

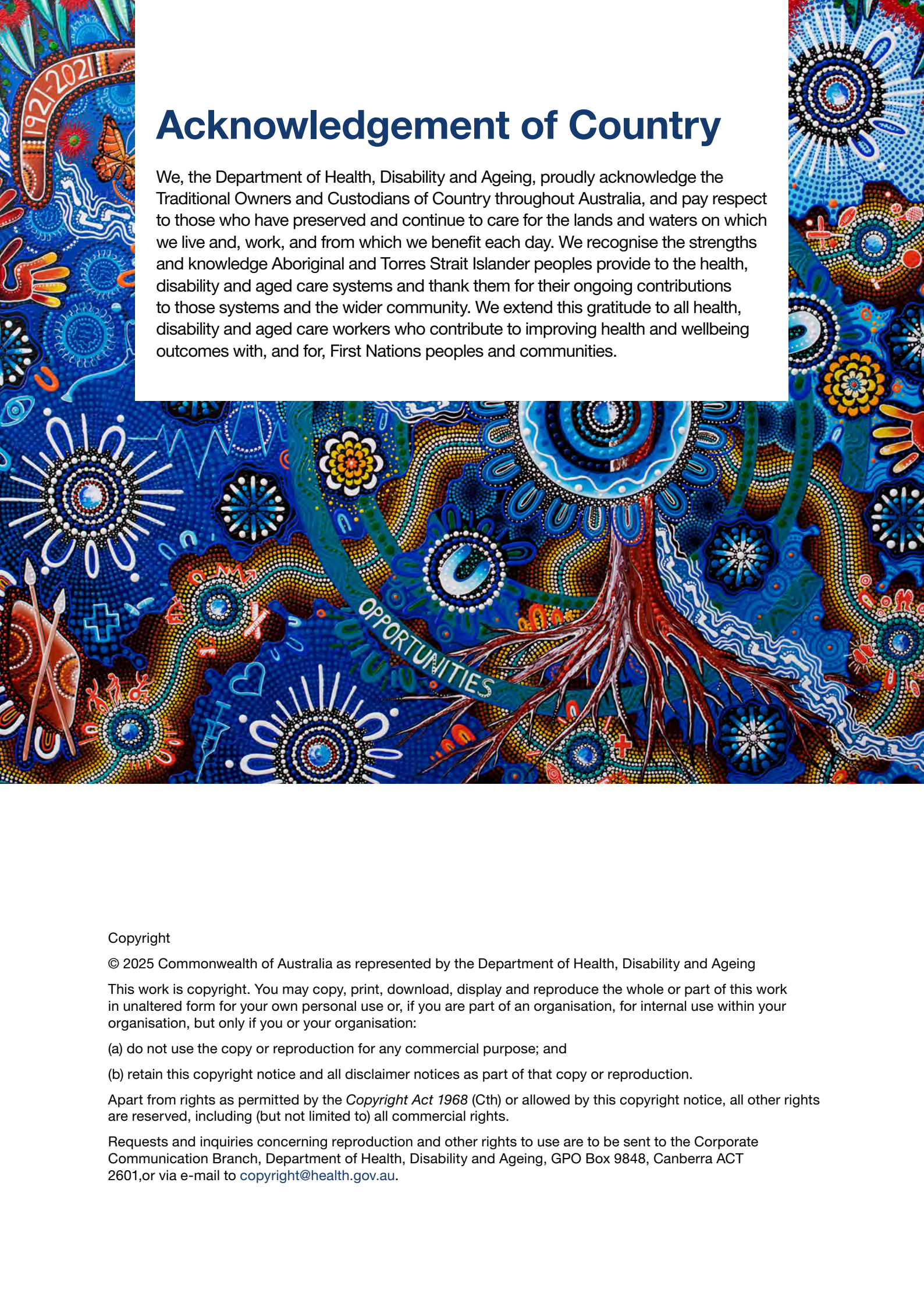


Australian Government

Department of Health, Disability and Ageing

Corporate Plan 2025–26





Acknowledgement of Country

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

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Secretary's Foreword

I am pleased to share the Department of Health, Disability and Ageing's 2025–26 Corporate Plan.¹ This is our primary planning document and outlines our objectives for the current financial year. It defines our approach to steward² the health, disability and aged care systems for the Australian Government, and provides a framework for measuring our performance.

This plan has been prepared to meet the obligations of paragraph 35(1)(b) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and covers the 4-year period from 2025–2026 to 2028–2029.

Our responsibilities now span some of Australia's most significant systems of social support: Medicare, the Pharmaceutical Benefits Scheme, aged care, and the National Disability Insurance Scheme. We see this as an opportunity to strengthen and better connect these sectors for individuals, providers and the workforce. Australians want care and support that is seamless, timely, and person-centered—enabling them to live the lives they choose.

We are committed to ensuring that people with disability feel included and respected, that older Australians age with dignity, and that the needs of all Australians are heard and addressed. We are also committed in particular to ensuring we support fully those from diverse communities.

The integration of disability into our portfolio enables a more coherent approach to policy and service delivery and strengthens our capacity to address complex, cross-system challenges.

Our work is guided by the Capability Review Action Plan and the department's strategic blueprint, *Future Direction*. *Future Direction* sets out 4 goals that describe our desired future state for Australia's health, disability and aged care systems:

1. improving the health of individuals
2. better care and services
3. reduced inequity of access, experience and outcomes
4. sustainable and affordable health, disability and aged care systems.

¹ Following the May 2025 election, and the Machinery of Government changes, the Department of Health and Aged Care was renamed the Department of Health, Disability and Ageing taking effect from 13 May 2025. This change reflects the department's evolving focus and broadening scope of responsibilities through the transfer of Disability and Carers functions from the Department of Social Services.

² Stewardship is a practice of caring for something that we have been trusted to look after. Being a good steward means accepting responsibility for that care and working to ensure the long-term integrity and sustainability of what has been entrusted to us. APSC – [Stewardship guidance](#)



“Our responsibilities now span some of Australia's most significant systems of social support: Medicare, the Pharmaceutical Benefits Scheme, aged care, and the National Disability Insurance Scheme.”

With data, evidence and a commitment to continuous improvement, 4 strategic priorities have been identified to shape our work going forward as we support the government. The department will focus on:

1. pivoting to prevention and early intervention
2. enhancing health equity
3. leveraging digital and health technology
4. ensuring integrated health systems.

In 2025–26, we will embed *Future Direction* into our planning, engagement and delivery processes. We will build the strategic policy, leadership and workforce capabilities required to drive reform. We will also continue modernising our workspaces and digital systems, with a strong focus on sustainability and climate-aware decision-making.

We remain committed to working collaboratively with state and territory governments, service providers, consumers, peak bodies and international partners. Strong partnerships are essential to building better systems of care and support, ensuring that our work delivers positive and lasting outcomes for individuals and communities. Investing in these relationships fosters collective action, expertise and use of resources to steward systems that benefit millions of Australians every day.

Blair Comley PSM
Secretary

Role of the Corporate Plan

The Department of Health, Disability and Ageing Corporate Plan sets out our operating environment, objectives and key activities. It also outlines how we will measure and assess our performance over the 4-year period, as required under Section 35 of the PGPA Act and the accompanying Rule.

Together with the 2025–26 Health and Aged Care Portfolio Budget Statements³, the Corporate Plan provides a framework for tracking and reporting on our work. It aligns our financial and non-financial planning to the outcomes and programs in the Budget Statements. Since the 2025–26 Portfolio Budget Statements, we have made some changes to our performance measures. Any changes are clearly documented in footnotes throughout the performance information sections. The measurement and assessment of the performance measures outlined in our 2025–26 corporate plan will be reconciled in our 2025–26 annual performance statements.

The plan also strengthens the connection between the department's strategic direction and the individual contributions of staff, reinforcing how everyone's work supports our shared vision and goals.

Our Vision

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

Our Purpose and Outcomes

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.

Our purpose is achieved through our outcomes and programs.

³ As a result of the Machinery of Government (MoG) change effective 13 May 2025, our department has assumed responsibility for elements of the disability and carers function previously managed by the Department of Social Services (DSS). Accordingly, these elements will be reported in our 2024–25 Annual Performance Statements.



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 Carers⁴

- 4.1 Disability and Carers
- 4.2 National Disability Insurance Scheme (NDIS)

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

Our Corporate structure

The Hon Mark Butler MP

Minister for Health and Ageing

Minister for Disability and the National Disability Insurance Scheme

Deputy Leader of the House

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 Rebecca White MP

Assistant Minister for Health and Aged Care

Assistant Minister for Indigenous Health

Assistant Minister for Women

The Hon Emma McBride MP

Assistant Minister for Mental Health and Suicide Prevention

Assistant Minister for Rural and Regional Health

Mr Dan Repacholi MP

Special Envoy for Men's Health



Secretary, Blair Comley PSM

Office of the Chief Medical Officer

Interim Australian Centre for Disease Control

- Health Protection Policy and Surveillance
- Health Security and Emergency Management
- Australian Centre for Disease Control (CDC) Establishment Taskforce

Health Products Regulation

- Medicines Regulation
- Medical Devices and Product Quality
- Regulatory Legal Services
- Regulatory Practice and Support

Ageing and Aged Care

- Reform Implementation
- Access and Home Support
- Residential Care
- Market and Workforce
- Service Delivery
- Quality and Assurance
- Systems, Engagement and Contributions

Primary and Community Care

- Population Health
- Cancer, Hearing and Chronic Conditions
- Mental Health and Suicide Prevention
- Primary Care
- National Immunisation
- National Mental Health Commission

Health Resourcing

- Health Workforce
- Technology Assessment and Access
- Benefits Integrity
- Medicare Benefits and Digital Health

Strategy and First Nations

- First Nations Health
- Health Economics and Research
- Health Systems Strategy
- Public Hospital and Health Reform
- Office of the Chief Health Economist

Corporate Operations

- Chief Digital Information Officer
- Digital Transformation and Delivery
- Financial Management
- Information Technology
- Integrity and Assurance
- Legal
- People, Communication and Parliamentary

Disability and Carers

- NDIS Markets and Safeguards
- Disability and Carer Programs
- Disability Reforms and Royal Commission
- NDIS Participants and Performance

Our Partners

We work with a diverse range of partners – across Australia and internationally – to improve health, disability and ageing outcomes for all Australians.

In Australia our partnerships include other Australian Government departments, state and territory governments, and our portfolio agencies. These collaborations help us plan and invest together to drive lasting improvements in health, disability and aged care systems. We also work closely with researchers, healthcare professionals, consumer groups and peak bodies to ensure policies and programs are evidence-based and responsive to people's needs.

Internationally we engage with key organisations – such as the World Health Organization, the G20 and the Organisation for Economic Co-operation and Development – to support Australia's health priorities and strengthen regional and global health security.

Our Operating Context

Australia's health, disability and aged care systems are complex and constantly changing, with responsibilities shared across all levels of government. Making sure Australians get the best outcomes from these systems – jointly and individually – is something we all share.

Many different people and organisations are involved in and affected by these systems – from governments and service providers to communities and individuals. Their priorities can sometimes differ making it important that we listen and consider them all.

The needs of Australians are shifting. Our population is growing and getting older. More people are living with long-term health conditions, including mental health conditions, and the risk of major public health emergencies is ever-present.

We also face challenges beyond our control, like global health issues, climate change, natural disasters, new technology, international cooperation and conflict, workforce shortages and changes in the economy. These all influence the work we do.

The inclusion of disability in our portfolio marks a significant shift. Many Australians engage with health, aged care and disability systems at different points in their lives – sometimes simultaneously. Yet these systems often do not work well together for individuals, providers or the workforce. We now have a critical opportunity to align these systems more coherently, reduce fragmentation, and improve outcomes.

We are also well positioned to ensure better coordination between Commonwealth and state and territory responsibilities in health and disability funding and service delivery. United within one department, we can facilitate joined-up national conversations on reform, integration and sustainability.

Every dollar allocated in health, disability and aged care must be spent efficiently, transparently and in a way that delivers the best possible outcomes for Australians. We are committed to managing our resources responsibly, in line with what the community expects and what the government has set as policy priorities.

All our decisions must be lawful and we must remain accountable to the Australian Parliament and the community.

We will continue to work closely with and leverage the expertise of others to research, learn and seek improvements to our policy design and program implementation. This includes our portfolio agencies, all levels of government, the broader health, disability and aged care sectors, consumers and their representative peak bodies, as well as international partners.

Our Regulatory Approach

The regulatory environment in the health, disability and aged care sectors is complex and broad. The Australian Government, through the department and its portfolio entities, has a significant responsibility for regulating a wide range of systems across those sectors, including:

- ageing and aged care services
- controlled drugs
- food standards
- gene technology
- health and aged care related grants
- health promotion
- health research and data
- health security and international health
- human cloning and embryo research
- industrial chemicals
- medical, pharmaceutical, dental and hearing benefits
- health professional practice, through joint ministerial responsibilities for the National Registrations and Accreditation Scheme
- organ and tissue donation
- private health insurance
- radiation protection and nuclear safety
- security sensitive biological agents
- therapeutic goods and products such as medicines, vaccines, cells and tissues, blood products and medical devices
- tobacco products.

Our regulators play a vital role in administering legislation that covers thousands of professionals, organisations and businesses that support the health and wellbeing of Australians.

The department aims to protect the health, safety, and wellbeing of all Australians by identifying risks to human health and the environment and managing those risks to prevent harm through education and effective, proportionate compliance activities.

The development, management and review of our regulation is guided by the Health Regulatory Policy Framework. It sets out the 3 principles of best practice that regulators are required to report on:

Principle 1. Continuous improvement and building trust.

We adopt a whole-of-system perspective to regulation, continuously improving our performance, capability and culture to build trust and confidence in our regulatory system.

Principle 2. Risk-based and data-driven.

We manage risks proportionately, apply treatments which are specific to the prevailing risks and maintain essential safeguards. We do this while minimising unnecessary regulatory burden and leverage data and digital technology to support those we regulate to comply and grow.

Principle 3. Collaboration and engagement.

We are transparent and responsive communicators, implementing regulations in a modern and collaborative way.

We recognise that we have a shared responsibility for the stewardship of our regulatory systems. We adopt a whole-of-system view to regulation and take a proactive and collaborative approach to regulatory functions which the department oversees.

Regulator/regulatory function	Program
* Regulatory oversight of therapeutic goods by the Therapeutic Goods Administration Program	Program 1.8
* Regulatory oversight of controlled drugs by the Office of Drug Control	Program 1.8
** Administration of the Australian Industrial Chemicals Introduction Scheme (AICIS) by the Office of Chemical Safety	Program 1.8
**Gene Technology Regulator (GTR)/Office of the Gene Technology Regulator	Program 1.8
* Supporting access to high-quality hearing services through the Hearing Services Program	Program 2.2
* Regulatory oversight of private health insurance and private hospitals ⁵	Program 2.4
* Supporting the integrity of health benefit claims	Program 2.6

* For these regulatory functions, the department has in place a Ministerial Statement of Expectations (SOE), which provides expectations of how the department will achieve its regulatory objectives. The SOE also demonstrates how the department carries out its regulatory functions and exercises its powers. The SOE responds to the Statement of Intent (SOI), which sets out the department's intentions on how the regulators and regulatory functions will deliver on those expectations. The SOE and SOI are available on the department's website.

** The Australian Industrial Chemicals Introduction Scheme and the Gene Technology Regulator have their own respective SOEs and SOIs, which are available on their websites.

⁵ Where those obligations do not fall within the prudential regulatory role of the Australian Prudential Regulation Authority.



Corporate Governance and Risk Oversight

Corporate governance plays an integral role in ensuring Australian Government priorities and program outcomes are delivered efficiently and effectively.

Six senior governance committees provide advice and make recommendations to our executive and the Accountable Authority on strategic portfolio policy issues. These committees focus on improving the performance of health, disability and aged care systems, organisational performance, delivery of administered programs and implementation of our change projects that have the highest risk.

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	Provides oversight of the department's Workforce Strategy, and other strategic workforce matters. It provides direction on people and culture matters, including integrity, and advises and makes recommendations to the Executive Committee.
Delivery Committee	Provides oversight of assurance reviews on existing sub-programs and implementation of new initiatives and measures. Provides visibility to the Executive Committee on the management and ongoing viability of the department's tier 1 projects and portfolios.
Finance Committee	Provides recommendations to the Secretary and the Executive Committee on strategic financial management policy initiatives and issues.
Digital Committee	Oversees the department's digital, data and ICT functions and capabilities. The Committee provides effective executive custodianship across both sustaining functions and health transformation programs, to drive strategic digital enablement across health systems.

Two other important committees help guide our work. The Strategic Policy Forum looks across the whole portfolio to support the development and improvement of policies. The Closing the Gap Committee leads efforts to embed the 4 key reforms from the National Agreement on Closing the Gap into our policies, processes and daily work.



Risk Management

Effective risk management assists our people to make better decisions, encourages engagement with risk and positions us to be more agile to deal with current and emerging challenges. We have embedded risk management in our governance structure, policies and processes. Our risk management framework supports us to meet obligations under Section 16 of the PGPA Act and reflects the Commonwealth Risk Management Policy. It guides how we respond to evolving opportunities and threats in line with our risk tolerance and appetite.

The department has a culture where people are encouraged to take appropriate and calculated risks. Our leaders encourage this through an open, no-blame approach that ensures our people are comfortable with reporting and escalating risks where necessary. By taking this proactive approach to risk, we can benefit from healthy risk-taking behaviour to achieve our objectives, whilst applying appropriate controls to manage those risks.

The Executive Committee monitors the department's emerging and strategic risks on a regular basis and determines the department's risk tolerance and appetite. The department maintains an Audit and Risk Committee (ARC) and an internal audit program to provide independent advice on the appropriateness of the department's financial and performance reporting responsibilities, system of risk oversight and management and system of internal control. This is in line with the requirements of Section 45 of the PGPA Act.

Enterprise Risks

Enterprise Risk Category	Enterprise Risk Statement
Delivery	Sub-risk 1.1 – Programs/Projects Failure to deliver programs/projects and/or achieve required milestones to ensure fit for purpose outcomes. Sub-risk 1.2 – Policy Failure to develop and/or incorporate strategic and evidence-based policy advice in a timely manner to government. Sub risk 1.3 – Regulatory Failure to comply with regulatory requirements that ensure the delivery of compliant outcomes.
Stakeholders	Ineffective partnering and engagement with external and internal stakeholders to achieve required outcomes.
Information Technology, Cyber Security, Data and Digital Services	Failure to provide fit-for-purpose, information technology, digital services, and security of data for programs, projects, and services.
People	Sub-risk 4.1 – Capability/Performance Failure to develop and maintain an accountable, capable, engaged and diverse workforce. Sub-risk 4.2 – Wellbeing Failure to address the physical and mental wellbeing of staff. Sub-risk 4.3 – Recruitment and retention Failure to onboard and retain an effective workforce in order to achieve government outcomes.
Financial	Ineffective management of financial resources to ensure compliance, prevention of potential fraud and the delivery of government priorities.
Legal Compliance	Failure to comply with relevant legislation, regulatory activities and requirements.

Our Capabilities

Corporate Operations Group (Corporate) Strategy 2024–2027

The Corporate Strategy 2024–2027 has 4 aims which the Corporate Operations Group aspires to achieve with the services we deliver and functions we are responsible for:

- Prioritise our customers
- Engage our people
- Pursue excellence
- Build for sustainability

Each aim includes its own indicators and targets, and serves as the base from which we seek to gradually improve Corporate services and functions. These aims are regularly reported on, and the outcomes presented to the Corporate Operations Board, which then provide actional insights and facilitate informed decision-making to drive continuous improvement in the way we deliver, with a particular focus on:

- Delivering consistently high-quality corporate services to meet customer needs
- Strengthening all aspects of project delivery
- Enabling improved policy development and program management
- Setting our strategic direction and clarify accountability and obligations across Corporate
- Enhancing our engagement model
- Planning for the future and build for sustainability.

The Corporate Strategy 2024–2027 is underpinned by the Corporate Transformation Plan 2024–2025 to 2026–2027 which sets out Corporate Operation Group’s major projects that will deliver benefits for our customers and support the department’s response to the Capability Review (August 2023). These projects will drive significant transformational change, helping equip the department to continue to deliver in a rapidly changing environment by:

- Building workforce and leadership capability
- Sharpening enterprise performance
- Strengthening our integrity culture
- Leveraging digital opportunities.

Each year, the major projects are reviewed and adjusted to reflect changing priorities and new opportunities for the department.

Monitoring and measuring our performance against our aims and planned project benefits and maintaining close engagement with the Health, Disability and Ageing Executive, will ensure our services, functions, major projects and divisional, branch and section business planning continue to be aligned with the department’s priorities.

The Corporate Strategy 2024–2027 supports the delivery of the department’s Corporate Plan and enables business areas to successfully deliver on their program objectives. We will continue to build and maintain our capability to support the Australian Government to lead and shape Australia’s health, disability and aged care system.

Workforce Capability

We have a workforce of more than 7,000 Australian Public Service (APS) employees around Australia. Most of our roles are in policy, program and project management, compliance and regulation, administration, science and health. Our vision is to build the capability of our organisation, ensuring we can meet evolving demands and deliver effectively in a changing environment.

We are doing this in many ways such as addressing recommendations from the then Department of Health and Aged Care's 2023 Capability Review (the Capability Review), implementing our Workforce Strategy and annual Learning and Development Roadmaps, and participating in APS Reform Agenda⁶ initiatives.

The department published its response to the Capability Review in October 2023. Our response, which is monitored and guided by the Capability Review Response Steering Committee, centres around 3 key themes:

- lifting our strategic policy capability
- deepening our engagement with the community and stakeholders
- unlocking our executive leader potential.

Significant work is underway to support the implementation of these themes. This progress is being monitored and reported on by the department's Capability Review Response Steering Committee, established in June 2024. This work includes:

- *Future Direction* – sets the direction of travel for the department for the next 10 to 15 years
- *Policy Playbook* – a best-practice 'how to' guide to support staff in solving policy problems or opportunities, driving strategic thinking and promoting collaboration across the department.

The People Committee oversees the implementation of the department's Workforce Strategy. The Workforce Strategy focuses on building our skills and preparing us to adapt to changes that may affect us over the next 3 to 5 years and has 4 strategic objectives:

1. compete for talent
2. grow our own
3. support and build agility
4. build our leadership and culture.

Annual implementation plans under the Workforce Strategy prioritise the actions we will take to support these objectives. The plans are informed by environmental scanning and operational workforce planning. Operational workforce planning identifies the capability requirements needed to meet our strategic objectives and guides initiatives to build and sustain a high-performing workforce.

⁶ Available at: www.apsreform.gov.au/about-aps-reform



The department's Learning and Development Roadmap 2024–25 (the Roadmap) outlined key learning and development actions to align to our capability to the Workforce Strategy and Capability Review Response. The Roadmap will include:

- putting in place targeted learning and development solutions to address identified barriers to uptake of learning activities for Executive Level and SES staff
- continuing to develop our leadership pathway products to support capability required when progressing to Executive and SES Levels
- updating our learning catalogue using evaluation data and to reflect our current priorities under our Workforce Strategy, undertaking a training needs analysis to provide recommendations for AI training within the department.

We provide targeted and contemporary learning and development opportunities to all staff in all locations. We align to the APS Continuous Learning Model, ensuring staff are aware of and can access, relevant high-quality learning suitable to their needs, from bite-sized options through to intensive offerings. We maximise use of our enhanced IT capability and have improved staff access to learning platforms. We are improving our learning governance and in 2025–26 will continue to embed and operationalise a new learning governance framework. This framework sets the standards of learning across the department and defines shared responsibilities across our learning ecosystem.

We continue to enhance our entry-level programs and participate in broader APS-wide pathways. In 2025–26, we will further embed the departmental Employee Value Proposition to help attract and retain people with the right skills and attributes. We will also strengthen workforce planning and review our organisational structures and work design, and refine our approach to mobility so we can focus our resources on the highest priority work and deliver our objectives efficiently and effectively.

Building on the successful conversion of 44 contractors to APS in 2024–25 and effectively reducing our expenditure on external outsourcing, the department remains committed to using APS employees for core work, rather than relying on external providers. When we do engage external providers, we follow the principles in the APS Strategic Commissioning Framework to guide our decision-making and ensure we plan to transfer knowledge to build the capability of our APS employees.

In 2025–26, the department will continue to focus on reducing outsourcing in the job families of Accounting and Finance; Administration; Communications and Marketing; Compliance and Regulation; Policy, Portfolio, Program and Project Management and Service Delivery. We anticipate a reduction of \$1,921,395 in outsourcing expenditure across these roles in 2025–26.

Workplace Culture

Our department has a strong sense of identity, clear values, and a supportive, professional culture. We encourage innovation and inclusivity, with highly engaged staff and a steadfast commitment to integrity. A recent employee survey showed 82% of respondents would recommend our department as a great place to work.

Staff continue to view our leadership as effective. We are committed to supporting our leaders, ensuring their wellbeing, and empowering them to lead hybrid and geographically dispersed teams effectively.

Clear communication and change management are crucial for a positive workplace. Our 2024 APS Employee Census results revealed mixed feedback on these areas, highlighting the need for improvement. We are focusing on enhancing these capabilities, particularly for our middle managers, to ensure better internal communication and support during change initiatives.

Our people have told us they do their best work when they are supported by a modern, flexible work environment and workplace culture that enables different working styles to thrive.

The New Ways of Working (NWOW) program continues to transform our workplace by delivering well-designed, inclusive and accessible spaces, underpinned by improved technology. It fosters a flexible environment that enables collaboration, performance and hybrid working – empowering our people to excel, no matter where they are based. By supporting hybrid work and geographically dispersed teams, we are able to attract and retain talent from across Australia.

Since introducing NWOW, we have seen significant positive changes in job satisfaction (+9%), staff choice in how they work (+9%), inclusive workplace culture (+7%), and workgroup efficiency (+9%), compared to the traditional ways of working in 2019 (APS Census, 2024). Our most recent culture survey also shows strong satisfaction with the office environment (72%) and high confidence among managers in leading flexible, hybrid teams (83%).

The program is nearing completion, with most department sites to be finalised by mid-2026. Alongside physical improvements, NWOW is embedding a cultural shift in how we work. In the coming year, we will focus on consolidating these changes to ensure their full benefits are achieved and sustained for the future.





Diversity and Inclusion

We value the range of views and approaches diversity brings to our workplace. We are committed to being inclusive, culturally aware and responsive to the needs of individuals in our policies and practices. We actively pursue initiatives to broaden diversity and inclusion in our workplace, supporting a wide range of diversity dimensions including gender, age, disability, LGBTIQ+, neurodivergence, First Nations peoples and cultural diversity.

Our [Inclusion Framework 2025–30](#) demonstrates our commitment to fostering a diverse and inclusive workforce that reflects the community we serve. By embracing diverse identities and perspectives, we enrich our organisation and create a culturally safe, accessible, inclusive and respectful workplace.

Our 6 staff diversity networks provide representation, networking opportunities, information, and peer support to staff. These networks continue to mature their approaches to engaging and supporting staff, including adapting to our increasingly geographically distributed workforce. Each network continues to receive support from diversity champions. Our 6 staff diversity networks are:

- Culturally and Linguistically Diverse Network (CALD)
- Disability and Carers Network (DCN)
- Gender Equality Network (GEN)
- Health Pride Network (HPN)
- National Aboriginal and Torres Strait Islander Staff Network (NATSISN), including Friends of the NATSISN
- Neurodiversity Network (NDN).

To deliver services, policies and programs that are safe and respectful for First Nations peoples, we need to understand and value their cultures, histories and experiences. Our Stretch Reconciliation Action Plan 2025–2028 will guide this, focusing on:

- recruitment and retention
- cultural capability in our leaders
- using procurement, grants, partnerships and engagement to increase opportunities for First Nations people
- cultural safety.

Our Stretch Reconciliation Action Plan builds on and complements the work of our Closing the Gap Steering Committee, which was established in 2022 to drive action across the department on the [Closing the Gap Priority Reforms](#).

Climate Action in Government Operations

We continue to support the Australian Government's efforts to enhance energy efficiency and reduce greenhouse gas emissions, aligning with the APS Net Zero 2030 policy⁷. Our initiatives promote sustainable practices and increase climate awareness.

To oversee actions, outcomes, and alignment with mandatory reporting requirements under the Commonwealth Climate Disclosure and our Emissions Reduction Plan 2024–25⁸, we have established a chief sustainability officer and governance arrangements.

Our waste reduction strategies focus on reducing, reusing, and recycling. Additionally, we are transitioning our fleet to low-emissions vehicles and collaborating with building owners to install charging infrastructure where possible.

We are cutting energy consumption through sustainable procurement, renewable energy, and prioritising the purchase of eco-friendly stationery. Policies are being updated to encourage sustainable travel practices.

We are continuing to maintain a 5.5 or higher National Australian Built Environment Rating System (NABERS) rating for energy, water, and Green Star performance.

Guided by the Climate Risk and Opportunity Management Program (CROMP), we continue to refine internal mechanisms to identify and evaluate climate-related risks and opportunities across our operations.

⁷ APS Net Zero Emissions by 2030 | Department of Finance

⁸ Emissions Reduction Plan 2024–25



Information Communications and Technology Capability

Digital Services aims to transform health and care in collaboration with the portfolio and its partners, by shifting the way the department delivers services across the health and care sectors. This will be achieved by:

1. bringing together health and aged care IT through the creation of a new operating model for Digital Services, under the direction of the Chief Digital Information Officer
2. redesigning the department's Tier 1 governance committee structure to ensure a dedicated focus on digital through the establishment of the Digital Committee and its associated subcommittees
3. delivering an overarching Digital Strategy, future state architecture/technology roadmap in collaboration with the portfolio and broader health and care sector, to drive more holistic health and care outcomes that harness the benefits of digital transformation
4. coordinating and driving the Portfolio's Digital Investment Plan (DIP), and delivering an overarching Digital Strategy, in collaboration with the portfolio and broader health and care sector
5. providing thought leadership and hands-on support for more coordinated investments into digital capabilities across the portfolio.

These efforts will support the department in delivering on government priorities. They will also leverage digital investments more effectively, and strengthen internal and external partnerships. The strategy, its implementation roadmap, and associated investment plan will drive digital transformation across the health and care sector through:

- streamlining, modernising and transforming the delivery of health and care services
- supporting better adoption and use of digital technologies across the health and care sector to reduce the administrative burden on providers
- enabling better workforce mobility across the health and aged care sectors
- helping people across Australia to access and navigate health and care services that best meet their needs
- enabling information flows across health, aged care and the broader care and support sector.

Digital Services continues to reliably provide critical shared services and digital platforms for health and aged care, and the wider health and care ecosystem. In addition, Digital Services continues to champion digital transformation, having built a strong and well-subscribed external sector engagement capability that employs an open culture of feedback and co-design to build holistic digital solutions in remedy of the sector's most pressing challenges.



Uplifting our protective and cyber security maturity and implementation of the Department of Health and Aged Care Security Strategy 2023–26 continues to be a priority to mitigate security risks. Significant progress has been made in ensuring our buildings, assets and personnel remain safe, along with a strong focus on continuing the rollout of our Essential 8 cyber security controls to protect our systems and data.

Digital Services is also focused on implementing the final of 3 “horizons” of deliverables for the Department of Health and Aged Care ICT Strategy 2023–2026 (ICT Strategy). This strategy commenced implementation in 2023–24 and is a candidate for refresh early in the 2025–26 financial year. The current ICT Strategy aligns our broad IT work program to the department’s program delivery framework encompassing the health and aged care sectors, wider health portfolio and whole-of-government contexts. It has ensured the department continues to leverage existing technologies, patterns and digital capabilities to effectively deliver new and emerging priorities of government.

The ICT Strategy focuses on 4 business-aligned strategic themes:

Modern workplace:

- Focusing on improving the desktop and internal, external and international collaboration experiences for our workforce
- Unifying the desktop experience for all staff working across unclassified and protected information.

Enterprise platforms:

- Establishing the necessary digital foundations to enable strategic transformation across our business and to improve external customer digital experiences
- Operationalising fit-for-purpose communication and collaboration tools that enable better internal and cross-government engagement.

Data and analytics:

- Empowering informed decision-making through an insights-driven approach to data access and use
- Implementing the necessary technology changes to support the department’s Data Strategy, to promote interoperability, seamless sharing and the exchange of data
- Enhancing the department’s data storage, sharing, interoperability and security capabilities.

ICT delivery and sustainment:

- Building critical foundations for our ICT operations and security, to foster industrialised, reliable, sustainable and unified IT across our department.

Implementation of the ICT Strategy in 2024–25 has laid the foundation for:

- a more efficient, collaborative and secure digital environment
- modern, agile and user-centric platforms to support health and aged care services
- transitioning from legacy technologies to more contemporary systems that support better performance and increased security
- key technology enablers that support the department’s data-driven focus in delivering better health, disability and ageing outcomes.

The continued implementation of the ICT Strategy in 2025–26 will focus on:

- concluding initiatives that remain in progress
- resolving a path forward for initiatives that remain on the backlog, due to funding availability or prioritisation
- development of a strategic approach to digital transformation, supporting broader whole-of-government initiatives and the delivery of health and aged care services in a digital-first world.

The drafting of a new Digital Strategy and the impending resolution of the ICT Strategy (2023–26) poses a timely opportunity for Digital Services to articulate a refreshed strategic intent, underpinned by a comprehensive strategic architecture technology roadmap for digital transformation.

Economic Capability

The department recognises the value of uplifting economic capability and building an economic evidence base to inform policy. As set out in the department's response to the capability review, the Chief Health Economist role was established to: help navigate the challenges facing the Australian health, disability and aged care systems, of which affordability, productivity and workforce are at the fore; act as an influential voice in the department; translate health economic principles and practices to policy design; and to help build economic capability in the department.

The Office of the Chief Health Economist (OCHE) Division has 3 inter-related pillars guiding its program of work:

1. Evidence-informed strategic policy advice from a whole of system perspective that is future focused, collaborative and responsive
2. Economic capability building across the department and sector
3. Stewardship through stakeholder engagement, using evidence informed approach, early peer review and partnerships.

OCHE Division works collaboratively across the department to provide practical and timely advice with a focus on economic capability uplift.

Data Capability

We foster a culture that promotes and values the safe and effective use of data to drive better health, disability and aged care outcomes for Australians.

We continue to implement the department's Data Strategy to improve our data governance arrangements, data asset discoverability, data sharing and data quality. We work collaboratively with other government entities, jurisdictions and non-government partners to enhance the availability of and access to national health data. We analyse this data securely and appropriately to provide insights to decision makers, building on a strong foundation of data governance.

We aim to attract and retain data professionals across a range of data fields and lift data literacy across the department. We will incorporate learnings and experience from the current Data Strategy into the development of the department's Data Strategy, to commence in 2026.

Evaluation

The Department of Health and Aged Care Evaluation Strategy 2023–26 provides a department-wide approach for consistent, robust and transparent evaluation of programs and policies. Our evaluation framework helps ensure decision making is evidence-based and covers policy outcomes, delivery, strategic contribution and value for money. The department scales evaluation activity to the size and risk of programs.

Financial Management Capability

We are responsible for a significant portion of the Commonwealth Budget. One of our core responsibilities is ensuring resources made available by government on behalf of the Australian community are managed in an efficient, effective, economical and ethical manner. We deliver a strong financial management framework to ensure we make evidence-based financial decisions and meet our financial accountability, performance and governance obligations. Our Finance Strategy sets out a long-term vision based on 3 pillars of our financial management framework:

1. a strong financial controls and assurance framework
2. providing credible, accurate and consistent financial information and advice
3. a financial governance framework which promotes the effective and efficient use of resources.

The department commissioned a comprehensive external review of its financial controls and assurance framework in 2023–24. The review assessed the financial controls and assurance activities across 10 financial functions and included a deep dive into the grant function. In addition, the review considered the department's finance strategy, financial delegations, and SAP financial application controls. The independent reviewer assessed the department's financial control and assurance framework as being fit for purpose, and operating at a defined maturity level. The review identified opportunities to improve the capability and maturity of both individual financial functions and the overall framework. These strategies include:

- development of a more in-depth risk-based assurance methodology
- adoption of automation opportunities
- enhancement of policy, procedural, and strategy documentation.

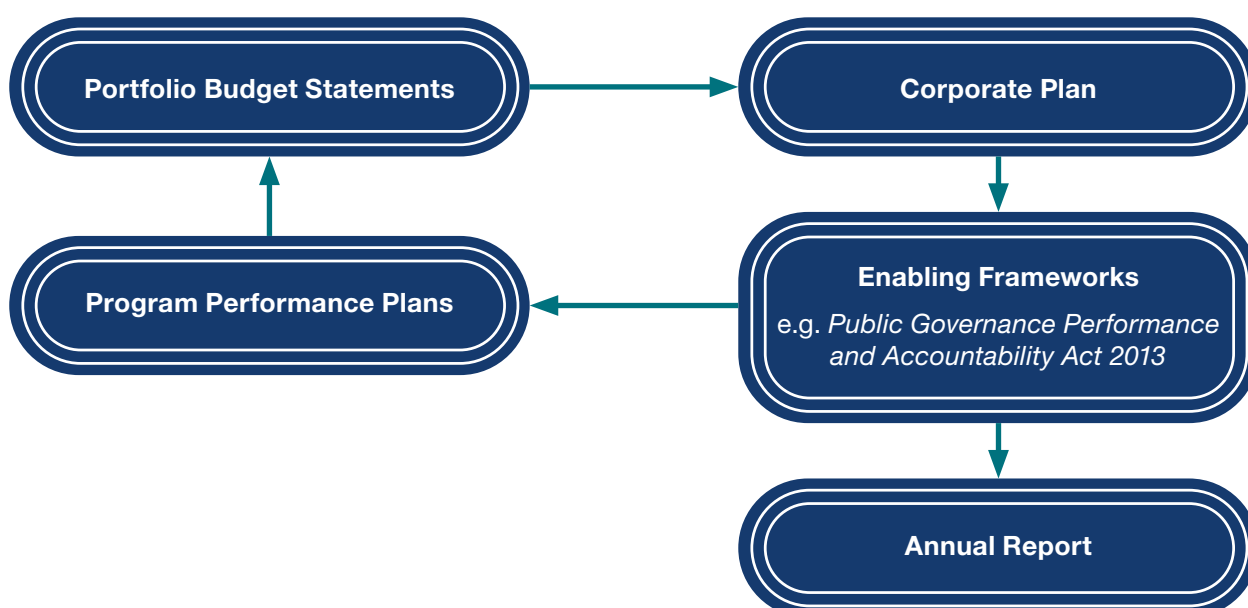


Our Performance Framework

Commonwealth Performance Framework

The Commonwealth Performance Framework is established by the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and requires entities to demonstrate how public resources have been applied to achieve their purposes. It outlines the obligations of accountable authorities to prepare corporate plans, with section 16E of the Public Governance, Performance and Accountability Rule 2014 (PGPA Rule) prescribing the requirements for corporate plans and performance information published by entities.

Department of Health, Disability and Ageing's Performance Planning Framework



Department's Performance Measurement and Reporting Framework

In addition to the Commonwealth Performance Framework, our Performance Measurement and Reporting Framework enables a clearer line of sight between planning, measuring, monitoring, evaluating and reporting performance, which in turn informs policy development and implementation.

	Planning	Reporting
External audience, less detail, broad scope	- Government priorities - Portfolio Budget Statements - Corporate Plan	- Annual Performance Statements - Annual Report
Internal audience, more detail, narrow scope	- Division business plans - Branch and section plans - Program and project plans - Individual performance and development plans	- Internal performance evaluation - Reporting to governance bodies - Program and project reporting - Individual performance reviews

Our Performance Assessment and Assurance

We assess our performance by measuring how we meet the objectives of our 21 Programs, and through them how we achieve our 4 Outcomes. For each program, we list the material key activities we will undertake, the associated delivery strategies, and the performance measures and planned performance results to track our progress.

These evidence-based performance elements are designed to both plan and report our performance reliably and consistently across multiple performance cycles. Assessments and results of our performance measurement identified in the 2025–26 Corporate Plan will be reported in the 2025–26 Annual Performance Statements (included in our Annual Report).

We seek to improve the clarity, reliability, and objectivity of our performance reporting through our Performance Measurement and Reporting Framework. This is achieved through:

- reviewing our performance information to ensure our key activities and corresponding performance measures are relevant, up-to-date and aligned with government priorities
- ongoing review to streamline and align performance information across the Portfolio Budget Statements, Corporate Plan and Annual Performance Statements
- ensuring performance data collected is reliable, verifiable and supported by proportionate assurance processes
- improving the identification and documentation of data sources and methodologies used to measure results against performance measures
- continuing analysis of performance measures to balance the mix of quantitative and qualitative measures of outputs, efficiency and effectiveness
- disclosing any limitations associated with the data and methodology used to assess performance
- seeking regular external assurance of performance information to ensure unbiased review of performance measures and the associated planned performance for adherence to the PGPA Rule.

These steps will help us ensure consistency and ‘clear read’ is achieved between key reporting documents, thereby making our reporting more aligned with our legislative requirements to the Australian Government, Parliament and the public.

Performance Measurement

To track how well we are delivering our programs, we use a clear rating system. Each goal we set is assessed using planned performance results, and we rate the outcomes as:

- **Achieved**
- **Substantially Achieved**
- **Not Achieved**

Each program in this Plan explains how its performance will be measured and what success looks like.

In some cases, it’s not practical to set a specific target—especially for programs that are demand-driven. Even so, we still monitor and assess these activities. The results will be reported in our 2025–26 Annual Performance Statements, along with an analysis explaining how we performed.

Outcome 1



Health Policy, Access and Support

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.

Outcome 1 is delivered through the following programs:

Program 1.1: Health Research, Coordination and Access

Program 1.2: Mental Health and Suicide Prevention

Program 1.3: First Nations Health

Program 1.4: Health Workforce

Program 1.5: Preventive Health and Chronic Disease Support

Program 1.6: Primary Health Care Quality and Coordination

Program 1.7: Primary Care Practice Incentives and Medical Indemnity

Program 1.8: Health Protection, Emergency Response and Regulation

Program 1.9: Immunisation

Program 1.1



Program 1.1: Health Research, Coordination and Access

Program Objective

Fund Australian health and medical research, blood fractionation and blood related products.

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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
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. Disburse at least 99% of MRFF funds available in 2026–27 towards grants of financial assistance. b. 100% of grants awarded in 2026–27 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.	a. Disburse at least 99% of MRFF funds available in 2027–28 towards grants of financial assistance. b. 100% of grants awarded in 2027–28 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.	a. Disburse at least 99% of MRFF funds available in 2028–29 towards grants of financial assistance. b. 100% of grants awarded in 2028–29 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.

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.⁹

Planned Performance Rationale:

The legislated purpose of the MRFF is to provide grants of financial assistance to support research that contributes to improving the health and wellbeing of all Australians. To do this, the *Medical Research Future Fund Act 2015* (MRFF Act) requires that funding decisions consider the Australian Medical Research and Innovation Priorities. These priorities are developed by the Australian Medical Research Advisory Board after stakeholder consultation.

By reporting MRFF funding decisions against the Australian Medical Research and Innovation Priorities, the department is demonstrating how research funded from the MRFF is addressing the health priorities of Australians.

Data Sources:

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 (BGH) 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.1 – Health Research, Coordination and Access – pages 54–55.

Measure owner:

Health Economics and Research Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective.

⁹ 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.

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.

Under the *National Health Act 1953*, the department receives funding for the National Blood Authority for blood fractionation products and blood related products through a Special Appropriation.

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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Program is demand driven	Program is demand driven	Program is demand driven	Program is demand driven

Planned Performance Rationale:

The Australian Government is committed to ensure a safe, secure, adequate and affordable supply of blood and blood products for all Australians. The National Blood Authority – as a statutory agency within the Australian Government’s Health, Disability and Ageing portfolio – manages and coordinates arrangements for the national supply of blood, blood products and blood services on behalf of all Australian governments in accordance with the National Blood Agreement.

The department is committed to support the National Blood Authority through annual funding against identified metrics in their Annual Report. This funding is complemented by funds from state and territory governments, under nationally agreed arrangements.

Data Sources:

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 National Blood Authority in 2025–26 for the national supply of blood and blood related products under the Special Appropriation.

Authority source:

New performance measure in 2025–26.

Measure owner:

Technology Assessment and Access Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

Program 1.2



Program 1.2: Mental Health and Suicide Prevention

Program Objective

Support the mental health and wellbeing of all Australians by facilitating access to high quality, affordable, culturally appropriate and timely mental health and suicide prevention services.

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

This key activity facilitates the delivery of national programs and services for mental health across the continuum of care, including Medicare Mental Health Centres and headspace.

Performance Measure 1.2A:

Number of mental health service contacts.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Program is demand driven ¹⁰	Program is demand driven	Program is demand driven	Program is demand driven

Planned Performance Rationale:

Mental health service utilisation is predominantly demand-driven and shaped by a range of external factors, including population needs and broader social determinants. Given the inherent variability in demand, establishing a fixed performance target for service usage is not considered a practicable or meaningful measure of system performance. An increase in the number of service contacts for mental health services indicates that the department has facilitated the delivery of mental health services along the continuum of care and that service capacity and access is improving.

Forecasted increasing provision of funding for delivery of new services is intended to contribute to an outcome of improved system capacity and access.

The department considers performance of this measure in the context of population mental health trends (e.g. prevalence and psychological distress) and uptake of other services (e.g. crisis lines, state and territory).

¹⁰ The planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements.

Data Sources:

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. Primary Mental Health Care Minimum Data Set (PMHC MDS). The PMHC MDS provides the basis for Primary Health Networks (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 (hAPI). 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 (hAPI). 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.2 – Mental Health and Suicide Prevention – page 56.

Measure owner:

Mental Health and Suicide Prevention Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

Key Activity 1.2B: Facilitate the implementation and delivery of suicide prevention initiatives.

This key activity facilitates the delivery of suicide prevention initiatives which aim to drive reform and improve the mental health and wellbeing of Australians.

Performance Measure 1.2B:

Number of service contacts for Universal Aftercare¹¹ services.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Program is demand driven ¹²	Program is demand driven	Program is demand driven	Program is demand driven

Planned Performance Rationale:

Mental health service utilisation is predominantly demand-driven and shaped by a range of external factors, including population needs and broader social determinants. Given the inherent variability in demand, establishing a fixed performance target for service usage is not considered a practicable or meaningful measure of system performance. An increase in the number of service contacts for suicide prevention services indicates that the department has facilitated the implementation and delivery of suicide prevention services and service capacity is improving.

The departmental disbursement of funds for delivery of these services is intended to contribute to an outcome aim of improved system capacity to respond to people who are at risk of suicide, experiencing suicidal distress or crisis or following a suicide attempt.

The department considers performance of this measure in the context of population mental health trends (e.g. prevalence and psychological distress), and uptake of other services (e.g. crisis lines, state and territory).

Data Source:

The Primary Mental Health Care Minimum Data Set (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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.2 – Mental Health and Suicide Prevention – page 56.

Measure owner:

Mental Health and Suicide Prevention Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

¹¹ 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.

¹² The planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements.

Program 1.3



Program 1.3: First Nations Health

Program Objective

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

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.¹³

This key activity provides funding to ACCHOs to enable the delivery of comprehensive primary health care and seeks to address barriers in accessing culturally appropriate health care through prioritising the community controlled health sector for the delivery of programs and services. This aligns to Priority Reform 2 of the National Agreement on Closing the Gap: Building the Community Controlled Sector.

Performance Measure 1.3A:

Increase the percentage of annual Indigenous Australians' Health Programme (IAHP) funding directed to ACCHOs.¹⁴

Planned Performance

2025–26	2026–27	2027–28	2028–29
74%	76%	78%	80%

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

- **Achieved:** $\geq 74\%$.
- **Substantially achieved:** 72.1% to 73.9%.
- **Not achieved:** $\leq 72\%$.

Planned Performance Rationale:

This program aims to deliver a year-on-year increase in the portion of funding directed to ACCHOs, in line with Priority Reform 2 of the National Agreement. The IAHP was established to fund First Nations-led, culturally appropriate initiatives to increase access to health care and improve the health of First Nations people.

Planned performance has been forecasted in line with ongoing commitment to transition.

Where appropriate, services delivered through non-indigenous organisations to ACCHOs support new entrants to the ACCHOs sector and work being undertaken as part of the department's First Nations Health Funding Transition Program.¹⁵ Increased investment in ACCHOs provides First Nations people with the choice and opportunity to access ACCHOs and receive culturally appropriate health care.

¹³ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

¹⁴ A minor amendment has been made to the performance measure since the release of the 2025–26 Portfolio Budget Statements to include the word 'increase'.

¹⁵ Further information on the First Nations Health Funding Transition Program can be found at: www.health.gov.au/our-work/first-nations-health-funding-transition-program-fnhftp

Data Source:

Financial data is sourced 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).

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.3 – First Nations Health – page 57–58.

Measure owner:

First Nations Health Division.

Changes since 2024–25 Corporate Plan:

Revisions to the program objective, key activity and performance measure.

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.¹⁶

This key activity seeks to increase access to comprehensive, holistic health care through targeted initiatives for health issues that have a significant, disproportionate impact on First Nations people. This activity supports needs-based, community-driven programs through health services including but not limited to ACCHOs. This is central to delivering on the objectives of the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 and contributes to Targets 1 (life expectancy) and 2 (healthy birthweight) of the National Agreement on Closing the Gap.

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.^{17,18}

Planned Performance

2025–26	2026–27	2027–28	2028–29
49% ¹⁹	51%	53%	55%

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

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

Planned Performance Rationale:

An annual Medicare Benefits Schedule 715 health check is available to all First Nations people. The planned performance targets are for First Nations people. Health checks have been determined as an appropriate measure on the basis that 715 health checks are an access point to comprehensive health care, including referral to targeted health initiatives supporting early intervention, prevention and chronic disease management.

Planned performance has been determined based on past performance trends and forecasted based on current policy initiatives²⁰ to drive an increased uptake of 715 health checks.

Current policy initiatives to increase health assessment uptake rates are expected to result in a gradual but steady improvement of around 2% per year during the 2025–29 period.

Data Source:

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

¹⁶ A minor amendment has been made to the key activity since the release of the 2025–26 Portfolio Budget Statements to include the word 'support'.

¹⁷ 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

¹⁸ A minor amendment has been made to the performance measure since the release of the 2025–26 Portfolio Budget Statements to include the word 'increase'.

¹⁹ Planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements to reflect calendar year reporting based on data availability and to include children under 15 years. This has resulted in a slight decrease in planned performance as uptake of 715 health checks is lower than adults aged 15 years plus.

²⁰ Further information on current policy initiatives can be found at: www.health.gov.au/ministers/the-hon-mark-butler-mp/media/government-backs-deadly-choices-preventative-health-program

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.3 – First Nations Health – page 58.

Measure owner:

First Nations Health Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.



Program 1.4



Program 1.4: Health Workforce

Program Objective

Improve the quality, distribution and planning of the Australian health workforce to better meet the needs of the community and deliver a sustainable, well distributed health workforce.

Key Activity 1.4A: Fostering a sustained growth of the health workforce.

This key activity reports the growth trend in the supply of the health workforce to ensure effectiveness of the National Medical Workforce Strategy in enabling a sustained growth across the health workforce.

Performance Measure 1.4A:

Annual change in headcount across the health workforce.

Planned Performance

2025–26 ²¹				2026–27	2027–28	2028–29
Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners	Number of Nurses & Midwives	Number of Allied Health practitioners ²²	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.
M1 – Metropolitan	28,052	285,440	167,179			
MM2 – Regional centres	4,763	40,453	18,538			
MM3 – Large rural towns	4,013	30,010	13,334			
MM4 – Medium rural towns	2,823	13,668	6,820			
MM5 – Small rural towns	3,630	14,617	5,887			
MM6 – remote communities	1,090	4,063	1,614			
MM7 – Very remote communities	1,327	2,646	865			

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

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

²¹ The planned performance targets have been updated since the release of the 2025–26 Portfolio Budget Statements.

²² 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.

Planned Performance Rationale:

The planned performance demonstrates the impact of a number of the program's activities under the National Medical Workforce Strategy related to improving the quality, distribution and planning of the Australian health workforce.

The planned performance seeks an annual increase to ensure Australian communities continue to be supported through access to Primary Care General Practitioners (GPs), nurses and allied health practitioners within their locations.

Data Sources:

Number of Primary Care General Practitioners: Medicare Benefits Schedule (MBS) dataset, **Calendar Year 2023** (latest available). 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), **2023** (latest available). 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.²³ 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 Practitioners²⁴ 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.4 – Health Workforce – page 59–60.

Measure owner:

Health Workforce Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and performance measure.

²³ Further information on the methodology to count GPs and calculate GP FTE can be found at: hwd.health.gov.au/resources/information/methods-gp-workload.html

²⁴ 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.

Key Activity 1.4B: Distributing Primary Care General Practitioners to facilitate equitable access to health care.

This key activity aims to facilitate improved access and more equitable distribution of medical services for communities, primarily through influencing the location of medical workforce in line with the geographic distribution of the population.

Performance Measure 1.4B:

Number of Primary Care General Practitioner FTE per 100,000 population (by Modified Monash Model).

Planned Performance

2025–26 ²⁵		2026–27	2027–28	2028–29
Location by Modified Monash Model (2023)	Primary Care GP FTE per 100,000 population	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.
MM1 – Metropolitan	111.9			
MM2 – Regional centres	107.5			
MM3 – Large rural towns	124.5			
MM4 – Medium rural towns	125.8			
MM5 – Small rural towns	77.8			
MM6 – Remote communities	66.8			
MM7 – Very remote communities	70.6			
Australia total	109.6			

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

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

²⁵ The planned performance targets have been updated since the release of the 2025–26 Portfolio Budget Statements.

Planned Performance Rationale:

This performance measure reports the number of Primary Care General Practitioner Full Time Equivalent (FTE) per 100,000 population by Modified Monash Model (MMM) region.

Locating adequate medical workforce in line with the geographic distribution of the population is a key factor in ensuring all Australians have access to the care they need when they need it.

The Australian Government administers several statutory schemes and workforce programs designed to geographically distribute medical workforce in line with need. While these activities cover GPs and non-GP specialists, the distribution of Primary Care GPs is a key focus because of their critical role in both direct service delivery and facilitating access to the wider health care system.

The planned performance projections consider:

1. The Supply and Demand Study for GPs²⁶ has a workforce projection model showing an undersupply of GPs over the next 25 years. The GP shortfall is further conflated with projections showing the departure rate of GPs from the workforce is outpacing the rate of new entrants.

The analysis indicates we will not have the total number of GPs required to keep up with the demand for GP services in many communities.

2. The Working Better for Medicare Review²⁷ examined how effective our current health workforce distribution levers are. These levers consist of policies and geographic classifications that are intended to distribute health workforce across areas that need them most.

Medical workforce distribution policies and programs seek to increase the overall Primary Care GP FTE per 100,000 population across Australia. An increase in planned performance targets demonstrates the departments commitment to drive and effectively implement into action key strategies and initiatives outlined in government policies.

Data Sources:

Primary Care GP FTE: Medicare Benefits Schedule (MBS) dataset, **Calendar Year 2023** (latest available). This administrative dataset capturing Medicare services is owned by the department in partnership with Services Australia.

Population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP), **Calendar Year 2023** (latest available) for 2025–26 figures. 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.²⁸

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: $100,000 * GP\ FTE / Population$.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.4 – Health Workforce – page 60.

Measure owner:

Health Workforce Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

²⁶ Further information on the Supply and Demand Study for GPs can be found at: hwd.health.gov.au/supply-and-demand/gp-supply-demand-study.html

²⁷ Further information on the Working Better for Medicare Review can be found at: www.health.gov.au/our-work/working-better-for-medicare-review

²⁸ Further information on the methodology to count GPs and calculate GP FTE can be found at: hwd.health.gov.au/resources/information/methods-gp-workload.html

Key Activity 1.4C: Training the next generation of Primary Care General Practitioners.

This key activity aims to support the delivery of a strong, well-distributed General Practitioner and Rural Generalist workforce across Australian communities.

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.

Planned Performance

2025–26 ²⁹		2026–27	2027–28	2028–29
Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners FTE active training	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2025–26 and further increases for each subsequent year.
MM1 – Metropolitan	1,571.4			
MM2 - Regional centres	529.2			
MM3 - Large rural towns	414.1			
MM4 - Medium rural towns	328.9			
MM5 - Small rural towns	300.0			
MM6 - Remote communities	106.9			
MM7 - Very remote communities	60.6			
Australia total	3,311.4			

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

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

Planned Performance Rationale:

The baseline performance levels report the enrolments of doctors in active general practitioner training, either by part-time or full-time training mode. Both the department and medical colleges are actively engaged to expand the awareness and benefits of a medical career in general practice.

Multiple pathways exist towards vocational registration as a specialist general practitioner in Australia. While government financial incentives are available to encourage doctors to specialise as a general practitioner, the decision and commitment towards undertaking such training resides with the individual. Medical colleges play a significant role to promote the benefits of general practice as a professional career – and in providing world-class medical training curricula and standards.

Government initiatives implemented in recent years encourage vocational training to be undertaken outside of metropolitan areas. Medical colleges have structured their medical training and mentor programs to accommodate doctors residing and working in regional and rural areas.

²⁹ The planned performance targets have been updated since the release of the 2025–26 Portfolio Budget Statements.

Data Sources:

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 2023** (latest available complete data). 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 June 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.4 – Health Workforce – page 61.

Measure owner:

Health Workforce Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

Program 1.5



Program 1.5: Preventative Health and Chronic Disease Support

Program Objective

Support health and wellbeing through providing access to cancer screening programs and undertaking activities to reduce rates of harmful alcohol consumption and illicit drug use. Undertake activities to promote smoking and e-cigarette cessation and prevent uptake and encourage healthy lifestyles.

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

This key activity aims to support smoking and nicotine cessation and prevention through health promotion, education and cessation support activities at the individual and community level.

Performance Measure 1.5A:

Achieve preventive health target for smoking through reducing percentage of adults who smoke daily.³⁰

Planned Performance

2025–26	2026–27	2027–28	2028–29
Progressive decrease of daily smoking prevalence towards <5%.	Progressive decrease of daily smoking prevalence towards <5%.	Progressive decrease of daily smoking prevalence towards <5%.	Progressive decrease of daily smoking prevalence towards <5%.

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.

Planned Performance Rationale:

The planned performance aligns with the National Preventive Health Strategy 2021–2030 (NPHS)³¹ and the National Tobacco Strategy 2023–2030 (NTS).³² The strategies commit to targets to reach a national daily smoking prevalence for adults (≥18 years) of less than 10% by 2025 and 5% or less by 2030.

Data Source:

Household, Income and Labour Dynamics in Australia (HILDA).³³

³⁰ The performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

³¹ Further information on the National Preventive Health Strategy 2021–2030 can be found at: www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030

³² Further information on the National Tobacco Strategy 2023–2030 can be found at: www.health.gov.au/resources/publications/national-tobacco-strategy-2023-2030

³³ Further information is available at: www.dss.gov.au/long-term-research/living-australia-household-income-and-labour-dynamics-australia-hilda-survey

Methodology:

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

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.5 – Preventative Health and Chronic Disease Support – page 62–63.

Measure owner:

Population Health Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and performance measure. The Data Source and Methodology has been updated from the Australian Bureau of Statistics National Health Survey and interim smoking datasets to HILDA data for 2025–26 to support annual data availability.

Key Activity 1.5B: Alcohol and other drug treatment services.³⁴

This key activity aims to support access to treatment services for alcohol and other drugs.

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.³⁵

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. Grant agreements with treatment service providers are executed on time.	a. As per 2025–26	a. As per 2025–26	a. As per 2025–26
b. Treatment service providers meet their identified key performance indicators.	b. As per 2025–26	b. As per 2025–26	b. As per 2025–26

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%.

Planned Performance Rationale:

- a. The timely execution of grants with alcohol and other drug treatment service providers supports patient access to services.
- b. Ensuring that expected contractual key performance indicators are met supports the delivery of treatment services provided.

Data Sources:

- 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.

³⁴ This key activity has been refined following the 2025–26 Portfolio Budget Statements.

³⁵ The performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.5 – Preventative Health and Chronic Disease Support – page 64.

Measure owner:

Population Health Division.

Changes since 2024–25 Corporate Plan:

Revision to the key activity and performance measure.



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.³⁶

This key activity administers the cancer screening programs, enabling eligible Australians to participate in cancer screening, to improve early detection, access to treatment and survival outcomes for people with cancer.

Performance Measure 1.5C:^{37, 38}

Administer the 3 cancer screening programs:

- National Bowel Cancer Screening Program.
- National Cervical Screening Program.
- National Lung Cancer Screening Program.

Planned Performance

2025–26	2026–27	2027–28	2028–29
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 (%).	As per 2025–26	As per 2025–26	As per 2025–26

³⁶ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

³⁷ The performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements. This performance measure was reported as 1.5E in the 2025–26 Portfolio Budget Statements.

³⁸ Please note the former component for c. – the BreastScreen Australia Program has been removed following the 2025–26 Portfolio Budget Statements, as the Commonwealth co-funds and provides national policy and clinical frameworks for the program. The Commonwealth does not have a direct role in program delivery.

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 <100.0% – a. b. and c.
2. Bowel test kits sent/due to be sent
 - a. 97.0% to <100.0% – a.
3. Follow up contacts made/due to be made
 - a. 97.0% to <100.0% – 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.

Planned Performance Rationale:

- a. National Bowel Cancer Screening Program.
 - b. National Cervical Screening Program.
 - c. National Lung Cancer Screening Program.
1. Correspondence sent/due to be sent – a. b. and c.
 - demonstrates the performance of the program in contacting participants who are due for screening.
 2. Bowel test kits sent/due to be sent – a.
 - demonstrates the performance of the program in sending kits to participants.
 3. Follow up contacts made/due to be made – a. b. and c.
 - demonstrates the performance of the program in contacting participants for follow up.

Data Sources:

- 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 - Combined (Australian Institute of Health and Welfare/ National Cancer Screening Register Service Provider/Bowel test kit supplier) (a.).
 3. Follow up contacts made/due to be made - National Cancer Screening Register Service Provider (a. b. and c.).
-

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.).
-

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.5 – Preventative Health and Chronic Disease Support – page 65–66

Measure owner:

Cancer, Hearing and Chronic Conditions Division.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity performance measure and planned performance targets. New performance measure added for component c. National Lung Cancer Screening Program. Removal of BreastScreen Australia Program from measure.



Program 1.6



Program 1.6: Primary Health Care Quality and Coordination

Program Objective

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

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.³⁹

This key activity aims to support PHNs to deliver national programs that ensure quality primary health care services are available to their communities.

Performance Measure 1.6A:

PHNs are meeting delivery objectives for national programs.⁴⁰

Planned Performance

2025–26	2026–27	2027–28	2028–29
28 ⁴¹	28	29	29

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

Achieved: 28.

Substantially achieved: 26 to 27.

Not achieved: ≤25.

Planned Performance Rationale:

The performance measure assesses performance across 3 national programs commissioned by PHNs in the areas of Mental Health (headspace National Youth Mental Health program), Aged Care (Care Finder program) and Drug and Alcohol treatment (National treatment program).

The planned performance target of 28 is selected, as it demonstrates the large majority of PHNs have met the individual performance criteria to achieve the result.

³⁹ This key activity has been refined following the 2025–26 Portfolio Budget Statements to detail the delivery of key national programs.

⁴⁰ This performance measure has been updated since the 2025–26 Portfolio Budget Statements to better reflect the key activities of PHNs and their impact in the primary health care system.

⁴¹ The planned performance targets have been updated since the 2025–26 Portfolio Budget Statements to align with the revised performance measure.

Data Sources:

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.6 – Primary Health Care Quality and Coordination – page 66.

Measure owner:

Primary Care Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

Key Activity 1.6B: Support state and territory governments and PHNs to deliver Medicare Urgent Care Clinics (UCCs).

This key activity aims to reduce pressure on hospital Emergency Departments (EDs) by supporting use of Medicare UCCs which provide access to a free alternative care option for urgent and non-life threatening conditions.

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.⁴²

Planned Performance

2025–26	2026–27	2027–28	2028–29
Establish baseline.	To be determined. ⁴³	To be determined.	To be determined.

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.

Planned Performance Rationale:

The measure assesses whether the Medicare UCC program is achieving the desired long-term outcome of reducing pressure on hospital emergency departments (EDs) by diverting patients to Medicare UCCs for treatment of urgent non-life-threatening conditions.

The Medicare UCC program is in its second year of operation and the planned performance for 2025–26 is for a baseline to be established. The 2025–26 baseline will be based on the current number of Medicare UCCs (76) that have compatible IT which enables them to submit Module data that captures information about where the patient would have otherwise gone.⁴⁴ The 2025–26 baseline figure will be used to extrapolate the expected number of ED diversions for future years for all clinics submitting Module data.

Data Sources:

- 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.

⁴² This performance measure was reported as 1.6D in the 2025–26 Portfolio Budget Statements.

⁴³ This will be determined after the 2025–26 baseline is established.

⁴⁴ There are currently a total of 87 Medicare UCCs operating. A further 50 Medicare UCCs are set to be established in 2025–26. Further information can be found at: www.health.gov.au/find-a-medicare-ucc

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.6 – Primary Health Care Quality and Coordination – page 68.

Measure owner:

Primary Care Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.



Program 1.7



Program 1.7: Primary Care Practice Incentives and Medical Indemnity

Program Objective

Provide incentive payments to eligible general practices through the Practice Incentives Program (PIP) to incentivise, promote and support general practices to deliver quality care, strengthen practice capacity, and enhance patient access and health outcomes.

Key Activity 1.7A: Providing Practice Incentives Program (PIP) payments to eligible general practices.

This key activity ensures eligible participating general practices are supported to deliver quality care, enhance capacity and improve access and outcomes for patients. To be eligible to participate in the PIP, a general practice, Aboriginal Medical Service or an Aboriginal Community Controlled Health Service must be accredited or registered for accreditation under the National General Practice Accreditation (NGPA) Scheme.

Performance Measure 1.7A:

The percentage of general practices accredited under the NGPA Scheme participating in PIP.⁴⁵

Planned Performance

2025–26	2026–27	2027–28	2028–29
≥95.0%	≥95.0%	≥95.0%	≥95.0%

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

- **Achieved:** ≥95.0%.
- **Substantially achieved:** ≥92.5% to 94.9%.
- **Not achieved:** <92.5%.

Planned Performance Rationale:

The percentage of general practices accredited under the NGPA Scheme participating in PIP has grown steadily since the commencement of the program in 1999.

The growth trajectory reflects a strong engagement from the sector. Current data and trend analysis indicate that PIP is approaching a natural saturation point, with the majority of general practices already participating.

The planned performance of ≥95.0% is expected to remain consistent for the duration of 2025–26 to 2028–29 as the percentage of general practices accredited under the NGPA Scheme participating in PIP has begun to reach saturation point.

While planned performance targets have been included for future years, it should be noted that PIP is a demand driven program which provides a challenge in predicting future outcomes.

⁴⁵ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

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.

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.7 – Primary Care Practice Incentives and Medical Indemnity – page 69.

Measure owner:

Primary Care Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and performance measure.

Program 1.8

Program 1.8: Health Protection, Emergency Response and Regulation

Program Objective

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

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

This key activity ensures the regulation of therapeutic goods in accordance with statutory timeframes.

Performance Measure 1.8A:

Percentage of therapeutic goods evaluations that meet statutory timeframes.

Planned Performance

2025–26	2026–27	2027–28	2028–29
100% ⁴⁶	100%	100%	100%

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

- **Achieved:** 100%.
- **Substantially achieved:** N/A.
- **Not achieved:** <100%.

Planned Performance Rationale:

The planned performance target has been established at 100% in evaluating therapeutic goods within statutory timeframes. This measure demonstrates the performance of the Therapeutic Goods Administration (TGA) against the requirements of the *Therapeutic Goods Act 1989*.

The TGA demonstrates success by publishing evaluation timeframes in external performance reports, the achievement of which builds public trust and confidence in the performance of our regulatory functions. It also ensures we continue to minimise duplication and harmonise activities with international regulators to achieve better regulatory outcomes, thus reducing the compliance burden on industry.

For the 2025–26 reporting period, the TGA will transition from averaging percentages from each evaluation area to reaching a percentage based on overall volumes of evaluation conducted. This transition will more accurately reflect the actual percentage of evaluations meeting the statutory timeframes, better aligning reporting with the intent of the measure.

⁴⁶ The planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements.

Data Sources:

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:

Individual program areas across TGA that conduct evaluations under statutory timeframes calculate the total number of evaluations completed (as defined for that program) and the total number of evaluations that met statutory timeframes (as defined for that program).

The data is converted into a percentage for the performance measure by using the total number of evaluations completed within statutory timeframes (numerator) divided by the total number of evaluations that are subject to statutory timeframes (denominator), undertaken during the reporting period for all of TGA.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.8 – Health Protection, Emergency Response and Regulation – page 70.

Measure owner:

Therapeutic Goods Administration.

Changes since 2024–25 Corporate Plan:

Revision made to the planned performance target (previously 98%).

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.

This key activity ensures the regulation of controlled drugs, including compliance monitoring and inspections of licence holders to prevent illicit supply and use whilst maintaining access to essential medications.

Performance Measure 1.8B:

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

Planned Performance

2025–26	2026–27	2027–28	2028–29
32	35	36	36

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

- **Achieved:** ≥ 32 .
- **Substantially achieved:** N/A.
- **Not achieved:** < 32 .

Planned Performance Rationale:

This measure demonstrates the Office of Drug Control's (ODC) performance against the program's objective by measuring compliance functions of regulated entities in relation to the *Narcotics Drugs Act 1967*, while increasing awareness and maintaining safety for all Australians.

Planned performance has been set to reflect realistic targets based on past performance data, risk assessment, operational capacity and the number of active licence holder sites.

While maintaining high compliance levels and completing inspections remains a priority, the planned performance levels ensure alignment with actual observed performance trends based on ODC's risk matrix and the resources available to conduct inspections under the *Narcotic Drugs Act 1967*.

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.8 – Health Protection, Emergency Response and Regulation – page 70.

Measure owner:

Office of Drug Control.

Changes since 2024–25 Corporate Plan:

No changes.

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).⁴⁷

This key activity ensures the department meets its obligations under the *Gene Technology Act 2000*, through ensuring regulation of the National Gene Technology Scheme.

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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. ≥98%	a. ≥98%	a. ≥98%	a. ≥98%
b. ≥98%	b. ≥98%	b. ≥98%	b. ≥98%

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%.

Planned Performance Rationale:

This measure focuses on the activities of the Office of Gene Technology Regulator (OGTR) in regulating dealings with GMOs to protect people and the environment. The measure reflects the annual reporting requirements prescribed in the *Gene Technology Act 2000*, regulatory functions of most interest to the Commonwealth, state and territory governments, and the majority of key outputs that deliver the object of the legislation. The measure will indicate the Regulator's performance in identifying and managing risks to human health and safety or to the environment posed by or as a result of gene technology.

- a. The Regulator routinely meets statutory timeframes, and this reflects the effectiveness of assessing human health and environmental risks while supporting the needs and expectations of the regulated community.
- b. A high level of industry compliance with requirements has been achieved through a combination of education, monitoring and compliance activities. The target measures our ability to maintain this high level of industry compliance by identifying and responding to potential non-compliances.

The Gene Technology Legislation places no limits on when and how many applications can be made. The planned performance target of ≥98% allows for flexibility in the case of a surge in the number of applications received beyond that which can be evaluated in the required timeframe, or when reports of non-compliance are received immediately prior to the end of the financial year.

⁴⁷ This key activity has been amended since the release of the 2025–26 Portfolio Budget Statements to better capture the breadth of the work being undertaken against this measure.

Data Sources:

- a. The date a new application is received by the 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 & 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 & 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).

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.8 – Health Protection, Emergency Response and Regulation – page 71.

Measure owner:

Office of the Gene Technology Regulator.

Changes since 2024–25 Corporate Plan:

Revision to the key activity.

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.

By completing industrial chemical risk assessments within statutory timeframes, the Australian Industrial Chemicals Introduction Scheme (AICIS) provides regulatory oversight of industrial chemical introduction through timely, evidence-based advice to risk managers and information to the public. This activity strengthens Australia's capacity to detect, prevent and respond to health and environmental risks, directly supporting the Program Objective. At the same time, it enables industry to make informed decisions and plan with confidence under the *Industrial Chemicals Act 2019*.

Performance Measure 1.8D:

Proportion of Industrial chemical risk assessments completed within statutory timeframes.

Planned Performance

2025–26	2026–27	2027–28	2028–29
≥95%	≥95%	≥95%	≥95%

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

- **Achieved:** ≥95%.
- **Substantially achieved:** ≥90% to <95%.
- **Not achieved:** <90%.

Planned Performance Rationale:

The planned performance target of ≥95% is designed to ensure sufficient time to thoroughly assess the risks associated with industrial chemicals and provide sound recommendations to mitigate those risks, aligning with community expectations for Government to prioritise clear, accurate safety outcomes. A 100% target is not practical given the complexity of pre-market chemical assessments and the potential for unpredictable factors, such as unique chemical profiles or the need for additional information, which can delay completion. As a cost-recovered Scheme, AICIS is resourced to minimise regulatory burden while maintaining high standards. The ≥95% target reflects a realistic and evidence-based benchmark, informed by operational experience since the scheme commenced.

Data Sources:

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

$$\text{Result} = \frac{a_{\text{completed within timeframe}} + b_{\text{completed within timeframe}} + c_{\text{completed within timeframe}}}{a_{\text{total completed}} + b_{\text{total completed}} + c_{\text{total completed}}}$$

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.8 – Health Protection, Emergency Response and Regulation – page 71.

Measure owner:

Australian Industrial Chemicals Introduction Scheme.

Changes since 2024–25 Corporate Plan:

No changes.

Program 1.9



Program 1.9: Immunisation

Program Objective

Implement the National Immunisation Program to protect the Australian community from vaccine preventable diseases.

Key Activity 1.9A: Increase immunisation coverage rates by implementing the National Immunisation Program.⁴⁸

This key activity aims to support access to immunisation through delivery of the National Immunisation Program.

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.⁴⁹
- 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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. ≥95.00%	a. ≥95.00%	a. ≥95.00%	a. ≥95.00%
b. Progressive increase towards ≥95.00%	b. Progressive increase towards ≥95.00%	b. Progressive increase towards ≥95.00%	b. Progressive increase towards ≥95.00%
c. Progressive increase towards ≥90.00%	c. Progressive increase towards ≥90.00%	c. Progressive increase towards ≥90.00%	c. Progressive increase towards ≥90.00%

⁴⁸ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁴⁹ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements. The measure remains equivalent to the 2024–25 measure.

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

- **Achieved:**
 - a. $\geq 95.00\%$.
 - 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.
-

Planned Performance Rationale:

The planned performance is set at 95% for children at 5 years of age and First Nations children 12 to 15 months of age to support herd immunity and contribute to closing the gap in immunisation coverage between First Nations and non-First Nations children. The target reflects the protective threshold required to prevent outbreaks of vaccine preventable diseases in the community.

The planned performance for HPV vaccinations among 15-year-olds is set at 90% by 2030, aligning with the National Strategy for the Elimination of Cervical Cancer in Australia.⁵⁰ This target supports the broader public health goal of eliminating cervical cancer as a public health issue.

The measures were selected because they represent the largest eligible population groups under the National Immunisation Program (NIP) and are critical to achieving long term public health outcomes. They also align with key national strategies, including the National Immunisation Strategy, Closing the Gap, the Essential Vaccines Schedule to the Federal Financial Agreement and the National Strategy for the Elimination of Cervical Cancer in Australia.

The performance measures assess the effectiveness of the NIP in increasing immunisation coverage and reducing the incidence of vaccine-preventable diseases. Coverage rates, sourced from the Australian Immunisation Register (AIR), provide annual visibility of community protection and program impact.

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.
-

Authority source:

Portfolio Budget Statements 2025–26, Outcome 1, Program 1.9 – Immunisation – page 72.

Measure owner:

National Immunisation Division.

Changes since 2024–25 Corporate Plan:

Revisions to the program objective and key activity. Minor update to the performance measure wording. The measure remains equivalent to the 2024–25 measure.

⁵⁰ Further information on the strategy can be found at: www.health.gov.au/resources/publications/national-strategy-for-the-elimination-of-cervical-cancer-in-australia

Outcome 2



Individual Health Benefits

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.

Outcome 2 is delivered through the following programs:

Program 2.1: Medical Benefits

Program 2.2: Hearing Services

Program 2.3: Pharmaceutical Benefits

Program 2.4: Private Health Insurance

Program 2.5: Dental Services

Program 2.6: Health Benefit Compliance

Program 2.7: Assistance through Aids and Appliances



Program 2.1



Program 2.1: Medical Benefits

Program Objective

Deliver a modern, sustainable Medicare Benefits Schedule (MBS) that provides rebates for Australians to support access to a wide range of clinical services, based on the best available evidence. Work with consumers, health professionals, private health insurers, and states and territories to implement Government initiatives to strengthen Medicare, and in particular bulk billed primary care services under Medicare.

Key Activity 2.1A: Provide access to subsidised health services.

This key activity assesses the effectiveness of the MBS policy and program in providing Australians with access to MBS services.

Performance Measure 2.1A:

Percentage of Australians accessing MBS services.

Planned Performance

2025–26	2026–27	2027–28	2028–29
>90%	>90%	>90%	>90%

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

- **Achieved:** >90%.
- **Substantially achieved:** 87% to 90%.
- **Not achieved:** <87%.

Planned Performance Rationale:

The Medicare system aims to provide eligible⁵¹ Australian residents and eligible visitors affordable, accessible and high-quality health care.

The planned performance of >90% demonstrates that the MBS is providing access to subsidised services that is at least equivalent to historical levels.

Any significant deviation from >90% within a 12 month period may be an indication of barriers that need to be addressed such as affordability, appropriateness of services offered, the availability of health professionals or of changes in the private hospital sector.

The planned performance reflects the Government's commitment to update the MBS, which includes recommendations emerging from the Continuous Review of the MBS, Medical Services Advisory Committee (MSAC) recommended listings and policy advice from the department.

⁵¹ Further information on who can enrol in Medicare can be found at: www.servicesaustralia.gov.au/enrolling-medicare

Data Sources:

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.⁵²

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.1 – Medical Benefits, page 78.

Measure owner:

Medicare Benefits and Digital Health Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective and key activity.

⁵² Further information can be found at: www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-downloads

Key Activity 2.1B: Patient visits to Medicare-subsidised General Practitioners.

This key activity aims to support patients to access General Practitioner services that are either fully or partially subsidised through Medicare.

Performance Measure 2.1B:

Percentage of Australians who had a GP Non-Referred Attendance claimed through the MBS.⁵³

Planned Performance

2025–26	2026–27	2027–28	2028–29
>85%	>85%	>85%	>85%

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

- **Achieved:** >85%.
- **Substantially achieved:** 82% to 85%.
- **Not achieved:** <82%.

Planned Performance Rationale:

The planned performance of >85% demonstrates that the program is providing support for Australians to receive primary care services, which are more effective and cost effective than other types of services (e.g. acute services) in preventing health conditions and managing existing chronic conditions. Any significant deviation from this level within a 12-month period would warrant a review to understand why people are changing their use of Medicare-subsidised General Practitioners.

The planned performance reflects the Government's commitment to update the MBS subsidies for Non-Referred GP attendances, which is supported by recommendations emerging from the Continuous Review of the MBS and policy advice from the department.

Data Sources:

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.⁵⁴

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.1 – Medical Benefits, page 79.

Measure owner:

Medicare Benefits and Digital Health Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

⁵³ The wording of this performance measure has been refined since the 2025–26 Portfolio Budget Statements (PBS). The measure remains equivalent to the 2025–26 measure reported in the PBS.

⁵⁴ Further information can be found at: www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-downloads

Key Activity 2.1C: Support access to bulk billed General Practice (GP) attendances.⁵⁵

This key activity aims to expand eligibility for GP bulk billing incentives to all Australians and support general practices to bulk bill all patients.

Performance Measure 2.1C:

GP Non-Referred Attendance Bulk Billing Rate.

Planned Performance

2025–26	2026–27	2027–28	2028–29
≥78.5% ⁵⁶	Annual increase on 2025–26 and further increases for each subsequent year.	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2027–28 and further increases for each subsequent year.

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

- **Achieved:** ≥78.5%.
- **Substantially achieved:** 78.0% to <78.5%.
- **Not achieved:** <78.0%.

Planned Performance Rationale:

The national GP Non-Referred attendance bulk-billing rate for the year to date (July to December 2024) is 77.5%. The planned performance for 2025–26 is based on the year to date bulk billing rate, plus 1 percentage point. The government is expanding GP bulk billing incentive eligibility to cover all Medicare-eligible patients from November 2025. Reducing financial barriers through improving access to bulk billed GP care supports Australians access to healthcare.

Data Source/s:

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.1 – Medical Benefits, page 79.

Measure owner:

Medicare Benefits and Digital Health Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

⁵⁵ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁵⁶ The planned performance target has been updated since the release of the 2025–26 Portfolio Budget Statements.

Program 2.2



Program 2.2: Hearing Services

Program Objective

Provide subsidised hearing services and devices to eligible people.

Key Activity 2.2A: Administration of the Hearing Services Program.⁵⁷

Performance Measure 2.2A:

The number of program clients that receive at least one hearing service in the reporting period.⁵⁸

Planned Performance

2025–26	2026–27	2027–28	2028–29
Program is demand driven ⁵⁹	Program is demand driven	Program is demand driven	Program is demand driven

Planned Performance Rationale:

The government is committed to ensuring eligible people have access to subsidised hearing services. Performance is subject to the number of eligible people that choose to seek program support for hearing loss within the reporting period.

Data Sources:

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.2 – Hearing Services, page 80.

Measure owner:

Cancer, Hearing and Chronic Conditions Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and performance measure. Revision to planned performance, reflecting demand driven status of the program.

⁵⁷ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁵⁸ The performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁵⁹ The Hearing Services Program is a demand driven program. The planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements.

Program 2.3



Program 2.3: Pharmaceutical Benefits

Program Objective

Administer the Pharmaceutical Benefits Scheme to provide eligible Australians with access to timely subsidised medicines, as prescribed by their treating clinicians.

Key Activity 2.3A: Ensure timely listing of prescription medicines on the Pharmaceutical Benefits Scheme.⁶⁰

This key activity aligns with the Government's broader National Medicines Policy, which aims to ensure timely and affordable access to medicines for all Australians.

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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
≥85% ⁶¹	≥90%	≥90%	≥90%

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

- **Achieved:** ≥85%.
- **Substantially achieved:** 80% to <85%.
- **Not achieved:** <80%.

Planned Performance Rationale:

This measure reports the percentage of PBAC recommendations for which negotiations with medicine sponsors and activities for listing on the Pharmaceutical Benefits Scheme are completed in a timely manner. The 6-month timeframe provides sufficient time to negotiate complex pricing and budget impact issues, seek agreement to listing arrangements, seek government approval, finalise and distribute the amended schedule of the Pharmaceutical Benefits Scheme.

Data Sources:

Data is sourced from internal departmental records and through the Medicine Status Website.⁶²

Data sources include the number of new medicines identified to be 'new drugs', the date of listing and the date of in-principle agreement.

⁶⁰ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁶¹ The planned performance targets have been updated since the release of the 2025–26 Portfolio Budget Statements.

⁶² Further information can be found at: www.pbs.gov.au/medicinesstatus/home.html

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 to calculate the measure:

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.3 – Pharmaceutical Benefits, page 81.

Measure owner:

Technology, Assessment and Access Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and planned performance targets.



Key Activity 2.3B: Provide affordable access to subsidised prescription medicines on the Pharmaceutical Benefits Scheme (PBS).⁶³

This key activity aims to support consumer affordability through maintaining the average cost for prescription medicines on the PBS.

Performance Measure 2.3B:

Average cost for prescriptions by consumer for PBS medicines.

Planned Performance

2025–26	2026–27	2027–28	2028–29
\$7.50	\$7.50	\$7.50	\$7.50

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

- **Achieved:** \$7.50.
- **Substantially achieved:** \$7.00 to <\$7.50.
- **Not achieved:** <\$7.00.

Planned Performance Rationale:

The planned performance seeks to maintain the average cost per script (subsidised and non-subsidised) paid by consumers for PBS medicines as an out-of-pocket cost payment. The government expenditure cost rate across all PBS subsidised prescriptions dispensed has increased from an average of \$28.00 per person per month in January 2013 to \$61.00 per person per month in December 2023. Recent statistics demonstrate the average patient contribution for subsidised medicines was around \$7.20. In part the staged introduction of the 60-day medicines⁶⁴ significantly reduced patient contribution costs. Initiatives, including the lowering of the Safety Net threshold⁶⁵ and the PBS co-payment freeze⁶⁶ are further reforms made by the government to provide Australians with access to affordable prescription medicines.

Data Sources:

Annual PBS Expenditure and Prescriptions Report.⁶⁷

Services Australia PBS claims data.

Methodology:

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

Average cost for prescriptions = $\frac{\text{Total Patient Contributions (by costs)}}{\text{Total PBS subsidised prescriptions (for Financial Year)}}$
by consumer for PBS medicines

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.3 – Pharmaceutical Benefits, page 81.

Measure owner:

Technology, Assessment and Access Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

⁶³ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁶⁴ 60-day prescriptions now apply to almost 300 medicines on the Pharmaceutical Benefits Scheme.

⁶⁵ As a cost-of-living measure, the Australian Government lowered the PBS Safety Net thresholds from 1 July 2022 by the equivalent of 12 fully priced scripts for concession card holders and the equivalent of approximately two fully priced scripts for non-concessional patients.

⁶⁶ On 1 January 2025, the government introduced a freeze on the maximum patient cost for all PBS medicines. This is a freeze on the co-payment Australians pay for PBS medicines. This means the cost of PBS medicines remains the same rate as 2024 and will not increase with indexation in 2025.

⁶⁷ Further information can be found at: www.pbs.gov.au/info/statistics/expenditure-prescriptions/pbs-expenditure-and-prescriptions

Program 2.4



Program 2.4: Private Health Insurance

Program Objective

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

Key Activity 2.4A: Assessment of private health insurer premium change applications.

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

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.⁶⁸

Planned Performance

2025–26	2026–27	2027–28	2028–29
100%	100%	100%	100%

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

- **Achieved:** 100%.
- **Substantially achieved:** N/A.
- **Not achieved:** <100%.

Planned Performance Rationale:

A 100% performance result demonstrates the department's capacity to undertake the detailed assessment and deliver timely advice to the Minister for Health, Disability and Ageing on applications from private health insurers within a limited timeframe. Timely approvals based on sector-agreed timeframes help maintain product availability for policyholders, provide insurers confidence in contracting with healthcare providers, support sector sustainability by aligning prices with healthcare costs, ensure effective administration of the \$7.2 billion PHI Rebate for 2024–25, and reinforce consumer confidence in value-for-money PHI products. Close consultation with private health insurers, APRA, and the Minister is required to meet the planned performance.

⁶⁸ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements. The measure remains equivalent to the 2024–25 measure.

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.
-

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.4 – Private Health Insurance, page 82.

Measure owner:

Health Systems Strategy Division.

Changes since 2024–25 Corporate Plan:

Minor revision to the performance measure.

Key Activity 2.4B: Implementation of private health insurance clinical category and procedure type classifications for Medicare Benefits Schedule (MBS) item changes.

This key activity aims to implement private health insurance clinical category and procedure type classifications for MBS item changes. This ensures that benefits payments and minimum benefits payments accurately reflect the MBS fee schedule.

Performance Measure 2.4B:

The percentage of PHI clinical category and procedure type classifications⁶⁹ which are implemented concurrently with associated MBS item changes.⁷⁰

Planned Performance

2025–26	2026–27	2027–28	2028–29
100%	100%	100%	100%

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

- **Achieved:** 100%.
- **Substantially achieved:** N/A.
- **Not achieved:** <100%.

Planned Performance Rationale:

The planned performance is set at 100% to provide assurance that PHI providers are appropriately funding healthcare providers and adequately supporting patients with accurate out of pocket costs.

If less than 100% of changes are classified and implemented private health insurers will not have the correct information for billing. Correct billing and minimal out of pocket costs are required to maintain consumer trust and position private health insurance as an affordable, cost-effective option for health care.

Data Source/s:

Data is sourced from the MBS XML files, published on the Medicare Benefits Schedule (MBS) Online website⁷¹ and the Private Health Insurance files, published on the department's website.⁷²

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.4 – Private Health Insurance, page 82.

Measure owner:

Health Systems Strategy Division.

Changes since 2024–25 Corporate Plan:

New performance measure in 2025–26.

⁶⁹ 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

⁷⁰ Further information on MBS items can be found at: mbsonline.gov.au

⁷¹ Further information can be found at: mbsonline.gov.au

⁷² Further information can be found at: www.health.gov.au/resources/collections/private-health-insurance-clinical-category-and-procedure-type

Program 2.5



Program 2.5: Dental Services

Program Objective

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

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.⁷³

This key activity aims to ensure eligible children are supported to access essential dental health services through the CDBS. Poor oral hygiene can lead to serious health issues, with early prevention key to fostering healthier communities.

Performance Measure 2.5A:

The percentage of eligible children⁷⁴ accessing essential dental health services through the Child Dental Benefits Schedule.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Program is demand driven ⁷⁵	Program is demand driven	Program is demand driven	Program is demand driven

Planned Performance Rationale:

The Child Dental Benefits Schedule (CDBS) is a demand driven program and it is not reasonably practicable to set a target. The department is committed to increasing the number of children accessing CDBS funded dental services for eligible children. This will improve oral health outcomes for eligible children (including in adulthood), with the aim to potentially reduce the adverse impact on the wider healthcare system.

Data Source:

CDBS Service Data (collected by Services Australia).

Methodology:

Data provided by Services Australia on CDBS utilisation.

⁷³ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁷⁴ 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

⁷⁵ The Child Dental Benefits Schedule is a demand driven program. The planned performance has been updated since the release of the 2025–26 Portfolio Budget Statements.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.5 – Dental Services, page 83.

Measure owner:

Primary Care Division.

Changes since 2024–25 Corporate Plan:

Revision to the key activity description. Revision to planned performance, reflecting demand-driven status of the CDBS program.



Program 2.6



Program 2.6: Health Benefit Compliance

Program Objective

Support the integrity of health benefit claims under the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Child Dental Benefits Scheme through identifying and treating non-compliance.

Key Activity 2.6A: Identify incorrect claiming and investigate for non-compliance.⁷⁶

This key activity aims to identify incorrect claiming and investigate for non-compliance, to support the integrity of health benefit claims.

Performance Measure 2.6A:

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

Planned Performance

2025–26	2026–27	2027–28	2028–29
>80%	>80%	>82%	>82%

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

- **Achieved:** >80%.
- **Substantially achieved:** 70% to 80%.
- **Not achieved:** <70%.

Planned Performance Rationale:

The department measures effectiveness of this program by identifying potentially incorrect claiming data and applying treatment through audits, practitioner reviews and/or investigations. The planned performance of >80% indicates that the mechanisms for identifying potentially incorrect claiming data are effective.

Data Sources:

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).

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.6 – Health Benefit Compliance, page 84.

Measure owner:

Benefits Integrity Division.

Changes since 2024–25 Corporate Plan:

Revision to the program objective and key activity.

⁷⁶ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

Program 2.7



Program 2.7: Assistance through Aids and Appliances

Program Objective

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

Key Activity 2.7A: Provide targeted assistance for aids and appliances to support Australians to manage diabetes.⁷⁷

This key activity aims to support access to diabetes supplies at subsidised costs to assist people with diabetes to better manage their condition. The department strives to strengthen the quality, availability, and affordability of diabetes supplies to ensure that people continue to have timely and reliable access to the supplies they need to manage their diabetes effectively.

Performance Measure 2.7A:

Number of people accessing subsidised products through the National Diabetes Services Scheme.

Planned Performance

2025–26	2026–27	2027–28	2028–29
>750,000	>765,000 ⁷⁸	>780,000	>795,000

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

- **Achieved:** >750,000.
- **Substantially achieved:** 725,000 to 750,000.
- **Not achieved:** <725,000.

Planned Performance Rationale:

The planned performance reports the number of people that have obtained National Diabetes Services Scheme (NDSS) subsidised supplies from one of the NDSS Access Points⁷⁹ over a calendar year. With over 1.48 million Australians⁸⁰ registered with diabetes on the NDSS, accessing subsidised diabetes products is critical for their ongoing health and assists with easing cost-of-living pressures. The number of people newly registered with the NDSS remained stabled in 2024–25 compared to the previous 12 months to 30 June 2024; on average 325 people with diabetes newly register with the NDSS every day.

The planned performance is based on historical trends and the estimates of people with diabetes who are eligible for subsidised diabetic products.

⁷⁷ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁷⁸ The planned performance targets have been updated since the release of the 2025–26 Portfolio Budget Statements.

⁷⁹ Further information on NDSS Access Points can be found at: www.ndss.com.au/products/access-points/

⁸⁰ An additional 189,336 women with post gestational diabetes are registered on the National Gestational Diabetes Register and receive NDSS information, support and communications.

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.

Authority source:

Portfolio Budget Statements 2025–26 Outcome 2, Program 2.7 – Assistance through Aids and Appliances, page 85.

Measure owner:

Technology, Assessment and Access.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity and planned performance targets.



Outcome 3



Ageing and Aged Care

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.

Outcome 3 is delivered through the following programs:

Program 3.1: Access and Information

Program 3.2: Aged Care Services

Program 3.3: Aged Care Quality

During 2025–26 the new rights-based *Aged Care Act 2024* will be implemented, along with the launch of the new Support at Home program and Single Assessment framework. These aged care reforms will put the rights of older people at the centre of the aged care system, making aged care safer, fairer and more respectful. New performance measures for home support assessments are reflected in Program 3.1 for 2025–26. As the staged implementation of the remaining new reforms continues across 2025–26, work will be undertaken to develop and benchmark meaningful performance measures to commence reporting against from 2026–27 onwards.



Program 3.1



Program 3.1: Access and Information

A transition will be occurring in 2025–26 to a Single Assessment System for aged care. The new system will provide a single assessment pathway for older people, so they do not have to change assessment providers as their needs change. The system will ensure access to assessments in regional, rural and remote areas and reduce wait times to access aged care assessment.

The implementation of this new program will instigate actions to improve data planning activities, to support strategic policy capability uplift and ongoing improvements in reporting capability.

Program Objective

To support access and assessments through My Aged Care and navigation supports. My Aged Care provides older people and their support networks with information about aged care services. Navigation services support vulnerable people to access aged care.

Key Activity 3.1A: Facilitate access to aged care services through My Aged Care and navigation services.⁸¹

This key activity aims to ensure older people, and their support networks have access to information about aged care services through My Aged Care. Navigation services additionally support vulnerable people who are not able to access aged care without this help.

Performance Measure 3.1A:

Older people and their support networks have access to information through My Aged Care.⁸²

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Website: ≥65%	a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Website: ≥65%	a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Website: ≥65%	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%	b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: >95%	b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: >95%	b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: >95%

⁸¹ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁸² This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements. The measure remains equivalent to the 2024–25 measure.

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. 55% to 59.9%.
 - b. 85% to 89.9%.

Planned Performance Rationale:

The website and 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.

Website: The ≥65% satisfaction target for the My Aged Care website is based on an assessment of the results from previous reporting years. The target provides a goal for the department to work towards in partnership with our digital supplier.

Contact Centre: The planned performance result increased from 90% as part of a range of measures aimed at meeting a higher expectation for customer satisfaction. The satisfaction level balances the desire for an enhancement to the level of customer satisfaction with a practicable and effective target. The target represents a very high level of service delivery and the high level of customer satisfaction with the Contact Centre.

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. 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. 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.1 – Access and Information – page 92.

Measure owner:

Access and Home Support Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective, key activity and performance measure.

Key Activity 3.1B: Facilitate access to aged care services: Eligibility/need assessments.

This key activity ensures timely and appropriate aged care assessments are aligned to the needs and goals of older people.

Performance Measure 3.1B:

Older people are assessed for service need.

Planned Performance

2025–26	2026–27	2027–28	2028–29
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. 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. 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. Home Support assessments completed within the allocated priority timeframes (≥90%): I. High priority: 10 calendar days II. Medium priority: 14 calendar days III. Low priority: 21 calendar days.
b. Comprehensive Community-based assessments completed within the allocated priority timeframes (≥90%): I. High priority: 10 calendar days II. Medium priority: 20 calendar days III. Low priority: 40 calendar days.	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. 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. 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.
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. 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. 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. 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.

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

- **Achieved:**

- a. Home Support assessments: $\geq 90\%$:
 - High priority: 10 calendar days
 - Medium priority: 14 calendar days
 - Low priority: 21 calendar days.
- b. Comprehensive Community-based assessments: $\geq 90\%$:
 - High priority: 10 calendar days
 - Medium priority: 20 calendar days
 - Low priority: 40 calendar days.
- c. Comprehensive Hospital-based assessments: $\geq 90\%$:
 - 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:**

70% to 79% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes.

Planned Performance Rationale:

The planned performance of 90% ensures clients receive timely assessments. External circumstances outside of the department's control (availability of representatives) can influence timeframes of assessments.

The target of $\geq 90\%$ is a contractual agreement with assessment organisations.

Data Source:

Data is logged by assessors in the My Aged Care system, stored in the Aged Care Data Warehouse (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-c), based on the referral acceptance date and the assessment completion date.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.1 – Access and Information – page 93.

Measure owner:

Access and Home Support Division.

Changes since 2024–25 Corporate Plan:

Revision to the key activity.

Program 3.2



Program 3.2: Aged Care Services

The new Support at Home program will replace the Home Care Packages Program and Short-Term Restorative Care Programme following the commencement of the new *Aged Care Act 2024*, while the Commonwealth Home Support Programme will transition no earlier than 1 July 2027. The new program is designed to enable services that help older people remain independent in their home and community for longer. Support at Home will fund approved providers to deliver services, products, equipment and home modifications so that older people can remain healthy, active and socially connected. The implementation of this new program will instigate actions to improve data planning activities, to support strategic policy capability uplift and ongoing improvements in reporting capability.

Program Objective

To provide support at home, residential care and respite care service programs for older people who require assistance.

Key Activity 3.2A: Enable the delivery of residential care and home care services that support older people.⁸³

This key activity aims to enable a range of flexible and individualised aged care services for older people who require assistance, including support at home, and residential care.

Performance Measure 3.2A:

Older people are treated with respect and dignity in receiving aged care services.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Increase the average Residents' Experience Survey (RES) Score for residential aged care homes by at least one percentage point from 2024–25.	Maintain or increase the average RES Score for residential aged care homes from the previous year's result.	Maintain or increase the average RES Score for residential aged care homes from the previous year's result.	Maintain or increase the average RES Score for residential aged care homes from the previous year's result.

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.

⁸³ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

Planned Performance Rationale:

The planned performance for 2025–26 aims to achieve an improvement in provider behaviour in response to the department's reform activities since 2022.

The performance result measures older peoples' experiences of residential aged care homes, including their perspectives on whether they are being cared for with respect and dignity. Success will be measured by steadily improving the average residents' experience survey score, as the sector matures in line with aged care reforms.

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.2 – Aged Care Services – pages 94–97.

Measure owner:

Quality and Assurance Division.

Changes since 2024–25 Corporate Plan:

Revision made to the program objective and key activity. Minor amendment made to the performance measure wording. The performance measure remains equivalent to the 2024–25 measure.

Key Activity 3.2B: Enable the delivery of residential care and home care services that support older people.⁸⁴

This key activity aims to enable a range of flexible and individualised aged care services for older people who require assistance, including support at home, and residential care.

Performance Measure 3.2B:

Older people receive residential care services that contribute to their quality of life.⁸⁵

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. Maintain or increase percentage of care recipients who completed the Quality of Life–Aged Care Consumers instrument (QOL-ACC)⁸⁶ 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. Maintain or increase 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. b. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by a RN per day. c. All 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. Maintain or increase 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. b. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by a RN per day. c. All 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. Maintain or increase 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. b. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by a RN per day. c. All 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.

⁸⁴ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁸⁵ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁸⁶ Further information on Quality of life – Aged Care Consumers (QOL-ACC) can be found at: www.qol-acc.org

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. Average percentage of reported hours an RN was on-site and on duty is between 98.00% and 99.99%.
 - **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 98.00%.
-

Planned Performance Rationale:

- a. QOL-ACC measures the quality of life of a resident in residential aged care. By establishing a baseline of the percentage of care recipients (or proxies on behalf of a care recipient) who complete a QOL-ACC survey and report 'good' or 'excellent' and then maintaining this, we are setting an expected performance that the number of care recipients (or proxies on behalf of a care recipient) who complete a QOL-ACC survey and report good or excellent quality of life will increase or be maintained.
- b. The initial 200 care minutes per resident per day was introduced as part of the Governments response to the Royal Commission into Aged Care Quality and Safety⁸⁷. In line with the Royal Commission's recommendations, the Government increased the care minutes to 215 minutes per resident per day in October 2024. The planned performance is set consistent with Government policy and legislation.
- c. The RN 24/7 measure was introduced as part of the Governments response to the Royal Commission into Aged Care Quality and Safety.

The Royal Commission found that there was a strong link between staffing levels, particularly nursing staffing levels, and aged care residents receiving quality care that meets their personal and clinical care needs. High quality care supports a high quality of life.

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 Aged Care Data Warehouse (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.
-

⁸⁷ Further information can be found at: www.royalcommission.gov.au/aged-care

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 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:

1. Summing the RN, EN and PCW 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.

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.2 – Aged Care Services – pages 94–97.

Measure owner:

Quality and Assurance / Residential Care Division.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity and performance measure. The performance measure remains equivalent to the 2024–25 measure.

Key Activity 3.2C: Enable the delivery of residential care and home care services that support older people.⁸⁸

This key activity aims to enable a range of flexible and individualised aged care services for older people who require assistance including support at home and residential care.

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.⁸⁹

Planned Performance

2025–25	2026–27	2027–28	2028–29
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%	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%	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%	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%	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%	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%	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%

⁸⁸ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁸⁹ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

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

- **Achieved:**
 - a. i. $\geq 2.7\%$.
 - ii. $\geq 1.3\%$.
 - b. $\geq 10.6\%$.
- **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. $\leq 2.2\%$.
 - ii. $\leq 1.0\%$.
 - b. $\leq 8.5\%$.

Planned Performance Rationale:

- a. The planned performance result assesses the output of activities in providing culturally safe and equitable care to older First Nations people with culturally diverse backgrounds and life experiences. Achieving the performance result demonstrates that departmental activities foster the environment in the aged care sector for which older First Nations people may best access and receive care that treats them with respect and dignity.

The planned performance is based on the current older population estimate from the Australian Bureau of Statistics (ABS) census data.⁹⁰

- b. The planned performance result assesses the output of activities providing culturally appropriate and safe care to older people in locations where they live, including those in rural and remote communities. The performance result measures the output of how many older people living in rural and remote areas are accessing care.
- The planned performance is based on the current older population estimate from the ABS census data. The department aims to ensure older people in rural and remote communities can access the care they are assessed as needing, regardless of where they live, to ensure they can stay close to their loved ones and communities for as long as possible.

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 Commonwealth Home Support Programme (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. Department of Social Services (DSS) Data Exchange (DEX) in the case of the Commonwealth Home Support Programme (CHSP))
 - the physical address of their provider as recorded in the Government Provider Management System (GPMS).

⁹⁰ Further information can be found at: www.abs.gov.au/statistics/people/population/population-census/latest-release

Methodology:

Client counts are first extracted from the Aged Care Data Warehouse (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 Home Care Packages; the Department of Social Services system 'Data Exchange' (DEX) for person- and episode-level attributes relating to recipients of basic support at home through the Commonwealth Home Support Programme (CHSP); the Government Provider Management System (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 First Nations (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 First Nations identity are 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 First Nations 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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.2 – Aged Care Services – pages 94–97.

Measure owner:

Market and Workforce Division.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity. Adjustments to the language of the 2024–25 performance measure have been made to reflect the terminology used in the new *Aged Care Act 2024*. The measure remains equivalent to the 2024–25 measure.

Key Activity 3.2D: Enable the delivery of residential care and home care services that support older people.⁹¹

This key activity aims to enable a range of flexible and individualised aged care services for older people who require assistance, including support at home, and residential care.

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.⁹²

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. 380,000	N/A ⁹³	N/A	N/A
b. 860,000			

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. 840,000 to 849,999.

Planned Performance Rationale:

This measure aims to ensure care and support that older people receive at home contributes to an improved quality of life. Success will be measured by the number of clients accessing the program nationally.

- a. The planned performance of 380,000 refers to the anticipated number of participants allocated a place in Support at Home. This includes both grandfathered Home Care Packages clients and new participants. This target is aligned with the projected demand for in-home aged care services in the community and a target wait time of 3 months to receive care by July 2027.⁹⁴

The target reflects the Government's commitment to how many Support at Home places will be allocated in the first year of the program. This enables the department to report its performance against the measure by assessing the output of its activities in contributing to older people receiving care in the home and remaining independent.

- b. The planned performance of 860,000 aligns to the 2024–25 performance target with the additional growth funding included in late 2024. The additional growth funding is to target an increase in service provision to assist approximately 20,000 new clients per annum. The funding is to be used in line with the *Aged Care Act 2024* from commencement, providing entry-level supports to assist older Australians to remain independent and living in their home. DEX performance and GPS funding data indicates that average client use being \$3,500 to \$3,750 per annum per client.

⁹¹ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁹² This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁹³ New performance measures for Commonwealth Home Support Program services (CHSP) and Support at Home will be developed as part of the 2026–27 Budget.

⁹⁴ The Support at Home is a new program for 2025–26. The department is undergoing a review to confirm how the approach to measuring this target and reporting performance will be determined. Future performance targets will be developed as part of the 2026–27 Budget.

Data Sources:

- a. Services Australia provides the main data source for billing and administrative data and is stored in the Aged Care Data Warehouse.

Data is drawn from Support at Home provider completed reports (Aged Care Financial Report, Quarterly Financial Report, and My Aged Care website).

- b. Department of Social Services' Data Exchange where provider service delivery is reported. Data is transferred to the department's Aged Care Data Warehouse.

Methodology:

- a. Data is extracted from the Aged Care Data Warehouse 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 Commonwealth Home Support Program (CHSP) sessions for a CHSP service in the given financial year.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.2 – Aged Care Services – pages 94–97.

Measure owner:

Access and Home Support Division.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity and performance measure.



Program 3.3



Program 3.3: Aged Care Quality

The Aged Care Quality and Safety Commission (ACQSC) is the national regulator of Commonwealth funded aged care services. It works with stakeholders to foster a world-class sector that safeguards the wellbeing and rights of older people in Australia, including approving providers to deliver Commonwealth-subsidised aged care services. The work of the ACQSC allows the department to have confidence that the providers it funds to deliver its aged care programs offer services that protect and enhance older people's safety, health and quality of life. The department will continue its engagement with the ACQSC and AIHW on data sharing and data improvement initiatives to support ongoing improvements in reporting capability.

Program Objective

To build and retain an aged care workforce to be available to meet the needs and rights of older people.

Key Activity 3.3A: Deliver programs that support the growth of the aged care workforce.⁹⁵

This key activity aims to ensure the aged care workforce is available, supported and appropriately skilled to support the aged care sector.

Performance Measure 3.3A:

Aged care workforce is available and appropriately skilled.⁹⁶

Planned Performance

2025–26	2026–27	2027–28	2028–29
Progressive decrease towards 25% or less for staff turnover in the aged care sector. ^{97, 98}	N/A ⁹⁹	N/A ¹⁰⁰	N/A ¹⁰¹

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.

⁹⁵ The key activity has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁹⁶ This performance measure has been amended since the release of the 2025–26 Portfolio Budget Statements.

⁹⁷ The planned performance target in 2025–26 has been updated to reflect a progressive decrease from the baseline figure in 2024–25.

⁹⁸ Data from the Aged Care Provider Workforce Survey is collected every 2 years and is used to determine the planned performance target for 2025–26.

⁹⁹ Forward year targets are not yet available for 2026–27 through to 2028–29 as a new measure using regular data updates will become available.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

Planned Performance Rationale:

The planned performance measures indicators of effectiveness in providing an appropriately skilled aged care workforce by surveying the workforce and monitoring staff turnover rates, including targets for workforce retention.

Retaining skilled aged care workers is critical to building a stable workforce that delivers continuous and high-quality care for older people. It also mitigates the risk of workforce shortages and benefits organisational succession planning and career development pathways for workers, which in turn can impact worker satisfaction. A stable and continuous workforce in aged care provides older people receiving care greater assurance that their needs and preferences will be met.

Data Source/s:

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.

Authority source:

Portfolio Budget Statements 2025–26, Outcome 3, Program 3.3 – Aged Care Quality – page 98.

Measure owner:

Market and Workforce Division.

Changes since 2024–25 Corporate Plan:

Revision made to the key activity and performance measure.

Outcome 4



Disability and Carers

Outcome 4: Disability and Carers

Supporting the independence of people with disability and carers by providing targeted supports.

Outcome 4 is delivered through the following programs:

Program 4.1: Disability and Carers

Program 4.2: National Disability Insurance Scheme



Program 4.1



Program 4.1: Disability and Carers

Program Objective

To support people with disabilities and carers to actively participate in community and economic life.

Key Activity 4.1A: Disability and Carer Support.

This key activity aims to provide assistance, support, and services for carers.

Performance Measure 4.1A:

Extent to which carers who are registered with Carer Gateway local service providers' wellbeing is assessed as improved.

Planned Performance

2025–26	2026–27	2027–28	2028–29
a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period.	a. As per 2025–26 b. As per 2025–26	a. As per 2025–26 b. As per 2025–26	a. As per 2025–26 b. As per 2025–26
b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.			

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

- **Achieved:**
 - a. $\geq 30\%$.
 - b. $\geq 35\%$.
- **Substantially achieved:**
 - a. N/A.
 - b. N/A.
- **Not achieved:**
 - a. $< 30\%$.
 - b. $< 35\%$.

Planned Performance Rationale:

Measuring the extent to which wellbeing of carers who are registered with Carer Gateway local service providers is assessed as improved aims to demonstrate the effectiveness of support for carers in relation to one of the long-term outcomes of the Integrated Carer Support Service (ICSS): improve carer wellbeing.

Targeting the proportion of carers registered with Carer Gateway who are assessed as having improved wellbeing demonstrates the effectiveness of the program activity in improving outcomes for carers. This is an ongoing measure with 2 targets:

- static target measuring the proportion of carers within the performance reporting period assessed as having improved wellbeing
- an increasing target in out-years for the proportion of all registered carers since the program commenced assessed as having improved wellbeing. This target recognises that improved carer wellbeing is a longer-term outcome. Reporting on the proportion of all registered carers with increased wellbeing on an annual basis also reflects an expectation of increasing levels of carer wellbeing as the program matures and carer uptake increases.

The 2 targets together will align with annual reporting timeframes by reporting on financial year, while also demonstrating the long-term outcome of carer wellbeing over time.

The targets will continue to be monitored and re-assessed over future years, as more wellbeing outcomes trend evidence becomes available. The target results that are currently set for future years are informed by trends to date.

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.

Authority source:

Department of Social Services Portfolio Budget Statements 2025–26 Outcome 3, Program 3.1 – Disability and Carers, page 59.

Measure owner:

Disability and Carer Programs.

Changes since 2024–25 Department of Social Services Corporate Plan:

No changes.

Key Activity 4.1B: Disability and Carer Support.

This key activity aims to provide assistance, support, and services for carers.

Performance Measure 4.1B:

Extent to which the evidence base is built for Australia's Disability Strategy 2021–2031 (ADS).

Planned Performance

2025–26	2026–27	2027–28	2028–29
The number of measures under the ADS Outcomes Framework with data reported is an increase on the previous reporting year.	Increase on previous year.	Increase on previous year.	Increase on previous year.

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.

Planned Performance Rationale:

Measuring the extent to which the evidence base is built for ADS aims to improve tracking of what is happening for people with disability over time and build an understanding of the effectiveness of ADS.

Increasing the number of measures under the ADS 2021–2031 Outcomes Framework relies on the department successfully leading efforts to build the evidence base for reporting progress for ADS. Reporting is available for 56 of the 85 measures as of 30 June 2025, and is found at Australia's Disability Strategy - Australian Institute of Health and Welfare¹⁰² (aihw.gov.au).

Data Source:

The data used for this performance measure is sourced by counting the number of measures on ADS Outcome Framework (ADS OF) webpages that have data available.

The department accesses the ADS OF measures from ADS Outcomes Framework.¹⁰³ 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 Outcomes Framework involves counting the outcomes measures that have data available at the end of the relevant financial year. The measure aims to increase transparency through increasing the number of ADS measures that are reported on above the 2023–24 baseline of 55 of the 85 measures.

A revised Data Improvement Plan was launched in December 2024 to improve the data needed to track progress against the ADS Outcomes Framework. The focus is on developing and collecting data on those measures (future measures) that are currently not being reported.

Authority source:

Department of Social Services Portfolio Budget Statements 2025–26 Outcome 3, Program 3.1 – Disability and Carers, page 59.

Measure owner:

Disability Reforms and Royal Commission.

Changes since 2024–25 Department of Social Services Corporate Plan:

No changes.

¹⁰² Reporting on Australia's Disability Strategy 2021–2031: www.aihw.gov.au/australias-disability-strategy

¹⁰³ Further information can be found at: www.aihw.gov.au/australias-disability-strategy

Program 4.2



Program 4.2: National Disability Insurance Scheme

Program Objective

To improve the wellbeing and social and economic participation of people with disability, and their families and carers, by building a NDIS that delivers individualised support through an insurance approach. This program also includes the Jobs and Market Fund.

Key Activity 4.2A: Sector Development Fund and Jobs and Market Fund.

Oversight of the NDIS Market is a shared responsibility of Commonwealth (the department, the NDIA and NDIS Quality and Safeguards Commission), state and territory governments. This key activity supports the department's role in activities that enable the continued functioning of the NDIS.

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.

Planned Performance

2025–26	2026–27	2027–28	2028–29
The department has advised on and/or delivered 8 market initiatives to develop the market and workforce.	a. As per 2025–26 b. As per 2025–26	a. As per 2025–26 b. As per 2025–26	a. As per 2025–26 b. As per 2025–26

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.

Planned Performance Rationale:

The department has a role in providing advice to government on ways to build a more responsive, supportive and sustainable market and workforce for provision of support to NDIS participants. Measuring effectiveness or impact can be challenging to connect policy development and advice to tangible impacts, especially on an open market environment, therefore the department is using a measure to assess effectiveness, advising on and/or delivering market initiatives, as this will show the department's role in building a more supportive and sustainable market and workforce for provision of support to NDIS participants.

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 Payments 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 management
- Integrated Care and Commissioning trials
- Pricing and payments regulatory framework development
- Ability First Australia Diploma of Leadership management.

Authority source:

Department of Social Services Portfolio Budget Statements 2025–26 Outcome 3, Program 3.2 – National Disability Insurance Scheme, page 61.

Measure owner:

NDIS Markets and Safeguards.

Changes since 2024–25 Department of Social Services Corporate Plan:

Revisions made to the wording of methodology and data source.

Key Activity 4.2B: NDIS Participant Plans.

This key activity assists in enabling the ongoing functioning of the NDIS.

Performance Measure 4.2B:

NDIS cost growth is sustainable.

Planned Performance

2025–26	2026–27	2027–28	2028–29
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.	Annual Scheme cost growth no more than 8%.	As per 2026–27	As per 2026–27

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 and subsequent years as reported in the Department of Social Services' 2025–26 Portfolio Budget Statements.¹⁰⁴

Planned Performance Rationale:

National Cabinet committed to an annual growth target in the total costs of the Scheme of no more than 8% by 1 July 2026. Ensuring Scheme cost growth of no more than 8% per annum contributes to the sustainability of the NDIS, ensuring it can continue to provide life-changing support to future generations of Australians with significant or permanent disability.

The 8% target represents effective actions undertaken (following NDIS Review) to see a decline in the Scheme's annual growth and greater sustainability into the future.

Data Source:

Projected scheme costs for 2026–27 as obtained from the Department of Social Service's Portfolio Budget Statements.

Methodology:

In 2024–25 and 2025–26 the department will report against projected scheme costs for 2026–27 and subsequent years as reported in the Department of Social Services Portfolio Budget Statements. Tracking projected Scheme costs for 2026–27 and subsequent years across the years will show if the 8% target is still expected to be met.

Authority source:

Department of Social Services Portfolio Budget Statements 2025–26 Outcome 3, Program 3.2 – National Disability Insurance Scheme, page 62.

Measure owner:

NDIS Participants and Performance.

Changes since 2024–25 Department of Social Services Corporate Plan:

Updates in wording but no material difference to the planned performance.

¹⁰⁴ Available at: www.dss.gov.au/budget-and-additional-estimates-statements/budget-2025-26

Key Activity 4.2C: NDIS Participant Plans.

This key activity assists in enabling the ongoing functioning of the NDIS.

Performance Measure 4.2C:

Legislative amendments developed for Government.

Planned Performance

2025–26	2026–27	2027–28	2028–29
Criterion is met if 3 of the 3 progress milestones are delivered.	Participants transition to new framework planning and access reform enables diversion of children to foundational supports.	As per 2026–27	As per 2026–27

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.

Planned Performance Rationale:

This performance measure has been chosen to reflect the department's progress implementing legislative reform in response to the NDIS Review.

The NDIS Review recommended a range of changes to NDIS access and budget-setting that required significant legislative amendments. NDIS reforms will support the government in achieving the annual growth target agreed by National Cabinet on 28 April 2023. The annual growth target aims to limit annual growth in total costs of the Scheme to no more than 8% by 1 July 2026 and continue to moderate as the Scheme matures.

On 6 December 2023, the National Cabinet agreed to introduce legislation and other changes to the NDIS in the first half of 2024 to improve the experience of participants and restore the original intent of the Scheme to support people with permanent and significant disability. This agreement supports the long-term effectiveness of measure 4.2C to deliver on the annual growth target.

The National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No.1) Act 2024 commenced on 3 October 2024. It establishes a legislative framework for a range of reforms to access and budget setting, including a flexible budget based on a holistic needs assessment. It also enabled rules to be made to implement changes to the current planning framework including funding periods and NDIS support lists.

Other NDIS Rules are being developed progressively, and in consultation with people with disability, their families and carers, disability sector and states and territories as key stakeholders in the co-governance of the Scheme.

Data Source:

Actual expenditure figures from the Central Budget Management System (CBMS).

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.

Authority source:

Department of Social Services Portfolio Budget Statements 2025–26 Outcome 3, Program 3.2 – National Disability Insurance Scheme, page 62.

Measure owner:

NDIS Participants and Performance.

Changes since 2024–25 Department of Social Services Corporate Plan:

Primary legislative amendments have been completed.

List of Requirements

The Corporate Plan has been prepared in accordance with the requirements of subsection 35(1) of the *Public Governance, Performance and Accountability (PGPA) Act 2013* and the PGPA Rule 2014.

This table details the requirements met by the Department of Health, Disability and Ageing Corporate Plan 2025–26 and the section references for each requirement.

Topic	Requirements	Sections
Introduction	- A statement that the plan is prepared for paragraph 35(1)(b) of the Act. - The reporting period for which the plan is prepared. - The reporting periods covered by the plan.	Secretary's Foreword
Purposes	The purposes of the entity.	Our Purpose
Key activities	For the entire period covered by the plan, the key activities that the entity will undertake to achieve its purposes.	Outcome 1 Outcome 2 Outcome 3 Outcome 4
Operating context	- The environment in which the entity will operate. - The strategies and plans the entity will implement to have the capability it needs to undertake its key activities and achieve its purposes. - A summary of the risk oversight and management systems of the entity, and the key risks that the entity will manage and how those risks will be managed. - Details of any organisation or body that will make a significant contribution towards achieving the entity's purposes through cooperation with the entity, including how that cooperation will help achieve those purposes. - How any subsidiary of the entity will contribute to achieving the entity's purposes.	Secretary's Foreword Our Partners Our Operating Context Our Regulatory Approach Corporate Governance and Risk Oversight Our Capability Our Performance Framework Outcome 1 Outcome 2 Outcome 3 Outcome 4 The department has no subsidiaries
Performance	- Specified performance measures for the entity that meet the requirements of section 16EA. - Specified targets for each of those performance measures for which it is reasonably practicable to set a target.	Our Performance Outcome 1 Outcome 2 Outcome 3 Outcome 4

