Our Impact

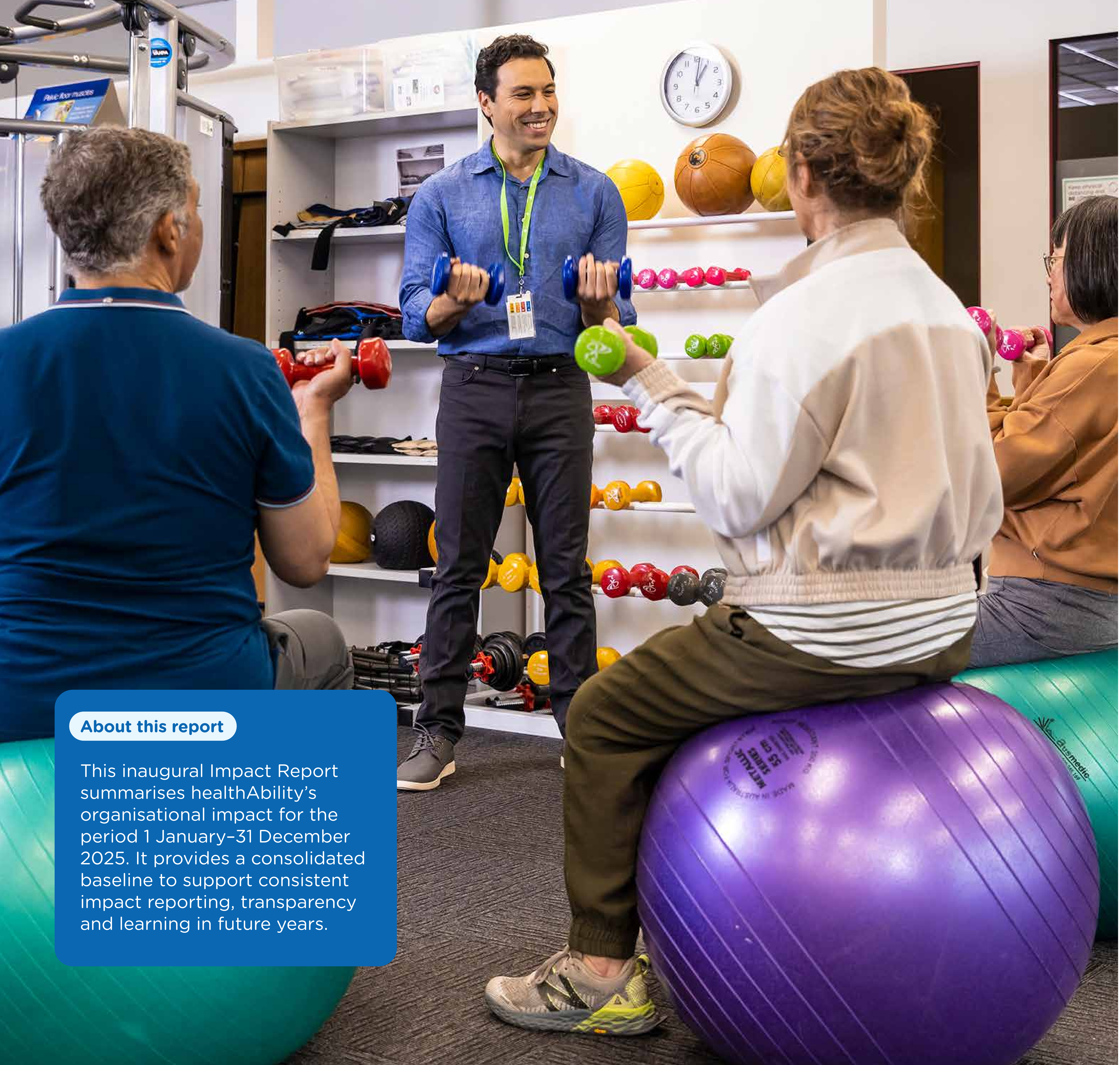
healthAbility Inaugural Impact Report 2025

healthAbility respectfully acknowledges the Traditional Owners of the lands on which we operate, the Wurundjeri-Woiwurrung people of the Kulin Nation and their connections to the land, waterways and community. We pay our respect to their ancestors and Elders past, present and emerging and to the Aboriginal and Torres Strait Islander peoples who we engage with and deliver programs and services to every day.

We are committed to inclusive communities.

We would especially like to acknowledge Auntie Gail Smith, Auntie Julieanne Axford, Uncle Colin Hunter Jr. and Charlie Woolmore for their guidance, wisdom and generosity as we seek to walk alongside community in our reconciliation journey.

We would also like to recognise Mullum Mullum Indigenous Gathering Place and Murrnong First Peoples Gathering Place for the collaboration and partnership opportunities, and look forward to deepening these relationships in the years to come.



About this report

This inaugural Impact Report summarises healthAbility's organisational impact for the period 1 January–31 December 2025. It provides a consolidated baseline to support consistent impact reporting, transparency and learning in future years.

healthAbility Inaugural Impact Report 2025

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Chair and CEO statement

We are proud to release our inaugural healthAbility Impact Report, which highlights the difference we made for the clients, carers and communities we supported throughout 2025.

The report reflects our commitment to measuring and improving our impact by celebrating what's working, identifying opportunities for improvement, and listening to the voices of clients, carers and future consumers. It also supports our aim to better enable people to achieve their health and wellbeing goals.

This publication represents an important milestone for healthAbility. It demonstrates the value of high-quality, meaningful data and reinforces our commitment to accountability across the organisation, to achieve our shared purpose of making wellbeing easy.

Our impact is made possible through the dedication of our staff, the guidance of our Board, and the collaboration of our partners. By working together across the system, we respond to emerging needs, adapt to change, and deliver accessible, person-centred care.

We sincerely thank the clients, carers and consumers who shared their insights, and particularly the Community Champions Advisory Group (CCAG) for their lived experience, guidance and co-design contributions.

Looking ahead, we remain focused on collaboration, innovation and continuous improvement as we work towards our vision: a world in which everyone is thriving and well.

John Rasa
Board Chair

Agata Jarbin
CEO

Reconciliation in practice

Our commitment

In partnership with Aboriginal and Torres Strait Islander peoples, we seek to understand and acknowledge injustices, support active expression of culture, apply culturally appropriate practice, and make a measurable difference by addressing inequities to improve health and social outcomes.

We are working towards our Innovate Reconciliation Action Plan (RAP) to deepen relationships and trust with Aboriginal and Torres Strait Islander peoples. To do this respectfully and sensitively, we are taking necessary time to create a workplace and service model that is culturally safe.

We commit to furthering our understanding of Aboriginal and Torres Strait Islander histories and inequities as the foundation of our reconciliation work.

Our reconciliation journey and impact in 2025

- Completed our Reflect RAP and commenced development of our Innovate RAP.
- Implemented organisation-wide education and cultural safety training modules to embed core First Nations wisdom and practices across our leadership, staff and volunteers.
- Actively supported fundraising and sustainability efforts with Murrnong First Peoples Gathering Place.
- Recognised National Reconciliation Week by:
  - Hosting a series of discussions and learning opportunities, including a yarn with Uncle Glenn Loughrey.
  - Participating in a session exploring culturally safe partnerships with Melbourne Indigenous Transition School.
  - Attending a forum with Reconciliation Australia.
  - Training staff on how to meaningfully Acknowledge Country.
- Marked NAIDOC Week with events across our sites celebrating First Nations art, music, food and culture.
- Co-convened the Eastern Reconciliation Network to coordinate and share reconciliation activity. This strengthened relationships between community health, for-purpose and local government organisations across Wurundjeri-Woiwurrung and Bunurong lands.
- Partnered with Nillumbik Reconciliation Group to redevelop the front garden at our Eltham site with Indigenous plants.
- Partnered with Mullum Mullum Indigenous Gathering Place's social enterprise Mullum Creations to cater our all-staff end of year event.

- Supported the Yoorrook Justice Commission's Walk for Truth through several legs of Commissioner Travis Lovett's journey, pictured above.
- Delivered a series of workshops with Balit Booboop Narrkwarren champion Mikayla George and the Djirri Djirri Dancers.

Our clients and community

Impact snapshot: 1 January – 31 December 2025

20,900*
clients received services directly

40,535†
clients and community members were supported or reached

Our resources and activities are available in these languages that are predominantly used in the communities we support:

- Mandarin
- Cantonese
- Greek
- Italian
- Dari
- Punjabi
- Hindi
- Arabic
- Vietnamese

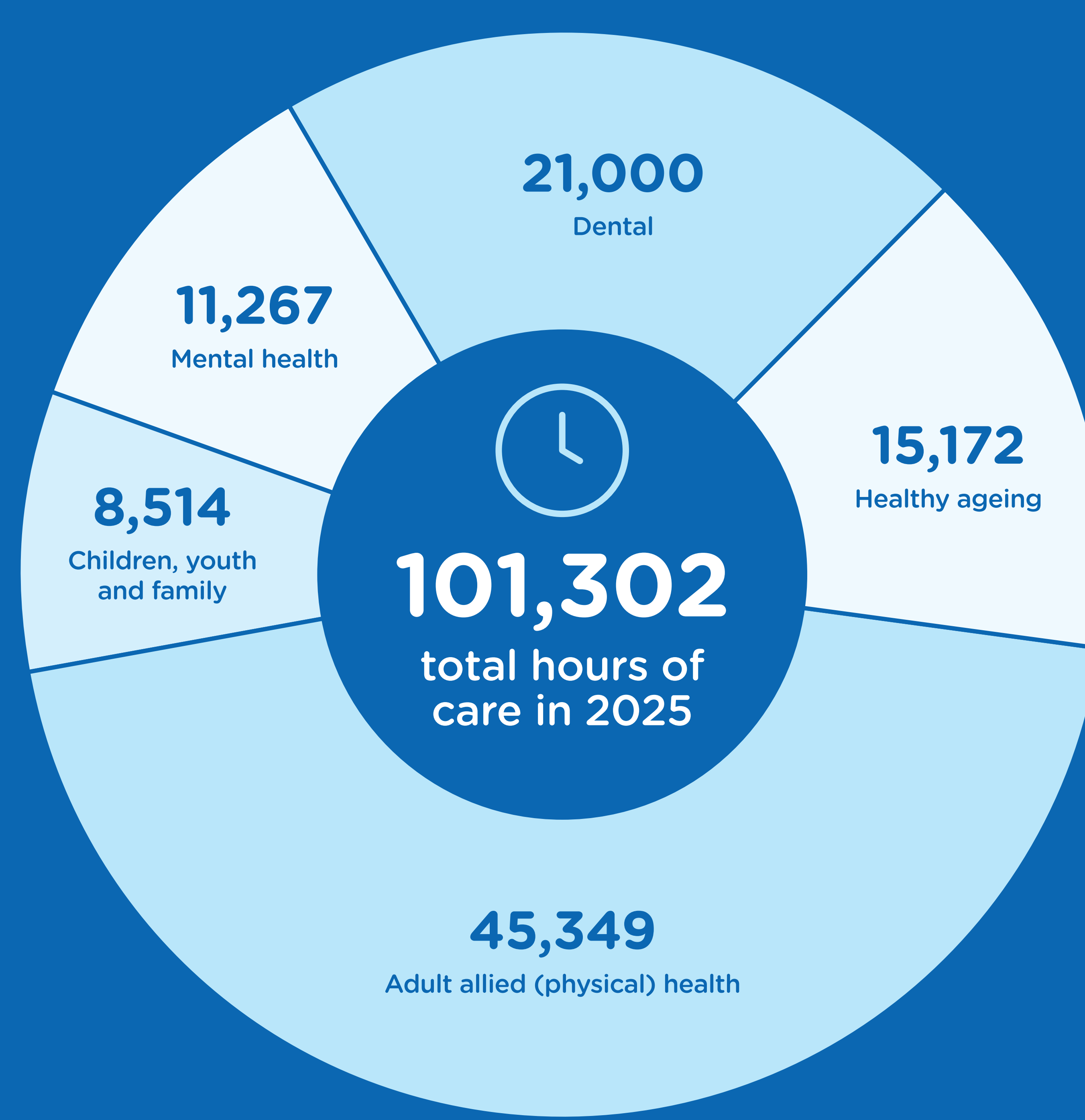
More than 60% of clients engaged with us over multiple years, demonstrating trust in our relationship-based care model.

*Total varies from our Annual Report, with a financial year reporting period.

†This estimated figure includes 500 anonymous After Hours Mental Health Nursing clients, 5,653 NSP and CHOPER outreach clients, 4,747 Baby Makes 3 families, and 8,735 community members engaged through health promotion and prevention activities, including the healthAbility Repair Café.

Hours of care by service segment

This breakdown shows where direct service time is concentrated, helping us understand demand, tailor our service mix, and identify opportunities to innovate and improve how we respond to community need.



Understanding need

We are continually strengthening our data collection processes so we can capture accurate, meaningful client demographic information.

Better data helps us better service the diverse communities we support by:

- understanding who we are reaching
- identify emerging needs
- filling gaps in access to improve equity
- continuously improving and tailoring our services.

We are committed to creating a safe, confidential environment where clients and carers feel comfortable sharing information such as country of birth, cultural background, gender identity and healthcare card status.

Clients receiving direct services

As seen on the right:

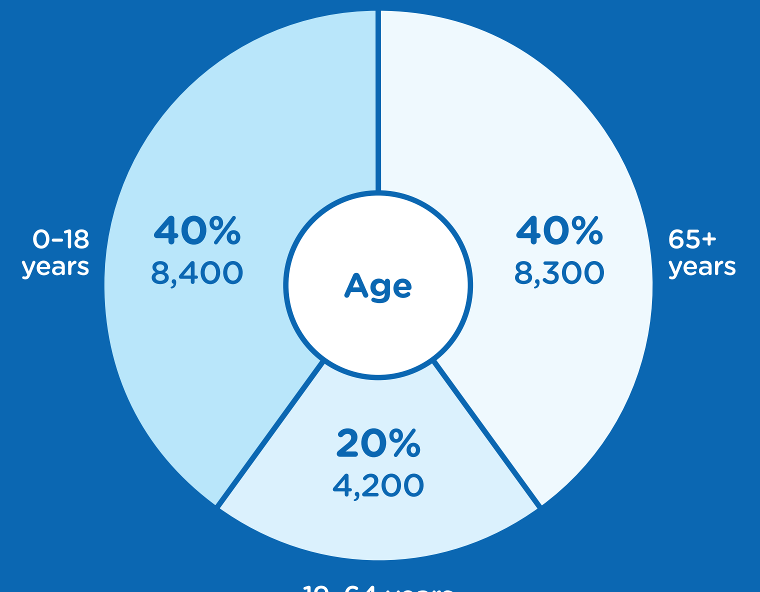
- there is an even split between those aged 0–18 and 65+ years
- we see a higher proportion of people identifying as female
- Australia is the primary country of birth.

Importantly when interpreting the data, the figures also show where information is often not recorded, such as preferred language and healthcare card status.

Reducing avoidable Emergency Department presentations

An estimated **15% of allied health clients and 70% of dental clients would deteriorate** without healthAbility's allied health and dental services, resulting in avoidable Emergency Department (ED) presentations, admissions, and dental emergencies. Many clients have complex, co-occurring health and psychosocial needs, making continuity of care essential to prevent crisis-driven hospital use.

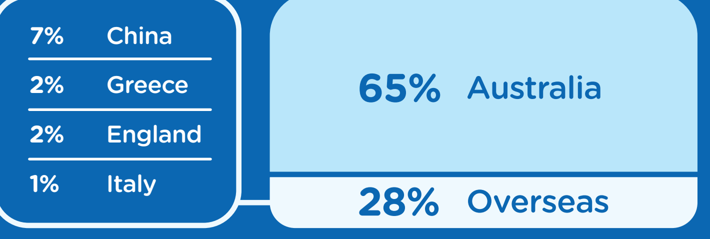
Demographic profile of clients receiving services directly



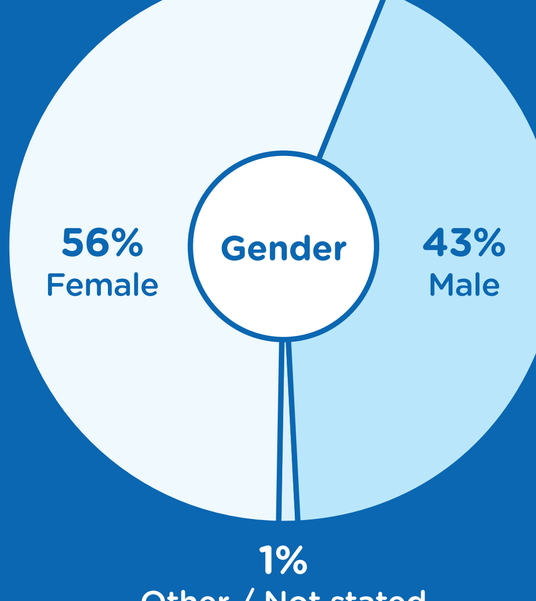
80% clients are children or older people

Most clients under 18 are dental clients

Country of birth



16% Other 7% Not stated



40% Not stated

Aboriginal/Torres Strait Islander

0.36%

57% Not stated

Preferred language

Note: Demographic information shown reflects clients who received services directly. For services where anonymity is essential (such as after-hours mental health support) and for indirect activities like capacity building, client demographic data is not collected.

Preparing for Support at Home reform

Support at Home commenced in late 2025, giving older people greater choice and tailored support to live safely and independently at home.

Since the new Aged Care Act passed in 2024 and throughout 2025, we focused on reform readiness to ensure a smooth, supported transition for clients from Home Care Packages to Support at Home. We also prepared our workforce to meet new requirements.

This work aimed to maintain continuity of care, reduce confusion during the transition and ensure clients felt informed and supported as the new program was implemented. Staff increased follow-up to reduce uncertainty for clients, as guidance and administrative processes evolved.

In 2026, we will keep strengthening our communications, client support and internal processes to improve clarity and confidence as the reform is embedded.

Support at Home transition

Key actions included:

- Established a cross-organisation working group, including 27 staff spanning service design, quality and compliance, communications, IT, finance and people and culture
- Updated client and provider agreements, policies and procedures
- Provided regular client communications for Home Care Package and CHSP clients (letters, booklets and monthly newsletters to 2,300+ clients), supported by Care Partners for one-to-one questions
- Hosted online drop-in sessions to answer common questions
- Transitioned IT systems to meet new requirements and continued embedding reform changes
- Delivered organisation-wide online training on the new Aged Care Act and Support at Home program

Client experience and outcomes

To deliver on our vision and purpose, we focus on the outcomes and experience our services create for clients, carers and communities.

Patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) provide us with a consistent way to listen to clients, track changes over time, and use what we learn to improve our services in line with our strategy. Alongside clinical measures, these tools give us a more complete understanding of both clinical outcomes, and the changes people notice in their everyday lives and their experience of care.

In the second half of 2024, we evolved and tested PREMs and PROMs across our services to consistently measure client experiences and outcomes, alongside clinical measures.

PREMs – Client Experience Survey

In February 2025, we introduced an enhanced and comprehensive Client Experience Survey (CES) to gather feedback on our services.

Clients can provide feedback at any time, with the survey available in English, Italian, Greek and Chinese.

CES results help measure our performance and identify opportunities for improvement, including our Net Promoter Score (NPS)*, which reflects how likely clients are to recommend healthAbility.

Between February and December 2025, our NPS was +74, well above our target of +30, with 77% of respondents indicating they would recommend us, placing our score in the world-class range.

Selected CES questions align with the Victorian Healthcare Experience Survey (VHES) for benchmarking and year-on-year comparison.

89–94% of Client Experience Survey respondents gave a positive response across 4 VHES aligned questions.

Ultimately clients felt highly informed and supported by staff introductions and roles, clear explanations, and help when questions were asked and felt safe to raise concerns. This result exceeded both our 2024 baselines and community health sector benchmarks.

We will continue to use CES insights to guide ongoing service improvement in 2026.

* NPS is a standardised metric used to understand satisfaction, advocacy and overall experience quality. NPS is calculated by subtracting the percentage of detractors (0–6 rating) from the percentage of promoters (9–10 rating). An NPS score of +30 or higher is considered good, +50 is considered excellent and +70 or higher is considered world-class.

Client Experience Survey – strengthening the survey and trialling new ways to reach clients

We refined the question set to make it easier for clients to provide feedback. This helped us more deeply understand our strengths and areas for improvement and continues to track progress against our strategic goals from the client perspective.

We expanded feedback channels by adding survey links to our website and other client communications so they can provide feedback at any time.

Sending the survey via email and SMS has increased response rates, enabling more timely feedback across a wider range of services.

Combined with Community Champions Advisory Group (CCAG) insights, CES results help us pinpoint what matters most in people's experience of care and where to improve.

Client Experience Survey

+74 Net Promoter Score (NPS)

77% respondents would recommend us, placing our score in the 'world-class' range

Our clients told us:

"The dentist here is super friendly and put my 7-year-old at ease. They are very friendly at the front desk. I saw they are attentive to non-English speaking elderly people."

"I am very happy with the care and services that I receive at healthAbility. I have always been given support and information when I've asked, including for physiotherapy, Wellness Gym, podiatry, dental and the dietitian."

"I felt good and comfortable; I don't see any area of improvement. I took my 5-year-old, and they took care of him well."

"I am extremely happy with the podiatry services I receive. I have been going there for years and appreciate the relationship between the Austin Hospital High Risk Foot Clinic and your staff."

PROMs – Personal Wellbeing Index

In late 2024, alongside our PREMs, we selected the Personal Wellbeing Index (PWI) as our organisation-wide PROM.

Aligned with our strategic vision, the PWI measures whole-of-person wellbeing across areas such as health, safety, relationships, living standards and community connection, generating a life satisfaction score (0–100) benchmarked against population norms (typically 70–80). Validated for adults, young people (12+), and people with intellectual or cognitive disability, it provides a consistent measure across services and over time.

After expanding the PWI to 80% of services, 2025 results showed a statistically significant increase in Personal Wellbeing Index score (71.5 to 81.1 +9.6 change), moving from the mid-normative range into the upper normative range. As a guide, general population PWI scores are typically between 70–80 out of 0–100 score[1].

Clients who completed the PWI at intake and again at 6 months or exit showed an average wellbeing increase of 8.8 points.

This is a meaningful improvement, as wellbeing usually stays within a narrow range time, and changes of this size are uncommon[2].

In 2026, we will keep using the PWI to monitor changes in client wellbeing, track progress, and help us improve and expand the approaches that work best.

1 International Wellbeing Group (2013). Personal Wellbeing Index: 5th Edition. Australian Centre on Quality of Life, Deakin University.

2 Cummins, R.A. (2003). Normative life satisfaction: Measurement issues and a homeostatic model. Social Indicators Research.

Qualitative insights: Community Champions Advisory Group (CCAG)

CCAG is a formal and moderated group of community members and clients that we regularly consult on key topics to gain a broader understanding of expected and desired experience with health services. A detailed list of CCAG topics discussed in 2025 is included in the Consumer voice and co-design section.

Themes that emerged from CCAG discussions and engagement sessions

1. Finding support in places and ways people feel safe and comfortable

People often seek help in places they know, like schools, libraries, sports clubs, pharmacies, neighbourhood houses and community groups, before going to health services. healthAbility runs education sessions and services in these community spaces to help everyone access helpful information. Clear signs, posters, brochures and friendly, plain-language communication make our services easier to find and less intimidating to access.

2. Holistic, guided, and connected support is needed to navigate care

Navigating health and social care can be overwhelming, particularly during major life changes. People need clear guidance on options, eligibility, costs, wait times and next steps. CCAG members highlighted the need for clearer pathways, stronger connections between services such as GPs and hospitals, and roles such as care coordinators, navigators, peer mentors or other trusted guides to help people access the right support.

3. Access to clear, practical, empowering information builds confidence

There is a need for simple, tailored and jargon-free health information, especially for people living with chronic conditions. Clear information is less overwhelming and increases confidence in accessing services when needed. One-page guides, checklists, practical steps, digital and printed formats, workshop and lived-experience stories are useful tools to help people understand what services we offer and how to access them.

4. People need connection, community and peer support

Loneliness, isolation and "going it alone" were described as major challenges. CCAG members emphasised the value of peer groups, intergenerational programs, lived-experience stories and community-based activities that build social connection and reduce isolation.

We validated and reviewed CCAG feedback, then incorporated it into our improvement planning.

This informed immediate changes including:

- strengthening outreach support and simplifying information
- setting longer term service design priorities, including clearer pathways, more connected care with partners and refreshed social connection activities.

We close the loop by updating CCAG members on how their suggestions shape our work. This feedback and improvement cycle will continue in 2026.

Service impact in focus: Prevention and early intervention

This section highlights two areas of service impact that demonstrate how we support community wellbeing across the continuum of care from prevention, early intervention and chronic conditions management. Baby Makes 3 and Diabetes Connect have each been independently evaluated, providing clear evidence of what's working and where we're learning to strengthen impact.

Prevention – Embedding gender equality with Baby Makes 3

What is Baby Makes 3?

Baby Makes 3 is a primary prevention initiative delivered through universal perinatal settings, funded by the Victorian Department of Families, Fairness and Housing and the Victorian Department of Health. Baby Makes 3 recieved additional grant funding from Western Australia Department of Communities. It works with maternity services, Maternal and Child Health services, childbirth educators and community organisations to embed gender equality into everyday practice. Target cohorts include health professionals working with new parents, and families during pregnancy and the first year of life, with adaptations for diverse communities.

Why it matters

The transition to parenthood is a pivotal moment in shaping lifelong patterns of caregiving, relationships and gender roles. Without intervention, rigid gender roles and expectations can become entrenched, increasing the risk of relationship strain, mental health challenges and family violence[3]. Evidence shows that around 30% of violence begins during pregnancy[4]. Prevention at this stage strengthens families early and reduces pressure on health, social and crisis systems in the longer term.

Evaluation reveals improved early outcomes, reach and engagement

Evaluation of Baby Makes 3 was undertaken by Deakin University and Seed Lifespan between May 2023 and September 2025. The report published in November 2025 demonstrated increased adoption and readiness of equal and respectful parenting in practice within their setting following Baby Makes 3. Of the sample group, 85% reported Baby Makes 3 training was helpful for their work with families and they could identify ways to easily integrate Baby Makes 3 into their practice.

Health professionals rated their confidence to apply 8 gender equality practices pre-training, 2 weeks post-training, and at 3 and 6 months (7-point scale: 0 = not at all confident; 6 = very confident). The mean confidence increased from 3.75 pre-training to 5.15 at 6 months.

37% Increase in professionals' confidence in applying gender equality principles

"It has already changed my practice. I address everything to both parents and have changed my language around 'women'."
– Health Professional and Baby Makes 3 participant

3 World Health Organisation, 2009

4 Research in Practice. 2024. *For Baby's Sake: Understanding the impact of domestic abuse on infants.* 25 November. Available at: https://www.researchinpractice.org.uk/children/news-views/2024/november/for-baby-s-sake-understanding-the-impact-of-domestic-abuse-on-infants/ (accessed 2 April 2026)

Our impact in prevention – stories from Baby Makes 3

Engaging grandparents in multicultural communities

In 2025, Indian Care adapted the Baby Makes 3 parent group program to engage grandparents and seniors in Victoria's Indian communities. Across Point Cook, Tarneit and Werribee/Truganina, five workshop series reached around 200 families, reflecting the important role grandparents play in family decision-making.

A key insight emerged early: participation increased when the program was reframed around supporting grandchildren's wellbeing. This approach resonated with established seniors' groups and created a trusted setting for conversations about healthy relationships.

The pilot also created a pathway to younger generations, with 22 new parents joining the Baby Makes 3 parent group program.

It highlighted practical barriers (time pressures and cultural views that parenting is instinctive) and reinforced the value of culturally responsive delivery and stronger links with Maternal and Child Health services.

This work shows prevention is strongest when communities lead and messages are grounded in culture.

Balit Booboop Narrkwarren

Balit Booboop Narrkwarren is Baby Makes 3's First Nations-led initiative, supporting strong families and healthy relationships through culture, connection and community leadership.

Following the launch of the Balit Booboop Narrkwarren Toolbox on Bunurong Country, Aboriginal Elder Uncle Shane Charles (Yorta Yorta, Wurundjeri, Boon Wurrung) shared a powerful challenge: "We have the art, we have the words – now where is the song and where is the dance?".

In response, healthAbility partnered with Balit Booboop Narrkwarren champion Mikayla George and the Djirri Djirri Dancers. Together, they delivered a series of community workshops where participants learned language and Biik Ngarrga (Country Dance), reconnecting cultural practice with the work of strengthening families.

The dance has become a core component of Balit Booboop Narrkwarren activities, enriching Aboriginal-led initiatives supporting families. The workshops created space for intergenerational learning, cultural pride and connection, strengthening identity as a foundation for healthy relationships and wellbeing.

This work demonstrates that prevention is not only about information, but about culture, belonging and community leadership.

Early intervention – Diabetes Connect

healthAbility supports people across Melbourne's northern, eastern and south-eastern metropolitan regions, where chronic conditions are common and often complex. The Public Health Information Development Unit (PHIDU) estimates around two million people in these regions live with 2 or more chronic conditions.

More than 40% of our direct-service clients are aged 65+, reflecting the higher likelihood of chronic conditions, as health needs accumulate over time. At least 26% of our clients have a Health Care Card, and socio-economic disadvantage can reduce access to prevention and ongoing care, contributing to higher burden and making conditions harder to manage[5].

To respond to this need, we work collaboratively across healthAbility and with local partners to deliver integrated, multidisciplinary care.

We offer support for 5 chronic conditions that are among the most prevalent in our regions, supporting better health outcomes, a simpler care journey, and fewer preventable hospital admissions.

Diabetes Connect is one example: our podiatrists, dietitians, exercise physiologists and diabetes nurse educators partnered locally to support people with type 2 diabetes to manage their condition and improve wellbeing.

What is Diabetes Connect?

Diabetes Connect was a Victorian community-based pilot commissioned by the Victorian Department of Health and funded by the Federal Department of Health, Disability and Ageing, delivered from March 2024 to June 2025. It supported people living with diabetes through earlier, coordinated, locally delivered care – building confidence to self-manage, improving access to the right supports sooner, and reducing preventable hospital visits. In Eastern Melbourne, the service was delivered through the Eastern Melbourne Health Alliance (EMHA), led by healthAbility in partnership with Access Health and Community and Each.

Why it matters

Diabetes Connect demonstrated the value of early intervention in chronic disease management, addressing needs before escalation, supporting people to stay well in the community, and delivering measurable value for clients and the health system. This aligns with healthAbility's focus on early intervention and prevention of chronic disease in community health.

↓5%

Overall reduction in Emergency Department presentations

↓~10%

Reduction in unplanned hospital admissions – early system-level impact

Overall impact of Diabetes Connect

People felt more confident and capable in managing their diabetes, as patient activation increased

People reported better access to the right services and high satisfaction with support

Reduced unplanned hospital use with longer-term system and social benefits expected

5 PHIDU; Australian Institute of Health and Welfare (AIHW) 2024)

Our impact in early intervention – Diabetes Connect in eastern Melbourne

Place-based delivery

Place-based delivery enabled services to respond to local population needs. Diabetes Connect was delivered across seven LGAs via EMHA.

- Banyule
- Nillumbik
- Whitehorse

ACCESS Health & Community

- Boroondara
- Manningham

Each

- Knox
- Maroondah

Reach and intensity

692 clients supported across the EMHA region

115% exceeded enrolment target

8,660 hours of coordinated diabetes support delivered

12.5 average hours of support per client

Type of support delivered

Needs identification

Care coordination

Diabetes education

Allied health

What changed for clients

Fewer Eastern Region clients presented to emergency departments or were admitted to hospital during the pilot period.

ED presentations have reduced by 5%. For context, 1% of Eastern Region clients attended ED during the pilot, compared with 2% across the full pilot. Within EMHA, ED presentations fell sharply after enrolment: **clients who attended ED prior to enrolment dropped from 41 to only 6 after enrolment – an 85% reduction**, indicating fewer acute escalations and improved support in the community.

Self-management confidence increased: average PAM* rose from 58.7 (baseline) to 67.4 (discharge), a clinically meaningful improvement (+8.7)[6] and a shift from Level 3 (taking action) to Level 4 (maintaining behaviours)[7].

Personal Wellbeing Index (PWI)† results: On average, healthAbility Diabetes Connect clients have reported a **7.9-point increase in perceived wellbeing** between the initial and follow-up surveys. In terms of the areas measured in this survey, the highest increase in wellbeing related to health.

* About PAM: the Patient Activation Measure reflects a person's knowledge, skills and confidence to manage their health. This result suggests clients left the service better equipped to monitor their condition, make lifestyle changes and engage with healthcare services.

† Please note: PWI is healthAbility's service-wide patient-reported outcome measure. These results reflect healthAbility clients only (not the full EMHA pilot cohort).

6 Boland, R., Descallar, J., Naylor, J.M., Williams, G. and Brady, B. (2026). The minimal clinically important difference for the patient activation measure in a culturally and linguistically diverse cohort with chronic conditions. Quality of Life Research.

7 Hibbard, J.H., Stockard, J., Mahoney, E.R. and Tusler, M. (2004). Development of the patient activation measure (PAM): Conceptualising and measuring activation in patients and consumers. Health Services Research, 39 (4 Pt 1).

Value to the health system

With an average cost per EMHA client of $1,918 (comparable to the pilot-wide average), provided significant value to the health system

Our impact in early intervention – a Diabetes Connect story

In October 2024, a 38 year-old client named Michael* joined Diabetes Connect following a new diagnosis of type 2 diabetes. He also experienced high anxiety, was the primary carer for an unwell parent and had a severe fear of needles, making the prospect of daily blood glucose monitoring difficult.

As a Diabetes Connect client, Michael had regular check-ins with a Care Coordinator, 4 appointments each with a Diabetes Nurse Educator and Dietitian, and 2 podiatry appointments.

With support from the Diabetes Nurse Educator, he gradually built confidence with finger-prick testing. By the third appointment he was willing to try having his finger pricked and found it more manageable than expected.

With the Dietitian, Michael learned practical ways to make simple, sustainable dietary changes.

By discharge, he reported less diabetes-related anxiety and greater confidence to manage his condition over the long-term, even during periods of ongoing stress.

Michael's outcomes

Blood sugar control (HbA1c):
Reduced from 6.8% to 5.7% (-1.1%). A reduction in HbA1c of ≥0.5 percentage points is commonly regarded as clinically meaningful[8].

HbA1c reflects average blood glucose over the past ~2–3 months and is a key marker of diabetes control – lower HbA1c is linked to lower risk of diabetes-related complications and helps guide treatment decisions.

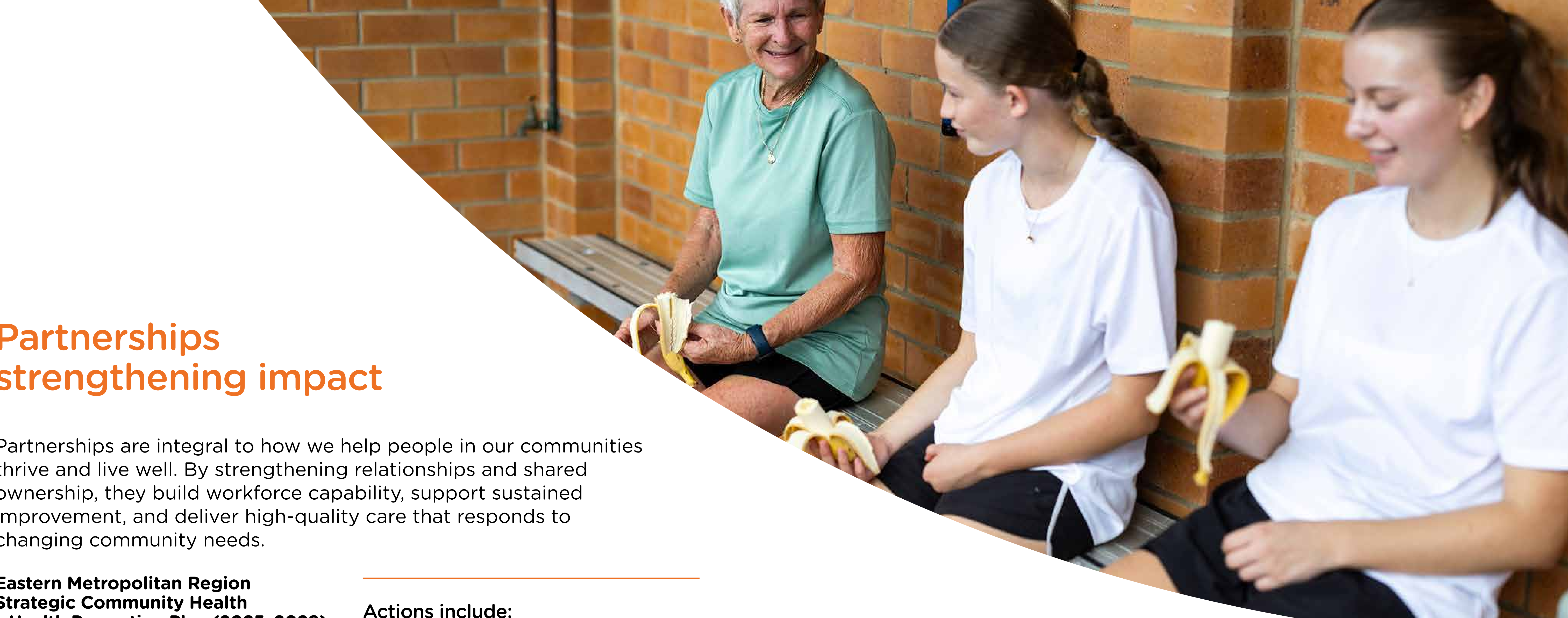
Self-management confidence (PAM):
Increased from 53.2 to 65.5 (+12.3), a meaningful improvement and a shift from Level 2 to Level 3 (from 'building knowledge' to 'taking action').

Personal wellbeing index (PWI):
7.9-point increase in perceived wellbeing between the initial and follow-up survey. Together with PAM, this indicates an overall improvement in both wellbeing and how confidently they can take action to manage their diabetes[6].

Weight: 11kg loss (99.2kg to 88kg). This equates to **13% body weight** loss. Evidence suggests losing **10% or more** of body weight can significantly improve metabolic health and glycaemic (blood sugar) control in people with type 2 diabetes[10].

Overall: Better blood sugar control, weight reduction, and stronger confidence to manage diabetes.

8 Bonaventura, J.M., et al. (2025). Minimal clinically important difference for HbA1c in type 2 diabetes interventions: a Bayesian network meta-analysis. Diabetes, Obesity and Metabolism.
Nathan, D.M., Buse, J.B., Davidson, M.B. et al. (2006). Management of Hyperglycemia in Type 2 Diabetes: A Consensus Algorithm for the Initiation and Adjustment of Therapy. Diabetes Care, 29(8), 1963–1972.
9 Roy Taylor et al. (2018). Primary care-led weight management for remission of type 2 diabetes (DiRECT trial). The Lancet.



Partnerships strengthening impact

Partnerships are integral to how we help people in our communities thrive and live well. By strengthening relationships and shared ownership, they build workforce capability, support sustained improvement, and deliver high-quality care that responds to changing community needs.

Eastern Metropolitan Region Strategic Community Health – Health Promotion Plan (2025–2029)

In 2025, 5 health agencies across Melbourne's Eastern Metropolitan Region (healthAbility, Access Health and Community/Inspiro, EACH, Eastern Health and Link Health and Community) co-designed the region's first unified Strategic Community Health, Health Promotion Plan (CHHP).

Backed by CEOs and leaders across the prevention workforce, partners developed a single 4 year plan aligned to CHHP guidelines through a shared planning day and cross-agency strategy sessions.

Implementation will be delivered through partner-led, 1 year place-based action plans across the settings where people live, learn, work and play, including early years, schools and community sport.

Actions include:

- **providing healthier food options**
- **creating more opportunities for active living and**
- **preventing smoking and vaping.**

Examples include healthier canteens, student-led wellbeing initiatives, educator capability building and grants to support local community cooking and connection.

This unified approach enables prevention action at scale, reduces duplication, and strengthens workforce capability and retention, supporting sustained, system-level change and reducing long-term chronic disease burden.

Student-led health promotion

In 2025, The Partnership (Access Health and Community, healthAbility and Link Health and Community) piloted the Student Leadership Project, an alternative, student-led model to help schools progress the Vic Kids Eat Well (VKEW) initiative by strengthening student voice, leadership and agency, while supporting healthier school food and drink environments.

The pilot ran across three schools in Manningham, Whitehorse and Nillumbik, directly involving 99 students, with broader reach to families and the school community.

Evaluation findings showed strong engagement and early gains in student knowledge and leadership.

In the recommended model trialled at Doncaster Secondary College, more than 95% of students consistently reported feeling empowered, engaged and clear on the project they wanted to deliver, a community garden for the whole school, planned for implementation in 2026. Recommendations included involving a cross-year mix of students to sustain actions beyond one year and supporting schools to access funding to progress initiatives.

Consumer voice and co-design

In line with our strategic focus on improving client experience and care, we continue to invest in service design. Using person-centred design and agile ways of working, we work to embed consumer voice and lived experience in service improvement and innovation.

Our service design team has implemented our Client Experience Survey (discussed in the Client experience and early outcomes section). In addition, as part of the ongoing Community Champions Advisory Group (CCAG), consumer consultations informed our practice.

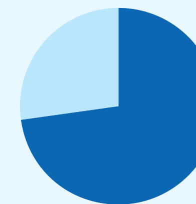
Community Champions Advisory Group

The group provides a valuable opportunity for community members and clients to shape service delivery, drawing on the experience of its 20 diverse members. The feedback we receive is essential to ongoing service improvement for clients.

CCAG in action

In 2025, CCAG met 6 times to explore topics nominated by members and generate practical ideas. Participation was strong, with an average of 12 members attending each session (of 20 members).

More than 70% of CCAG members will continue in 2026, with new recruits to fill remaining positions.



CCAG member feedback from 2025:

"It has been a very rewarding experience, and I've thoroughly enjoyed engaging with your team and the rest of the committee."

"Thanks for your continued commitment to these areas of the social services and community sector, it's very much needed. It was great to hear the varying opinions and experiences within the group to guide my own work and business in the sector."

Topics discussed included:

Healthy ageing: transition to retirement; quality care at home; navigating aged care; whole-of-person care experiences

Healthcare navigation: finding the right care at the right time to enable clients and carers to receive the health services they need

Children and youth: making mental health support easier to find; social media and fast-changing technology; benefits of intergenerational activities

Carers: supporting mental, emotional and physical wellbeing; support for young carers; financial and lifestyle transitions

Chronic conditions: availability of supports; addressing stigma; information for families; gaps between services

Consumer consultations

In 2025, we engaged clients, carers and community members to understand needs and co-design improvements, with a focus on healthy ageing and healthcare navigation.

Healthy Ageing consumer consultation

We consulted healthAbility Home Care Package clients and their carers to understand their experiences and awareness of the Support at Home changes from 1 November 2025. Key themes included the importance of trusted care relationships, confusion about available supports, and the need for clear communication.

This feedback now guides how we clearly and accessibly communicate about Support at Home through clients' preferred channels.

Consumer experience engagement

In September 2025, we held three in-depth consumer engagement sessions to understand end-to-end client and carer experiences and test interest in digital options to manage health interactions.

In response, we implemented immediate improvements (including an all-services flyer) and identified broader opportunities to inform future service design and strategic initiatives. Sessions also included concept-testing and co-design to ensure changes reflect consumer needs.

Key themes that emerged

Clients highly value healthAbility's service delivery and clinical care. Staff are considered empathetic and caring, providing individualised care and health guidance.

"The diabetes contact was excellent. I came in and they explained who I was going to see, so that I knew exactly what was going to be involved. It all tied in very well together." – Client

Many clients are not aware of the breadth of services healthAbility offers. In response, we created a service summary as a first step and are simplifying intake processes to improve awareness and make access easier.

"It's hard to know what you need, isn't it? You can look at a whole bunch of services, but does that apply to me?" – Client

Many clients reported moderate to high digital confidence and interest in managing appointments, billing and service history online. We will continue exploring options and testing concepts with clients throughout 2026.

"Going on a website to make an appointment would be alright, just like other doctors' surgeries." – Client

Environmental and community sustainability impact

Reducing our environmental footprint

Sustainability and ESG: Building our foundations

As expectations for environmental, social and governance (ESG) reporting continue to evolve in Australia, we are taking a considered and staged approach to sustainability and impact accountability.

The information in this section focuses on the environmental component of ESG (how we measure and reduce our organisational footprint) while social impact and governance are reflected throughout the report.

In 2025, our focus has been:

- **building reliable data**
- **strengthening governance mechanisms**
- **embedding practices that support transparency and accountability**

Over time, this will enable more consistent reporting on the environmental component of ESG, informed by robust and meaningful sustainability data.

Reducing our consumption in 2025

Water

We consumed 2,200 kilolitres (3.19 tonnes of CO_2 equivalent).

Actions we're taking to reduce this:

- **Replacing outdated tapware with water efficient units in dental clinics**

Paper

We consumed 4.7 tonnes of CO_2 equivalent.

Actions we're taking to reduce this:

- **Optimising our printers by replacing them with smaller, energy efficient models**

Electricity

We consumed 252,301 kilowatts (232 tonnes of CO_2 equivalent, 0.92 tonnes per 1,000 kilowatts).

Actions we're taking to reduce this:

- **Upgrading lighting to high efficiency LED downlights**
- **Replacing whitegoods, audio visual and IT equipment with energy efficient models as units reach end-of-life**

Fleet vehicles

We consumed 2.65 tonnes of CO_2 per 10,000 kilometres and we travelled 80,000 kilometres to deliver outreach services where clients live, socialise and learn.

Actions we're taking to reduce this:

- **Transitioning fleet vehicles from petrol/diesel to hybrid electric models**

Additional steps taken toward environmental sustainability

Beyond measuring and reducing consumption, we are taking further steps to minimise our environmental footprint and build a culture of sustainability, including:

- **Established a staff 'green team' to champion sustainable behaviours at work**
- **Improved waste separation and signage across sites including FOGO* bins in kitchens and composting in garden areas**
- **Introduced an e-waste recycling process for electrical items**
- **Phased out air-conditioning units that use environmentally harmful refrigerants**
- **Measured waste outputs across sites to strengthen baselines and track improvement**

* Food Organics and Garden Organics

healthAbility Repair Café

Since launching in 2023, the healthAbility Repair Café has become a local hub for community connection and reuse. Delivered with Whitehorse City Council and the Rotary Club of Box Hill Central, this free service helps extend the life of household items and diverts more than 1 tonne of goods from landfill each year.

In 2025:

1,210kg waste diverted from landfill by the healthAbility Repair Café

384 visitors to the Repair Café

healthAbility Men's Shed

The healthAbility Men's Shed helps reduce waste by accepting donated materials such as wood, metal and tools for participants to use in their projects. Items made are sold to help fund Men's Shed activities or donated to community causes.

What we're learning and building towards in 2026

This inaugural report demonstrates how reliable, meaningful data helps us understand what is working, where improvements are needed, and where need is greatest. It supports shared learning with clients, partners, and stakeholders, and highlights our progress in strengthening client feedback and outcomes measurement, grounded in transparency, accountability and continuous improvement.

Priorities for 2026

- Deepening social impact measurement, including client-reported outcomes (PROMs)
- Embedding governance and consumer voice mechanisms that support accountability
- Aligning impact reporting with emerging ESG and sustainability expectations where appropriate
- Strengthening environmental data consistency and baselines

Our commitment

We are committed to accessible, high-quality care; listening and responding to lived experience; working collaboratively with clients, communities and partners; and strengthening transparency and learning to support a stronger, more connected health and social care system. This report is the first step in continuously improving how we understand and measure our impact and using what we learn to make wellbeing easy.

healthAbility

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