,651)**	(85,814)
Net losses on financial assets	**(183,651)**	(85,814)

7.4 Fair Value Measurement

	Note	Fair Value measurements at the end of the reporting period 2026 $'000	2025 $'000
Non-financial assets			
Land and buildings	3.2A	**78,650**	52,739
Plant and equipment	3.2A	**6,815**	6,811
Total non-financial assets		**85,465**	59,550

Accounting Policy

The Department's assets are held for operational purposes, not for the purposes of deriving a profit. As allowed for by AASB 13 *Fair Value Measurement*, quantitative information on significant unobservable inputs used in determining fair value is not disclosed.

Assets held at fair value include land and buildings and property, plant and equipment. Assets not held at fair value include intangibles, assets under construction and ROU assets.

The Department reviews its valuation model each year via a desktop exercise with a formal revaluation undertaken every three years, with the most recent comprehensive revaluation undertaken in 2024. If during the conduct of the desktop valuation, indicators of a particular asset class change materially, that class is subject to specific valuation in the reporting period. Both the comprehensive revaluation and the desktop review were undertaken by JLL.

The categories of fair value measurement are:

a) Level 1: quoted prices (unadjusted) in active markets for identical assets that the entity can access at measurement date.

b) Level 2: inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly.

c) Level 3: unobservable inputs.

Departmental assets are held at fair value and are measured at category Levels 2 or 3 with no fair values measured at category Level 1.

Leasehold improvements are predominantly measured at category Level 3 and the valuation methodology used is Depreciated Replacement Cost (DRC). Under DRC the estimated cost to replace the asset is calculated, with reference to new replacement price per square metre, and then adjusted to take into account its consumed economic benefit (accumulated depreciation). The consumed economic benefit has been determined based on the professional judgement of JLL with regard to physical, economic and external obsolescence factors. For all leasehold improvement assets, the consumed economic benefit is determined based on the term of the associated lease.

Property, plant and equipment is measured at either category Level 2 or 3. The valuation methodology is either market approach or DRC, based on replacement cost for a new equivalent asset. The significant unobservable inputs used in the fair value measurement of PPE assets are the market demand and JLL's professional judgement.

The Department deems transfers between levels of fair value hierarchy to have occurred when there has been a change to the inputs to the fair value measurement (for instance from observable to unobservable and vice versa) and the significance that the changed input has in determining the fair value measurement.

Other Information

8.1 Current/Non-current Distinction for Assets and Liabilities

8.1A: Current/non-current distinction for assets and liabilities

	2026 $'000	2025 $'000
Assets expected to be recovered in:		
No more than 12 months		
Cash and cash equivalents	**165,414**	141,978
Trade and other receivables	**468,383**	454,112
Land and buildings	**10,065**	5,880
Plant and equipment	**1,456**	1,335
Computer software	**28,537**	24,046
Other financial assets	**5,184**	18,905
Other non-financial assets	**33,307**	23,139
Total no more than 12 months	**712,345**	669,394
More than 12 months		
Land and buildings	**468,969**	530,195
Plant and equipment	**5,428**	5,523
Computer software	**271,339**	238,146
Total more than 12 months	**745,737**	773,865
Total assets	**1,458,082**	1,443,259
Liabilities expected to be settled in:		
No more than 12 months		
Suppliers	**137,168**	127,386
Employee payables	**35,992**	31,670
Other payables	**3,369**	1,973
Leases	**45,602**	47,293
Employee provisions	**83,899**	78,580
Total no more than 12 months	**306,030**	286,902
More than 12 months		
Leases	**403,375**	466,112
Employee provisions	**195,702**	184,039
Other provisions	**15,049**	12,205
Total more than 12 months	**614,126**	662,356
Total liabilities	**920,156**	949,258

8.1B: Current/non-current distinction for assets and liabilities	2026 $'000	2025 $'000
Assets expected to be recovered in:		
No more than 12 months		
Cash and cash equivalents	**1,937,327**	245,490
Accrued recoveries revenue	**913,507**	1,145,533
Trade and other receivables	**3,657,775**	2,331,364
Inventories	**40,267**	133,967
Other non-financial assets	**-**	413,016
Total no more than 12 months	**6,548,876**	4,269,369
More than 12 months		
Trade and other receivables	**116,542**	124,015
Investment in portfolio entities	**2,966,063**	2,763,523
Other investments	**180,602**	190,860
Inventories	**514,076**	593,814
Total more than 12 months	**3,777,283**	3,672,212
Total assets	**10,326,159**	7,941,582
Liabilities expected to be settled in:		
No more than 12 months		
Suppliers payable	**215,614**	278,951
Subsidies payable	**108,035**	120,681
Personal benefits payable[1]	**2,351,001**	2,184,884
Grants payable[1]	**427,541**	253,172
Subsidies provision	**155,534**	122,124
Personal benefits provision	**1,394,094**	1,233,289
Total no more than 12 months	**4,651,819**	4,193,102
More than 12 months		
Subsidies provision	**535,241**	513,516
Total more than 12 months	**535,241**	513,516
Total liabilities	**5,187,060**	4,706,618

[1.] The 2024-25 financial statements incorrectly attributed $253.172m to personal benefits payable and $2,184.884m to grants payable. Comparative information has been restated to correct this.

8.2 Restructuring

Administrative Arrangements Order of 13 May 2025

The Administrative Arrangements Order (AAO) was re-issued on 13 May 2025. In response:

- The Department was renamed to the Department of Health, Disability and Ageing,
- Responsibility for the disability and carers function, which supports the independence of, and economic participation by people with disability and carers by providing targeted support, was transferred to the Department from the Department of Social Services (DSS), and
- Responsibility for the sport and recreation policy and functions was transferred from the Department to the Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts (DITRDCSA).

Administered investments assets were transferred during 2024-25. The remaining transfers of assets, liabilities, employees and funding occurred during 2025-26 in order to align with determinations made under section 72 of the *Public Service Act 1999* to move staff between agencies, and under section 75 of the *Public Governance, Performance and Accountability Act 201*3 to transfer appropriation funding between agencies.

Transfers of associated departmental and administered assets and liabilities took effect as at 3 July 2025 for the DITRDCSA Machinery of Government change (MoG) and 31 July 2025 for the DSS MoG. Additionally, Sport and Recreation Special Account was transferred to DITRDCSA effective 1 September 2025.

Establishment of the Australian Centre for Disease Control

The Australian Centre for Disease Control (CDC) was established as an agency within the Health, Disability and Ageing portfolio effective 1 January 2026 following the passage of the *Australian Centre for Disease Control Act 2025*.

Responsibility for the key public health functions, including communicable disease surveillance, pandemic preparedness, human biosecurity and health protection, and environmental health, was transferred from the interim CDC within the Department to the CDC during 2025-26.

8.2A: Departmental - restructuring

	2026 Disability and Carers function DSS $'000
FUNCTIONS ASSUMED	
Assets recognised	
Appropriations receivable	**17,813**
Trade and other receivables	**7**
Land, buildings and PPE	**17,074**
Other non-financial assets	**492**
Total assets recognised	**35,386**
Liabilities recognised	
Employee provisions and payables	**18,347**
Lease liabilities	**15,320**
Total liabilities recognised	**33,667**
Net assets recognised	**1,719**

No income or expenses relating to the Disability and Carers function were recognised by the DSS in the 2025-26 financial year.

	2026 Sport and Recreation function DITRDCSA $'000	2026 Interim Australian Centre for Disease Control function CDC $'000
FUNCTIONS RELINQUISHED		
Assets relinquished		
Appropriations receivable	**3,000**	**7,520**
Total assets relinquished	**3,000**	**7,520**
Liabilities relinquished		
Employee provisions and payables	**3,000**	**7,520**
Total liabilities relinquished	**3,000**	**7,520**
Net assets/(liabilities) relinquished	**-**	**-**

The net book value of assets and liabilities were transferred for no consideration.

8.2B: Administered - restructuring

	2026 Disability and Carers function DSS $'000	2025 Disability and Carers function DSS $'000
FUNCTIONS ASSUMED		
Assets recognised		
Cash in special accounts	**10,187**	-
Investments in portfolio agencies	**-**	2,365,991
Trade and other receivables	**83**	-
Total assets recognised	**10,270**	2,365,991
Liabilities recognised		
Suppliers payable	**2,605**	-
Grants payable	**45**	-
Total liabilities recognised	**2,650**	-
Net assets recognised	**7,620**	2,365,991

No income or expenses relating to the Disability and Carers function were recognised by the DSS in the 2025-26 financial year.

	2026 Sport and Recreation function DITRDCSA $'000	2025 Sport and Recreation function DITRDCSA $'000
FUNCTIONS RELINQUISHED		
Assets relinquished		
Cash in special accounts	**182**	-
Investments in portfolio entities	**-**	359,483
Total assets relinquished	**182**	359,483
Net assets relinquished	**182**	359,483

The net book value of assets and liabilities were transferred for no consideration.

8.3 Budget Variances Commentary

Explanations of Major Variances to Budget

The table below provides explanations for the major variances between the Department's original budget estimates, as published in the May 2025 Portfolio Budget Statements, and the actual financial performance and position for the year.

The information presented below should be read in the context of the following:

1. Variance commentary has been included when the variance is greater than 10% of the original estimate and it has been considered important for a reader's understanding or is relevant to the assessment of the discharge of accountability and for analysis of the Department's performance. Variances below this threshold are not included unless considered significant by their nature.

2. Variances attributable to factors which would not reasonably have been identifiable at the time of budget preparation, such as impairment of assets or impacts of Australian Government Bond Rates, have not been included in the explanations unless they have been considered important for a reader's understanding of the Department's performance.

3. Variances relating to cash flow are a result of the factors explained for variances related to net cost of services, or assets and liabilities.

4. The 2025-26 original budget was prepared before the 2024-25 final budget outcome was known. As a consequence, the opening balance of the statement of financial position was estimated, and in some cases variances between the 2024-25 final budget outcome and the 2025-26 original budget estimates can be attributable to unanticipated movements in prior year-end balances.

5. The 2025-26 original budget does not include the disability and carers function gained and still includes the sport and recreation function lost pursuant to the AAOs reissued on 13 May 2025.

6. The original budget is not audited.

Departmental budget variances

Variance explanation	Impacted line items
The variance in the net cost of services was as a result of the following factors:	
(a) Employee benefits expenses were higher than budgeted due to the costs of disability and carers employees transferred to the Department under the AAOs re-issued on 13 May 2025, together with the full-year impact of the March 2025 pay increase (3.8%) and three months of the March 2026 pay increase (3.4%).	Employee benefits
(b) Lower than budgeted depreciation and amortisation expense is consistent with a significantly lower value of additions to computer software during the year.	Depreciation and amortisation
The variance in total assets was a result of the following factors:	
(a) A higher than expected cash and cash equivalents balance was due to the cash in the Therapeutic Goods Administration special account.	Cash and cash equivalents
(b) A higher than expected trade and other receivables balance was driven by the value of unspent annual appropriations at the end of the year.	Trade and other receivables

(c) The value of computer software assets is the net result of asset capitalisations, the amortisation and impairment charges for the year, and the flow-on effects of previously capitalised development costs reclassified to operating expenses in prior years. Asset capitalisations have been significantly lower than the budget, reflecting delays across a range of projects.	Computer software
(d) Other non-financial assets relate to prepaid expenses and are driven by the value of IT-related prepayments. These balances fluctuate from year to year with no predictable pattern.	Other non-financial assets
The variance in total liabilities was a result of the following factors:	
(a) The variances in supplier payables and other payables are due to the difference in classification of unearned revenue between the original budget and the actual figures.	Supplier payables / Other payables
(b) The increase in employee-related balances is consistent with the significant increase in employee benefits expenses compared to the original budget. This increase was driven by the additional costs associated with the disability and carers employees transferred to the Department under the AAOs re-issued on 13 May 2025, together with the full-year impact of the March 2025 pay increase (3.8%) and three months of the March 2026 pay increase (3.4%). Employee payables were also affected by the timing of the final pay run relative to the last business day of the year.	Employee payables / Employee provisions
(c) The variance in other provisions is due to a reassessment and a resulting increase in the value of provisions for restoration costs in connection with the Department's leases.	Other provisions
The variance in the Department's net asset position overall was an increase in the net asset position compared to the original budget, attributable to cash in special accounts and unspent annual appropriations balances.	

Administered budget variances

Variance explanation	Impacted line items
The variance in the net cost of services was as a result of the following factors:	
(a) The variance in grants expenses is driven by additional funding announced since the 2025–26 Original Budget for Primary Care, Health Workforce, Mental Health and Health Research, as well as the inclusion of a full year of disability and carers grant payments. Due to the timing of the 2025 Machinery of Government changes relative to the preparation of the 2025–26 Original Budget, these grant payments were reported in the Original Budget by DSS.	Grants expenses
(b) The variance in supplier expenses is driven by the inclusion of a full year of participant plan payments to the NDIA. Responsibility for these payments was transferred to the Health, Disability and Ageing portfolio under the AAOs re-issued on 13 May 2025.	Suppliers expenses
(c)The higher value of payments reflects the inclusion of a full year of NDIA agency costs and Hearing Australia appropriations. These agencies were transferred to the Health, Disability and Ageing portfolio at the end of 2024–25 under the AAOs re-issued on 13 May 2025.	Payments to corporate Commonwealth entities

(e) The write-off relates to inventory, including National Medical Stockpile (NMS) and COVID-19 vaccines, that has been identified as impaired as it has passed its expiry date. Inventory balances have continued to decline gradually in the years following the COVID-19 pandemic, reflecting both the impairment of expiring stock and limited targeted replenishment based on modelled supply and demand. The current year's figures also include the write-off of prepaid inventory balances ahead of the planned transition of COVID-19 vaccines to the National Immunisation Program.	Write-down and impairment of non-financial assets
(f) Lower than anticipated recoveries of unspent grant funding and other miscellaneous receipts. These items can fluctuate with no predictable pattern.	Other revenue
The variance in total assets was as a result of the following factors:	
(a) The original budget included balances accumulated over multiple years in the Medicare Guarantee Fund (Health) Special Account. At 30 June 2025, the actual closing balance of that special account was nil. The purpose of this special account is to secure ongoing funding for the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). The closing balance at 30 June 2026 is within expectations.	Cash and cash equivalents
(b) The higher balance was driven by PBS drug recoveries from pharmaceutical companies that had been invoiced but not yet collected during the year. These amounts can fluctuate significantly depending on demand for relevant PBS items and when various medicines reach the thresholds that trigger recoveries.	Accrued recoveries revenue / Trade and other receivables
(c) The higher balance in investments in portfolio agencies is due to the transfer of the NDIA and Hearing Australia to the Health, Disability and Ageing portfolio late in 2024–25, pursuant to the AAOs re-issued on 13 May 2025.	Investments in portfolio agencies
(d) Inventory and prepaid inventory balances are driven by the value of in-year purchases, deployments and write-offs of NMS stock, COVID-19 vaccines and consumables. For budgeting purposes, a consistent level of inventory holdings is assumed. Actual inventory balances continue to decline gradually in the years following the COVID-19 pandemic due to a combination of expiring stock being impaired and limited targeted replenishment based on modelled supply and demand.	Inventories
(e) The remainder of prepaid inventory balances were written off during the year ahead of the planned transition of COVID vaccines to the National Immunisation Program.	Other non-financial assets (Inventory prepayments)
The variance in total liabilities was as a result of the following factors:	
(a) Variance in the personal benefits payable and provisions is consistent and in line with the variance in the personal benefit expense.	Personal benefits payable / provisions
(b) Grant liabilities vary from year to year depending on the timing of grant rounds and milestones	Grants payable

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Part 5:
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Appendix 1: Expenses and resources statements

Entity resource statement	Actual available appropriation for 2025–26 $'000 (A)	Payments made 2025–26 $'000 (B)	Balance remaining 2025–26 $'000 (A) – (B)
DEPARTMENTAL			
Annual appropriations – ordinary annual services[1]			
Prior year departmental appropriation	301,022	300,781	241
Departmental appropriation	1,713,495	1,408,754	304,741
Departmental capital budget[2]	15,335	11,736	3,599
Receipts retained under PGPA Act - section 74	235,910	235,910	-
Total annual appropriations – ordinary annual services	**2,265,762**	**1,957,181**	**308,581**
Annual appropriations – other services – non-operating[3]			
Prior year departmental appropriation	135,109	63,924	71,185
Equity injections	68,919	-	68,919
Total annual appropriations – other services – non-operating	**204,028**	**63,924**	**140,104**
Total departmental annual appropriations	**2,469,790**	**2,021,105**	**448,685**
Special accounts[4]			
Opening Balance	140,376		
Appropriation receipts[5]	85,629		
Non-appropriation receipts to special accounts	247,844		
Payments made		311,388	
Total special accounts	**473,849**	**311,388**	**162,461**
Less departmental appropriations drawn from annual/special appropriations and credited to special accounts	85,629		
TOTAL DEPARTMENTAL RESOURCING	**2,858,010**	**2,332,493**	**611,146**

Entity resource statement	Actual available appropriation for 2025–26 $'000 (A)	Payments made 2025–26 $'000 (B)	Balance remaining 2025–26 $'000 (A) – (B)
ADMINISTERED			
Annual appropriations – ordinary annual services[1]			
Outcome 1	8,565,704	7,840,614	
Outcome 2	2,150,250	2,144,190	
Outcome 3	6,630,876	5,861,158	
Outcome 4	38,717,335	38,526,416	
Receipts retained under PGPA Act - section 74	-		
Payments to corporate Commonwealth entities	2,750,114	2,750,114	
Total annual appropriations – ordinary annual services	**58,814,279**	**57,122,492**	
Annual appropriations - other services - non-operating[3]			
Prior year administered appropriation	54,877	43,811	
Administered assets and liabilities	155,278	29,378	
Receipts retained under PGPA Act - section 74	-		
Payments to corporate Commonwealth entities	22,949	22,949	
Total annual appropriations – other services – non-operating	**233,104**	**96,138**	
Total administered annual appropriations	**59,047,383**	**57,218,630**	
Administered special appropriations			
Special appropriations limited by criteria/entitlement			
Aged Care (Accommodation Payment Security) Act 2006		-	
Aged Care Act 1997		12,625,402	
Aged Care Act 2024		22,873,214	
Health Insurance Act 1973		-	
National Health Act 1953		2,723,868	
Medical Indemnity Act 2002		139,630	
Private Health Insurance Act 2007		7,613,134	
Dental Benefits Act 2008		361,357	
Medicare Guarantee Act 2017		-	
Public Governance, Performance and Accountability Act 2013-s77		1,228	
Total administered special appropriations		**46,337,833**	

Entity resource statement	Actual available appropriation for 2025–26 $'000 (A)	Payments made 2025–26 $'000 (B)	Balance remaining 2025–26 $'000 (A) – (B)
Special accounts			
Opening Balance	156,307		
Appropriation receipts[4]	15,726		
Appropriation receipts - other entities[5]	58,191,246		
Non-appropriation receipts to special accounts	44,651		
Payments made	-	56,793,282	
Total special accounts	**58,407,930**	**56,793,282**	**1,614,648**
Less administered appropriations drawn from annual/special appropriations and credited to special accounts	15,726		
Less payments to corporate entities from annual/special appropriations	2,773,063	2,773,063	
TOTAL ADMINISTERED RESOURCING[6]	**114,666,524**	**157,576,682**	**1,614,648**
Total resourcing and payments for the Department of Health, Disability and Ageing	**117,524,534**	**159,909,175**	**2,225,794**

Notes:

1 Appropriation Act (No.1) 2025–26, Appropriation Act (No.3) 2025–26, Appropriation Act (No.5) 2025–26 and Supply Act (No. 1) 2025–26. This also includes prior year Departmental appropriation and section 74 retained revenue receipts, and excludes amounts permanently withheld under s51 of the PGPA Act.

2 Departmental capital budgets are not separately identified in Appropriation Acts and form part of ordinary annual services items. For accounting purposes, this amount has been designated as a 'contributions by owners'.

3 Appropriation Act (No.2) 2025–26, Appropriation Act (No. 6) 2025–26 and Supply Act (No. 2) 2025–26.

4 Appropriation receipts from the Department of Health, Disability and Ageing's annual appropriations 2025–26 included above.

5 Appropriation receipts from other entities credited to the Department of Health, Disability and Ageing's special accounts.

6 Total resourcing excludes the actual available appropriation for all Special Appropriations.

Outcome 1 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 1.1: Health Research, Coordination and Access[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	161,992	169,315	7,323
to Services for Other Entities and Trust Moneys Special Account	(21,081)	(11,717)	9,364
Special Accounts			
Biomedical Translation Fund	-	3,814	3,814
Services for Other Entities and Trust Moneys Special Account	-	15,666	15,666
Expense adjustment[2]	-	(3,949)	(3,949)
Medical Research Future Fund	650,000	649,136	(864)
Special appropriations			
National Health Act 1953 – blood fractionation, products and blood related products to National Blood Authority	1,285,884	1,300,516	14,632
Public Governance, Performance and Accountability Act 2013 s77 – repayments	2,000	1,228	(772)
Health Infrastructure	-	34,069	34,069
Payments to corporate entities	359,616	359,616	-
Total for Program 1.1	**2,438,411**	**2,517,693**	**79,282**
Program 1.2: Mental Health and Suicide Prevention[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	1,606,220	1,611,834	5,614
Total for Program 1.2	**1,606,220**	**1,611,834**	**5,614**
Program 1.3: First Nations Health[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	1,223,316	1,199,603	(23,713)
Total for Program 1.3	**1,223,316**	**1,199,603**	**(23,713)**
Program 1.4: Health Workforce			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	1,984,364	1,995,142	10,778
Total for Program 1.4	**1,984,364**	**1,995,142**	**10,778**
Program 1.5: Preventive Health and Chronic Disease Support[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	863,135	856,012	(7,123)
Total for Program 1.5	**863,135**	**856,012**	**(7,123)**
Program 1.6: Primary Health Care Quality and Coordination			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	1,247,057	1,219,468	(27,589)
Total for Program 1.6	**1,247,057**	**1,219,468**	**(27,589)**

Outcome 1 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 1.7: Primary Care Practice Incentives and Medical Indemnity			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	508,609	515,109	6,500
Special appropriations			
Medical Indemnity Act 2002	135,562	175,636	40,074
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	5,793	12,881	7,088
Total for Program 1.7	**649,964**	**703,626**	**53,662**
Program 1.8: Health Protection, Emergency Response and Regulation[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	984,677	265,965	(718,712)
Other Services Appropriation Act (No. 2)	-	121	121
Non cash expenses[3]	166,644	629,340	462,696
Total for Program 1.8	**1,151,321**	**895,426**	**(255,895)**
Program 1.9: Immunisation[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	31,915	28,429	(3,486)
to Australian Immunisation Register Special Account	(7,133)	(4,009)	3,124
Special Accounts			
Australian Immunisation Register Special Account (s78 PGPA Act)	9,819	6,933	(2,886)
Expense adjustment [2]	-	-	-
Special appropriations			
National Health Act 1953 - essential vaccines	702,328	694,010	(8,318)
Total for Program 1.9	**736,929**	**725,362**	**(11,567)**

Outcome 1 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Outcome 1 totals by appropriation type			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	8,611,285	7,860,877	(750,408)
to Special Accounts	(28,214)	(15,726)	12,488
Other Services Appropriation Act (No. 2)	-	121	121
Special appropriations	2,131,567	2,218,339	86,772
Special Accounts	659,819	671,600	11,781
Non cash expenses[3]	166,644	629,340	462,696
Payments to corporate entities	359,616	359,616	-
Departmental expenses			
Departmental appropriation[4]	649,858	610,457	(39,401)
to Special Accounts	(80,407)	(85,629)	(5,222)
Expenses not requiring appropriation in the budget year[5]	12,120	12,373	253
Special Accounts			
AICIS [6]	23,110	21,828	(1,282)
OGTR[7]	8,312	9,137	825
TGA[8]	287,002	280,423	(6,579)
Expense adjustment[2]	(2,929)	8,433	11,362
Total expenses for Outcome 1	**12,797,783**	**12,581,188**	**(216,595)**
Average staffing level (number)	**3,333**	**3,409**	**76**

Notes:

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

2 Special accounts are reported on a cash basis. The adjustment reflects the difference between expense and cash, and eliminates any inter-entity transactions.

3 Non cash expenses relate to the write down of stockpile inventory due to expiration, consumption and distribution.

4 Departmental appropriation combines 'Ordinary annual services (Appropriation Act 1)' and 'Revenue from independent sources (s74)'.

5 Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and resources received free of charge.

6 Australian Industrial Chemicals Introduction Scheme (AICIS) Special Account.

7 Office of the Gene Technology Regulator (OGTR) Special Account.

8 Therapeutic Goods Administration (TGA) Special Account.

Outcome 2 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 2.1: Medical Benefits			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	144,062	129,809	(14,253)
Special account			
Medicare Guarantee Fund – medical benefits	34,959,960	35,270,804	310,844
accrual adjustment	40,155	(146,347)	(186,502)
Total for Program 2.1	**35,144,177**	**35,254,267**	**110,090**
Program 2.2: Hearing Services			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	700,787	681,093	(19,694)
Total for Program 2.2	**700,787**	**681,093**	**(19,694)**
Program 2.3: Pharmaceutical Benefits			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	1,165,372	989,696	(175,676)
Special account			
Medicare Guarantee Fund – pharmaceutical benefits	21,072,363	20,090,948	(981,415)
accrual adjustment	(128,785)	803,987	932,772
Total for Program 2.3	**22,108,950**	**21,884,631**	**(224,319)**
Program 2.4: Private Health Insurance			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	11,736	9,500	(2,236)
Special appropriations			
Private Health Insurance Act 2007 – incentive payments and rebate	7,562,910	7,651,067	88,157
Total for Program 2.4	**7,574,646**	**7,660,568**	**85,922**
Program 2.5: Dental Services[1]			
Administered expenses			
Special appropriations			
Dental Benefits Act 2008	374,288	362,685	(11,603)
Total for Program 2.5	**374,288**	**362,685**	**(11,603)**
Program 2.6 Health Benefit Compliance			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	19,009	11,959	(7,050)
Total for Program 2.6	**19,009**	**11,959**	**(7,050)**

Outcome 2 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 2.7: Targeted Assistance – Aids and Appliances			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	48,719	48,719	-
Special appropriations			
National Health Act 1953 – aids and appliances	510,653	517,577	6,924
Total for Program 2.7	**559,372**	**566,296**	**6,924**
Outcome 2 totals by appropriation type			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	2,089,685	1,870,777	(218,908)
Special appropriations	8,447,851	8,531,330	83,479
Payments to corporate entities			
Special accounts	56,032,323	55,361,752	(670,571)
accrual adjustment	(88,630)	657,640	746,270
Departmental expenses			
Departmental appropriation[2]	286,252	269,336	(16,916)
Expenses not requiring appropriation in the Budget year[3]	3,372	3,705	333
Total expenses for Outcome 2	**66,770,853**	**66,694,540**	**(76,313)**
Average staffing level (number)	**1,021**	**1,067**	**46**

Notes:

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

2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act 1)' and 'Revenue from independent sources (s74)'.

3 Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and resources received free of charge.

Outcome 3 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 3.1: Access and Information			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	838,986	788,208	(50,778)
Total for Program 3.1	**838,986**	**788,208**	**(50,778)**
Program 3.2: Aged Care Services[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)[2]	4,662,077	4,584,964	(77,113)
Zero Real Interest Loans			
– appropriation	-	-	-
– expense adjustment[3]	-	(3,441)	(3,441)
Special appropriations			
Aged Care Act 1997 – flexible care	373,008	362,578	(10,430)
Aged Care Act 1997 – residential and home care	11,496,300	11,485,221	(11,079)
Aged Care Act 2024 – Assistive Technology and Home Modification Scheme	198,124	358,047	159,923
Aged Care Act 2024 – Residential Care Subsidies	17,494,045	16,998,257	(495,788)
Aged Care Act 2024 – Specialist Aged Care Programs	441,594	404,105	(37,489)
Aged Care Act 2024 – Support at Home	6,599,045	5,871,840	(727,205)
National Health Act 1953 – continence aids payments	135,356	134,023	(1,333)
Aged Care Act 2006 – Accommodation Payment Security	-	4,456	4,456
Total for Program 3.2	**41,399,549**	**40,200,051**	**(1,199,498)**
Program 3.3: Aged Care Quality			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	459,538	427,348	(32,190)
Total for Program 3.3	**459,538**	**427,348**	**(32,190)**

Outcome 3 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Outcome 3 totals by appropriation type			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	5,960,601	5,800,520	(160,081)
– expense adjustment[3]	-	(3,441)	(3,441)
Special appropriations	36,737,472	35,618,527	(1,118,945)
Departmental expenses			
Departmental appropriation[4]	775,881	727,482	(48,399)
Expenses not requiring appropriation in the budget year[5]	19,655	20,245	590
Total expenses for Outcome 3	**43,493,609**	**42,163,333**	**(1,330,276)**
Average staffing level (number)	**2,295**	**2,106**	**(189)**

Notes:

1 This Program excludes special purpose payments issued to State and Territory Governments by the Treasury as part of the Federal Financial Relations (FFR) Framework.

2 'Ordinary annual services (Appropriation Act No. 1)' against program 3.2 excludes amounts appropriated in Bill 1 for Zero Real Interest Loans as this funding is not accounted for as an expense.

3 Payments under the zero real interest loans program are a loan to aged care providers and not accounted for as an expense. The concessional loan discount is the expense and represents the difference between an estimate of the market rate of interest, and that recovered under the loan agreement, over the life of the loan. This adjustment recognises the difference between the appropriation and the concessional loan discount expense.

4 Departmental appropriation combines 'Ordinary annual services (Appropriation Act 1)' and 'Revenue from independent sources (s74)'. Actual expenses include a significant adjustment to reflect the appropriate accounting treatment of IT Software services.

5 Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and resources received free of charge.

Outcome 4 – Expenses and Resources	Budget Estimate 2025–26 $'000 (A)	Actual 2025–26 $'000 (B)	Variation $'000 (B) – (A)
Program 4.1: Disability and Carers[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	477,071	476,280	(791)
to SOETM Special Account 2021	(9,029)	(7,133)	1,896
Special account expenses			-
SOETM Special Account 2021	9,729	7,833	(1,896)
Total for Program 4.1	**477,771**	**476,980**	**(791)**
Program 4.2: National Disability Insurance Scheme[1]			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	38,216,824	38,216,634	(190)
Payment to corporate entities	2,390,498	2,390,498	-
Total for Program 4.2	**40,607,322**	**40,607,132**	**(190)**
Outcome 4 totals by appropriation type			
Administered expenses			
Ordinary annual services Appropriation Act (No. 1)	38,693,895	38,692,915	(980)
to Special Accounts	(9,029)	(7,133)	1,896
Special accounts	9,729	7,833	(1,896)
Payment to corporate entities	2,390,498	2,390,498	-
Departmental expenses			
Departmental appropriation[2]	130,807	130,007	(800)
Expenses not requiring appropriation in the budget year[3]	1,288	1,539	251
Total expenses for Outcome 4	**41,217,188**	**41,215,659**	**(1,529)**
Average staffing level (number)	**424**	**456**	**32**

Notes:

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

2 Departmental appropriation combines 'Ordinary annual services (Appropriation Act 1)' and 'Revenue from independent sources (s74)'.

3 Expenses not requiring appropriation in the budget year are made up of depreciation expense, amortisation, make good expense, operating losses and resources received free of charge.

Appendix 2: Workforce statistics

The following tables show workforce statistics for the Department of Health, Disability and Ageing for 2025–26. This includes Indigenous staff numbers, staff numbers by classification, distribution of staff by state and territory, as well as a range of other information relating to workplace arrangements, remuneration and salary structures.

For information on the department's workforce composition and human resource policies, refer to **Part 3.4: People** in this Annual Report.

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Table 1: All Ongoing Employees (2025–26)

State/ Territory	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
Australian Capital Territory	1,214	69	1,283	2,518	641	3,159	18	2	20	-	-	-	-	-	-	4,462
New South Wales	218	21	239	434	93	527	4	1	5	-	-	-	-	-	-	771
Northern Territory	4	1	5	19	3	22	-	-	-	-	-	-	-	-	-	27
Queensland	148	12	160	371	92	463	2	3	5	-	-	-	-	-	-	628
South Australia	76	3	79	132	36	168	1	-	1	-	-	-	-	-	-	248
Tasmania	32	6	38	49	20	69	-	-	-	-	-	-	-	-	-	107
Victoria	231	17	248	417	86	503	3	1	4	-	-	-	-	-	-	755
Western Australia	28	6	34	75	26	101	-	-	-	-	-	-	-	-	-	135
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	3	1	4	4	1	5	-	-	-	-	-	-	-	-	-	9
Total	**1,954**	**136**	**2,090**	**4,019**	**998**	**5,017**	**28**	**7**	**35**	**-**	**-**	**-**	**-**	**-**	**-**	**7,142**

Table 2: All Non-Ongoing Employees (2025–26)

State/ Territory	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
Australian Capital Territory	15	10	25	32	13	45	2	-	2	-	-	-	-	-	-	72
New South Wales	13	2	15	15	1	16	-	-	-	-	-	-	-	-	-	31
Northern Territory	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Queensland	6	1	7	4	2	6	-	-	-	-	-	-	-	-	-	13
South Australia	1	-	1	2	-	2	-	-	-	-	-	-	-	-	-	3
Tasmania	1	-	1	2	-	2	-	-	-	-	-	-	-	-	-	3
Victoria	7	-	7	9	5	14	-	1	1	-	-	-	-	-	-	22
Western Australia	-	-	-	-	2	2	-	-	-	-	-	-	-	-	-	2
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**43**	**13**	**56**	**64**	**23**	**87**	**2**	**1**	**3**	**-**	**-**	**-**	**-**	**-**	**-**	**146**

Table 3: Australian Public Service Act Ongoing Employees (2025–26)[1]

Classification	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
SES 3	2	-	2	7	-	7	-	-	-	-	-	-	-	-	-	9
SES 2	19	-	19	21	-	21	-	-	-	-	-	-	-	-	-	40
SES 1	53	1	54	102	7	109	1	-	1	-	-	-	-	-	-	164
Holder of Public Office	1	-	1	1	-	1	-	-	-	-	-	-	-	-	-	2
EL 2[3]	291	8	299	548	69	617	3	-	3	-	-	-	-	-	-	919
EL 1	635	43	678	1,251	349	1,600	8	3	11	-	-	-	-	-	-	2,289
APS 6	529	43	572	1,126	340	1,466	9	3	12	-	-	-	-	-	-	2,050
APS 5	229	9	238	521	115	636	3	-	3	-	-	-	-	-	-	877
APS 4	58	7	65	187	35	222	1	-	1	-	-	-	-	-	-	288
APS 3	15	1	16	25	12	37	-	-	-	-	-	-	-	-	-	53
APS 2	4	2	6	8	4	12	-	-	-	-	-	-	-	-	-	18
APS 1	3	1	4	-	3	3	-	-	-	-	-	-	-	-	-	7
Health Entry Level Broadband	38	2	40	65	-	65	2	1	3	-	-	-	-	-	-	108
Legal 2	12	3	15	23	4	27	-	-	-	-	-	-	-	-	-	42
Legal 1	19	-	19	67	10	77	1	-	1	-	-	-	-	-	-	97
Chief Medical Officer	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Officer 6	1	-	1	2	-	2	-	-	-	-	-	-	-	-	-	3
Medical Officer 5	9	2	11	7	1	8	-	-	-	-	-	-	-	-	-	19
Medical Officer 4	10	3	13	16	11	27	-	-	-	-	-	-	-	-	-	40

Table 3: Australian Public Service Act Ongoing Employees (2025–26)[1] continued

Classification	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
Medical Officer 3	16	8	24	18	29	47	-	-	-	-	-	-	-	-	-	71
Medical Officer 2	1	2	3	1	2	3	-	-	-	-	-	-	-	-	-	6
Senior Public Affairs 2	1	-	1	5	-	5	-	-	-	-	-	-	-	-	-	6
Public Affairs 3	2	-	2	13	4	17	-	-	-	-	-	-	-	-	-	19
Public Affairs 2	3	-	3	2	2	4	-	-	-	-	-	-	-	-	-	7
Senior Principal Research Scientist	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	1
Principal Research Scientist	1	-	1	3	1	4	-	-	-	-	-	-	-	-	-	5
Senior Research Scientist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Research Scientist	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1
Other[4]	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1
Total	**1,954**	**136**	**2,090**	**4,019**	**998**	**5,017**	**28**	**7**	**35**	**-**	**-**	**-**	**-**	**-**	**-**	**7,142**

Notes:

1 Includes staff on leave and secondment and staff acting at a higher level for any period as at 30 June 2026.

2 SES are defined as Senior Executive Service staff.

3 EL are defined as Executive Level staff.

4 'Other' includes the Secretary.

Table 4: Australian Public Service Act Non-Ongoing Employees (2025–26)[1]

Classification	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
SES 3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SES 2	2	-	2	2	-	2	-	-	-	-	-	-	-	-	-	4
SES 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Holder of Public Office	-	-	-	2	1	3	-	-	-	-	-	-	-	-	-	3
EL 2	5	4	9	2	3	5	-	-	-	-	-	-	-	-	-	14
EL 1	13	4	17	11	6	17	-	1	1	-	-	-	-	-	-	35
APS 6	7	1	8	23	1	24	-	-	-	-	-	-	-	-	-	32
APS 5	7	-	7	9	5	14	-	-	-	-	-	-	-	-	-	21
APS 4	4	-	4	9	2	11	1	-	1	-	-	-	-	-	-	16
APS 3	1	-	1	3	-	3	-	-	-	-	-	-	-	-	-	4
APS 2	3	2	5	3	-	3	1	-	1	-	-	-	-	-	-	9
APS 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Entry Level Broadband	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Legal 2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Legal 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chief Medical Officer	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	1
Medical Officer 6	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	1
Medical Officer 5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Officer 4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Officer 3	1	-	1	-	1	1	-	-	-	-	-	-	-	-	-	2
Medical Officer 2	-	1	1	-	3	3	-	-	-	-	-	-	-	-	-	4
Public Affairs 3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 4: Australian Public Service Act Non-Ongoing Employees (2025–26) continued

Classification	Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	
Public Affairs 2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Senior Principal Research Scientist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Principal Research Scientist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**43**	**13**	**56**	**64**	**23**	**87**	**2**	**1**	**3**	**-**	**-**	**-**	**-**	**-**	**-**	**146**

Notes:

[1] Includes staff on leave and secondment and staff acting at a higher level for any period as at 30 June 2026.

Table 5: Australian Public Service Act Employment type by location (2025–26)

State/Territory	Ongoing	Non-Ongoing	Total
Australian Capital Territory	4,462	72	4,534
New South Wales	771	31	802
Northern Territory	27	0	27
Queensland	628	13	641
South Australia	248	3	251
Tasmania	107	3	110
Victoria	755	22	777
Western Australia	135	2	137
External Territories	-	-	-
Overseas	9	-	9
Total	**7,142**	**146**	**7,288**

Table 6: Australian Public Service Act Indigenous Employment (2025–26)

Employment status	Total
Ongoing	155
Non-Ongoing	3
Total	**158**

Table 7: Number of SES staff covered by Individual Agreements

Nominal Classification	Number of SES staff with Individual Agreements					Total
	Woman/ Female	Man/ Male	Non-binary	Prefers not to answer	Uses a different term	
SES 3	6	1	-	-	-	7
SES 2	19	19	-	-	-	38
SES 1	90	44	-	-	-	134
Chief Medical Officer	-	1	-	-	-	1
Medical Officer 6	2	1	-	-	-	3
Medical Officer 5	8	11	-	-	-	19
Total	**125**	**77**	**-**	**-**	**-**	**202**

Table 8: Key management personnel (KMP) length of term at 30 June 2026

During 2025–26, we had 14 executives who met the definition of key management personnel (KMP). Their names and length of term as KMP are summarised below:

Name	Position title	Term as KMP
Blair Comley	Secretary	Full year
Elizabeth Develin	Deputy Secretary	Full year
Sonja Stewart	Deputy Secretary	Full year
Anthony Lawler	Deputy Secretary	Full year
Penny Shakespeare	Deputy Secretary	Full year
Celia Street	Deputy Secretary	Full year
Michael Kidd	Chief Medical Officer	Full year
Mary Wood	Deputy Secretary	Full year
Rachel Balmanno	Chief Operating Officer	27 September 2025 to 30 June 2026
Robyn Shannon	Deputy Secretary	1 July to 31 December 2025
Charles Wann	Chief Operating Officer	1 July to 26 September 2025
Matthew Williams	Deputy Secretary (acting)	Part year (acting > 20 days)
Luke Mansfield	Deputy Secretary (acting)	Part year (acting > 20 days)
Susan Henderson	Deputy Secretary (acting)	Part year (acting > 20 days)

Table 9: Information about remuneration for key management personnel[1]

In the notes to the financial statements (Note 4.2 Key Management Personnel Remuneration), the department disclosed $5.8m in KMP expenses during 2025–26. In accordance with the Public Governance, Performance and Accountability Rule 2014, this information is disaggregated as follows.

		Short-term benefits $			Post employment benefits $	Long-term benefits $		Termination benefits $	Total remuneration $
Name	Position title	Base salary[1]	Bonuses	Other benefits and allowances	Superannuation contributions	Long service leave	Other long-term benefits		
Blair Comley	Secretary	986,529	-	3,266	30,169	23,750	-	-	1,043,714
Elizabeth Develin	Deputy Secretary	471,795	-	67,455	71,439	10,504	-	-	621,194
Sonja Stewart	Deputy Secretary	461,463	-	38,188	88,172	8,885	-	-	596,708
Anthony Lawler	Deputy Secretary	479,727	-	3,476	71,581	12,673	-	-	567,457
Penny Shakespeare	Deputy Secretary	452,374	-	3,266	83,123	16,816	-	-	555,580
Celia Street	Deputy Secretary	421,990	-	3,266	62,799	27,926	-	-	515,981
Michael Kidd	Chief Medical Officer	371,619	-	65,594	56,603	6,569	-	-	500,384
Mary Wood	Deputy Secretary	408,452	-	3,266	74,355	11,853	-	-	497,926
Rachel Balmanno	Chief Operating Officer	329,805	-	2,603	57,072	25,968	-	-	415,448
Robyn Shannon	Deputy Secretary	178,979	-	2,303	39,616	6,185	-	-	227,083
Charles Wann	Chief Operating Officer	79,043	-	1,101	19,697	2,837	-	-	102,678

Table 9: Information about remuneration for key management personnel[1] continued

		Short-term benefits $			Post employment benefits $	Long-term benefits $		Termination benefits $	Total remuneration $
Name	**Position title**	**Base salary[1]**	**Bonuses**	**Other benefits and allowances**	**Superannuation contributions**	**Long service leave**	**Other long-term benefits**		
Matthew Williams	Deputy Secretary (acting)[2]	37,605	-	313	5,812	2,590	-	-	46,321
Luke Mansfield	Deputy Secretary (acting)[2]	35,485	-	313	6,328	1,273	-	-	43,398
Susan Henderson	Deputy Secretary (acting)[2]	36,158	-	288	4,434	908	-	-	41,787

Notes:

1 Base salary includes unused annual leave and is adjusted for part time arrangements and part year employment.

2 Includes employees who have acted in a KMP position in excess of 4 weeks and who have exercised significant authority in planning, directing and controlling the activities of the department.

Table 10: Information about remuneration for senior executives

		Short-term benefits $			Postemployment benefits $	Other long-term benefits $		Termination benefits $	Total remuneration $
Total remuneration bands	Number of senior executives[1]	Average base salary	Average bonuses	Average other benefits and allowances	Average superannuation contributions	Average long service leave[2]	Average other long-term benefits	Average termination benefits[3]	Average total remuneration[4]
$0 - $220,000	34	103,651		3,172	19,273	3,805			129,901
$220,001- $245,000	4	180,379		2,459	39,093	6,827			228,758
$245,001- $270,000	4	208,303		4,399	36,300	9,815			258,817
$270,001- $295,000	19	233,018		2,941	39,472	11,209			286,639
$295,001- $320,000	53	250,496		4,364	40,025	13,122			308,007
$320,001- $345,000	38	269,656		6,740	45,671	11,717			333,785
$345,001- $370,000	23	285,637		11,123	46,685	13,931			357,376
$370,001- $395,000	12	291,398		18,309	51,734	22,400			383,840
$395,001- $420,000	10	325,156		10,710	53,251	16,644			405,761
$420,001- $445,000	12	343,409		9,685	58,498	20,090			431,681
$445,001- $470,000	2	362,233		32,871	48,174	12,927			456,205
$470,001- $495,000	1	403,950		10,877	59,835	14,206			488,868
$495,001- $520,000	2	406,465		27,808	62,724	10,242			507,239
$520,001- $545,000	1	447,917		3,266	81,506	452			533,141
$545,001- $570,000	-	-	-	-	-	-	-	-	-

Notes:

1 Any employee who held a substantive senior executive or equivalent position during 2025–26 is represented as one. This excludes those executives who have been disclosed in Table 9, and 3 senior executives who were on leave without pay for the entire financial year, or until their termination.

2 Excludes bond rate impacts on long service leave.

3 No termination payments were made to senior executives or equivalent employees during 2025–26.

4 The table includes the part year impact of senior executives who either commenced or separated during the year, including 6 senior executives who were partially reported in Table 9.

Table 11: Information about remuneration for other highly paid staff

		Short-term benefits $			Postemployment benefits $	Other long-term benefits $		Termination benefits $	Total remuneration $
Total remuneration bands	Number of other highly paid staff	Average base salary	Average bonuses	Average other benefits and allowances	Average superannuation contributions	Average long service leave[1]	Average other long-term benefits	Average termination benefits[2]	Average total remuneration[3]
$265,000- $270,000	-	-	-	-	-	-	-	-	-
$270,001- $295,000	10	225,627	-	10,252	36,388	7,036	-	-	279,302
$295,001- $320,000	1	106,027	-	-	29,064	3,167	-	179,318	317,576
$320,001- $345,000	-	-	-	-	-	-	-	-	-
$345,001- $370,000	-	-	-	-	-	-	-	-	-
$370,001- $395,000	-	-	-	-	-	-	-	-	-
$395,001- $420,000	-	-	-	-	-	-	-	-	-
$420,001- $445,000	-	-	-	-	-	-	-	-	-
$445,001- $470,000	-	-	-	-	-	-	-	-	-
$470,001- $495,000	-	-	-	-	-	-	-	-	-
$495,001- $520,000	-	-	-	-	-	-	-	-	-

Notes:

1 Excludes bond rate and changes to actuarial parameter impacts on long service leave.

2 A termination payment was made to one (1) employee during 2025–26.

3 The table includes the part year impact of some employees who have temporarily filled a senior executive position during 2025–26.

Table 12: Australian Public Service Act Employment salary ranges by classification level (Minimum/Maximum) (2025–26)

Classification	Minimum Salary $	Maximum Salary $
SES 3	406,379	472,163
SES 2	295,921	359,203
SES 1	232,938	281,034
EL 2	149,077	176,499
EL 1	124,951	142,509
APS 6	101,679	114,709
APS 5	90,830	98,228
APS 4	84,740	89,538
APS 3	74,795	82,905
APS 2	64,723	70,629
APS 1	57,497	62,195
Minimum/Maximum range	**57,497**	**472,163**

Table 13: Non-SES staff covered by Individual Flexibility Arrangements and the Enterprise Agreement (EA) at 30 June 2026

Number of staff covered by the:		Total
EA	EA and an approved Individual Flexibility Arrangement	
7,012	68	**7,080**

Disclaimer: To ensure all current Individual Flexibility Arrangements (IFAs) are captured, the information in Table 13 is based on the nominal position occupied by the staff member as at 30 June 2026. While IFAs are not applied during periods of higher duties, IFA entitlements are reinstated upon return to the nominal position.

Table 14: Non-salary benefits

Non-SES staff
Access to engage in private medical practice for Medical Officers
Access to Individual Flexibility Arrangements
Access to negotiated discount registration/membership fees to join a fitness or health club
Access to paid leave at half pay
Access to remote locality conditions
Access to the Employee Assistance Program
Additional cultural and ceremonial Aboriginal and Torres Strait Islander employee's leave
Australian Defence Force Reserve, full-time service or cadet leave
Annual close down and early stand down at Easter and Christmas Eve
Annual leave
Annual free onsite influenza vaccinations for staff
Bereavement and compassionate leave
Breastfeeding facilities and family care rooms
Cash-out of annual leave
Community service leave
Financial assistance to access financial advice for staff 54 years and older
Financial assistance to access financial advice for staff involved in a redundancy process
Flexible working locations and home-based work including, where appropriate, access to laptop computers, dial-in facilities, and mobile phones
Flex time (not all non-SES employees) and time in lieu
Hepatitis B vaccinations for staff who are required to come into regular contact with members of the community classified as at increased risk regarding hepatitis B
Miscellaneous leave with or without pay
Parental leave – includes maternity, adoption and partner leave
Personal/carers leave
Provision of eyesight testing and reimbursement of prescribed eyewear costs
Public Transport Loan Scheme
Purchased and extended purchased leave
Recognition of travel time
Relocation assistance
Reflection room
Study assistance
Support for professional and personal development
SES staff
All the above benefits except flex time and access to Individual Flexibility Arrangements
Car parking
Individual determinations made under section 24(1) of the *Public Service Act 1999*
Development allocation
Airport lounge membership (ceased May 2026)
IT Reimbursement Scheme (ceased August 2025)

Table 15: Health, Disability and Ageing Entry Level Broadband

Local title	APS classification	Salary ranges at 30 June 2026 $
Health Entry-Level (A, C, or T)[1]	APS 4	89,538
		87,072
		84,740
	APS 3	82,905
		79,144
		76,913
		74,795
	APS 2	70,629
		68,668
		66,665
		64,723
	APS 1	62,195
		59,301
		57,497
	Staff at 20 years of age	-
	Staff at 19 years of age	-
	Staff at 18 years of age	-
	Staff under 18 years of age	-

Notes:

[1] (A) = Apprentice, (C) = Cadet and (T) Trainee.

Table 16: Health, Disability and Ageing Graduate Broadband

Local Title	APS Classification	Salary ranges at 30 June 2026 $
Health and Aged Care Graduate	APS 5	98,228
		93,299
		90,830
Soft barrier		
Health and Aged Care Graduate	APS 4	89,538
		87,072
		84,740

Table 17: Professional 1 salary structure

Local title	APS classification	Salary ranges at 30 June 2026 $
Professional 1	APS 5	98,228
	APS 5	93,299
	APS 4	87,073
	APS 4[1]	84,741
	APS 3[2]	79,144
	APS 3	76,913

Notes:

[1] Salary on commencement for a professional with a 4-year degree (or higher).

[2] Salary on commencement for a professional with a 3-year degree.

Table 18: Medical Officer salary structure

Local title	Salary ranges at 30 June 2026 $
Medical Officer Class 6	359,203
	342,328
	325,455
	308,578
Medical Officer Class 5	306,345
	294,533
	282,720
	270,909
Medical Officer Class 4	212,009
	200,115
	192,612
Medical Officer Class 3	184,927
	176,624
Medical Officer Class 2	166,437
	157,964
Medical Officer Class 1	144,353
	130,768
	121,504
	112,161

Table 19: Legal salary structure

Local title	Classification	Salary ranges at 30 June 2026 $
Legal 2	EL 2	182,680
		174,749
		169,100
Legal 1	EL 1	154,622
		142,345
		130,387
	APS 6	112,198
		106,612
		101,679
	APS 5	94,111
	APS 4	88,229

Table 20: Public Affairs salary structure

Local title	Classification	Salary ranges at 30 June 2026 $
Senior Public Affairs 2	EL 2	183,562
		176,426
Senior Public Affairs 1	EL 2	168,026
Public Affairs 3	EL 1	153,195
		145,766
		136,905
Public Affairs 2	APS 6	114,827
		106,612
		101,679
	APS 5	98,228
		93,299
	APS 4	89,538
	APS 4[1]	84,741

Notes:

[1] This level is generally reserved for staff with less than 2 years' experience.

Table 21: Research Scientist salary structure

Local title	Classification	Salary ranges at 30 June 2026 $
Senior Principal Research Scientist	EL 2	224,156
		201,636
Principal Research Scientist	EL 2	197,680
		191,554
		183,736
		178,891
		172,257
Senior Research Scientist	EL 2	179,500
		168,026
		162,599
		149,077
Research Scientist	EL 1	134,270
		124,951
	APS 6	106,806
		101,231
		98,478

Appendix 3: Processes Leading to Pharmaceutical Benefits Advisory Committee Consideration – Annual Report for 2025–26

This is the 17th Annual Report to Parliament on the processes that lead to the Pharmaceutical Benefits Advisory Committee's (PBAC's) consideration of submissions and recommendations to list items on the Pharmaceutical Benefits Scheme (PBS).

This Annual Report has been prepared pursuant to subsection 99YBC(5) of the *National Health Act 1953* (the Act). The Act requires that:

The Secretary must, as soon as practicable after June 30 in each year, prepare and give to the Minister a report on processes leading up to PBAC consideration, including:

a. *the extent and timeliness with which responsible persons are provided copies of documents relevant to their submission to the PBAC*
b. *the extent to which responsible persons exercise their right to comment on these documents, including appearing at hearings before the PBAC*
c. *the number of responsible persons seeking a review of the PBAC recommendation.*

Pharmaceutical Benefits Advisory Committee

Section 100A of the Act establishes the PBAC as an independent expert body appointed by the Australian Government. Members include doctors, health professionals and health economists, as well as industry and consumer representatives. It considers medicines for listing on the PBS, and no new medicine can be listed unless the PBAC makes a positive recommendation to the Minister for Health, Disability and Ageing (the Minister). Other provisions of the Act also confer functions on the PBAC to consider vaccines for inclusion on the National Immunisation Program (NIP). The PBAC holds 3 scheduled meetings each year, usually in March, July and November, as well as 3 intracycle meetings each year.[153]

When considering a medicine for listing, the PBAC considers:

- the medical condition(s) for which the medicine was registered for use in Australia
- how effective and safe it is likely to be, compared to therapies Australians already have access to (including non-medical treatments)
- who is most likely to benefit
- whether any additional cost is commensurate with improvements over alternative therapies.

The PBAC has 2 sub-committees to help with analysis and advice in these areas. They are the:

- Economics Sub-Committee which assesses clinical and economic evaluations of medicines submitted to the PBAC for listing and advises the PBAC on the technical aspects of these evaluations.
- Drug Utilisation Sub-Committee which assesses estimates on projected usage and the financial cost of medicines. It also collects and analyses data on actual use, including in comparison with different countries, and provides advice to the PBAC.

[153] The data in this report does not include data for intracycle or extraordinary meetings. Applicants can only lodge submissions to the main meetings through the Health Products Portal.

Role of the PBAC

The PBAC:

- recommends medicines and medicinal preparations to the Minister for funding under the PBS
- recommends vaccines to the Minister for funding under the NIP
- advises the Minister and department about cost-effectiveness (value-for-money) which includes cost (overall budget)
- recommends the circumstances in which the government could fund a medicine (e.g. maximum quantities and repeats based on community use, and any restrictions on the indications)
- regularly reviews items listed on the PBS
- advises the Minister about any other matters relating to the PBS and NIP, including on any matter referred to it by the Minister.

Requirements of Section 99YBC of the Act

a) Extent and timeliness of the provision of relevant documents to responsible persons[154]

The PBAC provides applicants (usually pharmaceutical industry sponsors of medicines and medicinal products) with documents relevant to their submissions in an orderly, timely and transparent fashion. The PBAC Secretariat provides the documents to the applicants 7 weeks before the applicable PBAC meeting. The PBAC refer to these documents as commentaries.

The PBAC Secretariat receives applicants' pre-subcommittee response(s) 6 weeks before the relevant PBAC meeting. Following the meeting of PBAC sub-committees, the PBAC Secretariat provides relevant sub-committee papers to applicants 2 weeks before the relevant PBAC meeting. Applicants then provide their responses to the PBAC Secretariat one week before the PBAC meeting.

Following the PBAC meeting, the Secretariat provides summary advice on the outcomes of PBAC consideration to the relevant applicant on the Wednesday of the week after the meeting. The Secretariat provides detailed advice 3 weeks (positive recommendations) and 5 weeks (all other outcomes) after the relevant PBAC meeting.

b) Extent to which responsible persons comment on their commentaries

During 2025–26, the PBAC held 3 ordinary meetings. The PBAC received 84 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions for consideration by the PBAC in 2025–26. All submissions proceeded to evaluation. All except one applicant responded to their commentaries. Three submissions were evaluated but then withdrawn before the PBAC meeting. One submission was held over to a future meeting.

[154] Responsible person for a brand of a pharmaceutical item is defined by the *National Health Act 1953* to be a person determined by the Minister under section 84AF to be the responsible person for the brand of the pharmaceutical item.

The PBAC considered 80 of the submissions at its main meetings. For the:

- July 2025 PBAC meeting – Applicants lodged 28 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions.[155] The department received a total of 28 responses for the commentaries. One applicant withdrew their submission before the PBAC meeting. The PBAC had held over a Category 1 submission from the March 2025 meeting, but the applicant withdrew the submission before the July meeting. In total, the PBAC considered 27 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions. Fifteen responsible persons appeared before the PBAC.
- November 2025 PBAC meeting – Applicants lodged 28 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions. The department received a total of 28 responses for the commentaries. One applicant withdrew their submission before the PBAC meeting. In total, the PBAC considered 27 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions. Fourteen responsible persons appeared before the PBAC.
- March 2026 PBAC meeting – Applicants lodged 28 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions. The departmental received a total of 27 responses for the commentaries. The department did not receive a response for one of the submissions because it was withdrawn before the PBAC meeting. The PBAC held over one submission to a future meeting. In total, the PBAC considered 26 Category 1, Category 2, facilitated resolution pathway, and standard re-entry submissions. Sixteen responsible persons appeared before the PBAC.

c) Number of responsible persons seeking a review of PBAC recommendations

During the 2025–26 financial year, there were no requests to the PBAC for an Independent Review.

Number and category of submissions lodged for each PBAC meeting in 2025–26[156]

Table 1: July 2025 PBAC Meeting

Category	Number
1	6
2	18
3	9
4	7
Committee Secretariat	1
Early resolution	0
Early re-entry	2
Facilitated resolution	0
Standard re-entry	4
Total	**47**

[155] Submission categories 1-4 and resubmission pathways (including standard re-entry and facilitated resolution) are described in the PBS Procedure Guidance for Listing Medicines on the Pharmaceutical Benefits Scheme under Types of submissions and Resubmission pathways.

[156] The categories for submissions are prescribed by the National Health (Pharmaceuticals and Vaccines—Cost Recovery) Regulations 2022.

Table 2: November 2025 PBAC Meeting

Category	Number
1	10
2	14
3	5
4	7
Committee Secretariat	1
Early resolution	0
Early re-entry	1
Facilitated resolution	0
Standard re-entry	4
Total	**42**

Table 3: March 2026 PBAC Meeting

Category	Number
1	8
2	16
3	6
4	10
Committee Secretariat	0
Early resolution	0
Early re-entry	2
Facilitated resolution	0
Standard re-entry	4
Total	**46**

Number and category of withdrawn submissions for each PBAC meeting in 2025–26

Table 4: July 2025 PBAC Meeting

Category	Number	Reasons for withdrawal
1	1	Determined by applicant, reason not available
2	0	N/A
3	1	Determined by applicant, reason not available
4	1	Determined by applicant, reason not available
Committee Secretariat	0	N/A
Early resolution	0	N/A
Early re-entry	0	N/A
Facilitated resolution	0	N/A
Standard re-entry	0	N/A

Table 5: November 2025 PBAC Meeting

Category	Number	Reasons for withdrawal
1	1	Determined by applicant, reason not available
2	0	N/A
3	0	N/A
4	0	N/A
Committee Secretariat	0	N/A
Early resolution	0	N/A
Early re-entry	0	N/A
Facilitated resolution	0	N/A
Standard re-entry	0	N/A

Table 6: March 2026 PBAC Meeting

Category	Number	Reasons for withdrawal
1	0	N/A
2	1	Determined by applicant, reason not available
3	0	N/A
4	0	N/A
Committee Secretariat	0	N/A
Early resolution	0	N/A
Early re-entry	0	N/A
Facilitated resolution	0	N/A
Standard re-entry	0	N/A

Number of responsible persons that responded to their commentaries, including appearing before PBAC meetings

All except one of the responsible persons who submitted a Category 1, Category 2, facilitated resolution pathway, and standard re-entry submission to the PBAC during 2025–26 responded to their commentary.

Responsible persons can appear before the PBAC by attending the meeting (either live or virtually) or via a pre-recorded or written mechanism.

July 2025 PBAC Meeting

Number of Category 1, Category 2, facilitated resolution pathway and standard re-entry submissions[157]	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC	
		Live/ Virtual	Pre-recorded/ Written
28	28	7	8

[157] This does not include Category 3, Category 4, Early re-entry and Early resolution submissions. See Number and category of submissions lodged for each PBAC meeting in 2025–26 for a count of all submissions lodged for each PBAC meeting.

November 2025 PBAC Meeting

Number of Category 1, Category 2, facilitated resolution pathway and standard re-entry submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC	
		Live/ Virtual	Pre-recorded/ Written
28	28	6	8

March 2026 PBAC Meeting

Number of Category 1, Category 2, facilitated resolution pathway and standard re-entry submissions	Number of responsible persons that responded to their commentaries	Number of responsible persons that appeared before PBAC	
		Live/ Virtual	Pre-recorded/ Written
28	27	7	9

Number of pre-submission meetings held in 2025–26

Pre-submission meetings per month	Meetings held
2025	
July	0
August	5
September	9
October	0
November	0
December	3
2026	
January	2
February	0
March	0
April	3
May	7
June	0
Total	**29**

Appendix 4: Report on the operation of the Australian Industrial Chemicals Introduction Scheme for 2025–26

About the Australian Industrial Chemicals Introduction Scheme (AICIS): Protecting Australians and the environment from industrial chemical risks through robust scientific risk assessments, risk-proportionate regulation and the information we make available.

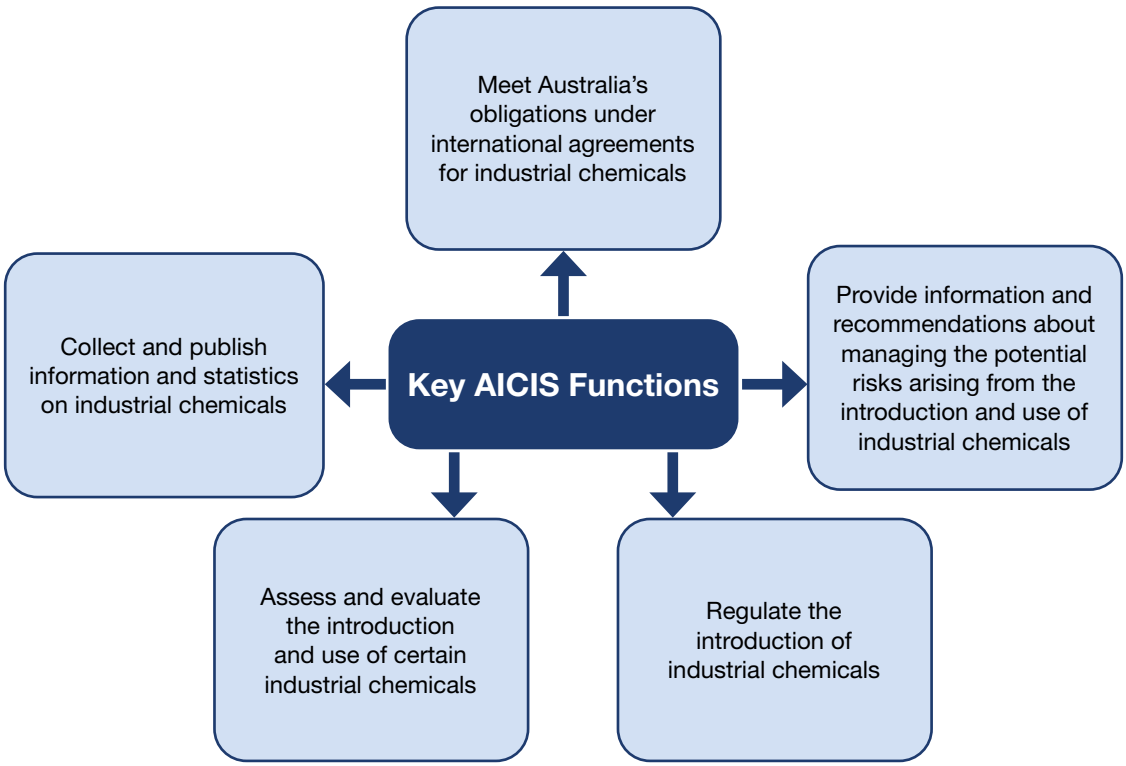
The *Industrial Chemicals Act 2019* establishes AICIS as the regulatory scheme for the introduction (importation and manufacture) of industrial chemicals in Australia. The Executive Director leads AICIS and is an independent statutory office holder appointed by the Governor-General with specific powers and functions under the *Industrial Chemicals Act 2019*. Staff in the Department of Health, Disability and Ageing and scientific staff from the Department of Climate Change, Energy, the Environment and Water (DCCEEW) support the Executive Director.

AICIS aids in the protection of the Australian people and the environment by:

- assessing the human health and environmental risks posed by industrial chemicals
- providing information to promote their safe use
- making risk management recommendations to Commonwealth standard setting bodies, and state and territory risk managers.

AICIS aims to make regulatory effort proportionate to the risks posed by industrial chemical introductions.

Figure 1: AICIS functions



The Regulator Performance Guide (RPG) requires AICIS to report against 3 principles of regulator best practice:

Figure 2: Regulator Performance principles[158]

RPG1: Continuous improvement and building trust	RPG2: Risk based and data driven	RPG3: Collaboration and engagement

These principles have informed and supported AICIS's organisational vision:

'Australia's people and businesses can safely use industrial chemicals, supported by clear, trusted information about risks to human health and the environment, and how to manage them'.

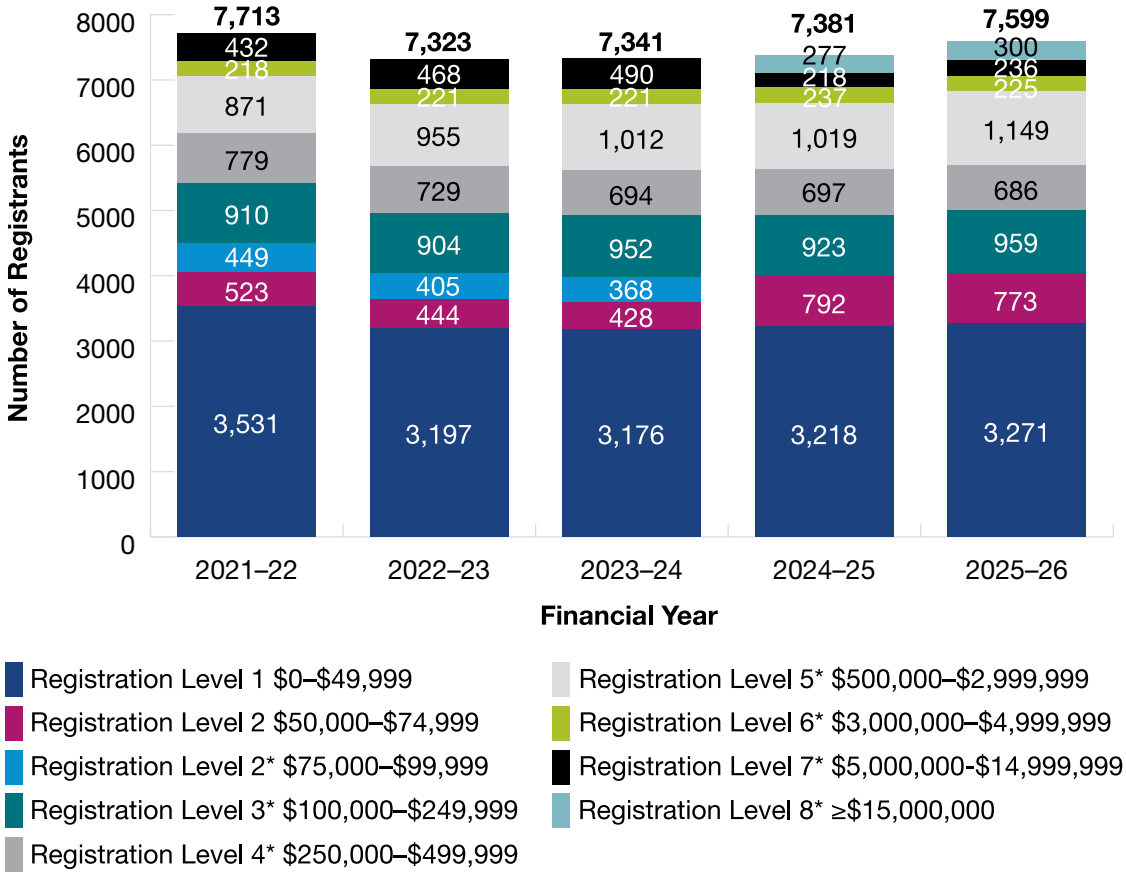
Facilitating safe chemical introductions through registration

Importers and manufacturers must be registered on the AICIS Register of Industrial Chemical Introducers before they can introduce industrial chemicals to Australia. To register, introducers pay a low flat fee and an annual charge based on the value of relevant industrial chemicals introduced in the previous financial year. The revenue from registration funds post-market evaluations of industrial chemicals, compliance monitoring and management of contraventions of relevant laws, and provides for scheme support and communication activities.

In 2025–26, 7,599 introducers were registered with AICIS, up from 7,381 in 2024–25 (**Figure 3**). This included 1,259 new registrations and 6,340 renewed registrations (**Figure 4**). The number of new registrants each year can reflect both businesses seeking to commence introduction of industrial chemicals, or those identified by AICIS compliance activity as needing to become registered. AICIS will continue to monitor registration trends in 2026–27.

[158] Department of Finance, **Regulator Performance (RMG 128)**, Department of Finance, November 2025, accessed August 2026.

Figure 3: Number of registrants by registration level for 2025–26 compared to 2024–25, 2023–24, 2022–23 and 2021–22[159]

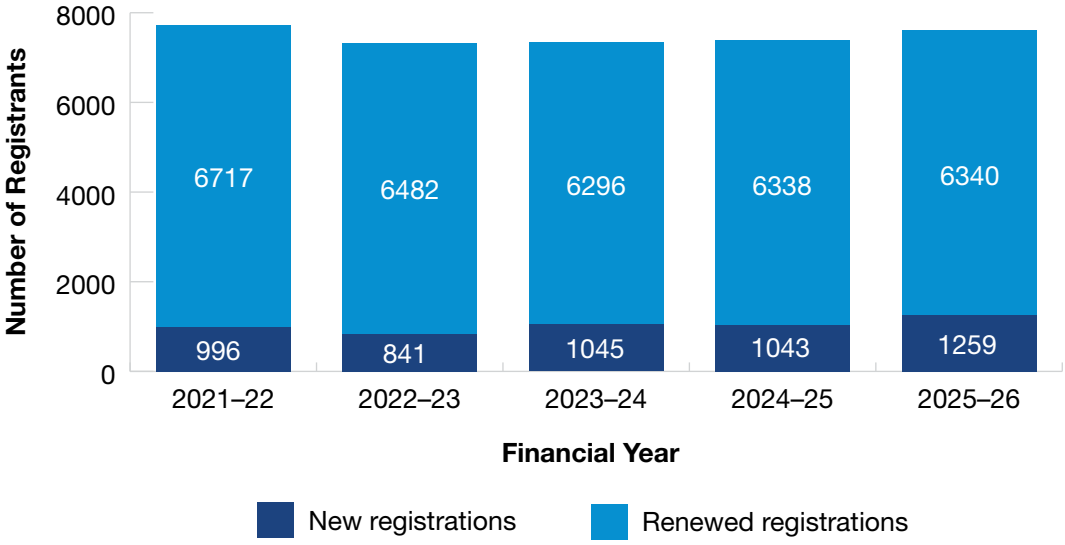


Notes:

*Registration thresholds were revised in 2024–25. The previous Level 2 ($50,000–$74,999) and Level 3 ($75,000–$99,999) thresholds were combined into a single Level 2 threshold of $50,000–$99,999. The remaining registration levels were adjusted accordingly, and a new Level 8 threshold was introduced for introductions valued at $15,000,000 or more. The revised registration level structure continued to apply in 2025–26.

[159] Source: AICIS internal data.

Figure 4: Number of new registrants and registration renewals from 2021–22 to 2025–26[160]



Risk-based introduction categories for risk-proportionate regulation

RPG2: Risk based and data driven	**The scheme's introduction categories are based on the level of risk associated with the industrial chemical introduction.**

Introducers of industrial chemicals into Australia must categorise their introduction and follow the requirements of the relevant category. Introduction categories are based on the level of risk to human health and the environment from the introduction.

Industrial chemicals listed on the Australian Inventory of Industrial Chemicals (Inventory) can be introduced as 'listed introductions' by registered introducers. Listed introductions must follow any regulatory obligations and restrictions stipulated in an industrial chemical's inventory terms of listing. Terms of a listing may include a defined scope of assessment, conditions of introduction or use, or specific information requirements.

Chemicals not listed on the Inventory are not available for industrial use in Australia unless their introduction is authorised under one of the following introduction categories (**Figure 5**):

- exempted
- reported
- assessed
- commercial evaluation.

Very low to low-risk introductions (exempted and reported) can be made without pre-market assessment by AICIS. Medium to high-risk introductions must be authorised under an assessment certificate issued by the Executive Director of AICIS.

[160] Source: AICIS internal data.

Figure 5: AICIS's risk proportionate introduction categories

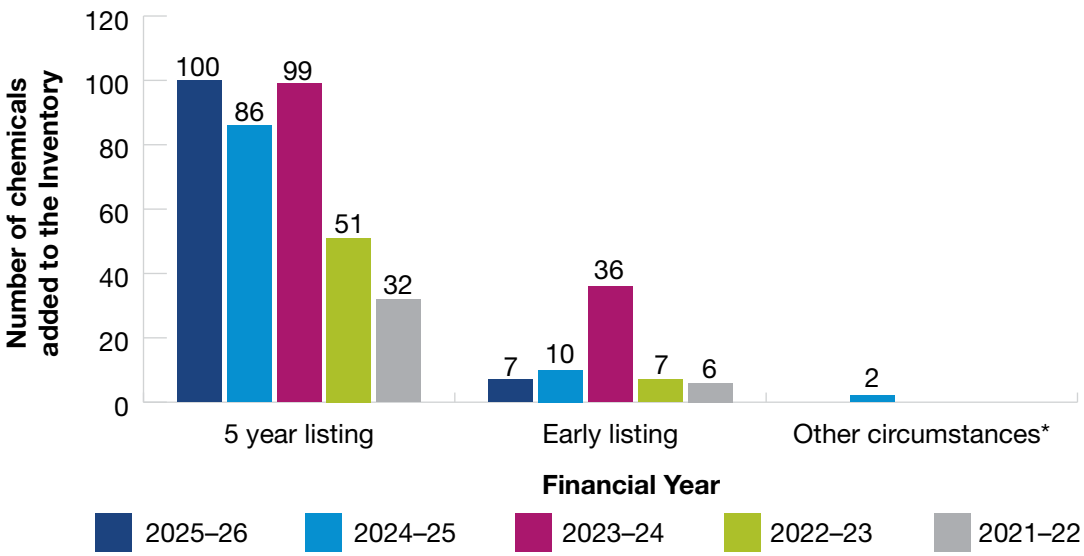
If a chemical is not on the Inventory, or the introduction is outside the chemical's 'Inventory terms of listing'

Listed	Exempted	Reported	Assessed	Commercial Evaluation
• Is already listed on the Inventory • It can be imported or manufactured if the terms of the Inventory listing are met	• It's categorised as an exempted *(very low-risk)* introduction • A once-off declaration required **after** the chemical's introduction	• It's categorised as a reported *(low-risk)* introduction • A once-off pre-introduction report required **before** the chemical's introduction	• It's categorised as an assessed *(medium to high risk)* introduction • An assessment certificate is required **before** the chemical's introduction	• Determine the chemical's commercial potential • A CEA is required **before** the chemical's introduction

Listed Introduction

Listed Introductions cover the importation and domestic manufacture of industrial chemicals that are listed on the Inventory and where the introducer meets the industrial chemical's terms of Inventory listing. Industrial chemicals are routinely listed on the Inventory 5 years after an assessment certificate is issued, unless the certificate holder applies for and is granted an early listing. In 2025–26, a total of 38 industrial chemicals were added to the Inventory (32 routine listings and 6 early listings – refer to **Figure 6**). These industrial chemicals can now be imported and/or domestically manufactured by any registered introducer if the terms of the Inventory listing are met.

Figure 6: Industrial chemicals added to the Inventory by listing type from 2021–22 to 2025–26[161]



*Other circumstances include variations following amendments to the rules.

[161] Source: AICIS internal data.

Exempted Introductions

The Exempted Introduction category supports innovation by providing a no-cost, fast option for very low indicative risk introductions. This includes certain polymers of low concern. Regulatory requirements are proportionate to risk, where introducers using this introduction pathway keep records and, for prescribed introductions, give a once-off post-introduction declaration after the industrial chemical's initial introduction.

In 2025–26, a total of 1,742 post-introduction declarations were submitted. This included 1,630 post-introduction declarations classified as 'highest indicative risk is very low risk', 96 as 'polymers of low concern' and 16 as 'low concern biological polymers'. Following a decline from the 2022–23 peak, when 5,275 post-introduction declarations were submitted as transitional arrangements were ending, post-introduction declaration submissions increased in 2025–26 compared to 2024–25. The increase was driven primarily by growth in introductions classified as 'highest indicative risk is very low risk', with all post-introduction declaration categories recording higher submission numbers than the previous year. **Table 1** shows cumulative post-introduction declarations continuing to increase, reaching 14,137 in 2025–26. The continued growth in cumulative post-introduction declarations demonstrates the ongoing use of the Exempted Introduction category by industry to support their very low indicative risk introductions.

Table 1: Submitted post-introduction declaration by type of exempted introductions from 2021–22 to 2025–26[162]

Type of exempted introduction	2021–22	2022–23	2023–24	2024–25	2025–26
Highest indicative risk is very low risk	1,592	5,193	3,955	1,328	1,630
Polymers of low concern*	97	69	51	76	96
Low concern biological polymers	9	13	4	8	16
Total post-introduction declarations	**1,698**	**5,275**	**4,010**	**1,412**	**1,742**
Cumulative post-introduction declarations	**1,698**	**6,973**	**10,983**	**12,395**	**14,137**

*A single post-introduction declaration of this type can be submitted for multiple industrial chemicals.

Reported Introductions

The Reported Introduction category supports innovation by providing a no-cost option for low indicative risk introductions. Regulatory requirements are proportionate to risk, where introducers using this introduction pathway maintain records and provide a once-off pre-introduction report (PIR) before the industrial chemical's introduction. Once a PIR is submitted, an introducer can commence importing or manufacturing the industrial chemical.

In 2025–26, AICIS received 5,525 PIRs. **Table 2** shows PIR submission volumes over the past 5 years. Following a peak in 2022–23 as transitional arrangements were ending, submissions in the 'highest indicative risk is low risk (other)' subtype increased from 2,354 in 2024–25 to 2,711 in 2025–26. The '10 kg or less' subtype continued to show strong growth, increasing from 1,419 submissions in 2024–25 to 2,422 in 2025–26 and accounting for around 44% of all PIRs received during the year. **Table 2** also shows cumulative PIRs continuing to increase steadily, reaching 23,064 in 2025–26. The sustained growth in cumulative PIRs demonstrates the ongoing utility and use of the reported introduction category by industry to support their low indicative risk introductions.

[162] Source: AICIS internal data.

Table 2: Submitted PIRs by type of Reported Introduction from 2021–22 to 2025–26[163]

Type of Reported Introduction	2021–22	2022–23	2023–24	2024–25	2025–26
Highest indicative risk is low risk (other)	1,164	5,858	2,851	2,354	2,711
Low-risk ingredient of a flavour/ fragrance blend	200	331	351	620	365
International assessment pathway	16	16	7	48	18
Research and development	4	34	49	10	9
10 kg or less	0	544	881	1,419	2,422
Total pre-introduction reports	**1,384**	**6,783**	**4,139**	**4,451**	**5,525**
Cumulative pre-introduction reports	**2,166**	**8,949**	**13,088**	**17,539**	**23,064**

RPG1: Continuous improvement and building trust **RPG2: Risk based and data driven** **RPG3: Collaboration and engagement**	**The reported introduction type of '10 kg or less' represented 44% of all PIRs submitted in 2025–26, compared to 32% in 2024–25 and 21% in 2023–24. The continued increase in uptake indicates that this regulatory option has been successful in reducing regulatory burden and supporting risk-proportionate regulation.**

Assessed introductions

RPG1: Continuous improvement and building trust **RPG2: Risk based and data driven** **RPG3: Collaboration and engagement**	**AICIS completed 100% of assessment certificate applications within statutory timeframes in 2025–26. Timely, risk-based decisions provided certainty to businesses and confidence that industrial chemicals can be introduced safely in Australia.**

Assessed introductions are those with a medium to high indicative risk. Introducers must apply for and be issued an assessment certificate before introduction. AICIS publishes an assessment statement on its website with a summary of the risk assessment and information about how any identified risks can be managed by introducers and relevant risk managers.[164] Risk-management recommendations are referred to the relevant Australian standard-setting bodies and/or states and territories risk-management agencies.

There are 5 main types of applications for assessment certificates:

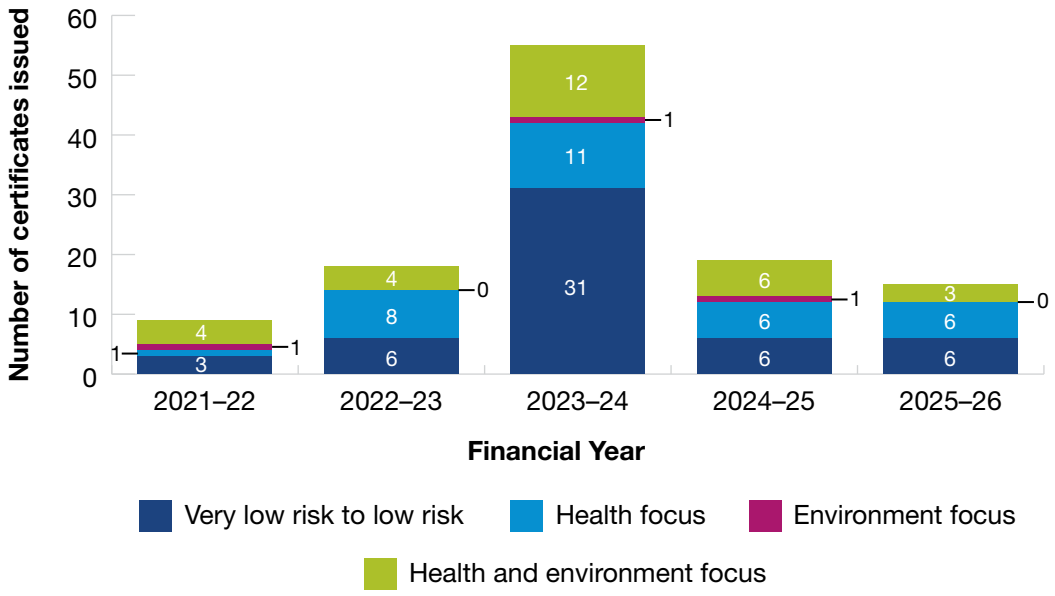
- health and environmental focus
- health focus
- environmental focus
- very low to low risk
- comparable hazard assessments.

[163] Source: AICIS internal data.

[164] Department of Health, Disability and Ageing, **Australian Industrial Chemicals Introduction Scheme**, Department of Health, Disability and Ageing, n.d. accessed August 2026.

AICIS issued 15 assessment certificates during 2025–26 (**Figure 7**). The certificates were issued for 3 health and environment focus, 6 health focus and 6 very low to low-risk applications. Assessments of chemicals with very low to low indicative risk provide a pathway for businesses to have their chemicals added to the Inventory and broaden their supply chain. Of the 6 very low to low risk assessment certificates issued during the year, 3 chemicals were subsequently approved for early listing on the Inventory. No certificates were issued for environmental focus or comparable hazard assessment types in 2025–26. AICIS assessed and approved one application to vary the terms of an assessment certificate.

Figure 7: Certificates issued by type from 2021–22 to 2025–26[165]



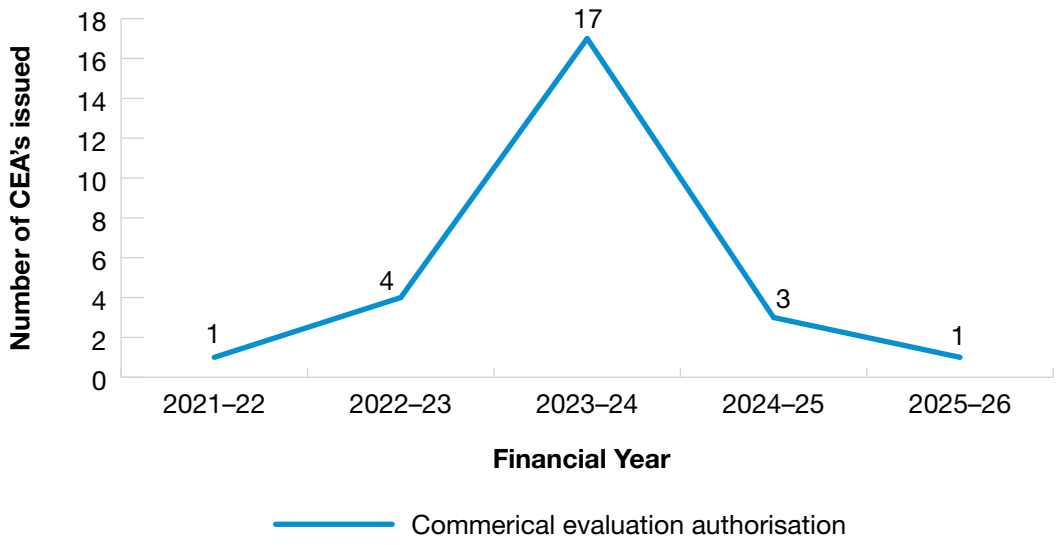
Commercial Evaluation Introductions

RPG1: Continuous improvement and building trust	**AICIS supports innovation by providing a faster, cost-effective way to introduce a chemical to evaluate its commercial potential and is demonstrated in the continued utility of the CEA pathway.**
RPG2: Risk based and data driven	
RPG3: Collaboration and engagement	

The Commercial Evaluation Introduction category supports innovation by providing a fast, cost-effective option for introducers to evaluate an industrial chemical's commercial potential. Introducers must apply for and be issued a Commercial Evaluation Authorisation (CEA) before introduction. The annual number of CEAs issued has varied since the commencement of AICIS (**Figure 8**). In 2025–26, AICIS issued one CEA, compared with 3 in 2024–25 and 17 in 2023–24. The 2023–24 result was largely driven by applications from a single introducer for a group of related chemicals. AICIS assessed and approved one application to vary the terms of a CEA in 2025–26.

[165] Source: AICIS internal data.

Figure 8: CEA from 2021–22 to 2025–26[166]



Delivering Australia's international obligations for the import and export of restricted industrial chemicals

AICIS can approve, restrict or refuse applications to introduce or export industrial chemicals listed in international conventions. It also helps Australia meet its obligations by monitoring compliance for industrial chemicals under the Rotterdam and Minamata Conventions.

Anyone seeking to import or export certain banned or severely restricted industrial chemicals into or out of Australia are subject to the Prior Informed Consent (PIC) procedure of the Rotterdam Convention or the Minamata Convention and must apply for, and receive, authorisation from the Executive Director. The PIC procedure ensures Australia and other countries are informed about the risks of toxic chemicals before agreeing to import or export them, making informed decisions and preventing exposure.

During 2025–26, AICIS:

- approved 8 annual export authorisations under the Rotterdam Convention
- approved one export authorisation under the Minamata Convention
- did not approve any Rotterdam Convention import authorisations
- did not approve 5 applications, comprising:
  - 4 Rotterdam Convention export authorisation applications
  - one Minamata Convention export authorisation application.

AICIS did not approve applications where mandatory requirements were not met, including where applications were incomplete, required approvals from the importing country had not been obtained, or required fees had not been paid. AICIS monitored imports and exports relating to active Rotterdam and Minamata Convention authorisations to ensure the terms of those authorisations were met. In 2025–26, AICIS undertook 8 import assessments and 6 export assessments relating to industrial chemicals subject to international agreements.

[166] Source: AICIS internal data.

Evaluating industrial chemicals for safe use and regulatory confidence

RPG1: Continuous improvement and building trust	**AICIS evaluated 1,057 unique chemicals to provide information and make recommendations about managing the risks posed by their introduction and use. AICIS completed 100% of evaluations within timeframes.**
RPG2: Risk based and data driven	
RPG3: Collaboration and engagement	

AICIS may initiate, at any time, evaluations of industrial chemicals and matters relating to industrial chemicals. These post-market evaluations can address industrial chemicals listed on the Inventory, authorised by assessment certificates, introduced under reported or exempted introduction categories, and those excluded from other parts of the *Industrial Chemicals Act 2019*. Evaluations produce information to support the risk management of chemicals where required.

AICIS prioritises industrial chemicals for evaluation using technological tools and expert judgement, drawing on hazard and exposure information to estimate relative risk and with consideration of available resources, data and information. Prioritisation ensures that initiated evaluations are risk proportionate, timely and targeted.

In 2025–26, AICIS initiated an evaluation of 522 per- and Polyfluoroalkyl Substances (PFAS) listed on the Inventory. The evaluation will help AICIS better understand which PFAS are being introduced and used in Australia and identify chemicals that may require further evaluation. To support this work, AICIS issued a mandatory notice under section 76 of the *Industrial Chemicals Act 2019* requiring current and former registrants to provide information on the introduction and use of listed PFAS during the 2023–24 and 2024–25 registration years. The information gathered will inform the evaluation, which is still underway.

In 2025–26, AICIS received 773 submissions in relation to ‘specific information requirements.’ A specific information requirement (SIR) is a term of the Inventory listing for certain chemicals. It means the introducer must provide information to AICIS about chemical introductions under specified circumstances set out in the SIR. AICIS used information from these submissions to decide if the chemicals should be prioritised for an evaluation.

In 2025–26, AICIS completed 19 evaluations for human health and/or the environment for 1,057 unique industrial chemicals, including 1,056 chemicals listed on the Inventory and one chemical being introduced under the exempted and reported categories.

Providing information and recommendations about the risks and uses of industrial chemicals

RPG1: Continuous improvement and building trust **RPG2: Risk based and data driven** **RPG3: Collaboration and engagement**	**AICIS publishes assessment and evaluation statements on its website. Risk management recommendations are also published where relevant. Together, these publications provide information about industrial chemicals introduced in Australia and support transparency in decision-making and industrial chemical risk management.**

AICIS publishes pre-market assessments (assessment statements) and post-market assessments (evaluation statements) on its website for use by all stakeholders. This includes other Australian and state and territory regulatory agencies such as public health, worker health and safety, environmental, transport and consumer product safety agencies. Assessment and evaluation statements support introducers by outlining safe introduction and use practices, including suggested control measures to manage risks from exposure to assessed chemicals, based on hazard, volume and use information.

When AICIS identifies risks, it makes recommendations to the relevant risk management agencies. These recommendations help risk managers ensure appropriate controls are in place for industrial chemicals introduced into Australia, and support nationally consistent decisions based on current evidence.

AICIS maintains the Risk Management Recommendations Register, which provides a convenient central repository of all AICIS's risk management recommendations. This provides transparency to all stakeholders about the implementation status of AICIS recommendations made to these risk management agencies.

AICIS does not have any statutory oversight over the processes or decisions of the risk managers to whom recommendations are made.

In 2025–26, AICIS made a total of 49 risk management recommendations to risk managers:

- 27 to Safe Work Australia (Hazardous Chemical Information System)
- 6 to the Department of Health, Disability and Ageing (the Poisons Standard for the Uniform Scheduling of Medicines and Poisons)
- 6 to the Australian Competition and Consumer Commission
- One to Food Standards Australia New Zealand
- 9 to state and territory environmental agencies.

Maintaining a trusted Australian Inventory of Industrial Chemicals to support safe chemical use and introduction

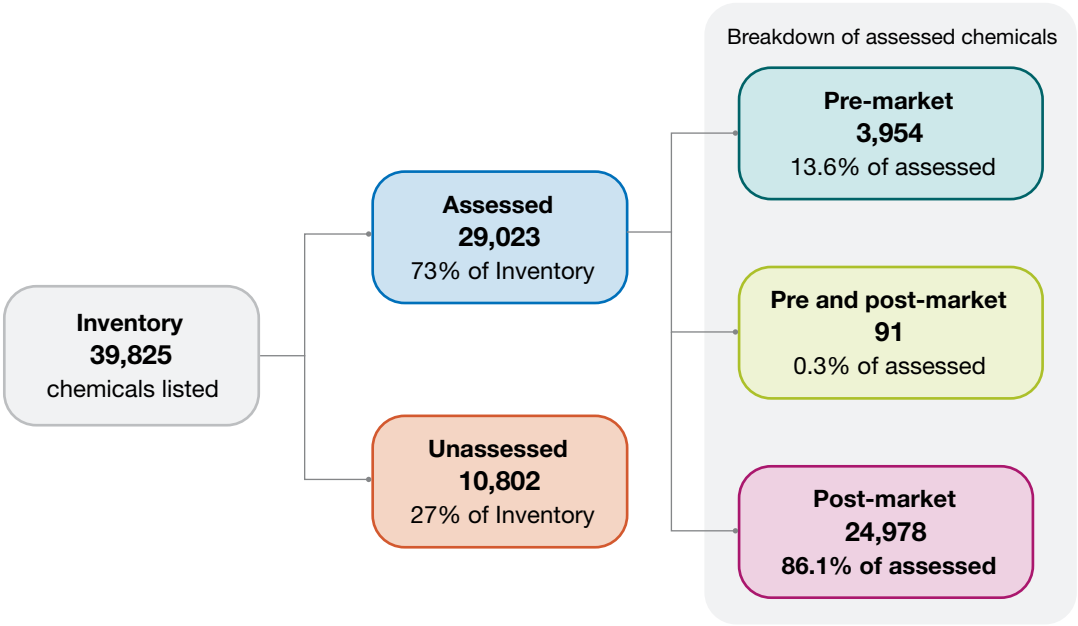
AICIS manages the Inventory, a database of chemicals available for industrial use in Australia. The Inventory holds chemical identity details and regulatory obligations relating to the importation and manufacture of industrial chemicals. It was created from the former Australian Inventory of Chemical Substances, under the predecessor to AICIS, the National Industrial Chemicals Notification and Assessment Scheme (NICNAS), which ran from 1990 to 30 June 2020.

Status of the Inventory

At the commencement of AICIS, NICNAS has assessed approximately 47% of the Inventory. By 30 June 2026, AICIS had raised this to 73% through pre-market assessments and post-market evaluations.

Figure 9 breaks down the Inventory according to the number of industrial chemicals on the Inventory and whether and how they have been assessed as at 30 June 2026.[167]

Figure 9: Assessment status of industrial chemicals on the Inventory as at 30 June 2026[168]



Following the completion of evaluations, the Inventory terms of listing for 9 chemicals were varied in 2025–26. The variations align the obligations for introducers to provide specific information with the risks identified and considered in the evaluations.

[167] Pre-market includes assessment certificates, certificate variations and NICNAS new chemical assessments. Pre and post-market includes chemicals that underwent both pre-market and subsequent post-market assessment. Post-market includes AICIS evaluations and IMAP, PEC and secondary notification assessments completed under NICNAS.
[168] Source: AICIS internal data.

Protecting confidential information

Industrial chemicals can be listed on the Inventory with Confidential Business Information (CBI) protection. Applications for protection of CBI are subject to a statutory test that balances commercial prejudice and public interest. Confidential listings are subject to review every 5 years.

Under AICIS, 13 industrial chemicals listed on the Inventory have had the proper name for the industrial chemical and/or end use protected. Where the proper name for the industrial chemical is protected, this is done by use of an AICIS Approved Chemical Name (AACN). An AACN is a generic or 'masked' chemical name. Where end use is protected this is done by publishing a generalised end use.

Under transitional arrangements, the Inventory contains 91 industrial chemicals where the identity is CBI and not publicly disclosed.

In 2025–26, AICIS approved 10 applications for continued CBI protection, while 9 industrial chemical listings became publicly searchable after CBI protection was revoked.

Minor variations for accuracy

In 2025–26, AICIS made 2,544 minor variations of chemicals on the Inventory. Most variations were associated with updates to specific information requirement terms of listing introduced in July 2025 to make it easier for introducers to find information and understand their compliance responsibilities.

Minor variations did not change the identity or regulatory status of these industrial chemicals.

Public availability of the Inventory

The Inventory is publicly available and searchable - excluding protected information. To support industry stakeholders, AICIS published downloadable snapshots of the publicly available information on the Inventory 3 times in 2025–26, enabling bulk searches of industrial chemicals.

Ensuring safe chemical introduction through compliance monitoring and enforcement

RPG1: Continuous improvement and building trust	**AICIS uses a risk-proportionate compliance strategy to enhance efficiency, prioritise critical areas and promote effective chemical management.**
RPG2: Risk based and data driven	
RPG3: Collaboration and engagement	

Compliance monitoring and enforcement activities are proportionate to risk, with an initial focus on fostering voluntary compliance through education and awareness raising activities to assist introducers' understanding of their regulatory obligations under the *Industrial Chemicals Act 2019*.

AICIS assessment and prioritisation of non-compliance include consideration of the indicative risk posed by the introduction of the subject industrial chemical, the offending entity's willingness to comply, the compliance history of the entity involved and how the issue relates to the objects and intent of the *Industrial Chemicals Act 2019*.

AICIS uses a range of data sources to inform compliance monitoring activities. It uses data provided by the Australian Border Force to detect unregistered introducers and confirm their appropriate level of registration. Using this information, 1,899 businesses registered with AICIS in 2025–26. Following compliance monitoring, 993 introducers adjusted their registration level.

AICIS monitors introducers' self-categorisation of their introductions and record keeping obligations under the *Industrial Chemicals Act 2019*. AICIS contacted a total of 43 high-level introducers in 2025–26 as part of the listed category monitoring activity. This identified 44 unauthorised introductions which are being case managed. Other issues that required AICIS intervention included record-keeping obligations and terms of listing requirements.

Post-introduction declarations are due by 30 November following the first year of certain types of exempted introductions. Submitted post-introduction declarations undergo rapid pre-screening to select those for further analysis. AICIS screened 44 post-introduction declarations for possible mis-categorisation. This led to AICIS action, ranging from advice on the type of exempted introduction to case management of 13 unauthorised introductions. This helped ensure introducers correctly categorise these and future introductions.

The number of post-introduction declarations screened stabilised for 2025–26. There were larger numbers in previous years, as introductions were declared that did not require a post-introduction declaration submission. The cumulative number of post-introduction declarations screened since screening began in 2020–21 was 3,194, representing 22.6% of all post-introduction declarations.

PIRs are submitted prior to proposed introduction. PIRs undergo rapid, pre-screening to select those for further analysis. AICIS screened 65 PIRs for possible mis-categorisation. This led to AICIS action, ranging from advice on the type of reported introduction, including whether to vary or withdraw the PIR, to case management of 25 unauthorised introductions. This helped ensure introducers correctly categorise these and future introductions.

AICIS attributes the reduction in screened PIRs in 2025–26 to the relevant resources being temporarily reallocated to higher priority evaluations and decreased effort relating to listed category introductions for which a PIR has been submitted. The cumulative number of PIRs screened since screening began in 2020–21, was 1,332, representing 5.8% of all PIRs.

AICIS conducted one Commercial Evaluation introduction monitoring activity to ensure compliance with the terms of the authorisation.

Introducers submit an annual declaration each year, confirming all industrial chemicals introduced during the previous AICIS registration year (1 September to 31 August) were authorised under the *Industrial Chemicals Act 2019*. In 2025–26, AICIS received 5,162 annual declarations for the previous registration year. Low level registrants (<$50k registration value) account for the largest proportion of overdue annual declarations. The lower rates of annual declarations observed among Level 1 introducers likely reflect their status as predominantly new entrants to the Scheme, who may lack familiarity with the requirements of the *Industrial Chemicals Act 2019* and those who have ceased introduction since the beginning of the registration year. AICIS manages all instances of non-compliance with reporting obligations in accordance with its published risk proportionate compliance approach.

In 2025–26, AICIS received a total of 604 referrals of non-compliance. They screened and prioritised all referrals for response. During this period, AICIS opened 538 compliance cases and resolved 617 cases. Case management includes formal evidence-gathering and information collation activities where AICIS suspects or identifies non-compliance.

The formal enforcement provisions of the *Regulatory Powers (Standard Provisions) Act 2014* are available to AICIS. Where an entity is in breach of the *Industrial Chemicals Act 2019*, they can propose an enforceable undertaking. AICIS doesn't accept enforceable undertakings in all circumstances and consider them to be case dependent.

In 2025–26, AICIS published an Enforceable Undertaking with an Australian importer and distributor of fragrance and personal care products. The written agreement required the entity to provide evidence of destruction or re-export of quarantined unauthorised introductions and implement systems to ensure all introductions are authorised under the *Industrial Chemicals Act 2019*.

Strengthening safe introduction through regulatory stewardship

RPG1: Continuous improvement and building trust	**AICIS implemented changes to the Categorisation Guidelines to maintain modern regulatory approaches that are risk proportionate without compromising essential safety and environmental protection.**
RPG2: Risk based and data driven	
RPG3: Collaboration and engagement	

Amendments to the Industrial Chemicals Categorisation Guidelines commenced on 1 September 2025 following stakeholder consultation. The Categorisation Guidelines contain technical and operational details that support the Scheme. The changes in this version included additions to the 'List of chemicals with high hazards for categorisation' that introducers may need to check when categorising their chemical introductions. The additions help to better align the regulatory status of highly hazardous chemicals with trusted global and domestic sources and contribute to the protection of human health and the environment.

AICIS confirmed information requirements for assessment certificate applications of designated fluorinated chemicals (a subset of highest concern PFAS), following stakeholder consultation regarding their clarity. The requirements support the robust assessment of designated fluorinated chemicals and provide greater regulatory certainty for applicants.

In 2025–26, AICIS consulted on further proposed changes to the Industrial Chemicals Categorisation Guidelines that are scheduled to commence on 1 September 2026. The changes at this time will include further updates to chemicals on the 'List of Chemicals with High Hazards for Categorisation' and other improvements to ensure the Scheme remains contemporary and operates effectively within existing policy settings.

In addition, AICIS consulted on and implemented improvements to the Scheme that do not require amendments to the *Industrial Chemicals Act 2019*, the Industrial Chemicals (General) Rules 2019 or the Industrial Chemicals Categorisation Guidelines. This included simplifying compliance with specific information requirements for listed introductions and improving guidance and support materials for introducers.

Delivering safer introductions through international regulatory cooperation and alignment

RPG1: Continuous improvement and building trust	**AICIS influences, collaborates and shares information with international bodies to harmonise regulatory approaches, promoting consistency, reducing regulatory burden and facilitating safer industrial chemical introduction.**
RPG2: Risk based and data driven	
RPG3: Collaboration and engagement	

Under the *Industrial Chemicals Act 2019*, the promotion of international harmonisation of regulatory controls or standards for industrial chemicals is a function of the Executive Director. In 2025–26, AICIS participated in international activities to harmonise, develop, and adopt international standards and methods. In 2025–26, AICIS actively collaborated with international counterparts on regulatory and scientific matters through regular teleconferences, working groups, and conferences.

The Organisation for Economic Co-operation and Development's (OECD) Chemicals and Biotechnology Committee (CBC) and its key subsidiary Working Parties remain the primary channels for multilateral engagement. AICIS staff participated in 16 meetings of OECD technical groups and responded to 194 requests on various topics. AICIS contributed to regulatory methodologies, engaging in workshops and expert groups on topics including exposure and hazard assessment, manufactured nanomaterials and advanced materials. In 2025–26, AICIS participated in several OECD forums including the Working Party on Manufactured Nanomaterials, Working Party on Hazard Assessment, Working Party on Exposure Assessment and the OECD CBC. AICIS also provided a presentation to the International Uniform Chemical Information Database (IUCLID) User Expert Panel Group on planned use cases for AICIS, and to the OECD Workshop on Biodiversity from a Chemicals Perspective. AICIS also participated in broader multilateral forums, attending 4 non-OECD international meetings and responding to 82 requests for input on regulatory and scientific matters.

AICIS provided input into 11 requests from the United Nations Environment Programme conventions and related forums, including matters associated with the Rotterdam, Stockholm and Minamata Conventions. Formal bilateral cooperative arrangements and memoranda of understanding are in place with counterpart agencies in Canada, Europe, New Zealand and the United States of America. AICIS maintained regular dialogue with these agencies in 2025–26 on emerging topics of interest, including chemical assessment methodologies, scientific developments and regulatory practice.

In 2025–26, AICIS participated in 4 bilateral international meetings and 35 exchanges between bilateral partners, including Health Canada and the New Zealand Environmental Protection Authority, on issues related to technical cooperation and sharing of industrial chemical information relating to assessments.

Continued collaboration with our bilateral and multilateral partners enhances our awareness of international developments in chemicals risk assessment and increases in-house understanding in use and interpretation of non-animal test methodologies in risk assessment. Evaluations benefited from the use of international assessment materials, chemical intelligence, and use of information from our international counterparts.

International collaboration and regulatory cooperation within AICIS compliance activities supports the exchange of regulatory information, enhances oversight of chemical movements across borders, and supports alignment with global obligations, such as those under the Rotterdam Convention. In 2025–26, AICIS collaborated with the US Environmental Protection Agency under the *Toxic Substances Control Act* section 12(b), receiving 30 export notifications and related regulatory actions of certain chemical movements. For Australia, these notifications are non-binding and do not trigger any regulatory action under Australian law, but they serve as information-sharing mechanisms, supporting regulatory oversight and international responsibility in the international trade of potentially hazardous chemicals.

Enhancing safe introductions through workforce development and expertise

RPG1: Continuous improvement and building trust	**AICIS supports capability building to strengthen performance, foster innovation and contribute to the Scheme being a trusted regulator that encourages safe and sustainable use of industrial chemicals.**

Capability building continued across the organisation in 2025–26. AICIS developed a range of in-house guidance materials to further staff technical capability. These relate to principles of quantitative risk assessment, efficient use of key data sources, endocrine disruption guidance, and quantitative risk assessment for chemicals used in cosmetic and domestic products.

The AICIS Learning Management System continued to help self-directed computer-based learning. The AICIS Learning Management System has resources to build staff capability including:

- guides to toxicology and chemistry
- introduction to regulation and conducting peer reviews
- membership to an online commercial provider supporting product safety
- chemical compliance through on-demand conferences, courses and eLearning modules.

AICIS strengthened its internal capability by hosting 6 staff forums. These forums supported knowledge exchange and professional growth through engagement with national and international experts, regulators, academia and industry across diverse scientific and non-scientific topics.

A cohort of AICIS staff also participated in the Professional Regulators Program, delivered through the National Regulators Community of Practice in partnership with the Australian New Zealand School of Government. The program strengthens regulatory capability and supports consistent application of contemporary regulatory practice.

AICIS also supported staff development through mobility opportunities, including cross-team placements. These opportunities contributed to workforce capability development and helped the sharing of skills and knowledge across AICIS.

AICIS has identified further staff development needs through the AICIS training needs survey conducted in 2025–26 and the application of the Regulatory Science Capability Framework.

AICIS continued to participate in the Australian Government Regulatory Science Network's Annual Symposium and interagency webinars.

Delivering regulatory confidence through stakeholder engagement and communication

RPG3: Collaboration and engagement	**AICIS continues to engage genuinely and regularly with stakeholders to assist with education of compliance obligations, improve and consult on regulatory practices, obtain feedback on evaluations, and provide guidance and information that is clear, concise and easily accessible.**

In 2025–26, AICIS continued active engagement via a range of mechanisms with government entities, the industrial chemicals industry, community groups and academia. This process aimed to provide collaborative communication, transparency and a deepening of public trust.

AICIS had 22 meetings with registrants and industry associations to help these stakeholders understand regulatory requirements, compliance obligations and to share operational experience of the Scheme. This included a site visit to enable AICIS staff to better understand processes and controls in place for the use of a chemical being assessed under a certificate application.

In 2025–26, AICIS received and addressed 3,824 stakeholder phone enquiries and 6,378 written enquiries.

AICIS collaborated with government departments and agencies in 2025–26, including the:

- Department of Health, Disability and Ageing
- Therapeutic Goods Administration
- DCCEEW
- Food Standards Australia New Zealand
- Safe Work Australia.

AICIS participated in 7 meetings and provided technical input into 21 requests related to industrial chemicals.

The AICIS Stakeholder Engagement Committee, with representatives drawn from peak industry and community groups, continued as an essential forum for transparent stakeholder engagement. The AICIS Stakeholder Engagement Committee held 2 meetings in 2025–26.

In 2025–26, AICIS used its Consultation Hub for 2 draft evaluation waves, proposed changes to the Industrial Chemicals Categorisation guidelines, and proposed changes to AICIS fees and charges for 2026–27. AICIS also promoted consultations through stakeholder communications, industry associations, and subscription newsletters. Open consultations seek to identify practical challenges, unintended consequences and areas for improvement. AICIS publishes past consultation outcomes and responses to ensure transparency and build public trust.

AICIS issued 11 stakeholder newsletters to over 2,912 subscribed stakeholders, enabling regular, direct engagement. The newsletters included information for stakeholders on a range of matters including changes to online forms, guidance materials, regulatory notifications and consultation opportunities.

AICIS published 61 news items and announcements on its website. This included 35 Inventory notices, 15 regulatory notices and 11 news articles and updates on information on upcoming consultations, updated guidance and regulatory changes.

In 2025–26, AICIS also expanded its communication channels through the launch of its official LinkedIn page, introduced a new website navigation structure and published new guidance materials to support assessment certificate applications and the creation of chemical datasets in IUCLID. AICIS also published Versions 7, 8 and 9 of the downloadable Inventory to support industry access to chemical information.

Enhancing safe introduction through digital transformation

RPG1: Continuous improvement and building trust	**AICIS continues to deliver digital tools for stakeholders and staff, though cheminformatics, enhancements to the AICIS IT System and website.**
RPG2: Risk based and data driven	

The AICIS ICT System is a comprehensive platform for managing information, standardising workflows, helping digital interactions between AICIS staff and industrial chemical introducers, applicants and their representatives, and supporting transparent access to application and payment information through AICIS Business Services.

The AICIS Business Services portal integrates with Microsoft Dynamics Customer Relationship Management and the IUCLID. Customer Relationship Management supports customer and business process management across AICIS, while IUCLID enables the recording, storage, maintenance and exchange of internationally harmonised chemical information using OECD Harmonised Templates. IUCLID helps applicants to meet regulatory information requirements and supports AICIS in conducting chemical risk assessments.

AICIS also expanded its suite of self-service digital tools. This included the release of a new online decision tool to help introducers to determine whether a chemical introduction for end use limited to research and development meets the criteria for either an exempted or reported introduction category.

To support the responsible adoption of emerging technologies, AICIS developed the AICIS Copilot Governance Framework during 2025–26. The framework aligns with, and complements, artificial intelligence policies and guidance issued by the Department of Health, Disability and Ageing and provides a structured approach to the governance and safe use of Copilot-enabled tools and capabilities within AICIS.

In 2025–26, AICIS continued to contribute internationally through participation in the OECD IUCLID Management Group and engagement with the European Chemicals Agency to support the ongoing development and implementation of IUCLID and internationally harmonised approaches to chemical data management.

Financial performance and management

Revenue from industry fees and charges totalled $21.9 million, an increase of $0.8 million compared to the previous financial year. The increase was primarily driven by higher registration revenue following the introduction of real-time registration level monitoring, which enabled AICIS to correct registration levels earlier for introducers who had under-declared their introduction values.

Total expenses for 2025–26 were $22.8 million, a decrease of $5.9 million compared to the previous financial year. The decrease primarily reflects the accounting adjustment relating to information technology expenditure that occurred in 2024–25 and did not recur in 2025–26.

The AICIS net result for 2025–26 is a surplus of $1.1 million, which has been factored into the overall departmental result.

Table 3: AICIS financial results for 2025–26 compared to 2024–25

	2024–25 $'000	2025–26 $'000
Industry cost recovered revenue	21,128	21,918
Other revenue	1,802	1,936
Total revenue	22,930	23,854
Total expenses	28,674	22,760
Operating surplus/deficit	-5,744	1,094

Acknowledgements

The Executive Director of AICIS, an independent statutory office holder, is grateful for the assistance of staff from the Department of Health, Disability and Ageing in both day-to-day administration of the Scheme, and in the scientific assessment of the human health risks of industrial chemicals.

The Executive Director of AICIS is also grateful for the assistance of scientific staff from the Department of Climate Change, Energy, the Environment and Water, in the assessment of the environmental risks of industrial chemicals.

Contact details

Dr Sarah Rumble
A/g Executive Director of AICIS

Address: GPO Box 58, Sydney NSW 2001 Australia

Level 9, 260 Elizabeth Street Surry Hills NSW 2010

Free call: 1800 638 528

AICIS website: **www.industrialchemicals.gov.au**

Email address: **aicis.enquiries@industrialchemicals.gov.au**

Appendix 5: Advertising and market research

Advertising and market research

The department must report on payments over $16,900 made to advertising agencies, market research organisations, polling organisations, direct mail organisations, and media buying organisations.

This section details these payments, along with the names of advertising campaigns conducted by the department in 2025–26.

Advertising campaigns

During 2025–26, the department conducted the following advertising campaigns. The Secretary certified each campaign in line with the Guidelines on Information and Advertising Campaigns:[169]

- Sexually Transmissible Infections Campaign (Phase 2)
- Bulk Billing for all Australians Campaign (Stream 1 – practices)
- Pharmaceutical Benefits Scheme Awareness Campaign (Phase 3)
- National Tobacco and E-cigarette Campaign (Phase 2)
- Youth Vaping Education Campaign (Phase 3)
- Bulk Billing for all Australians Campaign (Stream 2 – consumers)
- Maternal Respiratory Syncytial Virus (RSV) Vaccination Campaign (Phase 2)
- Winter Vaccination Campaign
- Childhood Immunisation Campaign
- Medicare Urgent Care Clinics Campaign (Phase 3)
- National Menopause and Perimenopause Awareness Campaign
- 1800MEDICARE Campaign
- Medicare Mental Health Check In Campaign (Stream 1 – health professionals).

Further information on those advertising campaigns is available at **www.health.gov.au** and in the reports on Australian Government advertising prepared by the Department of Finance. Those reports are available on the Department of Finance's website.[170]

Table 1: Advertising, market research, direct mail and media advertising payments for 2025–26

Organisation	Service provided	Paid (GST inclusive)
Advertising agencies		
BMF Advertising	Creative services for the National Tobacco and E-cigarette Campaign (Phase 2)	$1,885,746.30

[169] Department of Finance, **Australian Government Guidelines on Advertising and Information Campaigns by non-corporate Commonwealth entities**, Department of Finance, December 2025, accessed August 2026.
[170] Department of Finance, **Campaign advertising by Australian Government departments and agencies - Report 2024–25**, Department of Finance, 2025, accessed August 2026.

Organisation	Service provided	Paid (GST inclusive)
BMF Advertising	Creative services for the Youth Vaping Education Campaign (Phase 3)	$1,547,310.89
Carbon Media Pty Ltd	First Nations specialist communication services for the Sexually Transmissible Infections Campaign (Phase 2)	$115,500
Carbon Media Pty Ltd	First Nations creative services for the National Tobacco and E-cigarette Campaign (Phase 2)	$17,600.00
Carbon Media Pty Ltd	First Nations creative services for the Winter Vaccination Campaign	$1,015,058.00
Carbon Media Pty Ltd	First Nations creative services for the Childhood Immunisation Campaign 2025–26	$13,200
Cultural Perspectives Pty Ltd	Multicultural creative services for National Tobacco and E-cigarette Campaign (Phase 2)	$63,173.64
Cultural Perspectives Pty Ltd	Multicultural creative services for the Childhood Immunisation Campaign 2025–26	$54,286.93
Cultural Perspectives Pty Ltd	Multicultural creative services for the Pharmaceutical Benefits Scheme Awareness Campaign (Phase 3)	$92,477.00
Cultural Perspectives Pty Ltd	Creative services for the National Menopause and Perimenopause Awareness Campaign Multicultural	$87,012.21
Cultural Perspectives Pty Ltd	Multicultural creative services for the Winter Vaccination Campaign	$59,208.80

Organisation	Service provided	Paid (GST inclusive)
Cultural Perspectives Pty Ltd	Creative services for Bulk Billing for all Australians Campaign (Stream 2 – consumers)	$55,825.00
Cultural Perspectives Pty Ltd	Creative services for the 1800MEDICARE Campaign	$164,894.62
Fenton Communications Pty Ltd	Creative services for Bulk Billing for all Australians Campaign (Stream 1 – BBPIP)	$24,585.00
Fenton Communications Pty Ltd	Creative services for the Medicare Mental Health Check In campaign (Stream 1 – Health professionals)	$30,323.70
Ogilvy Australia	Creative services for the Childhood Immunisation Campaign 2025-26	$142,189.81
Ogilvy Australia	Creative services for the Pharmaceutical Benefits Scheme Awareness Campaign (Phase 3)	$283,415.15
Ogilvy Australia	Creative services for the National Menopause and Perimenopause Awareness Campaign	$1,497,565.52
Ogilvy Australia	Creative services for mental health campaign	$222,862.71
Ogilvy Australia	Creative services for the Winter Vaccination Campaign	$836,541.82
Ogilvy Australia Pty Ltd	Creative services for the Sexually Transmissible Infection Campaign (Phase 2)	$282,831.01
Ogilvy Australia Pty Ltd	Creative services for the Medicare Urgent Care Clinics Campaign (Phase 3)	$124,356.50
Ogilvy Australia Pty Ltd	Creative services for Bulk Billing for all Australians Campaign (Stream 2 – consumers)	$1,010,205.34
Ogilvy Australia Pty Ltd	Creative services for the 1800MEDICARE Campaign	$1,410,881.70
Ogilvy Australia Pty Ltd	Creative services for the Medicare Mental Health Check In campaign (Stream 2 – consumers)	$1,231,919.60
Ogilvy Australia Pty Ltd	Creative development services for aged care	$762,388.60

Organisation	Service provided	Paid (GST inclusive)
Market research		
89 DEGREES EAST PTY LTD	Study to understand the attitudes and mindsets that impact preventative health	$79,750.00
Accenture Australia Pty Ltd	Concept testing for 1800MEDICARE communications	$239,240.89
Accenture Australia Pty Ltd	Concept testing for bulk billing communications	$255,536.07
Accenture Australia Pty Ltd	Concept testing for Pharmaceutical Benefits Scheme communications	$164,535.80
Accenture Australia Pty Ltd	Concept testing for phase 2 of STI awareness communications	$131,813.36
Accenture Australia Pty Ltd	Concept testing for winter vaccination communications	$254,827.13
Accenture Australia Pty Ltd	Concept testing mental health communications	$354,634.89
Accenture Australia Pty Ltd	Concept testing research for the National Medicare Mental Health Campaign	$292,891.02
Accenture Australia Pty Ltd	Continuous sentiment tracking research	$698,500.00
Accenture Australia Pty Ltd	Developmental research for perimenopause and menopause communications	$670,282.34
Accenture Australia Pty Ltd	Exploratory research - Thriving Kids	$330,000.00
Accenture Australia Pty Ltd	Message testing research – Medicare assignment of benefit	$595,901.90
Accenture Australia Pty Ltd	Research for aged care communications	$121,803.00
Accenture Australia Pty Ltd	Research on sexual health and sexually transmitted diseases	$126,329.12
Anti Cancer Council of Victora T/A The Cancer Council Victoria	Delivery of the Australian Secondary School Students Alcohol and Drugs Survey	$220,000.00
Australian Institute of Health and Welfare	2025 National Drug Strategy Household Survey	$512,219.00
Bastion Insights Pty Ltd	Market research to support development of new tobacco health warnings and health promotion inserts	$386,694.00
Cancer Council Victoria	National Bowel Cancer Screening Program partnership kit return analysis	$101,655.40
Fifty-Five Five Pty Ltd	Research for the National Early Intervention Service	$218,130.00
Fifty-Five Five Pty Ltd	Development and concept testing for aged care	$411,812.50
Hall & Partners Pty Ltd	Evaluation research childhood immunisation communications	$129,310.50
Hall & Partners Pty Ltd	Evaluation research for 1800MEDICARE communications	$49,500.00
Hall & Partners Pty Ltd	Evaluation research for bulk billing communications	$97,438.00

Organisation	Service provided	Paid (GST inclusive)
Hall & Partners Pty Ltd	Evaluation research for perimenopause menopause awareness communications	$71,500.00
Hall & Partners Pty Ltd	Evaluation research for Pharmaceutical Benefits Scheme communications	$83,715.52
Hall & Partners Pty Ltd	Evaluation research for STIs awareness communications	$167,365.00
Hall & Partners Pty Ltd	Evaluation research for the Childhood Immunisation Campaign	$32,909.25
Hall & Partners Pty Ltd	Evaluation research for the Medicare Mental Health Check In Campaign (Streams 1 and 2)	$56,458.88
Hall & Partners Pty Ltd	Evaluation research for the Medicare Urgent Care Clinics Campaign - Phase 2	$32,019.63
Hall & Partners Pty Ltd	Evaluation research for the National Primary Care Health Workforce Campaign	$49,161.20
Hall & Partners Pty Ltd	Evaluation research for tobacco and vaping communications	$405,933.00
Hall & Partners Pty Ltd	Evaluation research for Medicare Urgent Care Clinics communications - Phase 3	$127,836.51
Hall & Partners Pty Ltd	Evaluation research for winter vaccination communications	$188,501.52
Healthcare Management Advisors Pty Ltd	Evaluation services for the Chronic Wound Consumables Scheme	$357,146.00
Healthconsult Pty Ltd	Aged Care Provider Workforce Survey	$550,000.00
Kantar Public Australia Pty Ltd	Development research for the Youth Vaping Education Campaign	$123,750.00
Kantar Public Australia Pty Ltd	Developmental research for National Lung Cancer Screening Program	$286,457.60
Multicultural Centre for Women's Health INC	Research on culturally and linguistically diverse women's experiences of gender bias in the health system and health resources	$103,011.63
Nous Group Pty. Ltd	Evaluator consultancy services	$550,000.00
Orima Research Pty Ltd	Consumer facing health software research	$218,541.19
Orima Research Pty Ltd	Independent advice for the curation and authorisation of resources	$125,000.00
Orima Research Pty Ltd	Services to explore the clinical support practices	$223,857.92
Painted Dog Research Pty Ltd	Consumer concept testing lung cancer screening	$482,735.66
Painted Dog Research Pty Ltd	Consumer evaluation lung cancer screening	$96,376.50
Painted Dog Research Pty Ltd	Evaluation research for the Skin Cancer Awareness Campaign	$407,000.00
Painted Dog Research Pty Ltd	Qualitative research services to support the Encounter Record Research Project	$133,933.75
PriceWaterHouseCoopers Consulting (Australia) Pty Ltd	Evaluation research for Lifeline Australia's Aboriginal and Torres Strait Islander crisis support phone line	$290,391.70

Organisation	Service provided	Paid (GST inclusive)
Qualtrics LLC	Online survey of parents/carers on infant formula marketing	$26,938.78
The Australian Council for Education Research Limited	Provision of the National Registrar Survey 2024 and 2025	$106,982.80
The Cancer Council NSW	National research insights into electronic cigarette use among young people	$165,000.00
The Social Research Centre Pty Ltd	Australia Food Frequency Survey Project	$138,148.87
THE SOCIAL RESEARCH CENTRE PTY LTD	Consultancy services deliver the National Census of the Lived Experience (Peer) Workforce	$1,272,052.70
THE TRUSTEE FOR JWS RESEARCH UNIT T JWS RESEARCH PTY LTD	Concept testing for bowel cancer screening	$371,800.00
University of New South Wales	Qualitative data to inform the National Suicide Prevention Outcomes Framework	$186,824.00
Verian Group Australia Pty Ltd	Concept testing for tobacco and e-cigarette communications	$432,960.00
Verian Group Australia Pty Ltd	Concept testing for youth vaping communications	$324,720.00
Verian Group Australia Pty Ltd	Developmental research illicit tobacco	$385,000.00
Verian Group Australia Pty Ltd	Exploratory research youth smoking	$55,000.00
WhereTo Research Based Consulting Pty Ltd	Community Visitor Scheme's Children Research Project	$383,900.00
WhereTo Research Based Consulting Pty Ltd	Evaluation research - bowel cancer screening	$70,246.00
WhereTo Research Based Consulting Pty Ltd	Evaluation research - national cervical screening self-collect	$55,550.00
WhereTo Research Based Consulting Pty Ltd	Evaluation research for bowel cancer screening communications	$495,000.00
WhereTo Research Based Consulting Pty Ltd	Exploratory research illicit drugs	$880,000.00
WhereTo Research Based Consulting Pty Ltd	First Nations GP training evaluation and research consultancy services	$320,834.00
WhereTo Research Based Consulting Pty Ltd	Health professionals research	$123,200.00
WhereTo Research Based Consulting Pty Ltd	Healthcare Consumer Survey on Antisemitism	$50,000.00
WhereTo Research Based Consulting Pty Ltd	Policy and program development services	$377,811.71

Direct mail organisations (includes organisations which handle the sorting and mailing out of information material to the public)		
Organisation	**Service provided**	**Paid (GST inclusive)**
National Mail and Marketing	Carer Gateway mailout	$213,194.32
Services Australia	Mailout to Australians approaching their 31st birthday, and newly enrolled migrants to Australia approaching their first 12-month anniversary of enrolling in Medicare for Interim or Full Medicare benefits. The annual Mailout is the primary mechanism used to inform people of the implications of not being covered by an appropriate level of private health insurance hospital cover – it is intended to reduce the risk of people being significantly disadvantaged by not having prior knowledge of the Lifetime Health Cover loading, as well as the Medicare Levy Surcharge, and comprises of a letter and fact sheet personally addressed to the recipient.	$531,051.81[171]
National Mail and Marketing	Warehousing, posting, printing, recycling.	$12,468.46

Media advertising organisations (the master advertising agencies which place Government advertising in the media – this covers both campaign and non-campaign advertising)		
Mediabrands Australia Pty Ltd	Media buy for the Childhood Immunisation Campaign	$2,981,812.48
Mediabrands Australia Pty Ltd	Media buy for the Pharmaceutical Benefits Scheme Awareness Campaign (Phase 3)	$10,065,000.00
Mediabrands Australia Pty Ltd	Media buy for the Maternal RSV Campaign (Phase 2)	$390,499.95
Mediabrands Australia Pty Ltd	Media buy for the Winter Vaccination Campaign	$7,842,277.99
Mediabrands Australia Pty Ltd	Media buy for the National Tobacco and E-cigarette Campaign (Phase 2)	$12,420,491.85
Mediabrands Australia Pty Ltd	Media buy for the National Menopause and Perimenopause Awareness Campaign	$1,124,513.58
Mediabrands Australia Pty Ltd	Media buying services for the Youth Vaping Education Campaign (Phase 3)	$7,286,052.99
Mediabrands Australia Pty Ltd	Media buying services for the Sexually Transmissible Infections Campaign (Phase 2)	$3,679,932.25
Mediabrands Australia Pty Ltd	Media buy for the Medicare Urgent Care Clinics Campaign (Phase 3)	$5,016,979.31
Mediabrands Australia Pty Ltd	Media buy for the Bulk Billing for all Australians Campaign (Stream 1 – BBPIP)	$326,538.84
Mediabrands Australia Pty Ltd	Media buy for the Bulk Billing for all Australians Campaign (Stream 2 – consumers)	$10,597,833.76
Mediabrands Australia Pty Ltd	Media buy for the 1800MEDICARE Campaign	$5,195,075.76
Mediabrands Australia Pty Ltd	Media buy for the Medicare Mental Health Check In campaign – Stream 1	$165,102.29

[171] Costs recovered from private health insurers.

Media advertising organisations (the master advertising agencies which place Government advertising in the media – this covers both campaign and non-campaign advertising)		
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Adverse events reporting (CALD) campaign	$49,548.94
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Health practitioners – how to access medicines during a national shortage	$49,548.94
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Advertising on social media	$49,999.94
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Reporting suspected advertising breaches	$39,999.95
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Buying health products safely online	$49,999.94
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Are you unknowingly taking too much vitamin B6?	$49,999.95
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Clinicians and pharmacists – Are your patients aware of the risks of buying melatonin online?	$19,999.95
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: What to know if you've been prescribed medicinal cannabis	$98,821.71
Mediabrands Australia Pty Ltd	Media buy for TGA campaign: Do your patients know the risks of unapproved medicinal cannabis products?	$79,999.95
Mediabrands Australia Pty Ltd	Media buy for 2027 GradConnection marketing for 2027 Graduate Program	$82,514.64

Appendix 6: Work health and safety

We are committed to providing a safe, supportive and respectful workplace that protects and promotes the physical and psychological health, safety and wellbeing of staff, contractors and visitors. In 2025–26, we continued to meet our obligations under the *Work Health and Safety Act 2011* (Cth) (WHS Act) and the *Safety, Rehabilitation and Compensation Act 1988* (Cth). We took all reasonably practicable steps to:

- eliminate or minimise risks
- maintain policies, procedures and practices to identify and respond to hazards
- support high standards of ethical behaviour consistent with the APS Values, APS Employment Principles and APS Code of Conduct.

The Work Health and Safety Committee, our consultative mechanism for health and safety matters, met quarterly throughout 2025–26. The Health and Safety Representative network and first aid officers helped the Committee maintain a safe and healthy work environment and guide workforce safety initiatives. Family and Domestic Violence Officers also support health, safety and wellbeing.

During 2025–26, we reported 14 notifiable incidents to Comcare under Part 3 of the WHS Act. Under the WHS Act, investigations and enforcement action relating to workplace incidents are undertaken by Comcare inspectors (for Commonwealth agencies and other Comcare-jurisdiction employers).

We delivered a range of prevention, early intervention and rehabilitation programs to support employee wellbeing, reduce the impact of illness and injury, and strengthen workforce capability and resilience. These initiatives promoted healthy work practices, supported recovery and return-to-work outcomes, and contributed to a positive, safe and respectful workplace culture.

We delivered our annual influenza vaccination program to support employee health and wellbeing. The program was delivered through a combination of onsite clinics and free pharmacy vaccination vouchers. During the reporting period, our onsite clinics administered 3,570 vaccinations. In addition, staff redeemed 668 vouchers at participating pharmacies.

Our Employee Assistance Program (EAP) provided employees and their immediate family members with access to confidential counselling, coaching and specialist support services. The program helped across a broad range of personal and workplace matters, including dedicated support for:

- Aboriginal and Torres Strait Islander employees
- LGBTIQA+ employees
- people with disability
- carers
- eldercare, family and domestic violence
- financial well-being
- career planning
- manager coaching.

We also made enhanced EAP support available during significant local, national, and global events.

EAP utilisation remained strong during the reporting period, with department usage at 24.4% compared to the Commonwealth average of 10.3%. This reflects a strong culture of help-seeking and engagement with wellbeing services. Virtual appointments remained the preferred access method, followed by telephone consultations.

Personal matters continued to be the primary reason employees accessed support services. Utilisation relating to most workplace psychosocial hazards remained below industry benchmark rates, while an increase in presentations associated with family-related concerns contributed to higher overall program usage compared to 2024–25. These results show the ongoing value of providing comprehensive wellbeing supports that helps employees to navigate both personal and workplace challenges.

We also offered a comprehensive wellbeing webinar program covering a range of personal and workplace topics. Topics included mental health awareness, growth mindset, sleep, and health, thriving under pressure, resilience, motivation, and compassion fatigue.

Other wellbeing initiatives offered include:

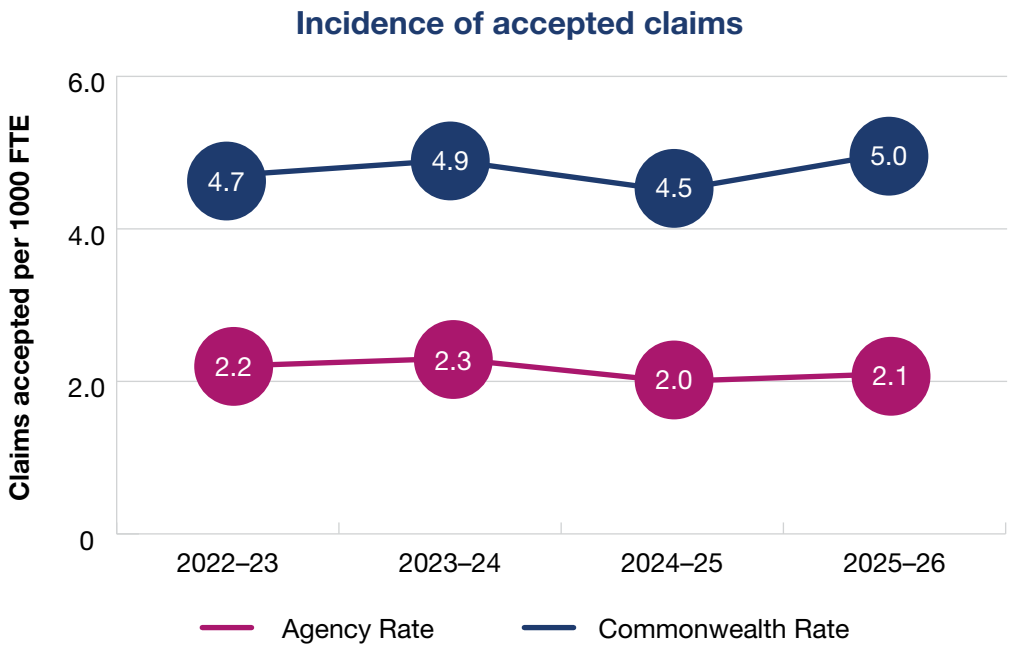
- Occupational therapy-led workstation assessments delivered both in person and virtually, to support evidence-based workplace adjustments and employee wellbeing, including for employees working remotely.
- Early intervention and rehabilitation case management services to support employee recovery and facilitate safe, timely and durable return-to-work outcomes.
- Mental health and wellbeing initiatives, including the implementation of the Healthy Minds at Work Strategy, psychologist-led education and awareness sessions, and mental health capability development for employees and managers.
- Practical fact sheets, tools and resources on topics such as psychological safety, resilience, fatigue, workload management, burnout prevention, vicarious trauma, mental health awareness and available support pathways.

Injury management

Our workers' compensation premium rate was lower in 2025–26 compared to the previous reporting period. We have a small number of accepted Comcare claims each year. Comcare accepted 14 claims in 2025–26. This was consistent with the 14 accepted claims in 2024–25, despite an increase in submitted claims. Our incidence of accepted claims per 1,000 full-time equivalent staff is 2.1. This remains lower than the Commonwealth average of 5.0.

Our most common mechanisms of injury for accepted claims across the 2022–23 to 2025–26 period were mental stress, body stressing and falls, trips and slips. We continue to enforce and review policies, procedures, and practices to appropriately protect workers from, and respond to, potential hazards.

Figure 1: Number of accepted compensation claims from 2022–23 to 2025–26 12.0 Commonwealth rate/1000 FTE by financial year, agency claims, agency rate and Commonwealth rate



Appendix 7: Environment protection and biodiversity conservation

Ecologically sustainable development principles

The principles of ecologically sustainable development, outlined in section 3A of the *Environment Protection and Biodiversity Conservation Act 1999*, are that:

- decision making processes should effectively integrate both long term and short term economic, environmental, social and equity considerations
- if there are threats of serious or irreversible environmental damage, lack of full scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation
- the present generation should ensure the health, diversity and productivity of the environment is maintained or enhanced for the benefit of future generations
- the conservation of biological diversity and ecological integrity should be a fundamental consideration in decision making
- improved valuation, pricing and incentive mechanisms should be promoted.

The department administers legislation relevant to the principles of ecologically sustainable development.

Gene Technology Act 2000

Through the Gene Technology Regulator, we protect the health and safety of people and the environment by identifying risks posed by gene technology and managing those risks by regulating activities with genetically modified organisms. These activities range from contained work in certified laboratories to the release of genetically modified organisms into the environment. The Gene Technology Regulator imposes licence conditions to protect the environment and uses extensive powers to monitor and enforce those conditions.

Industrial Chemicals Act 2019

The Australian Industrial Chemicals Introduction Scheme (AICIS) aids in the protection of the Australian people and the environment by assessing the risks from the introduction and use of industrial chemicals and making recommendations to promote their safe use. AICIS operates within an agreed framework for chemical management consistent with the National Strategy for Ecologically Sustainable Development and is aligned with the United Nations Conference on Environment and Development Agenda 21 chapter on the environmentally sound management of toxic chemicals.

Commonwealth Climate Disclosure 2025–26

Commonwealth Climate Disclosure is the government's policy for Commonwealth entities to publicly report their exposure to climate-related risks and opportunities and the actions taken to manage them. This is our climate disclosure for the 2025–26 reporting period. It has been prepared against the Year 2 requirements applying to Tranche 1 entities and is structured across governance, strategy, risk management, and metrics and targets.

During 2025–26, we:

- strengthened our climate governance
- endorsed and implemented our Net Zero and Climate Risk Committee Action Plan 2025–26
- introduced monthly action tracking and quarterly committee reporting
- completed a preliminary organisation-wide climate risk and opportunity assessment
- embedded climate resources in policy guidance
- engaged senior executives to validate priority risks and opportunities
- continued implementation of our Emissions Reduction Plan 2025–26[172]
- reported Scope 1, Scope 2 and relevant Scope 3 emissions in accordance with the whole-of-government emissions reporting approach.

This disclosure also identifies areas for further and future work. We will continue to strengthen our scenario analysis, quantify financial effects, integrate climate risk into enterprise and divisional risk processes, and evaluate control effectiveness in 2026–27.

Our reporting is based on reasonable and supportable information available at the time of preparation. It includes qualifications where data completeness, estimation or organisational changes affect interpretation. In accordance with the Commonwealth Climate Disclosure Year 2 Requirements, we used all reasonable and supportable information available without undue cost or effort to assess climate-related risks and opportunities.

Further information about the APS Net Zero 2030 Target is provided in the APS Net Zero 2030 Target Factsheet (FY2025–26).[173] This includes its scope, emissions boundary, target period, the covered greenhouse gases and monitoring and review arrangements.

1. Governance

In 2025–26, we maintained our climate-related governance arrangements under the Commonwealth Climate Disclosure policy and the APS Net Zero 2030 Target. We use our Risk Management Framework and Risk Management Policy in our climate governance. They also support the Secretary's responsibility under section 16 of the *Public Governance, Performance and Accountability Act 2013* to maintain systems of risk oversight and management, including for climate-related risks and opportunities.

As the department's accountable authority, the Secretary oversees climate-related risks and opportunities, including their implications for our strategy and risk management, and the setting and monitoring of climate-related targets. The Secretary is supported by our Executive Committee, Audit and Risk Committee (ARC), Chief Sustainability Officer and Net Zero and Climate Risk Committee.

The Executive Committee, chaired by the Secretary, provides strategic direction and considers organisational performance, risk, financial management, culture and capability. The ARC provides independent advice to the Secretary on financial and performance reporting, risk oversight and management, and internal control systems. The Chief Sustainability Officer coordinates oversight of climate-related risks and opportunities.

[172] Department of Health, Disability and Ageing, **Emissions Reduction Plan 2025–2026**, Department of Health, Disability and Ageing, October 2025, accessed September 2026.
[173] Department of Finance, **APS Net Zero 2030 Target Factsheet**, Department of Finance, July 2026, accessed August 2026.

They also work with the Executive Committee, ARC, and Net Zero and Climate Risk Committee to implement the APS Net Zero 2030 Target, the Emissions Reduction Plan and related reporting obligations.

The Net Zero and Climate Risk Committee remains the principal forum for coordinating emissions reduction, sustainable procurement, climate risk management and reporting across the department. The Environment Health and Climate Change Branch transferred to the Australian Centre for Disease Control through a Machinery of Government change in January 2026. We reviewed and updated governance arrangements to support ongoing engagement on health system adaptation and resilience.

Governance outcomes in 2025–26

The Net Zero and Climate Risk Committee oversaw the delivery of climate risk management and net zero priorities, monitoring progress against agreed actions and milestones. The Committee's Action Plan focused on:

- emissions reduction in operations
- strengthening sustainable procurement
- embedding climate risk into business, policy and risk planning through the Climate Risk and Opportunity Management Program (CROMP)
- strengthening governance, oversight and reporting.

We implemented a central reporting tool to capture monthly reporting from action owners. Quarterly reporting to the Committee improved their visibility of progress, delayed milestones, delivery risks and matters requiring attention. We established mechanisms to track performance, escalate issues and monitor follow-up actions.

The Chief Sustainability Officer provides progress reports to the ARC at least twice a year and escalates material matters to the executive when required.

In 2025-26 we pursued a whole-of-organisation approach. We:

- completed a preliminary organisation-wide assessment using CROMP guidance to identify organisational values and material physical and transition risks
- integrated climate risk and APS Net Zero resources into the department's Policy Playbook
- delivered a senior executive climate risk and priorities workshop to validate risks and opportunities and identify priority actions.

Capability and assurance

We support the Secretary, as the accountable authority, as well as the relevant governance bodies through:

- executive briefings
- climate-risk workshops
- CROMP-based guidance
- cross-government communities of practice
- intranet resources
- communications
- APS learning resources
- specialist advice.

These mechanisms are building and maintaining the skills we need for future climate-related oversight and risk assessments. Our governance arrangements provide executive and independent risk oversight. We will continue to grow and improve these skills to meet the challenges ahead.

Forward priorities

In 2026–27, we will maintain our established governance arrangements to oversee implementation of sustainability initiatives, monitor progress and escalate material barriers, resourcing issues and delivery risks as required. The Net Zero and Climate Risk Committee will continue to consider priority risks, ensure accountability for actions, consider resourcing needs and implementation priorities. We will also validate the climate-risk baseline, confirm controls and owners, test the CROMP approach with selected business areas and complete a post-implementation review.

2. Strategy

During 2025–26, we continued to assess how climate change may affect our operations, service continuity, policy responsibilities, programs and financial prospects. Information from the preliminary climate risk and opportunity assessment, CROMP workshops and the National Climate Risk Assessment was used to identify climate-related risks and opportunities across our services, workforce, property, energy, fleet, procurements, information and communications technology (ICT), policy and programs. Executive discussions focused on confirming current risks and opportunities, identifying any gaps, and agreeing on practical actions to address them.

Our Emissions Reduction Plan for 2025–26 set out practical actions to reduce operational emissions and support the APS Net Zero 2030 Target, with a focus on buildings, electricity, fleet, travel, procurement, staff engagement and reporting maturity. During the year, we progressed fleet electrification and charging infrastructure, building efficiency, Green Lease Schedules, National Australian Built Environment Rating System performance, renewable electricity arrangements, ICT lifecycle work and improved emissions data. We incorporated climate prompts into our policy guidance, action tracking and procurement and asset considerations.

Material climate-related risks and opportunities

For this disclosure, ‘current effects’ are effects experienced during the 2025–26 reporting period. The short-term horizon extends to 2030 because it aligns with the APS Net Zero 2030 Target, our current planning and investment cycles, and near-term operational decisions. The medium-term horizon extends from 2031 to 2050 because it aligns with Australia’s net zero emissions commitment and captures longer-term changes to assets, infrastructure, workforce, service delivery and policy responsibilities. We will consider longer-term effects beyond 2050 as scenario-analysis capability matures.

We expect operational effects to be concentrated in the department’s regional and remote service dependencies, critical ICT and data systems, leased property portfolio, workforce availability, energy supply, procurement and critical supplier arrangements.

For public-policy, we expect effects to be concentrated in health-system resilience, climate-sensitive disease, emergency preparedness, aged care and disability policy and programs, and outcomes for Aboriginal and Torres Strait Islander and regional and remote communities.

Risk or opportunity	Effects by time horizon	Strategy and decision-making response
Service continuity and critical service delivery Physical risk	**Current effects — 2025–26** No material climate-related effect on departmental service continuity was identified during the reporting period. Extreme weather and climate-sensitive events nevertheless remained relevant to business continuity and emergency coordination planning. **Anticipated effects — short term, 2026–2030** More frequent extreme heat, bushfires, poor air quality, floods, severe storms and climate-sensitive infectious disease events may disrupt departmental operations, priority programs, emergency coordination and continuity of health, disability and aged care services, particularly in regional and remote areas. **Anticipated effects — medium term, 2031–2050** Increasing frequency, severity and compounding of climate events may require substantial changes to continuity arrangements, service-delivery models, infrastructure dependencies and coordination with delivery partners.	Update and test business continuity plans; confirm escalation pathways for regional and remote disruption; incorporate priority service-continuity risks into governance, divisional planning and enterprise risk processes; and use exercises and climate evidence to test current controls.
Health-system resilience and priority cohort impacts Physical risk	**Current effects — 2025–26** No material current effect on departmental policy, programs or system stewardship was separately identified during 2025–26. Climate-related health demand and inequity remained relevant to policy and planning. **Anticipated effects — short term, 2026–2030** Climate-related health demand and inequity may increasingly affect policy, prevention priorities, program design, system stewardship and advice to government. Older Australians, people with disability, Aboriginal and Torres Strait Islander people, and rural and remote communities may face disproportionate exposure and vulnerability. **Anticipated effects — medium term, 2031–2050** Persistent and compounding climate-related health impacts may require longer-term changes to prevention, preparedness, service models, funding priorities and health-system resilience, with particular attention to priority cohorts.	Use climate-health evidence in policy and program planning; assess vulnerability to extreme heat, poor air quality and climate-sensitive disease; and incorporate resilience and equity considerations into prevention, preparedness and long-term system planning.

Risk or opportunity	Effects by time horizon	Strategy and decision-making response
Workforce capacity and supply-chain resilience Physical risk	**Current effects — 2025–26** No material climate-related workforce or supply-chain disruption was identified during the reporting period. Workforce dispersion, flexible work and resilient ICT supported continuity arrangements. **Anticipated effects — short term, 2026–2030** Climate events may reduce workforce availability and disrupt critical goods, medicines, equipment, suppliers and supporting services. Flexible work, workforce dispersion and resilient ICT will remain material to maintaining operations. **Anticipated effects — medium term, 2031–2050** More sustained or widespread disruption may require diversification of critical suppliers, redesigned workforce and surge arrangements, and stronger resilience requirements in procurement and contract management.	Identify critical suppliers and single points of failure; incorporate climate resilience into procurement and contract management; assess workforce availability and wellbeing risks; maintain flexible work, workforce dispersion, ICT resilience and surge arrangements; and escalate material dependencies.
Technology, infrastructure and governance resilience Physical and transition risk	**Current effects — 2025–26** No material climate-related failure of digital, infrastructure, energy or governance systems was identified during the reporting period. Current effects included implementation effort and expenditure associated with emissions reporting, building efficiency, fleet transition, data quality and governance maturity; these effects were not separately quantified. **Anticipated effects — short term, 2026–2030** Failure or underperformance of digital, infrastructure, energy, data or governance systems may affect operational resilience, emergency coordination, assurance, reporting quality and executive decisions. Adaptation, emissions reduction, procurement reform and reporting may affect budget and investment priorities. **Anticipated effects — medium term, 2031–2050** More significant infrastructure adaptation, technology renewal and transition investment may be required. Failure to maintain resilient systems or meet evolving obligations may create material operational, compliance, governance and reputational consequences.	Confirm owners for material risks; assess ICT, facility and energy dependencies; include climate risk, APS Net Zero implementation and disclosure obligations in assurance and committee reporting; improve data quality; and incorporate building efficiency, fleet electrification and procurement reform into planning and investment decisions.

Risk or opportunity	Effects by time horizon	Strategy and decision-making response
Climate adaptation and system transformation Physical and transition opportunity	**Current effects — 2025–26** Current benefits included stronger climate governance, improved action tracking, expanded climate-risk guidance and progress on building efficiency, fleet electrification and emissions data. The operational and financial value of these benefits was not separately quantified. **Anticipated effects — short term, 2026–2030** Adaptation and transition may improve organisational flexibility, distributed service delivery, data and surveillance, population health outcomes, operational resilience and lower-emissions performance. **Anticipated effects — medium term, 2031–2050** Continued adaptation and system transformation may support more sustainable service models, stronger climate-informed stewardship, improved resilience and lower long-term operating exposure.	Use climate scenarios to test future service models; strengthen surveillance and climate intelligence; align adaptation with emissions reduction, efficient buildings, fleet electrification and procurement reform; build staff capability; and incorporate opportunities into strategic planning, investment, policy design and reporting.

Strategic resilience and financial effects

Our current assessment indicates that climate-related effects may influence:

- service continuity
- workforce arrangements
- emergency coordination
- property and energy performance
- ICT resilience
- procurement
- fleet transition
- data capability
- policy outcomes.

Associated financial effects may include:

- adaptation and resilience expenditure
- building and charging infrastructure
- lower-emissions vehicles
- renewable electricity
- data and reporting capability
- sustainable procurement
- business-continuity measures.

During 2025–26 we assessed these impacts using qualitative information. Work is underway to develop consistent methods for measuring these impacts and linking them to budgets, investment proposals, asset plans and financial reporting processes.

Forward priorities

We did not complete comparative scenario analysis during 2025–26. In 2026–27, we will undertake proportionate analysis using at least two plausible climate futures. The analysis will document:

- scenario sources
- temperature and policy assumptions
- time horizons
- geographic and operational scope
- macroeconomic and regional variables
- energy-use assumptions
- technology developments
- limitations and the reporting period in which the analysis is completed.

We will:

- validate and prioritise our material risks and opportunities
- extend assessment of service continuity, workforce, critical suppliers, policy outcomes and priority cohorts
- improve consideration of climate impacts in budgets, investment and New Policy Proposals.

We will strengthen our transition planning through a clearer emissions trajectory, interim milestones, accountable owners, financing and dependency information, and stronger links between climate-related effects and financial reporting.

3. Risk Management

Our Risk Management Policy establishes risk accountabilities, appetite and tolerance and requires divisional business and risk planning. During 2025–26, we used CROMP guidance and the government's approach to climate risk and opportunity management to develop a preliminary organisation-wide climate risk and values assessment. We considered our functions and values, physical and transition risks, APS Net Zero and climate-risk resources, and available climate evidence. We held a senior executive workshop to check the draft profile was correct and identify future priorities.

We identified and assessed climate-related opportunities through the same CROMP-based process used for climate-related risks. We considered opportunities against their potential strategic, operational, policy, financial and emissions-reduction benefits. We then prioritised them regarding their feasibility, timing, dependencies, available resources and alignment with our objectives. Significant opportunities are assigned to responsible officers and tracked through the Action Plan and regular committee reporting.

Climate-related risks and actions are managed through our core business, risk and planning processes. Progress of actions is tracked centrally, including action status, risk levels, owners, due dates, achievements, challenges, next steps and supporting evidence.

Current maturity and limitations

Our work in 2025–26 improved our visibility of climate-related risks across operations, services, workforce, procurement, assets, ICT, policy and programs. We also identified that ownership, assessment dates, controls, evidence and the mapping of climate risks to enterprise and divisional risk registers were not consistently completed. The preliminary assessment provides a baseline, rather than a fully finalised end-to-end climate risk management process.

Forward priorities

In 2026–27, we will focus on establishing our climate risk baseline and finalising our most significant climate-related risks and opportunities. We will assign senior leaders with responsibility for managing these risks, including documenting controls, actions, timeframes, measures and reporting requirements. We will improve our approach to assessing and prioritising climate risks, align them with existing risk frameworks, and define when risks need to be escalated. We will also review the effectiveness of existing controls.

We will use targeted engagement across the department to build climate risk awareness and support the practical use of climate risk assessments in planning and decision-making. We will also further embed climate risk considerations into key processes, including risk management, business planning, procurement, investment, business continuity, and policy and program development.

4. Metrics and Targets

We use quantitative and qualitative metrics aligned with the Australian Government Emissions Reporting Framework to assess our progress. These include:

- Scope 1, Scope 2 and relevant Scope 3 greenhouse gas emissions
- electricity consumption and energy efficiency
- renewable electricity uptake
- fleet composition
- integration of climate resilience into policies and operations
- implementation of climate-risk treatments
- staff engagement and learning opportunities.

We measure emissions in tonnes of carbon dioxide equivalent. Our principal target is the APS Net Zero 2030 Target, supported by entity-specific actions and interim milestones in the Emissions Reduction Plan.

We have not disclosed the optional cross-industry metrics specified in criterion M2 for the 2025–26 reporting period.

Table 1: 2025–26 Greenhouse Gas Emissions Inventory – Location-Based Method

Emission Source	Scope 1 t CO_2-e	Scope 2 t CO_2-e	Scope 3 t CO_2-e	Total t CO_2-e
Electricity (Location Based Approach)	N/A	2965.85	157.07	3122.92
Natural Gas	350.78	n/a	89.18	439.96
Solid Waste	0.00	n/a	166.05	166.05
Refrigerants	n/a	n/a	n/a	0.00
Fleet and Other Vehicles	29.58	n/a	7.45	37.03
Domestic Commercial Flights	n/a	n/a	1335.21	1335.21
Domestic Hire Car	n/a	n/a	26.51	26.51
Domestic Travel Accommodation	n/a	n/a	421.92	421.92
Other Energy	0.00	n/a	0.00	0.00
Total t CO_2-e	**380.36**	**2965.85**	**2203.39**	**5549.60**

Note:

1. The table above presents emissions related to electricity usage using the location-based accounting method.
2. Scope 1, Scope 2, Scope 3 and Total Emissions are presented as tonnes carbon dioxide equivalent (t CO2-e).
3. Refrigerants are being phased and are an optional source in 2025–26 emissions reporting.

n/a = not applicable.

Table 2: 2025–26 Greenhouse Gas Emissions

Emission Source	Scope 2 t CO_2-e	Scope 3 t CO_2-e	Total t CO_2-e	Electricity kWh
Electricity (Location Based Approach)	2965.85	157.07	3122.92	4749377.18
Market-based electricity emissions	524.91	71.29	596.20	648032.48
Total renewable electricity	n/a	n/a	n/a	4101344.71
Renewable Power component	n/a	n/a	n/a	821167.32
Jurisdictional Renewable Power component	n/a	n/a	n/a	3280177.39
GreenPower	n/a	n/a	n/a	0
Large-scale generation certificates	n/a	n/a	n/a	0

Note:

n/a = not applicable.

1. The table above presents emissions related to electricity usage using both the location-based and the market-based accounting methods.
2. Scope 2, Scope 3 and Total emissions are presented in tonnes carbon dioxide equivalent (t CO2-e). Electricity data is reported in kilowatt hours (kWh).
3. Total renewable electricity excludes behind-the-meter solar other than generation used to create large-scale generation certificates (LGCs).
4. The renewable power percentage (RPP) accounts for the portion of electricity used, from the grid, that falls within the Renewable Energy Target (RET).
5. Jurisdictional Renewable Power refers to the Jurisdictional Renewable Power Percentage (JRPP). Currently, the Australian Capital Territory is the only jurisdiction with a JRPP.

Targets and Progress

Total location-based emissions decreased by approximately 21.6% from 2024–25 to 2025–26, subject to the boundary and data qualifications below. Location-based electricity and natural-gas emissions decreased. Our workforce declined by approximately 4% during the reporting period, and this change should be considered when interpreting absolute emissions movements.

The vehicle fleet continued to transition toward lower-emissions technologies. Battery electric and plug-in hybrid vehicles increased from 9 in 2024–25 to 16 in 2025–26, a 77.8% increase, raising their share of the fleet from 37.5% to 66.7%. Direct fleet emissions nevertheless increased by 6.7%, reflecting utilisation and fleet-operating factors. This demonstrates that fleet composition and actual emissions performance must be monitored together.

Data boundaries, methods and qualifications

- The reported inventory uses whole-of-government emissions reporting methods and includes the stated Scope 1, Scope 2 and relevant Scope 3 sources.
- Refrigerants are not included for 2025–26 as applicable sites do not fall within the reporting boundary based on Net Lettable Area in square metres.
- Domestic travel may include a small amount of portfolio-agency activity because of shared-services arrangements.
- Hire-car and accommodation data may be incomplete; data quality is expected to improve as reporting matures.
- Some solid-waste data was estimated using customised operational benchmarks because landlord-managed services in multi-tenanted buildings limited access to actual waste volumes. The lower of full-time equivalent or work-point numbers was used for relevant office tenancies, based on the latest published APS employment data.
- We operated across 15 office spaces, including a specialised laboratory, and had staff accommodated at a further 16 sites under memoranda of understanding. This dispersed footprint, shared premises and Machinery of Government changes add complexity to organisational boundaries and comparability.
- Renewable electricity components are presented in kilowatt hours; the labels describe the source of renewable electricity rather than a percentage measure in the table.

Emissions inventories are subject to ongoing validation and quality assurance processes. Where errors are identified, reporting methodologies are refined, emissions factors are updated, or more complete source data becomes available, previously reported emissions figures may be revised. Consequently, year-on-year emissions data may not be directly comparable where amendments have been made to improve the accuracy and integrity of reported information.

Overall assessment and 2026–27 priorities

We made substantive progress during 2025–26. Governance arrangements are established and supported by accountable-authority oversight, an endorsed Action Plan, monthly tracking, quarterly reporting and executive engagement. Strategy and risk-management maturity improved through a preliminary CROMP-based assessment, clearer articulation of material risks and opportunities, and integration of climate prompts into policy and planning resources. Emissions reporting provides quantitative evidence of operational performance and identifies material data limitations.

The principal priorities for 2026–27 are to:

- complete and document proportionate scenario analysis using at least 2 plausible climate futures
- quantify financial effects where reasonable and supportable and connect them to budgets, investment, procurement, assets and financial reporting
- validate material risks and opportunities and assign accountable senior owners
- integrate climate risks into enterprise and divisional risk registers and planning cycles
- document controls, treatments, residual risk, monitoring indicators and control-effectiveness testing
- strengthen sustainable procurement and Scope 3 data capture
- refine the emissions trajectory, interim milestones, dependencies and resourcing requirements
- improve data quality, reporting boundaries and year-on-year comparability
- review governance membership and authority following organisational changes.

5. Emissions Reduction Plan 2025–26

During the year, we progressed property initiatives, including Green Lease Schedules and Energy Management Plans at eligible major leased sites, workplace consolidation and occupancy optimisation.

We require further evidence on all-electric lease preferences, separate metering, and completion of audit and energy-efficiency actions.

Our Energy initiatives include transitioning ACT buildings to Whole-of-Australian-Government electricity arrangements through the Department of Finance. Other electricity arrangements will transition as existing arrangements expire.

Our fleet initiatives included lower-emissions vehicles and landlord engagement on charging infrastructure. We will continue to strengthen fleet planning, supporting infrastructure and sustainable travel initiatives.

In 2026–27, we will strengthen data collection, baselines, performance indicators and supporting evidence, and establish clearer mechanisms for monitoring progress against emissions-reduction objectives.

Appendix 8: Compliance with the *Carer Recognition Act 2010*

Disability confidence and recognition of carers

We strive to be an inclusive organisation that supports staff with disability and those with caring responsibilities.

We fund the International Day of People with Disability (IDPwD) program.[174] This is aligned with Australia's Disability Strategy 2021-2031 and implements initiatives that acknowledge Carers Week and the IDPwD.

We held a range of successful activities in 2025–26, including:

- National Carers Week, where the department's Disability and Carers Network produced a video featuring staff with lived experience of caring responsibilities. The Network also hosted the 'You are one, know one or will be one' Virtual Panel.
- IDPwD, were we supported an All Abilities cross-agency basketball games and the 'Fostering disability inclusive societies for advancing social progress' Virtual Panel.

The Disability and Carers Network brings together staff with disability, chronic conditions and those with caring responsibilities, as well as allies. The Network raises awareness, shares lived experience and supports improvements to policies, systems and the work environment.

Working with carer organisations

We recognise the significant contribution Australia's 3 million unpaid carers make to the community and the economy, and, as such, deliver a range of services and supports to help carers in their caring role, including the Carer Gateway program.

The *Carer Recognition Act 2010* provides a legislative framework to recognise carers and includes the Statement for Australia's Carers that stipulates carers should have the same rights, choices and opportunities as other Australians. This Act also includes a range of public service agency obligations, including ensuring carers are recognised in human resource policies, consulting with carers and peak bodies when creating or changing care supports and ensuring we adhere to the principles in the Statement for Australia's Carers.

Section 7(1) – Each public service agency is to take all practicable measures to ensure that its employees and agents have an awareness and understanding of the Statement for Australia's Carers.

As the lead department for carer policy and programs, we inform the public about the *Carer Recognition Act 2010* through the Carer Gateway website. Additionally, in 2025–26 we funded Carers Australia, the national peak body for Australia's unpaid carers, to coordinate and manage National Carers Week activities in October 2025. The activities aim to raise awareness and inform carers about services and supports available to them.

[174] Department of Health, Disability and Ageing, **International Day of People with Disability**, Department of Health, Disability and Ageing, n.d., accessed August 2026.

Section 7(2) – Each public service agency's internal human resources policies, so far as they may significantly affect an employee's caring role, are to be developed having due regard to the Statement for Australia's Carers.

Our human resources policies comply with the principles contained in the Statement for Australia's Carers. Our Enterprise Agreement 2024–27 includes carer's leave entitlements and flexible working arrangements. Some of these arrangements are:

- changes in hours and patterns of work
- part-time work
- compressed hours
- job sharing home-based work.

We also uphold the requirements of the National Employment Standards under the *Fair Work Act 2009*, including entitlements for employees who are recognised carers.

Our staff have access to health and diversity facilities, including dedicated rooms to help manage unforeseen caring responsibilities.

In addition, they can access free counselling arranged through the Employee Assistance Program.

Our intranet also provides employees and managers with information about carers' entitlements and internal and external resources.

Section 8(1) – Each public service care agency is to take all practicable measures to ensure that it, and its employees and agents, take action to reflect the principles of the Statement for Australia's Carers in developing, implementing, providing or evaluating care supports.

To ensure we meet the needs of carers in the development of carer policy, we fund and regularly consult with Carers Australia on matters relating to carer policy and services and seek advice on issues affecting unpaid carers.

We support Carers Australia to undertake an annual national survey asking carers about their health and wellbeing, and the types of supports they have accessed in their caring role. We use the findings of this survey to inform ongoing policy and program development, including developing and evaluating carer supports such as Carer Gateway.

In 2025–26, we funded Carers Australia to lead the Carer Policy Forum. The Forum strengthened engagement with the community, advocacy and service organisations to inform the development of carer policy and services. Through its advisory and consultative role, the forum provided a mechanism for us to draw on diverse expertise and stakeholder perspectives, supporting evidence-informed policy development and cross-sector collaboration. Insights from the 2 forum events held during 2025–26 are being applied to:

- improving carer recognition within health systems
- supporting carers to access and sustain paid employment
- contributing to National Carer Strategy objectives to recognise and value carers and support their financial security.

In 2025–26, we strengthened cross-government coordination on carer issues by establishing new intergovernmental engagement mechanisms to support more consistent and coordinated policy development and program delivery. The Australian Government exchange brings together key agencies, including the Department of Social Services, Services Australia, Department of Education, Department of Employment and Workplace Relations, and the National Disability Insurance Agency. The state and territory forum is sharing information, emerging issues and better practice across jurisdictions. These forums support alignment of policies and programs that affect carers, strengthen recognition of the critical role unpaid carers play, and support implementation of the National Carer Strategy.

Appendix 9: Gender equality reporting

Under Working for Women: A Strategy for Gender Equality, government departments have committed to report on their efforts to achieve gender equality and build gender analysis capability in their annual reports. As part of this initiative, this annual report includes case studies to show how the department is working towards the ambition of a better, gender equal Australia for everyone.

We use the terms 'women' and 'girls', while recognising that services are designed to be accessible to non-binary, gender-diverse and transgender people. We also recognise that these groups may face additional barriers to safe, appropriate and inclusive care.

Portfolio overview

The department plays a key role in advancing gender equality through our stewardship of Australia's health, aged care and disability systems.

During 2025–26, we contributed across all 5 priority areas of Working for Women: A Strategy for Gender Equality through:

- health reform
- prevention and early intervention
- family, domestic and sexual violence responses
- disability inclusion
- support for carers
- aged care reform
- health workforce initiatives
- medical research.

Our efforts supported improved:

- health outcomes
- safety and recovery
- economic security
- workforce participation
- access to high-quality, culturally safe and inclusive services.

For all Australians, we will continue to strengthen:

- the use of gender analysis across policy
- program and research activities to ensure health, disability and aged care reforms deliver equitable outcomes.

Case study: Strengthening women's health through system reform

During 2025–26, we continued to improve access to affordable, evidence-based healthcare for women across their life course. As at 30 June 2026, over 900,000 women have accessed cheaper medicines for contraception, endometriosis and menopause through the new PBS listings, saving them almost $150 million.

We expanded access to long-acting reversible contraception (LARC) through higher MBS rebates, new bulk-billing incentives, and supporting access through nurse practitioners. We began work to establish LARC Centres of Excellence in every state and territory. More than 21,000 LARC services were bulk billed following introduction of the new incentive, helping address cost and provider availability barriers that have historically limited access.

We also expanded the Endometriosis and Pelvic Pain Clinic network to 33 clinics and introduced new MBS items for longer gynaecology consultations. These initiatives delivered more than 32,000 services for women with complex gynaecological conditions. We also introduced new MBS items for longer specialist gynaecology consultations, supporting women with complex conditions such as endometriosis, pelvic pain and adenomyosis.

In addition, we strengthened support for women experiencing perimenopause and menopause through new MBS health assessments, workforce training and development of national clinical guidelines. This resulted in more than 137,000 menopause and perimenopause health assessments during the year. Meanwhile, more than 11,000 health professionals enrolled in the Menopause Education Program, helping build workforce capability and confidence in menopause care.

We delivered Australia's first national menopause and perimenopause awareness campaign. The campaign delivers evidence-based information through national advertising and a dedicated website. This aims to help people better understand perimenopause and menopause, access support and make informed decisions about their health.

The campaign is committed to enhancing inclusion and health equality. The campaign website includes information for trans and gender diverse people, and people with innate variations in sex characteristics.[175] It also hosts a collection of resources on perimenopause and menopause for First Nations and multicultural women as well as information for health professionals.

We continued to support BreastScreen Australia and the National Cervical Screening Program, contributing to Australia's goal of eliminating cervical cancer as a public health problem by 2035.

We also supported the new Ministerial Expert Panel on Women's Health, which is providing advice to government on improving women's cardiovascular health outcomes.

Case study: Supporting victim-survivors of family, domestic and sexual violence

Family, domestic and sexual violence is still a significant health and wellbeing issue for women and children. During 2025–26, we strengthened the health system response through workforce capability building, trauma-informed care and improved service integration.

The Supporting Health System Navigation for victims and survivors of sexual violence measure improved the ability of the primary care workforce to recognise and respond to family, domestic and sexual violence and provide coordinated support for victim-survivors.

[175] Department of Health, Disability and Ageing, **Information for trans and gender diverse people, and people with innate variations in sex characteristics**, Department of Health, Disability and Ageing, n.d., accessed August 2026.

An interim evaluation report published in February 2026[176] shows the measure delivered 721 training sessions to 3,751 participants nationally. It also supported 1,513 primary care referrals, resulting in more than 1,000 referrals to specialist family, domestic and sexual violence services. It also found almost all referrals were for women (96%). A fifth of individuals referred identified as Aboriginal and/or Torres Strait Islander (21%) and around 15% of individuals were from culturally and linguistically diverse backgrounds.

We continued to deliver the Supporting Recovery pilot and the Supporting Outreach Healthcare pilot. These pilots provide trauma-informed mental and physical health care services for victim-survivors in community and crisis accommodation settings.

We continued to fund the Women's Trauma Recovery Centre in the Illawarra region to provide long-term multidisciplinary support for women recovering from violence. Since opening in September 2024, the centre has delivered healing and recovery services to 280 women.

Together, these initiatives are delivering safer, more connected and trauma-informed care for women affected by violence.

Case study: Boosting women's economic participation through care and workforce reform

Women's economic participation is closely linked to the strength of Australia's care economy and support for unpaid carers. Women make up most unpaid carers and around 85% of the aged care workforce.

Since 2023, the government has provided $17.7 billion to support wage increases arising from the Fair Work Commission's Aged Care Work Value Case decisions, benefiting around 400,000 aged care workers. This includes award wage increases provided to registered and enrolled nurses working in aged care and to many aged care workers from October 2025.

We also continued to deliver the Carer Inclusive Workplace Initiative, which helps employers self-assess how they support workers with caring responsibilities. It also provides free tools and help to improve carer inclusiveness and reduce staff turnover. The Carer Inclusive Workplace Initiative has supported 485 businesses and 198 employers to achieve recognised carer inclusive status.

We supported women and families through the Pregnancy, Birth and Baby service, a national service providing support and information for expecting parents and parents of children from birth to 5 years of age. The service received almost 33,000 calls and attracted 8.8 million website visits during 2025–26, including more than 7,200 calls from rural locations.

The government also announced the Thriving Kids program, which will improve access to developmental and early intervention supports for children and families from October 2026.

[176] Department of Health, Disability and Ageing, **Interim evaluation of the Supporting the Primary Care Sector Response to Family, Domestic and Sexual Violence Primary Health Network Pilot**, Department of Health, Disability and Ageing, February 2026, accessed September 2026.

Case study: Advancing gender equality through inclusive and intersectional approaches

Health outcomes are shaped by multiple factors, including disability, culture, language, geography and sexuality. We continue to target initiatives to populations experiencing additional barriers to care.

We funded Birthing on Country models, which provided a range of culturally safe, First Nations-led models of care. These models of care resulted in continuity of maternal health services and improved maternal and infant outcomes for Aboriginal and Torres Strait Islander families. This included improvements in healthy birthweight, reductions in preterm birth, increased antenatal attendance and higher breastfeeding rates.

The Health in My Language program delivered 515 sessions to more than 8,000 participants across 96 cultural groups and 34 languages, improving health literacy and service navigation among multicultural communities.

We also supported Women with Disabilities Australia through the Disability Representative Organisations Program which helps people with disability and their representative organisations to share their views with government. We progressed initiatives under Australia's Disability Strategy to strengthen safeguarding, participation and leadership opportunities for people with disability.

In addition, we continued implementation of the National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–35, by investing in workforce capability, community-led services, research and inclusive healthcare initiatives.

Building capability and embedding gender equality

Alongside targeted initiatives, we are strengthening capability to embed gender considerations across policy, research, workforce development and service delivery.

During 2025–26, new Medical Research Future Fund and National Health and Medical Research Council funding requirements strengthened the consideration of sex and gender in medical research.

They did this through the implementation of the Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research from 1 January 2026.[177] This includes new requirements for applicants to consider and integrate sex, gender, variations of sex characteristics and sexual orientation in funding applications to the Medical Research Future Fund and National Health and Medical Research Council. Monitoring of activity funded by the Medical Research Future Fund to shows equal funding success rates for women and men researchers, with women leading more than $1.4 billion in funded research.

We also supported gender-informed decision-making through the Therapeutic Goods Administration's Women's Health Products Working Group, health workforce education reforms and increasing use of gender analysis in policy and program development.

Together, these efforts are helping ensure Australia's health, disability and aged care systems deliver more equitable outcomes and support the government's commitment to gender equality.

[177] NHMRC (National Health and Medical Research Council), **Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research**, NHMRC, 2025, accessed August 2026.

Appendix 10: Correction of material errors in previous annual report

Omission from the 2024–25 annual report

The Department of Health, Disability and Ageing advises that the following information was inadvertently omitted from the 2024–25 Annual Report.

Page 354 – Statement of Comprehensive Income

The following footnote should be included:

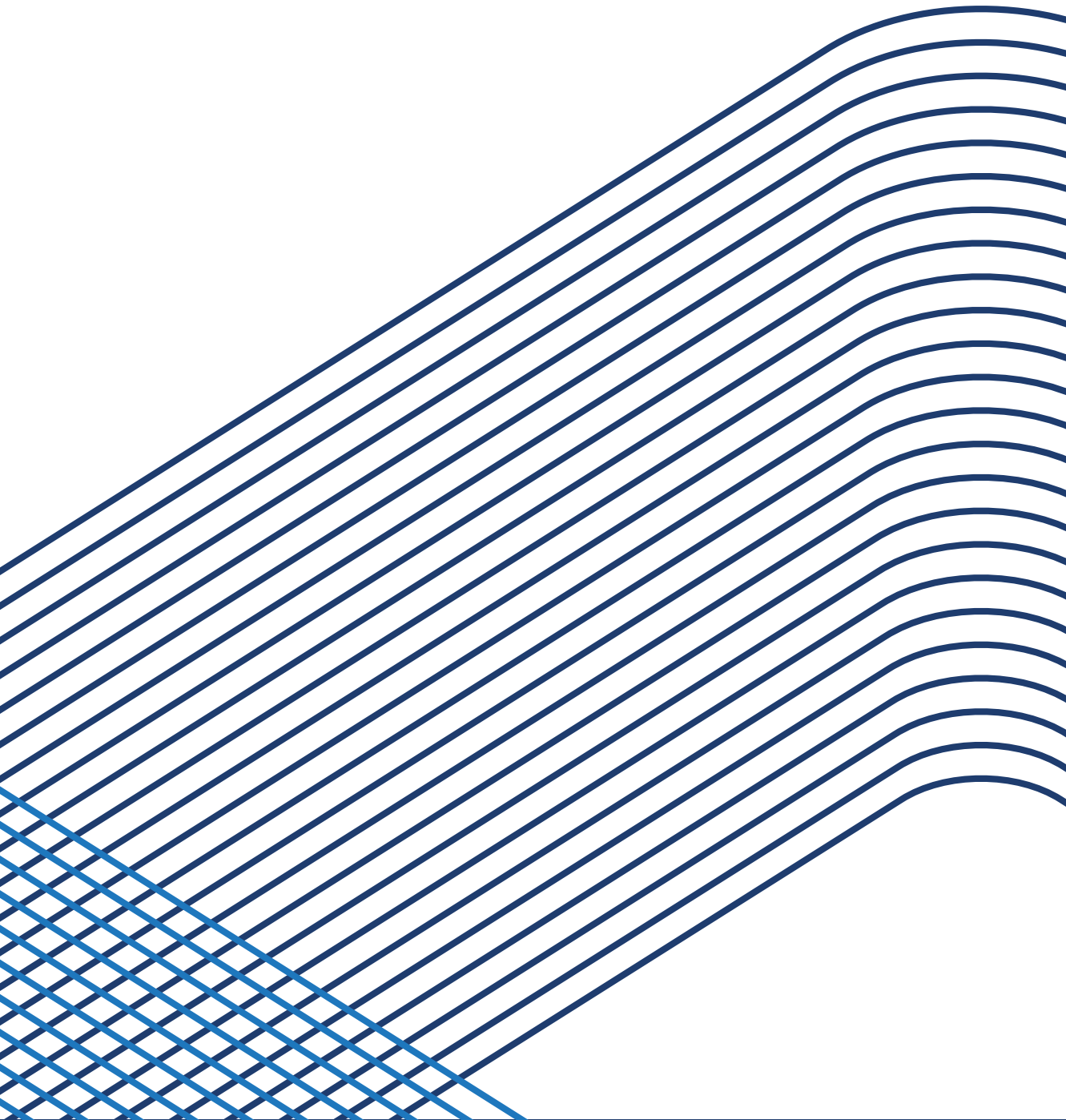
"Expenses incurred and revenue recognised relate to the costs associated with preparation and audit of the financial statements in line with the requirements of AASB 1058 *Income for Not-for-Profit Entities*".

Correction for the 2024–25 annual report

The Department of Health, Disability and Ageing advises a correction is required for the 2024–25 Annual Report.

Page 188 – Grants

The CGRPs are a legislative instrument established by the Minister for Finance under section 105C(1) of the *Public Governance, Performance and Accountability Act 2013 Act, not section 105D*.



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List of requirements

The list below outlines compliance with key annual performance reporting information, as required in section 17AJ(d) of the Public Governance, Performance and Accountability Rule 2014.

This Schedule is made for subsection 46(3) of the Act.

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AD(g)	**Letter of transmittal**			
17AI		A copy of the letter of transmittal signed and dated by accountable authority on date final text approved, with statement that the report has been prepared in accordance with section 46 of the Act and any enabling legislation that specifies additional requirements in relation to the annual report.	Mandatory	Page 1
17AD(h)	**Aids to access**			
17AJ(a)		Table of contents (print only).	Mandatory	Page 2
17AJ(b)		Alphabetical index (print only).	Mandatory	Page 390
17AJ(c)		Glossary of abbreviations and acronyms.	Mandatory	Page 378–390
17AJ(d)		List of requirements.	Mandatory	Page 370
17AJ(e)		Details of contact officer.	Mandatory	Page ii
17AJ(f)		Entity's website address.	Mandatory	Page ii
17AJ(g)		Electronic address of report.	Mandatory	Page ii
17AD(a)	**Review by accountable authority**			
17AD(a)		A review by the accountable authority of the entity.	Mandatory	Page 4–7
17AD(b)	**Overview of the entity**			
17AE(1)(a)(i)		A description of the role and functions of the entity.	Mandatory	Page 13
17AE(1)(a)(ii)		A description of the organisational structure of the entity.	Mandatory	Page 168–169
17AE(1)(a)(iii)		A description of the outcomes and programmes administered by the entity.	Mandatory	Page 14
17AE(1)(a)(iv)		A description of the purposes of the entity as included in corporate plan.	Mandatory	Page 13
17AE(1)(aa)(i)		Name of the accountable authority or each member of the accountable authority.	Mandatory	Page 11
17AE(1)(aa)(ii)		Position title of the accountable authority or each member of the accountable authority.	Mandatory	Page 11
17AE(1)(aa)(iii)		Period as the accountable authority or member of the accountable authority within the reporting period.	Mandatory	Page 11

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AE(1)(b)		An outline of the structure of the portfolio of the entity.	Portfolio departments mandatory	Page 11
17AE(2)		Where the outcomes and programs administered by the entity differ from any Portfolio Budget Statement, Portfolio Additional Estimates Statement or other portfolio estimates statement that was prepared for the entity for the period, include details of variation and reasons for change.	If applicable, Mandatory	Page 19
17AD(c)	**Report on the Performance of the entity**			
	Annual Performance Statements			***Part 2***
17AD(c)(i); 16F		Annual performance statement in accordance with paragraph 39(1)(b) of the Act and section 16F of the Rule.	Mandatory	Page 18
17AD(c)(ii)	***Report on Financial Performance***			***Part 4***
17AF(1)(a)		A discussion and analysis of the entity's financial performance.	Mandatory	Page 194
17AF(1)(b)		A table summarising the total resources and total payments of the entity.	Mandatory	Page 282–292
17AF(2)		If there may be significant changes in the financial results during or after the previous or current reporting period, information on those changes, including: the cause of any operating loss of the entity; how the entity has responded to the loss and the actions that have been taken in relation to the loss; and any matter or circumstances that it can reasonably be anticipated will have a significant impact on the entity's future operation or financial results.	If applicable, Mandatory.	Page 194
17AD(d)	**Management and Accountability**			
	Corporate Governance			***Part 3.1***
17AG(2)(a)		Information on compliance with section 10 (fraud and corruption systems).	Mandatory	Page 146–147
17AG(2)(b)(i)		A certification by accountable authority that fraud and corruption risk assessments and fraud and corruption control plans have been prepared.	Mandatory	Page 161
17AG(2)(b)(ii)		A certification by accountable authority that appropriate mechanisms for preventing, detecting incidents of, investigating or otherwise dealing with, and recording or reporting fraud and corruption that meet the specific needs of the entity are in place.	Mandatory	Page 161

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(2)(b)(iii)		A certification by accountable authority that all reasonable measures have been taken to deal appropriately with fraud and corruption relating to the entity.	Mandatory	Page 161
17AG(2)(c)		An outline of structures and processes in place for the entity to implement principles and objectives of corporate governance.	Mandatory	Page 138
17AG(2)(d) – (e)		A statement of significant issues reported to Minister under paragraph 19(1)(e) of the Act that relates to non compliance with Finance law and action taken to remedy non compliance.	If applicable, Mandatory	Page 148
	Audit Committee			***Part 3.1***
17AG(2A)(a)		A direct electronic address of the charter determining the functions of the entity's audit committee.	Mandatory	Page 143
17AG(2A)(b)		The name of each member of the entity's audit committee.	Mandatory	Page 143
17AG(2A)(c)		The qualifications, knowledge, skills or experience of each member of the entity's audit committee.	Mandatory	Page 143–144
17AG(2A)(d)		Information about the attendance of each member of the entity's audit committee at committee meetings.	Mandatory	Page 143
17AG(2A)(e)		The remuneration of each member of the entity's audit committee.	Mandatory	Page 143
	External Scrutiny			***Part 3.6***
17AG(3)		Information on the most significant developments in external scrutiny and the entity's response to the scrutiny.	Mandatory	Page 184–191
17AG(3)(a)		Information on judicial decisions and decisions of administrative tribunals and by the Australian Information Commissioner that may have a significant effect on the operations of the entity.	If applicable, Mandatory	Page 189
17AG(3)(b)		Information on any reports on operations of the entity by the Auditor General (other than report under section 43 of the Act), a Parliamentary Committee, or the Commonwealth Ombudsman.	If applicable, Mandatory	Page 187
17AG(3)(c)		Information on any capability reviews on the entity that were released during the period.	If applicable, Mandatory	Not applicable
	Management of Human Resources			***Part 3.4***
17AG(4)(a)		An assessment of the entity's effectiveness in managing and developing employees to achieve entity objectives.	Mandatory	Page 170–177

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(4)(aa)		Statistics on the entity's employees on an ongoing and non ongoing basis, including the following: (a) statistics on full time employees (b) statistics on part time employees (c) statistics on gender (d) statistics on staff location.	Mandatory	Page 294–300
17AG(4)(b)		Statistics on the entity's APS employees on an ongoing and non ongoing basis; including the following: • Statistics on staffing classification level • Statistics on full time employees • Statistics on part time employees • Statistics on gender • Statistics on staff location • Statistics on employees who identify as Indigenous.	Mandatory	Page 294–311
17AG(4)(c)		Information on any enterprise agreements, individual flexibility arrangements, Australian workplace agreements, common law contracts and determinations under subsection 24(1) of the *Public Service Act 1999*.	Mandatory	Page 171, Page 300–306
17AG(4)(c)(i)		Information on the number of SES and non SES employees covered by agreements etc identified in paragraph 17AG(4)(c).	Mandatory	Page 300–306
17AG(4)(c)(ii)		The salary ranges available for APS employees by classification level.	Mandatory	Page 306
17AG(4)(c)(iii)		A description of non salary benefits provided to employees.	Mandatory	Page 307
17AG(4)(d)(i)		Information on the number of employees at each classification level who received performance pay.	If applicable, Mandatory	Not applicable
17AG(4)(d)(ii)		Information on aggregate amounts of performance pay at each classification level.	If applicable, Mandatory	Not applicable
17AG(4)(d)(iii)		Information on the average amount of performance payment, and range of such payments, at each classification level.	If applicable, Mandatory	Not applicable
17AG(4)(d)(iv)		Information on aggregate amount of performance payments.	If applicable, Mandatory	Not applicable
	Assets Management			***Part 3.5***
17AG(5)		An assessment of effectiveness of assets management where asset management is a significant part of the entity's activities.	If applicable, mandatory	Page 178

PGPA Rule Reference	Part of Report	Description	Requirement	Location
	Purchasing			***Part 3.5***
17AG(6)		An assessment of entity performance against the *Commonwealth Procurement Rules*.	Mandatory	Page 174–182
	Reportable consultancy contracts			***Part 3.5***
17AG(7)(a)		A summary statement detailing the number of new reportable consultancy contracts entered into during the period; the total actual expenditure on all such contracts (inclusive of GST); the number of ongoing reportable consultancy contracts that were entered into during a previous reporting period; and the total actual expenditure in the reporting period on those ongoing contracts (inclusive of GST).	Mandatory	Page 181
17AG(7)(b)		A statement that *'During [reporting period], [specified number] new reportable consultancy contracts were entered into involving total actual expenditure of $[specified million]. In addition, [specified number] ongoing reportable consultancy contracts were active during the period, involving total actual expenditure of $[specified million]'*.	Mandatory	Page 181
17AG(7)(c)		A summary of the policies and procedures for selecting and engaging consultants and the main categories of purposes for which consultants were selected and engaged.	Mandatory	Page 181
17AG(7)(d)		A statement that *'Annual reports contain information about actual expenditure on reportable consultancy contracts. Information on the value of reportable consultancy contracts is available on the AusTender website.'*	Mandatory	Page 181
	Reportable non-consultancy contracts			***Part 3.5***
17AG(7A)(a)		A summary statement detailing the number of new reportable non-consultancy contracts entered into during the period; the total actual expenditure on such contracts (inclusive of GST); the number of ongoing reportable non-consultancy contracts that were entered into during a previous reporting period; and the total actual expenditure in the reporting period on those ongoing contracts (inclusive of GST).	Mandatory	Page 182

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(7A)(b)		A statement that *'Annual reports contain information about actual expenditure on reportable non-consultancy contracts. Information on the value of reportable non-consultancy contracts is available on the AusTender website.'*	Mandatory	Page 182
17AD(daa)	***Additional information about organisations receiving amounts under reportable consultancy contracts or reportable non-consultancy contracts***			***Part 3.5***
17AGA		Additional information, in accordance with section 17AGA, about organisations receiving amounts under reportable consultancy contracts or reportable non-consultancy contracts.	Mandatory	Page 182
	Australian National Audit Office Access Clauses			***Part 3.5***
17AG(8)		If an entity entered into a contract with a value of more than $100 000 (inclusive of GST) and the contract did not provide the Auditor General with access to the contractor's premises, the report must include the name of the contractor, purpose and value of the contract, and the reason why a clause allowing access was not included in the contract.	If applicable, Mandatory	Not applicable
	Exempt contracts			***Part 3.5***
17AG(9)		If an entity entered into a contract or there is a standing offer with a value greater than $10 000 (inclusive of GST) which has been exempted from being published in AusTender because it would disclose exempt matters under the FOI Act, the annual report must include a statement that the contract or standing offer has been exempted, and the value of the contract or standing offer, to the extent that doing so does not disclose the exempt matters.	If applicable, Mandatory	Page 182
	Small business			***Part 3.5***
17AG(10)(a)		A statement that *'[Name of entity] supports small business participation in the Commonwealth Government procurement market. Small and Medium Enterprises (SME) and Small Enterprise participation statistics are available on the Department of Finance's website.'*	Mandatory	Page 180
17AG(10)(b)		An outline of the ways in which the procurement practices of the entity support small and medium enterprises.	Mandatory	Page 180

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AG(10)(c)		If the entity is considered by the department administered by the Finance Minister as material in nature—a statement that *'[Name of entity] recognises the importance of ensuring that small businesses are paid on time. The results of the Survey of Australian Government Payments to Small Business are available on the Treasury's website.'*	If applicable, Mandatory	Page 180
	Financial Statements			***Part 4***
17AD(e)		Inclusion of the annual financial statements in accordance with subsection 43(4) of the Act.	Mandatory	Page 198
	Executive Remuneration			***Part 3.5 & Appendix 1***
17AD(da)		Information about executive remuneration in accordance with Subdivision C of Division 3A of Part 2 3 of the Rule.	Mandatory	Page 171, Page 302–305
17AD(f)	**Other Mandatory Information**			
17AH(1)(a)(i)		If the entity conducted advertising campaigns, a statement that *'During [reporting period], the [name of entity] conducted the following advertising campaigns: [name of advertising campaigns undertaken]. Further information on those advertising campaigns is available at [address of entity's website] and in the reports on Australian Government advertising prepared by the Department of Finance. Those reports are available on the Department of Finance's website.'*	If applicable, Mandatory	Page 338–345
17AH(1)(a)(ii)		If the entity did not conduct advertising campaigns, a statement to that effect.	If applicable, Mandatory	Not applicable
17AH(1)(b)		A statement that *'Information on grants awarded by [name of entity] during [reporting period] is available at [address of entity's website].'*	If applicable, Mandatory	Page 183
17AH(1)(c)		Outline of mechanisms of disability reporting, including reference to website for further information.	Mandatory	Page 175
17AH(1)(d)		Website reference to where the entity's Information Publication Scheme statement pursuant to Part II of FOI Act can be found.	Mandatory	Page 186
17AH(1)(e)		Correction of material errors in previous annual report.	If applicable, mandatory	Page 366

PGPA Rule Reference	Part of Report	Description	Requirement	Location
17AH(2)		Information required by other legislation.	Mandatory	Page 190–192, Page 312, Page 318, Page 346, Page 348, Page 360

Acronyms and abbreviations

AACN	AICIS Approved Chemical Name
ABS	Australian Bureau of Statistics
ACCAP	Aged Care Capital Assistance Program
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Services
ACDW	Aged Care Data Warehouse
ACMPS	Aged Care Management Payment System
ACPR	Aged Care Planning Region
ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADS OF	ADS Outcome Framework
AGPT	Australian General Practice Training
AHPRA	Australian Health Practitioner Regulation Agency
AI	Artificial intelligence
AICIS	Australian Industrial Chemicals Introduction Scheme
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
AN-ACC	Australian National Aged Care Classification
ANAO	Australian National Audit Office
AOD	Alcohol and other drug
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
APRA	Australian Prudential Regulation Authority
APS	Australian Public Service
APSC	Australian Public Service Commission
ARC	Audit and Risk Committee
ARTG	Australian Register of Therapeutic Goods
AT-HM	Assistive Technology and Home Modifications
BBPIP	Bulk Billing Practice Incentive Program
BGH	Business Grants Hub
CBC	Chemicals and Biotechnology Committee

CBI	Confidential Business Information
CDBS	Child Dental Benefits Schedule
CDPP	Commonwealth Director of Public Prosecutions
CEA	Commercial Evaluation Authorisation
CGRP	Commonwealth Grant Rules and Principles
CPR	Commonwealth Procurement Rules
CSO	Community Service Obligations
DCCEEW	Department of Climate Change, Energy, the Environment and Water
DCN	Disability and Carers Network
DEX	Data Exchange
DRMC	Disability Reform Ministerial Council
DSOG	Disability Senior Officials Group
DSS	Department of Social Services
EDW	Enterprise Data Warehouse
EN	Enrolled nurse
EOL	End-of-Life
ERP	Estimated Resident Population
ESD	Ecologically sustainable development
ETL	Extract, transform and load
FNHGG	First Nations Health Governance Group
FOI Act	*Freedom of Information Act 1982*
FTE	Full-time equivalent
GID	Governance of Indigenous Data
GLP-1	Glucagon-Like Peptide-1
GMO	Genetically Modified Organism
GP	General Practitioner
GP NRA	GP Non-Referred Attendance
GPJR	Government Procurement Judicial Review
GPMS	Government Provider Management System
GPS	Grant Payment System
GPT MDS	GP Training Minimum Dataset
HCP	Home Care Package/s

HILDA	Household, Income and Labour Dynamics in Australia
HPV	Human Papillomavirus
HR	Human resources
HSO	Hearing Services Online
IAHP	Indigenous Australians' Health Programme
IAWP	Internal Audit Work Plan
IC Act	*Industrial Chemicals Act 2019*
ICT	Information and communications technology
IDPwD	International Day of People with Disability
IFA	Individual Flexibility Agreement
IHACPA	Independent Health and Aged Care Pricing Authority
IPS	Information Publication Scheme
IUCLID	International Uniform Chemical Information Database
KMP	Key management personnel
KPI	Key Performance Indicator
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual
LMS	Learning management system
MBS	Medicare Benefits Schedule
MEL	Monitoring, Evaluation and Learning Framework
MMHC	Medicare Mental Health Centre
MMM	Modified Monash Model
MPS	Multi-Purpose Services
MPSP	Multi-Purpose Services Program
MRFF	Medical Research Future Fund
NAIDOC	National Aborigines and Islanders Day Observance Committee
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NBA	National Blood Authority
NBCSP	National Bowel Cancer Screening Program
NCIRS	National Centre for Immunisation Research and Surveillance
NCSP	National Cervical Screening Program
NCSR	National Cancer Screening Register
NDIA	National Disability Insurance Agency

NDIS	National Disability Insurance Scheme
NDIS Commission	National Disability Insurance Scheme Quality and Safeguards Commission
NDSS	National Diabetes Services Scheme
NGPA	National General Practice Accreditation
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NHWDS	National Health Workforce Dataset
NIP	National Immunisation Program
NIS	National Immunisation Strategy 2025–2030
NLCSP	National Lung Cancer Screening Program
NSPLSP	National Suicide Prevention Leadership and Support Program
NZCRC	Net Zero and Climate Risk Committee
ODC	Office of Drug Control
OECD	Organisation for Economic Co-operation and Development
OGTR	Office of Gene Technology Regulator
PB	Pharmaceutical Benefits
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PCGP	Primary Care General Practitioner
PCW	Personal Care Worker
PDS	Performance Development Scheme
PFAS	Per- and poly-fluoroalkyl substances
PGPA Act	*Public Governance, Performance and Accountability Act 2013*
PGPA Rule	Public Governance, Performance and Accountability Rule 2014
PHI	Private Health Insurance
PHN	Primary Health Network
PIC	Prior informed consent
PID	Public Interest Disclosure
PIR	Pre-introduction report
PMHC MDS	Primary Mental Health Care Minimum Data Set
QI	Quality Improvement
QOL-ACC	Quality of Life–Aged Care Consumers instrument

RAC	Reform Advisory Committee
RACGP	Royal Australian College of General Practitioners Standards for general practices
RAP	Reconciliation Action Plan
RCP	Restorative Care Pathway
RES	Residents' Experience Survey
RGTS	Rural Generalist Training Scheme
RVTS	Remote Vocational Training Scheme
SAH	Support at Home
SES	Senior Executive Service
SIL	Supported Independent Living
SIR	Specific information requirement
SME	Small and medium enterprises
TGA	Therapeutic Goods Administration
UCC	Urgent Care Clinic
WHS Act	*Work Health and Safety Act 2011*
WIP	Workforce Incentive Program

Glossary

Aboriginal and Torres Strait Islander Lived Experience Centre	The Aboriginal and Torres Strait Islander Lived Experience Centre elevates the voices of First Nations people and shares their stories to co-design, inform, and deliver culturally safe mental health and suicide prevention initiatives.
Aboriginal Community Controlled Health Organisations (ACCHO)	ACCHO is a community-run primary healthcare service that provides comprehensive, culturally informed care for Aboriginal and Torres Strait Islander people. These services address not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities, aiming to support healthier, happier lives.
Aboriginal Community Controlled Health Services	Primary health care organisations initiated, operated, and governed by local Aboriginal and Torres Strait Islander communities to deliver holistic, culturally safe care.
ACON	Established in NSW in 1985, ACON delivers support for people living with HIV to live healthy and connected lives.
Advanced materials	Australian Industrial Chemicals Introduction Scheme advanced materials are primarily regulated through specific, stringent guidelines for chemicals at the nanoscale.
Aged Care Data Warehouse	The department's data repository containing information drawn from aged care administrative systems and third-party sources for analysis and reporting.
Aged Care Quality and Safety Commission	The national regulator responsible for the quality and safety of aged care services in Australia.
Australia's Disability Strategy 2021–2031 (ADS)	Australia's Disability Strategy 2021–2031 is a national framework that all Australian governments have signed up to. It sets out a plan for continuing to improve the lives of people with disability in Australia over 10 years. ADS replaces and builds on the first National Disability Strategy 2010–2020.
Australian Centre for Disease Control (CDC)	The Australian Centre for Disease Control is an independent national entity responsible for monitoring public health risks and preparing for disease outbreaks and other health emergencies. The Australian Centre for Disease Control became an independent non-corporate Commonwealth entity on 1 January 2026 under the *Australian Centre for Disease Control Act 2025*.
Australian Industrial Chemicals Introduction Scheme (AICIS)	AICIS is the regulatory scheme for the introduction of industrial chemicals in Australia, either through importation and manufacture. AICIS focuses on prevention and early intervention to protect human health and the environment, through effective regulatory oversight of industrial chemicals introduction.
Australian National Aged Care Classification (AN-ACC)	The Australian Government funding classification used to determine residential aged care funding based on residents' care needs and other funding considerations.
Birthing on Country Programs	Birthing on Country supports Aboriginal women and babies by providing culturally safe continuity of midwifery care including antenatal, birthing and postnatal support.

Blood fractionation	Components made from donated blood, including red blood cells, platelets, plasma and plasma-derived products, used to treat a range of medical conditions.
Bond rate impacts	Bond rate impacts refer to how changes in market interest rates alter the market prices of existing bonds and influence broader borrowing costs in the economy.
Bonded Medical Program	A program that encourages medical practitioners to work in areas of workforce need in return for government-supported medical training opportunities.
BreastScreen Australia Program	BreastScreen Australia is a joint initiative of the Australian and state and territory governments and aims to reduce illness and death from breast cancer by detecting the disease early. Women over 40 can have a free mammogram every 2 years and women aged 50 to 74 are actively invited to screen.
Bulk Billing	A billing arrangement where a medical practitioner accepts the Medicare benefit as full payment for a service, resulting in no out-of-pocket cost for the patient.
Bulk Billing Practice Incentive Program	An Australian Government program that provides incentives to general practices that bulk bill Medicare-eligible patients for eligible services.
Chronic disease	The term applied to a diverse group of diseases, such as heart disease, cancer and arthritis, that tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), chronic disease is usually confined to non-communicable diseases.
Climate Risk and Opportunity Management Program (CROMP)	CROMP is an Australian government initiative that helps the public sector identify and manage climate-related risks.
Closing the Gap	The National Agreement on Closing the Gap (the National Agreement) commenced on 30 July 2020. Closing the Gap refers, broadly, to the collective commitment of Australian federal, state and territory governments to addressing 'the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.
Cognitive Behavioural Therapy	A structured, evidence-based psychological treatment that helps people identify and change unhelpful patterns of thinking and behaviour to improve mental health and wellbeing.
Comcare	Comcare is the national work health and safety regulator and workers' compensation authority.
Commonwealth Home Support Program/ Programme (CHSP)	The CHSP provides entry level support for older Australians who need help to live independently in their homes and communities. Support includes help with daily tasks, home modifications, transport, social support, and nursing care.

Communicable disease	An infectious disease transmissible (as from person to person) by direct contact with an infected individual or the individual's discharges or by indirect means. Communicable (infectious) diseases include sexually transmitted diseases, vector-borne diseases, vaccine preventable diseases and antimicrobial resistant bacteria.
Community Service Obligations (CSO)	Hearing services provided by Hearing Australia to eligible people with specialist hearing needs who may not be adequately supported through the voucher scheme.
Contraventions	A contravention is the act of breaking a law, rule, or court order.
COVID-19	Coronavirus disease 2019. An illness caused by the SARS-CoV-2 virus that was first identified in December 2019. Formerly known as 2019-nCoV.
Department of Climate Change, Energy, the Environment and Water (DCCEEW)	The Department of Climate Change, Energy, the Environment and Water lead Australia's response to climate change and sustainable energy use, and protect our environment, heritage and water.
Diabetes	Refers to a group of syndromes caused by a malfunction in the production and release of insulin by the pancreas leading to a disturbance in blood glucose levels. Type 1 diabetes is characterised by the abrupt onset of symptoms, usually during childhood, and inadequate production of insulin requiring regular injections to regulate insulin levels. Type 2 diabetes is characterised by gradual onset commonly over the age of 45 years, but increasingly occurring in younger age groups. Type 2 diabetes can usually be regulated through dietary control.
eInvoicing	Electronic invoicing is the automated, direct exchange of structured, machine-readable invoice data between a seller's and a buyer's accounting or ERP software via a secure network.
ELevate and Activate: management programs	Leadership and management development programs designed to build capability, strengthen leadership skills and support career development across the department.
Emissions Reduction Plan (ERP)	ERP is a key component of the Net Zero and Climate Risk Committee Action Plan and guides efforts to reduce and track operational emissions. It outlines practical actions the department will undertake to reduce emissions across electricity, buildings, vehicles, travel and procurement.
Employee Engagement Index score	An employee engagement index score is a quantitative metric measuring how emotionally committed, motivated, and loyal employees are to an organisation, based on employee survey results.
Endometriosis	Endometriosis is a complex, chronic condition where tissue that is similar to the lining of the uterus grows outside of the uterus on other organs. It can be painful and debilitating, but there are effective treatments that may relieve the symptoms of endometriosis.
Financial year	The 12 month period from 1 July to 30 June.

Freedom of Information Act (FOI Act 1982)	The Freedom of Information Act 1982 is an Act of the Parliament of Australia which guarantees freedom of information and the rights of access to official documents of the Commonwealth Government and of its agencies to members of the public.
Future Fit Program	An Australian Government initiative designed to help Meals on Wheels Australia prepare for major aged care reforms and the transition to the Support at Home model.
Gene technology	Gene technology is a technique for the modification of genes or other genetic material.
General practitioner (GP)	A medical practitioner who provides primary care to patients and their families within the community.
Genetically modified organisms (GMO)	Organisms modified by gene technology.
GLP-1 inhibitors	Glucagon-like peptide-1 receptor agonists (GLP-1s) are medicines that help control blood sugar levels. They slow digestion (which makes an individual feel full for longer), may act on the brain to reduce hunger, and may reduce inflammation.
Gold Employer status	This status recognises organisations that demonstrate the highest levels of inclusion through their internal policies, employee support networks, and visible leadership championing diversity.
GradConnection	A free online job board and career platform that connects university students and recent graduates with employers.
GreenPower	A government accredited renewable electricity product that enables households and businesses to purchase electricity generated from renewable energy sources.
headspace	A mental health support service for young people. It covers a critical gap by providing tailored and holistic mental health support to 12 to 25 year olds.
Health care	Services provided to individuals or communities to promote, maintain, monitor or restore health. Health care is not limited to medical care and includes self-care.
Health outcome	A health outcome is a measurable change in an individual's, group's, or population's health status resulting from medical care, interventions, or lifestyle changes.
Home Care Package (HCP)	A coordinated mix of services that can include help with household tasks, equipment (such as walking frames), minor home modifications, personal care, and clinical care such as nursing, allied health, and physiotherapy services. These services support older people with complex needs to live independently in their own homes.
Human papillomavirus (HPV)	A virus that causes genital warts which is linked in some cases to the development of more serious cervical cell abnormalities.
Immunisation	Inducing immunity against infection by the use of an antigen to stimulate the body to produce its own antibodies. See vaccination.
Immunoglobulin	A plasma-derived blood product containing antibodies. It can be used to support immune function or help prevent or reduce the severity of some infections.

Incidence	The number of new cases (of an illness or event) occurring during a given period. Compare with prevalence.
Indemnity insurance	A form of professional indemnity cover that provides surety to medical practitioners, midwives and their patients in the event of an adverse outcome arising from medical negligence.
Indigenous Health Scholarship Program	Provides funding to support Aboriginal and/or Torres Strait Islander students undertaking health-related tertiary or vocational courses.
Influenza (flu)	Caused by the influenza virus, which is easily spread from person to person and is not the same as the common cold. The flu is a serious disease as it can lead to bronchitis, croup, pneumonia, ear infections, heart and other organ damage, brain inflammation and brain damage, and death.
Jurisdictions	In the Commonwealth of Australia, these include the 6 states, the Australian Government and the 2 territories.
KMP expenses	Expenses relating to Key Management Personnel (KMP), including remuneration and other benefits disclosed in accordance with Australian Accounting Standards.
Machinery of Government	A Machinery of Government (MoG) change occurs when the Australian Government changes the administrative responsibilities of departments or agencies.
Medical Research Future Fund (MRFF)	MRFF delivers better and more advanced health care and medical technology for Australians. It provides support to researchers to discover the next penicillin, pacemaker, cervical cancer vaccine or cochlear ear.
Medicare	Medicare is Australia's universal health insurance scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider MBS (Medicare).
Medicare Mental Health Check In service	A free Australian Government digital service providing low-intensity mental health support for people aged 16 and over.
Modified Monash Model (MMM)	A geographic classification that categorises locations according to remoteness and town size, from MM1 metropolitan areas to MM7 very remote communities.
NAIDOC	National Aborigines and Islanders Day Observance Committee.
Nanomaterials	Nanomaterials are functional substances that have at least one external dimension measuring between 1 and 100 nanometers. A nanometer is one billionth of a meter.
National Bowel Cancer Screen Program (NBCSP)	The NBCSP aims to reduce deaths from bowel cancer by detecting the early signs of the disease. Eligible Australians aged 45 to 74 years are sent a free, simple test that is completed at home.
National Carer Strategy 2024–2034	The National Carer Strategy provides a national framework to support Australia's unpaid carers, recognising the critical role carers play in society and the profound contribution they make to the lives of people they care for.

National Cervical Screening Program	Aims to reduce illness and death from cervical cancer. Women and people with a cervix aged 25 to 74 years are invited to have a cervical screening test every 5 years through their healthcare provider.
National Diabetes Services Scheme (NDSS)	Helps people with diabetes to understand and manage their life with diabetes. It also provides timely, reliable, and affordable access to NDSS support services and products, including syringes and needles, blood glucose strips, insulin pump consumables, and continuous glucose monitoring products.
National Disability Insurance Scheme (NDIS)	The NDIS provides funding to eligible people with disability to gain more time with family and friends, greater independence, access to new skills, jobs, or volunteering in their community, and an improved quality of life. The NDIS also connects anyone with disability to services in their community.
National Drug Strategy 2017–2026 (The Strategy)	The Strategy is an 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.
National General Practice Accreditation Scheme (NGPA Scheme)	The national scheme under which general practices are assessed against approved safety and quality standards by authorised accrediting agencies.
National Health Reform Agreement (NHRA)	The NHRA is signed by all Australian governments. The NHRA agreement is between the Australian Government and state and territory governments that sets out the funding, governance and performance arrangements for Australia's public hospital system and related health services.
National Incident Centre	The National Incident Centre is the department's emergency response centre. It coordinates national responses to health emergencies, significant events and emerging threats, where there is an impact on human health or health systems.
National Preventive Health Strategy 2021–2030 (NPHS)	The NPHS aims to improve the health and wellbeing of all Australians at all stages of life through a systems-based approach to prevention that addresses the wider determinants of health, reduces health inequities and decreases the overall burden of disease.
National Quality Indicator Program	A national aged care program that collects and reports information about specified indicators of residential aged care quality.
Organisation for Economic Co-operation and Development (OECD)	OECD is an intergovernmental organisation of 38 member countries (mostly developed and some emerging, such as Mexico, Chile and Turkey), including Australia. The OECD's aim is to promote policies that will improve the economic and social wellbeing of people around the world.

Outcomes	Outcomes are the government's intended results, benefits or consequences for the Australian community. The government requires entities, such as the department, to use Outcomes as a basis for budgeting, measuring performance and reporting. Annual administered funding is appropriated on an Outcomes basis. The department's current Outcomes are listed in **Part 2: Annual Performance Statements** of this Annual Report.
Pandemic	A pandemic is a worldwide spread of a new disease, such as a new influenza virus, or the coronavirus that causes COVID-19.
Pharmaceutical Benefits Advisory Committee (PBAC)	PBAC is an independent expert body appointed by the Australian Government. Members include doctors, health professionals, health economists and consumer representatives. Its primary role is to recommend new medicines for listing on the PBS. No new medicine can be listed unless the committee makes a positive recommendation.
Pharmaceutical Benefits Scheme (PBS)	A national, government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs for all Australians to help them afford standard medications. The PBS lists all the medicinal products available under the PBS and explains the uses for which they can be subsidised.
Poly-fluoroalkyl substances (PFAS)	These are per- and polyfluoroalkyl substances, a large group of man-made synthetic chemicals used since the 1950s to make everyday products resistant to water, stains, grease, and heat. PFAS can persist for a long time in the environment and in humans and are sometimes referred to as "forever chemicals".
Portfolio Budget Statements (PB Statements)	Statements prepared by portfolios to explain the Budget appropriations in terms of Outcomes and programs.
Prevalence	The number or proportion (of cases, instances, and so forth) in a population at a given time. In relation to cancer, prevalence refers to the number of people alive who had been diagnosed with cancer in a prescribed period (usually 1, 5, 10 or 26 years). Compare with incidence.
Primary care	Provides the patient with a broad spectrum of care, both preventive and curative, over a period of time and coordinates all of the care the person receives.
Primary Health Networks (PHNs)	PHNs are independent organisations funded to coordinate primary health care in their regions. PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it.
Program/Programme	A specific strategy, initiative or grouping of activities directed toward the achievement of government policy or a common strategic objective.

Public health	Activities aimed at benefiting a population, with an emphasis on prevention, protection and health promotion as distinct from treatment tailored to individuals with symptoms. Examples include anti-smoking education campaigns and screening for diseases such as cancer of the breast or cervix.
Star Ratings	Star Ratings are an internationally recognised symbol for quality accommodation standards for residential aged care.
Support at Home	Designed to support older Australians with more complex or intensive care needs. It provides ongoing and short-term access to services to help them stay at home.
Therapeutic Goods Administration (TGA)	TGA is Australia's regulatory authority for therapeutic goods such as medicines, medical devices, and diagnostic tests.
Thin market	A market in which limited provider availability or other local conditions reduce access to services or affect providers' ability to operate viably.
Thriving Kids program	A national Australian initiative designed to provide early intervention and foundational support for children aged 8 and under who have low-to-moderate support needs related to developmental delay or autism.
Vaccination	The process of administering a vaccine to a person to produce immunity against infection. See immunisation.
Vaping	Recreational use of vapourised nicotine and/or e-cigarettes.
World Health Organization (WHO)	WHO is a specialised agency of the United Nations (UN). Its primary role is to direct and coordinate international health within the UN system. The WHO has 194 member states, including Australia.

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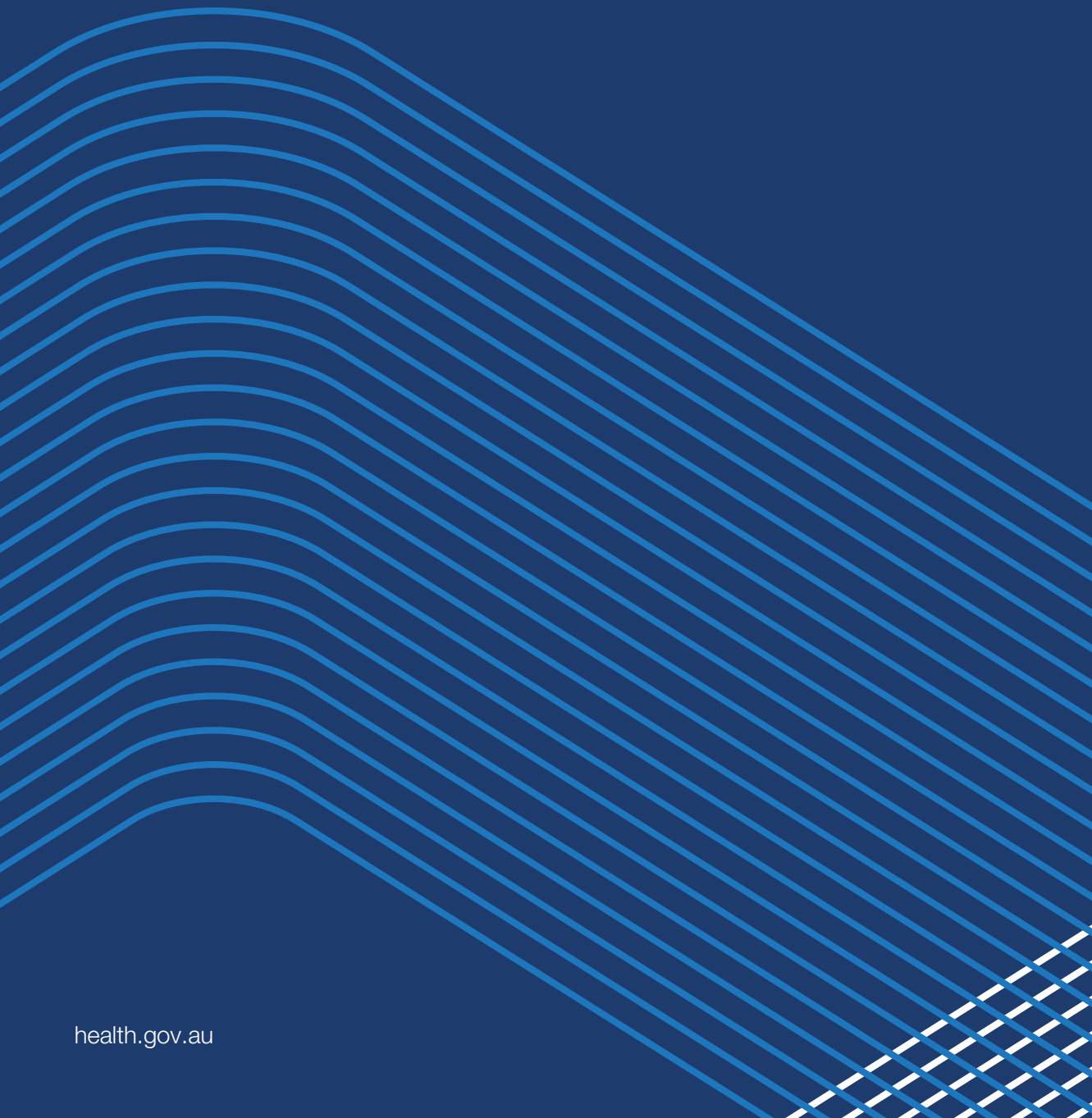
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